

BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the First Amended  
Accusation Against:

Sarah Ash Combs, M.D.

Physician's and Surgeon's  
Certificate No. A 125860

Respondent.

Case No.: 800-2020-067207

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 14, 2022.

IT IS SO ORDERED: September 14, 2022.

MEDICAL BOARD OF CALIFORNIA



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Laurie Rose Lubiano, J.D., Chair  
Panel A

1 ROB BONTA  
Attorney General of California  
2 ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General  
3 ROSEMARY F. LUZON  
Deputy Attorney General  
4 State Bar No. 221544  
600 West Broadway, Suite 1800  
5 San Diego, CA 92101  
P.O. Box 85266  
6 San Diego, CA 92186-5266  
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7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

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10 **BEFORE THE**  
11 **MEDICAL BOARD OF CALIFORNIA**  
12 **DEPARTMENT OF CONSUMER AFFAIRS**  
13 **STATE OF CALIFORNIA**

13 In the Matter of the First Amended Accusation  
14 Against:

15 **SARAH ASH COMBS, M.D.**  
16 **3700 10th Avenue, Apt. 3H**  
**San Diego, CA 92103**

17 **Physician's and Surgeon's Certificate**  
18 **No. A 125860,**

19 Respondent.

Case No. 800-2020-067207

OAH No. 2021100901

**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

20  
21 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-  
22 entitled proceedings that the following matters are true:

23 **PARTIES**

24 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of  
25 California (Board). He brought this action solely in his official capacity and is represented in this  
26 matter by Rob Bonta, Attorney General of the State of California, by Rosemary F. Luzon, Deputy  
27 Attorney General.

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1 and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of  
2 licensure in the State of California, if any. Following the completion of each course, the Board or  
3 its designee may administer an examination to test Respondent's knowledge of the course.  
4 Respondent shall provide proof of attendance for 40 hours of CME in satisfaction of this  
5 condition.

6 3. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby  
7 ordered to reimburse the Board its costs of investigation and enforcement in the amount of  
8 \$7,887.50 (seven thousand eight hundred eighty-seven dollars and fifty cents). Costs shall be  
9 payable to the Medical Board of California. Failure to pay such costs shall be considered a  
10 violation of this Order.

11 Any and all requests for a payment plan shall be submitted in writing by Respondent to the  
12 Board.

13 The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility  
14 to repay investigation and enforcement costs.

15 4. FAILURE TO COMPLY. Any failure by Respondent to comply with the terms and  
16 conditions of the Disciplinary Order set forth above shall constitute unprofessional conduct and  
17 grounds for further disciplinary action.

18 5. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for  
19 a new license or certification, or petition for reinstatement of a license, by any other health care  
20 licensing action agency in the State of California, all of the charges and allegations contained in  
21 First Amended Accusation No. 800-2020-067207 shall be deemed to be true, correct, and  
22 admitted by Respondent for the purpose of any Statement of Issues or any other proceeding  
23 seeking to deny or restrict license in the State of California.

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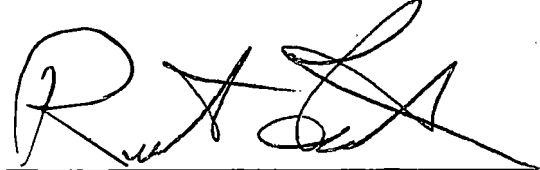
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**ACCEPTANCE**

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert W. Frank, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 125860. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

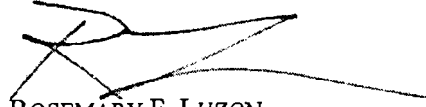
DATED: June 15, 2022   
SARAH ASH COMBS, M.D.  
*Respondent*

I have read and fully discussed with Respondent Sarah Ash Combs, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6-15-22   
ROBERT W. FRANK, ESQ.  
*Attorney for Respondent*

**ENDORSEMENT**

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 6/15/22 Respectfully submitted,  
ROB BONTA  
Attorney General of California  
ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General  
  
ROSEMARY F. LUZON  
Deputy Attorney General  
*Attorneys for Complainant*

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**Exhibit A**

**First Amended Accusation No. 800-2020-067207**



1 ROB BONTA  
Attorney General of California  
2 ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General  
3 ROSEMARY F. LUZON  
Deputy Attorney General  
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8 *Attorneys for Complainant*

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**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

In the Matter of the First Amended Accusation  
Against:  
**SARAH ASH COMBS, M.D.**  
3700 10th Avenue, Apt. 3H  
San Diego, CA 92103  
**Physician's and Surgeon's Certificate**  
No. A 125860,  
  
Respondent.

Case No. 800-2020-067207  
**FIRST AMENDED ACCUSATION**

Complainant alleges:

**PARTIES**

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).
2. On or about May 22, 2013, the Medical Board issued Physician's and Surgeon's Certificate No. A 125860 to Sarah Ash Combs, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on December 31, 2016, and has not been renewed.

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JURISDICTION

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3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . .

5. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

...

6. Section 2234 of the Code states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

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(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

...

7. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

8. Section 118 of the Code states:

...

(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

...

**COST RECOVERY**

9. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

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1 (c) A certified copy of the actual costs, or a good faith estimate of costs where  
2 actual costs are not available, signed by the entity bringing the proceeding or its  
3 designated representative shall be prima facie evidence of reasonable costs of  
4 investigation and prosecution of the case. The costs shall include the amount of  
5 investigative and enforcement costs up to the date of the hearing, including, but not  
6 limited to, charges imposed by the Attorney General.

7 (d) The administrative law judge shall make a proposed finding of the amount  
8 of reasonable costs of investigation and prosecution of the case when requested  
9 pursuant to subdivision (a). The finding of the administrative law judge with regard  
10 to costs shall not be reviewable by the board to increase the cost award. The board  
11 may reduce or eliminate the cost award, or remand to the administrative law judge if  
12 the proposed decision fails to make a finding on costs requested pursuant to  
13 subdivision (a).

14 (e) If an order for recovery of costs is made and timely payment is not made as  
15 directed in the board's decision, the board may enforce the order for repayment in any  
16 appropriate court. This right of enforcement shall be in addition to any other rights  
17 the board may have as to any licensee to pay costs.

18 (f) In any action for recovery of costs, proof of the board's decision shall be  
19 conclusive proof of the validity of the order of payment and the terms for payment.

20 (g) (1) Except as provided in paragraph (2), the board shall not renew or  
21 reinstate the license of any licensee who has failed to pay all of the costs ordered  
22 under this section.

23 (2) Notwithstanding paragraph (1), the board may, in its discretion,  
24 conditionally renew or reinstate for a maximum of one year the license of any  
25 licensee who demonstrates financial hardship and who enters into a formal agreement  
26 with the board to reimburse the board within that one-year period for the unpaid  
27 costs.

28 (h) All costs recovered under this section shall be considered a reimbursement  
for costs incurred and shall be deposited in the fund of the board recovering the costs  
to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of  
the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in  
that board's licensing act provides for recovery of costs in an administrative  
disciplinary proceeding.

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 10. Respondent has subjected her Physician's and Surgeon's Certificate No. A 125860 to  
4 disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of  
5 the Code, in that she committed repeated negligent acts in her care and treatment of Patient A, as  
6 more particularly alleged hereinafter:<sup>1</sup>

7 11. On or about the night of January 6, 2016, Patient A, who was a teenager, presented at  
8 the emergency department of Rady Children's Hospital in San Diego, California. According to  
9 Patient A's father, Patient A had intentionally ingested seven tablets of Midol and 10 tablets of  
10 iron approximately one and a half hours prior to arrival.

11 12. At the time, Respondent was a board-certified pediatrician and in training for her  
12 subspecialty fellowship in pediatric emergency medicine. Respondent provided care and  
13 treatment to Patient A, alongside Dr. S.L., her direct supervisor.

14 13. Upon arrival at the emergency department, Patient A complained of dizziness,  
15 nausea, and vomiting. Patient A was ordered ondansetron for her dizziness and nausea at  
16 approximately 23:39, followed by a fluid bolus approximately two and a half hours later.

17 14. Patient A's vital signs were taken, showing a heart rate of 133 beats per minute,  
18 which was markedly tachycardic. An EKG also showed a heart rate of 108 beats per minute.  
19 However, Patient A's cardiovascular status was noted on the physical exam as follows: "Normal  
20 rate, regular rhythm and normal heart sounds."

21 15. According to the ED Provider Notes, lab tests were to be ordered, including an iron  
22 level test. However, on or about January 7, 2016, at approximately 01:55, a ferritin level test was  
23 erroneously ordered, not an iron level test.<sup>2</sup> The lab results reported the findings for "Ferritin,"  
24 which were received at approximately 02:57. According to the lab results, the ferritin test showed

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<sup>1</sup> References to "Patient A" herein are used to protect patient privacy.

26 <sup>2</sup> Ferritin is a protein that stores iron inside the cells. A ferritin test measures the level of  
27 ferritin in the body. Ferritin levels indicate the amount of stored iron, but they do not measure the  
28 iron outside of the cells. An iron test, in contrast, measures the amount of iron in the blood.  
After a suspected overdose of iron, a serum iron level is the most appropriate test to order to  
assess for acute toxicity.

1 a level of "8" ng/mL, with a reference range of 6-70 ng/mL. There were no lab results for iron.  
2 Nevertheless, the ED Provider Notes stated: "Labs as per below, grossly WNL . . . Iron well  
3 below threshold." The Plan and Discharge Instructions further stated: "Your iron level here was  
4 normal."

5 16. At approximately 04:00 on or about January 7, 2016, Patient A complained of  
6 additional nausea to the ED nurse. At approximately 04:02, an additional dose of ondansetron  
7 was ordered, which was administered at 04:07. Approximately one hour later, Patient A was  
8 discharged home, with the last physician re-assessment occurring at approximately 04:12. Prior  
9 to discharge, there was no assessment done and no documentation made as to the etiology of  
10 Patient A's continuing nausea and whether or not it would persist.

11 17. Following discharge, Patient A subsequently developed severe abdominal and chest  
12 pain and returned to the emergency department later the same day. Patient A's lab results showed  
13 a hemoglobin of 11.1 g/dL. Patient A was found to be in fulminant liver failure due to iron  
14 overdose and required an emergency liver transplant.

15 18. On or about January 14, 2021, Respondent was interviewed in connection with the  
16 Board's investigation regarding her care and treatment of Patient A. Respondent stated that she  
17 intended to order a total body iron test for Patient A, not a ferritin test. When placing the order,  
18 Respondent explained that she typed the word "iron" into the electronic medical record system.  
19 According to Respondent, the system automatically defaulted to "ferritin" and, as a result, a  
20 ferritin test was ordered instead of an iron test. However, the lab test options that appeared on the  
21 screen were actually as follows, from top to bottom:

22 FERRITIN (IRON)

23 IRON

24 IRON + TIBC

25 Despite "IRON" appearing on the screen, the test for iron was not ordered.

26 19. At her Board interview, Respondent further stated that when she reviewed the labs,  
27 the results appeared as either "ferritin paren iron" or "iron paren ferritin." Despite the word  
28 "ferritin" appearing on the results, Respondent stated she expected that the results were

1 measuring what she thought she had ordered (*i.e.*, an iron level), so she “glanced past it, as you  
2 often do in the emergency room, [and] saw a normal level . . .” According to Respondent, she  
3 presumed that the result would likely be normal given the amount of iron tablets that Patient A  
4 had reportedly ingested.

5 20. Respondent committed repeated negligent acts in her care and treatment of Patient A,  
6 which included, but were not limited to the following:

7 (i) Respondent failed to order the correct test to assess for acute iron toxicity  
8 and she failed to appropriately review and interpret the test results received;

9 (ii) Respondent failed to properly assess and document the etiology of Patient  
10 A’s continuing nausea and whether or not the patient’s nausea would persist; and

11 (iii) Respondent failed to properly document Patient A’s tachycardia.

12 **SECOND CAUSE FOR DISCIPLINE**

13 **(Failure to Maintain Adequate and Accurate Medical Records)**

14 21. Respondent has subjected her Physician’s and Surgeon’s Certificate No. A 125860 to  
15 disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that  
16 she failed to maintain adequate and accurate records regarding her care and treatment of Patient  
17 A, as more particularly alleged in paragraphs 10 through 20, above, which are hereby  
18 incorporated by reference and re-alleged as if fully set forth herein.

19 **PRAYER**

20 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
21 and that following the hearing, the Medical Board of California issue a decision:

22 1. Revoking or suspending Physician’s and Surgeon’s Certificate No. A 125860, issued  
23 to Respondent Sarah Ash Combs, M.D.;

24 2. Revoking, suspending or denying approval of Respondent Sarah Ash Combs, M.D.’s  
25 authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced  
26 practice nurses;

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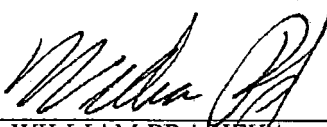
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3. Ordering Respondent Sarah Ash Combs, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: MAR 03 2022

  
\_\_\_\_\_  
WILLIAM PRASIFKA  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

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