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

In the Matter of the Accusation Against: Genara Turallo Dela Roca, M.D. Physician's and Surgeon's Certificate No. A 74083 Respondent.	Case No. 800-2020-070176

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 December 31, 2024.

IT IS SO ORDERED JUN 11 2024.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese, Executive Director

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
Deputy Attorney General
State Bar No. 182198
California Department of Justice
2550 Mariposa Mall, Room 5090
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Telephone: (559) 705-2320
Facsimile: (559) 445-5106
Attorneys for Complainant

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

In the Matter of the Accusation Against: **GENARA TURALLO DELA ROCA, M.D.** **11509 Haydock Ct.** **Bakersfield, CA 93311-9284** **Physician's and Surgeon's Certificate No. A 74083** Respondent.	Case No. 800-2020-070176 OAH No. 2023120663 **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 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 Lynette D. Hecker, Deputy Attorney General.

2. GENARA TURALLO DELA ROCA, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road, Irvine, CA 92620.

3. On or about March 15, 2001, the Board issued Physician's and Surgeon's Certificate No. A 74083 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2020-070176 and will expire on September 30, 2024, unless renewed.

JURISDICTION

4. Accusation No. 800-2020-070176 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 August 14, 2023. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2020-070176 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. 800-2020-070176. 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 allegations in Accusation No. 800-2020-070176, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

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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 hereby gives up her right to contest that cause for discipline exists based on those charges.

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

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

13. Respondent understands that, by signing this stipulation, she enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of her Physician's and Surgeon's Certificate No. A 74083 without further notice to, or opportunity to be heard by, Respondent.

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands

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and agrees that she may not withdraw her agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

16. This Stipulated Surrender of License 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.

17. The parties agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Disciplinary Order, including PDF and facsimile copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

18. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 74083, issued to Respondent GENARA TURALLO DELA ROCA, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's 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 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. The effective date of the Board's Decision and Order shall be on the date specified by the Board, but in no event shall it be earlier than December 31, 2024.

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. 800-2020-070176 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 $67,980.25 (sixty-seven thousand, nine hundred, eighty dollars and twenty-five cents) 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. 800-2020-070176 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 Raymond J. McMahon, Esq. I understand the stipulation and the effect it will have on my Physician's 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: ~~30/05/24~~

Dr. Dela Roca (May 30, 2024 16:03 PDT)

GENARA TURALLO DELA ROCA, M.D.
Respondent

I have read and fully discussed with Respondent GENARA TURALLO DELA ROCA, 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: _____

RAYMOND J. McMAHON, ESQ.
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: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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California, all of the charges and allegations contained in Accusation No. 800-2020-070176 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 Raymond J. McMahon, Esq. I understand the stipulation and the effect it will have on my Physician's 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: _____

GENARA TURALLO DELA ROCA, M.D.
Respondent

I have read and fully discussed with Respondent GENARA TURALLO DELA ROCA, 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: May 30, 2024

RAYMOND J. McMAHON, ESQ.
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: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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California, all of the charges and allegations contained in Accusation No. 800-2020-070176 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 Raymond J. McMahon, Esq. I understand the stipulation and the effect it will have on my Physician's 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: _____

GENARA TURALLO DELA ROCA, M.D.
Respondent

I have read and fully discussed with Respondent GENARA TURALLO DELA ROCA, 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: _____

RAYMOND J. McMAHON, ESQ.
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: 5/31/2024

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2020-070176

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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: **Genara Turallo Dela Roca, M.D.** **11509 Haydock Ct.** **Bakersfield, CA 93311** **Physician's and Surgeon's Certificate No. A 74083,** Respondent.	Case No. 800-2020-070176 **ACCUSATION**

Complainant alleges:

PARTIES

1. Reji Varghese (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 or about March 15, 2001, the Medical Board issued Physician's and Surgeon's Certificate Number A 74083 to Genara Turallo Dela Roca, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2024, unless renewed.

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 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.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY 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 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.

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.

DEFINITIONS

8. The American Society of Anesthesiologists (ASA) physical status classification system is a grading system to determine the health of a person before a surgical procedure that requires anesthesia. It helps predict the patient's risk of surgical complications, along with other factors like the type of surgery, the patient's age, the extent of the procedure, surgery timeframe

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and more. ASA classification uses a grading system of 1 (one) through 5 (five), with 1 identifying a person in good health and 5 as a person with a severe, life-threatening condition.

9. An arrhythmia, or irregular heartbeat, is a problem with the rate or rhythm of a patient's heartbeat. The heart may beat too quickly, too slowly, or with an irregular rhythm.

10. Asystole is a type of cardiac arrest, which is when the heart stops beating entirely.

11. Atrial fibrillation (AF or Afib) is a type of arrhythmia, or abnormal heartbeat, which is caused by extremely fast and irregular beats from the upper chambers of the heart (usually more than 400 beats per minute).

12. Atropine is a medication given before aesthesia to decrease mucus secretions, such as saliva. During anesthesia and surgery, atropine is used to help keep the heart beat normal.

13. Bradycardia is a low heart rate.

14. Calcium chloride is a mineral indicated in the immediate treatment patients with abnormally low levels of calcium in the body that cause muscle spasm. It is also used in cardiac resuscitation after a heart attack which causes decreased cardiac contraction, resulting in the use of calcium as a treatment in cardiac surgery.

15. Debridement is removal of dead or unhealthy tissue from a wound. Doctors do this to help a wound heal.

16. Dopamine is a chemical released in the brain that makes people feel good. Having the right amount of dopamine is important both for the body and the brain. Dopamine helps nerve cells to send messages to each other. It is useful both during surgery and post-surgery treatment of patients with low cardiac output states after open-heart surgery.

17. General anesthesia is a state of controlled unconsciousness where medicines are used to send a patient to sleep, so the patient is unaware of surgery and does not move or feel pain while it's carried out.

18. Electrocardiogram (ECG or EKG) records the electrical signal from the heart to check for different heart conditions. Electrodes are placed on the chest to record the heart's electrical signals, which cause the heart to beat.

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19. An endotracheal tube is a tube that is placed between the vocal cords through the trachea. It serves to provide oxygen and inhaled gases to the lungs and protects the lungs from contamination, such as gastric contents or blood.

20. Ephedrine is FDA-approved primarily for the treatment of clinically significant hypotension perioperatively. Induction of general anesthesia and ongoing anesthesia during operative cases results in vasodilatation and hypotension, requiring treatment with vasopressors.

21. Epinephrine is a medication commonly used in surgeries to reduce the blood loss; the lowest and the most effective dosage of epinephrine can improve the results of the surgery.

22. Gangrene is a serious condition where a loss of blood supply causes body tissue to die. Wet gangrene occurs if bacteria invade this tissue. This makes the area swell, drain fluid, and smell bad. It may develop after a severe burn, frostbite, or other injury. It often occurs in people with diabetes who unknowingly injure a toe or foot.

23. Gastroesophageal reflux (GER or GERDs or reflux) happens when a patient's stomach contents come back up into their esophagus.

24. Glycopyrrolate has been widely used as a preoperative medication to inhibit salivary gland and respiratory secretions. The most frequent reasons for administering it is to create a sedative and amnesic effect, and to prevent reflex bradycardia.

25. Intubate means to insert a tube into (a person or a body part, especially the trachea for ventilation).

26. Lidocaine belongs to the family of medicines called local anesthetics. It prevents pain by blocking the signals at the nerve endings in the skin. It does not cause unconsciousness as general anesthetics do when used for surgery.

27. Neuromonitoring is used during surgery to assess the functional integrity of the brain, brainstem, spinal cord, or peripheral and cranial nerves.

28. Neuromuscular blockade is frequently used in anesthesia to facilitate endotracheal intubation, optimize surgical conditions, and assist with mechanical ventilation in patients who have reduced lung compliance.

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29. Non-shockable rhythms are rhythms of the heart that are not amenable to shock, including pulseless electrical activity and asystole. In these cases, identifying primary causation, performing good CPR, and administering epinephrine are the only tools to resuscitate the patient.

30. Pepcid or Tagamet reduce the flow of stomach acid and help prevent an upset stomach from medications before, during, and after surgery.

31. Towards the end of pregnancy, a hormone called oxytocin stimulates the uterine muscles and causes contractions that begin the process of labor. Pitocin® is a synthetic version of oxytocin, and doctors use this IV medication for labor induction.

32. The body produces pleural fluid in small amounts to lubricate the surfaces of the pleura. This is the thin tissue that lines the chest cavity and surrounds the lungs. Pleural effusion is an abnormal, excessive collection of this fluid.

33. Propofol is an intravenous anesthetic used for procedural sedation, during monitored anesthesia care, or as an induction agent for general anesthesia. It may be administered as a concentrated single dose or an infusion, or some combination of the two.

34. Sinus tachycardia is a common condition that happens sometimes in response to stressful situations wherein the heart beats more than 100 times per minute. It usually returns to normal after the stressful event has passed.

35. Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. It happens when an infection already in the body triggers a chain reaction throughout the body. Infections that lead to sepsis most often start in the lung, urinary tract, skin, or gastrointestinal tract.

36. Sleep apnea is a potentially serious sleep disorder in which breathing repeatedly stops and starts.

37. Sodium bicarbonate (SB) administration has been considered an important part of treatment for severe metabolic acidosis (buildup of acid in the body) in cardiac arrest, because normalization of extracellular and intracellular acid-base balance is considered a meaningful endpoint of resuscitation.

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38. Toradol, also known as ketorolac, is a medication frequently used for pain relief after surgery. It is a non-steroidal anti-inflammatory drug (NSAID), which works to reduce pain by interfering with the body's production of hormones that influence pain.

39. Transcutaneous pacing is where an electrodes-based medical device is used to regulate the contractility of specialized cells in the heart that are capable of producing and transmitting electrical activity. The device helps to maintain adequate heart rate and so cardiac output.

40. A peripheral nerve stimulator, also known as a train-of-four monitor, is used to assess neuromuscular transmission when neuromuscular blocking agents are given to block musculoskeletal activity.

41. Peripheral vascular disease is the reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel.

42. Vasodilators are medications that dilate (open) blood vessels. They affect the muscles in the walls of the arteries and veins, preventing the muscles from tightening and the walls from narrowing. As a result, blood flows more easily through the vessels.

43. Zofran is used to prevent nausea and vomiting that may be caused by surgery, cancer chemotherapy, or radiation treatment.

FACTUAL ALLEGATIONS

44. At all times relevant to the charges brought herein, Respondent worked as an anesthesiologist at a hospital in Bakersfield, California. Respondent was the anesthesiologist for each of the patients discussed below who were undergoing various surgical procedures.

Patient #1[1]

45. On or about December 11, 2017, Patient #1, a 47-year-old male with back pain that radiated down into his leg, presented for back surgery. Pre-operatively, Respondent performed a focused history and physical, and found he also had a history of high blood pressure, obstructive sleep apnea, and high cholesterol, and determined him to be American Society of Anesthesiologists (ASA) status 3 with a plan for general anesthesia. During the procedure,

[1] The patients' names are redacted to protect their privacy.

Respondent appropriately placed the patient on ASA-standard monitors and utilized neuromuscular blockade in the setting of neuromonitoring. Respondent did not utilize train-of-four monitoring to assess the depth of the neuromuscular blockade, and the patient moved during the operation.

Patient #2

46. On or about January 17, 2019, Patient #2, a 67 year-old-male who had had back surgery ten (10) days previously, presented to the hospital for an urgent removal of an accumulation of blood in the area of the surgery that was compressing his spinal cord. Respondent was on call that day, but was told there was another anesthesiologist available for this surgery, so left the hospital. However, the other anesthesiologist became unavailable, and Respondent was unable to be reached despite multiple calls and text messages. Another anesthesiologist had to be found to staff this surgery.

Patient #3

47. On or about January 22, 2019, Patient #3, a 93-year-old woman with a history of asthma and hypertension, was admitted for surgery to repair a broken hip. Pre-operatively, Respondent performed a focused history and physical, noting Patient #3 had a history of reflux and diabetes. Her note includes vital signs (blood pressure averaged 110s/60s, which is low) and labs and notes a weight of 43 kg. Respondent assessed Patient #3 to be ASA status 3 and planned for general anesthesia. At or around the beginning of the procedure, the surgeon inquired of Respondent about Patient #3's low blood pressure; Respondent was not concerned. During the procedure, Patient #3 became unstable and the surgeon asked Respondent if Patient #3 had a pulse, was breathing, or if there was a blood pressure. Respondent did not respond, but at some point she stated "I need help." At or about 12:25,[2] Patient #3 went into cardiac arrest. Respondent administered epinephrine 1 mg at that time, and then atropine 1 mg at or about 12:27. Return of spontaneous circulation (ROSC) was noted at or about 12:27 with a rhythm of sinus tachycardia. Respondent noted additional medications subsequently given included ephedrine 50

[2] All times referred to herein are based on the full twenty-four hours of the day (i.e. a "twenty-four-hour" clock).

mg at or about 12:26, sodium bicarbonate 5 mEq (i.e. 84 mg.) at or about 12:27, and lidocaine 100 mg at or about 12:28 in Patient #3's cardiac arrest flowsheet. In total, Respondent gave Patient #3 five doses of ephedrine during the procedure. It is unclear if the ephedrine was multiple doses noted by Respondent earlier in the procedure, or an additional dose not documented by Respondent in the anesthesia data record (ADR). Respondent was unable to resuscitate or care for Patient #3 and another anesthesiologist had to be called in to administer medications and resuscitate her. The procedure was aborted, and Patient #3 was taken to the Intensive Care Unit.

48. Respondent's ADR and notes for the beginning of the procedure on Patient #3 are somewhat legible and contain standard data and explanations. However, Respondent did not legibly fill out the ADR pertaining to the cardiac arrest, even retrospectively.

Patient #4

49. On or about October 3, 2019, Patient #4, a 64 year-old man with a history of paraplegia due to a gunshot wound and recurrent bed sores, was admitted for surgical cleaning of bed sores on his lower back and hip. Pre-operatively, Respondent performed a focused history and physical, additionally noting several other pertinent medical issues including anemia, hypertension, and anxiety and that his medications include the use of methadone. Respondent noted Patient #4's vital signs (BP 126/86) and labs, and a weight of 74.5 kg. Respondent assessed Patient #4 to be ASA status 4 and planned for general anesthesia. Patient #4 was placed on ASA-standard monitors. Towards the end of the procedure, Patient #4's oxygen saturation level decreased to 85%. Respondent then asked the surgical team to stop the procedure, and at some point noted a low blood pressure and asked for a pressure bag. A code blue was called by someone, but Respondent repeatedly called "we need help" without effectively communicating, and appeared overwhelmed. There is no record of a cardiac arrest "code blue" situation in the medical record for this procedure. Rather, it appears the code blue was called to obtain additional assistance for Respondent in the operating room. Further, while Respondent wrote Zofran and Pepcid on the ADR, she did not note the doses given either contemporaneously or retrospectively.

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Additionally, Respondent did not make any notes or document Patient #4's intraoperative desaturation and what interventions were done either contemporaneously or retrospectively.

Patient #5

50. On or about March 22, 2019, Patient #5, a 36 year-old woman, presented for scheduled repeat cesarean-section with bilateral tubal ligation (i.e. to get her fallopian tubes tied). Pre-operatively, Respondent performed a focused history and physical, additionally noting a history of gastroesophageal reflux and severe anxiety. Respondent noted Patient #5's vital signs and labs and that she was noted as not taking any home medications. Respondent assessed Patient #5 to be ASA status 2 and planned for spinal or general anesthesia. Anesthesia start time was documented as 8:25, with in room time at 8:40. Respondent started attempting a spinal around 8:45, and with the patient quite anxious, administered medication to calm her around 9:00. Respondent continued attempting to place a spinal until about 9:10, when another anesthesiologist arrived to help. After a few more minutes of failed attempts, at 9:15 the decision was made to proceed with general anesthesia. The obstetrician arrived at 9:25 to discuss general anesthesia with the patient as well. Respondent did not document the induction medications, though Patient #5 was successfully intubated. Anesthesia was maintained with several appropriate medications. Among those medications, Respondent listed a Pitocin drip, but did not record its administration. A few of the other medications Respondent noted are illegible.

Patient #6

51. On or about June 19, 2020, Patient #6, a 72-year-old female with a history of diabetes, high blood pressure, high cholesterol, heart failure, and end-stage renal disease on dialysis thrice weekly, presented to the hospital for a vein graft placement in her left arm by a vascular surgeon. An electrocardiogram (ECG) obtained on or about three days prior showed atrial fibrillation with a heart rate of 80 beats per minute. Pre-operatively, Respondent performed a focused history and physical, including lab review, noting the patient's height, weight, and body-mass index as well as her glucose level and additional medical history including pleural effusion, sleep apnea, and reflux. Respondent assessed the patient to be ASA status 4. She recorded a plan for monitored anesthesia care. Monitors were placed and Respondent proceeded

with general anesthesia. Anesthesia was maintained throughout the procedure with various appropriate medications. However, while Respondent noted Zofran, Pepcid, and Toradol on the ADR, their administration is not documented. After the procedure, Patient #6 was taken to the recovery room awake with stable vital signs.

Patient #7

52. On or about June 18, 2020, Patient #7, an 8-year-old male, presented to the hospital after a dog bite injury to the lip and cheek with a plan for repair the following day with a plastic surgeon. Pre-operatively, Respondent performed a focused history and physical, assessed Patient #7 to be ASA status 2, and planned for general anesthesia. Patient #7's height was recorded as 130 cm, weight as 36.5 kg, with a body mass index of 20. Anesthesia start time was noted as at or around 11:00 with in-room time at or around 11:20. Monitors were placed and Respondent proceeded with general anesthesia. Anesthesia was maintained throughout the procedure with various medications. However, during the procedure, Respondent administered Toradol 30 mg to Patient #7. After the procedure, Patient #7 was taken to the recovery room awake with stable vital signs.

Patient #8

53. On June 19, 2020, Patient #8, a 78-year-old man with a history of coronary artery disease with stents, heart failure, diabetes, high blood pressure, high cholesterol, and repair of swelling of the main blood vessel that leads away from the heart through his abdomen (abdominal aortic aneurysm), presented for removal of a tumor in his right upper arm and lymph node biopsy with possible skin grafting. Pre-operatively, Respondent performed a focused history and physical, and noted the patient's height, weight, and body mass index. There were no labs noted. Respondent assessed the patient to be ASA status 4 and planned for general anesthesia with endotracheal tube. Monitors were placed and Respondent proceeded with general anesthesia. Anesthesia was maintained throughout the procedure with various appropriate medications. However, Respondent gave Patient #8 two to three other medications for which her documentation is illegible, possibly including ephedrine or glycopyrrolate. After the procedure, Patient #8 was taken to the recovery room awake with stable vital signs.

Patient #9

54. On or about June 17, 2020, Patient #9, a 72-year-old male with a history of diabetes with resultant toe amputation, high blood pressure, heart failure, and end-stage renal disease on dialysis, presented to the hospital, having been sent there by his podiatrist. He was found to have severely low sodium and calcium levels and severely high blood sugar levels with concern for sepsis and wet gangrene, and was admitted by the hospital's on-staff physician. Additional medical history included peripheral vascular disease and hepatitis C. Patient #9 underwent urgent surgical debridement with open mid-foot amputation that day and tolerated that procedure well.

55. On or about June 19, 2020, a scan revealed that Patient #9 had severe enlargement of the left atrial and right-side chamber of his heart, globally decreased movement of his heart, that the amount of blood that his heart pumped each time it beats (ejection fraction) was only about 36% (normal is 50% or higher), that the valves of both the right and left sides of his heart did not close completely, and that his aortic valve was severely narrowed. Patient #9 was taken to the operating room for heart surgery. Pre-operatively, Respondent performed a focused history and physical noting Patient #9 had a height of 68 inches, weighed 76 kg, and had a body mass index of 25. His vital signs were BP 112/49, heart rate 97, respirations 16, and oral temperature 36.6. She assessed the patient to be ASA status 4 and planned for general anesthesia, via an endotracheal tube with an arterial line (which is a tube inserted in an artery in the wrist, groin, or other location to measure blood pressure).

56. Anesthesia start time was documented as 15:15, with in-room time at 15:30. Monitors were placed and Respondent also placed an arterial line. Respondent administered Versed 2 mg, and induced anesthesia with propofol 200 mg, among other medications. Respondent successfully intubated the patient on the first attempt. Anesthesia was maintained with various medications. About two hours into the procedure, Patient #9's blood pressures were quickly decreasing and the patient had also become bradycardic. Respondent then turned off anesthetic gases and opened the IV fluids, then she administered epinephrine and atropine and called for help to start chest compressions. Another anesthesiologist arrived to assist. Patient #9's heart stopped beating entirely and CPR was started at or around 18:24. The surgeon placed a

line in Patient #9's left common femoral vein (a large vein where the left leg meets the hip/groin area) at or around 18:26. There were seven rounds of epinephrine given, spaced mostly five minutes apart, though two doses were given seven minutes after the previous dose, with the first dose at or around 18:28 and the last dose at or around 19:00. At or around 18:44, external pacing was attempted until around 18:47 and then turned back on at or around 18:54, with it documented that Patient #9's heart was not beating. Atropine 1 mg was given at or around 18:49 and at or around 18:58. Calcium chloride 1 g was given at or around 18:36. Dopamine 160 mcg was given at or around 19:04 and at or around 19:08, Patient #9's heart was noted as not beating. Lidocaine 100 mg x 2 was given and sodium bicarbonate x 2 was given five minutes apart as directed by Respondent, though precise times either was administered were not noted. The other anesthesiologist pronounced Patient #9 dead at 19:09.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

57. Respondent has subjected her Physician's and Surgeon's Certificate Number A 74083 to disciplinary action under sections 2227 and 2234, as defined by subdivision (c), of the Code, in that she committed repeated acts of negligence in her care and treatment of Patients #1-9. The circumstances are set forth in paragraphs 44 through 56, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

Patient #1

58. The standard of care requires that all patients undergoing an anesthetic should have ASA-standard monitors, including blood pressure, heart rate, EKG, pulse oximetry, and CO2 monitoring. The ASA standard also states that qualified anesthesia personnel should be present to monitor the patient and provide anesthesia care, except in limited circumstances. Patients undergoing surgery with neuromuscular blockade, especially in cases during which neuromonitoring is used, should have train-of-four monitoring.

59. Respondent appropriately placed Patient #1 on ASA-standard monitors. Given that neuromuscular blockade was used in the setting of neuromonitoring, train-of-four monitoring should have been used to assess the depth of the neuromuscular blockade. This may have

prevented or reduced the patient moving while the surgeon was operating. Though a patient moving during an operation can occur without any departure from the standard of care, not monitoring the patient's level of neuromuscular blockade can increase the likelihood of this occurring. Respondent's failure to perform neuromuscular blockade monitoring constitutes negligence.

Patient #2

60. The standard of care for duties for an on-call anesthesiologist may vary depending on the call description and the policy of the hospital or department or group. In this case, the on-call anesthesiologist includes a duty to answer calls from the hospital and be available to return to the hospital to anesthetize patients who may need urgent or emergent surgery. Respondent's failure to return phone calls and text messages when she was needed for Patient #2's urgent surgery constitutes negligence.

Patient #3

61. The standard of care requires that all patients undergoing an anesthetic should have ASA-standard monitors, including blood pressure, heart rate, EKG, pulse oximetry, and CO2 monitoring. The ASA standard also states that qualified anesthesia personnel should be present to monitor the patient and provide anesthesia care, except in limited circumstances. Respondent placed Patient #3 on ASA-standard monitors and was present for the entirety of the documented time. There was no documented significant hypotension in the ADR at the beginning of the surgery. However, when Patient #3 became unstable, which was also noticed by the surgeon, Respondent either did not respond to the surgeon's questions or address Patient #3's hemodynamic instability. Respondent eventually stated "I need help," but failed to give clear direction or communicate to anyone else as to what was occurring or what help she needed, to the extent that another anesthesiologist was called who gave direction regarding resuscitation of the patient. Respondent's failure to monitor and communicate to the surgical team when Patient #3 was unstable constitutes negligence.

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62. The standard of care for intra-procedural medication management is to appropriately choose and dose medications based on the patient's condition and monitor the patient for changes that would require either intervention or adjustments in medication dosages. Starting around the time of Patient #3's hypotension, Respondent documented giving five (5) doses of ephedrine, although the documentation is not clear regarding the timing these doses were given. Nonetheless, repeated doses of ephedrine in a patient who is rapidly declining due to hemodynamic instability is not appropriate. Escalating medications to different vasopressors and interventions was required, especially since Patient #3 was not appropriately responding to the ephedrine. Respondent's failure to appropriately escalate medications given to Patient #3 when she was hemodynamically unstable constitutes negligence.

63. The standard of care for management of cardiac arrest is to follow the most recent appropriate ACLS algorithm. At the time of the incident with Patient #3, the most recent ACLS guidelines were from 2015. There are different algorithms to follow depending on the specific arrest situation. For asystole, this involves immediate chest compressions and giving epinephrine every 3-5 minutes while reassessing the patient and rhythm every 2 minutes. For non-shockable rhythms, epinephrine should be given as soon as feasible. The guidelines specifically mention that atropine and transcutaneous pacing have not been found to be beneficial during asystolic arrests. Patient #3 arrested at or around 12:25 with a rhythm of asystole, with chest compressions performed by the surgeon. Respondent administered epinephrine 1 mg at that time, and then atropine 1 mg at or around 12:27. Return of spontaneous circulation was noted at or around 12:27, with a rhythm of sinus tachycardia. Respondent noted additional medications including ephedrine 50 mg at or around 12:26, sodium bicarbonate 5 mEq at or around 12:27, and lidocaine 100 mg at or around 12:28 in the cardiac arrest flowsheet, though it is unclear if the ephedrine was the multiple doses noted earlier or an additional dose not documented in the ADR. Ephedrine is not indicated in cardiac arrest. Although routine use of bicarbonate is not recommended in the asystole algorithm, it is commonly given during in-hospital cardiac arrests and would have been reasonable to administer during this period. Lidocaine and atropine are not indicated for asystole, though they would be reasonable to administer in the setting of ventricular

tachycardia and bradycardia, respectively. However, neither of these rhythms was noted in the Code Blue flowsheet or ADR for Patient #3. Respondent's administering inappropriate medications during Patient #3's cardiopulmonary arrest constitutes negligence.

64. The standard of care requires timely, accurate, and legible medical records. The ASA has also released a statement on what items should be documented in the pre-anesthesia evaluation, during the anesthetic, and post-anesthesia assessment. The anesthesia data record and notes provided are somewhat legible and contain all standard data and explanations, at least for the beginning of the case. However, while it is common for some parts of an ADR to be difficult to read without guidance from the writer, it would be important to ensure that any significant events be discussed in further detail retrospectively. Furthermore, it appears that the ADR was not legibly filled out after the cardiac arrest. It is understandable that the record would not be able to be filled out in real time while the patient is unstable, a legible record of what happened during and after any significant events is required. Respondent's records on the procedures for Patient #3 lacked legibility and detailed description of significant intraoperative events which constitutes negligence.

Patient #4

65. The standard of care requires all patients undergoing an anesthetic to have ASA-standard monitors, including blood pressure, heart rate, EKG, pulse oximetry, and CO_2 monitoring. The ASA standard also states that qualified anesthesia personnel should be present to monitor the patient and provide anesthesia care, except in limited circumstances. Patient #4 was placed on ASA-standard monitors and the record reflects that Respondent was present for the entirety of the documented procedure time. However, towards the end of the procedure, Patient #4's oxygen saturation levels dropped (hypotension), and the procedure was abandoned. Respondent appropriately asked for Patient #4 to be turned supine to further assess the situation and then also at some point asked for a pressure bag to administer fluids for hypotension, but subsequently became overwhelmed and did not communicate with the rest of the intraoperative team. Respondent's failure to monitor and communicate with the rest of the intraoperative team when Patient #4 became unstable constitutes negligence.

66. Respondent's entries in the ADR and notes are mostly legible and contain standard data and explanations. Zofran and Pepcid were written on the ADR, but with no doses given. Typically, if a medication is written into the ADR, it suggests that it was given to the patient. However, given the amount of text and speed at which ADRs must be completed, there are often some parts that are not clearly legible. It would also be important to ensure that any significant events be documented in further detail retrospectively. There does not appear to be any documentation from Respondent regarding the intraoperative desaturation and what interventions were done, either contemporaneously or retrospectively, during the care and treatment of Patient #4. Respondent's administration of Zofran and Pepcid without documenting the doses given constitutes negligence. Respondent's failure to document the intraoperative desaturation event, including what interventions were taken also constitutes negligence.

Patient #5

67. The standard of care requires timely, accurate, and legible medical records. The ASA has also released a statement on what items should be documented in the pre-anesthesia evaluation, during the anesthetic, and post-anesthesia assessment. The ADR and Respondent's notes are mostly legible. However, there is inadequate documentation of the spinal attempts and the general anesthetic. Respondent failed to document any of the induction medications and multiple of the medications noted are illegible. Given the situation, Patient #5 should have received a rapid sequence intubation, but there is no documentation that this was done. Respondent's failure to document induction medications for general anesthesia, with a rapid sequence intubation, as well as the failure to document the administration of Pitocin constitutes negligence.

Patient #6

68. Respondent's ADR entries and notes for Patient #6 are mostly legible and for the most part contain standard data and explanations. However, Respondent wrote Zofran, Pepcid, and Toradol on the ADR, but with no doses given, which would be an unusual practice. Writing a medication in the ADR suggests that it was given. However, given the amount of text and speed at which ADRs must be completed, there may be some parts that are not clearly legible.

Respondent's administration of Zofran, Pepcid, and Toradol to Patient #6 without documenting the doses given constitutes negligence.

Patient #7

69. The standard of care for intra-procedural medication management is to appropriately choose and dose medications based on the patient's condition and monitor the patient for changes that would require either intervention or adjustments in medication dosages. The dose of Toradol (ketorolac) in a pediatric patient is 0.5 mg/kg. Thus, for a patient of 36 kg, the closest dose should be 15-20 mg. The dose of Toradol Respondent gave to Patient #7 constitutes negligence.

Patient #8

70. Respondent's ADR entries and notes for Patient #8 are mostly legible and for the most part contain standard data and explanations. However, there are two to three medications which Respondent gave Patient #8, possibly including ephedrine or glycopyrrolate, which are illegible. Respondent's illegible medication documentation constitutes negligence.

Patient #9

71. The standard of care for intra-procedural medication management is to appropriately choose and dose medications based on the patient's condition and monitor the patient for changes that would require either intervention or adjustments in medication dosages. The induction dose of propofol of 200 mg for this patient was too high. The induction dose of propofol for a normal patient is 2-3 mg/kg, and with a weight of 76 kg, the dose given was over 2 mg/kg. This dose should be reduced significantly in patients with co-morbidities such as severe aortic stenosis and reduced ejection fraction who would be at a much higher risk of decompensation from a medication that has vasodilatory and cardio-depressive effects. An alternative induction agent could also have been appropriate. Respondent's failure to give Patient #9 an appropriate dose of propofol constitutes negligence.

72. The standard of care for management of symptomatic bradycardia with a pulse is to follow the most recent appropriate ACLS algorithm. At the time of the incident, the most recent ACLS guidelines were from 2015. In those guidelines, the "bradycardia with a pulse" algorithm was reaffirmed from the 2010 guidelines, and states that a patient with symptomatic bradycardia

should receive atropine 0.5 mg, which can be repeated every 3-5 minutes to a maximum dose of 3 mg. Subsequent treatment is to consider starting dopamine, epinephrine, or transcutaneous pacing. If a patient's condition changes, then the appropriate algorithm for the patient's condition should be followed.

73. Bradycardia was noted in several records such as the operative note and the Cardiopulmonary Arrest Record, which Respondent admitted occurred. However, Respondent failed to document it either in the ADR or in her notes. Respondent first attempted to treat hypotension with phenylephrine and other vasopressors, such as ephedrine. Although phenylephrine should be used with great caution if already concerned about bradycardia, it is unclear when Patient #9 started to become bradycardic. When Patient #9 continued to deteriorate, Respondent "immediately" started to give epinephrine and atropine, which would be a reasonable action if the patient was hypotensive and bradycardic. However, the recorded doses of atropine 1 mg x 2 occurred during the cardiopulmonary arrest and Respondent documented even more doses (possibly 8 doses of 1 mg) on the ADR. Giving atropine during the arrest was inappropriate timing, and giving 8 mg of it was inappropriate dosing. While there are also recorded doses of dopamine 160 mcg x 2 and transcutaneous pacing attempted, it was attempted when Patient #9 was in asystole, not when Patient #9 was bradycardic. The treatments for symptomatic bradycardia should occur when the patient is bradycardic, and should the patient progress to a different rhythm, such as asystole, that algorithm should be followed. Respondent's timing and dosages of bradycardia interventions given to Patient #9 constitutes negligence.

74. The standard of care for management of cardiac arrest is to follow the most recent appropriate ACLS algorithm. At the time of the incident, the most recent ACLS guidelines were from 2015. There are different algorithms to follow depending on the specific arrest situation. For asystole, this involves immediate chest compressions and giving epinephrine every three to five minutes while reassessing the patient and rhythm every two minutes. For non-shockable rhythms, epinephrine should be given as soon as feasible. The guidelines specifically mention that atropine and transcutaneous pacing have not been found to be beneficial during asystolic arrests.

75. Patient #9 was noted to become asystolic at 18:24, and CPR (likely chest compressions) was started. A total of seven rounds of epinephrine (18:28, 18:35, 18:42, 18:46, 18:50, 18:55, and 19:00) were given, along with atropine 1 mg (18:49, 18:58), calcium chloride 1 g (18:36), lidocaine 100 mg (x 2, no times noted), and sodium bicarbonate (x 2, every 5 minutes, no times given). For the treatment of asystole, the doses of epinephrine given here are appropriate, and the timing is as close to the algorithm as can reasonably be expected in such circumstances. However, lidocaine (a treatment for ventricular arrhythmias), atropine (a treatment in the bradycardia algorithm), and dopamine (a treatment in the bradycardia algorithm) are not indicated for asystole. Although routine use of calcium and bicarbonate are not recommended in the asystole algorithm, they are commonly given during in-hospital cardiac arrests and would have been reasonable to administer during this period. Transcutaneous pacing was attempted from 18:44 to 18:47, and then resumed at 18:54. While the records note consistent asystole, there is a notation of "HR 124" at 18:44, which if it means a heart rate of 124 was detected, would be inconsistent with the note of consistent of asystole. Transcutaneous pacing has not been found to be useful for asystole. Respondent's administering ineffective medications during the cardiopulmonary arrest constitutes negligence.

76. While most of the ADR is legible, and the illegible parts are not significant enough to be a departure from the standard of care, the lack of appropriate documentation of the hemodynamic instability and subsequent cardiac arrest and attempts at resuscitation are. It is understandable that during such an acute event, there would be no time to document. However, the anesthesiologist would be expected to document as best as possible the events that occurred within a reasonable time thereafter. The ADR would not be expected to have enough space to describe the events, so an additional note would be expected. Respondent's short post-anesthesia note is incomplete in describing the events and medications given to Patient #9. Additionally, Respondent did not describe the bradycardia episode in the medical record. Respondent's documentation in Patient #9's ADR should also have a reasonably accurate description of the medications given, but it has drastically different doses of atropine compared to the Cardiopulmonary Arrest Record, and no record of bicarbonate or lidocaine. While some leeway

in accuracy given the acuity of the situation is reasonable, there should at least be some description in the narrative description if not in the ADR itself. Respondent's failure to provide appropriate descriptions of intraoperative events and the lack of her documentation of medications administered constitutes negligence.

SECOND CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Recordkeeping)

77. Respondent has further subjected her Physician's and Surgeon's Certificate Number A 74083 to disciplinary action under sections 2227 and 2234, as defined by section 2266 in that she failed to maintain adequate and accurate medical records in her care and treatment of Patient #3, Patient #4, Patient #5, Patient #6, Patient #8, and Patient #9. The circumstances are set forth in paragraphs 47 through 76, above, which are incorporated here by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 74083, issued to Genara Turallo Dela Roca, M.D.;

2. Revoking, suspending or denying approval of Genara Turallo Dela Roca, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Genara Turallo Dela Roca, 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: AUG 14 2023

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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