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

In the Matter of the Accusation Against: Katherine Anne O'Hanlan, M.D. Physician's and Surgeon's Certificate No. G70108 Respondent	Case No. 800-2017-036490

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 15, 2021.

IT IS SO ORDERED March 8, 2021.

MEDICAL BOARD OF CALIFORNIA

By: _____
William Prasifka
Executive Director

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
LAWRENCE MERCER
Deputy Attorney General
State Bar No. 111898
455 Golden Gate Avenue, Suite 11000
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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: **KATHERINE ANNE O'HANLAN, M.D** **40 Buckeye** **Portola Valley CA 94028** **Physician's and Surgeon's Certificate No. G 70108** Respondent.	Case No. 800-2017-036490 OAH No. 2020100544 **STIPULATED SURRENDER OF LICENSE AND ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Surrender and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. William Prasifka (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 Xavier Becerra, Attorney General of the State of California, by Lawrence Mercer, Deputy Attorney General.

2. KATHERINE ANNE O'HANLAN, M.D (Respondent) is represented in this proceeding by her attorneys Shannon Baker and Rothschild, Wishek & Sands, LLP, whose address is: 765 University Avenue, Sacramento, CA 95814.

3. On or about October 22, 1990, the Board issued Physician's and Surgeon's Certificate No. G 70108 to KATHERINE ANNE O'HANLAN, 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. 800-2017-036490 and will expire on February 28, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-036490 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 25, 2019. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2017-036490 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-036490. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2017-036490, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent believes that she could present evidence disputing the factual basis for the charges in the Accusation, but she hereby gives up her right to contest that cause for discipline exists based on those charges as she has retired from the practice of medicine.

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

RESERVATION

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

CONTINGENCY

12. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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 Surrender 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. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 70108, issued to Respondent KATHERINE ANNE O'HANLAN, M.D, is surrendered and accepted by the Board.

1. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

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

3. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2017-036490 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

ACCEPTANCE

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

DATED: 02/24/2021

KATHERINE ANNE O'HANLAN, M.D
Respondent

I have read and fully discussed with Respondent KATHERINE ANNE O'HANLAN, M.D the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 2/24/2021

SHANNON BAKER
Attorney for Respondent

ENDORSEMENT

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

DATED: February 26, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

LAWRENCE MERCER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-036490

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Katherine Anne O'Hanlan, M.D.** **4370 Alpine Rd Ste. 103-104** **Portola Valley, CA 94028-7952** **Physician's and Surgeon's Certificate No. G 70108,** Respondent.	Case No. 800-2017-036490 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 22, 1990, the Medical Board issued Physician's and Surgeon's Certificate Number G 70108 to Katherine Anne O'Hanlan, M.D. (Respondent). Effective April 25, 2005, said certificate was revoked, the revocation stayed, and a three-year probation, with an actual suspension for 30 days, was imposed. 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 February 29, 2020, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts)

7. Respondent Katherine Anne O'Hanlan, M.D. is subject to disciplinary action under sections 2234 and/or 2234(b) and/or 2234(c) in that Respondent was grossly negligent and/or engaged in repeated acts of negligence in her care and treatment of Patient 1.[1] The circumstances are as follows:

8. On or about August 8, 2017, Respondent performed a pre-operative history and physical for Patient 1. The patient was a 65-year old female with a history of a total abdominal hysterectomy and lymph node dissection for endometrial cancer in 2014. The patient had recurrent pain to the hip and back beginning in 2016. The patient had multiple imaging studies and a cholecystectomy (gall bladder removal) until, in June 2017, a CT of the abdomen and pelvis

[1] Patient names are redacted to protect privacy.

showed a mixed attenuation mass-like structure in the periaortic tissues. An MR Angiogram of the abdomen showed an infrarenal periaortic mass. There was a subtle intimal contour irregularity in the abdominal aorta over an area measuring 1 cm in width and 3.5 cm in length, which appeared to be subjacent to the enlarged node. Respondent's plan was to perform a resection of the mass.

9. After Respondent reviewed the films with another surgeon, her impression was that the findings raised concern for invasion of the wall of the aorta. Anticipating that the aortic lymph node dissection might involve the aorta, Respondent had a verbal consultation with a vascular surgeon to ascertain his availability should his assistance be required. She also followed up by text message to the vascular surgeon with the patient's medical record number to enable him to review the patient's MR Angiogram films. She did not arrange for a formal consultation so that the vascular surgeon would see, evaluate and obtain consent from the patient, nor did she coordinate OR schedule with the vascular surgeon.

10. Also on August 8, 2017, Respondent obtained the patient's informed consent to a "second-look open incision surgery with resection of aortic nodes," but, although she had a major concern over the encroachment of the mass on the wall of the aorta, she did not obtain the patient's informed consent to do the possible aortic repair or resection, and stated above, nor did she arrange for the vascular surgeon to do so.

11. On August 9, 2017, Respondent undertook the planned second-look laparotomy for tumor debulking, inframesenteric and infrarenal radical lymphadenectomy and suprarenal vein lymph note dissection. During the procedure the nodes were seen on the aorta and, as these were being dissected free, Respondent became aware that the muscularis had been invaded by the tumor. Respondent continued with the dissection, but did not summon the vascular surgeon until a hole was encountered in the aorta. During this time, the patient had significant blood loss. When the vascular surgeon was summoned urgently, he was already scrubbed into another case and there was a delay before he arrived and replaced a 6 cm segment of the aorta.

12. After finishing her procedure on Patient 1, Respondent proceeded to dictate two operative summaries, one for her role in the procedure and another for the surgeon who assisted

her in the procedure. Her purpose was to support billing at a higher rate by the other surgeon. Later the assistant surgeon advised that he did not require the additional designation as co-surgeon and Respondent asked that the two operative reports, which in any case were inaccurate in many respects, be deleted.

13. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Business and Professions Code sections 2234 and/or 2234(b) and/or 2234(c) based on her gross negligence and/or repeated negligent acts, including but not limited to:

A. Respondent failed to arrange for a formal vascular surgery consultation;

B. Respondent failed to obtain informed consent for aortic repair and resection;

C. Respondent failed to have the vascular surgeon either assisting in surgery or immediately available to address anticipated complications in resecting around the aorta;

D. Respondent improperly dictated an operative summary for another surgeon.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts)

14. Respondent Katherine Anne O'Hanlan, M.D. is subject to disciplinary action under sections 2234 and/or 2234(b) and/or 2234(c) in that Respondent was grossly negligent and/or engaged in repeated acts of negligence in her care and treatment of Patient 2. The circumstances are as follows:

15. Patient 2 was a 42-year old woman who had undergone an ultrasound on August 17, 2016, which study revealed a large 10 cm complex ovarian mass. Of significance, preoperatively, Patient 2 had hemoglobin (HGB) measured at 13 and hematocrit (HCT) of 36.5.

16. On September 13, 2016, Respondent performed a laparoscopic bilateral salpingectomy and left oophorectomy. A laparoscopic appendectomy with partial resection of the distal small bowel was performed by an assistant surgeon in the same operation. Once the operation was completed, Respondent wrote same day discharge orders and transferred the patient to the Post Anesthesia Care Unit (PACU). Estimated blood loss (EBL) for the procedure was 50 cc.

17. Postoperatively Patient 2 initially did well, but after a couple of hours she experienced a few hypotensive episodes and, several hours later, she became near syncopal when she attempted to sit up. A stat complete blood count showed a very low HCT of 23.7 and HGB of 7.9. Given the small EBL and the marked drop from preoperative HCT and HGB levels, Respondent suspected an internal bleed and the patient was taken back to the OR at approximately 10:30 p.m. on the same day.

18. At the re-operation, Respondent performed a laparoscopic evacuation of a pelvic hematoma, removing approximately 650 cc of clotted blood, but could find no definitive site for bleeding. Patient 2 was transfused and post-operative HCT came back at 34.9. The patient appeared to do well after the second procedure and Respondent, feeling reassured that there were no active bleeding sites, did not order serial vitals and serial HCT and HGB tests to monitor the patient's condition over night. Although she did not document it in a progress note, Respondent later reported that she did see the patient the following morning and felt that she was okay for discharge.

19. Patient 2 was discharged on the morning of September 14, 2016; however, within an hour Patient 2's husband contacted Respondent and stated that his wife was not doing well on their long drive home. According to Patient 2's husband, Respondent stated that the patient might be having a panic attack and no action was warranted. Within a couple of more hours of travel, however, Patient 2 had a bloody bowel movement and Respondent was called again. At that time, she advised the couple to return to the hospital.

20. When Patient 2 returned to the hospital, she was pale, diaphoretic and clearly anemic. An abdominal CT was performed which indicated a suspected small focus of active hemorrhage in the right lower quadrant adjacent to the small bowel loop and to the surgical clips placed in the initial surgery. Her HCT was 23.7 and her HGB was 7.9. Respondent took the patient back to the OR where a laparoscopic evacuation of the hematoma and small bowel resection with primary anastomosis was performed. After three surgeries in four days, the patient was kept in the hospital until September 17, when she was discharged.

21. In a subsequent interview, Respondent acknowledged that she did not order serial HCT and HGB tests and that she would do so in all similar future cases.

22. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Business and Professions Code sections 2234 and/or 2234(b) and/or 2234(c) based on her gross negligence and/or repeated negligent acts, including but not limited to:

A. Respondent failed to closely monitor the patient by ordering serial vital signs, HCT and HGB tests;

B. Respondent failed to document that she had seen the patient on the morning of discharge on September 14, 2016 and determined that the patient was ready for discharge.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts)

23. Respondent Katherine Anne O'Hanlan, M.D. is subject to disciplinary action under sections 2234 and/or 2234(b) and/or 2234(c) in that Respondent was grossly negligent and/or engaged in repeated acts of negligence in her care and treatment of Patient 3. The circumstances are as follows:

24. Patient 3, a 41-year old female, had undergone a pelvic ultrasound which revealed an 11 cm x 9 cm uterine fibroid. On February 17, 2017, Respondent saw the patient for a preoperative history and physical. At that time the patient was consented for a laparoscopic hysterectomy with bilateral salpingectomy and incidental appendectomy. After discussion with the patient, Respondent wrote: "We will save the ovaries." However, in error, she scheduled the procedure with the hospital's OR scheduler as a laparoscopic hysterectomy and bilateral salpingo-oophorectomy.

25. On February 18, 2017, Patient 3 was brought to the OR. Prior to the incision, a surgical pause was performed by the surgical team and lead by Respondent. She stated from memory that the procedure to be performed was a laparoscopic hysterectomy and bilateral salpingo-oophorectomy, which was erroneous. Because she believed that she recalled the procedure accurately, she did not consult the preoperative history and physical or the signed

consent to verify the procedure that the patient had consented to. As stated above, the surgery had also been incorrectly scheduled as such, and OR nursing staff did not correct Respondent's error. The surgical pause, which is one step in a mandated safety checklist procedure, is lead by the circulating nurse. By leading the surgical pause herself, Respondent eliminated the possible detection of her error by the circulating nurse.

26. On February 19, 2017, Respondent visited Patient 3 on her postsurgical rounds and advised her that the surgery had gone very well and that Respondent had removed her uterus, tubes, ovaries, and appendix, with a minimum of blood loss. Thereupon, Patient 3 reminded Respondent they had agreed to save the ovaries. Respondent confirmed that there had been a wrong-procedure error and so advised the patient. In a subsequent interview, Respondent stated that she now conducts the surgical pause by reading directly from the surgical consent form.

27. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Business and Professions Code sections 2234 and/or 2234(b) and/or 2234(c) based on her gross negligence and/or repeated negligent acts, including but not limited to:

A. Respondent failed to check the preoperative history and physical and/or signed consent form to verify the procedure to be performed;

B. Respondent failed to properly perform the perioperative surgical safety check.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts)

28. Respondent Katherine Anne O'Hanlan, M.D. is subject to disciplinary action under sections 2234 and/or 2234(b) and/or 2234(c) in that Respondent was grossly negligent and/or engaged in repeated acts of negligence in her care and treatment of Patient 4. The circumstances are as follows:

29. Patient 4, a 64-year old female, had developed irregular bleeding and had an endometrial biopsy on December 14, 2015, that showed a grade 1 to 2 endometrial adenocarcinoma. She was evaluated by Respondent on January 13, 2016, for endometrioid adenocarcinoma of the uterus and uterovaginal prolapse. Respondent noted a normal HCT of 43

and HGB of 14. Respondent's plan was a total laparoscopic hysterectomy with bilateral salpingo-oophorectomy and appendectomy, and the patient was consented for this procedure.

30. On January 14, 2016, Respondent and an assistant surgeon performed a total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, appendectomy and uterosacral ligament colpoplexy. The EBL was 300 cc and Respondent reported good hemostasis, especially at the uterine artery incision sites.

31. The patient initially did well postoperatively, but in the early morning hours she had a brief episode of hypotension and emesis. Respondent was notified by nursing staff and requested a Rapid Response Team (RRT) be called to evaluate the patient and to get a stat CBC. The RRT recommended waiting for the test results and bedrest until Respondent could see the patient. At approximately 3 A.M., the patient had another hypotensive episode. Nursing staff informed Respondent of all these events and also advised her at 5 A.M. that the HCT had come back at 27.4 and HGB at 8.9. Although she did not document it in a progress note, Respondent saw the patient at approximately 7 A.M. and her impression was that the patient was doing well. She did not order serial HCT and HGB tests, nor did she keep the patient in the hospital for observation.

32. Patient 4 returned through the Emergency Department (ED) on January 16, 2016, after a syncopal episode. In the ED, she was described as pale with a diffusely tender abdomen. Her HCT was measured at 16.7. A CT of the abdomen/pelvis showed a large amount of heterogeneous, slightly hyperdense fluid in the pelvis, consistent with hemoperitoneum/hematoma. Respondent was advised and admitted the patient to the hospital. At a subsequent surgery, Respondent laparoscopically evacuated 750 cc of clot.

33. In a later interview, Respondent stated that she was falsely reassured by the patient's appearance when she saw her the morning following the date of her surgery. She acknowledged that she should have had a higher index of suspicion for a post-operative bleed and kept the patient for monitoring and serial HCT and HGB tests. Respondent stated that she now orders serial HCT and HGB tests.

34. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Business and Professions Code sections 2234 and/or 2234(b) and/or 2234(c) based on her gross negligence and/or repeated negligent acts, including but not limited to:

A. Respondent failed to have a high index of suspicion for an intra-abdominal bleed, failed to see the patient at the time that she was showing signs and symptoms consistent with a bleed and failed to order serial HCT and HGB tests;

B. When Respondent did see the patient later in the morning, she failed to write a progress note documenting the encounter.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Records)

35. Respondent Katherine Anne O'Hanlan, M.D. is subject to disciplinary action under section 2266 in that she failed to maintain adequate and accurate records, including:

A. Respondent improperly dictated an operative report for another surgeon;

B. Respondent failed to document her encounter with Patient 2, as set forth above;

C. Respondent failed to document her encounter with Patient 4, as set forth above.

DISCIPLINARY CONSIDERATIONS

36. To determine the degree of discipline, if any, to be imposed on Respondent, Katherine Anne O'Hanlan, M.D., Complainant alleges that on or about April 25, 2005, in a prior disciplinary action entitled "In the Matter of the Accusation Against Katherine Anne O'Hanlan, M.D." before the Medical Board of California, in Case Number 03-2003-142292, Respondent's license was revoked, the revocation stayed, and a three-year probation, with an actual suspension for 30 days, was imposed. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 70108, issued to Respondent;

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

3. Ordering Respondent, if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: March 25, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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