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

In the Matter of the Accusation Against: Mangano Christina T. Mora, M.D. Physician's and Surgeon's Certificate No. G 81274 Respondent.	Case No. 800-2021-083856

DECISION

The attached Default Decision 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 April 1, 2025.

IT IS SO ORDERED March 20, 2025.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Executive Director

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

In the Matter of the Accusation Against: **MANGANO CHRISTINA T. MORA, M.D.** 30 Genevra Road Hillsborough, CA 94010 Physician's and Surgeon's Certificate No. G 81274 Respondent.	Case No. 800-2021-083856 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On November 25, 2024, Complainant Reji Varghese, in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Accusation No. 800-2021-083856 against Mangano Christina T. Mora, M.D. (Respondent). [Exhibit Package[1], Exhibit 1, Accusation]

2. On May 24, 1995, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G 81274 to Respondent. The Physician's and Surgeon's Certificate is

[1] The evidence in support of this Default Decision and Order is submitted herewith as the "Exhibit Package."

delinquent, having expired on May 31, 2023. [Exhibit Package, Exhibit 2, License Status BREEZE printout]

3. On November 25, 2024, an employee of the Board served by Certified Mail a copy of Accusation No. 800-2021-083856, Statement to Respondent; Notice of Defense; Request for Discovery; and Discovery Statutes to Respondent's address of record with the Board, which was and is 30 Genevra Road, Hillsborough, CA 94010. The United States Postal Service (USPS) tracking service shows that the Accusation package was delivered on November 27, 2024. [Exhibit Package, Exhibit 1, Accusation Package, Proof of Service and USPS Tracking document]

4. On December 18, 2024, an employee of the Attorney General's Office served by Certified mail a Courtesy Notice of Default, advising Respondent of the service of the Accusation and providing her with another opportunity to submit a Notice of Defense. The USPS tracking shows that delivery was attempted, but that the package was unclaimed and returned to sender. [Exhibit Package, Exhibit 3, Courtesy Notice of Default, Proof of Service and USPS tracking document]

5. The Accusation charges Respondent with cause for discipline under sections 2234 (unprofessional conduct), 2234(c) (repeated negligent acts) and 2266 (failure to maintain accurate and adequate medical records.) The Board finds that the following facts as alleged in the Accusation are true:

A. At the time of the events set forth in this Accusation, Respondent was board certified in anesthesiology and was practicing as a cardiac anesthesiologist.

B. Patient 1 was a 63-year-old man in acute respiratory failure when he was admitted to the hospital on September 12, 2021. His condition deteriorated and by September 18, 2021, Patient 1 required intubation. A lung transplant was planned. A decision was made to initiate Veno Venous Extracorporeal Circulation Membrane Oxygenation[2] (VV ECMO) to support Patient 1's respiratory system until the transplant could take place.

[2] VV ECMO is a temporary mechanical technique that provides cardiopulmonary support by circulating blood outside of the body through a tube or catheter. The procedure is done by (continued...)

C. Patient 1 underwent the VV ECMO procedure on September 29, 2021. Respondent was the attending anesthesiologist. Respondent's preoperative assessment noted that she would utilize transesophageal echocardiography (TEE)[3] imaging during the procedure. The imaging would assist the surgeon to guide the placement of the guidewire and the cannula and confirm proper placement of the cannula.

D. During the procedure, Respondent placed the TEE probe. Respondent had difficulty obtaining quality images, seeing the structures of the heart, or visualizing the guidewire or the cannula. Respondent stated during her interview with the Board's investigators that she attempted various maneuvers to improve the images, but they were not successful. Respondent stated that she informed the surgeon that she was unable to obtain quality images sufficient to visualize the location of the guidewires and catheters, or the position of the cannula. The surgeon has stated that Respondent informed him throughout the procedure that she had visualized the guidewires and catheters in the correct position. Both the surgeon and an anesthesia resident who was present have stated that Respondent guided the cannula insertion. The surgeon placed the cannula, and ECMO was initiated through the cannula. Another cardiac anesthesiologist joined Respondent in the operating room, and TEE imaging revealed that the cannula was mispositioned. Patient 1 was removed from ECMO and the cannula was then properly positioned without complication.

E. Respondent's medical record for the procedure does not document the TEE probe placement or the insertion or removal times of the TEE probe. Respondent's record contains no complete written report of the TEE exam and findings. Respondent's medical record contains no mention of any problem with the TEE imaging, that there were problems or complications with the procedure, or that the surgeon elected to proceed with the procedure

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insertion of catheters or tubes known as cannulate, into the veins and/or arteries. ECMO requires the precise placement of cannulas to ensure proper flow dynamics.

[3] TEE is an imaging technique that uses high frequency ultrasound to create detailed images of the heart and arteries that lead to and from the heart. The TEE probe is attached to a thin tube that passes through the mouth, down the esophagus, and is able to obtain clear images of the heart and valves. ECMO requires the precise placement of cannulas to ensure proper flow dynamics, and TEE is used to provide real-time visualization of wire placement and cannula position.

despite Respondent's claim that she informed him that she could not obtain adequate images. Respondent did not save any of the TEE images.

F. Respondent is subject to disciplinary action under sections 2234 and/or 2234 (c) of the Code in that Respondent engaged in unprofessional conduct and/or committed repeated acts of negligence in her care and treatment of Patient 1. As the anesthesiologist, it was Respondent's responsibility to obtain adequate TEE imaging to assist in guiding the ECMO cannula insertion. If Respondent was unable to obtain appropriate TEE imaging, she was required to unambiguously inform the surgeon that he could not rely upon TEE imaging for guidance and should utilize another modality for real time imaging, or to stop the procedure and call for help before the surgeon attempted to place the cannula without TEE guidance. Respondent failed to appropriately communicate with the surgeon, and failed to ensure there was adequate imaging for her to assist in the guidance of ECMO cannula insertion.

[Exhibit Package, Exhibit 4, Declaration of Chi-Bew Chan, M.D]

G. Respondent is subject to disciplinary action under sections 2234 and/or 2266 of the Code, in that Respondent failed to adequately document the TEE procedure, the events that transpired during the procedure, or that there were complications with the procedure. Respondent also failed to fully and adequately document the TEE exam and findings or to save TEE images. [Exhibit Package, Exhibit 4, Declaration of Chi-Bew Chan, M.D.]

6. The Board incurred costs of investigation in the amount of 8,663.50. [Exhibit Package, Exhibit 5, Health Quality Investigative Unit Declaration of Investigative Activity]. The Board also incurred enforcement prosecution costs in the amount of $11,391.50. [Exhibit Package, Exhibit 6, Certification of Prosecution Costs]

STATUTORY AUTHORITY

7. Business and Professions Code section 118 states, in pertinent part:

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

disciplinary action against the license on any such ground.

8. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

Respondent failed to file a Notice of Defense within 15 days after service upon female of the Accusation, and therefore waived female right to a hearing on the merits of Accusation No. 800-2021-083856.

9. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Business and Professions Code section 125.3 states, in pertinent part:

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

11. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c). Respondent failed to file a Notice of Defense. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in Exhibit Package, Exhibits 1-6, finds that the allegations in Accusation No. 800-2021-083856 are true.

DETERMINATION OF ISSUES

1. Based on the foregoing Findings of Fact, Respondent Mangano Christina T. Mora, M.D.'s conduct constitutes cause for discipline within the meaning of Business and Professoins Code sections 2234, 2234(c) and 2266.

2. The Board has jurisdiction to adjudicate this case by default. Respondent was duly served with the Accusation and thereafter with a Courtesy Notice of Default, but failed to file a Notice of Defense.

3. Pursuant to Business and Professions Code section 125.3, the Board is authorized to order Respondent to pay the Board the reasonable costs of investigation and enforcement of the case prayed for in the Accusation total $20,055.00.

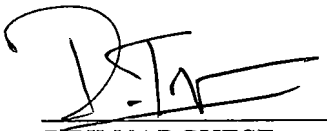
ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. G 81274, heretofore issued to Respondent Mangano Christina T. Mora, M.D., is revoked. Respondent Mangano Christina T. Mora, M.D. is ordered to pay the Board the costs of the investigation and enforcement of this case in the amount of $20,055.00.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion setting forth good cause for relief from default. However, such showing must be made in writing by way of a motion to vacate the Default Decision, andd stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The Board in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on April 1, 2025

It is so ORDERED March 20, 2025



REJI VARGHESE
EXECUTIVE DIRECTOR
FOR THE MEDICAL BOARD OF
CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

In the Matter of the Accusation Against: **Mangano Christina T. Mora, M.D.** 30 Genevra Road Hillsborough, CA 94010 Physician's and Surgeon's Certificate No. G 81274, Respondent.	Case No. 800-2021-083856 **ACCUSATION**

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 May 24, 1995, the Medical Board issued Physician's and Surgeon's Certificate Number G 81274 to Mangano Christina T. Mora, M.D.[1] (Respondent). The Physician's and Surgeon's Certificate expired on May 31, 2023, and has not been renewed.

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[1] Respondent's Physician's and Surgeon's Certificate is issued under the name Mangano Christina Mora, M.D. Respondent also goes by the name Christina T. Mora-Mangano, M.D.

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JURISDICTION

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

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

5. Section 2234 of the Code states, in pertinent part:

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.

(c) Repeated negligent acts.

6. Section 2266 of the Code provides that 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.

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FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Inadequate Records)

8. At the time of the events set forth in this Accusation, Respondent was board certified in anesthesiology and was practicing as a cardiac anesthesiologist.

9. Patient 1[2] was a 63-year-old man in acute respiratory failure when he was admitted to the hospital on September 12, 2021. His condition deteriorated and by September 18, 2021, Patient 1 required intubation. A lung transplant was planned. A decision was made to initiate Veno Venous Extracorporeal Circulation Membrane Oxygenation[3] (VV ECMO) to support Patient 1's respiratory system until the transplant could take place.

10. Patient 1 underwent the VV ECMO procedure on September 29, 2021. Respondent was the attending anesthesiologist. Respondent's preoperative assessment noted that she would utilize transesophageal echocardiography (TEE)[4] imaging during the procedure. The imaging would assist the surgeon to guide the placement of the guidewire and the cannula and confirm proper placement of the cannula.

11. During the procedure, Respondent placed the TEE probe. Respondent had difficulty obtaining quality images, seeing the structures of the heart, or visualizing the guidewire or the cannula. Respondent stated during her interview with the Board's investigators that she attempted various maneuvers to improve the images, but they were not successful. Respondent stated that she informed the surgeon that she was unable to obtain quality images sufficient to visualize the location of the guidewires and catheters, or the position of the cannula. The surgeon has stated

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[2] The patient is referred to as Patient 1 to protect privacy and confidentiality.

[3] VV ECMO is a temporary mechanical technique that provides cardiopulmonary support by circulating blood outside of the body through a tube or catheter. The procedure is done by insertion of catheters or tubes known as cannulate, into the veins and/or arteries. ECMO requires the precise placement of cannulas to ensure proper flow dynamics.

[4] TEE is an imaging technique that uses high frequency ultrasound to create detailed images of the heart and arteries that lead to and from the heart. The TEE probe is attached to a thin tube that passes through the mouth, down the esophagus, and is able to obtain clear images of the heart and valves. ECMO requires the precise placement of cannulas to ensure proper flow dynamics, and TEE is used to provide real-time visualization of wire placement and cannula position.

that Respondent informed him throughout the procedure that she had visualized the guidewires and catheters in the correct position. Both the surgeon and an anesthesia resident who was present have stated that Respondent guided the cannula insertion. The surgeon placed the cannula, and ECMO was initiated through the cannula. Another cardiac anesthesiologist joined Respondent in the operating room, and TEE imaging revealed that the cannula was mispositioned. Patient 1 was removed from ECMO and the cannula was then properly positioned without complication.

12. Respondent's medical record for the procedure does not document the TEE probe placement or the insertion or removal times of the TEE probe. Respondent's record contains no complete written report of the TEE exam and findings. Respondent's medical record contains no mention of any problem with the TEE imaging, that there were problems or complications with the procedure, or that the surgeon elected to proceed with the procedure despite Respondent's claim that she informed him that she could not obtain adequate images. Respondent did not save any of the TEE images.

13. Respondent is subject to disciplinary action under sections 2234 and/or 2234 (c) of the Code in that Respondent engaged in unprofessional conduct and/or committed repeated acts of negligence in her care and treatment of Patient 1. As the anesthesiologist, it was Respondent's responsibility to obtain adequate TEE imaging to assist in guiding the ECMO cannula insertion. If Respondent was unable to obtain appropriate TEE imaging, she was required to unambiguously inform the surgeon that he could not rely upon TEE imaging for guidance and should utilize another modality for real time imaging, or to stop the procedure and call for help before the surgeon attempted to place the cannula without TEE guidance. Respondent failed to appropriately communicate with the surgeon, and failed to ensure there was adequate imaging for her to assist in the guidance of ECMO cannula insertion.

14. Respondent is subject to disciplinary action under sections 2234 and/or 2266 of the Code, in that Respondent failed to adequately document the TEE procedure, the events that transpired during the procedure, or that there were complications with the procedure. Respondent also failed to fully and adequately document the TEE exam and findings or to save TEE images.

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 G 81274, issued to respondent Mangano Christina T. Mora, M.D.;

2. Revoking, suspending or denying approval of respondent Mangano Christina T. Mora, M.D. 's authority to supervise physician assistants and advanced practice nurses;

3. Ordering respondent Mangano Christina T. Mora, 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;

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

DATED: NOV 25 2024

for

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

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