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

In the Matter of the Accusation Against: Virginia Joyce Griswold, M.D. Physician's and Surgeon's Certificate No. A 41281 Respondent.	Case No. 800-2020-064781

DECISION

The attached Stipulated Surrender of License and 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 March 16, 2023.

IT IS SO ORDERED March 9, 2023.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Interim Executive Director

ROB BONTA
Attorney General of California
GREG W. CHAMBERS
Supervising Deputy Attorney General
HARRIET NEWMAN
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **VIRGINIA JOYCE GRISWOLD, M.D.** **24 Alviso St.** **San Francisco CA 94127-2841** **Physician's and Surgeon's Certificate** **No. A 41281** Respondent	Case No. 800-2020-064781 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Interim Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Harriet Newman, Deputy Attorney General.

2. VIRGINIA JOYCE GRISWOLD, M.D. (Respondent) is represented in this proceeding by attorney Shannon V. Baker, whose address is: 765 University Avenue, Sacramento, CA 95825.

3. On October 15, 1984, the Board issued Physician and Surgeon's Certificate No. A 41281 to Respondent. The Physician and Surgeon's Certificate expired on February 28, 2022, and has not been renewed.

JURISDICTION

4. Accusation No. 800-2020-064781 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 22, 2022. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2020-064781 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2020-064781. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegation in Accusation No. 800-2020-064781, if proven at hearing, constitute cause for imposing discipline upon her Physician and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual

basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent believes she could present evidence disputing the factual basis for the charges in the Accusation, but she herby gives up her right to contest that cause for discipline exists based on those charges as she has retired from the practice of medicine.

10. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Physician and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw this agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13, This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician and Surgeon's Certificate No. A 41281, issued to Respondent VIRGINIA JOYCE GRISWOLD, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2020-064781 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement, in the amount of $5556 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2020-064781 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Shannon V. Baker. I understand the stipulation and the effect it will have on my Physician and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: March 5 2023

VIRGINIA JOYCE GRISWOLD, M.D.
Respondent

I have read and fully discussed with Respondent VIRGINIA JOYCE GRISWOLD, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: March 6, 2023

SHANNON V. BAKER
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 3/1/23

Respectfully submitted,

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

Harriet Newman

HARRIET NEWMAN
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2020-064781

ROB BONTA
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **VIRGINIA JOYCE GRISWOLD, M.D.** **24 Alviso St.** **San Francisco CA 94127-2841** **Physician's and Surgeon's Certificate No. A 41281,** Respondent.	Case No. 800-2020-064781 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On October 15, 1984, the Board issued Physician's and Surgeon's Certificate Number A 41281 to Virginia Joyce Griswold, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on February 28, 2022, and has not been renewed.

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JURISDICTION

3. This 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 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

STATUTORY AND REGULATORY PROVISIONS

5. 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:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(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.

(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.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2226 of the Code states: the failure to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTS

8. At all times relevant, Respondent practiced medicine as a licensed physician specializing in nuclear and diagnostic radiology. On around March 26, 2018, her employer initiated an investigation into her practice, based on issues of judgment and/or technical skill in a number of cases in which she provided medical care and services. On around July 1, 2019, her employer revoked her clinical privileges based on the following: failure to report issues, reporting issues where none exists, and unnecessary radiological follow-up.

PATIENT 1[1]

9. On March 29, 2018, Patient 1, an 81-year-old obese male with a history of melanoma[2] and new lung lesions presented to the radiology department (department) for an

[1] The patients are designated as Patients 1 through 6 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

[2] Melanoma is the most serious type of skin cancer. It develops in the cells (melanocytes) that produce melanin — the pigment that gives skin its color.

ultrasound guided left axillary node[3] biopsy. None of the ultrasound images Respondent generated showed appropriate needle position or even showed the needle in the field of view. Respondent made multiple unsuccessful attempts at a node biopsy using suboptimal techniques including angle of needle placement.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligence)

10. Respondent is subject to disciplinary action under sections 2234(b) [gross negligence] and (c) [repeated negligence] in that her care and treatment of Patient 1 included repeated gross negligence and repeated negligent acts. The circumstances are as follows:

11. The allegations in paragraph 9 are incorporated herein as if set out in full.

12. The applicable radiology standard of care is to obtain ultrasound images demonstrating the full length of the needle after each biopsy attempt to show appropriate needle positioning and technique relative to the lesion of interest as part of documentation.

12. The inappropriate needle position and technique as shown in the Computer Tomography (CT) images of the procedure comprise negligent acts and/or gross negligence.

13. Respondent's failure to note in the records that she did not have appropriate needle position and technique comprises inadequate record keeping.

PATIENT 2

14. On March 12, 2018, Patient 2, an 82-year-old male, presented to the department for a Low-Dose CT Cancer Screening examination. A CT image showed a mass highly suspicious for either primary lung malignancy or metastasis. Respondent failed to identify a suspicious right lung mass on the radiology interpretation report.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligence)

15. Respondent is subject to disciplinary action under sections 2234(b) [gross negligence] and (c) repeated negligence of the Code, in that her care and treatment of Patient 2 included gross negligence and/or repeated negligent acts. The circumstances are as follows:

[3] Axillary nodes are collections of tissue located in the underarm area.

16. The allegations in paragraph 14 are incorporated herein as if set out in full.

17. The failure to identify a suspicious right lung mass on the radiology interpretation report constitutes negligent acts and/or gross negligence.

18. Respondent's failure to note a lung mass comprises inadequate record keeping.

PATIENT 3

19. On March 13, 2018, Patient 3, a 92-year old male with left hip pain after a fall presented to the department for an MRI of his pelvis and left hip. The MRI image demonstrated at least four fractures: large left sacral[4], left superior pubic ramus, left inferior pubic ramus[5] and left parasymphyseal[6] fracture. The standard of care for MRI hip interpretation is to identify all fractures in a patient with a recent fall. Respondent failed to identify the majority of fractures on the radiology interpretation report.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligence)

20. Respondent is subject to disciplinary action under sections 2234(b) [gross negligence] and (c) [repeated negligence] of the Code, in that her care and treatment of Patient 3 included gross negligence and/or repeated negligent acts. The circumstances are as follows:

21. The allegations in paragraph 19 are incorporated herein as if set out in full.

22. The failure to identify all fractures on the radiology report of a patient with a recent fall constitutes negligent acts and/or gross negligence.

23. Respondent's failure to note all fractures in the records comprises inadequate record-keeping.

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[4] Sacral is of or near the sacrum. The sacrum is a single bone comprised of five separate vertebrae that fuse during adulthood. It forms the foundation of the lower back and the pelvis.

[5] What we commonly call our "hip bones" are actually each three separate bones: the pubis, the ischium, and the ilium. The pubis itself is made up of two smaller bones: the superior ramus and the inferior ramus.

[6] Parasymphyseal insufficiency fractures are a subtype of pelvic insufficiency fracture. Insufficiency fracture is a subgroup of stress fracture caused by normal or physiologic stress upon weakened bone. Pelvic insufficiency fractures are among the most common insufficiency fractures that occur in patients with osteoporosis.

PATIENT 4

24. On April 4, 2018, Patient 4, a 36-year-old male presented to the department for a chest x-ray to evaluate for severe pain. Respondent failed to identify a medium sized pneumothorax[7] when she interpreted the x-ray.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligence)

25. Respondent is subject to disciplinary action under sections 2234(b) [gross negligence] and (c) [repeated negligence] of the Code, in that her care and treatment of Patient 4 including gross negligence and/or repeated negligent acts. The circumstances are as follows:

26. The allegations in paragraph 24 are incorporated herein as if set out in full.

27. The failure to identify a collapsed lung upon reading the x-ray constitutes negligent acts and/or gross negligence.

28. Respondent's failure to note the collapsed lung in the records comprises inadequate record keeping.

PATIENT 5

29. On April 6, 2018, Patient 5, a 72-year-old male with a history of hepatocellular carcinoma[8], abdominal pain and lung nodule[9] presented to the department for multiphasic Liver Computed Tomography. The patient's clinical history suggested a concern of portal vein thrombosis.[10] Respondent failed to identify portal vein thrombosis on the x-rays.

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[7] A pneumothoraxis a collapsed lung. A pneumothorax occurs when air leaks into the space between your lung and chest wall. This air pushes on the outside of your lung and makes it collapse. A pneumothorax can be a complete lung collapse or a collapse of only a portion of the lung.

[8] Hepatocellular carcinoma is the most common type of liver cancer in adults.

[9] A lung nodule (or mass) is a small abnormal area that is sometimes found during a CT scan of the chest.

[10] Portal vein thrombosis is a vascular disease of the liver that occurs when a blood clot occurs in the hepatic portal vein, which can lead to increased pressure in the portal vein system and reduced blood supply to the liver.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligence)

30. Respondent is subject to disciplinary action under sections 2234(b) [gross negligence] and (c) [repeated negligence] of the Code, in that her care and treatment of Patient 5 included gross negligence and/or repeated negligent acts. The circumstances are as follows:

31. The allegations in paragraph 29 are incorporated herein as if set out in full.

32. The failure to identify the diseased liver on the image constitutes negligent acts and/or gross negligence.

33. Respondent's failure to note the existence of the diseased liver in the records comprises inadequate record keeping.

PATIENT 6

34. On May 9, 2018, Patient 6, a 50-year-old male with a history of right hip/groin pain presented to the department for a non-contrast MRI of the right hip. Respondent failed to identify a right labrum[11] tear, which explained Patient 6's symptoms of hip pain.

35. Respondent failed to clearly delineate in the records the right labrum tear.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligence)

36. Respondent is subject to disciplinary action under sections 2234(b) [gross negligence] and (c) [repeated negligence] of the Code, in that her care and treatment of Patient 6 included gross negligence and/or repeated negligent acts. The circumstances are as follows:

37. The allegations in paragraphs 34 and 35 are incorporated herein as if set out in full.

38. The failure to identify a labium tear on the image as the cause of Patient 6's pain constitutes gross negligence and/or repeated negligence.

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[11] The labrum is made of thick fibrocartilage that lines the hip socket, sealing and stabilizing the bones of the hip joint.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

39. The allegations in paragraphs 13, 19, 23, 28, 33, and 35 are incorporated herein as if set out in full.

40. Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of Patients 1 through 6.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 41281, issued to Virginia Joyce Griswold, M.D.;

2. Revoking, suspending or denying approval of Virginia Joyce Griswold, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Virginia Joyce Griswold, 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: DEC 22 2022

Reji Varghese
Deputy Director

for WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant