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

In the Matter of the Accusation Against: Karishma Arora, M.D. Physician's and Surgeon's Certificate No. A 105196 Respondent.	Case No.: 800-2022-086160

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 June 6, 2025.

IT IS SO ORDERED: May 8, 2025.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

Michelle A. Bholat, M.D., Chair
Panel A

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

In the Matter of the Accusation Against:

KARISHMA ARORA, M.D.,

Physician's and Surgeon's Certificate No. A 105196

Respondent.

Agency Case No. 800-2022-086160

OAH No. 2024080648

PROPOSED DECISION

Administrative Law Judge Karen Reichmann, State of California, Office of Administrative Hearings, heard this matter on March 3, 5, and 6, 2025, by videoconference.

Deputy Attorneys General C. Hay-Mie Cho and Thomas Ostly represented complainant Reji Varghese, Executive Director of the Medical Board of California.

Attorney Kevin Cauley represented respondent Karishma Arora, M.D., who was present.

The record closed and the matter was submitted for decision on March 6, 2025.

FACTUAL FINDINGS

Jurisdictional Matters

1. On August 13, 2008, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 105196 (Certificate) to respondent Karishma Arora, M.D. The Certificate was in full force and effect at all times relevant to the charges in the Accusation. There has been no prior discipline against respondent's Certificate.

2. On March 28, 2024, complainant Reji Varghese, acting solely in his official capacity as the Board's Executive Director, filed the Accusation. Complainant seeks to discipline respondent for gross negligence and repeated negligent acts, alleging that while working as an anesthesiologist in December 2019, her treatment of a patient during the recovery period after a lengthy surgery fell below the standard of care. The patient suffered a brain injury. Respondent filed a timely Notice of Defense.

Patient 1

3. Patient 1 was 47 years old in December 2019, and had been diagnosed with colon cancer that had metastasized to the liver. He underwent a lengthy surgery on December 17, 2019, at the Kaiser Permanente San Jose Medical Center (KPSJ).

4. Deepak Sidhu, M.D., was the anesthesiologist assigned to Patient 1. Dr. Sidhu placed a thoracic epidural catheter, through which he infused the anesthetic Bupivacaine during surgery. He intended also to use the catheter after surgery for pain management. Patient 1 was intubated and oxygenated with a ventilator. Anesthesia was administered intravenously. An arterial line was established to monitor blood pressure.

5. Several hours into the procedure, Dr. Sidhu, who was respondent's supervisor, called her and asked her to take over the case because he wanted to attend a meeting. Respondent was reluctant to cover for him because she was not on the panel of anesthesiologists to perform liver cases. It was not the normal practice for anesthesiologists on her shift to take over responsibility for liver cases from other doctors. The policy at KPSJ also was that the same anesthesiologist who starts a liver case finishes the case, taking only short breaks to eat or use the bathroom. Respondent resisted Dr. Sidhu's request for coverage but ultimately agreed after she was also asked by the designated anesthesiologist on call and the chief of anesthesiology. At hearing, she testified that she felt forced to take the case. She added that she felt her status as an Indian woman played a role in the way the other anesthesiologists at KPSJ expected her to submit to their demands.

6. Respondent took over from Dr. Sidhu at around 15:00, believing that she would be covering him only for about 30 minutes. She felt that too much anesthesia was being administered to the patient and made changes to the medications being given, with Dr. Sidhu's consent. She contacted Dr. Sidhu after 30 minutes, and he told her his meeting was running late. She called him again after another hour, and he told her that he wanted to go home and that she should finish the case. Respondent resisted, but because she felt that she could not argue with Dr. Sidhu, she prepared to finish the case.

7. At around 17:20, respondent injected a bolus of Bupivacaine into the epidural catheter in preparation for the end of surgery. This was a much larger volume of fluid than had previously been infused through the catheter.

8. Surgery ended at around 17:30; the patient had been under general anesthesia for more than nine and one-half hours. The patient took a long time to wake up after surgery.

9. At 18:06, the patient's blood pressure and heart rate were both elevated. The patient was extubated at around 18:10. A simple mask was placed on his face for oxygenation. The arterial line was disconnected from the monitor in the operating room.

10. The allegations in the Accusation all pertain to respondent's treatment of Patient 1 once he was taken to the Post-Anesthesia Care Unit (PACU) (also known as recovery room) between 18:17 and 18:30.

11. Respondent brought Patient 1 to the PACU by 18:17. When they arrived at the assigned bay, there was initially no nurse there to take over care. Respondent and a nurse from the operating room attached the patient to a vital signs monitor. At 18:17, the vital signs monitor recorded Patient 1's heart rate as 32, which is extremely low. His blood pressure was also low, 95/53. His oxygen level was 98%. The blood pressure reading came from a blood pressure cuff because the arterial line had not been connected to a monitor in the PACU.

12. At 18:20, Patient 1's heart rate was 37, still extremely low; and his blood pressure had decreased to 65/43, also extremely low. The monitor did not pick up an oxygen reading.

13. Respondent believed that the patient's decreased vital signs were due to improper placement of the epidural catheter. She believed that when she administered the bolus in the catheter towards the end of surgery, the large amount of fluid went into the subdural space. She believed that the low heart rate and blood pressure

caused by the misplaced fluid caused the patient's poor oxygenation and decided to treat the patient's heart rate and blood pressure with medications.

14. Registered nurse Julie Weldon was finishing her shift in the PACU and getting ready to leave. At around 18:20, Weldon walked by respondent who asked her if she was the nurse assigned to Patient 1. Weldon observed that the patient needed immediate treatment and began assisting respondent.

15. Respondent and Weldon gave different testimony regarding their interaction during the treatment of Patient 1. According to respondent, she asked Weldon for medications to resuscitate Patient 1 and Weldon refused because she did not want to be late going home. According to Weldon, Weldon offered to obtain medications from a nearby crash cart, but respondent did not respond, was manipulating the patient's oxygen probe, stated that the patient might be bleeding, and never asked Weldon to bring medications or attach the arterial line. At hearing, Weldon described respondent as atypically hesitant for a doctor in an emergency situation.

16. Respondent directed Weldon to call for the backup anesthesiologist on call, and she did.

17. Respondent left the PACU and went to the nearest operating room to obtain medications herself. She grabbed an assortment of medications from a drawer and returned to Patient 1's bedside in the PACU. She was away from the patient for less than one minute.

18. After she returned, respondent administered 50 mg of ephedrine. A few minutes later, she administered a second 50-mg dose of ephedrine. The ephedrine did not improve the patient's heart rate. She then gave the patient 1 mg of glycopyrrolate,

which also was not effective. Respondent then administered two 0.5-mg doses of epinephrine, which also did not increase the patient's heart rate.

19. At 18:25, the patient's heart rate was down to 28, blood pressure was down to 45/32, and oxygenation was 89%. The arterial line was connected at around 18:25, and reported a higher blood pressure. Respondent administered 1 mg of atropine.

20. At 18:30, the patient's heart rate and blood pressure increased significantly, but his oxygenation fell to 83%. Respondent observed that the patient was not breathing and had fixed and dilated pupils. She performed a jaw thrust and directed a nurse to start bag mask ventilation.

21. The back up anesthesiologist arrived at around 18:30 and immediately began reintubating Patient 1. Reintubation was completed at 18:35. Patient 1 was later transferred to the ICU. He was diagnosed with acute hypoxemic respiratory failure.

22. This matter came to the Board's attention on February 23, 2022, when a report was submitted pursuant to Business and Profession Code section 801.01. This report notified the Board that a $410,000 settlement had been paid to Patient 1 based on allegations of negligence against respondent. Respondent stated that she was contacted by KPSJ about the case, but was not consulted about the settlement, was never deposed, and did not have a lawyer representing her in settlement negotiations.

23. Respondent was interviewed by a Board investigator in August 2023. She stated that because Weldon was uncooperative, she felt that leaving the patient rather than arguing with Weldon would be the fastest way to treat the patient. Respondent also stated that she checked the patient's pulse and breathing several times as she administered medications between 18:20 and 18:30.

24. The Board's investigator contacted Weldon in January 2025. Weldon provided a statement and a timeline of events she had drafted within a few days of the incident in December 2019. Weldon reported that she offered medications to respondent, but respondent got up and went to retrieve them herself.

25. Clear and convincing evidence did not establish whether Weldon was uncooperative, whether there was miscommunication, or whether respondent ever asked Weldon for medications before leaving the PACU to retrieve them.

Expert Witnesses

COMPLAINANT'S EXPERT, RICHARD JOHN NOVAK, M.D.

26. Complainant retained Richard John Novak, M.D., to serve as an expert witness. Dr. Novak is board certified in anesthesia and internal medicine. He has been licensed by the Board since 1981. He is a member of a medical group and provides anesthesia 15 days per month. He is the medical director of an outpatient clinic. At this point in his career, he does primarily outpatient cases, including some long cases. Dr. Novak teaches residents and attends weekly grand rounds at Stanford University Medical Center. He previously served on the quality assurance committee at Stanford.

27. Dr. Novak has a blog called Anesthesia Consultant where he has posted approximately 300 essays, focusing on the private practice of anesthesia.

28. Dr. Novak has been an expert reviewer for the Board for about 20 years, reviewing approximately one case each year. He has served as an expert witness in civil trials, both for the plaintiff and for the defendant.

29. Dr. Novak reviewed the medical records, the transcript and audio recording of respondent's investigative interview, some materials provided by

respondent to the investigator, and the KPSJ report of settlement. Dr. Novak did not have Weldon's statement or timeline at the time of his initial expert review. Dr. Novak wrote a report[1] with his findings and testified at hearing.

30. Dr. Novak defined an extreme departure from the standard of care as "something a reasonable doctor would not do."

31. Dr. Novak analyzed respondent's treatment of Patient 1 as follows.

a. According to Dr. Novak, the standard of care for an acutely decompensating patient is to address the patient's airway, breathing, and circulation, in that order, and to look for causes without delaying treatment. For a patient with an extremely low heart rate, the physician should first ensure that the patient's airway is not obstructed and the patient is breathing before treating low blood pressure and heart rate with appropriate medication, including atropine or epinephrine, but not ephedrine. Dr. Novak believes that respondent committed an extreme departure from the standard of care by focusing on the patient's heart rate without first assessing and managing his airway and breathing. He believes the patient needed to be reintubated immediately.

b. Dr. Novak opined that it is an extreme departure from the standard of care for an anesthesiologist to leave the bedside of a critically ill patient to retrieve

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[1] Dr. Novak apologized for two errors in his report. First, he referred to respondent throughout the report as "he" rather than "she." Second, he incorrectly recorded the surgery date as March 17, 2020, rather than December 17, 2019. These errors did not undermine the persuasiveness of his opinions.

medications. The standard of care is for the anesthesiologist to direct nursing staff to obtain medications and to remain at the patient's bedside. It is a departure from the standard of care to leave the patient, even for a few seconds. In his experience, all necessary medications are located in a crash cart in the PACU. If a nurse is not cooperating, the standard of care is for the physician to be assertive and demand compliance or call out to another nurse for assistance. Dr. Novak has never experienced an attending physician leave a patient's bedside in this manner in his 40-year career.

c. Dr. Novak explained that the standard of care for an anesthesiologist taking care of an acutely decompensating patient with unstable blood pressure, heart rate, and oxygenation, is to call for additional help, such as by a code blue, to manage care. Dr. Novak concluded that respondent's failure to call a code blue was an extreme departure from the standard of care. Respondent needed assistance to care for Patient 1, who needed medications, intubation, and his arterial line restored. Calling a code blue would bring a team of practitioners, including a respiratory therapist who can intubate a patient, a pharmacist who will bring medications, and a physician and nurse trained in critical care. Dr. Novak does not believe that merely calling for the anesthesiologist on call was within the standard of care because more people were needed to treat the critically unstable patient.

d. Dr. Novak explained that it is the standard of care for the arterial line to be connected to a monitor upon the patient's arrival in the PACU, to obtain accurate second-to-second blood pressure and heart rate data. It is ordinarily the duty of a nurse to connect the arterial line, and takes only a short time. The physician should be assertive if nursing staff has not connected the line. Patient 1's arterial line was not connected for at least eight minutes after his arrival in the PACU, resulting in

inadequate blood pressure readings. Dr. Novak concluded that respondent committed an extreme departure from the standard of care by not ordering that the arterial line be immediately connected, because of the critical need for accurate data.

e. Dr. Novak believes that respondent departed from the standard of care by fixating on her belief that the catheter was the cause of the patient's deterioration. He believes that her fixation on this cause distracted her from providing appropriate treatment. He also believes that even if the catheter had been the cause for the patient's deteriorating condition, the treatment would have been the same, namely managing the airway, breathing, and circulation. He deemed respondent's misguided fixation on the cause to be a simple departure from the standard of care.

32. Dr. Novak does not believe the epidural catheter was misplaced and caused the patient's emergency. He noted that the catheter was used for many hours in the operating room before the crisis and for many hours in the ICU afterwards.

33. Dr. Novak believes that "in all medical probability," respondent's actions caused injury to Patient 1.

RESPONDENT'S EXPERT, ANDREW GELLER, M.D.

34. Respondent retained Andrew Geller, M.D., a board certified anesthesiologist, as her expert witness. Dr. Geller is the co-chair of the anesthesiology department at Cedars-Sinai Medical Center in Los Angeles, where he works regularly with residents and fellows. He previously served on the hospital's peer review committee for four years. He frequently responds to emergencies in the PACU at Cedars-Sinai.

35. Dr. Geller has served as an expert witness in numerous civil proceedings.

36. Dr. Geller reviewed the patient's medical records, the transcript of respondent's interview, Dr. Novak's expert report, and other materials provided to him by respondent's counsel. Like Dr. Novak, Dr. Geller had not seen Weldon's statement to the Board investigator or her timeline prior to writing his report.

37. Dr. Geller opined that an extreme departure from the standard of care requires severe harm to the patient. He defined a simple departure as not doing the minimum that a physician of similar background would do in similar circumstances.

38. Dr. Geller disagreed with Dr. Novak's conclusions that respondent departed from the standard of care in her treatment of Patient 1.

a. Dr. Geller believes that it was appropriate for respondent to focus on treating Patient 1's low heart rate by administering ephedrine, and that the patient was reintubated in an acceptable amount of time. He believes respondent adequately assessed airway and breathing, based in part on statements she made during her Board investigation interview. He agrees that the standard of care is to address airway, breathing, and circulation in that order.

b. Dr. Geller concluded that it was within the standard of care for respondent to leave the patient to access quickly the medications she needed after the nurse refused to comply with her verbal order for the medications and in light of her view that this was the fastest method for her to get them. He acknowledged that the standard of care is for the anesthesiologist to treat the patient until the patient is stable before leaving the patient in the PACU; however, he believes that respondent had no other option. If other nurses were nearby, he conceded that respondent "potentially" should have asked them for help before leaving the patient's bedside.

c. Dr. Geller concluded that it was within the standard of care and within the practice at KPSJ for respondent to call for backup anesthesia support and not to call for a code blue. He explained that calling a code blue is not a typical practice in the PACU, where the usual practice is to call anesthesia back up and other PACU nurses for assistance. He believes calling a code blue can bring in too many people, create chaos, and delay care.

d. Dr. Geller stated that it is ideal for the arterial line to be connected when the patient arrives in the PACU. The fact that the PACU was not ready when respondent brought the patient was not in her control. He called the arterial line a luxury and not the utmost priority because the patient was monitored by other means, with the cuff and pulse oximeter, and respondent was able to take his pulse. He did not believe the delay in this case was unreasonable and that respondent had higher priorities than insisting that someone connect the arterial line.

e. Dr. Geller disagrees with Dr. Novak's opinion that respondent departed from the standard of care by fixating on the epidural catheter as the cause of the patient's symptoms. He agrees with respondent that the catheter was the likely cause, and he believes that the standard of care is to correct the cause while simultaneously treating the patient's condition.

39. Dr. Geller does not believe respondent's actions caused harm to Patient 1.

Respondent's Evidence

40. Respondent grew up and attended medical school in India. She received post-graduate surgical training in India for two years before immigrating to the United States. She then completed a transitional internship followed by a three-year residency

in anesthesia and a one-year anesthesia fellowship. She has been board certified in anesthesia since 2011. Respondent began working at KPSJ in late 2011. In 2017, she reduced her hours to a part-time schedule, after her husband suffered an acute illness and she needed more time to support her family.

41. Respondent defended her actions and believes strongly that she did nothing wrong in her treatment of Patient 1. She feels that she has been scapegoated by KPSJ to protect others. She feels that a male physician's clinical judgment and actions would not have been questioned. Respondent testified that Weldon's refusal to cooperate "was the whole problem." She asserted that Weldon refused to get medications because she did not want to be late going home and stayed at the computer charting rather than helping respondent with the patient. Respondent also testified that she asked Weldon to attach the arterial line, and that Weldon brought a cable but did not connect it. Respondent stated that calling a code blue would have been chaotic and disruptive. Respondent feels that she has been treated like a criminal despite having tried to do what was right for Patient 1. Having the Accusation published on the Board's website has been emotionally devastating for respondent.

42. Respondent testified that she was disciplined at KPSJ about a year before this incident, in 2018. She was suspended for five days, did not receive a pay increase and bonus, and was directed to take a course with a communication consultant. Respondent explained that the discipline was based on an incident when she was finishing up a case near the time that the assisting nurse and scrub tech were about to change shifts. According to respondent, the nurse and tech wanted respondent to wait 15 minutes before moving the patient so that they could receive overtime pay, but that respondent "put her foot down" and was firm with them. The two staff members complained that they felt unsafe and threatened by respondent. Respondent was

advised that doctors at KPSJ cannot raise their voices and are viewed as being on the same footing as nurses and other staff. After this discipline, respondent never raised her voice while working for fear of being terminated.

43. Respondent left Kaiser in 2022. She explained that she injured her shoulder twice moving heavy patients and decided to retire early. She denied receiving any discipline at KPSJ related to this case.

44. Respondent has been working part-time at Bay Area Ketamine Center in Los Altos. She works one to two days per week. She administers ketamine to 8 to 12 patients in a day, to treat chronic mental health conditions, chronic pain, and fibromyalgia. She finds it rewarding and has received thank you letters from patients.

Respondent also works two to six hours a week providing telemedicine for Dr. Torrez & Associates in Aptos. She interviews patients and determines whether the patients are good candidates for ketamine treatment.

Respondent's monthly income from her two jobs is between $5,000 to $8,000, much less than she previously earned working at KPSJ.

45. Respondent has been married for 21 years and has a 14-year-old son.

46. Paul Wender, M.D., is the owner of Bay Area Ketamine Center and supervises respondent's practice there. He is a board certified anesthesiologist. Dr. Wender wrote a letter on behalf of respondent and testified at the hearing. He reached out to other doctors before hiring respondent and all spoke positively about her. Dr. Wender provided extensive training to respondent and works side by side with her. He described her as an exemplary physician who treats her patients with empathy. He has found her to be hardworking, ethical, honest, safe, and responsible. He has

received no complaints about her from patients. Respondent is well regarded by the clinic's staff and vendors.

Dr. Wender has discussed this case with respondent and reviewed the accusation. He reported that respondent takes this matter very seriously but does not believe that the allegations against her are correct.

47. James W. Tseng, M.D., testified at hearing and wrote a letter on respondent's behalf. Dr. Tseng is a board certified anesthesiologist who has worked at KPSJ since 2000, including the entire time respondent worked there. As colleagues, Dr. Tseng observed respondent in the operating room, PACU, and interacting with patients. He worked with her on cases and consulted with her on cases.

Dr. Tseng fully trusted respondent when they worked together. She had a reputation for excellent clinical judgment and technical skills.

Dr. Tseng has discussed this case with respondent. He reported that respondent is upset by the charges against her and maintains that she did not do anything wrong. She takes this matter seriously and is upset about having these allegations against her. Dr. Tseng's practice in an emergency is to call the back up anesthesiologist on call. He has never called a code blue while working at KPSJ.

48. Paul Wong, M.D., is also board certified in anesthesiology. He retired from KPSJ in March 2020, after working there for 33 years. He also taught anesthesiology to nursing students at Samuel Merritt University for 15 years. He wrote a letter in support of respondent and testified at the hearing.

Dr. Wong worked with respondent at KPSJ for nine years. He worked alongside her and observed her providing patient care. They worked on cases together and

consulted with each other. He found her to be extremely competent and compassionate and stated she had a reputation at KPSJ as one of the safest practitioners. After he retired in 2020, Dr. Wong recommended respondent to doctors seeking an anesthesiologist to treat their own family members.

Dr. Wong's practice during an emergency at KPSJ was to direct a nurse to call the back up anesthesiologist. He never called a code blue.

Respondent expressed to Dr. Wong that she feels she is wrongly blamed for the outcome of Patient 1. He stated that he cannot judge her actions because he was not there. Based on his experience working with respondent, he believes that she would appropriately handle an emergency situation.

49. Amitha Ravulapati, M.D., wrote an undated letter in support of respondent. Dr. Ravulapati went to medical school with respondent and is a board certified internist in North Carolina. She wrote that respondent is a hardworking, empathetic, conscientious physician who maintains composure during stressful situations. Dr. Ravulapati travelled to California for a medical procedure in order to have respondent provide treatment.

50. Respondent's attorney submitted a declaration and records establishing that respondent had incurred $44,488.89 in legal fees through February 28, 2025, for his representation of respondent in this matter. Respondent contends that, should the Accusation be dismissed, she would be entitled to cost recovery from complainant.

Ultimate Findings on Causes for Discipline

51. The expert opinions of Dr. Novak were more persuasive than those of Dr. Geller. Dr. Geller credited respondent's explanation and reporting of events, even

when her testimony was not corroborated by the medical records. Dr. Geller's definitions of simple and extreme departures from the standard of care were incorrect. Extreme harm to a patient does not need to occur for a physician's actions to constitute an extreme departure from the standard of care.

52. Clear and convincing evidence, based on the persuasive opinions of Dr. Novak and corroborated by other evidence, established the following four extreme departures from the standard of care:

a. Respondent did not address Patient 1's airway, breathing, and circulation in that order, instead focusing on treating circulation with medications and delaying necessary reintubation.

b. Respondent left Patient 1 to retrieve medications while his condition was unstable and deteriorating. This action constituted an extreme departure regardless of whether Weldon was uncooperative and refused to obtain the medications for respondent.

c. Respondent failed to call a code blue or use other means to obtain the necessary additional personnel, medication, and equipment to treat Patient 1.

d. Respondent failed to make sure the arterial line was connected promptly, in order to obtain more accurate blood pressure and heart rate data.

53. Clear and convincing evidence also established that respondent departed from the standard of care by focusing on identifying the cause of the patient's deteriorating condition rather than on treating him.

Costs

54. Complainant seeks to recover $45,810.75 for legal services provided by the Department of Justice through February 7, 2025. These costs are supported by declarations in compliance with the requirements of California Code of Regulations, title 1, section 1042. Respondent objected to these costs as excessive, noting that two attorneys were assigned to this relatively straightforward case involving a single patient, and that significant expenses were incurred after respondent provided Dr. Geller's report to complainant.

Because these costs reflect duplicative work due to the assignment of two attorneys, a reduction in costs on this basis is appropriate. The reasonable costs for legal services in this matter are $35,000.

LEGAL CONCLUSIONS

1. It is complainant's burden to demonstrate the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's Certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Business and Professions Code section 2227 authorizes the Board to take disciplinary action against licensees who have been found to have committed violations of the Medical Practice Act. Business and Professions Code section 2234, included in the Medical Practice Act, provides that a licensee may be subject to discipline for committing gross negligence (Bus. & Prof. Code, § 2234, subd. (b)) or for repeated negligent acts (*id.*, subd. (c)).

3. Clear and convincing evidence established that respondent committed gross negligence (Finding 52) and repeated negligent acts (Findings 52 and 53) in her care and treatment of Patient 1. Cause for discipline was established for violations of Business and Professions Code section 2234, subdivisions (b) and (c).

4. In exercising its disciplinary functions, protection of the public is the Board's highest priority. (Bus. & Prof. Code, § 2229, subd. (a).) The Board is also required to take disciplinary action that is calculated to aid the rehabilitation of the physician whenever possible, as long as the Board's action is not inconsistent with public safety. (*Id.*, subds. (b), (c).)

5. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016; Cal. Code Regs., tit. 16, § 1361) provide for a minimum discipline of five years' probation and a maximum discipline of revocation for licensees who have committed gross negligence or repeated negligent acts.

6. Respondent committed several departures from the standard of care in her handling of an emergency situation arising after she took over care from another anesthesiologist. Her actions likely contributed to the patient suffering an injury. Respondent does not accept responsibility for her actions and feels scapegoated. In mitigation, hospital culture and a lack of cooperation by others may have played a role in respondent's lapses. Respondent has no prior history of Board discipline and is respected by colleagues. She is now working in different clinical setting where she is less likely to face a similar emergency situation. On this record, revocation is not warranted. A five-year period of probation on standard terms and conditions will adequately protect the public.

7. Business and Professions Code section 125.3 authorizes the Board to recover its reasonable costs of investigation and enforcement if the licensee is found to have committed a violation of the licensing act. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth standards by which a licensing board must exercise its discretion to reduce or eliminate cost awards to ensure that licensees with potentially meritorious claims are not deterred from exercising their right to an administrative hearing. Those standards include whether the licensee has been successful at hearing in getting the charges dismissed or reduced, the licensee's good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate to the alleged misconduct. No basis for a reduction of costs was established. As set forth in Factual Finding 54, the reasonable costs in this matter are $35,000.

8. Respondent raises numerous constitutional challenges to the Accusation and to the imposition of cost recovery. These issues are beyond the scope of this administrative hearing.

ORDER

Physician's and Surgeon's Certificate No. A 105196, issued to respondent Karishma Arora, M.D., is revoked; however, revocation is stayed, and respondent is placed on probation for five years under the following terms and conditions.

1. Notification

Within seven days of the effective date of this decision, respondent shall provide a true copy of this decision and the accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

3. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

6. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

7. Non-Practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of

that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations.

8. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

9. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. License Surrender

Following the effective date of this decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an

annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

12. Cost Recovery

Respondent 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 $35,000.

DATE: 04/03/2025

Karen Reichmann

KAREN REICHMANN
Administrative Law Judge
Office of Administrative Hearings