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

In the Matter of the First Amended Accusation Against: Lolita Vernette Palmer, M.D. Physician's and Surgeon's Certificate No. A 112491 Respondent.	Case No.: 800-2017-032704

DECISION

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

This Decision shall become effective at 5:00 p.m. on August 20, 2021.

IT IS SO ORDERED: July 22, 2021.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
STEVEN D. MUNI
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 First Amended Accusation Against: **LOLITA VERNETTE PALMER, M.D.** **5406 Crossings Dr., Ste. 102-175** **Rocklin, CA 95677-3932** **Physician's and Surgeon's Certificate No. A 112491** Respondent.	Case No. 800-2017-032704 OAH No. 2020010654 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. 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 Rob Bonta, Attorney General of the State of California, by Jannsen Tan, Deputy Attorney General.

2. Respondent Lolita Vernette Palmer, M.D. (Respondent) is represented in this proceeding by attorney Lawrence S. Giardina Esq., whose address is: 400 University Ave. Sacramento, CA 95825-6502

3. On or about May 21, 2010, the Board issued Physician's and Surgeon's Certificate No. A 112491 to Lolita Vernette Palmer, 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 the First Amended Accusation No. 800-2017-032704, and will expire on September 30, 2021, unless renewed.

JURISDICTION

4. The First Amended Accusation No. 800-2017-032704 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on August 25, 2020. Respondent timely filed her Notice of Defense contesting the First Amended Accusation.

5. A copy of the First Amended Accusation No. 800-2017-032704 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the First Amended Accusation No. 800-2017-032704. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended 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.

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in the First Amended Accusation No. 800-2017-032704, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up her right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in the First Amended Accusation No. 800-2017-032704, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected her Physician's and Surgeon's Certificate, No. A 112491 to disciplinary action.

12. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

13. 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

14. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or 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 Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

15. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in the First Amended Accusation No. 800-2017-032704 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

ADDITIONAL PROVISIONS

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

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 112491 issued

to Respondent Lolita Vernette Palmer, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. EDUCATION COURSE. Within 120 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. MEDICAL RECORD KEEPING COURSE. Within 120 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

15 calendar days after the effective date of the Decision, whichever is later.

3. PROHIBITED PRACTICE. During probation, Respondent is prohibited from performing laparoscopic surgery.

4. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended Accusation to the Administrator, 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.

5. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses. Respondent is allowed to teach mid-level practitioners including but not limited to bedside rounds, didactic and preceptorship.

6. 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.

7. 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.

8. 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, subdivision (b).

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.

9. 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.

10. 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 Boards' 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in the First Amended Accusation No. 800-2017-032704 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Lawrence S. Giardina Esq. I understand the stipulation and the

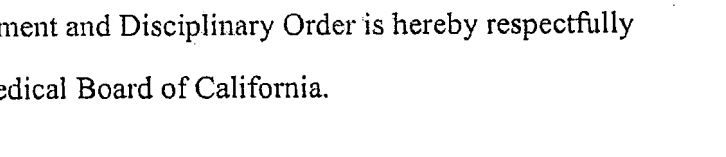
effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5-21-2021

LOLITA VERNETTE PALMER, M.D.
Respondent

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

DATED: May 21, 2021



LAWRENCE S. GIARDINA ESQ.
Attorney for Respondent

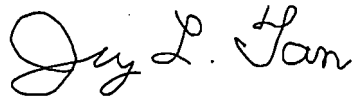
ENDORSEMENT

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

DATED: May 25, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General



JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2017-032704

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

In the Matter of the First Amended Accusation Against: **LOLITA VERNETTE PALMER, M.D.** **5406 Crossings Dr., Ste. 102-175** **Rocklin, CA 95677-3932** **Physician's and Surgeon's Certificate No. A 112491,** Respondent.	Case No. 800-2017-032704 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about May 21, 2010, the Medical Board issued Physician's and Surgeon's Certificate No. A 112491 to Lolita Vernette Palmer, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2021, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code provides, in pertinent part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in pertinent part:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"..."

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)

7. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she committed gross negligence during the care and treatment of Patient A and Patient B. The circumstances are as follows:

Patient A:

8. Patient A[1] was a sixty-six (66) year old male with a history of alcoholism, advanced Chronic Obstructive Pulmonary Disease (COPD), alcoholic related pancreatitis, esophagitis, chronic hepatitis B and hepatitis C, cirrhosis of the liver, and tuberculosis.

9. On or about December 1, 2016, Patient A was seen by Respondent, a general surgeon, at Sutter Hospital, in Roseville, California, for management of gallstones, in the setting of prior pancreatitis and pancreatic psuedocyst.[2] Respondent performed a laparoscopic cholecystectomy[3] on Patient A. Prior to the operation, while in an outpatient setting, Respondent failed to carefully explain the full risks and benefits of such an operation to Patient A. Specifically, prior to Patient A's hospitalization, Respondent failed to discuss provider orders for life-saving treatment and advance directives—including, but not limited to, a living will; instruction directive; health care proxy; or health care power of attorney. Respondent additionally failed to discuss, in depth, Patient A's strong reluctance to undergo re-intubation.

10. During Patient A's pre-operative consultation, Respondent failed to document any discussion of the possible need to re-intubate Patient A, Intensive Care Unit care for potential respiratory failure, or code status (what type of intervention the healthcare team will conduct

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[1] Patient names and information have been removed. All witnesses will be identified in discovery.

[2] A pancreatic pseudocyst is a collection of tissue and fluids that forms on your pancreas. It can be caused by injury or trauma to the pancreas but the most common cause of pancreatic pseudocysts is pancreatitis.

[3] Laparoscopic cholecystectomy is the surgery to remove the gallbladder. The operation is performed by inserting a tubed device (laparoscope), equipped with a camera and tools, into the abdomen.

should Patient A's heart stop beating or lungs stop moving air). Additionally, Respondent failed to mention in her notes whether Patient A had a cholecystectomy tube (tube for drainage of the gallbladder) as the indication for the operation. Moreover, Respondent failed to address alternate explanations and interventions, other than performing a laparoscopic cholecystectomy on Patient A—which, based on Patient A's age; heavy alcohol consumption; and other morbidities, presented an increased risk to Patient A.

11. During the laparoscopic cholecystectomy, Respondent discovered that Patient A was suffering from cirrhosis of the liver, as well as moderate estimated blood loss, with a subscapular hematoma from a small liver laceration, which required cautery (surgical burning to mitigate bleeding). Following the operation, Patient A was admitted to the hospital for observation.

12. On or about December 2, 2016, Patient A reported uncontrolled abdominal pain. As the day progressed, Patient A experienced increased white blood cell count, indicating a potential hidden infection. Additionally, Patient A's oxygen requirements increased.

13. Between December 2, 2016, and December 7, 2016, Patient A's health continued to worsen, and he was placed on a BiPAP machine (a ventilation machine that pushes supplementary oxygen into the lungs). On December 6, 2016, Patient A signed a "Do Not Resuscitate / Do Not Intubate (DNR/DNI)" order. Patient A continued to worsen, and had marked hypoxia with saturation in the 70's on 45 liters of high flow oxygen. On or about December 7, 2016, Patient A expired.

14. Respondent committed gross negligence in her care and treatment of Patient A, as more particularly alleged hereinafter:

A. Failing to address and/or document alternate explanations and interventions for Patient A's pancreatitis and pseudocyst in the decision to operate—including a non-surgical option, that could have avoided the need for surgery.

Patient B:

15. Patient B was a seventy (70) year old male with hypertension, peripheral vascular disease, and osteoarthritis. Patient B additionally had a ten (10) year history of bloating, gas, and indigestion that was unimproved with dietary changes.

16. On or about March 22, 2017, Respondent performed a laparoscopic cholecystectomy on Patient B. During the procedure, an intra-operative common bile duct injury was discovered, in which bile appeared to flow out of the defect. Respondent conferred with a colleague by telephone, and decided not to convert to an open procedure (when an endoscopic service is attempted and fails and another surgical service is sometimes necessary) or place a T-tube[4] in Patient B's bile duct. Instead, Respondent performed a primary laparoscopic suture repair on Patient B. Following the procedure, Patient B was found to have a mild white blood cell increase.

17. On or about March 23, 2017, Patient B was seen by a gastroenterologist, who performed an endoscopic sphincteronomy[5] / Endoscopic retrograde cholangiopancreatography (ERCP)[6] on Patient B and placed a stent[7] into Patient B's bile duct. Following the ERCP, the gastroenterologist conferred with Respondent and recommended that Patient B be transferred to the care of an expert hepatobiliary surgeon, after expressing concerns that Patient B had a right hepatic duct[8] injury.

18. Patient B received a physical examination, which revealed no biliary dilation or fluid collection, which would have indicated that the attempted laparoscopic suture repair was unsuccessful.

19. On or about March 24, 2017, Patient B received a hepatobiliary iminodiacetic acid[9]

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[4] A T-tube is a plastic "T" shaped tube, placed into the common bile duct, through the skin, and used to drain bile while the patient is healing.

[5] Endoscopic sphincteronomy is a procedure where instruments and a camera are inserted through small incisions, in order to allow a physician to correct a problem with the common bile duct, which is located between the pancreas and liver.

[6] Endoscopic retrograde cholangiopancreatography is a procedure used to diagnose and treat certain problems of the pancreatic ductal systems. Through an endoscope (a small, tubular, internally placed device, equipped with a small camera), the physician can see the inside of the stomach and duodenum. The physician can additionally inject dye into the ducts in the pancreas to assist imaging on radiographs.

[7] A biliary stent is a tube that is inserted into the common bile duct of the liver in cases when the duct has become blocked. The stent is inserted after surgery to unblock the duct and ensure that it remains inflated and operative.

[8] The right hepatic duct extends outside of the liver. The right hepatic duct leaves the liver, carrying bile that eventually ends up in the small intestine to aid in digestion.

[9] A HIDA scan is an imaging procedure used to diagnose problems of the liver, gallbladder and bile ducts, in which a radioactive tracer is injected into a vein in the patient's arm. The tracer travels through the bloodstream to the liver, into the gallbladder and through the bile ducts to the small intestine, and creates computer images.

(HIDA) scan, which did not reveal evidence of a bile leak. A magnetic resonance cholangiopancreatography[10] (MRCP) was additionally performed on Patient B, which did not reveal bile duct dilation. (Bile leak could be indicative of damage from the previous operation).

20. On or about March 25, 2017, Patient B was discharged to his home. Although the gastroenterologist recommended involving a hepatobiliary expert, Respondent failed to retain the services of one, following radiological imaging on Patient B, and additionally failed to consult with one, prior to Patient B's discharge.

21. On or about April 5, 2017, Patient B was seen in an outpatient setting, in which his post-operative drain (Jackson-Pratt Drain) was removed. Patient B was then re-admitted to Sutter, following a diagnosis of leukocytosis.[11] A computed tomography[12] scan revealed that Patient B had a subhepatic fluid collection, which was indicative of the failure of the March 22, 2017 suture repair.

22. On or about April 7, 2017, a HIDA scan was repeated on Patient B, which showed a leak of tracer into his gallbladder fossa. Patient B was placed on intravenous therapy, and accepted for transfer to California Pacific Medical Center (CPMC) in San Francisco, California, by a hepatobiliary expert. On or about April 9, 2017 Patient B was transferred to CPMC, where he was managed with a longer stent, repeat ERCP, and his drain was removed, with no additional medical issues.

23. Respondent committed gross negligence in her care and treatment of Patient B, as more particularly alleged hereinafter:

A. Attempting to try to suture Patient B's common bile duct injury laparoscopically and not converting to an open procedure.

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[10] An MRCP is a special type of magnetic resonance imaging (MRI) exam that produces detailed images of the hepatobiliary and pancreatic systems.

[11] Leukocytosis is white cells above the normal range in the blood. It is frequently a sign of an inflammatory response, most commonly the result of infection.

[12] A computed tomography scan makes use of computer-processed combinations of many X-ray measurements taken from different angles to produce cross-sectional images of specific areas of a scanned object, allowing the user to see inside the object without cutting.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

24. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts during the care and treatment of Patients A, B, and C, as more fully described in paragraphs 7 through 23, above, and those paragraphs are incorporated by reference as if fully set forth herein.

Patient C:

25. Patient C was a 70-year-old obese male with a fairly significant cardiac history. He had a history of coronary artery disease (CAD), CABG x2, and pacemaker with history of atrioventricular block, hypothyroidism, multi-joint DJD and multiple previous inguinal hernia repairs (Right Inguinal Hernia [RIH] repair at age 12 and Left Inguinal Hernia [LIH] repair with mesh in 1998) who complained about a right groin bulge for at least 3 years and appeared to have minimal symptoms from it.

26. On or about December 7, 2015, Respondent saw Patient C at her office at Sutter Roseville Medical Center (Sutter). After a physical exam was performed by Respondent, she confirmed that Patient C had a recurrent right inguinal hernia (RRIH). She also mentioned that Patient C's scrotum appeared normal with bilateral, normally descended testes. She also did not find any recurrent inguinal hernia on the left side. As she had planned to perform Patient C's RRIH repair later that same day, Respondent spent some time discussing the pathophysiology of inguinal hernias and obtained an informed consent from Patient C. Respondent failed to discuss the possibility of a laparoscopic approach and the risks and benefits of this approach. Respondent planned to perform an open RRIH repair with mesh. Respondent failed to assess Patient C's perioperative Venous Thromboembolism (VTE) risk correctly and did not order sequential compression devices (SCD) and/or any pharmacologic agent as VTE prophylaxis for a redo open recurrent right inguinal hernia repair with mesh in a patient with moderate risks for developing a Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) intra or postoperatively.

27. At 10:26 am on December 7, 2015, Respondent began her open recurrent right inguinal hernia repair using a medium sized prolene hernia system (PHS) mesh. Monitored

Anesthesia Care (MAC) was used for deep sedation and a Foley catheter was placed prior to starting the procedure due to the patient's reported h/o postoperative urinary retention. In her operative report, Respondent documented that the dissection of the subcutaneous fatty tissue down to the external oblique was routine. Respondent documented that she could not find the superficial inguinal ring immediately and felt that it was secondary to the scarring from the previous surgery. After that, Respondent documented that she was able to isolate the cord structure (with a penrose drain), incised the cremasteric muscles, identified and isolated the hernia sac, dilated the internal ring and was securely able to place the inner leaflet of the PHS mesh without issue. Respondent then tailored the outer leaflet of the PHS mesh around the cord structures at the internal ring and then fixed the mesh to the ilioinguinal ligament laterally, to the conjoint ligament medially and tucked the upper wing of the mesh under the intact external oblique. The split mesh was then sutured to itself along the floor of the inguinal with prolene sutures. After use of local anesthesia, Respondent closed the wound in multiple layers without any problems. Patient C was discharged the next day without issue.

28. On or about December 10, 2015, Patient C contacted his primary care doctor, Dr. Q, complaining that he was experiencing increasing scrotal pain and swelling and that he also had a worsening right inner groin rash which was not responding to the OTC antifungal cream he was using. Dr. Q ordered an ultrasound of the scrotum which revealed that the right testicle showed no internal vascularity and the findings were highly suspicious for a testicular torsion. Patient C was sent directly to the Sutter Emergency Department, where Dr. K and Dr. P found Patient C to be mildly febrile with a white blood cell count (WBC) of 12.0K. Patient C was immediately admitted and was evaluated by a urologist, Dr. M. Dr. M agreed with the assessment that Patient C had a very painful and swollen right testicle and that the scrotal ultrasound showed the right testicle to be avascular. These findings were most consistent with a right testicular torsion which had been symptomatic for over 48 hours. Patient C was taken to the operating room emergently where Dr. M performed a right orchiectomy versus a right detorsion and orchiopexy.

29. Dr. M documented delivering the right testicle through an incision made in the median raphe of the scrotum to reveal a black and extremely necrotic right testicle. After

establishing that the right testicle had no dopplerable blood flow and there was no torsion of the cord, a high ligation of the cord was performed and the testicle was removed from the field. On further examination of the testicular artery, it was found that the artery was completely thrombosed. After thorough irrigation of the wound, it was closed in multiple layers without issue. Respondent assisted in the procedure.

30. Postoperatively, Patient C did well with resolution of the severe right testicular pain. He was in the hospital for 2 days, during which time he was eating well, ambulating independently and his surgical wound was healing as expected. He was discharged from the hospital on December 12, 2015.

31. Respondent committed repeated negligent acts in her care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

A. Respondent failed to document discussions with Patient A regarding perioperative risk – including code status, and possible need for reintubation and Intensive Care Unit stay.

B. Respondent failed to transfer Patient B to a hepatobiliary expert in a timely manner.

C. Respondent failed to give Patient C complete informed consent when she failed to discuss all of the surgical options available to repair Patient C's recurrent right inguinal hernia. The laparoscopic approach, which Respondent did not discuss with Patient C, is the preferred approach by many surgeons for the repair of recurrent inguinal hernias and is associated with less spermatic cord injuries when compared to an open redo RRIH.

D. Respondent failed to assess Patient C's perioperative VTE risk correctly and did not order SCDs and/or any pharmacologic agent as VTE prophylaxis for a redo open recurrent right inguinal hernia repair with mesh for Patient C who was at moderate risk for developing DVT or PE intra or postoperatively.

THIRD CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)

32. Respondent's license is subject to disciplinary action under section 2266 of the Code in that she failed to maintain adequate and accurate medical records relating to her care and

treatment of Patient A, B, and C as more fully described in paragraphs 7 through 31, above, and those paragraphs are incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

33. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, of the Code, in that she has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 7 through 32, above, which are hereby realleged and 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 No. A 112491, issued to Lolita Vernette Palmer, M.D.;

2. Revoking, suspending, or denying approval of Lolita Vernette Palmer, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Lolita Vernette Palmer, M.D., 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: AUG 25 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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