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

In the Matter of the Accusation Against: Ruwanthi Samaranayake Campano, M.D. Physician's & Surgeon's Certificate No A 69121 Petitioner.	Case No.: 800-2022-085523

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Tracy Green, Esq., attorney for Ruwanthi Samaranayake Campano, for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on March 9, 2026.

IT IS SO ORDERED: March 9, 2026

MD.

Veling Tsai, M.D., Chair
Panel A

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

In the Matter of the Accusation Against: **Ruwanthi Samaranayake Campano, M.D.** **Physician's & Surgeon's Certificate No. A 69121** **Respondent.**	**Case No. 800-2022-085523** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Tracy Green, Esq. on behalf of Respondent, Ruwanthi Samaranayake Campano, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of February 26, 2026, at 5:00 p.m.

Execution is stayed until March 9, 2026, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: February 24, 2026

Sharlene Smith For

Reji Varghese
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against: Ruwanthi Samaranayake Campano, M.D. Physician's and Surgeon's Certificate No. A 69121 Respondent.	Case No.: 800-2022-085523

DECISION

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

This Decision shall become effective at 5:00 p.m. on February 26, 2026.

IT IS SO ORDERED: January 27, 2026.

MEDICAL BOARD OF CALIFORNIA

MD.

Veling Tsai, M.D., Chair
Panel A

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

In the Matter of the Accusation Against:

RUWANTHI SAMARANAYAKE CAMPANO, M.D.,

Physician's and Surgeon's Certificate No. A 69121,

Respondent.

Agency Case No. 800-2022-085523

OAH No. 2025030124

PROPOSED DECISION

Thomas Heller, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on August 18-21, 2025.

Marsha E. Barr-Fernandez, Deputy Attorney General, represented complainant Reji Varghese, Executive Director, Medical Board of California (Board), Department of Consumer Affairs.

Brian D. Bill, Esq., Chudnovsky Law, represented respondent Ruwanthi Samaranayake Campano, M.D.

Oral and documentary evidence was received. After the hearing, the administrative law judge held the record open for respondent to lodge the hearing transcripts. After respondent lodged the transcripts, the administrative law judge issued an order for post-hearing briefing. Complainant timely filed and served a brief on December 5, 2025, which was marked for identification as Exhibit 50. Respondent filed and served an untimely brief on December 8, 2025, along with a statement that respondent's counsel was never served with the order for post-hearing briefing. Respondent's brief was marked for identification as Exhibit BB, and it has been considered despite its untimely filing.

Upon completion of post-hearing briefing, the matter was deemed submitted for decision as of December 8, 2025.

SUMMARY

Complainant accuses respondent of gross negligence, repeated negligent acts, and failure to maintain adequate and accurate medical records in connection with her care and treatment of a patient who had a medical emergency after an in-office nasal surgery and died three days later. For privacy reasons, this proposed decision refers to the patient as "Patient 1." Respondent contends the evidence does not support the disciplinary charges. Despite that contention, clear and convincing evidence proves the charge of gross negligence with respect to how respondent was ventilating Patient 1 when emergency personnel arrived at respondent's office. Complainant did not prove the remaining charges by clear and convincing evidence.

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Considering the proven charge, a stayed revocation with probation is the appropriate disciplinary action. Complainant also requests an award of the Board's investigation and enforcement costs; that request is granted in part.

FACTUAL FINDINGS

Background

1. On July 1, 1999, the Board issued Physician's and Surgeon's Certificate Number A 69121 to respondent. The certificate is renewed and current with an expiration date of October 31, 2026.

2. Respondent is an otolaryngologist, which is an ear, nose, and throat (ENT) specialist who diagnoses and treats conditions affecting the head and neck. Respondent is a solo practitioner in private practice with three office locations in Southern California. In addition to practicing otolaryngology, respondent also performs body contouring and surgical and nonsurgical cosmetic procedures. Respondent is a member of the American Academy of Otolaryngology – Head & Neck Surgery, and she has no prior disciplinary history with the Board.

Patient 1

3. In late 2020, Patient 1 was a 23-year-old female actively serving as a Senior Airman in the United States Air Force at Edwards Air Force Base in Southern California. In October 2020, a primary care physician at the base referred Patient 1 to respondent for reported chronic nasal and sinus issues, persistent allergy symptoms, facial pressure, headaches, and sinus infections.

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4. Patient 1's initial visit with respondent was on October 20, 2020. In the progress note for the visit, respondent documented that Patient 1 "states that she has had chronic sinus problems and she moved to the desert in[] 2018." (Exhibit 8, p. A71.) After performing a physical examination and a nasal endoscopy, respondent diagnosed Patient 1 with nasal obstruction, nasal valve collapse, septal deviation, and suspected chronic rhinosinusitis (inflammation of the nasal passages and sinus cavities). Based on these findings, respondent's plan for Patient 1 included ordering a CT scan of her sinuses, obtaining a radioallergosorbent (RAST) test (a blood test used to check for allergies), and starting a medical management protocol of levocetirizine (brand name: Xyzal, an antihistamine used to relieve allergy symptoms), azelastine hydrochloride (brand name: Astelin, an antihistamine nasal spray to prevent nasal allergy symptoms), montelukast (brand name: Singulair, used to control and prevent symptoms caused by asthma and seasonal allergic rhinitis), and nasal washes.

5. On October 30, 2020, Patient 1 had the paranasal sinus CT scan that respondent ordered. The interpreting radiologist's findings were:

> The maxillary sinuses are clear without significant mucosal thickening or air-fluid levels. The ostiomeatal units are patent [i.e., open] bilaterally despite the presence of a left-sided Haller cell [an air sinus located in the floor of the eye orbit]. There is mild mucosal thickening and patchy opacification of the right anterior ethmoid air cells. The sphenoethmoidal recesses are both patent. The sphenoid sinuses are clear. The frontal recesses are both patent. The right frontal sinus is hypoplastic. The frontal sinuses are clear. There is moderate rightward nasal septal deviation of

> the upper portion of the nasal septum. A large left agger nasi cell [a normal anatomical manifestation of the development of the paranormal sinus] is seen. Small concha bullosa [an air-filled cavity] of the lamellar portions of both middle turbinates are present. The contours of the nasopharynx are normal.

(Exhibit 17, p. A955.)

6. On December 8, 2020, Patient 1 visited respondent again for a "[r]echeck." (Exhibit 8, p. A73.) In the progress note for the visit, respondent noted Patient 1's statement that the medical management protocol "has helped." (*Ibid.*) Respondent also noted the results of the CT scan, a reduction in turbinate hypertrophy (an abnormal enlargement of scroll-shaped bones in the nasal cavity that regulate airflow and can cause breathing problems, frequent infections, or nosebleeds), and a positive result for one antigen (ragweed) on the RAST test.

7. At this visit, respondent offered Patient 1 three treatment options: (1) "continued medical management;" (2) an "operative intervention in the OR [i.e., an operating room];" or (3) a "minimally invasive," in-office balloon sinuplasty with TRACT septoplasty and bilateral inferior turbinate outfractures. (Exhibit 8, p. A74.) A balloon sinuplasty is a widening of blocked or narrowed sinus passages using a small balloon inserted under endoscopic guidance. A TRACT septoplasty is a surgical correction of a deviated septum, and bilateral inferior turbinate outfractures involve surgical fracturing and repositioning of the inferior turbinates to widen the nasal airway. Respondent noted that Patient 1 wanted to proceed with the third option.

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8. On January 25, 2021, Patient 1 visited respondent again for another recheck. By that time, Patient 1 was 24 years old. Respondent's progress note for the visit does not document any discussion about whether medical management was still helping with Patient 1's nasal symptoms. (Exhibit 8, p. A75.) Respondent and Patient 1 confirmed the plan to undergo an in-office balloon endoscopic sinus surgery with septoplasty and bilateral inferior turbinate outfractures. Respondent discussed the risks and benefits of the procedure with Patient 1, and respondent's office also provided Patient 1 with written pre-surgery instructions.

9. On February 4, 2021, Patient 1 presented to respondent's office for the surgery. According to the medical record, at 8:40 a.m., Patient 1's initial pulse was 94, her temperature was 98.7 degrees Fahrenheit, and her oxygen saturation level on room air was 97 percent. Patient 1's blood pressure, respiratory rate, height, and weight were not recorded.

10. At about 8:50 a.m., Patient 1 was premedicated orally with ondansetron 4 mg (brand name: Zofran, to prevent nausea and vomiting), oxycodone-acetaminophen 5/325 mg (brand name: Percocet, an opioid pain medication), and triazolam 0.125 mg (a triazolobenzodiazepine hypnotic agent for sedation). Thereafter, respondent placed nasal pledgets (small absorbent pads) soaked with tetracaine 4 percent (a local anesthetic) into Patient 1's nose bilaterally for 30 minutes. At about 9:45 a.m., respondent injected approximately 20cc of 2 percent lidocaine with 1:100,000 epinephrine into Patient 1's lateral nasal walls and middle turbinates. After the injection, respondent reapplied the tetracaine-soaked nasal pledgets for 15 more minutes.

11. Patient 1 was then moved to the procedure room at about 10:00 a.m., where respondent performed the procedure with help from Cortnie Day Nemeth, her

medical assistant. Respondent monitored Patient 1's pulse and blood oxygen levels during the procedure with a pulse oximeter clipped to Patient 1's finger. Patient 1 was awake during the procedure, which respondent performed without an anesthesiologist and without blood pressure or cardiac monitoring.

12. During the balloon sinuplasty portion of the procedure, respondent encountered mucopurulence (fluid containing mucus and pus), which respondent aspirated. During the septoplasty portion of the procedure, respondent anesthetized the septum with topical 8 percent tetracaine pledgets bilaterally. Per respondent's operative note, the procedure ended at approximately 10:30 a.m.

13. Patient 1 initially seemed to tolerate the procedure well, and she reportedly stated she "could finally breathe again, after all these years." (Exhibit 21, p. A967.) She remained on the procedure bed for about 10 or 15 minutes. According to respondent, the pulse oximeter remained clipped to Patient 1's finger until the end of that period, when it was removed. Patient 1 was then placed in a wheelchair, and she was about to be taken into the lobby when she complained of feeling dizzy. As a result, Patient 1 was returned to the procedure bed, and the pulse oximeter was clipped back on her finger. Per the medical record, Patient 1's oxygen saturation level at the time was 94 percent on room air, and her pulse was noted to be in the 90's.

14. Respondent placed cool compresses on Patient 1's forehead and neck and used a nasal cannula to deliver oxygen to Patient 1 at two liters per minute. Initially, respondent thought Patient 1 "was going to pass out like a vasovagal reaction" due to anxiety. (Tr., vol. III, p. 84.) Patient 1's oxygen saturation levels decreased to 84 percent, and respondent increased the oxygen delivery to 10 liters per minute via facemask, which reportedly caused Patient 1's oxygen saturation levels to increase into the 90's.

15. Patient 1 vomited, and respondent suctioned Patient 1's mouth and held her upright on the procedure bed to avoid aspiration. Patient 1 subsequently lost consciousness, and respondent used ammonia smelling salts to awaken her. Patient 1 awakened, but she did not have a normal response to the smelling salts. Instead, Patient 1 became disoriented and combative, and she started to push and struggle with respondent and Nemeth.

16. In response, respondent opened the procedure room door and yelled for a staff member to call 911. Patient 1 was not lucid, tried to stand up from the procedure bed, and ended up on the floor, where she started to crawl across the room. Patient 1's oxygen saturation level dropped to 31 percent at its lowest measurement, and her pulse dropped to 50 at the same time. Respondent used a bag valve mask (BVM) to attempt to ventilate Patient 1. A BVM, also known as an Ambu bag, is a self-inflating bag used to provide ventilation to a person not breathing normally.

17. Per the ambulance records, the 911 call was received at 10:50 a.m., and a team of firefighter/paramedics and emergency medical technicians (EMTs) arrived at Patient 1's side at approximately 10:56 a.m. Upon entering the room, the emergency responders reportedly observed Patient 1 on the floor in a semi-Fowlers position while respondent was ventilating the patient with the BVM. A semi-Fowler's position is a position in which an individual is lying on their back with their head elevated at 30 to 45 degrees.

18. The emergency responders noted that Patient 1 appeared pale and had a Glasgow Coma Scale (GCS) score of 3 (no eye opening, no verbal response, and no motor response). The emergency responders asked respondent and Nemeth whether they had checked for a pulse, to which they reportedly answered, "'No.'" (Exhibit 9, p. A97.)

19. The emergency responders placed Patient 1 supine on the ground, checked for pulses, and initiated chest compressions upon discovering Patient 1 was pulseless and without respirations. They also inserted an oropharyngeal airway (a device used to keep the pharyngeal airway open) and encountered a "copious amount of blood from [the] nasooropharynx," which they suctioned. (Exhibit 10, p. A122.)

20. The emergency responders ventilated Patient 1 with a BVM and high flow oxygen and placed an automatic external defibrillator (AED) on her. The AED showed Patient 1 was in pulseless electrical activity (PEA), a form of cardiac arrest in which the electrocardiogram shows a heart rhythm that should produce a pulse but does not. The AED did not indicate an electric shock was advisable at that time.

21. The emergency responders checked Patient 1's pulse every two minutes while taking turns performing chest compressions. After the third pulse check, they felt a carotid pulse on Patient 1. Patient 1 was placed on a backboard and gurney and loaded onto an ambulance for transport to Antelope Valley Hospital at approximately 11:16 a.m. Patient 1 went into cardiac arrest on the way to the hospital, and CPR was continued on Patient 1 throughout transport.

22. The emergency responders transferred Patient 1's care to hospital staff with CPR in progress at approximately 11:26 a.m. Hospital personnel intubated Patient 1 and found her to have a large volume of blood in her airway. The blood was suctioned and Patient 1 was stabilized, but a CT scan of Patient 1's head performed at 12:10 p.m. showed diffuse cerebral and cerebellar edema. The findings were deemed compatible with global hypoxic ischemic encephalopathy, which is a brain injury that occurs due to a lack of oxygen and blood flow to the brain.

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23. Patient 1 did not recover, and she died on February 7, 2021. The Los Angeles County Coroner's Office performed an autopsy, but the record does not include the autopsy report after complainant withdrew it as a proposed exhibit. (Tr., vol. IV, p. 144.) Patient 1's death certificate lists her cause of death as complications of acute diffuse hypoxic encephalopathy due to the effects of tetracaine and lidocaine during an outpatient balloon sinuplasty. (Exhibit 19.)

Procedural History

24. In February 2022, the Board received a complaint from Patient 1's mother alleging that respondent administered "too much pain medication" to Patient 1 while she was "not being monitored." (Exhibit 5, p. A29.) The Board assigned Special Investigator Shelby McGarry to investigate the complaint. McGarry obtained Patient 1's medical records, interviewed emergency response personnel and Nemeth, corresponded with respondent by letter, and interviewed respondent with assistance from a Board medical consultant. Respondent stated she felt she met or exceeded the standard of care at each step of her care of Patient 1, and there was nothing respondent could have changed or done better that would have led to a different outcome.

25. A Board analyst forwarded the investigative materials to Richard Isaacs, M.D., a board-certified otolaryngologist, for review. Following his review, Dr. Isaacs concluded that respondent committed three extreme departures from the standard of care with respect to her care and treatment of Patient 1. On January 22, 2025, complainant filed an Accusation in his official capacity requesting revocation or suspension of respondent's physician's and surgeon's certificate and an award of the Board's investigation and enforcement costs. The Accusation includes five disciplinary charges: (1) gross negligence; (2) repeated negligent acts; (3) failure to maintain

adequate and accurate medical records; (4) failure to report a patient death; and (5) unprofessional conduct in aiding and abetting Nemeth to practice beyond the scope of a medical assistant. Respondent timely filed a notice of defense.

Hearing

26. At the hearing, complainant's counsel withdrew the fourth cause for discipline for failing to report a patient death (Tr., vol. IV, p. 159) and stated the fifth cause for discipline for unprofessional conduct involving Nemeth was no longer at issue (*id.* at pp. 160-161). Therefore, the causes for discipline that remain at issue are: (1) gross negligence; (2) repeated negligent acts; and (3) failure to maintain adequate and accurate records.

COMPLAINANT'S CASE

Cristian Sanchez

27. Cristian Sanchez is a firefighter paramedic with the Los Angeles County Fire Department. On February 4, 2021, Sanchez was with his paramedic partner, Mathew Rush, and they responded to the dispatch call regarding Patient 1. Sanchez believes he and Rush were either the first emergency responders to arrive at respondent's office, or they arrived at the same time as the ambulance.

28. Upon entering respondent's office, office staff pointed Sanchez and Rush in the direction of the room where Patient 1 was. Sanchez testified he remembered "no fewer than three personnel of the office there," two of whom were standing, and one of whom was on the ground. (Tr., vol. I, p. 33.) According to Sanchez, Patient 1 "was in the lap of the third personnel on the ground," with that person (a woman in scrubs) holding Patient 1 up in a sitting position from behind and attempting BVM

ventilations. (*Id.* at p. 34.) "With one hand, she was trying to get a good seal and with the other hand she was trying to squeeze. So wrapped around hands behind the patient." (*Ibid.*) Sanchez had never seen that type of ventilation done on a patient during a call, and he testified, "that's not how we're taught to bag [i.e., ventilate] patients." (*Id.* at p. 60.)

29. Sanchez asked why the personnel had called 911, and the response was, "We think she had a seizure." (Tr., vol. I, p. 35.) Sanchez checked Patient 1 for a pulse and confirmed she had none. After doing so, the emergency responders laid Patient 1 down immediately in a supine position, and one of them initiated CPR.

30. The emergency responders administered naloxone (brand name: Narcan) intravenously to Patient 1, but there was no response. They were subsequently able to detect a pulse and took Patient 1 out of respondent's office and into an ambulance while providing BVM ventilation. Patient 1 went into cardiac arrest again in the ambulance on the way to the hospital. After more resuscitative measures, Patient 1 had a return of spontaneous circulation at the hospital.

Alondra Valadez

31. Alondra Valadez is an EMT who worked for American Medical Response (AMR) at the time of the incident with Patient 1. Valadez responded to 911 call with a partner (Jacob Ward) in an AMR ambulance. Valadez testified she and Ward arrived at respondent's office at the same time as the paramedics, and she was right behind Sanchez when Sanchez entered the room where Patient 1 was. After hearing Sanchez ask, "Does she have a pulse?", Valadez entered and saw respondent "sitting on the floor, her back laying against the wall, her legs straightened out with the patient sitting on her lap having her head resting against her left shoulder. There we witnessed her

ventilating the patient with a BVM." (Tr., vol. I, p. 108.) According to Valadez, Patient 1 was in a semi-Fowler's position, and respondent was "kind of just hovering over the patient ventilating her," "trying to squeeze the bag from behind" the patient. (*Id.* at p. 109.) Valadez had never seen a patient ventilated in that manner in seven years as an EMT. (*Ibid.*)

32. Valadez testified she then heard respondent say Patient 1 did not have a pulse, and the emergency responders began chest compressions after placing Patient 1 in a supine position on the floor. Valadez took over the ventilation of Patient 1 from respondent. There was no cardiac monitor on Patient 1 before the paramedics arrived.

33. After the third pulse check and CPR cycle, the emergency responders were able to obtain a strong carotid pulse for Patient 1. The emergency responders put Patient 1 on a backboard and took her on a gurney to the AMR ambulance. Valadez was in the back of ambulance with Sanchez and a firefighter from the fire engine during Patient 1's transport to Antelope Valley Hospital.

Jacob Ward

34. Ward is a paramedic with AMR. He was an EMT at the time of the incident with Patient 1. Ward was the driver of the AMR ambulance that day, and Valadez was his partner.

35. Like Sanchez and Valadez, Ward testified that when he arrived in the room where Patient 1 was, "we saw our patient being sat up in what we call a semi-Fowler's, almost a Fowler's position, right, kind of sitting forward with a staff member behind the patient and using . . . a bag valve mask to give artificial ventilation to that patient." (Tr., vol. I, p. 161.) Patient 1's upper body was at "maybe . . . like a 70 degree-ish angle" from her legs. (*Id.* at p. 177.) That was "not standard" and something that

Ward was not trained to do; "when we're going to give artificial ventilations to anyone, we're going to have them in what's called a supine position." (*Id.* at p. 161.)

36. Ward also testified that Patient 1 was ventilated continuously from the time the emergency responders arrived on scene. At one point, the emergency responders had to suction Patient 1's airway to remove "some sort of blood clot." (Tr., vol. I, p. 168.)

Richard Isaacs, M.D.

37. Dr. Isaacs is an otolaryngologist and a head and neck oncologist surgeon. Since 2023, he has served as the Dean of California Northstate University College of Medicine in Elk Grove, California. Prior to 2023, Dr. Isaacs worked with Kaiser Permanente for 28 years in various leadership capacities, including Chair of the Department of Otolaryngology Head and Neck Surgery for the Northern California region; a physician and the chief of a medical center in Sacramento; and the CEO and Executive Director of the Permanente Medical Group, which is the care delivery arm of Kaiser Permanente Northern California.

38. Dr. Isaacs earned his medical degree in 1988 from Wayne State University in Detroit, Michigan. He completed a residency in otolaryngology – head and neck surgery in 1993, and a fellowship in head and neck oncologic and skull base surgery/microvascular surgery in 1995. Dr. Isaacs is board certified by the American Board of Otolaryngology, and he has served as an expert reviewer for the Board since 2003.

39. Dr. Isaacs opined respondent committed three extreme departures from the standard of care with respect to Patient 1. First, Dr. Isaacs opined respondent committed an extreme departure by performing a balloon sinuplasty on Patient 1

without evidence and symptoms of sinus disease. Balloon sinuplasty is generally indicated for patients with chronic or recurrent sinusitis that has not responded to medical therapy, particularly when there is evidence of sinus obstruction or inflammation. According to Dr. Isaacs, performing a balloon sinuplasty on a sinus without mucosal thickening, air-fluid levels, or obstruction is not appropriate, as the procedure is intended to relieve blocked sinuses and improve drainage. It is essential to have positive findings of sinus disease on a CT scan and sinonasal symptoms to justify the procedure.

40. Patient 1 suffered from nasal obstruction and bilateral nasal valve collapse, as well as allergic rhinitis with allergy to ragweed. According to Dr. Isaacs, both findings are known to contribute to a patient's sinonasal symptoms, and respondent should have explored those other causes of symptoms further before considering surgical intervention. Furthermore, in Patient 1's medical records, respondent noted that Patient 1 said medical management was helping, and on examination, respondent noted that Patient 1's turbinate hypertrophy was improving. Thus, Patient 1's sinusitis was responding to medical therapy.

41. In addition, Dr. Isaacs opined that Patient 1's CT scan presented "a very good picture of health of the paranasal sinuses" and looked "basically normal." (Tr., vol. II, p. 30.) The findings of clear maxillary, frontal, and sphenoid sinuses on the CT scan "did not appear to be a surgical indication." (*Id.* at p. 33.) In Dr. Isaac's opinion, performing a balloon sinuplasty on Patient 1 with those CT scan findings was inappropriate.

42. Second, Dr. Issacs opined that respondent committed an extreme departure from the standard of care by monitoring Patient 1 inadequately after the procedure. There was a pre-procedure administration of Percocet and triazolam to

Patient 1 that posed a risk of respiratory depression. Given that risk, and the highly variable response of different patients to medications, a physician must ensure stability of consciousness, stability of air, and stability of breathing in the immediate post-procedure period.

43. According to Dr. Isaacs, "Simple monitoring, using [a] pulse oximeter[,] is very effective [in] monitoring how much oxygen is in the blood that's circulating through the body." (Tr., vol. II, p. 44.) Furthermore, continuous pulse oximeter monitoring will alert to the start of a decrease in oxygen with an audible sound. (*Id.* at pp. 45-46.)

44. While respondent used a pulse oximeter on Patient 1, there are no recorded pulse oximeter readings between the end of the procedure at 10:30 a.m. and Patient 1's complaint of dizziness at 10:46 a.m. (Tr., vol. II, p. 128; Exhibit 8, p. A87.) After that, there are only intermittent pulse oximeter readings recorded during the next 10 minutes until emergency responders arrived. Furthermore, Dr. Isaacs "would have like[d] to see more recording of the respiratory rate" of Patient 1 during the immediate post-operative period. (Tr., vol. II, p. 49.) Dr. Isaacs opined that respondent's post-procedure monitoring was inadequate and resulted in respondent missing early signs of hypoxia in Patient 1.

45. Third, Dr. Isaacs opined that respondent committed an extreme departure from the standard of care in how she responded to Patient 1's medical emergency. Emergency responders reported observing Patient 1, who was unconscious, in a semi-Fowler's position with respondent attempting to ventilate Patient 1 from behind. Dr. Isaacs testified it is very difficult to expand the neck when an unconscious patient is in essentially a seated position. The patient needs to be on their back, with the neck extended and the jaw pulled forward to maximally extend the

airway. Furthermore, by ventilating Patient 1 from behind, respondent lacked clear visualization of Patient 1's airway or the expansion of Patient 1's lungs. Ventilating Patient 1 in this manner was below the standard of care, particularly since "the otolaryngologist is the most experienced [physician] in managing airway." (Tr., vol. II, p. 51.)

46. Additionally, according to Dr. Isaacs, "when you experience a patient who has respiratory suppression and hypoxemia, who has had opiates, sedatives, I think it's reasonable to give a trial of naloxone, which is a medication which reverses the respiratory depression from such agents." (Tr., vol. II, p. 49.) Respondent did not administer naloxone to Patient 1, although respondent had naloxone available to her. Respondent also did not deploy an AED on Patient 1 during the emergency, although respondent had an AED available in her office.

47. Dr. Isaacs has never performed a balloon sinuplasty himself; he has only referred patients to other physicians for surgical consultations about the procedure.

Investigation and Prosecution Costs

48. Complainant also presented cost certifications stating the Board incurred $97,478 in investigation and prosecution costs related to the case. The amount includes $43,627.25 in costs associated with the Board's investigation and Dr. Isaacs's analysis, and $53,850.75 in Department of Justice costs billed to the Board for attorney and paralegal time to prepare the case for hearing. Complainant requests that the Board order respondent to reimburse those costs if she is found to have committed misconduct that subjects her license to discipline.

49. McGarry testified the investigation of the complaint against respondent took more time than the average investigation due to the amount of records needed

and the travel required to pick up records and interview witnesses. Some witnesses lived far from the Board's field office, and some interviews were lengthy and complex. In total, the Board's investigation of the complaint took 238.5 hours, and the Department of Justice billed the Board for another 238 hours of attorney and paralegal time.

RESPONDENT'S CASE

Ruwanthi Samaranayake Campano, M.D.

50. Respondent testified she started doing balloon sinuplasties in 2010 and in-office balloon sinuplasties in 2012. She considers herself "more critical of what truly constitutes someone who needs the procedure" than her colleagues. (Tr., vol. III, p. 28.) Her standard procedure for patients with nasal symptoms is to prescribe a six-week course of medication as a first line of treatment, not to proceed immediately to surgical intervention. Respondent followed that procedure with Patient 1.

51. Respondent disagrees with Dr. Isaacs that a balloon sinuplasty was inappropriate for Patient 1. According to respondent, the standard for performing that procedure has "evolved" since about 2015, such that "we can really start treating patients with minimal findings on CT scan, but significant complaints." (Tr., vol. III, p. 52.) Under the changed standard, "if a patient has a sinus infection three or four times a year, but it's intermittent, so like their CT scan is clear in between, it's called RARS, recurrent acute rhinosinusitis. We can treat those patients [with balloon sinuplasty]." (Tr., vol. II, p. 41.) "Whereas before, the indication was chronic sinusitis, you have to have a concern[ing] amount of mucosal thickening on the CT scan. It was very rigid." (*Ibid.*)

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52. Respondent's initial impression of Patient 1 was that she was "basically an allergy sufferer." (Tr., vol. III, p. 71.) But Patient 1's allergy test yielded a positive response for only one antigen (ragweed). This result, the CT results, and the patient's symptomatology changed respondent's initial impression and led her to diagnose Patient 1 with chronic rhinosinusitis, which respondent also described at the hearing as "acute recurrent sinusitis." (*Id.* at pp. 71-72, 145.) Respondent considered Patient 1 a candidate for balloon sinuplasty based on the allergy test and CT results, Patient 1's symptomatology, and the diagnosis.

53. At the visit with Patient 1 on December 8, 2020, respondent offered Patient 1 the option of continued medical management, but the patient declined. Patient 1 preferred the in-office surgical option, and the patient's insurer approved that surgery. Furthermore, according to respondent, Patient 1 had "improvement with multiple other medications temporarily. Then the next cold or the next allergy attack happens and she's right back where she started. She wanted something more definitive and she is a military patient..... [w]e actually have a lower threshold for military patients, because we know that they could get deployed to the desert where there's a lot of things, you know, going to their nose and sinuses, especially in the Middle East and it affects them." (Tr., vol. III, p. 170.)

54. Before the surgery, respondent had Patient 1 take only a small dose of Percocet (5/325 milligrams) and a small dose of triazolam (0.125 milligrams), along with Zofran as an anti-nausea agent. During the surgery, Patient 1 "was fine" and showed no adverse reaction to those medications, the tetracaine pledgets, or the lidocaine injection. (Tr., vol. III, p. 78.) Patient 1 had a pulse oximeter on her finger during the procedure, and respondent testified the pulse oximeter remained on Patient 1 during the 15-minute post-procedure recovery period. According to

respondent, her patients "don't have any monitors taken off them until they leave," although the monitoring data may be recorded only intermittently. (*Id.* at p. 38.)

55. Respondent testified she discharged Patient 1 at 10:45 a.m., and staff put her in a wheelchair and went to wheel her out of the room. When Patient 1 complained of dizziness, respondent and Nemeth placed her back on the treatment bed and raised the bed's incline past 45 degrees to prevent aspiration. Patient 1 vomited and passed out on the treatment bed in that position.

56. After Patient 1 awakened from the smelling salts, "all hell broke out." (Tr., vol. III, p. 88.) Patient 1 was combative for about three or four minutes and struggled with respondent and Nemeth to pull off the oxygen mask and the pulse oximeter. When Patient 1 was on the floor, respondent suctioned and swept her mouth while Patient 1 was positioned on her side. After Nemeth reestablished the pulse oximeter, which showed Patient 1's oxygen saturation was 31 percent, respondent "grabbed my Ambu bag, because it was just right there," added oxygen, and "just kept ventilating and ventilating her." (*Id.* at p. 93.) Nemeth documented some of the continuous pulse oximeter readings on a piece of paper. The pulse oximeter readings in Patient 1's medical records are the ones respondent and Nemeth "remembered immediately after the procedure." (Tr., vol. III, p. 195; see Exhibit 8, p. A87.)

57. Respondent testified she ventilated Patient 1 while the patient was lying on her back and respondent was kneeling over her. Respondent denies she ventilated Patient 1 from behind while the patient was in a semi-Fowler's position, as reported by emergency response personnel.

58. Respondent explained she did not initiate CPR on Patient 1 because the patient had a pulse when respondent was ventilating her. Respondent considered

placing an AED on Patient 1, but she did not do so. According to respondent, Patient 1 had an "adequate pulse" at the time, and respondent "was in survival mode trying to get her oxygen up." (Tr., vol. III, p. 193.) Respondent also had naloxone in the office, but she contended Patient 1 "did not have an opioid overdose" since she received such a small dosage of Percocet. (*Id.* at p. 200.) Respondent was also concerned about Patient 1 vomiting and aspirating if respondent administered Narcan. Similarly, respondent had flumazenil (a reversal agent for benzodiazepines), but she decided that administering it to Patient 1 was not necessary. According to respondent, a side effect of flumazenil is seizure, so she does not "just give flumazenil willy-nilly." (Tr., vol. IV, p. 114.)

Cortnie Day Nemeth

59. Nemeth has been employed as respondent's medical assistant since 2009. She testified the actual procedure on Patient 1 went "very smoothly," with nothing unusual occurring during the procedure itself. (Tr., vol. III, p. 114.) After the procedure, Patient 1 was happy and said she could breathe better, or words to that effect. Nemeth stayed in the procedure room to monitor Patient 1, and Patient 1 was sitting up on the bed and talking to Nemeth for about 10 to 15 minutes. Nemeth testified she does not remember whether the pulse oximeter remained on the patient's finger during that period. (Tr., vol. III, p. 129.)

60. Respondent came back into the room to check on Patient 1 before discharging her. However, Patient 1 stated she felt dizzy after standing up from the bed to get into a wheelchair for discharge. Respondent immediately told Patient 1 to lie back down, and "we put the pulse ox[imeter] back on her finger....." (Tr., vol. III, p. 116.) Patient 1's pulse oximeter reading "was a little bit low, so [respondent] wanted to give her some oxygen, so we put the oxygen on her." (*Ibid.*) Patient 1 then started to

pass out, and respondent used smelling salts to awaken her. Patient 1 awakened but did not respond to any commands, so respondent immediately opened the door and told a staff member to call 911.

61. While Nemeth held Patient 1's hand on the procedure bed, Patient 1 started to get combative and "kind of [threw] herself off of the table." (Tr., vol. III, p. 117.) Nemeth "kind of went down with her onto the ground," and she and respondent had Patient 1 on her stomach, where it started to seem like Patient 1 was passing out again. Respondent and Nemeth rolled Patient 1 onto her side to check that her mouth was clear, and then put Patient 1 on her back. Nemeth was then able to reattach the pulse oximeter to Patient 1's finger, which Nemeth had been unable to keep on because Patient 1 kept flinging it off. Patient 1's pulse and oxygen saturation level were both very low.

62. Respondent immediately grabbed an Ambu bag and started using it to ventilate Patient 1. According to Nemeth, Patient 1 was lying on the ground on her back when respondent did so; Nemeth never saw respondent ventilating the patient in another position. Paramedics or firefighters arrived about one or two minutes after respondent started using the Ambu bag.

Brian H. Weeks, M.D.

63. Brian H. Weeks, M.D., is an otolaryngologist – head and neck surgeon in private practice in San Diego, California. He is the President and CEO/Director of Minimally Invasive Head and Neck Surgery at SENTA Clinic, where he has practiced since 2002. Most of Dr. Weeks's practice involves rhinologic procedures and airway procedures, with a primary focus on rhinology and obstructive sleep apnea. Dr. Weeks estimates he has performed over 5,000 balloon sinuplasty procedures, including over

1,500 in-office procedures. In August 2025, Dr. Weeks had a book chapter he wrote about office procedures published in the Otolaryngology Clinics of North America. He also authored a textbook section on office balloon sinuplasty procedures that was scheduled to be published in November 2025.

64. Dr. Weeks earned his medical degree in 1996 from the University of Michigan in Ann Arbor, Michigan. He completed his residency training in otolaryngology-head and neck surgery in 2002. Dr. Weeks is board certified by the American Board of Otolaryngology.

65. Dr. Weeks reviewed Patient 1's medical record file, including the patient's initial consultation with respondent, respondent's follow up notes, the radiologist report of the CT imaging, and respondent's operative report and notes. Dr. Weeks also reviewed the emergency responders' notes, Antelope Valley Hospital medical records, the medical examiner report regarding Patient 1's death, and statements by respondent regarding her care and treatment of Patient 1. Following that review, Dr. Weeks prepared a written report of his findings and opinions.

66. In his hearing testimony and report, Dr. Weeks opined that respondent complied with the standard of care in all respects. First, with respect to indications for surgery, Dr. Weeks opined that there were proper indications for the surgery respondent performed on Patient 1. In Dr. Weeks's opinion, "This was a patient who was suffering from a number of sinus and nasal-related symptoms, had utilized medical therapy. There were numerous reported visits to her, you know, base doctors. [Respondent] reiterated the need for medical therapy, and the patient was continuing to suffer symptoms despite those – you know, those recommendations, and then imaging was done and the decision collectively was made to proceed with an office procedure." (Tr., vol. IV, p. 42.) The radiologist's report of the CT imaging also

identified anatomic abnormalities in Patient 1 that could contribute to outflow tract narrowing. Dr. Weeks disagrees with Dr. Isaacs's opinion that there was no indication for surgery under these circumstances.

67. Second, with respect to post-procedure monitoring, Dr. Weeks opined that respondent performed sufficient monitoring of Patient 1. For such surgeries, "[s]tandard monitoring within most offices, includes oxygen saturation and heart rate monitoring. It is extremely rare to see continuous blood pressure and cardiac rhythm monitoring as well as respiratory rate monitoring." (Exhibit A, p. B16.) According to Dr. Weeks, no monitoring device other than a pulse oximeter is required for the surgery that respondent performed. (Tr., vol. IV, p. 46.) In Dr. Weeks's own practice, the pulse oximeter is not even maintained on a patient during the post-operative procedure observation period. (Tr., vol. IV, p. 74.) Furthermore, a 10-minute observation period after an in-office surgery is sufficient to identify any potential problems.

68. In Dr. Isaacs's written report, Dr. Isaacs opined that "[c]ontinuous monitoring of vital signs, including oxygen saturation, cardiac rhythm, and respiratory rate, is essential for detecting early signs of hypoventilation or apnea," and "[s]ome centers utilize end-tidal CO2 (capnography) to identify hypoventilation more effectively." (Exhibit 32, p. A1331.) Dr. Weeks opined that this level of monitoring "was just not even potentially realistic" for anybody performing in-office sinus surgery, and Dr. Weeks has never encountered end-tidal CO2 monitoring when visiting numerous office practices around the country. (Tr., vol. IV, p. 46.)

69. Third, with respect to emergency preparedness, Dr. Weeks opined that respondent acted appropriately in response to Patient 1's medical emergency; in fact, the response was "heroic in some ways." (Tr., vol. IV, p. 47.) Given the low dosages of Percocet and triazolam, the likelihood of opioid or benzodiazepine sensitivity or

overdose was "remote," and the standard of care did not required respondent to administer naloxone or flumazenil. (Exhibit A, p. B17.) Furthermore, "the literature is clear that resuscitative efforts should not be paused to administer those drugs." (Tr., vol. IV, p. 48.) According to Dr. Weeks, there was also no indication for the use of an AED on Patient 1 before emergency personnel arrived. "[W]hen a patient has a pulse, or when they have what's called pulseless electrical activity, those are not scenarios where an AED is recommended or utilized." (Tr., vol. IV, p. 49.)

70. Regarding the position for ventilation, Dr. Weeks testified "the reporting is really the whole story." (Tr., vol. IV, p. 50.) Respondent stated she ventilated Patient 1 in a supine position; emergency response personnel reported that respondent had Patient 1 in a semi-Fowler's position. Dr. Weeks testified he does not know how a small person such as respondent could "take a person in extremis on the ground and put them in a semi-Fowler's position, and I don't know why they would do that in the first place." (*Id.* at p. 51.) Patient 1 was larger and weighed more than respondent. Accepting respondent's account of the ventilation, Dr. Weeks opined that there was no standard of care violation.

71. While acknowledging the tragic outcome of the case, Dr. Weeks believes "it is imperative that the end result be separated from the performance and treatment by respondent and her staff." (Exhibit A, p. B17.) "Retrospective analysis is always educational and clarifying, however pre-procedure preparation was in place and standard protocols followed, not dissimilar from most offices around the United States that are performing these office based nasal procedures on a regular basis." (*Ibid.*) Therefore, Dr. Weeks opined that respondent did not depart from the standard of care.

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Other Evidence

72. Respondent also presented letters of reference from two physician colleagues (Barry M. Rasgon, M.D. and Denise Dru, M.D., Ph.D.) describing respondent as a well-trained and outstanding physician whose surgical techniques are skilled and up to date.

Analysis of Evidence

73. Dr. Isaacs opined that respondent committed an extreme departure from the standard of care by performing a balloon sinuplasty on Patient 1 without evidence and symptoms of sinus disease. But the evidence does not show a clear and convincing departure from the standard of care with respect to this issue. Dr. Weeks opined that there were proper indications for the surgery, including a number of sinus and nasal-related symptoms, prior visits to other doctors, and continued symptoms despite medical therapy. According to Dr. Weeks, the radiologist's report of the CT imaging also identified anatomic abnormalities in Patient 1 that could contribute to outflow tract narrowing. Dr. Weeks is also much more experienced in performing balloon sinuplasties than Dr. Isaacs, who has never performed the procedure himself. Therefore, Dr. Weeks's opinions about the indications for surgery create substantial doubts about the opinions of Dr. Isaacs with respect to that issue.

74. Dr. Isaacs also opined that respondent committed an extreme departure from the standard of care by monitoring Patient 1 inadequately after the procedure. But again, Dr. Weeks's opinions create substantial doubts about the Dr. Isaacs's opinions with respect to patient monitoring. Dr. Weeks opined that the monitoring of Patient 1 was adequate and consistent with standard practice for the procedure at issue, which Dr. Isaacs has never performed. According to Dr. Weeks, no monitoring

device other than a pulse oximeter is required for the procedure, and a 10-minute observation period after an in-office surgery is sufficient to identify any potential problems. During that post-procedure observation period, Dr. Weeks does not even keep the pulse oximeter on his own patients. Furthermore, Dr. Isaacs's testimony that he "would have like[d] to see more recording of the respiratory rate" of Patient 1 during the immediate post-operative period (Tr., vol. II, p. 49) is not clear evidence that the standard of care required it. This evidence calls into question Dr. Isaacs's opinions with respect to the alleged inadequacy of respondent's post-operative monitoring of Patient 1.

75. Finally, Dr. Isaacs opined that respondent committed an extreme departure from the standard of care in how she responded to Patient 1's medical emergency. On this issue, Dr. Isaac's opinion is persuasive with respect to how respondent was ventilating Patient 1 when emergency responders arrived at the scene. According to all three emergency personnel who testified, respondent was attempting to ventilate Patient 1 in a semi-Fowler's position when they entered the room. Respondent and Nemeth testified Patient 1 was in a supine position, but the three emergency personnel testified the patient was not. The emergency personnel also described Patient 1's position as unusual and something they had not seen before for ventilation, which made it memorable to them. This testimony lends credence to their specific recollection of the patient's position.

76. Dr. Isaacs opined that this positioning of Patient 1 was inappropriate for airway access during the medical emergency. Dr. Weeks did not opine otherwise; instead, he accepted respondent's account that she did not ventilate Patient 1 in this manner. But the account of the three emergency personnel proves to a high probability that she did. Based on the evidence presented, this aspect of respondent's

management of the medical emergency involving Patient 1 was an extreme departure from the standard of care.

77. Dr. Isaacs also faults respondent for not administering naloxone to Patient 1 or placing an AED on her during the emergency, while Dr. Weeks found no departure from the standard of care with respect to either issue. Dr. Weeks' opinions call into question whether respondent committed an extreme departure from the standard of care with respect to these issues. As to naloxone, Dr. Weeks opined that the low dosages of the drugs at issue and the relevant literature did not support interrupting resuscitative efforts on Patient 1 to administer naloxone. Dr. Weeks also opined that there was no indication for placing an AED on Patient 1 before emergency personnel arrived. Given these opinions, the evidence is insufficient to support a finding of an extreme departure from the standard of care with respect to naloxone or an AED.

78. The Accusation includes other factual allegations that appear to be additional criticisms of respondent's treatment of Patient 1, such as respondent not recording Patient 1's height or weight; respondent's preoperative instruction for Patient 1 to eat a full breakfast on the day of surgery; and respondent not obtaining a preoperative clearance for Patient 1. (See Exhibit 1, p. A9.) Dr. Isaacs did not opine that respondent departed from the standard of care with respect to those matters.

LEGAL CONCLUSIONS

Legal Standards

1. "The [B]oard shall take action against any licensee who is charged with unprofessional conduct." (Bus. & Prof. Code, § 2234.) Unprofessional conduct

"includes, but is not limited to," gross negligence (*id.*, subd. (b)), repeated negligent acts (*id.*, subd. (c)), and "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients . . ." (Bus. & Prof. Code, § 2266).

2. "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 . . . and who is found guilty, . . . may, in accordance with the provisions of this chapter: [¶] (1) Have his or her license revoked..... [¶] (2) Have his or her right to practice suspended for a period not to exceed one year.....[¶] (3) Be placed on probation and be required to pay the costs of probation monitoring..... [¶] (4) Be publicly reprimanded.....[¶] (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." (Bus. & Prof. Code, § 2227, subd. (a).)

3. Complainant bears the burden of proving the alleged grounds for disciplinary action by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence "requires a finding of high probability," and has been described as "requiring that the evidence be '"so clear as to leave no substantial doubt"; "sufficiently strong to command the unhesitating assent of every reasonable mind."' [Citation.]" (*In re Angelia P.* (1981) 28 Cal.3d 908, 919.) "Evidence of a charge is clear and convincing so long as there is a 'high probability' that the charge is true. [Citations.] The evidence need not establish the fact beyond a reasonable doubt." (*Broadman v. Commission on Judicial Performance* (1998) 18 Cal.4th 1079, 1090.)

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Analysis

FIRST CAUSE FOR DISCIPLINE – GROSS NEGLIGENCE

4. In the first cause for discipline, complainant alleges respondent is subject to disciplinary action for gross negligence under Business and Professions Code section 2234, subdivision (b), for: (1) performing a balloon sinuplasty on Patient 1 without adequate indications for surgery; (2) failing to provide appropriate monitoring of Patient 1 with respect to the procedure; and (3) failing to timely and adequately recognize and respond to Patient 1's respiratory compromise.

5. A physician is negligent if he or she departs from the standard of care, i.e., fails to use the skill and care that a reasonably careful physician would have used in similar circumstances. (California Civil Jury Instructions (CACI) No. 600.) "'Gross negligence' long has been defined in California and other jurisdictions as either a 'want of even scant care' or 'an extreme departure from the ordinary standard of conduct.' [Citations.]" (*City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 754; *Franz v. Board of Medical Quality Assurance* (1982) 31 Cal.3d 124, 138; *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-198.)

6. Complainant proved this cause for discipline with respect to how respondent was ventilating Patient 1 when emergency responders arrived at respondent's office. The testimony of Sanchez, Valadez, and Ward proves to a high probability that respondent was ventilating Patient 1 from behind in a semi-Fowler's position when they arrived. This was not an appropriate position in which to ventilate Patient 1, and the evidence presented proves the error was an extreme departure from the standard of care with respect to the response to Patient 1's respiratory compromise.

7. Complainant did not prove the remaining allegations of gross negligence against respondent by clear and convincing evidence. The evidence from Dr. Weeks leaves substantial doubts about those other allegations.

SECOND CAUSE FOR DISCIPLINE – REPEATED NEGLIGENT ACTS

8. In the second cause for discipline, complainant alleges respondent is subject to disciplinary action for repeated negligent acts under Business and Professions Code section 2234, subdivision (c), based on the same allegations of gross negligence as in the first cause for discipline. "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." (Bus. & Prof. Code, § 2237, subd. (c).)

9. Complainant did not prove this cause for discipline. The record does not include clear and convincing proof of two or more separate and distinct departures from the standard of care. The evidence proves an extreme departure from the standard of care with respect to way in which respondent was ventilating Patient 1 when emergency personnel arrived at the scene, but it proves no other separate and distinct departure from the standard of care. Therefore, complainant has not proven respondent committed repeated negligent acts.

THIRD CAUSE FOR DISCIPLINE – FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS

10. In the third cause for discipline, complainant alleges respondent is subject to disciplinary action for failure to maintain adequate and accurate records under Business and Professions Code section 2266. "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of

services to their patients for at least seven years after the last date of service to a patient constitutes unprofessional conduct." (Bus. & Prof. Code, § 2266.)

11. The cause for discipline does not list the alleged recordkeeping deficiencies; instead, it incorporates by reference the allegations in the first and second causes for discipline. During closing arguments, complainant's counsel identified two alleged recordkeeping deficiencies with respect to this cause for discipline: (1) "The lack of documentation in the office visits. There's claims that the patient's condition was getting worse, or at least not improving, and there's inadequate documentation about that." (2) "There's inadequate documentation about the postoperative monitoring and the vital signs in the postoperative period." (Tr., vol. IV, p. 160.)

12. These alleged recordkeeping deficiencies pertain to complainant's underlying allegations that there were insufficient indications for surgery and inadequate monitoring of Patient 1. Those underlying allegations were not proven by clear and convincing evidence. With insufficient proof of the underlying allegations, the alleged recordkeeping deficiencies are not grounds for disciplinary action against respondent.

FOURTH AND FIFTH CAUSES FOR DISCIPLINE – FAILURE TO REPORT DEATH CERTIFICATE AND UNPROFESSIONAL CONDUCT

13. As noted above, complainant's counsel withdrew the fourth cause for discipline (Tr., vol. IV, p. 159) and stated the fifth cause for discipline was no longer at issue (*id.*, p. 161). Therefore, respondent is not subject to disciplinary action with respect to these causes for discipline.

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DISPOSITION

14. With one cause for discipline established, the Board must exercise its discretion to determine the appropriate disciplinary action. "Protection of the public shall be the highest priority for the [Board] in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount." (Bus. & Prof. Code, § 2001.1.)

15. In exercising its discretion, the Board is required to consider its adopted disciplinary guidelines entitled "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). (Cal. Code Regs., tit. 16, § 1361, subd. (a).) The disciplinary guidelines state the recommended minimum discipline for gross negligence is a stayed revocation with five years of probation. (Disciplinary Guidelines, p. 24.) The maximum disciplinary action is revocation. (*Ibid.*) "Deviation from these orders and guidelines, including the standard terms of probation, is appropriate where the Board in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation – for example: the presence of mitigating factors; the age of the case; evidentiary problems." (Cal. Code Regs., tit. 16, § 1361, subd. (a).)

16. Considering the evidence, the recommended minimum discipline of a stayed revocation and five years' probation is the appropriate disciplinary action. Respondent's unprofessional conduct was serious and involved a tragic patient outcome, but her lack of prior disciplinary history weighs against outright revocation, which is a "drastic penalty." (*Cooper v. State Board of Medical Examiners* (1950) 35 Cal.2d 242, 252.) Almost five years have elapsed since the unprofessional conduct, and complainant presented no evidence of any other misconduct since then. Under the

circumstances, a stayed revocation with probationary terms that include the Board's standard conditions, plus the Board's optional education course condition, will address the proven charges and protect the public. The remaining optional conditions of probation for gross negligence are not warranted in this case.

COSTS

17. Complainant also requests $97,478 in investigation and enforcement costs under Business and Professions Code section 125.3. "Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the [Department of Consumer Affairs] 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." (Bus. & Prof. Code, § 125.3, subd. (a).)

18. In evaluating a request for costs, the administrative law judge must consider whether complainant's investigation was "disproportionately large" compared to the violations, and whether the licensee: (1) committed some misconduct but "used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed;" (2) had a "'subjective good faith belief in the merits of his or her position;'" (3) raised a "'colorable challenge'" to the proposed discipline; and (4) "will be financially able to make later payments." (*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45 [quoting *California Teachers Assn. v. State of California* (1999) 20 Cal.4th 327, 342, 345].)

19. Complainant presented certifications of the Board's investigation and enforcement costs, which are prima facie evidence that those costs are reasonable.

(Bus. & Prof. Code, § 125.3, subd. (c).) But respondent used the hearing process to obtain a reduction in the severity of the discipline imposed from the maximum discipline of revocation. The total of over 575 hours of investigative, attorney, and paralegal time spent preparing the case for hearing is also high. These considerations warrant a reduced cost award. An award of a total of $50,000 in costs is appropriate under the circumstances.

ORDER

Physician's and Surgeon's Certificate No. A 69121 issued to respondent Ruwanthi Samaranayake Campano, M.D., is revoked. However, revocation is stayed, and respondent is placed on probation for five years upon the following terms and conditions.

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. 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. 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 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Cost Recovery

Respondent is hereby ordered to reimburse the Board the amount of $50,000 within 90 days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Board's cost of its investigation and prosecution shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan.

3. Notification

Within seven (7) days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

4. Supervision of Physician Assistants and Advanced Practice Nurses

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

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5. Obey All Laws

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

6. Quarterly Declarations

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

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

7. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

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Place of Practice

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

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

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

8. Interview with the Board or its Designee

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

9. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period

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

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

Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

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

Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

10. Completion of Probation

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

11. Violation of Probation

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

12. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent

shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATE: 01/07/2026

Thomas Heller (Jan 7, 2026 12:58:55 PST)

THOMAS HELLER

Administrative Law Judge

Office of Administrative Hearings