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

In the Matter of the Accusation Against: Charles Wellington Chidsey III, M.D. Physician's and Surgeon's Certificate No. G 46524 Respondent.	Case No. 800-2022-086502

DECISION

The attached Stipulated Surrender of License and Disciplinary 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 OCT 0 1 2025.

IT IS SO ORDERED SEP 2 4 2025.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
TESSA L. HEUNIS
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **CHARLES WELLINGTON CHIDSEY, III, M.D.** **12506 Indianapolis Street** **Los Angeles, CA 90066** **Physician's and Surgeon's Certificate No. G 46524,** Respondent.	Case No. 800-2022-086502 OAH No. 2025031074 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY 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 Marsha E. Barr-Fernandez, Deputy Attorney General.

2. Charles Wellington Chidsey, III, M.D. (Respondent) is represented in this proceeding by attorney John C. Kelly, Esq., whose address is: P O Box 22636, Long Beach, CA 90801-5636.

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3. On or about November 23, 1981, the Board issued Physician's and Surgeon's Certificate No. G 46524 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2022-086502, expired on July 31, 2025, and has not been renewed.

JURISDICTION

4. On February 26, 2025, Accusation No. 800-2022-086502 was filed before the Board and is currently pending against Respondent. A true and correct copy of the Accusation and all other statutorily required documents were properly served on Respondent on February 26, 2025. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A true and correct copy of Accusation No. 800-2022-086502 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2022-086502. Respondent also has carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Order.

7. Respondent is fully aware of his 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 him; the right to present evidence and to testify on his 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.

8. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands that the charges and allegations in Accusation No. 800-2022-086502, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. 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 his right to contest that cause for discipline exists based on those charges.

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

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, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. G 46524 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 he may not withdraw his 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 46524, issued to Respondent CHARLES WELLINGTON CHIDSEY, III, 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 his pocket license and, if one was issued, his 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. 800-2022-086502 shall be deemed to be true, correct, and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. 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. 800-2022-086502 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.

6. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $ 52,214.75 prior to issuance of a new or reinstated license.

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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 John C. Kelly, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G 46524. Having the benefit of counsel, 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: 09/15/2025

CHARLES WELLINGTON CHIDSEY, III, M.D.
Respondent

I have read and fully discussed with Respondent CHARLES WELLINGTON CHIDSEY, III, 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: September 15, 2025

JOHN C. KELLY, 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: September 22, 2025

Respectfully submitted,

ROB BONTA
Attorney General of California
TESSA L. HEUNIS
Supervising Deputy Attorney General

MARSHA E. BARR-FERNANDEZ
Deputy Attorney General
Attorneys for Complainant

LA2025600516

Exhibit A
Accusation No. 800-2022-086502

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

In the Matter of the Accusation Against: **Charles Wellington Chidsey, III, M.D.** **12506 Indianapolis Street** **Los Angeles, CA 90066** **Physician's and Surgeon's Certificate No. G 46524,** Respondent.	Case No. 800-2022-086502 **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 November 23, 1981, the Board issued Physician's and Surgeon's Certificate Number G 46524 to Charles Wellington Chidsey, III, 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, 2025, unless renewed.

JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

6. 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.

7. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

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STATUTORY PROVISIONS

8. 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.

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COST RECOVERY

9. Section 125.3 of the Code states:

(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.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

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(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FACTUAL ALLEGATIONS

10. Respondent is a general surgeon who, at all relevant times, maintained a solo practice. Respondent was a member of the Medical Staff and had surgical privileges at Providence Holy Cross Medical Center (PHCMC), where Respondent also served on the emergency room call panel. Respondent is not board certified in surgery.

PATIENT 1

11. Patient 1[1] was a 69-year-old man who presented to the emergency room at PHCMC at approximately 1432 on November 17, 2020. Patient 1 was complaining of 3 days of severe diarrhea, worsening abdominal pain with nausea, and frequent episodes of vomiting. A CT scan ordered in the emergency room showed the colon "distended with gas and fecal material" with "gas in the wall of the cecum and ascending colon." At approximately 2014, Patient 1 was admitted to the telemetry unit at PHCMC, and Respondent was assigned as a consulting physician to see Patient 1 in surgical consultation.

12. Respondent completed his evaluation of Patient 1 by 2113 on November 17, 2020. According to Respondent's consultation note, Patient 1 reported that "his bowels abruptly stopped moving and ... no [bowel movements] for the past two days." Respondent's diagnostic impression at the time was, among other things, megacolon,[2] possible Ogilvie syndrome,[3] and "consider ischemic colitis."[4] On examination, Respondent noted Patient 1's abdomen was "[m]arkedly distended, no surgical scars or hernias, few bowel sounds present, firm, tympanitic,

[1] The patients are identified in this Accusation by number for privacy purposes.

[2] Megacolon is an abnormal dilation of the colon that is not caused by physical obstruction. If left untreated, it may result in serious complications, such as colonic perforation, peritonitis (inflammation of the lining of the abdomen due to a fungal or bacterial infection), and/or sepsis (an illness in which the body has a severe, inflammatory response to bacteria or other germs).

[3] Ogilvie syndrome is a sudden and unexplained paralysis of the colon, characterized by a large bowel distention without any physical blockage.

[4] Ischemic colitis is inflammation and injury of the large intestine (colon) due to inadequate blood supply.

non-tender on the left, 2+ tenderness on the right without guarding or rebound tenderness." Respondent's treatment plan included, among other things, medical (IV fluid) resuscitation[5] and "[i]f patient's condition deteriorates, laparotomy with partial or subtotal colectomy [surgical removal of part or all of the colon] may be necessary."

13. Respondent did not re-evaluate or see Patient 1 on November 18, 2020. On November 19, 2020, at approximately 0100, Patient 1 was noted to decompensate clinically. Patient 1 began complaining of increased abdominal pain not controlled with medication. At 0114, Respondent was called and asked to see Patient 1 for further evaluation "due to possible acute abdomen"[6] and concern about "possible perforation." At 0250, Respondent was called and advised that Patient 1 had low blood pressure and tachycardia to the 150s, and once or twice to the 300 range, and a drop in the oxygen saturation level to 88%, resulting in the rapid response team (RRT) being called. At 0345, Patient 1 was transferred to the intensive care unit (ICU).

14. At 0400, Respondent was again contacted by phone and advised of Patient 1's continuing clinical decompensation. At 0500, Patient 1 was noted to have worsening respiratory status, with shortness of breath and desaturations to the low 80s, resulting in emergency intubation. At 0528, the hospitalist noted that he "spoke to [Respondent] regarding this patient, and he said that most likely will take the patient to OR for suspected perforation." At 0825, Respondent was called by hospital staff to evaluate Patient 1, but Respondent was not able to be reached. The intensivist on duty called Respondent. According to the records, Respondent told the intensivist that Respondent would be in shortly to take Patient 1 to the operating room and would call to schedule an operating room urgently. During Respondent's interview with the Board, Respondent indicated he did not have a backup physician because Respondent's backup physician had retired. Patient 1 remained "very critical throughout morning and early afternoon."

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[5] Intravenous fluid (IV) resuscitation is a procedure used primarily to maintain organ perfusion and substrate (oxygen, electrolytes, among others) delivery through the administration of fluid and electrolytes.

[6] Acute abdomen refers to sudden, severe abdominal pain. It is a condition that demands urgent attention and treatment, and many times it is a sign of a medical emergency that requires immediate surgery.

15. Respondent re-evaluated Patient 1 at the hospital at approximately 1145 and performed surgery on Patient 1 at 1518 on November 19, 2020. Upon opening Patient 1's abdomen, Respondent found "gross fecal contamination of entire peritoneal cavity with predominantly liquid feces. Entire colon appeared to be ischemic and/or infarcted." At 1524, Patient 1 became pulseless and cardiopulmonary resuscitation (CPR) was started. Despite CPR and defibrillation, Patient 1 was declared deceased at 1548.

PATIENT 2

16. Patient 2 was a 65-year-old male who presented to the emergency room at PHCMC at 0833 on June 12, 2020, for evaluation of abdominal pain rated at a 10 out of 10 with multiple episodes of vomiting and diarrhea. A CT scan of the abdomen, without contrast, performed at 1010 was notable for a perforation involving the gastroduodenal junction[7] resulting in a 4.9 cm collection of gas and fluid with an adjacent 2.6 cm calcified stone. At 1210, Respondent was assigned as a consulting physician, and Patient 2 was ordered admitted to the medical-surgical unit at PHCMC at 1241. At approximately 1538, Respondent evaluated Patient 2 and recommended evaluation by the gastroenterologist. Respondent also ordered a CT of the abdomen with contrast.

17. The CT of the abdomen with contrast was performed at approximately 2323 on June 12, 2020. The CT showed "interval worsening of perforated viscus" with "[i]ncreased leakage of gastric contents and oral contrast material into the upper abdomen and pelvis noted, with a new large collection of gas within the soft tissues of the mesentery." Additionally, the "previously noted question of gas and fluid has increased in size and now measures up to 11.7 x 6.3 cm. Significant volume of oral contrast has leaked into the collection."

18. On June 13, 2020, at approximately 2023, Respondent noted that Patient 2 had "slowed mentation," and the CT scan "demonstrated worsening of the subhepatic fluid leak" and "[w]ill plan for exploratory laparotomy." Overnight, Patient 2's condition deteriorated.

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[7] The gastroduodenal junction is the point where the stomach joins the small intestine.

19. On June 14, 2020, at approximately 0814, Patient 2 was seen by the gastroenterologist who noted, "patient looks more septic today." The gastroenterologist's plan was to transfer Patient 2 to a "monitored bed or ICU" and "may need interventional radiology to drain the abscess..."

20. On June 14, 2020, at approximately 0945, Respondent re-evaluated Patient 2 and noted that "[o]ver the past 12 hours, the patient's general condition has deteriorated. He appears to be developing septic shock. Fluid resuscitation and urgent surgical intervention are required as a life-saving measure."

21. On June 14, 2020, at 1153, Respondent performed an exploratory laparotomy on Patient 2 and found Patient 2 to have a large lateral perforation of the duodenum (first part of the small intestine) into the retroperitoneum (space located behind the abdominal or peritoneal cavity). Respondent performed a partial distal gastrectomy (removal of a portion of the stomach) with gastrojejunostomy (surgical connection of the remaining portion of the stomach to the second part of the small intestine), cholecystectomy (gallbladder removal), and gastrostomy (feeding) tube placement. Patient 2 developed multiple postoperative complications including respiratory and renal failure and ultimately expired on June 27, 2020.

PATIENT 3

22. Patient 3 was a 40-year-old man who presented to the Emergency Department at PHCMC complaining of epigastric pain and right upper quadrant pain with nausea and vomiting on March 8, 2020, at approximately 0611. Imaging studies of the abdomen were performed and resulted in Patient 3 being diagnosed with acute cholecystitis (inflammation of the gallbladder due to gallstone obstruction of the bile duct). At 0838, the emergency room provider consulted Respondent about Patient 3, and at 0839, Respondent was assigned as the consulting physician. At 0905, a hospitalist ordered Patient 3 admitted to the medical surgical floor for further evaluation. Respondent did not see Patient 3 at the hospital on March 8, 2020.

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23. On March 9, 2020, Patient 3 was seen by a hospitalist and a gastroenterologist. The gastroenterologist's treatment plan for Patient 3 included performing further diagnostic studies, including magnetic resonance cholangiopancreatography (MRCP),[8] endoscopic ultrasound (EUS),[9] and possible endoscopic retrograde cholangiopancreatography (ERCP).[10] The MRCP performed on that day showed "mild central intrahepatic and common hepatic ductal dilatation possibly reflecting extrinsic compression from stone filled gallbladder." The EUS also performed that day showed "chronic cholecystitis with gallstones." The recommendation was to consider cholecystectomy (gall bladder removal). The hospitalist noted that they were "waiting for further evaluation recommendations from the surgeon." Respondent did not see Patient 3 at the hospital on March 9, 2020.

24. On March 10, 2020, at approximately 1557, Respondent saw Patient 3 at the hospital for the first time. After seeing Patient 3, Respondent recommended outpatient surgical care. Per the medical records, "since patient was initially told that he was going to have cholecystectomy this hospitalization and was told otherwise by the surgeon, he got angry and left AMA [against medical advice]."

PATIENT 4

25. Patient 4 was an 82-year-old man with a history of lymphoma (cancer) who developed right upper quadrant pain, nausea, and vomiting. Patient 4 presented to PHCMC for elective outpatient laparoscopic (minimally invasive) cholecystectomy by Respondent at approximately 0745 on June 6, 2019.

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[8] Magnetic resonance cholangiopancreatography (MRCP) is a special type of magnetic resonance imaging (MRI) exam that produces detailed images of the hepatobiliary and pancreatic systems. It is used to visualize the biliary and pancreatic ducts in a non-invasive manner. MRCP is used to diagnose gallstones and choledochal cysts.

[9] Endoscopic ultrasound (EUS) is a procedure that combines endoscopy and ultrasound to create images of the digestive tract and nearby organs and tissues.

[10] Endoscopic retrograde cholangiopancreatography (ERCP) is a procedure that uses an endoscope with a dedicated camera and X-ray to view the bile and pancreatic ducts to look for abnormalities such as blockages, irregularity in the tissue, problems with the flow of bile or pancreatic fluid, stones, or tumors. If a problem is found, the endoscopist can often perform a procedure to repair or improve the condition and take tissue samples if needed.

26. On June 6, 2019, at approximately 1433, Respondent performed the cholecystectomy on Patient 4. Per Respondent's operative report, Respondent used three trocars (a surgical device that allows access to body cavities through small incisions) during Patient 4's surgery. Respondent noted, "[t]he hepatoduodenal ligament was incised with the cautery and the cystic duct identified. This was skeletonized to its junction with the common bile duct. The critical view was achieved." By 1556, the surgery was completed. Respondent's intraoperative findings were notable for a "contracted fibrotic gallbladder." The excised gallbladder was sent to the pathology department for examination. The final pathology report indicated the specimen consisted of "a hemorrhagic gallbladder with a large amount of attached liver tissue...spanning an area of 4.5 x 3.5 x 1 cm." The final pathologic diagnosis was notable for "severe acute on chronic cholecystitis." Patient 4 was discharged home at approximately 1842 on June 6, 2019.

27. On June 13, 2019, Patient 4 presented to the emergency room at Providence St. Joseph Medical Center by ambulance for "evaluation of abdominal pain presenting as chest pain that started 1 week ago after laparoscopic cholecystectomy." Patient 4 was found to have a bile (fluid produced by the liver) leak resulting in a biloma (an intrahepatic or extrahepatic encapsulated collection of bile outside of the biliary tree and within the abdominal cavity). An ERCP showed sudden cutoff of the bile duct. Patient 4 underwent percutaneous biliary drain placement to drain the biloma and was subsequently transferred to PHCMC on June 22, 2019.

28. On June 25, 2019, Patient 4 underwent a transhepatic biliary drain replacement. The report notes "[p]atient with bile duct transection and bile leak." The cholangiogram (an x-ray of the bile ducts) showed "[s]ignificant contrast extravasation from the confluence of the intrahepatic bile duct. The superior common hepatic duct is probably macerated." On June 29, 2019, Respondent performed an exploratory laparotomy and Roux-en-Y hepaticojejunostomy[11] for a bile duct injury on Patient 4. In the operative report of June 29, 2019, Respondent noted "anomalous anatomy was noted in the hepatoduodenal ligament region with the portal vein being superficial to the common hepatic duct...The common hepatic duct appeared to have been

[11] Roux-en-Y hepaticojejunostomy is a surgical procedure that connects the liver duct to the jejunum (middle part of the small intestine) to allow bile to drain from the liver directly into the small intestine.

transected near the confluence of the right and left hepatic ducts and was not dilated...Eventually, the common hepatic duct was identified, however it appeared to lie deep to the portal vein in an anomalous location. Upon closer inspection, the distal common hepatic duct could not be identified and only a short segment of the proximal duct remained attached to the confluence of the right and left hepatic ducts." On July 13, 2019, Patient 4 was discharged to a skilled nursing facility and expired due to liver abscess on August 20, 2019.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

29. Respondent Charles Wellington Chidsey, III, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent in the care and treatment of Patients 1 and 2. The circumstances are as follows:

30. The facts and allegations set forth in paragraphs 10 to 21 are incorporated herein by reference as if fully set forth.

Patients 1 And 2: Delay In Providing Surgical Care.

31. The standard of care requires that patients presenting with acute surgical conditions, or conditions which may progress to needing surgical intervention, be promptly and frequently re-evaluated. The timing of surgery is critically important. In the case of perforated intestine, for instance, delay in surgical care can result in fecal contamination of the abdomen which can rapidly progress to sepsis and death if not addressed in a timely fashion. While there are instances where medical resuscitation is necessary prior to surgery, a patient with a surgical abdomen, meaning a condition that demands urgent attention and treatment, who is plainly septic needs prompt surgical intervention to prevent death.

32. Patient 1 was admitted to PHCMC on November 17, 2020, and evaluated by Respondent. Respondent's assessment included megacolon, Ogilvie's syndrome, and ischemic colitis, and Respondent's recommendation was medical resuscitation and "if patient's condition deteriorates, laparotomy with partial or subtotal colectomy may be necessary." Respondent did not re-evaluate Patient 1 on November 18, 2020. Patient 1 started to decompensate at approximately 0130 on November 19, 2020. Respondent was promptly alerted to Patient 1's

deteriorating condition, was kept apprised of Patient 1's continued deterioration thereafter, and was asked multiple times to come to the hospital to evaluate Patient 1 and take him to surgery. Respondent delayed coming to the hospital and delayed more than 12 hours after Patient 1 began decompensating to take him to surgery. Respondent's failure to evaluate Patient 1 on November 18, 2020, delay in providing emergent surgical care on November 19, 2020, and failure to arrange for a backup surgeon to provide the emergent surgical care if Respondent was incapacitated or unavailable to see the patient emergently, constitutes an extreme departure from the standard of care.

33. Patient 2's clinical record demonstrates that Patient 2 developed worsening signs of intestinal perforation between the initial CT scan performed at approximately 1000 on June 12, 2020, and the follow-up CT scan ordered by Respondent and performed at approximately 2300 on June 12, 2020. The radiographic findings demonstrated that there was no longer a contained perforation given that the size of the fluid and gas collection had increased from 4.9 cm to 11.7 cm with "a new large collection of gas within the soft tissues of the mesentery." These findings represent a true surgical emergency and portend impending sepsis. Patient 2 developed sepsis on the morning of June 14, 2020, just prior to being taken for surgical exploration by Respondent. Respondent's more than 24-hour delay in providing surgical care after evidence of intestinal perforation constitutes an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

34. Respondent Charles Wellington Chidsey, III, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent was negligent in his care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

35. The facts and allegations set forth in the First Cause for Discipline are incorporated by reference as if fully set forth. Each of the alleged acts of gross negligence set forth in the First Cause for Discipline, above, is also a negligent act.

36. The facts and allegations set forth in paragraphs 22 to 28 are incorporated herein by reference as if fully set forth.

Patient 3: Delay In Providing Surgical Evaluation.

37. The standard of care requires that patients who present with acute surgical conditions or conditions which may progress to needing surgical intervention need to be promptly and frequently re-evaluated. Because only a surgeon has the training, knowledge, and legal responsibility to ascertain whether a patient needs surgery and to perform that surgery, it is incumbent on the surgeon to evaluate the patient to render a clinical opinion. In the case of patients who are admitted through the emergency room, there is a reasonable expectation that once a formal surgical consultation is called, the surgeon will evaluate the patient in a reasonable time period not to exceed 24 hours in most facilities. Patient 3 was admitted to PHCMC on March 8, 2020, for evaluation of acute cholecystitis and possible cholecystectomy. Respondent was called by the emergency room provider on March 8, 2020, at 0839, and asked for surgical consultation. Respondent did not provide the surgical consultation until March 10, 2020. The delay in providing the surgical consultation on Patient 3 for more than 24 hours after the initial consultation constitutes a simple departure from the standard of care.

Patient 4: Iatrogenic Bile Duct Injury.

38. Bile duct injury is a known complication of cholecystectomy and occurs in approximately 1-2 per 1000 cases. Causes for injury can include aberrant anatomy, inflammation, and surgical error. Misidentification of the biliary tree is a known complication of this operation. However, this type of injury is avoidable. When surgeons are confronted with aberrant anatomy or difficult gallbladders precluding safe excision of the gallbladder, the standard of care requires utilization of intraoperative maneuvers such as conversion to an open procedure, intraoperative cholangiogram, or subtotal cholecystectomy to mitigate against bile duct injury. Imaging studies taken of Patient 4 one week after the laparoscopic cholecystectomy performed by Respondent on June 6, 2019, showed that Respondent transected the bile duct. On June 29, 2019, when Respondent reoperated on Patient 4, Respondent described "anomalous anatomy" in the hepatoduodenal ligament region. During Respondent's Board interview, Respondent stated that he had difficulty establishing a plane between the gallbladder and other structures during the surgery of June 6, 2019. Respondent's iatrogenic transection of the bile duct in the setting of

unrecognized aberrant anatomy and unclear surgical planes represents a simple departure from standard of care.

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 46524, issued to Respondent Charles Wellington Chidsey, III, M.D.;

2. Revoking, suspending or denying approval of Respondent Charles Wellington Chidsey, III, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Charles Wellington Chidsey, III, 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: FEB 2 6 2025

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

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