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

In the Matter of the Accusation Against: **Richard Anthony Williams, M.D.** **Physician's and Surgeon's Certificate No. A 40188** **Respondent.**	**Case No.: 800-2022-084813**

ORDER CORRECTING NUNC PRO TUNC CLERICAL ERROR IN "CASE NUMBER" PORTION ON PAGE 3 AND PAGE 7 OF THE DECISION

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error on Page 3 and Page 7 of the Decision in the above-entitled matter and that such mistake or clerical error should be corrected.

IT IS HEREBY ORDERED that the case number 800-2022-087276 on Page 3 under Culpability and the case number 800-2021-076921 on Page 7 under Future Admission Clause of the Decision in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as "800-2022-084813".

February 27, 2026

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

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

In the Matter of the Accusation Against: Richard Anthony Williams, M.D. Physician's & Surgeon's Certificate No. A 40188 Respondent.	Case No. 800-2022-084813

DECISION

The attached Stipulated Settlement 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 February 27, 2026.

IT IS SO ORDERED: January 29, 2026.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
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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: **RICHARD ANTHONY WILLIAMS, M.D.** **1334 W. Covina Blvd., Suite 102** **San Dimas, CA 91773** **Physician's and Surgeon's Certificate** **No. A 40188** Respondent.	Case No. 800-2022-084813 OAH No. 2025030730 **STIPULATED SETTLEMENT 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 Catherine B. Kim, Deputy Attorney General.

2. Respondent Richard Anthony Williams, M.D. (Respondent) is represented in this proceeding by attorney Derek F. O'Reilly-Jones, Esq., of Bonne, Bridges, Mueller, O'Keefe & Nichols, whose address is: 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071.

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3. On or about July 18, 1983, the Board issued Physician's and Surgeon's Certificate No. A 40188 to Richard Anthony Williams, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2022-084813, and will expire on November 30, 2026, unless renewed.

JURISDICTION

4. On December 30, 2024, Accusation No. 800-2022-084813 was filed before the Board and is currently pending against Respondent. A true and accurate copy of the Accusation and all other statutorily required documents were properly served on Respondent on December 30, 2024. Respondent timely filed his Notice of Defense contesting the Accusation. A true and accurate copy of Accusation No. 800-2022-084813 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2022-084813. Respondent has also carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

6. 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.

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

8. Respondent acknowledges the fact that, if adopted by the Board, the Board will report this Stipulated Settlement and Disciplinary Order to the National Practitioner Data Bank (NPDB) and Federation of State Medical Boards (FSMB) and publicly post such enforcement action, and Respondent hereby waives any and all objections thereto.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2022-084813, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. A 40188.

10. Respondent agrees that, at a hearing, Complainant could establish a *prima facie* case or factual basis for the charges in Accusation No. 800-2022-087276, and that Respondent hereby gives up his right to contest those charges. Respondent further agrees that if he ever petitions for modification of the disciplinary order, or if an accusation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2022-087276 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A 40188 is subject to discipline and agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this above-entitled matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 40188 issued to Respondent RICHARD ANTHONY WILLIAMS, M.D., shall be and is hereby Publicly Reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Respondent's care and treatment of Patient 1, is as follows:

> During Respondent's management of Patient 1's pregnancy from February 2021 through August 2021, Respondent committed acts of negligence when he failed to (1) perform a diagnostic three-hour glucose tolerance test despite an elevated screening test result and recommendations by a maternal-fetal specialist; (2) timely prepare operative reports of the Cesarean Section and Exploratory Laparotomy, Total Abdominal Hysterectomy procedures performed on August 26, 2021; (3) measure and document Patient 1's estimated blood loss while Patient 1 was experiencing postpartum hemorrhage in the post-anesthesia care unit; and (4) provide adequate medical management of Patient 1's postpartum hemorrhage prior to surgical intervention. This conduct is in violation of California Business and Professions Code sections 2234, subdivision (c), and 2266.

IT IS FURTHER ORDERED that Respondent is subject to the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) for a total of 60 hours. The educational program(s) or course(s) shall be

aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure and any other coursework required by this stipulation. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 85 hours of CME of which 60 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully

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complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation as determined by the program for the assessment and clinical education and evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation.

4. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $81,548.80 (eighty-one thousand five hundred forty-eight dollars and eighty cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered unprofessional conduct and grounds for further disciplinary action.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with the payment plan shall be considered unprofessional conduct and grounds for further disciplinary action.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

5. FUTURE ADMISSIONS CLAUSE. 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 action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2022-084813 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 license. Respondent further agrees that if an Accusation is ever filed against him before the Board, all of the charges and allegations contained in the Accusation No. 800-2021-076921 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent, before the Board.

6. FAILURE TO COMPLY. Any failure by Respondent to comply with terms and conditions of the Stipulated Settlement and Disciplinary Order set forth above shall constitute unprofessional conduct and grounds for further disciplinary action.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Derek F. O'Reilly-Jones, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 40188. Having the benefit of counsel, I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 17 NOV 2025

RICHARD ANTHONY WILLIAMS, M.D.
Respondent

I have read and fully discussed with Respondent Richard Anthony Williams, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11/17/2025

DEREK F. O'REILLY-JONES, ESQ.
Attorney for Respondent

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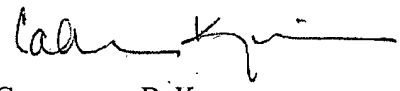
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 11/17/2025

Respectfully submitted,

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



CATHERINE B. KIM
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2022-084813

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

In the Matter of the Accusation Against: **RICHARD ANTHONY WILLIAMS, M.D.** **1334 W. Covina Blvd., Suite 102** **San Dimas, CA 91773** **Physician's and Surgeon's Certificate No. A 40188,** Respondent.	Case No. 800-2022-084813 OAH No. **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 18, 1983, the Medical Board issued Physician's and Surgeon's Certificate Number A 40188 to Richard Anthony Williams, 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 November 30, 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 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:
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> (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.

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.

9. 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

10. 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.

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(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.

(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

11. At all times relevant to the allegations herein, Respondent was an obstetrician-gynecologist with a private practice in San Dimas, California and the Chairman of the Department of Obstetrics and Gynecology at San Dimas Community Hospital (SDCH).

12. On or about February 3, 2021, Patient 1[1] first came under Respondent's care for the care and treatment of her fourth pregnancy. At that time, Patient 1 was 35 years and 10 months old, with a history of three prior pregnancies that resulted in one full term vaginal delivery in 2007 and two spontaneous abortions in 2003 and 2012. Patient 1 returned to Respondent for follow-up examinations throughout her pregnancy.

13. As of her examination on or about March 15, 2021, Patient 1's gestation was estimated at 16 weeks and 5 days. Sometime prior to April 2021, Respondent referred Patient 1 to Dr. G.D., a maternal-fetal medicine specialist, due to concerns related to advanced maternal age.

14. On or about April 2, 2021, Patient 1 was seen for the first time by Dr. G.D. Dr. G.D. noted no abnormalities in fetal anatomy or fetal echocardiography from the ultrasound study he performed. Dr. G.D. also noted no anomalies in the maternal anatomy survey. Due to advance maternal age, Dr. G.D. discussed genetic amniocentesis which the patient declined. Dr. G.D. recommended Patient 1 to return for a follow up ultrasound at 32 weeks. Dr. G.D.'s signed report is contained in Respondent's chart for Patient 1.

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[1] To protect the privacy of the patient involved, the patient is referred to as Patient 1 and her name is not included in this pleading. Respondent is aware of the identity of the patient referred herein.

15. On or about June 15, 2021, at gestational age of 29 weeks 6 days, Respondent ordered lab studies for Patient 1 including a 1-hour glucose tolerance test (GTT) that returned an elevated blood sugar level of 140 mg/dL.

16. On or about June 25, 2021, Patient 1 was seen by Dr. G.D. for evaluation of fetal growth and development at estimated gestation of 31 weeks and 1 day. On this date, the ultrasound study revealed: 1. Acceleration of growth of the fetal abdomen, 2. INCREASED amniotic fluid, 3. No evidence of cardiac dysfunction, 4. No evidence of placental dysfunction, and 5. Normal Doppler of the umbilical arteries. Based on these findings, Dr. G.D. noted the presence of acceleration of fetal growth and increased amniotic fluid that are often associated with maternal glucose intolerance that manifests in the third trimester of pregnancy, and recommended Patient 1 undergo a 3-hour GTT. Dr. G.D.'s signed report is contained in Respondent's chart for Patient 1.

17. Patient 1's medical chart does not show that a 3-hour GTT was ordered at any time, either after the June 15, 2021 lab study ordered by Respondent or after the recommendation by Dr. G.D. on June 25, 2021. Respondent stated in his subject interview on September 6, 2023 (hereinafter "subject interview"), that he did not order a 3-hour GTT for Patient 1.

18. Patient 1 was last seen at Respondent's office on or about August 24, 2021, at 39 weeks 6 days, at which time Respondent noted "no complaints" and "AFI good" and instructed Patient 1 to return in one week.

19. Respondent stated in his subject interview that he performed an ultrasound on August 24, 2021, to determine if the amniotic fluid was increased and found that it was not and documented "AFI good" on the progress note dated August 24, 2021. Respondent did not perform any fetal growth parameters such as measurements of the fetal dimensions in the August 24, 2021 ultrasound. There is no documentation of any measurements of the amniotic fluid or fetal dimensions, and there is no printed copy or report of the ultrasound in Patient 1's chart.

20. Respondent stated in his subject interview that during the examination on August 24, 2021, he informed Patient 1 that "her baby was a good size baby" and that "she could consider

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induction[.]" Patient 1 telephoned Respondent the following day on August 25, 2021 electing to proceed with the induction of her labor.

21. Patient 1 was admitted to SDCH on or about August 25, 2021 at approximately 9:56 p.m. for induction of labor.

22. On or about August 26, 2021, at approximately 12:24 p.m., Patient 1 was taken to the operating room (OR) for a Cesarean Section procedure and delivered a baby girl at 12:38 p.m. Patient 1's estimated blood loss for the surgery is noted to be 700 mL. Once the procedure ended, Patient 1 was taken to PACU (post anesthesia care unit) at 1:29 p.m.

23. Respondent's standing post-Cesarean Section protocol orders included continuing Pitocin infusion in "next three liters of IV fluids."

24. While Patient 1 was being transferred from the OR to the PACU, Patient 1's IV bag became empty and the assigned anesthesiologist Dr. S.P. placed a replacement IV bag that did not contain Pitocin and the Pitocin infusion was not continued. There is a discrepancy between Dr. S.P.'s notes and the nursing record as to why Pitocin was discontinued at this time. According to Dr. S.P., he instructed the nurse to continue Pitocin infusion per Respondent's post-Cesarean Section protocol order. The nursing note at 1:34 p.m. states Nurse F.G. asked Dr. S.P. re Pitocin, and "MD said already gave total of 40 units" while in OR.

25. While Patient 1 was in the PACU, numerous entries were made referring to Patient 1's ongoing blood loss:

a) At 1:34 p.m., Nurse F.G. entered "Received from OR via bed, ... Sinus tachycardia[2] on telemetry. ... Fundus[3] firm on palpation. Peripad soaked with lochia,[4] removed. Verified with Dr. [S.P.] if Pitocin needed ... and MD said he already gave total of 40 units Pitocin while in OR."

b) At 1:45 p.m., Nurse F.G. entered "... SBP [systolic blood pressure] = 82."

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[2] Tachycardia refers to abnormally fast heart rate.
[3] Fundus refers to the top of the uterus.
[4] Lochia refers to postpartum bleeding.

c) At 1:55 p.m., Dr. S.P. entered "Acute vaginal bleeding with hypotension[5] and tachycardia. Immediately, fluid resuscitation began, and [Respondent] at the bedside. He started Pitocin plus Methergine when we discovered that his routine Pitocin order was not followed.... At the moment vaginal bleed appeared controlled and BP stabilized."

d) At 2:08 p.m., Nurse F.G. entered "... Perineal area checked, noted peripad soaked and pool of blood on the bed. At this point, [Respondent] was called ... arrived and examined pt [patient]. ... gave order to add Pitocin 40 units + Methergine 0.2 mg mix in IVF."

e) Between 2:08 p.m. and 2:18 p.m. entries, Nurse F.G. added the following note: "[Respondent] examined pt. ... Gross vaginal bleeding noted. Ultrasorb pads changed. ... Ordered type and cross and blood transfusion, PRBC (packed red blood cells) x 4 ..."

f) At 2:19 p.m., Dr. S.P. entered "Intermittent episodes of uncontrolled vaginal bleeding despite ongoing Pitocin and Methergine. Pt again started becoming hypotensive. As per Blood bank, PRBC is picked up at 1419. At this time, I anticipated a quick decision for a surgical control for bleeding."

g) At 2:30 p.m., Dr. S.P. entered "OR Charge Nurse initiated the PRBC transfusion but stated that she was only able to transfuse 50 cc of PRBC using the rapid infusor before it failed. ... I yelled out for Y-tubing, blood warmer, and pressure bag for transfusion. The nurses in the PACU stated "WE DON'T HAVE BLOOD WARMER." ... [Respondent] standing next to me did not provide any help or suggestions ..."

h) At 2:34 p.m., Dr. S.P. entered "Because pt's BP [blood pressure] remained hypotensive, I began actively transfusing ... The nurses made multiple attempts for additional IV access without success, when one IV failed during transfusion."

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[5] Hypotension refers to low blood pressure.

i) At 2:34 p.m., Nurse F.G. entered "First unit uncrossed match PRBC administered by Dr. [S.P.]."

j) At 3:10 p.m., Dr. S.P. noted "After completing transfusion of 1st 2 units of PRBC, I asked Dr. [J.J.] for help with central line. He suggested to place and order for ED physician ... This was ordered at 1519. ..."

k) At 3:19 p.m., Nurse F.G. entered "[Respondent] ordered Methergine IM, done. Drs. [J.J.] and [S.P.] at bedside. Central line ordered."

l) At 3:46 p.m., Dr. S.P. noted "Central line placed by ED physician, 27 min after the order made at 1519."

m) At 3:46 p.m., Nurse F.G. entered "Central line inserted by Dr. Peek on right femoral. Pt appears lethargic but easily arousable. Pt states she feels very weak."

n) At 3:55 p.m., Nurse F.G. entered "Total of 4 units PRBC transfused at this time. Waiting for ICU bed. [Respondent] spoke to patient's husband."

o) At 4:30 p.m., Nurse F.G. entered "Pt c/o feeling nauseated. ... Dr. [J.J.] at bedside, assessing pt. [Respondent] on the phone orders made."

p) At 4:31 p.m., Dr. [S.P.] entered in the ANESTHESIA NOTES "Vag bleeding while in PACU. [Respondent] called immediately + present at the bedside."

q) At 5:11 p.m., Nurse F.G. entered "Pt noted getting lethargic, O2 saturation = 70's, Bag-mask-valve maneuver done for airway maintenance. ... Rapid Response team at bedside. Dr. Peek arrived and prepared pt for intubation. ... Prepared pt for emergency hystrectomy [*sic*]."

r) RT (Respiratory Therapist) Note entered: "1715 (5:15 pm) Responded to Rapid Response in PACU. Pt was intubated around 1720 ... OR staff took over after tube was secured."

s) At 5:33 p.m., Nurse F.G. entered "Pt wheeled to OR 4."

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26. While Patient 1 was in PACU, Patient 1 was administered the following uterotonics:[6]

a) At or about 1:55 p.m. (per Dr. S.P.) to 2:08 p.m. (per Nurse F.G.), Pitocin was restarted in the IV fluids pursuant to Respondent's orders.

b) At the same time Pitocin was restarted, Respondent ordered Methergine 0.2 mg. Respondent stated in his subject interview that he administered Pitocin and Methergine together or quickly added Methergine after Pitocin. The nursing records show Methergine was given at 3:19 p.m.

c) Respondent stated in his subject interview that he administered Cytotec rectally and Hemabate intrauterine at the same time before calling his colleague Dr. W.B. at or about 3:00 p.m. The nursing records show 800 mcg of Cytotec was given at 4:50 p.m.

27. The records do not show that additional doses of Methergine, Cytotec or Hemabate were given to Patient 1 while she remained in PACU.

28. Respondent stated in his subject interview that he performed a uterine massage when he was first called to PACU at approximately 2:00 p.m. The records show a uterine massage was performed at or about 2:29 p.m. with [the passage of an] estimated 10 ml lochia.

29. Respondent stated in his subject interview, that he telephoned and spoke with a colleague, Dr. W.B., at approximately 3:00 p.m. and discussed the possibility of administering TXA (Tranexamic Acid[7]) to Patient 1 but determined it was too late to do so and did not give TXA to Patient 1.

30. Respondent stated in his subject interview that he did not attempt to use a uterine tamponade[8] such as a Bakri balloon, or uterine packing[9] while in PACU because the uterus had become too large and he did not believe the tamponade would work.

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[6] Uterotonics are medications that cause the uterus to contact or become more toned. Uterotonics are used to induce labor and to reduce postpartum hemorrhage.

[7] TXA or Tranexamic Acid is a medication commonly used to treat postpartum hemorrhage.

[8] Uterine tamponade or uterine balloon tamponade is a minimally invasive method where a uterine balloon is placed within the uterus and inflated to put sustained pressure on the uterus from the inside to slow or stop uterine hemorrhage.

[9] Uterine packing is a procedure that involves filling the uterus with gauze or tamponade for management of postpartum hemorrhage.

31. Respondent stated in his subject interview that he considered an embolization of the uterus while in PACU and contacted the head of the radiology department at SDCH. He was informed SDCH did not have the equipment for an embolization.

32. There is no documentation in the records of Respondent's conversation with the head radiologist regarding a possible uterine artery embolization.

33. Patient 1's heart rate upon entering PACU at 1:34 p.m. was 133, and continued to elevate throughout her time in PACU during the next several hours.

a) At 2:34 p.m., Patient 1's heart rate was 140.

b) At 3:34 p.m., Patient 1's heart rate was 153.

c) At 4:34 p.m., Patient 1's heart rate was 157.

d) At 5:04 p.m., Patient 1's heart rate was 169.

e) At 5:19 p.m., Patient 1's heart rate was 172.

f) At 5:28 p.m., Patient 1's heart rate was 182.

34. There is no entry or documentation of Patient 1's estimated or measured blood loss during the time Patient 1 remained in the PACU, from the end of the cesarean section until she was transported back to the OR.

35. Upon returning to the OR at or about 5:33 p.m. on August 26, 2021, Respondent documented performing the following procedures (collectively referred to herein as "hysterectomy") on Patient 1: "1. Exploratory laparotomy. 2. Total abdominal hysterectomy. 3. Attempt to control generalized pelvic oozing. 4. Placement of JP catheters. 5. Packing of pelvis. 6. Temporary closure."

36. Respondent identified the following preoperative diagnoses in the operative report for the hysterectomy: "1. Postpartum bleeding. 2. Uterine atony.[10] 3. Possible coagulopathy."

37. Respondent identified the following postoperative diagnoses in the operative report for the hysterectomy: "1. Postpartum uterine atony. 2. Uncontrolled or massive hemorrhage. 3. Suspected coagulopathy disorder."

[10] Uterine atony refers to a soft and weak uterus after childbirth which can lead to life-threatening blood loss after delivery.

38. Under the CLINICAL NOTE section of the operative report, Respondent noted: "While in the recovery room, the uterus became atonic and elevated up to the upper abdomen where I was called and she had a hypotensive episode. Upon presentation, the uterus was found to be midway between the umbilicus and the symphysis, very soft and boggy, massaging the uterus expressed approximately 200 mL of blood."

39. Respondent stated in his subject interview that he believed the primary or root cause of the postoperative hemorrhage was due to uterine atony.

40. The operative report noted the ESTIMATED BLOOD LOSS during the hysterectomy as "[a]pproximately 500 mL perioperatively, but still occurring."

41. Respondent stated in his subject interview that at the completion of the hysterectomy, Patient 1 was in DIC [Disseminated Intravascular Coagulopathy[11]].

42. Patient 1 arrived at the Intensive Care Unit (ICU) following the hysterectomy at or about 7:45 p.m. on or about August 26, 2021. Patient 1 remained on multiple vasopressors[12] in an effort to keep her blood pressure elevated. Patient 1 coded at 11:45 p.m. on or about August 26, 2021, and again at 4:19 a.m. on or about August 27, 2021, at which time Patient 1 could not be revived and was pronounced dead at 5:01 a.m.

43. Respondent stated in his subject interview that he dictated the operative report for the Cesarean Section, that was completed at or about 1:29 p.m. on August 26, 2021, at 12:16 a.m. on or about August 27, 2021. Respondent stated in his subject interview that the report for the second procedure, Exploratory Laparotomy and Total Abdominal Hysterectomy, that was completed at or about 7:35 p.m. on August 26, 2021, was dictated at 12:29 a.m. on August 27, 2021.

44. The certified Death Certificate listed the cause of death as (A) Coagulopathy, (B) Postpartum Hemorrhage, and (C) Uterine Atony.

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[11] DIC or disseminated intravascular coagulopathy is a blood clotting disorder that can result in life-threatening hemorrhage.

[12] Vasopressors refer to drugs that constrict blood vessels to increase blood pressure.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

45. Respondent Richard Anthony Williams, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in the care and treatment of Patient 1. The circumstances are as follows:

46. Paragraphs 11 through 44 are incorporated by reference as though fully set forth herein.

47. Respondent was negligent in his care and treatment of Patient 1 in that:

a) Respondent failed to timely and/or properly screen for gestational diabetes mellitus (GDM);

b) Respondent failed to timely prepare operative reports following the Cesarean Section and the hysterectomy performed on or about August 26, 2021;

c) Respondent failed to properly measure and document Patient 1's blood loss following Cesarean Section delivery; and

d) Respondent's medical management of Patient 1's uterine atony was inadequate and departed from the standard of care.

Screening for Gestational Diabetes Mellitus (GDM) in Pregnancy

48. The standard of care in caring for pregnant patients is to order a standard "1-hour Glucose Tolerance Test (GTT)" to screen for GDM, also known as Pregnancy Induced Diabetes between 24 and 28 weeks of pregnancy.

49. If the result of the 1-hour GTT is 140 mg/dL or above, which may signal a symptom of GDM, the standard of care is to order a diagnostic test called 3-hour GTT to confirm the diagnosis, of GDM.

50. If there is increased amniotic fluid noted in the ultrasound, which may also signal a symptom of GDM, it is the standard of care to order the 3-hour GTT to confirm the GDM diagnosis.

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51. If there are signs of possible GDM such as results of the 1-hour GTT or increased amniotic fluid noted in the ultrasound, the standard of care is to continue monitoring such signs by measuring the amniotic fluid and fetal dimensions when performing ultrasounds.

52. Respondent's failure to order the 1-hour GTT until June 15, 2021, when Patient 1 was at 29 weeks and 6 days gestation, is a simple departure from the standard of care.

53. Respondent's failure to order the 3-hour GTT to follow up on the elevated result of the 1-hour GTT and the recommendation from Dr. G.D., the perinatology consultant, based on the acceleration of fetal growth and increase in amniotic fluid seen in the June 25, 2021 ultrasound is a simple departure from the standard of care.

54. Respondent's failure to measure the amniotic fluid level or the baby's estimated fetal weight when he performed an ultrasound on August 24, 2021, despite noting that the baby looked appreciably large for gestational age and despite prior reporting of acceleration of fetal growth and an increase in amniotic fluid from Dr. G.D., the perinatology consultant, is a simple departure from the standard of care.

Timely Documentation of Operative Reports

55. The standard of care is to dictate or write a report of a surgery or a high risk procedure immediately after the surgery or procedure, before the patient is transferred to the next level of care to ensure that pertinent information is available to the next caregiver.

56. If the operative or procedural report is not placed in the medical record immediately following the procedure, the standard of care is to place a progress note immediately after the procedure so that pertinent information can be provided to the next provider of care.

57. Respondent's failure to dictate the operative report, or prepare a progress note, for the Cesarean Section procedure until 12:16 a.m. on August 27, 2021, nearly 11 hours after the surgery ended at or about 1:29 p.m. on August 26, 2021, constitutes a long delay and is a simple departure from the standard of care.

58. Respondent's failure to dictate the operative report, or prepare a progress note, for the Exploratory Laparotomy and Total Abdominal Hysterectomy until 12:29 a.m. on August 27,

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2021, until nearly five hours after the surgery ended at or about 7:35 p.m. on August 26, 2021, is well outside the standard of care and is a simple departure from the standard of care.

Measuring Post Cesarean Section Procedure Blood Loss

59. The standard of care during a hemorrhage is tracking and measuring blood loss in order to respond appropriately and in a timely manner to the degree of emergency that is ensuing. The amount of blood loss may be determined by (1) graduated drapes, (2) weighing pads, and (3) provider estimates.

60. Respondent's failure to determine Patient 1's ongoing blood loss or to tally the total amount of blood lost while in PACU when blood transfusions were being given to Patient 1, before she was taken to the OR for the hysterectomy, is a simple departure from the standard of care.

61. Respondent's failure to document the amount of Patient 1's ongoing blood loss or the total amount of blood lost before going into the OR for the second time for the hysterectomy or even in the operative report of the hysterectomy is a simple departure from the standard of care.

Medical Management of Uterine Atony

62. In treating postpartum hemorrhage caused by uterine atony, the standard of care is to utilize less invasive methods such as medications (uterotonics) and tamponade to attempt to improve uterine tone and control bleeding prior to employing more invasive approaches such as embolization of pelvic arteries by an interventional radiologist, surgical techniques (vascular ligation, compression sutures), or ultimately hysterectomy (removal of the uterus). The uterotonics typically include Pitocin, Methergine, Hemabate and Cytotec, and thrombotic agent (Traexamic Acid or TXA). Uterine tamponade includes manual massage, intrauterine balloons, or intrauterine packing.

63. A Pitocin bolus at the time of surgery followed by a continuous Pitocin infusion was found to reduce the need for additional uterotonics as compared to a bolus alone without the continued infusion and is typically the routine protocol. Methergine and Cytotec are used after Pitocin prior to giving Hemabate which can cause significant diarrhea.

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64. For timing of administering uterotonics, the standard of care provides:

a) Methergine can be re-dosed every 2-4 hours until postpartum hemorrhage is controlled.

b) Cytotec can be given once every 24 hours.

c) Hemabate can be re-dosed every 15 to 90 minutes for up to 8 doses.

d) For postpartum hemorrhage, the standard of care for Tranexamic Acid (TXA) is to administer 1 gram through the IV as soon as possible after giving birth, followed by a second dose if bleeding continues after 30 minutes or restarts within 24 hours after the first dose. If TXA is not first administered within three (3) hours after traumatic injury, there is a significant and paradoxical increased risk of death due to bleeding.

65. While Respondent's reinitiation of Pitocin and the initial administration of Methergine, Cytotec and Hemabate were appropriate, Respondent's failure to administer additional doses of Methergine and Hemabate, despite ongoing hemorrhage, while Patient 1 remained in PACU for approximately four hours is a simple departure from the standard of care.

66. Respondent's failure to timely administer TXA despite ongoing postpartum hemorrhage is a simple departure from the standard of care.

67. Respondent's failure to attempt a uterine tamponade, such as a Bakri balloon, beyond a manual massage or plain gauze soaked in thrombin while Patient 1 continued hemorrhaging in PACU for four hours is a simple departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

68. Respondent Richard Anthony Williams, M.D. is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate medical records during his care of Patient 1. The circumstances are as follows:

69. Paragraphs 11 through 44 are incorporated by reference as though fully set forth herein.

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70. The facts and allegations set forth in Paragraphs 55 through 58 in the First Cause for Discipline are incorporated by reference as though fully set forth herein.

71. The facts and allegations set forth in Paragraphs 59 through 61 in the First Cause for Discipline are incorporated by reference as though fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

72. Respondent Richard Anthony Williams, M.D. is subject to disciplinary action under section 2234 of the Code, in that Respondent engaged in unprofessional conduct during his care of Patient 1. The circumstances are as follows:

73. Paragraphs 11 through 44 are incorporated by reference as though fully set forth herein.

74. The facts and allegations set forth in Paragraphs 55 through 58 in the First Cause for Discipline are incorporated by reference as though fully set forth herein.

75. The facts and allegations set forth in the Second Cause for Discipline are incorporated by reference as though fully set forth herein.

DISCIPLINE CONSIDERATION

76. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about May 10, 2024, in a prior disciplinary action before the Board, a Pre-Accusation Public Letter of Reprimand was issued against Respondent's Physician's and Surgeon's Certificate in Case Number 800-2022-091833, for the failure to maintain adequate and accurate medical records pertaining to his post-operative care and treatment of a patient which departed from the standard of care. Respondent was also required to take a medical record keeping course. That decision is now final and is incorporated by reference as if fully set forth.

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 A 40188, issued to Respondent Richard Anthony Williams, M.D.;

2. Revoking, suspending or denying approval of Respondent Richard Anthony Williams, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Richard Anthony Williams, 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: DEC 30 2024

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

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