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

In the Matter of the Accusation Against: Jane So-Chun Lee, M.D. Physician's and Surgeon's Certificate No. G 169390 Respondent.	Case No. 800-2022-090520

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on JUL 0 8 2025.

IT IS SO ORDERED JUL 0 1 2025.

MEDICAL BOARD OF CALIFORNIA

Sharlene Smith For
Reji Varghese, Executive Director

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JANE SO-CHUN LEE, M.D.** **271 Tally Ho Road** **Arroyo Grande, CA 93420-2317** **Physician's and Surgeon's Certificate No. G 169390,** Respondent.	Case No. 800-2022-090520 OAH No. 2024120619 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Latrice R. Hemphill, Deputy Attorney General.

2. Jane So-Chun Lee, M.D. (Respondent) is represented in this proceeding by attorney Steven L. Simas, Esq., whose address is: 7355 Morro Road, Suite 101, Atascadero, CA 93422.

3. On or about July 21, 2020, the Board issued Physician's and Surgeon's Certificate No. G 169390 to Respondent. That license was in full force and effect at all times relevant to the

charges brought in Accusation No. 800-2022-090520 and will expire on July 31, 2026, unless renewed.

JURISDICTION

4. Accusation No. 800-2022-090520 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on September 4, 2024. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2022-090520 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2022-090520. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2022-090520, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline.

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

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

RESERVATION

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

CONTINGENCY

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

13. Respondent understands that, by signing this stipulation, she enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of her Physician's and Surgeon's Certificate No. G 169390 without further notice to, or opportunity to be heard by, Respondent.

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that she may not withdraw her agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the

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

ADDITIONAL PROVISIONS

16. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

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

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

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 169390, issued to Respondent Jane So-Chun Lee, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2022-090520 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $44,125.75 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2022-090520 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Steven L. Simas, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 6/13/2025

Signed by:
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JANE SO-CHUN LEE, M.D.
Respondent

I have read and fully discussed with Respondent Jane So-Chun Lee, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 6/13/25

STEVEN L. SIMAS, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

LATRICE R. HEMPHILL
Deputy Attorney General
Attorneys for Complainant

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Steven L. Simas, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

JANE SO-CHUN LEE, M.D.
Respondent

I have read and fully discussed with Respondent Jane So-Chun Lee, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: _____

STEVEN L. SIMAS, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: June 13, 2025

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

L. Hemphill

LATRICE R. HEMPHILL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2022-090520

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

In the Matter of the Accusation Against: **Jane So-Chun Lee, M.D.** **271 Tally Ho Road** **Arroyo Grande, CA 93420-2317** **Physician's and Surgeon's Certificate No. G 169390,** Respondent.	Case No. 800-2022-090520 **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 or about July 21, 2020, the Medical Board issued Physician's and Surgeon's Certificate Number G 169390 to Jane So-Chun Lee, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2026, unless renewed.

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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 states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

(h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.

(i) Dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee.

6. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

8. On or about July 28, 2022, the Board was notified by Sierra Vista Regional Medical Center (SVRMC), pursuant to Business and Professions Code section 805, that Respondent

resigned her staff privileges at the time when "she was on notice of a pending investigation." The Board investigated the circumstances surrounding Respondent's resignation, and discovered as follows:

9. Respondent is board-certified by the American Board of Obstetrics and Gynecology (ABOG) who practiced medicine as an Obstetrician - Gynecologist (OBGYN) in the state of New Jersey since 1994, with no record of professional discipline there. Respondent moved to California in or about early 2020.

10. As a part of her employment for a national medical group, Respondent applied for and received privileges to practice at SVRMC on or about March 16, 2021. In her interview with the Board's investigators, Respondent explained that prior to her resignation, her privileges at SVRMC were "just the earliest privilege that you have when you sign up to work at the hospital. So it was still under a proctorship, and I had not completed the required amounts of cases to be on my own."

11. After several events related to patient care at SVRMC, some of which are detailed below, Respondent's SVRMC staff privileges were restricted to require additional proctoring. Respondent's employer chose not to schedule her to work at SVRMC instead of scheduling proctors, and Respondent subsequently resigned her privileges at SVRMC. The Board's investigation of the incidents that led to Respondent's resignation of her privileges revealed the following:

PATIENT 1[1]

12. Patient 1 was a 19-year-old female college student who presented to the emergency room at SVRMC on or about May 17, 2022, complaining of two days of increasing and radiating left lower quadrant pain. A pelvic sonogram revealed a 5.7 cm left ovarian cyst with absent arterial blood flow, which was suspicious for ovarian torsion. Respondent, who was on call, evaluated Patient 1 and admitted her to the hospital. Respondent scheduled Patient 1 for surgery

[1] The patients are designated by a number to protect their privacy. Respondent is aware of the patients' hospital record identification numbers, and that information shall also be provided to her in response to a written Request for Discovery.

that same evening. Another physician agreed to proctor Respondent. Respondent consented Patient 1 for a diagnostic laparoscopy, among other procedures.

13. Respondent previously requested and was granted the authority to perform diagnostic laparoscopies, but when she was asked during her interview with the Board's investigators when she last performed a laparoscopic procedure before her treatment of Patient 1, Respondent stated: "Uh -- it would be a guess. Maybe -- what -- four or five years prior." She further stated: "Well, I mean I was a little rusty, and I was not familiar with the instruments that they had at the hospital." Respondent explained that she decided to perform a laparoscopy for Patient 1, because the patient needed to return to school for exams as soon as possible, and because Respondent was going to have a proctor present and available to help her during the procedure. Respondent, however, did not inform her proctor about being "rusty" with laparoscopic procedures, her unfamiliarity with the instruments, or any other potential difficulties.

14. When the operation began, Respondent had significant and repeated difficulties advancing laparoscopic tools into Patient 1's abdomen, due to Respondent's lack of knowledge, ability, or experience in performing laparoscopic procedures. Because of Respondent's continued difficulties, which lasted in excess of 10 minutes, the proctor took over and completed the surgery.

15. Following the surgery the proctor prepared a Report of Obstetrical Observation, dated May 31, 2022, in which she concluded: "do not believe [Respondent] is capable of performing laparoscopy." The proctor described Respondent's difficulties as follows:

> "She was having difficulty getting the trocars into the abdomen. They were not penetrating and would slide as she attempted causing more trauma to the subcutaneous and muscular layers. The initial umbilical port was eventually placed by me. The second port she attempted was the right lower quadrant and this was attempted under direct video visualization but the same issue occurred. She had difficulty advancing the trocar and was sliding around instead of directly penetrating. The trocar finally got in but then she pulled out accidentally and did the attempt sliding all over again. There was close penetration to bowel underneath when she did get intraperitoneal placement. I offered to take over the case at this point. The remainder of the surgery was performed by me with very little of her assistance. I am concerned of her ability to perform laparoscopy."

16. When the surgery was completed and a surgical technician was attempting to clean Patient 1 and apply the dressing, she realized the umbilical incision was still open as the suture did not hold. When she called back for the proctor, Respondent entered the room and stated it was okay since it was not actively bleeding. The surgical tech, however, stated in a later report to hospital administration, "It was not okay as my pinky could fit directly inside and it was indeed still bleeding and showed when I wiped it. [The proctor donned] sterile gloves and helped me to close the site and apply dressing to the patient."

17. Respondent did not prepare a surgical report about the early stages of Patient 1's surgery, and did not otherwise document her difficulties during Patient 1's surgery in Patient 1's medical record, even though Respondent consented Patient 1 for surgery and was the surgeon of record until the proctor took over.

18. During a meeting between Respondent, and hospital leadership shortly after Patient 1's surgery, it was noted that Respondent does not typically perform laparoscopic procedures and she did not wish to continue to do them.

PATIENT 2

19. On May 31, 2022, Patient 2 underwent a Trial of Labor, attempting a vaginal birth after cesarean delivery (VBAC) under the care of a midwife. Respondent was the covering hospitalist. During the labor, when the mother was approximately 5 to 6 cm dilated, the infant's heart rate decelerated, which prompted the midwife to notify Respondent. Respondent, however, was not requested to see the patient at that time, because the labor progressed. Sometime later the infant had a second prolonged heart rate deceleration, and Respondent was called to Patient 2's bedside. Respondent advised Patient 2 to have a repeat Cesarean section, and Patient 2 agreed.

20. During the Cesarean delivery, the infant's head was stuck in the mother's pelvis and the infant was delivered using a vacuum. After the infant was delivered and handed off to the Neonatal Intensive Care Unit staff, Respondent noticed that the balloon of the Foley catheter was exposed and protruding from the mother's bladder. The Urologist later described in the operative report the difficulty in finding the dome portion of Patient 2's bladder, which he believed was excised during the performance of uterine incision.

21. Patient 2 was also bleeding profusely. Patient 2's estimated blood loss at the end of the procedure was noted at 1662 ml. Intraoperative hemorrhage can be lessened with the use of uterotonic medications, but no consideration of the use of these medications was made and/or documented. Patient 2 was not given any medication to attempt to mitigate the bleeding. Nor was there any consideration made and/or documented to give Patient 2 additional prophylactic antibiotics to prevent surgical site infection.

22. Respondent attempted to repair the mother's bladder and to close the uterus. During this, Respondent unintentionally sutured the mother's bladder to her uterus. Respondent stated during her interview with the Board investigators: "I started closing the uterus because she was bleeding profusely from the edges. And usually, the instruments that I use – T-clamps – they did not have at Sierra Vista. Uh – so it was difficult to identify the edges. I did the best what I could to close it because it was bleeding. And I controlled the bleeding until the urologist came. So when the urologist came, they identified the bladder edges and realized that my suturing was caught – the bladder and the uterus was all meshed together."

23. Respondent further explained how she assisted the urologist: "I had to slowly undo the uterine stitches so that he could get the bladder edges, and we would have to do a stitch at a time because every time I loosened the uterine stitch, it would start bleeding. But we identified it all the way to the end, and it was very edematous at that point. And then I had the uterus closed. And then he was able to close the bladder side of the -- um -- his part of the surgery."

24. Patient 2 was discharged several days after delivery, with a Foley catheter to allow bladder rest. Patient 2 then wrote a letter to the hospital to request further explanation of what occurred during the delivery. She wrote, in pertinent part: "I was very surprised and disappointed that no one explained the extent of my bladder injury to me until two days later. The hospitalist never explained what was going on while I was in the OR for over three hours, while awake. I was consistently told my bladder was 'nicked' during the surgery. When the urologist came to see me two days later, he explained thoroughly and I think he was surprised I wasn't aware of what happened." Respondent did not discuss and/or document a discussion or review of operative findings with Patient 2.

25. Respondent's description of the injury to Patient 2 during surgery was inaccurate and deceptive, minimizing the actual extent of the injury. Even if Respondent minimized the extent of the injury because she sought not to upset Patient 2 during surgery, this was not corrected during patient debrief, which should occur after the procedure or the subsequent day if circumstances do not provide an opportunity immediately after the procedure. Respondent did not have a patient debrief with Patient 2. Respondent failed to accurately give Patient 2 a clear understanding of operative findings.

PATIENT 3

26. On or about June 6, 2022, Patient 3, who had prior vaginal deliveries, was induced into labor to deliver twins (Twin A and Twin B). Patient 3 was laboring under the care of another physician (lead physician) at SVRMC. Twin A was known to be in vertex presentation[2] and Twin B was known to be in transverse presentation.[3] Therefore, Patient 3 was consented for vaginal delivery with a back-up option to deliver by Cesarean section. Respondent was the hospitalist on service at that time. Patient 3 was not Respondent's patient.

27. Twin A was delivered vaginally with no complications. Twin B, however, was transverse and did not progress. Respondent came to the Operating Room to help and was present during the discussion about how to proceed with delivery of Twin B. The lead physician decided to deliver Twin B by Cesarean section due to Patient 3's discomfort level. The lead physician announced the decision to those in the room, including Respondent.

28. At that time, Respondent told the lead physician that a C-section was not needed and that Twin B could be delivered vaginally. Respondent disagreed with the lead physician's plan to rupture Patient 3's amniotic sac. In her interview with the Board's investigators, Respondent explained:

> "...I advised her that usually you should not break the water because you want the bag to help dilate the cervix and bring the presenting part down."

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[2] Vertex presentation describes a fetus lying head-first or head down in the birth canal.
[3] Transverse presentation describes a fetus lying horizontally across the uterus, rather than vertical.

29. The lead physician disagreed with Respondent because she feared that, by continuing with vaginal delivery, or by pushing, Twin B might end up in the same position but further down in the birth canal, which would create more of an emergent need for a Cesarean section. The lead physician performed an amniotomy (ruptured Twin B's amniotic sac) and stepped out of the operating room into the adjacent scrub room to prepare for the Cesarean section. At that time Respondent asked if she could examine Patient 3 and/or continue trying the vaginal delivery. This conversation began in the Operating Room and continued into the scrub room. Respondent did not tell the lead physician or the patient that she intended to attempt a manual extraction. The lead physician, who believed that Respondent would simply continue with trial of labor, told Respondent it was fine.

30. Respondent did not communicate with Patient 3 and did not obtain Patient 3's informed consent for a manual extraction delivery. Respondent attempted to deliver Twin B by manual extraction while the lead physician was scrubbing outside of the operating room. Respondent reached into Patient 3's uterus and pulled out one of Twin B's legs. This action disrupted monitoring of Twin B's heart rate. Respondent then reached into Patient 3's uterus in an apparent attempt to find and deliver Twin B's other leg. The lead physician could see into the operating room. She believed that Respondent was attempting to deliver Twin B feet-first, which is not what she permitted Respondent to do. The lead physician re-entered the OR and directed Respondent to stop what she was doing. Because Twin B's heart rate could not be monitored, the lead physician performed an emergency Cesarean section to deliver Twin B.

31. Respondent did not complete a procedure note and did not otherwise document her attempted manual extraction delivery and did not document her actions in the care and treatment of Patient 3.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

32. Respondent Jane So-Chun Lee, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that Respondent was grossly negligent in her care and treatment of three patients. The circumstances are as follows:

33. The allegations of paragraphs 8 through 31 are incorporated herein by reference.

34. Each of the following was an extreme departure from the standard of care:

A. Respondent requesting privileges to perform laparoscopic procedures when she did not have the experience to do so, and subsequently attempting to perform a laparoscopic procedure on Patient 1 was an extreme departure from the standard of care.

B. Respondent's failure to document her difficulties during the care and treatment of Patient 1 was an extreme departure from the standard of care.

C. Respondent's failure to properly access and address a failed closure of a trocar stab wound on Patient 1 was an extreme departure from the standard of care.

D. Minimizing an intraoperative bladder injury as a "nick" to Patient 2, when the urologist described in his op-note the difficulty in finding the dome portion of the bladder, which is opined to have been excised during uterine incision, was an extreme departure from the standard of care.

E. Respondent's failure to use medications to control Patient 2's bleeding was an extreme departure from the standard of care.

F. Respondent's failure to advise the lead physician that she would attempt a manual extraction delivery of Twin B during Patient 3's labor was an extreme departure from the standard of care.

G. Attempting manual extraction delivery of Twin B without informed consent of Patient 3 was an extreme departure from the standard of care.

H. Respondent's failure to document an incomplete manual extraction delivery of Twin B, requiring that an emergency Cesarean section to be performed on Patient 3 was an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

35. Respondent Jane So-Chun Lee, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that Respondent committed repeated acts of negligence in her care and treatment of three patients. The circumstances are as follows:

36. The allegations of the First Cause for Discipline are incorporated herein by reference.

37. In addition to the departures from the standard of care alleged in the First Cause for Discipline, Respondent also committed the following acts of negligence:

A. Respondent's inability to perform surgery using laparoscopic approach under the circumstances alleged pertaining to Patient 1 was a departure from the standard of care.

B. Respondent's failure to communicate her inability to perform laparoscopic procedures to her proctor under the circumstances alleged pertaining to Patient 1 was a departure from the standard of care.

C. Respondent's failure to attempt to medically control Patient 2's bleeding was a departure from the standard of care.

D. Respondent's failure to administer additional prophylactic antibiotics under the circumstances alleged pertaining to Patient 2 was a departure from the standard of care.

E. Respondent's failure to document indication for surgery or that informed consent was obtained with regard to Patient 2's surgery was a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

38. Respondent Jane So-Chun Lee, M.D. is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that she was incompetent in her care and treatment of one patient. The circumstances are as follows:

39. The allegations of the First Cause for Discipline are incorporated herein by reference.

40. Respondent demonstrated a lack of knowledge or ability in performing laparoscopic procedures in her care and treatment of Patient 1.

FOURTH CAUSE FOR DISCIPLINE

(Record Keeping)

41. Respondent Jane So-Chun Lee, M.D. is subject to disciplinary action under section 2266 of the Code, in that she failed to maintain complete and accurate records of her care and treatment of three patients. The circumstances are as follows:

42. The allegations of the First Cause for Discipline are incorporated herein by reference.

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 169390, issued to Respondent Jane So-Chun Lee, M.D.;

2. Revoking, suspending or denying approval of Respondent Jane So-Chun Lee, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Jane So-Chun Lee, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: SEP 04 2024

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

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