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

In the Matter of the Accusation Against: Patrick E. Wherry, M.D. Physician's and Surgeon's Certificate No. A 32798 Respondent.	Case No. 800-2021-074960

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 March 26, 2025.

IT IS SO ORDERED February 24, 2025.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against:

PATRICK E. WHERRY, M.D.,

Physician's and Surgeon's Certificate No. A 32798

Respondent.

Agency Case No. 800-2021-074960

OAH No. 2024040420

PROPOSED DECISION

Administrative Law Judge Michael C. Starkey, State of California, Office of Administrative Hearings, heard this matter on November 12 and 13, 2024, in Oakland.

Deputy Attorney General Caitlin Ross represented complainant Reji Varghese, Executive Director, Medical Board of California, Department of Consumer Affairs.

Attorney Bradford J. Hinshaw represented respondent Patrick E. Wherry, M.D., who was present.

The matter was submitted on November 13, 2024.

FACTUAL FINDINGS

Jurisdictional Matters

1. On August 15, 1978, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 32798 to respondent Patrick E. Wherry, M.D. This certificate was in full force and effect at all relevant times and is scheduled to expire on September 30, 2025, unless renewed.

2. On May 22, 2023, acting in his official capacity as Executive Director of the Board, complainant Reji Varghese issued and served an accusation against respondent. Complainant alleges that cause exists to discipline respondent's certificate because: on November 18, 2020, he committed gross negligence by performing a partial penectomy on Patient A (name withheld for privacy), who only consented to a circumcision; there was a lack of adequate informed consent for this procedure; respondent failed to abort surgery before removal of part of Patient A's glans penis; and respondent failed to maintain accurate medical records. Complainant also seeks costs.

3. Respondent filed a notice of defense and this proceeding followed.

Background

4. Respondent, Patient A, Patient A's daughter, the Board investigator, and an expert witness for each party testified at hearing.

5. Respondent is a urologist and treated Patient A in this capacity for more than a dozen years.

6. In 2010 respondent treated Patient for bladder cancer, including surgeries. In the decade that followed, Patient A underwent routine follow-up cystoscopies (inspection of the urethra and bladder via a long thin optical instrument). Patient A developed problems with his foreskin, including tightness that prevented full retraction of the foreskin. Records show these problems date back to at least 2012. In 2016 and 2018, Patient A was treated for Urinary Tract Infections (UTI's). In 2016, he also reported nocturnal urinary frequency and urge incontinence.

7. On October 10, 2020, Patient A reported a burning sensation, spraying, and a slow stream, when urinating over the previous year. A test showed mixed flora, attributed to the inability to retract his foreskin and maintain good hygiene.

8. On October 20, 2020, Patient A reported to respondent that it took him 15 minutes to void his bladder.

9. On November 3, 2020, respondent attempted to perform another cystoscopy on Patient A, but was unable to insert the device into Patient's A's urethra, due to phimosis (inability to retract the foreskin). Respondent prescribed antibiotics, but they did not improve Patient A's urinary symptoms.

10. Respondent recommended a circumcision surgery to remove the foreskin of his penis. Patient A agreed.

11. On November 11, 2020, respondent and Patient A both executed a written consent form. This document is primarily a pre-printed form. However, in handwriting near the top of the form, the procedure is prominently stated as "Circumcision."

12. This form also contains the following statement: "I acknowledge that I have read and understand the information provided on this form and have had the opportunity to ask questions. By my signature below, I confirm that " This statement is followed by 10 numbered paragraphs, including one that states: "I understand that in an emergency there may be different or further procedures required if the doctor believes they are necessary, and I consent to such procedures."

The November 18, 2020, Surgery and Postoperative Care

13. The circumcision surgery was scheduled for the afternoon of November 18, 2020, at El Camino Hospital in Los Gatos. Patient A was 84 years old at the time of the surgery.

14. Patient A's daughter accompanied him to the hospital. Neither were concerned about the procedure.

15. Patient A was placed under anesthesia at 3:29 p.m. and handed off to a recovery nurse at 5:36 p.m. The surgery took approximately two hours.

16. Respondent entered a "Urology Surgery Post Procedure Note" into Patient's A's medical record shortly thereafter, at 5:57 p.m. Respondent stated:

> **Pre-Procedure Diagnosis:** Phimosis [N47.1]
>
> **Post- Procedure Diagnosis**: Same
>
> **Procedures performed and description**: Procedure(s):
> Circumcision
> Reconstruction of distal penis and urethra

Findings: severe phimosis and chronic balanitis with obliterated plane between glans and forskin [sic]

Surgeon: [respondent]

Anesthesiologist: Haehn, Melissa Rae, MD

Type of Anesthesia: General

Specimens sent to pathology: None

Estimated Blood Loss: 5 cc

Drains and Tubes: Foley catheter

Complications: none

Condition at the end of procedure: stable

(Emphasis in original.) Respondent did not mention an emergency or emergent situation. The term penectomy was not used.

17. On November 19 or 20, 2020, respondent's "Full Operative Report" was entered into Patient A's medical record (complainant's expert witness explained that a Full Operative Note is dictated [presumably at the end of the surgery], but it takes some time for it to be transcribed and entered into the medical record.) The medical record indicates that respondent electronically signed both the Urology Surgery Post Procedure Note and the Full Operative Report.

18. Respondent's Full Operative Report states, in relevant part:

DATE OF SERVICE: 11/18/2020

SURGEON: [respondent]

ASSISTANT: None.

¶ . . . ¶

ANESTHETIC: General.

PREOPERATIVE DIAGNOSES: Phimosis, balanitis.

POSTOPERATIVE DIAGNOSES: Phimosis, balanitis.

OPERATION: Distal penectomy.

OPERATIVE FINDINGS: There was a pinpoint phimosis. The plane between the glans, and the foreskin, could never be defined and [was essentially] obliterated. Indeed, it was found these were adherent and no plane can be developed. This was all concluded after significant dissection. At that time, it was realized, the standard circumcision could not be performed. Therefore, in order to afford adequate egress of urine, essentially a distal penectomy, partial, was performed. The dissection transected the urethra. It appeared also to incorporate some of the distal corporal body and perhaps glans, although attempted to find a plane as close to the original plane between the glans and the foreskin as possible.

DESCRIPTION OF PROCEDURE: After satisfactory anesthesia had been obtained, the patient was shaved, prepped, and

draped in a standard fashion. Per routine, the meatus was opened slightly with a clamp and the plane between the foreskin and the glans attempted to be developed. This could never be found. A circumcising incision, just proximal to the corona, was then made and using this approach it was attempted to find the plane between the glans and the foreskin. This could never be found. Indeed even the urethra could not be determined. It was also not possible to insert a catheter from below as this approach [also] was obliterated.

Because of this, it was elected to do a distal penectomy, thereby removing the cause of the obstruction and blockage. It was attempted to stay in the plane, or develop a plane, between the glans and the undersurface of the foreskin. However, this was not completely possible and some glandular or corporal tissue was incorporated within the specimen. In order to try and evaluate this plane, urethra have been dissected slightly proximally. This portion of the urethra was then reconstructed. The skin was then approximated over the end of the penis as is customary with a partial penectomy. Skin around the urethra was attached with interrupted sutures and then the remainder of the skin closed dorsally with running and interrupted sutures.

Because of this, it is planned to leave a catheter in for at least several weeks until the urethra heals well.

OPERATIVE PROCEDURE: After satisfactory anesthesia was obtained, the patient was shaved, prepped, and draped in a standard fashion. The phimotic opening was probed and indeed an entrance essentially not be found. Indeed, any probes will not enter the urethra. It was attempted to develop this plane slightly between the glans and the underside of the foreskin, but this was not possible.

Because of this, a circumferential incision was then made proximal to the glans by approximately 3/4 cm and this plane developed. Even when doing this, it was not possible to enter into the plane between the glans and the foreskin. After many attempts, it was felt that a distal penectomy would be the solution of choice. Because of this, the plane between the glans and the foreskin was attempted to be developed, although some glandular or corporal material could have been included in this as the plane was poorly defined. The urethra was then transected. This has been probed, this had open [sic] several centimeters more proximally. This was closed longitudinally. The urethra was then closed longitudinally with running sutures of 4-0 chromic. This was an area of approximately 1.75 cm. The distal urethra was left slightly spatulated. This was then sewn to the skin around the urethra using interrupted

> sutures of 4-0 chromic. The subcutaneous tissue of the penis was then closed in several layers using interrupted sutures of 3-0 chromic. The skin was then closed with interrupted sutures of 4-0 chromic.
>
> At the termination of the procedure, there was an excellent cosmetic appearance with a standard post-penectomy appeara[n]ce being present. ¶ . . . ¶
>
> The patient tolerated the procedure and was taken to the recovery room in stable condition.

19. Patient A's daughter reports that the surgery took much longer than she expected and they did not speak to a physician after Patient A was brought out of surgery. She reports that a nurse explained that a catheter remained in place, which was unexpected. Patient A's daughter reports that Patient A has bone spurs in his neck and was unable to bend over. She reports that her father was groggy, but he reached down and touched the surgical area and when he lifted his hand up it was bloody.

20. Patient A reports that he understood the surgery was only to be a circumcision and the purpose was to just find out what was wrong, not to improve his urine flow. He confirms that his neck problem prevented him from looking down. He reports that when he put his hand "down there" the day after surgery his penis was gone and he thought "how can this be?" He reports that due to the catheter and his inability to look down it took a couple of days for him to determine what had happened.

21. Respondent sent three pieces of tissue from Patient A's penis to a pathologist for analysis, which was performed by Ankur R. Sangoi, M.D. Dr. Sangoi

issued a pathology report dated November 20, 2020. He reported that he received, labelled "foreskin," three pieces of tissue, as follows:

> FINAL PATHOLOGICAL DIAGNOSIS:
>
> Foreskin, distal penectomy: Benign epidermis overlying stromal hyalinization
>
> ¶ . . . ¶
>
> Piece #1 (7.5 x 3.5 x 2 cm) appears large and irregular. consisting of fibrous tissue and an attached unoriented irregular piece of skin. The skin surface appears brown and wrinkled with a smooth flat portion. The presumed resection margin is inked black. Sectioning reveals soft fibrous cut surfaces and penile tissue.
>
> Piece #2 (2.8 x 1.6 cm x 2.4 cm in length) appears approximately cylindrical. The specimen is inked entirely black. Sectioning reveals rubbery fibrous cut surfaces consistent with penile tissue.
>
> Piece #3 (3 x 0.8 x 0.4 cm thickness) is a small piece of unoriented wrinkled skin. A definitive urethra is not grossly identified.
>
> ¶ . . . ¶
>
> Microscopic Description:

> Sections demonstrate mildly reactive epidermis overlying mild stromal fibrous change. The underlying peri-corporal tissue shows dense hyanlinization [*sic*] reminiscent of plaque. There is no evidence of malignancy.
>
> Clinical Diagnosis:
>
> Distal penectomy specimen per Epic chart review.

22. On November 28, 2020, Patient A was admitted to the hospital due to postoperative bleeding.

23. On November 29, 2020, Randy Cheng-Sheng Liang, D.O., reported, in relevant part:

> 84 y.o. M hx chronic afib on eliquis f/b Dr. Kao, CAD, hx TIA/CVA, HTN, IDDM, CKD, BPH [benign prostatic hyperplasia, also known as enlarged prostrate], with recent distal penectomy done by [respondent] 11/18 dc on foley, who presents to hospital with gross hematuria with acute on chronic kidney injury. CTAP showed some possible fluid collection along left side of kidney likely from blood.

24. Apparently during this period, David Nudell, M.D., a urologist who is a member of respondent's practice group, sent a text message to respondent, stating:

> [Y]our patient got admitted Saturday afternoon at ECH – The one who had what appears to have been a distal penectomy – he has started his Elliquis and started bleeding both in the ur[i]ne and more around the catheter from the

> penis – it was much better today with hydration and stopping the eliquis – hard to see much in the wound it is quite buried – he will be there in the AM the hospitalist wanted you to see him – they did a CT in ER sho[w]ed fluid along the penis I sins see [*sic*] it assumed it was just some blood.

Respondent replied "Got it ... thanks."

25. On November 30, 2020, at 6:59 a.m. respondent entered the following note into Patient A's medical record:

> 11-18-20 distal penectomy with obliter[a]ted distal urethra . . reconstructed per a distal penectomy
>
> As anticipated some penile retraction ... but clean and healing well
>
> Would Hold el[i]quis for present .. [can] retry [in] another 10 - 14 days
>
> discussed hygiene
>
> Plan to leave cath[eter] [in] for at least two months

26. Patient A was discharged on November 30, 2020. At 2:02 p.m. that afternoon, Cynthia Pei, M.D., reported:

> This is a pleasant 84-year-old male with history of atrial fibrillation, followed by Dr. John Kao, on Eliquis [an anticoagulant]; history of TIA/CVA; diabetes mellitus type 2;

chronic kidney disease; hypothyroidism; hyperlipidemia; hypertension; history of BPH, who was recently seen by [respondent] on 11/18 for distal penectomy for phimosis and balanitis. He presented into the emergency department with complaints of gross blood in his Foley bag and around his Foley, he has noticed over the last 1-2 days associated with some mild shortness of breath. He is followed by [respondent] and underwent distal penectomy without any complications and went home on a Foley. He resumed his Eliquis later on that night. Over the first 24 hours after surgery, there was only blood-tinged urine. This then resolved to clear urine. He continued to remain at this baseline until about 1-2 prior to admission when he started noticing increased gross blood within the Foley bag and around. He was sitting down on the toilet bowl and noticed drops of blood in the toilet bowl. Due to continued presence of gross hematuria, the patient then presented into the emergency department for further workup.

In the emergency department, his labs were notable for evidence of acute on chronic kidney injury with elevated lactic acid. He had no leukocytosis and his hemoglobin was at 11 .7. He was seen in consultation by Dr. Nudell, covering for [respondent]. There was a small amount of blood coming from deep in the area, but it was difficult to determine exactly where. After a L of IV fluids, his urine is only light red in the tubing. Given this, there was concern

for surgical bleeding likely in the setting of taking his Eliquis and dissolution of sutures.

Gross hematuria

- the patient had recent urologic surgery and the etiology was suspected to be surgical site bleeding from dissolution of sutures and eliquis use. He was on 5mg in setting of acute on chronic kidney injury. After admission and observation with the eliquis on hold, there was no further active bleeding.

- the patient was evaluated by [respondent] and the decision was to continue foley catheter drainage for another 2 months and the patient would follow up with him in 1-2 week with plan to resume eliquis in 2 weeks time. In the future the patient was advised to take asa now but when eliquis resumed in 2 weeks to not use both medications at the same time. The plan also d/w Dr. Kao his cardiologist . . . .

27. At discharge, Dr. Pei diagnosed Patient A with:

Postoperative hemorrhage involving genitourinary system following genitourinary procedure

Acute blood loss anemia

S/p recent distal penectomy and distal urethra reconstruction

28. On December 15, 2020, respondent conducted a follow-up examination of Patient A. Respondent reported:

> Discussed in detail with patient
>
> multiple issues present ... all reviewed and addressed in depth ...follow-up requirements co-ordinated ... surveillance recall notices (phone .. electronic .. mall) generated

29. Also notable in relation to the allegation that respondent failed to maintain accurate medical records, after the heading "Breast Inspection," this December 15, 2020, medical record signed by respondent states: "Normal in size with no skin changes or nipple discharge present. The nipples and areolas are within normal limits. No implants present." Patient A is male.

30. After the heading "Thyroid" it states: "normal size without tenderness, nodules or masses." Patient A had his thyroid removed many years prior to this examination.

31. Respondent also reported "Penis : now a [tight] phimosis n... unable to access with small male soiuds [sic]." This is identical (including spelling errors) to the corresponding entry in Patient A's medical record for the November 3, 2020, visit, prior to the November 18, 2020, surgery, and appears to be a remnant from the prior note, not a new post-surgery observation.

32. On December 21, 2020, Mark W. Noller, M.D., a urologist and apparently a member of respondent's practice group, conducted a follow-up examination of Patient A. Under the heading "History of Present Illness," Dr. Noller noted:

1 month s/p distal penectomy for phimosis. Upon review of notes, appears that foreskin fused to glans. Unable to delineate skin for penis. No cancer on path. Daughter of patient inquiring about how I would handle to the intraoperative situation. I told her that I was not sure, but would recommend she follow up with [respondent] for follow up and catheter management. Also put in a referral to discuss with Dr. Harris, reconstructive urologist at VMC [Santa Clara Valley Medical Center].

33. On January 5, 2021, respondent conducted a follow-up examination of Patient A. Respondent noted:

he has returned for follow-up

when irrigation has urgency and voiding peri catheter

multiple questions re procedure

did not mention they had sought a second opinion

patient worried re penile length

34. This medical record also contains the same inaccuracies regarding examination of Patient A's thyroid and "breasts" as in respondent's December 15, 2020, medical record (discussed in Factual Findings 29 and 30). The medical record of Dr. Noller's December 21, 2020, examination of Patient A looks similar, but does not contain an erroneous report regarding examination of Patient A's non-existent thyroid or any reference to a "breast examination." The medical record of Dr. Nudell's January 11, 2021, examination of Patient A (discussed directly below in Factual Finding 35)

contains an erroneous statement, similar to respondent's, regarding examination of Patient A's thyroid, but no mention of a breast examination of the 84-year-old male patient.

35. On January 11, 2021, respondent's colleague Dr. Nudell, evaluated Patient A's urinary symptoms. On January 12, 2021, Dr. Nudell reported

> Recent circumcision that appears due to dense scarring to have led to a distal penectomy - Came to me for second opinion - regarding now buried phallus - catheter is out and is voiding with predictable difficulty directing the stream - PVR low however today - they have an appointment with Catherine Harris later this week who I told them would be the best resource to decide if a procedure can be done to free the urethral opening and ensure its patency or whether another surgical option is necessary.

36. On January 15, 2021, Catherine Rand Harris, M.D., M.P.H., a urologist in a different practice group, evaluated Patient A for complaints regarding his urination, specifically that the "urine is spraying everywhere" and "the stream is not as strong as it was prior to catheter placement." Dr. Harris reported:

> History of Present Illness: [Patient A] a 84 y.o. male with BPH, low grade bladder tumor (pathology uncertain approximately 10 years ago), and phimosis referred here for consideration of reconstructive surgery after distal penectomy (done by [respondent]) on 11/18/20.

The patient had been having difficulty retracting his foreskin for about a year and was spraying urine when voiding. He also had occasional burning of the foreskin during urination as well. During an attempted cystoscopy for surveillance of bladder cancer, a pinpoint phimosis was noted and the scope was unable to be passed. He was taken to the operating room for a circumcision. However, intra-operatively the foreskin was found to be attached to the glans and the plane between the dermis and Buck's fascia appeared to be obliterated. Thus, a distal penectomy was performed and the urethra was surrounded with healthy shaft skin. A catheter was in place for about 8 weeks and was removed on 1/5/21.

Since then, the patient has had to sit while voiding and has been urinating down his leg frequently. He also continues to have urgency and frequency and often will have to double void. He finds the lack of length distressing as well as the inconvenience of not being able to control his stream. Notably, he does feel that the force of stream is mildly improved.

¶ . . . ¶

Prior to the surgery, the patient had intermittency, frequency, and spraying. However, he is significantly bothered by urgency. He would also have to strain to void.

> Today, the patient reports wetting himself when voiding as he is unable to control his stream. He can only urinate while sitting. He is also concerned about possible stricture as he recently switched [u]rologists to Dr. Nudell, who voiced this concern.

37. Regarding her physical examination of Patient A's penis, Dr. Harris reported: "The penile skin incision appears to be well healed. There is some granulation tissue that was gently wiped off. The new urethral meatus was identified and appeared patent. Remnant corporal bodies are palpable, soft."

38. Dr. Harris identified several potential treatment options for Patient A, including:

> Penoplasty with penile skin grafting to try to maximize penile length. Inpatient procedure, ~5 day hospital stay. Risks are graft loss, wound healing complications. May still not have enough functional length to urinate standing/using urinal. Spraying likely to persist.

39. Dr. Harris opined that a "[p]enile transplant and neophallus creation [was] not recommended due to age/comorbidities"

40. On January 26, 2021, Dr. Harris performed a cystoscopy procedure upon Patient A. She reported that his urethra appeared normal. Under "Assessment & Plan," she wrote:

> Cause of urine spraying is likely both lack of penile length to aim, and ho urethral meatal surgery. Even if able to

unbury penis for 1-2 cm more functional length it is unclear if this would give enough length to urinate standing, and urine spraying is likely to persist. Do not recommend urethral reconstruction as this time stenosis appear quite functional and can be gently dilated to accommodate cystoscopy.

Patient A's Complaint and the Investigative Interview of Respondent

41. On February 3, 2021, Patient A filed a complaint against respondent with the Board. Patient A provided a lengthy statement, the relevant essence of which is that Patient A consented only to a circumcision, but during the surgery respondent removed Patient A's penis, without Patient A's permission or knowledge.

42. Approximately two and one-hon September 26, 2023, respondent, with his attorney present, was interviewed by a Board investigator and Geeta Singh, M.D., a medical consultant to the Board. During this interview, respondent reported:

- Patient A had a "buried penis" for many years and his hygiene was "non-existent." Respondent explained that his penis was "essentially, slightly retracted within the foreskin, trapped within it" and "you can't open it and you can't do hygiene. You can't access anything."

- In response to questions why his medical records do not say this and instead only report a diagnosis of phimosis and "general normal appearance," respondent stated "I agreé, that's very bad nomenclature because -- uh -- the thing was in the impression in the notes, but it wasn't documented in the -- uh -- physical exam part."

- Patient A's "buried penis" or tight foreskin gave the appearance that his penis was shorter, but there was no actual penile shortening.

- After his examination of Patient A on November 3, 2020, his phimosis was so tight that respondent "expected him to call me at 3:30 in the morning and say, I can't pee. And then I was worried that he'd have a whole scenario at night in the hospital trying to find the things that you need to do to fix it."

- Respondent did not discuss with Patient A the possibility that he would be unable to complete the circumcision procedure because it was "a situation which I had never encountered before and did not anticipate. And so, in my wildest imagination, I probably would have not discussed that possibility with him ahead of time because it's so remote."

- There was no way to preoperatively diagnose that the plane between the glans and the foreskin of Patient A's penis was obliterated.

- During the surgery, when respondent discovered that Patient A's foreskin has fused with the glans penis and could not be removed as planned, his main concern was a "malignancy of the penis" and he wanted to "get a tissue diagnosis" from the pathologist. "And the second thing is I wanted to reconstruct the meatus so he wouldn't block off and could pee."

- When asked why he did not stop the surgery at that point, respondent stated:

> You know, I'm not naïve enough to . . . not be aware that one of the choices, I could do nothing. But the gentleman is about to block off, so I can't leave him like that.

I would have to do a suprapubic incision and put a catheter in the bladder called a suprapubic tube. That is a fairly significant procedure in itself.

People are not happy when you do that to them. And because of my prior experience with dealing with these things, I felt very comfortable exploring the area until I identify the urethra and reconstructed it which is exactly what happened.

And I used the remaining foreskin to put it together like it had looked for 30 years and make it functional. And that's what worked, and it's still working.

So I guess the proof in the pudding to me is the fact that it worked.

¶ . . . ¶

Uh -- one of the choices -- and I -- I w- -- probably would do this now that I know all the trouble it causes you if you do something good for someone. No good deed will go unpunished.

The easy way out is to say, I'm going to abandon this. I'll tell him I can't do it, put a suprapubic tube in, send him off to the teaching hospital.

That is the safe solution for the surgeon because you're not going to get reprimanded. Not the right solution for the patient, but a great solution for the doctor. Right.

- When asked if he made the decision to proceed with the partial penectomy, respondent stated:

  Now, now, let -- let me clarify. Bad choice of nomenclature. I said a partial penectomy as we concerned -- what I was concerned about truthfully, was the pathology department.

  Some of the tissue I took in trying to get enough tissue for pathology was glandular tissue from the glans penis. I didn't want him to come back and say you didn't document that you took some glans, so I just used the term, partial penectomy.

  What I really did was simply a complex meatotomy or meatoplasty or both. It was not a partial penectomy. I used that language so that if I had some glandular material within the foreskin specimen, that the pathology department would rake me over the coals. Right.

  But it wasn't a partial pene- -- well ----- I guess removing the foreskin, theoretically, is a partial penectomy, isn't it? You're taking away part of the penis. But that's not what the usual usage or nomenclature refers to.

- Respondent was asked if "when you saw" Patient A in the recovery room after the surgery, respondent told him "that he didn't have a circumcision, that he had a partial penectomy? Did you tell the patient that?" Respondent replied: "Of course. I explained to him exactly what we've done. And I phoned his family and I explained it to them because they weren't – there wasn't anyone downstairs."

- Respondent admitted that he was aware that Patient A had a diagnosis of atrial fibrillation. Regarding his documentation in Patient A's medical record that Patient A had a regular heart rate with a normal rhythm, respondent stated "even as a urologist, I recogni -- I recognize the discrepancy."

- When asked if he removed any part of Patient A's penis, respondent stated "The foreskin. Little piece."

- Regarding respondent's medical records for Patient A, which reflect very detailed and nearly identical physical examinations during each visit, including a rectal examination during each visit, even when there were multiple visits per year, respondent was asked if he actually performed "a full physical exam from head to toe of all the organ systems?" He replied:

  > You know, I think I- -- you can do a fairly quick -- look at the patient and cover a lot of systems. And you deal with -- you deal with the appropriate ones.
  >
  > Uh -- these templates are an issue, aren't they? Because I don't remember, and you -- if you want me to try and remember, I cannot say.

- Then respondent was specifically asked whether he performed multiple rectal examinations per year on a patient. Respondent replied:

> I've changed the notes at present because I document when I do it in the note as the date it was done. Just to get around that problem as a modification I've made.
>
> As I said, templates create -- uh -- an issue.

Additional Testimony of Patient A and His Daughter

43. At hearing Patient A described his penis, after the surgery, as "hardly anything left." He reports that when the catheter was removed "it felt like a little bump." He also reports that the length of his penis "changed from normal to no penis." Patient A reports that he subsequently was examined by three other urologists, who said that his penis was removed. One recommended a penis reconstruction specialist. Patient A reports that this surgery "ruined my sex life forever." Patient A reports that he only consented to a circumcision, not any other procedure.

44. Patient's A's daughter reports that they were "blindsided by the outcome" and "devastated."

Respondent's Testimony

45. Respondent testified at hearing. He graduated from medical school in 1970, completed a five-year residency in general surgery in 1975, and a three-year residency in urology in 1978, including one year of special training in microsurgery. Since then, he has practiced general urology in the San Jose area. For the last ten years, he has specialized in men's health, erectile dysfunction, and prostate problems. Respondent is board-certified in urology and surgery.

46. Respondent reports that he plans to retire in six months to one year, but he is currently still seeing patients and performing surgeries.

47. Regarding the inaccuracies in Patient A's medical records pointed out by the Board's expert (see Factual Finding 55), respondent testified that he did not choose the software he uses for patient's medical records, rather his practice group makes that decision. He also testified that the medical record is a collaborative effort with nurses and medical assistants also making entries. However, respondent did not deny that the information about examining the thyroid, breasts, and regularity of Patient A's heart rhythm constitutes inaccurate information contained within medical record notes that he signed. When asked if, as the treating physician, he was ultimately responsible for the accuracy of the medical record, respondent replied "that's an interesting question," but did not acknowledge such responsibility.

48. Regarding the surgical procedure he performed on Patient A, respondent testified that it was a "reconstruction." He admits that he transected the urethra, and that some glandular or corporal tissue was incorporated in the specimen sent to pathology. Respondent was not specifically asked and did not testify regarding the amount of this tissue that was removed or whether that constituted a partial distal penectomy.

49. Respondent testified that Patient A's urinary retention was an emergent situation on the date (November 3, 2020) that he tried but was unable to perform another cystoscopy on Patient A. Respondent then testified that he knew it would "evolve into emergency in the next several days." When asked where he had documented that, respondent replied that he documented that it was an "urgent situation" in the medical records in late October or early November.

Expert Opinions

DR. WEINBERG

50. Complainant engaged Alan C. Weinberg, M.D., F.A.C.S., as an expert witness for this matter. Dr. Weinberg has been licensed as a physician in California since 1982. After receiving a medical degree, he completed a one-year surgical internship and then a four-year urology residency. He practiced as a urological surgeon, with a focus on cancer, from 1986 through 2023, when he retired. He is board-certified in urology and surgery. During his career, Dr. Weinberg performed 30 to 40 surgical procedures per week, including penile, testicular, kidney, bladder, and urethra surgeries, as well as cystoscopies. He has reviewed approximately 15 to 20 matters for the Board, dating back to 2010. Dr. Weinberg reviewed Patient A's complaint, the relevant medical records, respondent's curriculum vitae, the transcript of the investigative interview of respondent, and the report of respondent's expert. Dr. Weinberg issued a report dated November 13, 2023, and testified at hearing.

51. Dr. Weinberg opines that respondent committed an extreme departure from the standard of care on November 18, 2020, by performing a partial distal penectomy upon Patient A when Patient A consented only to a circumcision and did not consent to a partial penectomy. Dr. Weinberg also opines that respondent committed an extreme departure from the standard of care by not aborting the surgery when respondent concluded that he was unable to perform a circumcision, as planned. In his report, Dr. Weinberg explained:

> Standard of care, if surgery is required for phimosis, is to perform either dorsal slit of the prepuce or circumcision. This is an elective procedure and distal or partial penectomy

is outside the scope of this procedure that could have been aborted prior to removing the patient's glans penis, allowing either referral to a specialist or appropriate informed consent regarding the necessity of removing part of the penis. Buried penis has options for surgical correction beside partial penectomy and in fact uses the penile foreskin in achieving penile shaft coverage after releasing the buried penis.

¶ . . . ¶

Not only was this likely malpractice to perform a distal penectomy when only circumcision had been consented, but it also represents medical battery. The patient could have been awakened and the procedure aborted before a point of no return. If there were such significant scarring that the penis and foreskin could not be separated or differentiated, something the doctor admits in his interview that he had never before seen in his years of practice, the surgery could have been stopped. Also, [respondent] attempts in his interview to deny that the partial penectomy was performed, saying "It was not a partial penectomy," though his many documented notes indicate "essentially a distal penectomy, partial, was performed," and "a distal penectomy would be the solution of choice," and "standard post-penectomy appearance [sic] being present," in addition to urologic consultant Dr. Catherine Harris noting

> that the patient was post partial penectomy. [Respondent's] operative report also notes the procedure performed to have been "distal penectomy." Of course, the pathology showing a 2.4 cm circumferential specimen of penile tissue further corroborates that a partial or distal penectomy was performed despite the interview protestations of [respondent].

Dr. Weinberg opines that consenting to a circumcision does not include consenting to a partial penectomy or transection of the urethra. Dr. Weinberg opines that cutting the urethra longitudinally (in the direction of its length) is an "incision," and "transection" of the urethra (as respondent reported doing) means a cut perpendicular or oblique to the length of the urethra.

52. Regarding respondent's claim during the investigative interview, that he did not perform a partial penectomy, but rather a "complex meatotomy or meatoplasty or both," Dr. Weinberg opines that transecting the urethra is not part of meatotomy. He opines that to surgically treat meatal narrowing, a surgeon makes a small cut on the ventral side to open it up, which provides no specimen to send to pathology.

53. Dr. Weinberg opines that respondent removed at least two centimeters of Patient A's penis, but Dr. Weinberg is not exactly sure how much because respondent's operating report is "vague." Regarding the pathology report, Dr. Weinberg opines that the second specimen (2.8 cm by 1.6 cm by 2.4 cm) is too big to be just foreskin, because skin is less than one centimeter thick. Dr. Weinberg also notes that the pathologist described this specimen as "approximately cylindrical," which is inconsistent with skin tissue. Dr. Weinberg opines that pathologists do not

refer to penile skin as "penile tissue." Dr. Weinberg opined that if a pathologist writes that something (here urethra tissue) is not "definitively" identified, that does not mean it is not part of the specimen. He explained that pathologists just sample tissue, and here the tissue was sent in three pieces and may have been hard to identify. Dr. Weinberg also opined that the pathology report mentions peri-corporal fibrosis, and the pathologist could not have identified peri-corporal tissue without corporal tissue.

54. Dr. Weinberg also points to the fact that, after the surgery, respondent and numerous other physicians stated that a partial penectomy had been performed, and that Dr. Harris's records mentioned "partial penis amputation" and "neo meatus," which is the new opening respondent had to create after removing the distal end of Patient A's penis.

55. Dr. Weinberg opines that respondent committed a simple departure from the standard of care for medical recordkeeping, by the inappropriate repeated use of templated physical examinations. In his report, he explained:

> Standard of Care:
>
> Documentation of history, examination, and decision making should be accurate and reflect what was done during the visit. Falsifying the record using templates or other means to "upcode" the visit is fraudulent. Work done should reflect the level of complexity of the visit and not be more comprehensive than needed to "upcode."
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> ¶ . . . ¶

> [Respondent] uses templated physical exams that are detailed far beyond what is necessary for a urology visit and each visit's physical exam is virtually identical, in this case including a normal thyroid exam in a patient who was post total thyroidectomy, a normal heart rhythm in a patient with chronic atrial fibrillation, as well as unnecessary breast exams, femoral artery auscultation, to name a few. He admits in his interview that "templates create—uh— an issue" and that he had subsequently modified his recordkeeping.

56. At hearing, Dr. Weinberg further opined that electronic medical records were supposed to improve medical recordkeeping, but they allow previous histories or examination findings to be "pulled into" a new record, even when not actually performed.

DR. KARPMAN

57. Edward Karpman, M.D., F.A.C.S., issued a report dated April 10, 2024, and testified at hearing on behalf of respondent. Dr. Karpman has been licensed as a physician in California since 2000. After receiving a medical degree, he completed a one-year surgical internship and then a four-year urology residency. He then completed a one-year fellowship in male reproductive medicine and surgery. Since then, he has been practicing as a urological surgeon. He is the Medical Director of the Men's Health Center at El Camino Hospital in Los Gatos. He is an attending physician in the El Camino Urology Medical Group, and a colleague of respondent. Dr. Karpman performs circumcision surgeries weekly and estimates that he performs a circumcision

surgery with the complexity of the surgery performed upon Patient A about twice a year.

58. Dr. Karpman reviewed the relevant medical records, the transcript of the investigative interview of respondent, and the report of Dr. Weinberg.

59. Dr. Karpman opines that respondent did not breach the standard of care during his treatment of Patient A. In his report Dr. Karpman explained:

> [Respondent] did not perform a distal penectomy on 11/18/2020. The review of his operative note description does not show any of the hallmark maneuvers that would be required to perform a distal penectomy. The corpora cavernosa (CC) and corpora spongiosa (CS) are very vascular structures. The urethra is inside the CS. A distal penectomy would require transection of one or all three of these structures. Transection of these structures or oversewing these structures is not mentioned in the operative report. All of the medical experts and physicians reviewing this case have relied solely on [respondent's] stated operation and the GROSS description by the pathologist. Dr Weinberg conveniently only mentioned the GROSS description of the pathology specimen and omitted the very crucial MICROSCOPIC description of the specimen in his report. When a specimen arrives to the pathologist for review, it is just a piece of flesh and the pathologist relies on the diagnosis and surgical description from the operative note to understand its origin. That is why the

> GROSS description states the tissue is consistent with "penile tissue." However, this is an inconclusive statement of what part of the penis it comes from. Tissue from a circumcision would also be described as "penile tissue" since this is accurate. The GROSS description also stated that "A definitive urethra is not grossly identified." The urethra extends to the very distal margin of the penis. How can a distal penectomy be performed without any urethra in the specimen? . . . .
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> More importantly, the microscopic description of the different tissue layers which are easily identifiable and confirmatory for the presence of these structures does not make any mention of corpora cavernosa, corpora spongiosa or urethral origins. The pathologist only saw "peri-corporal" tissue at best which was stated in the MICROSCOPIC description. Peri-corporal tissue means that they only saw tissue that is found around the corpora and not the corporal structures themselves. A finding of peri-corporal tissue would be consistent with the degree of severity and extent of surgery in this case.

Dr. Karpman also opined that Patient A's "disability as a result of the circumcision is also overstated" and post-surgery symptoms do not suggest a distal penectomy was performed.

60. At hearing, Dr. Karpman opined that a "true partial penectomy" requires amputating the entire glans, corpus spongiosum, and urethra. He emphasized that the

pathology report does not include a finding of urethra tissue. Later, Dr. Karpman opined that a partial penectomy is removal of anything less than the whole penis, and could include removal of a portion of the glans. Dr. Karpman also opines that the operative report shows that respondent had transected Patient A's urethra vertically (along its length), not obliquely or horizontally as Dr. Weinberg opined.

61. When asked about statements in respondent's operative report that "some glandular or corporal tissue was included in the specimen" and "although some glandular or corporal material could have been included," Dr. Karpman replied that this was "such a bad case of neglect" by Patient A and reiterated that the pathologist stated "at best peri-corporal tissue" was included in the specimens.

62. Dr. Karpman opined that the numerous subsequent references to a partial penectomy were the result of "broken telephone," meaning that each subsequent physician was just repeating the term respondent used in the operative reports.

63. Dr. Karpman reported that he is very familiar with the pathologist who examined the tissue in this case, because they are colleagues and Dr. Karpman has reviewed hundreds of his reports. Dr. Karpman opines that, when reading this report, his interpretation is "it's almost like he's [the pathologist is] incredulous at the description of a distal penectomy."

64. Dr. Karpman also opined that the procedure respondent performed upon Patient A that was outside the scope of a circumcision was an emergency procedure, due to the risks of a second round of general anesthesia on an 84-year-old patient with several other health problems. He explained that to get Patient A's express consent to the additional procedure, Patient A would have to have been woken from

the general anesthetic and then it would have been necessary to wait until Patient A was no longer under the influence of the anesthetic. So, the surgery could not have been resumed until the following day. Dr. Karpman opined that one "can't wake every patient every time something slightly different from the surgical plan" occurs. Dr. Karpman opined that Patient A's pre-surgery difficulty urinating could have caused "serious imminent trouble." Dr. Karpman opined that a penectomy was appropriate, including slicing the urethra, but there was no evidence that glandular tissue was removed.

65. In his report, Dr. Karpman did not address the allegation that respondent maintained inaccurate medical records. At hearing, Dr. Karpman simply opined that he believed that respondent complied with the standard of care for recordkeeping, "even though we can all do better with documentation."

Ultimate Findings

66. Respondent committed a simple departure from the standard of care by keeping inaccurate medical records for Patient A. Specifically, respondent reported physical examination findings that were either grossly inaccurate or never conducted, regarding purported physical examinations of Patient A's thyroid, breasts, and heart rhythm. Dr. Weinberg's opinion is persuasive. Dr. Karpman's opinion was less persuasive, because it was summary and did not address the many inaccuracies proven. Dr. Karpman's professional association with respondent also suggests a bias that renders all of his opinions less persuasive than they would otherwise have been. No motive for the inaccuracies in respondent's medical records was alleged or proven.

67. Respondent committed an extreme departure from the standard of care on November 18, 2020, by performing a partial distal penectomy upon Patient A when

Patient A consented only to a circumcision, and did not consent to a partial penectomy. Respondent's failure to abort the surgery before removing part of Patient A's glans penis was also an extreme departure from the standard of care. Dr. Weinberg's opinions to this effect were more persuasive than those of Dr. Karpman.

68. Respondent performed a partial distal penectomy and removed a significant portion of Patient A's glans penis. This was not a circumcision. Respondent himself described the procedure as a "distal penectomy" numerous times in his full operative report shortly after the November 18, 2020, surgery, and again in Patient A's medical record on November 30, 2020. In the investigative interview, respondent admitted that he understood the term "partial penectomy" does not refer to merely removing foreskin. Nor did respondent express disagreement when Dr. Nudell referred to Patient A in a text as the "one who had what appears to have been a distal penectomy." Five other physicians also noted in Patient A's medical record that a distal penectomy or partial distal penectomy had been performed. Respondent admitted that he removed some tissue from Patient A's glans penis and sliced open Patient A's urethra, which are not part of a circumcision procedure. The pathologist reported that one of the specimens from Patient A's penis was approximately cylindrical, measured 2.8 cm by 1.6 cm by 2.4 cm in length (approximately two-thirds of cubic inch), and its smallest dimension was 1.6 cm (almost two-thirds of an inch thick); not plausibly just foreskin.

69. Patient A did not consent to the procedure respondent performed. Patient A consented to circumcision. He did not consent to a partial penectomy or any other procedure. In the written consent form he consented to other procedures, but only if necessary and in an emergency.

70. There was no emergent situation that relieved respondent of the obligation to secure informed consent from Patient A to the procedure that respondent performed. It is plausible and perhaps even likely, that—absent surgical intervention—Patient A's difficulty urinating would have deteriorated into a total or near total inability to urinate and become an emergent situation in the days, weeks, or months that followed the November 18, 2020, surgery. However, Dr. Weinberg's opinion that there was not such an emergent situation at the time of the surgery is far more persuasive than the opinion of Dr. Karpman and the testimony of respondent, primarily because of the absence of any documentation of such an emergency in the medical records. There is no report in the record that Patient A was unable to urinate or that there was an emergency, despite respondent entering very detailed operative notes, including a description of why he abandoned the circumcision procedure and instead performed a partial penectomy. Additionally, respondent scheduled the surgery to occur 15 days after he was unable to perform the cystoscopy, not immediately afterwards.

71. Respondent did not acknowledge wrongdoing or demonstrate significant rehabilitation.

Costs

72. In connection with the investigation and enforcement of this accusation, complainant requests an award of costs in the total amount of $62,466.25, comprising $12,773.50 in investigative services, $1,650 in expert witness fees, and $48,042.75 in attorney and paralegal services provided by the Department of Justice and billed to the Board. That request is supported by declarations that comply with the requirements of California Code of Regulations, title 1, section 1042. These costs are found to be reasonable.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant is required to prove cause for discipline of a professional license, permit, or registration by "clear and convincing proof to a reasonable certainty." (Cf. *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) To the extent respondent contends mitigation or rehabilitation, it is his burden to prove those contentions by a preponderance of the evidence. (Evid. Code, §§ 115, 500.)

First Cause for Discipline (Gross Negligence – Patient Consented to Different Procedure)

2. The Board may discipline the physician's and surgeon's certificate of a licensee who commits unprofessional conduct. (Bus. & Prof. Code, § 2234 [all further statutory references are to the Business and Professions Code unless stated otherwise].) Unprofessional conduct includes conduct that is grossly negligent (§ 2234, subd. (b)), or repeatedly negligent (§ 2234, subd. (c)). An extreme departure from the standard of care constitutes gross negligence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) Respondent committed an extreme departure from the standard of care on November 18, 2020, by performing a partial distal penectomy upon Patient A when Patient A consented only to a circumcision. (Factual Finding 67.) Cause exists to discipline respondent's physician's and surgeon's certificate under section 2234, subdivision (b).

Second Cause for Discipline (Gross Negligence – Lack of Informed Consent)

3. Respondent committed an extreme departure from the standard of care on November 18, 2020, by performing a partial distal penectomy upon Patient A, when Patient A did not consent to this procedure. (Factual Finding 67.) Cause exists to discipline respondent's physician's and surgeon's certificate under section 2234, subdivision (b).

Third Cause for Discipline (Gross Negligence – Failure to Abort Surgery)

4. Respondent committed an extreme departure from the standard of care on November 18, 2020, by failing to abort the surgery before removing part of Patient A's glans penis, where Patient A did not consent to this procedure. (Factual Finding 67.) Cause exists to discipline respondent's physician's and surgeon's certificate under section 2234, subdivision (b).

Fourth Cause for Discipline (Inaccurate Recordkeeping)

5. Pursuant to section 2266, a licensee's failure to maintain adequate and accurate records also constitutes unprofessional conduct. Cause exists to discipline respondent's physician's and surgeon's certificate under section 2266, in light of the matters set forth in Factual Finding 66.

Fifth Cause for Discipline (Repeated Negligent Acts)

6. Respondent committed repeated negligent acts. (Factual Findings 66 and 67.) Cause exists to discipline respondent's physician's and surgeon's certificate under section 2234, subdivision (c).

Determination of Discipline

7. Cause for discipline having been established, the next issue is what discipline is appropriate. The Board's highest priority is protection of the public. (§ 2229.) However, "to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees." (Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines ("Guidelines") (12th ed. 2016), at p. 2; see Cal. Code Regs., tit. 16, § 1361.) The Board may consider a respondent's attitude toward his offense and his character, as evidenced by his behavior and demeanor at hearing. (*Yellen v. Board of Medical Quality Assurance* (1985) 174 Cal.App.3d 1040, 1059–1060.) The Guidelines expressly provide for disciplinary orders that deviate from the recommended discipline, in appropriate circumstances where the departures and supporting facts are identified.

8. For the violations found in this case, the Guidelines recommend a minimum disciplinary order of revocation, stayed, with a five-year period of probation, and a maximum discipline of outright revocation. Complainant argues for outright revocation. Respondent maintains that there is no cause for discipline.

9. Respondent has had a long and distinguished career with no prior discipline. He performed a procedure upon Patient A that he believed was medically appropriate and best for Patient A. However, Patient A did not consent to removal of a portion of his penis and there was no emergency that permitted respondent to make

this decision for Patient A. In doing so, respondent committed an extreme departure from the standard of care. He also maintained inaccurate medical records. Perhaps more concerning, respondent accepts no responsibility for his acts of unprofessional conduct and he demonstrated no significant rehabilitation. Respondent is not a good candidate for probation. Public protection requires the outright revocation of his physician's and surgeon's certificate.

Costs

10. A licensee who is found to have committed a violation of the licensing act may be ordered to pay a sum not to exceed the reasonable costs of investigation and enforcement. (§ 125.3.) Cause exists to order respondent to pay the Board's costs in the amount of $62,466.25. (Factual Finding 72 and Legal Conclusions 2–6.)

11. Cost awards must not deter licensees with potentially meritorious claims from exercising their right to an administrative hearing. (*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) Cost awards must be reduced where a licensee has been successful at hearing in getting the charges dismissed or reduced; a licensee is unable to pay; or where the scope of the investigation was disproportionate to the alleged misconduct. (*Ibid.*) The agency must also consider whether the licensee has raised a colorable challenge to the proposed discipline, and a licensee's good faith belief in the merits of his or her position. (*Ibid.*). There is no basis to reduce the cost award in this matter.

ORDER

1. Physician's and Surgeon's Certificate No. A 32798, issued to respondent Patrick E. Wherry, M.D., is revoked

2. Respondent Patrick E. Wherry, M.D., shall pay to the Board costs associated with its enforcement of this matter, pursuant to Business and Professions Code section 125.3, in the amount of $62,466.25.

DATE: 12/12/2024

Michael C. Starkey

MICHAEL C. STARKEY
Administrative Law Judge
Office of Administrative Hearings