

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

In the Matter of the Accusation
Against:

Timothy James Marten, M.D.

Physician's and Surgeon's
Certificate No. G 52421

Respondent.

Case No. 800-2020-065658

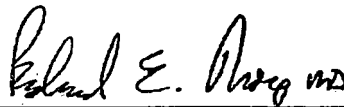
DECISION

The attached Proposed Decision 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 April 15, 2024.

IT IS SO ORDERED March 15, 2024.

MEDICAL BOARD OF CALIFORNIA



Richard E. Thorp, M.D. , Chair
Panel B

**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the Accusation Against:

**TIMOTHY JAMES MARTEN, M.D.,
Physician's and Surgeon's Certificate No. G 52421**

Respondent.

Agency Case No. 800-2020-065658

OAH No. 2023050031

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on January 4, 5, 8, and 11, 2024, by videoconference.

Deputy Attorney General Jason J. Ahn appeared representing complainant Reji Varghese, Executive Director of the Medical Board of California.

Attorney Elisabeth A. Madden appeared representing respondent Timothy James Marten, M.D., who also was present throughout the hearing.

The matter was submitted for decision on January 11, 2024.

FACTUAL FINDINGS

1. The Medical Board of California issued Physician's and Surgeon's Certificate No. G 52421 to respondent Timothy James Marten, M.D., on May 29, 1984. At the time of the hearing, this certificate was active and was scheduled to expire on January 31, 2024.

2. On March 8, 2023, acting in his official capacity as then-Interim Executive Director of the Board, complainant Reji Varghese filed an accusation against respondent. Complainant seeks disciplinary action based on allegations that respondent committed unprofessional conduct with respect to a surgical procedure and its follow-up on a single patient. Respondent requested a hearing.

Professional Experience

3. Respondent graduated from medical school in 1982. After a one-year internship, he completed a four-year residency in general surgery followed by a two-year residency in plastic surgery.

4. Following his residencies, respondent completed three fellowships over the next eighteen months, training him specifically in aesthetic plastic surgery. Respondent is certified by the American Board of Plastic Surgery.

5. Respondent has been in solo private practice in San Francisco since 1990. He has a clinic space with examination and consultation rooms, and an adjacent accredited outpatient surgery suite. Respondent shares this office and surgery space, and some employees, but not patients, with another plastic surgeon.

6. For the past approximately 25 years, respondent's practice has emphasized surgical and non-surgical procedures to "rejuvenate the aging face." He publishes and lectures regularly on this topic, and has written several textbook chapters. Respondent estimates that he has performed between 2,000 and 3,000 facelift procedures during his career. This matter is his first Board disciplinary matter.

Surgery and Follow-Up for Patient A

7. Patient A, a physician with experience performing outpatient surgeries, contacted respondent in early 2017 regarding facial cosmetic surgery. Patient A lived in San Diego, but was willing to travel to San Francisco to see respondent because a friend had recommended him highly.

PRE-SURGERY CONSULTATION AND PREPARATION

8. Respondent met Patient A in his office on March 30, 2017. They discussed her interest in surgery, and respondent evaluated Patient A's face and neck. A staff member took photographs of Patient A, and respondent used them to illustrate to Patient A how surgery might address her concerns and to discuss non-surgical alternatives. Patient A also completed a short document summarizing her health status, smoking history, medications, and known allergies.

9. Patient A decided that day to have respondent perform several aesthetic surgical procedures on her face and neck. She paid a deposit, and scheduled: (1) a pre-operative telephone consultation on Wednesday, April 5, 2017; (2) surgery on Wednesday, April 19, 2017; (3) a first post-operative suture removal office visit for Monday, April 24, 2017; and (4) a second post-operative suture removal office visit for Wednesday, April 26, 2017. She left with a document listing these appointments, and telling her as well that she might have a third post-operative office visit "for

[respondent] to evaluate you before you leave San Francisco.” The document also warned Patient A that each suture removal office visit was likely to last about an hour.

10. Helen Sung, R.N., interviewed Patient A by telephone on April 5, 2017. Before or during this conversation, Patient A completed a health history questionnaire with much more detail than the brief history she had provided on March 30; she later sent it to respondent’s office. Sung discussed some of the health history issues with Patient A, and also counseled Patient A about preparing for, undergoing, and recovering from surgery.

11. Patient A arranged for one of her primary care providers to send records to respondent’s office regarding a physical examination of Patient A in February 2017, and regarding laboratory blood tests she had undergone that month. Patient A also asked one of her primary care providers to perform an electrocardiogram and to send the results to respondent. The provider did so on April 4, 2017, noting that Patient A was “cleared for surgery.”

12. Patient A saw respondent again on April 18, 2017, to finalize her surgical plan and cover her outstanding questions.

13. Before her surgery, Patient A received several pre-printed documents describing in detail how to prepare for surgery and what to expect from surgery. The document describing what to expect from facelift surgery lists, as an “inherent risk” of such surgery, the possibility that “ear plug insertion” may cause “earwax impaction, injury to ear canal or ear drum etc.” This statement is the only reference in these documents to ear protection. The pre-printed disclosures do not state that respondent might choose purposely to send a patient home with sponges or similar absorbent material in the patient’s ear canals.

14. Documents in evidence from respondent's records regarding Patient A refer to a booklet with comprehensive instructions regarding post-operative home care. Patient A received this booklet, but it was not in evidence. She testified credibly that she read the booklet carefully but does not recall its mentioning that she might leave surgery with sponges in her ear canals, which someone would need to remove later if they did not simply fall out.

SURGERY ON APRIL 19, 2017

15. Before starting Patient A's surgery, respondent dictated a "pre-procedure note." It states that he reviewed Patient A's health history and her recent laboratory results and examination notes, and confirmed with Patient A that her health status had not changed. Patient A confirmed in testimony that she and respondent discussed her health history and the surgical plans in the morning before her surgery.

16. After Patient A met with respondent in the early morning on April 19, respondent introduced Patient A to the anesthesiologist (Andrew Infosino, M.D.). Dr. Infosino performed a physical examination of Patient A and discussed her health briefly with her.

17. After Patient A was unconscious under anesthesia, but before beginning surgery, respondent placed a small absorbent sponge in each of her external ear canals. He used forceps to place the sponges in the outer third of the ear canal, where they would not be easily visible to someone looking at Patient A's external ears. The sponges respondent used come in sterile packages of five, and each sponge has a radio-opaque thread in it to make it visible on X-ray. Respondent uses such sponges regularly during facelift surgeries, to prevent blood or irrigation fluid from running into the ear canals and causing later obstruction, dizziness, or pain.

18. In the vast majority of facelift surgeries respondent performs, he removes the patient's ear sponges before sending the patient to the surgical recovery room. Occasionally, however, respondent elects to leave the sponges in place, to continue protecting the patient's external ear canal from blood or fluid during the post-surgical period. Respondent testified that he has chosen to leave absorbent ear sponges in place after facelift surgery fewer than 12 times in his career.

19. In Patient A's case, respondent did not remove the sponges at the end of her surgery. He testified, credibly in light of other evidence, that he made this choice deliberately, rather than simply having forgotten to remove the sponges.

20. Except for the absorbent sponges that remained in Patient A's ear canals at the conclusion of her surgery, Patient A's surgery ended unremarkably. Respondent moved her to a recovery room, where nursing staff members monitored her. When she had recovered sufficiently, respondent discharged Patient A. She spent the night in a hotel-type bedroom suite in the same building, with a nurse present to offer her comfort care such as analgesic medication and hydration. Her adult daughter picked her up the next morning.

21. Respondent uses a form to track small disposable items during surgery, to ensure that the surgical team does not inadvertently leave sponges, needles, or other similar items within the patient's body or in a location where they may injure anyone. After surgery, the form becomes part of the patient's medical record. According to both respondent and Sung, surgical team members review and reconcile every entry on the surgical count form at the end of each patient's surgery.

22. The surgical count form for Patient A's surgery shows that a staff member made five ear sponges available for respondent's use by placing them "on to

field" and that at the end of surgery the staff member responsible for counting sponges confirmed that the team had removed all five "off of field." The form also has a space for respondent or another surgical team member specifically to confirm removal of any sponges that respondent has placed in the patient's ear canals:

Confirmation of "Ear Plug" (Kittner or "peanut" sponge) Removal

ear peanuts removed R ear L ear N/A

_____ (must be initialed by staff member actually removing peanuts)

For Patient A, this portion of the count form shows no initials or other writing, and no mark on any of the three check boxes.

23. Aside from the absence of any initials on the count form confirming that someone had removed sponges from Patient A's ears, Patient A's medical record includes no other individualized documentation regarding the presence of sponges in her ear canals when her surgery ended. In particular,

- Respondent's operative report regarding Patient A includes no description of any clinical decision-making regarding leaving or removing absorbent ear sponges;
- Respondent's written instructions to the recovery room staff include no mention of sponges in Patient A's ear canals;
- Respondent's written instructions to the overnight after-care nurse include no mention of sponges in Patient A's ear canals;
- The after-care nurse's handwritten notes regarding her counseling to Patient A's daughter when Patient A's daughter picked up Patient A refer to diet,

exercise, medication, and surgical drain management, but not to sponges in Patient A's ear canals; and

- Respondent's written instructions to Patient A regarding post-surgical follow-up office visits mention that a staff member will remove her sutures, but do not mention sponges in Patient A's ear canals.

24. Sung routinely performs suture and surgical drain removal at facelift patients' post-operative office visits. She was present early in Patient A's surgery, but was not present when the surgery ended and the surgical team completed the count form described above in Findings 21 and 22. Neither respondent nor any other staff member orally alerted Sung that sponges remained in Patient A's ears.

25. Respondent testified that his plan with respect to the sponges he left in Patient A's ears was to remove them no later than Patient A's second post-operative suture removal appointment, if they had not already fallen out of her ears by then. This testimony is credible to the extent that it describes respondent's thought process as he wrapped up Patient A's surgery. Nevertheless, as stated above in Findings 23 and 24 and below in Findings 30 through 35, respondent did not document or carry out this plan.

FOLLOW-UP CARE

26. Patient A stayed with her daughter after her surgery. In the first few days, she experienced more pain than she had anticipated, including pain when she touched her external ears.

27. Patient A's daughter called respondent's after-hours service on Friday, April 21, 2017, chiefly to ask questions regarding care for Patient A while the electricity

in Patient A's daughter's apartment was out. Neither Patient A's daughter nor Sung could recall precisely in testimony what Patient A's daughter told Sung during that call about Patient A's ears. Sung understood, however, that Patient A was experiencing pain primarily on and around her external ear, where respondent had made surgical incisions. Sung recommended warm compresses on the ears and noted this recommendation in her chart entry about this telephone call.

28. Patient A's daughter spoke again with Sung on Sunday, April 23, 2017. They both recall discussing Patient A's ear pain during this conversation, although their memories regarding the details of this discussion differ. Patient A's daughter recalls no mention of the possibility that sponges might remain in Patient A's ears, and Sung's note regarding the call also does not mention this possibility.

29. Either on April 21 or on April 23, or on both dates, Sung relayed an offer from respondent to pay a house call on Patient A. She and her daughter declined this offer.

30. On Monday, April 24, 2017, Patient A came to respondent's clinic for her first post-operative appointment. Sung removed some of Patient A's sutures, and her surgical drains. She did not remove any sponges from Patient A's ear canals, or look at Patient A's ear canals except incidentally during the course of removing sutures around Patient A's external ears. She also did not ask Patient A whether sponges had fallen out of her ears since her surgery, such as onto her pillow or in the shower.

31. Patient A recalls that she complained to Sung on April 24 that she was experiencing excruciating pain in her ears, as well as muffled hearing. Sung recalls no such discussion, and her note regarding the visit does not refer to Patient A's ears or hearing. To the contrary, the note describes Patient A as "in good spirits." Because

Sung does not recall and did not document any discussion at all regarding Patient A's ears, Patient A's testimony that she described extreme pain that day is not credible.

32. Patient A returned to respondent's office for her second post-operative appointment on Wednesday, April 26, 2017. Sung removed the rest of Patient A's sutures, including sutures on Patient A's lower body at the site where respondent had harvested body fat for use in Patient A's facial surgery. Patient A then saw someone who taught her how to do facial self-massage to encourage lymphatic drainage, and who advised Patient A about post-surgical make-up techniques and applied make-up to Patient A's face.

33. Patient A, her daughter, Sung, and respondent all testified about other aspects of Patient A's April 26 office visit. Their testimony conflicts irreconcilably on critical details, and no witness's testimony is clearly and convincingly more credible or accurate on every issue than any other witness's testimony. Nevertheless, the testimony establishes:

- Ensuring that absorbent sponges no longer remained in Patient A's ear canals after Sung had removed all Patient A's surgical sutures was not part of either Sung's or respondent's explicit agenda for Patient A's April 26 office visit;
- Patient A complained on April 26 that her ears still hurt and that her hearing was muffled;
- If Sung or respondent looked inside Patient A's ear canals, they saw some material that resembled either dried blood or ear wax, but could not see past that material to anything else in the canals; and

- Patient A left respondent's office on April 26 intending to follow up at home in San Diego with her primary care provider if her ear pain and poor hearing did not improve.

34. Sung made notes regarding Patient A's second post-operative visit on April 26. Sung's notes reflect no complaint by Patient A regarding her ears or her hearing. Sung and respondent also testified to several matters that Sung's notes do not reflect, and that are inconsistent with Patient A's and her daughter's memories.

- Sung and respondent say that respondent met with Patient A during her office visit on April 26;
- Sung and respondent say that respondent offered to irrigate Patient A's ear canals, or to refer her to an otolaryngologist in the same medical office building for examination, but that Patient A declined both offers; and
- Sung and respondent say that respondent mentioned specifically to Patient A that absorbent sponges that he had left in Patient A's ear canals after surgery might still be present and might explain her ear discomfort.

35. With respect to the first two points summarized in Finding 34, the evidence does not establish clearly and convincingly whether this testimony is true or false. With respect to the third point, however, the totality of evidence establishes that neither Sung nor respondent mentioned specifically to Patient A at any time after her surgery on April 19, 2017, that absorbent sponges that respondent had left in Patient A's ear canals might still be present and might explain her ear discomfort.

36. Patient A returned to San Diego a few days later. Her muffled hearing and ear pain persisted.

37. On Monday, May 8, 2017 (about 10 days after her return to San Diego, and 19 days after her surgery), Patient A consulted Ngocbich Nguyen, M.D., an internal medicine physician who is Patient A's colleague and who sometimes provides primary care to Patient A. Dr. Nguyen looked in Patient A's ear canals and observed what her notes describe as a "dark, hard mass" in each ear. After attempting unsuccessfully to remove the masses with an ear curette, Dr. Nguyen irrigated each ear canal for more than 30 minutes. This process softened the masses enough for Dr. Nguyen to remove them. They turned out to be small, absorbent surgical sponges of exactly the same type that respondent had placed in Patient A's ear canals before starting surgery, coated with dark material that appeared consistent with dried blood and ear wax.

38. Removing the sponges relieved Patient A's pain and hearing difficulty almost immediately. She experienced no permanent negative consequences potentially attributable to the sponges.

Expert Opinions

39. Complainant offered expert opinion about respondent's treatment of Patient A from Paul Chugay, M.D. Dr. Chugay is a cosmetic surgeon in private practice in southern California. Although he performs facelift surgeries, his practice emphasizes cosmetic surgeries to the trunk and limbs. He nevertheless described experience that is adequate to support an expert opinion about respondent's conduct toward Patient A.

40. Respondent offered expert opinion about respondent's treatment of Patient A from Robert J. Troell, M.D. Dr. Troell is a plastic surgeon and head and neck surgeon in private practice in southern California. His practice emphasizes facial surgery, and he has considerable research and teaching experience as well.

PRE-OPERATIVE MEDICAL HISTORY AND PHYSICAL EXAMINATION

41. Dr. Chugay testified that respondent committed a simple departure from the standard of care by relying on Sung to gather Patient A's medical history, and by relying on physical examination reports from Patient A's primary care physician and from Dr. Infosino. According to Dr. Chugay, the standard of care requires a surgeon such as respondent to gather the patient's medical history, and to perform a physical examination, personally before performing surgery on the patient.

42. Dr. Troell agrees with Dr. Chugay that because facelift surgery involves the risks of general anesthesia, as well as of bleeding or poor wound healing, the standard of care requires a complete pre-surgical health history and physical examination. Dr. Troell disagrees, however, that the surgeon must perform these pre-surgical assessments personally. Rather, Dr. Troell believes that the standard of care permits a surgeon to delegate health history collection and physical examination to other physicians or qualified nurses, as long as the surgeon reviews these persons' reports before surgery.

43. In light of all evidence in this matter, including without limitation the statutory requirement in Business and Professions Code section 2259.8, Dr. Troell's opinion on this issue is more persuasive than Dr. Chugay's opinion. Respondent did not depart from the standard of care in his manner of obtaining and evaluating information about Patient A's health history and current condition before her surgery.

EAR SPONGE PLACEMENT AND REMOVAL

44. Dr. Chugay and Dr. Troell agree that respondent acted in accordance with the standard of care by using absorbent material to block Patient A's ear canals

during surgery. They also agree that the sponges respondent used were a reasonable medical choice for this purpose, and not a departure from the standard of care.

45. Dr. Chugay and Dr. Troell agree that the standard of care requires a surgeon to remove absorbent material from a facelift patient's ear canals after surgery. Leaving such material in the ear canal for weeks or months can impair hearing, and risks infection in the ear canal.

Timing of Removal

46. Dr. Chugay testified to his opinion that the standard of care required respondent either to remove the sponges from Patient A's ear canals at the end of her surgery, or to have and to document a specific reason for leaving them in place. In the absence of any such documentation (as summarized in Finding 23), Dr. Chugay considers respondent's failure to have removed the sponges before discharging Patient A from the operating room to the recovery room an extreme departure from the standard of care.

47. Dr. Troell testified to his opinion that a surgeon does not need to observe significant immediate post-surgical bleeding to justify leaving absorbent sponges in a patient's ears after a facelift surgery. Rather, because bleeding may resume, sponges may continue to benefit the patient; and if they do not remain in the ear canals for too long, their risk to the patient is minimal. For this reason, Dr. Troell believes that leaving absorbent sponges in a patient's ears after facelift surgery without documenting a specific reason to do so is not, in itself, a departure from the standard of care.

48. Dr. Troell's opinion on this issue is more persuasive than Dr. Chugay's opinion. Respondent did not depart from the standard of care simply by choosing at

the end of Patient A's surgery not to remove the absorbent sponges from her ear canals.

Post-Surgical Follow-Up

49. Dr. Troell emphasized in his testimony, however, that the standard of care permits a surgeon to leave sponges or other absorbent material in a patient's ears after a facelift only if the surgeon (1) tells the patient that sponges remain in the patient's ears, and (2) makes and documents a plan for removing them. He emphasized as well, both in describing the standard of care and describing his own practice, that for a facelift patient whose recovery proceeds without complication, any medical justification for absorbent ear protection ends when the patient's surgical wounds have healed sufficiently to allow suture removal. In his own practice, if Dr. Troell leaves sponges in a patient's ears after a facelift surgery, he plans for their removal not later than the second post-operative suture removal appointment. In his report, he opined that the standard of care allows a surgeon to leave sponges in a facelift patient's ear canals "up to one week post-operatively."

50. In developing his expert opinion, Dr. Troell relied on respondent's and Sung's statements to the effect that respondent had told Patient A that respondent had left sponges in her ears. He also relied on their statements to the effect that respondent had offered on April 26 to irrigate Patient A's ears, either to remove the sponges or to confirm that they no longer were there, but that she had declined in favor of consulting someone at home in San Diego if her ear discomfort persisted. Dr. Troell concluded in reliance on these statements that respondent did not depart from the standard of care by allowing Patient A to leave San Francisco without confirming that she no longer had absorbent sponges in her ear canals.

51. As summarized above in Findings 23, 24, and 35, however, the totality of evidence in this matter establishes that respondent did not tell Patient A (or Sung) that he had left sponges in Patient A's ear canals on April 19. The totality of evidence also establishes that neither respondent nor Sung told Patient A at any time after her surgery that her ear discomfort might be due to sponges that remained in her ear canals. Although respondent may have offered on April 26 to irrigate Patient A's ear canals or to send her to an otolaryngologist, as summarized in Finding 34, he did not explain to Patient A that attention to her ear discomfort might be important to avoid potential infection from a long-retained sponge. For all these reasons, Dr. Troell's opinion that respondent acted in accordance with the standard of care with respect to post-operative ear sponge removal is not persuasive.

52. Instead, the evidence in this matter (including Dr. Troell's opinion, summarized in Finding 49) makes Dr. Chugay's opinion persuasive with respect to respondent's actions after Patient A's surgery ended. Leaving absorbent sponges in Patient A's ears may have been both deliberate and initially reasonable, but respondent committed an extreme departure from the standard of care by failing to document and to implement a plan to ensure that these sponges did not remain in Patient A's ear canals after her surgical wounds had healed.

POST-OPERATIVE EXAMINATION

53. Although respondent's and Patient A's memories differ (as summarized above in Findings 33 and 34), Dr. Chugay assumed in developing his opinion that respondent did see Patient A on April 26, 2017. He believes that respondent committed a simple departure from the standard of care by failing to see Patient A sooner, however, given her complaints regarding ear pain and hearing impairment. Dr. Chugay also believes that respondent committed a simple departure from the

standard of care by failing to recommend more strongly that Patient A consult an otolaryngologist on April 26, 2017.

54. Patient A described ear pain and muffled hearing after her surgery, but the matters summarized above in Findings 31 and 32 do not establish that she described extraordinary or extreme pain. Moreover, the matters summarized in Findings 25, 45, and 49 do not establish that respondent would have departed from the standard of care by waiting until April 26 to ensure that sponges no longer remained in Patient A's ears; and these matters also show affirmatively that respondent should not have needed an otolaryngologist to recognize that sponges might explain Patient A's ear complaints. Under these circumstances, Dr. Chugay's opinions that respondent departed from the standard of care by failing to examine Patient A before April 26 and by failing to insist that she see an otolaryngologist are not persuasive.

SURGICAL DOCUMENTATION

55. Dr. Chugay considers the surgical count form described in Findings 21 and 22 to be inaccurate. In his view, describing sponges that remain in a patient's ear canal at the end of surgery as being "off of field" is incorrect, because the sponges leave the operating room with the patient. Moreover, he considers the concept that the absence of any entry on the portion of the form relating specifically to ear sponges would indicate affirmatively that sponges remain in the patient's ears "the most absurd thing I've ever heard."

56. Respondent's statements on this issue before hearing were inconsistent. For example, in a written statement, respondent likened the sponges he used in Patient A's ears "to the packing that is placed in a patient's nose following nasal

surgery." He noted in a deposition, however, that in that case he would not count the packing material "off" the field, because "we would be removing it later." In his hearing testimony, however, respondent explained that he considers a patient's ear canal to be outside the "surgical field" for a facelift, and that for this reason he believes his form states accurately that sponges in the patient's ear canals are not "on" the field.

57. Dr. Chugay's skepticism about respondent's surgical count form does not establish that it is inaccurate. Surgical team members using the form in the manner summarized in Findings 21 and 22 could count five sponges "off the field" either by seeing five, along with initials confirming that someone had removed sponges from the ear canals, or by seeing three and accounting for two more by noting that no one had initialed to confirm removal from either ear canal. A person who reviewed Patient A's surgical count form after her surgery could have determined correctly from the form that sponges had remained in her ear canals when her surgery ended.

58. The totality of evidence in this case demonstrates, however, that respondent's surgical documentation regarding Patient A is inadequate. Respondent would not have included a space specifically to document sponge removal on his count form if this step were not important (in accordance with Dr. Chugay's and Dr. Troell's opinions, summarized in Finding 45, regarding the potential long-term harm that forgotten sponges might cause). Respondent's own testimony, summarized in Findings 6 and 18, establishes that his choice to discharge Patient A from surgery with sponges in her ear canals was extraordinary. Yet as summarized in Findings 22 and 23, the count sheet is the only aspect of Patient A's surgical documentation that reveals that important, extraordinary choice.

59. As summarized above in Findings 32 through 35, when Patient A complained at her final suture removal session on April 26, 2017, that she could not

hear well and that her ears remained uncomfortable, neither respondent nor Sung told her that sponges remaining in her ear canals might explain why. These facts suggest strongly that the surgical documentation did not alert or remind them that respondent had left sponges in Patient A's ear canals. Adequate documentation would have allowed respondent or Sung to recognize and resolve this issue.

60. Although Dr. Chugay considered the entire course of events that resulted in Patient A's having sponges in her ears for nearly three weeks to be an extreme departure by respondent from the standard of care, he testified that this inadequate documentation in and of itself was a simple departure from the standard of care. This opinion is persuasive.

POST-OPERATIVE EXAMINATION DOCUMENTATION

61. By testifying that he did see Patient A on April 26, 2017, despite having made no record that he did so, respondent acknowledged that his records regarding Patient A are incomplete. Moreover, this omission renders these records inadequate, because (as summarized above in Findings 33 through 35) they do not explain whether respondent remembered that he had left sponges in Patient A's ear canals, or how he counseled her about what to do if her ear discomfort persisted.

62. All medically trained witnesses agree that medical records must provide clear information about a physician's patient encounters and decision-making. Dr. Chugay's opinion is persuasive that the omission summarized in Finding 61 is a simple departure from the standard of care.

Costs

63. Between January 1, 2023, and January 2, 2024, the Board incurred \$32,545.00 in costs for legal services provided to complainant by the California Department of Justice in this matter. In addition, complainant's counsel estimated that complainant would incur an additional \$1,760.00 in costs between January 3, 2024, and the hearing date. Complainant's claim for reimbursement of these costs (\$34,305.00 in total) is supported by a declaration that complies with California Code of Regulations, title 1, section 1042, subdivisions (b)(2) and (b)(3). These costs are reasonable.

64. Complainant also presented evidence showing that the Board incurred \$2,750.00 in costs for expert evaluation of this matter. This sum includes \$500 in costs for services from an expert whose opinion did not affect complainant's prosecution. The remainder, \$2,250.00, is reasonable, and is supported by a declaration that complies with California Code of Regulations, title 1, section 1042, subdivision (b)(2).

65. Finally, complainant presented evidence showing that the Board incurred \$6,596.50 in costs for investigative services from the Department of Consumer Affairs Health Quality Investigations Unit. Testimony by investigator Daniel Schuman demonstrated, however, that much or all of this cost related to issues that complainant did not pursue, and to evidence that complainant did not present, at hearing. The declaration supporting complainant's claim for reimbursement for these costs fails to establish what portion, if any, is reasonable in light of the allegations complainant made against respondent.

LEGAL CONCLUSIONS

1. The Board may take disciplinary action against respondent only if clear and convincing evidence establishes cause for such action. The factual findings above rest on clear and convincing evidence.

2. The Board may suspend or revoke respondent's physician's and surgeon's certificate if he has engaged in unprofessional conduct. (Bus. & Prof. Code, §§ 2227, 2234.) Unprofessional conduct includes medical practice reflecting gross negligence or repeated negligence. (*Id.*, § 2234, subds. (b), (c).) It also includes failure to maintain adequate and accurate medical records. (*Id.*, § 2266.)

First Cause for Discipline: Gross Negligence

3. Gross negligence in medical care is an act or decision that is an extreme departure from the standard of care. Respondent's failure to document and implement a plan to ensure that absorbent sponges did not remain in Patient A's ear canals after her surgical wounds had healed, as summarized in Findings 23 through 25, 28 through 35, and 49 through 52, constitutes gross negligence, and is cause for discipline under Business and Professions Code section 2234, subdivision (b).

Second Cause for Discipline: Repeated Negligence

4. A simple departure from the standard of care is medical negligence. Respondent committed two acts of ordinary negligence in addition to the gross negligence summarized in Legal Conclusion 3: (1) as summarized in Findings 21 through 23 and 57 through 60, his documentation regarding disposition of Patient A's ear sponges at the end of her surgery was inadequate, though not inaccurate; and (2) as summarized in Findings 34, 61, and 62, his documentation regarding interaction

with Patient A on April 26, 2017, was both inaccurate and inadequate. These repeated acts of negligence are cause for discipline under Business and Professions Code section 2234, subdivision (c).

5. As summarized in Findings 41 through 43, 53, and 54, complainant failed to establish that respondent committed any negligence with respect to Patient A's pre-operative medical history or physical examination; with respect to his failure to examine her personally between April 19, 2017, and April 26, 2017; or with respect to consulting an otolaryngologist regarding Patient A's ear discomfort. These matters do not constitute cause for discipline against respondent.

Third Cause for Discipline: Unprofessional Conduct

6. The matters stated in Findings 21 through 23, 34, and 57 through 62 establish two instances in which respondent's medical records were inadequate. In one of these instances the records also were inaccurate. These matters are cause for discipline against respondent for unprofessional conduct under Business and Professions Code section 2266.

7. The negligence summarized in Legal Conclusions 3 and 4 is cause for discipline against respondent for unprofessional conduct under Business and Professions Code sections 2227 and 2234, subdivisions (b) and (c).

Disciplinary Considerations

8. The matters stated in Findings 4 through 6 show respondent to have practiced successfully and carefully, with an excellent reputation, for many years. His error with respect to Patient A was serious, but it also was unusual and it occurred almost seven years ago.

9. Complainant advocates for an order placing respondent on five years' probation, with conditions including requirements to take remedial courses, to undergo a clinical competence assessment, and to abandon his solo medical practice. Probationary orders are common in matters involving acts of gross negligence. (See Manual of Model Disciplinary Orders and Disciplinary Guidelines [12th ed. 2016]; Cal. Code Regs., tit. 16, § 1361.) In this matter, however, in light of all evidence, such an order would impose burdens on respondent, the Board, and his patients that are not necessary to achieve the Board's critical public welfare mission. (Bus. & Prof. Code, § 2229.)

10. The Board may issue a public reprimand to respondent, on terms including requirements that he take courses and reimburse the Board for its reasonable enforcement costs. (Bus. & Prof. Code, §§ 125.3, subd. (a), 495, 2227, subd. (a)(4).) The matters stated in Findings 25, 33, and 35 show respondent's refusal to acknowledge his personal responsibility for ensuring that Patient A did not leave San Francisco with surgical sponges in her ear canals; these matters show that a professionalism course will be appropriate here. In addition, an order for cost reimbursement should accompany the Board's reprimand to respondent.

Costs

11. A physician who has committed a violation of the laws governing medical practice in California may be required to pay the Board the reasonable costs of the investigation and enforcement of the case, but only as incurred on and after January 1, 2022. (Bus. & Prof. Code, § 125.3.) The matters stated in Findings 63 through 65 establish that these costs for this matter total \$36,555.00.

12. In *Zuckerman v. State Bd. of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth the standards by which a licensing board or bureau must exercise its discretion to reduce or eliminate cost awards to ensure that the board or bureau does not deter licensees with potentially meritorious claims from exercising their administrative hearing rights. The court held that a licensing board requesting reimbursement for costs relating to a hearing must consider the licensee's "subjective good faith belief" in the merits of his position and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Id.*, at p. 45.) The board also must consider whether the licensee will be "financially able to make later payments." (*Ibid.*) Last, the board may not assess full costs of investigation and enforcement when it has conducted a "disproportionately large investigation." (*Ibid.*)

13. All these matters have been considered. Respondent's successful defense to some of the allegations against him justifies reduction of his reimbursement obligation to \$20,000.00.

ORDER

1. Physician's and Surgeon's Certificate No. G 52421, held by respondent Timothy James Marten, M.D., is hereby publicly reprimanded.

2. Within 60 calendar days after the effective date of this order, respondent shall enroll in a professionalism program that meets the requirements of California Code of Regulations, title 16, section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after

initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after completing the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education requirements for license renewal.

A professionalism program taken after the acts that gave rise to the charges in the accusation, but prior to the effective date of the order may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this order.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the order, whichever is later.

3. Respondent must pay \$20,000.00 to the Board, to reimburse the Board for its enforcement costs in this matter, within 30 days after the effective date of this order.

DATE: 02/02/2024



JULIET E. COX

Administrative Law Judge

Office of Administrative Hearings