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

In the Matter of the Accusation Against: **Matthew August Gilmartin, M.D.** **Physician's and Surgeon's Certificate No. A 93851** **Respondent.**	**Case No.: 800-2018-050766**

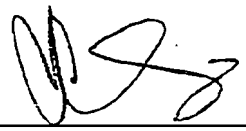
DECISION

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 December 17, 2021.

IT IS SO ORDERED: November 17, 2021.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
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STATE OF CALIFORNIA

In the Matter of the Accusation Against:

MATTHEW AUGUST GILMARTIN, M.D.,

Physician's and Surgeon's Certificate No. A 93851

Respondent.

Agency Case No. 800-2018-050766

OAH No. 2021040389

PROPOSED DECISION

Administrative Law Judge Karen Reichmann, State of California, Office of Administrative Hearings, heard this matter on October 4 through 8, 2021, by videoconference.

Deputy Attorney General Ana Gonzalez represented complainant William Prasifka, Executive Director of the Medical Board of California.

Attorney Dominique Pollara represented respondent Matthew August Gilmartin, M.D., who was present.

The record closed and the matter was submitted for decision on October 8, 2021.

FACTUAL FINDINGS

Jurisdictional Matters

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

2. On January 25, 2006, the Board issued Physician's and Surgeon's Certificate No. A 93851 (Certificate) to respondent Matthew August Gilmartin, M.D. The Certificate was in full force and effect at all times relevant to the charges in the Accusation. It will expire on August 31, 2023, unless renewed. This is the first disciplinary action against respondent's Certificate.

3. This matter arose from a consumer complaint filed by a patient who alleged that respondent touched her vagina during an osteopathic manipulative medicine treatment, without warning and without obtaining her consent. Complainant alleges that respondent touched the patient's genital area without medical necessity, providing cause for discipline for gross negligence and/or sexual misconduct. Complainant also alleges cause for discipline for repeated negligent acts and/or incompetence and/or inadequate medical records in relation to his examination, treatment, and documentation of treatment provided to the same patient.

Respondent's Background

EDUCATION

4. Respondent graduated college with a degree in humanities in 1991. He worked for a few years for non-profit arts organizations before deciding to pursue a career in medicine.

5. Respondent attended a pre-med program at San Francisco State University in 1996. In the program, he befriended Daniel Shadoan, a fellow student who was preparing to study osteopathic medicine. Respondent developed an interest in osteopathic medicine, especially the field of osteopathic manipulative medicine[1].

6. Respondent attended a joint M.D./M.S. program at University of California, San Francisco (UCSF) and University of California, Berkeley. While in medical school, he audited classes in osteopathic manipulative medicine for two years, taught at Touro University, where his friend Shadoan was a student. Respondent's master's thesis was on the history and practice of osteopathic medicine. Respondent graduated from medical school in 2003. While they were medical students, respondent and Shadoan became acquainted with Eliott Blackman, D.O., a prominent practitioner of

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[1] Osteopathic manipulative medicine is more commonly practiced by doctors of osteopathic medicine. It involves the use of one's hands to diagnose and treat illnesses and injuries. Treatment is performed by osteopathic manipulative maneuvers. Pressure is applied by hand to bones and soft tissue to lessen musculoskeletal pain, increase mobility, and improve body functioning.

osteopathic manipulative medicine in San Francisco. Respondent spent a half-day a week at Dr. Blackman's clinic in San Francisco during medical school.

PROFESSIONAL EXPERIENCE

7. Respondent completed the UCSF Sutter Santa Rosa residency in family medicine in 2007. He was chief resident for two years. His residency included a stint as an osteopathic resident at an osteopathic hospital in New York. Respondent has been board certified in family medicine since 2007; he recertified in 2017.

8. After completing his residency in 2007 through the end of 2018, respondent worked both as a hospitalist and emergency room physician, and as a provider of osteopathic manipulative medicine. He worked as a hospitalist for two years at Mendocino Coast District Hospital, followed by 10 years at Sonoma Valley Hospital. He worked from 2007 through 2011 as an emergency room physician at Sutter Medical Center of Santa Rosa. Respondent concurrently worked two to five days per week at Dr. Blackman's office, performing osteopathic manipulative medicine. His friend Dr. Shadoan also joined Dr. Blackman's practice.

9. In September 2018, respondent and Dr. Shadoan left Dr. Blackman's practice and moved into a medical office suite on Post Street in San Francisco. The office consists of two adjacent treatment rooms and a small, shared waiting room. There is no reception area and no staff on site. There is a clipboard in the waiting room with forms for patients to fill out. The doctors escort patients from the waiting room to the treatment rooms. In respondent's treatment room, there is a desk, a chair for patients to sit in while he discusses their medical history and complaints, and a treatment table where osteopathic manipulations are performed. Respondent and Dr. Shadoan operate separately as solo practitioners, but they share a scheduler who

works offsite, in addition to sharing the office suite. At the end of 2018, respondent stopped working as a hospitalist to focus solely on his private practice in osteopathic manipulative medicine.

Patient 1

10. Patient 1, a woman in her 30s, sought treatment from respondent in late 2018. She suffered from chronic pain in the left hip, radiating down her left leg, which was severely interfering with her activities and limited her walking. She had been diagnosed with femoroacetabular impingement and a labral tear in the left hip. Patient 1 spoke with respondent on the phone prior to her first appointment and asked whether he had been successful treating patients with her diagnoses. He told her that he had experienced mixed results; some patients had improved, but others did not and required surgery.

NOVEMBER 20, 2018, APPOINTMENT

11. Patient 1 first saw respondent on November 20, 2018. Patient 1 filled out forms provided to her by respondent, including marking the location where she experienced pain on an anatomic diagram. She and respondent discussed Patient 1's medical history, current complaints, and prior treatment with physical therapy, acupuncture, and herbal remedies. Patient 1 reported that ibuprofen helped with her pain, but that she was reluctant to depend on it, and she hoped to avoid surgery.

12. Respondent's medical record for Patient 1 reflects that she discussed the history of her left hip pain in detail. There are also notes regarding her difficult and painful pregnancy and labor. Patient 1 described severe pelvic pain during pregnancy which rendered her incapable of doing anything during the second and third trimesters. She described being in labor for 68 hours, with the baby's shoulder getting

stuck and the midwife having to push hard on Patient 1's lower left quadrant during delivery. She reported experiencing significant postpartum depression and anxiety. She began to experience hip pain about one year after her child was born, and she believed that carrying the child on her left hip was a factor. Patient 1 told respondent that she was unable to exercise or engage in any self-care for the first year after giving birth, and she expressed her belief that some of her pain condition could have been prevented.

Respondent performed an examination of Patient 1, and then performed osteopathic manipulative medicine techniques. The appointment lasted approximately one hour.

13. Respondent's medical record for the November 20, 2018, appointment contains the following notations, under the heading "Objective:"

Extremities

Standing/Seated flexion negative

S/S intact bilateral LE

L TFL, IP, OI, glut max spasm

L femur IOS

L SI S pole restriction

L fibular head restriction

a/p

hip pain – myofascial pain

discussed possible labral tear as underlying cause

precautions

gentle omt

will bring MRI reports and images if possible

14. Patient 1 was satisfied with the treatment she received from respondent at this first appointment and scheduled a second appointment.

DECEMBER 6, 2018, APPOINTMENT

15. Patient 1 returned to respondent's office on December 6, 2018. They reviewed an MRI report that Patient 1 provided. Respondent again performed osteopathic manipulative maneuvers on Patient 1, on his treatment table. This appointment session lasted about 45 minutes. At the end of this appointment, Patient 1 told respondent that she had been uncomfortable with the work he had done in her "groin" area, without first asking for permission.

16. Respondent's medical record for the December 6, 2018, appointment contains the following notations, under the heading "Objective:"

Extremities

Seated/standing tests negative

Step test negative

L IP piriformis/adductor magnus spasm

L immonimate IOS

L SI restriction

L femur IOS

L fibular head restricted

L anterior compartment tight

Anterior diaphragm restricted

a/p

L labral tear

hip pain

gentle omt

precautions

NOTE: Pt said at end of appointment that she had been taken aback by my work in her groin area without asking permision (I had asked for permission to palpate the area of her ischial tuberosities and pevlic floor earlier and she had said "it's fine")

I asked her if she did not want me to work in that area or if she wanted me to ask permission before doing so. She said it was oK to work in that area but that I should ask permission before doing so. I asked her if she had any questions or concerns and she said no. [*sic*]

17. Patient 1 sent respondent an email at 9:08 p.m. on the evening of December 6. She wrote:

> I'm requesting a full refund for the treatment provided earlier today, December 6th. I'm beyond unsatisfied. You informed me that you planned to touch my abdomen and buttocks and asked for my permission. I consented and relaxed on your table. I was nearly asleep when I noticed that your hand was touching my vagina. I quickly became extremely alert, tense and uncomfortable. My level of discomfort and lack of trust for you prevented the session from being effective. Frankly, I'm surprised that you asked for my credit card after the session given that I told you about my discomfort at the completion of the session.
>
> Your speedy resolution of this matter is appreciated.

18. Respondent was shocked when he received Patient 1's email, because he did not believe that he had touched her vagina, and because she had not alleged that he had done so during their discussion at the end of the appointment.

19. Respondent sent Patient 1 an email in response. He wrote:

> Of course I will give you a full refund. I am so sorry for this misunderstanding. My goal is to always have my patients feel comfortable under my care, in addition to the resolution of the clinical problem that I am treating.

> If you would like to, we can discuss this further by phone tomorrow. I can be available at lunch or at the end of the day.
>
> I will also process the refund tomorrow. Please send me the last four digits of your credit card to facilitate this.

20. Respondent sent Patient 1 another email the following afternoon. He wrote:

> I was able to process the refund without the credit card information I requested. I remain available to discuss the treatment; generally the end of the work day is when I am available.

21. Patient 1 never contacted respondent and did not return for further treatment.

22. On December 13, 2018, Patient 1 submitted an online consumer complaint to the Board. She wrote:

> I had been laying on my stomach, face down, for several minutes when [respondent] reached and placed his hand on my vagina (I was fully clothed but wearing thin, loose-fitting pants and could feel his fingers pressing ontop of my vagina). One or more of his fingers pressed lightly on my vagina while what felt like his thumb applied some pressure to my pubic bone right above my labia. This position was held for what felt like several minutes. [Respondent] did

NOT ask for permission to do this. Moments before his hand was placed on my vagina, I had been very sleepy and relaxed laying on my stomach until his hand moved on top of my vagina when I became alert, alarmed, and tense. At the time I was confused about if what was going on was appropriate medical procedure.

I remained on the table distracted and tense as [respondent] completed the treatment. Not surprisingly I was very uncomfortable for the duration (10 or so minutes) of the treatment, and felt no longer in a safe place for medical care.

Eventually I said I was not comfortable with the work you were doing in my . . . (I paused, wanted to say vagina, but hesitated still in shock that that was what happened) pelvic area. It felt very uncomfortable for me.

He apologized repeatedly then took my credit card ("are you paying by credit card?") He apologized again for making me uncomfortable.

While working on other areas of my body, [respondent] explained what he was going to do and asked for permission (i.e. I'm going to touch your abdomen now, here and here, is that okay?) When he moved to my vagina, no explanation was offered, no warning was given nor permission requested.

PATIENT 1'S TESTIMONY

23. Patient 1 testified at the hearing and was a credible witness. She is a public health professional. She was previously physically active and enjoyed hiking, jogging, dancing, and yoga. About a year after she gave birth in 2015, she became unable to engage in these activities due to her severe left hip and leg pain. She sought a variety of treatments. Patient decided to try osteopathic manipulative medicine treatment upon the suggestion of a friend who is a medical doctor.

24. Patient 1 testified that at her first session with respondent, he performed simple adjustments on her while she was on the treatment table. Respondent gave verbal notice and asked for consent as he was touching her, and he administered subtle, light touch. She was mostly on her back. She found respondent to be polite, professional, and careful, and felt hopeful that she might have relief from her pain. She felt better for a brief time after the treatment.

25. Patient 1 testified that at the second session, respondent again asked for permission as he touched her, and she felt comfortable and trusting. Respondent then asked her to lie face down and he continued to explain what he was doing and ask for consent as he performed more treatment, and she felt relaxed. Patient 1 testified that while she was lying face down with her legs together, respondent, without explanation, placed his hand under her waist and on her labia, on top of her clothing, with one finger pressing on her pubic bone. She thought to herself, "This doesn't feel right. Is this normal? This feels like a violation." She was nervous and afraid to offend respondent, and gave him the benefit of the doubt because he was a highly reputable physician. She related that respondent's hand was on her labia on top of her clothing for several minutes.

26. Patient 1 stated that the treatment session lasted for about 10 more minutes, and that she was very uncomfortable during this time and that she felt disappointed in herself for not saying anything to respondent while he was touching her. When respondent asked for payment, Patient 1 told him that she was uncomfortable. She told him that he had asked for verbal consent except before he put his hand on her "groin." She used this word euphemistically because she was upset and was struggling internally about whether to confront respondent. Respondent apologized and asked her whether she did not want him to work in that area again, or whether she wanted him to ask for consent. He explained the anatomy he had worked on, and why he performed the osteopathic manipulative maneuvers that he had done. Patient 1 acknowledged in her testimony that respondent apologized to her, but stated that he only said he was sorry she was uncomfortable and did not say he was sorry for his actions. She described his apology as "an erasure."

27. Patient 1 discussed what happened at the December 6, 2018 treatment session with her husband and her friend the medical doctor. She felt unsure about whether it was an acceptable touch, and wanted to understand what was normal. Her doctor friend told her that if the touching was not consensual, it was "not okay," and recommended that Patient 1 report it to the Board.

28. Patient 1 explained that she asked respondent to refund her payment because she did not feel that his services were done in a way to benefit her.

29. Patient 1's husband and friend testified at the hearing and confirmed that she reported to them that respondent touched her vulva without warning and that she had been confused and uncomfortable.

RESPONDENT'S TESTIMONY

30. Respondent testified at the hearing and was a credible witness. Respondent has treated thousands of patients with osteopathic manipulation. He estimated that approximately 70 percent of these patients have been female. He has treated neonates to nonagenarians. He treats patients for a variety of complaints, with about 50 to 60 percent seeking care for musculoskeletal issues.

31. Respondent described his custom and practices for providing osteopathic manipulative medical care. When treating a patient who is new to osteopathic manipulative medicine, he gives a brief explanation of its history and what to expect during treatment. He tells patients that he will ask for permission and to tell him if they do not want him to touch an area. For a new patient, the discussion portion of the first session will take about 30 minutes. Respondent does not specifically recall having this discussion with Patient 1 at her first session, but noted that it is his custom to do so. He acknowledged that there is no documentation of consent in his records for Patient 1.

32. Respondent explained the evaluation that he performed on Patient 1 at the first treatment session. He described it as an "osteopathic evaluation" performed in the manner that he was taught during his osteopathic manipulative medicine studies. He distinguished his evaluations from what might be performed by a primary care physician. Respondent stated that he performed standing and seated flexion tests, by having Patient 1 bend forward at the hip from both a standing and seated position. Respondent testified that he observed the range of motion of her hip and knee, but that he did not document any findings. Respondent explained that the notation "S/S intact bilateral LE" signifies normal strength and sensation in both lower extremities.

Respondent stated that his practice was to document pertinent positives and relevant negatives, and not to document everything he observes and evaluates.

33. Respondent explained the following four notations, which he described as four different abnormalities he identified while treating Patient 1:

a. "L TFL, IP, OI, glut max spasm" signifies left tensor fascia lata iliopsoas obturator internus, gluteus maximus spasm.

b. "L femur IOS" signifies left femur intraosseous strain.

c. "L SI S pole restriction" signifies left sacroiliac superior pole restriction.

d. "L fibular head restriction" signifies left fibular head restriction.

34. Respondent testified that he performed osteopathic manipulative treatments on these four areas during the first treatment session with Patient 1, and that he explained to her where he would be touching her and asked for permission as he performed the procedures. Respondent described and demonstrated six osteopathic manipulative maneuvers that he asserts he performed on Patient 1 during the first appointment. Respondent acknowledged that he did not identify the specific osteopathic manipulative techniques performed in the medical record. He explained that he learned how to document osteopathic care while working with Dr. Blackman, and that he had not been trained to specify the specific maneuvers in his records. Respondent believes his documentation is similar to that of other osteopathic manipulative medicine providers.

Respondent further explained that the list of abnormal conditions, together with the notation "gentle omt" signifies that a procedure was performed to address those conditions. There are a variety of techniques that different practitioners use on the

various abnormalities. Respondent knows what maneuvers he performs on these conditions, but he acknowledged that another clinician who is not personally familiar with respondent's practice might not be able to figure out which maneuvers he used from reviewing his records.

35. Respondent explained his medical record notations for the various abnormalities he identified and treated during the December 6 session:

a. "L IP piriformis/adductor magnus spasm" signifies left iliopsoas piriformis adductor magnus spasm.

b. "L immonimate IOS" signifies left innominate intraosseous strain.

c. "L SI restriction" signifies left sacroiliac restriction.

d. "L femur IOS" signifies left femur intraosseous strain.

e. "L fibular head restricted" signifies left fibular head restriction.

f. "L anterior compartment tight" signifies left leg anterior compartment.

g. "Anterior diaphragm restricted" requires no further explanation.

Respondent testified that he performed some of the same maneuvers on Patient at this session that he performed during the first session, but that he also performed new maneuvers. Respondent described and demonstrated the maneuvers, and again testified that he explained what he would be doing and asked permission. At this session, respondent performed several maneuvers while Patient 1 was lying face down. He acknowledged that his record does not identify which maneuvers he performed.

36. Respondent testified that at the end of the second session, Patient 1 appeared uncomfortable, was pressing her hands on her left groin area as if in pain, and told him that she was upset that he had touched her groin without asking for permission. Respondent was concerned by her discomfort, and tried to explain the procedures he had performed and to describe the anatomy and rationale for the procedures. Respondent thought Patient 1's discomfort might have been due to a maneuver he performed on her iliapsoas muscle (located in the hip joint), which can cause pain. Patient 1 did not use the word vagina or labia to describe where she had been touched. Respondent asked Patient 1 whether she wanted no more treatment in that area or whether she needed a more detailed description of what he was doing, and she responded that she wanted more explanation. He felt at the end of the session that they had "talked it through" and would be able to move forward. Respondent documented their discussion in his note in the medical record prior to receiving Patient 1's email.

37. When respondent received Patient 1's email accusing him of touching her vagina, he was horrified and extremely upset. From her description, he came to believe that Patient 1's complaint related to an osteopathic manipulative maneuver he used to treat her innominate intraosseous strain, which he referred to as the "balanced ligamentous tension technique" (BLTT). Respondent has performed the BLTT hundreds of times and has taught it at a continuing education course.

Respondent provided photographs of the technique and demonstrated it at the hearing. During the BLTT, the patient is lying on the table face down with legs together. The practitioner pulls the left leg away from the patient's body and externally rotates it to place the knee in his or her lap. The practitioner slides the fingers (but not the thumb) of his or her left hand under the hip crease and applies pressure to the

patient's pubic bone with the middle finger. The practitioner places his or her right hand on the patient's lower buttock area. Pressure is applied for a period of time ranging from 90 seconds to several minutes. The practitioner then returns the leg to its original straight position. Respondent believes that he administered the technique on Patient 1 for about 90 seconds.

Respondent was adamant that he did not touch Patient 1's labia while performing the BLTT, or at any other time during the treatment session. Respondent testified that he sometimes adjusts or straightens out patients' clothing while performing osteopathic manipulative techniques, and his counsel argued that it is possible that Patient 1 perceived the movement of clothing during the BLTT maneuver as respondent's finger touching her labia.

38. Respondent has altered his practice in light of this experience. He now documents consent discussions, puts more details about his examinations in his notes, and lists the osteopathic maneuvers performed.

39. Respondent related that he has been depressed and haunted by Patient 1's allegations, which he described as counter to the way he practices. He has been unable to sleep through the night for two years, and works hard to shield his children from the stress the allegations have caused him.

40. Despite denying the allegations, respondent expressed empathy towards Patient 1 and her husband. He regrets that he was unable to help her chronic pain, and he feels terrible about her ongoing pain and her negative experience under his care.

Expert Testimony

MICHAEL STELMAN, M.D.

41. Complainant retained Michael Stelman, M.D., as an expert. Dr. Stelman is board certified in family medicine. He has served as an expert reviewer for the Board since 2005. For the past 10 years, he has been in solo practice serving primarily adults, including a large number of geriatric patients. Dr. Stelman has no education or training in osteopathic manipulative medicine.

42. Dr. Stelman reviewed the certified medical records, Patient 1's complaint, the investigation report, and the transcript of respondent's investigation interview. Dr. Stelman wrote a report and testified at the hearing. Dr. Stelman noted that respondent used abbreviations in his medical records that are not standardly used by medical doctors, but might be familiar to doctors of osteopathy. Dr. Stelman was better able to understand respondent's records after reviewing the transcript of the investigation interview, during which respondent explained his notations.

43. Dr. Stelman explained that the standard of care for evaluating a patient complaining of hip pain radiating down the leg is for the physician to perform a physical evaluation to determine the potential cause or causes to justify the subsequent treatment. He believes the evaluation, at a minimum, must include an examination of the lumbar nerve function, an assessment of the strength of the hip joint flexion and extension, a sensory examination of the leg, and documentation of the range of motion of the hip and knee. He believes this evaluation is necessary even if the patient reports a prior diagnosis of labral tear, because there can sometimes be more than one cause of a patient's pain.

Dr. Stelman did not see in respondent's documentation that he performed an evaluation of Patient 1 that complied with the standard of care. He concluded that respondent's inadequate evaluation, including his failure to assess (or to document) hip and knee range of motion and strength testing, prior to providing osteopathic manipulative treatment and not another type of treatment, constituted a simple departure from the standard of care.

44. Dr. Stelman explained that the standard of care for documenting treatment requires a physician to document the information gathered that supported the diagnosis and treatment decisions, including the patient's chief complaint, a review of systems related to the complaint, a review of the patient's medical history, details of the physical examination performed, an assessment or diagnosis, and the treatment performed or proposed. The documentation should allow anyone reviewing it to have a firm idea of what treatment was administered. Treatment should be referred to by standardized name or a detailed step-by-step description, and the records should reflect the structures treated and the side of the body treated.

Dr. Stelman explained the rationale for proper medical documentation: it provides information needed for subsequent treatment decisions by tracking treatment over time and how the patient responded; it provides support for billing and to assess any patient concerns that arise; and it provides protection to the physician.

In reviewing respondent's medical records for Patient 1, Dr. Stelman identified several deficiencies. He found that respondent failed to identify the specific osteopathic manipulative maneuvers performed on Patient 1, such that he could not ascertain what body structures were treated, the side treated, and the duration of each treatment. In addition, there was no documentation that respondent obtained

informed consent by giving a description of the procedures to be performed and informing the patient about alternative treatments and the risks of treatment.

Dr. Stelman testified that respondent's failure to document the specific maneuvers performed, failure to consider and/or document considering other treatment alternatives, and the failure to obtain and/or document obtaining informed consent constituted simple departures from the standard of care.

45. Dr. Stelman discussed the standard of care for examining a patient's anogenital structures. A physician must advise the patient that the examination is warranted, obtain consent, and have a chaperone present. There must be a medical necessity in order for a physician to touch any area of a patient's body, but especially the anogenital area. Non-incidental contact with a patient's genitalia without medical necessity is an extreme departure from the standard of care.

Reviewing the medical records, Dr. Stelman ascertained no medical necessity to touch Patient 1's labia, and no indication of a recognized medical treatment or procedure that includes touching of a patient's labia.

Dr. Stelman concluded that if respondent touched Patient 1's genital area in the manner that she described in her consumer complaint, respondent committed an extreme departure from the standard of care.

HOLLIS KING, D.O., PH.D.

46. Respondent retained Hollis King, D.O., Ph.D., as an expert witness. Dr. King earned his Ph.D. in clinical psychology and practiced as a psychologist before attending osteopathic medical school. He has been licensed by the Osteopathic Medical Board of California since 1984 and has had a distinguished career. He has two

osteopathic board certifications, in family medicine and osteopathic manipulative medicine. He has numerous publications. In 2002, he was named physician of the year by the Osteopathic Physicians and Surgeons of California.

Dr. King has been on the faculty of University of California San Diego (UCSD) School of Medicine since 2015 and is also a service provider at UCSD. He also has a private practice. Dr. King was previously clinical professor and residency director at the University of Wisconsin. He has extensive professional experience reviewing the medical records of osteopathic manipulative medicine practitioners.

Dr. King was acquainted with respondent prior to reviewing this case, but does not know him well. He remembered seeing respondent demonstrate procedures at a one-day course in 2017. Dr. King did not interview or speak with respondent in the course of his review or prior to testifying.

47. Dr. King was initially provided with the Accusation, the medical records, the interview transcript, Dr. Stelman's report, and the investigation report. He contacted respondent's counsel and asked for additional information about the specific interventions performed. Respondent provided a written narrative with further explanation of the treatment he provided to Patient 1, including photographs of the osteopathic manipulative maneuvers he asserts he performed.

Dr. King wrote a report and testified at hearing, concluding that respondent did not violate the standard of care in his evaluation and treatment of Patient 1, or in his documentation.

48. Dr. King opined that respondent's examination of Patient 1 was appropriate and within the standard of care for treating a patient who is already receiving medical care from other providers and is specifically seeking osteopathic

manipulative treatment to address pain. Dr. King explained that an osteopathic evaluation does not follow the same procedure as an orthopedic evaluation. For example, the standing/seated flexion test is performed during an osteopathic evaluation, but not during an orthopedic evaluation. He does not believe that respondent's failure to document the hip and knee range of motion and strength testing deviated from the standard of care.

49. Dr. King explained that the term "gentle omt" is understood to refer to certain standard osteopathic manipulative maneuvers, and that he had a "good idea" of the "most likely" procedures that respondent performed on Patient 1 in light of the conditions that respondent documented. Dr. King has reviewed many medical records of osteopathic treatment. He stated that there is a spectrum of documentation in practice. He described respondent's documentation as "skimpy" and "minimal" but "sufficient" and within the standard of care. He stated, however, that more detail, such as identifying the maneuvers performed "would be nice." He also testified that it is "more typical" for practitioners to include this information in their records, and that he includes it in his own records. Dr King explained that failing to include the maneuvers performed could cause him problems if his records are audited, but that respondent does not have the same concerns because he accepts private pay patients only.

50. Dr. King acknowledged that there is no documentation that respondent obtained informed consent prior to treating Patient 1. He believes that respondent did obtain informed consent based on respondent's representations that his practice is to explain what he is doing and to ask permission during every step of treatment. Dr. King does not document informed consent in his records. He noted, however, that in his work at UCSD, there is already a signed informed consent document in patient files before he treats them. Dr. King also does not believe it was necessary for respondent

to document discussing alternative treatments with a patient who had already received treatment from other providers and who has chosen to seek osteopathic manipulative medicine treatment.

51. Dr. King agreed with Dr. Stelman that the standard of care requires medical necessity and a chaperone if a treatment involving touching a patient's labia is to be performed, and that there was no medical necessity for respondent to touch Patient 1's labia.

Dr. King is familiar with the BLTT technique and has performed it himself. Dr. King explained that the patient's genitals are not touched during this technique. Dr. King believes a patient receiving this treatment could misperceive the placement of the practitioner's fingers. He also believes that a patient's clothing could tighten and put pressure on the genitals while the practitioner is performing the treatment, although he acknowledged that he has not encountered this in his own practice.

Ultimate Findings re: Causes for Discipline

52. The opinions of Dr. Stelman regarding the standard of care were more persuasive than the opinions of Dr. King. Although respondent practices osteopathic manipulative medicine, he is a licensed medical doctor and not a licensed doctor of osteopathic medicine. Accordingly, he must practice within the standard of care of a licensed medical doctor, where it differs from the standard of care of an osteopathic medicine doctor. Dr. Stelman articulated the governing standard of care, and his opinions were consistent with the evidence. Furthermore, Dr. King's lukewarm endorsement of respondent's medical records was not persuasive.

By failing to document his evaluation of Patient 1's hip and knee range of motion and strength, failing to consider or document considering alternative

treatments, failing to document obtaining informed consent, and failing to document the osteopathic manipulative techniques performed, respondent committed several simple departures from the standard of care. Respondent credibly testified that he did in fact evaluate Patient 1's hip and knee range of motion and strength, that he discussed the benefits and limitations of treatment with Patient 1, and that he obtained verbal consent prior to treatment, although his records do not adequately document him doing so.

53. The experts agreed that touching a patient's genitalia without medical necessity constitutes an extreme departure from the standard of care, and both agree that there was no medical necessity for respondent to touch Patient 1's genitalia.

Patient 1 credibly testified that respondent's fingers touched her pubic bone and labia during her treatment session of December 6, 2018, and that respondent held his fingers in that position for several minutes. She further testified that respondent did not warn her or ask her permission before touching her in this area, although she also described being very relaxed and sleepy during the session. Respondent credibly testified that he put his finger on Patient 1's pubic bone while performing an osteopathic manipulative maneuver, but that he did not touch Patient 1's labia.

The testimony of the two witnesses was evaluated pursuant to the factors set forth in Evidence Code section 780: the demeanor and manner of each witness while testifying, the character of the testimony, the capacity to perceive at the time the events occurred, the character of the witnesses for honesty, the existence of bias or other motive, other statements of the witnesses which are consistent or inconsistent with the testimony, the existence or absence of any fact to which the witnesses testified, and the attitude of the witnesses toward the proceeding in which the testimony has been given. Weighing these factors, neither the testimony of

respondent nor of Patient 1 was more credible than the other. Accordingly, it was not established by clear and convincing evidence that respondent touched Patient 1's genitalia during treatment on December 6, 2018.

Respondent's Additional Evidence

54. Respondent's wife, Fiona Gilmartin, testified at the hearing. She is a third-grade teacher. She has been married to respondent for 17 years, and they have two children, ages 15 and 11. She related that respondent generally calls her to check in at the end of the workday, as he is heading home. She related that he mentioned to her in one of these calls that he had a disconcerting appointment with a new patient. Later that evening, respondent showed her the email that Patient 1 sent. They were both aghast and in shock.

COLLEAGUES

56. Four doctors of osteopathic medicine wrote letters and testified on respondent's behalf. All were aware of the allegations in the Accusation.

a. Daniel Shadoan, D.O., is respondent's close friend and colleague. As noted above, Dr. Shadoan met respondent in a pre-med program, and they worked together in Dr. Blackman's practice before moving together to the shared office suite where they both currently practice. Over the years they have consulted with each other, shared patients, covered for each other, and taught courses together. Dr. Shadoan has a very busy schedule and his patients have often sought treatment from respondent when Dr. Shadoan is unavailable. He has never had any patients complain to him about the care they received from respondent. He has also sent family members to respondent for treatment.

Dr. Shadoan has never observed respondent to treat women disrespectfully. He described respondent as a person with "strong moral fiber" who calls out others for being disrespectful.

Dr. Shadoan was present at the office suite and treating patients on both days when Patient 1 had appointments with respondent. He did not see or hear anything unusual. Respondent called Dr. Shadoan on the evening of December 6, after receiving Patient 1's email, and they discussed the treatment respondent gave the patient and how respondent should respond. Dr. Shadoan advised respondent to communicate with Patient 1 on the phone, and not to engage in a discussion over email.

b. Eliott Blackman, D.O., has been practicing osteopathic medicine in San Francisco since 1976. As noted above, they first met when respondent was in medical school, and respondent joined Dr. Blackman's practice in 2007. They have collaborated on treatment of patients, including treating patients together at times. Dr. Blackman observed respondent to have a clear and effective communication style, and found him to be skilled and knowledgeable. Dr. Blackman described respondent as mature and appropriate, and someone who takes his position as a doctor seriously. Dr. Blackman never observed him treating women disrespectfully. There were no patient complaints of inappropriate touching or other inappropriate acts during respondent's 11 years working at Dr. Blackman's practice.

c. James Binkerd, D.O., has been a licensed osteopathic physician in California since 1986. He has been on the faculty of Touro University since 1998, and currently serves as the Associate Dean of Student Affairs. Dr. Binkerd met respondent when respondent was a medical student auditing Dr. Binkerd's two-year long osteopathic manipulative medicine course. Dr. Binkerd described respondent as an eager, avid, self-driven learner. Over the past several years, Dr. Binkerd has co-taught

several five-day long courses with respondent, where respondent has been praised. There have been no complaints about respondent touching anyone inappropriately. Dr. Binkerd has never observed respondent acting inappropriately towards women.

Dr. Binkerd believes respondent is a practitioner of the highest quality and level of skill. He would have no qualms referring his family and friends to respondent for care.

d. Annette Hulse, D.O., has known respondent for 12 years. They met at an osteopathic conference, while Dr. Hulse was in medical school. She has seen respondent at many courses and conferences over the years and has been impressed by his knowledge. Dr. Hulse is on the Board of Directors of the Osteopathic Cranial Academy and has served concurrently with respondent. Dr. Hulse has referred several patients to respondent for care and none have reported any inappropriate acts. Dr. Hulse described respondent as open, honest, earnest, good-hearted, trustworthy, and possessing a deep knowledge of anatomy, physiology, and osteopathic manipulation.

57. Two staff members from Dr. Blackman's practice wrote letters on behalf of respondent. Both were aware of the allegations in the Accusation.

a. Sami Jo Buffington worked as a receptionist for Dr. Blackman's practice during the entire time respondent worked there. She wrote that respondent always acted in professional manner, and that his patients always sang his praises and referred friends and family members to him. Buffington was also occasionally treated by respondent for migraines, and wrote that he was always professional and appropriate during treatment. She was shocked when she read the allegations in the Accusation, because respondent is the "last person" she could imagine intentionally touching a patient inappropriately.

b. Taryn Blackman is the officer manager of Dr. Blackman's practice and worked closely with respondent for 10 years. She wrote that respondent was professional and conducted himself with respect and compassion. She noted that there were no patient complaints about respondent, and that the feedback from patients was always glowing.

58. Several former colleagues from respondent's hospital practice wrote letters on his behalf.

a. Susan Rolling, R.N., works in the ICU at Sonoma Valley Hospital. She worked with respondent from 2009 through 2019. She described respondent as caring, empathetic, knowledgeable, thorough, forthright, respectful, and one of the best diagnosticians she has worked with. She lauded his patient care and clear and detailed communication with nurses. Respondent was selected by the nursing staff as the Physician of the Year in 2014. Rolling added that there no complaints about respondent during his time at the hospital. Rolling is aware of the allegations in the Accusation.

b. Pauline Headley, R.N., is a nursing supervisor at Sonoma Valley Hospital, and worked with respondent from 2009 until 2019. She wrote that respondent displayed excellent commitment, honesty, reliability, and commitment. She related that the feedback from patients about his care was always positive, that he was respectful in all his interactions with colleagues, and that there were no complaints about him during his tenure. It was unclear whether Headley was aware of the allegations in the Accusation when she wrote her letter.

c. Lawrence R. Burchett, IV, M.D., is a hospitalist and emergency room doctor who worked with respondent at Sonoma Valley Hospital and Mendocino Coast

District Hospital for 10 years. He wrote that respondent is an excellent and highly regarded physician and that there were no instances of unprofessionalism. Dr. Burchett would not hesitate to partner with him in the future. He wrote that he is aware of the Accusation pending against respondent.

d. Dennis Verducci, M.D., is an internal medicine and critical care medicine specialist at Sonoma Valley Hospital. Dr. Verducci worked with respondent for 10 years, and was the chief hospitalist with supervisory oversight for most of that time. Dr. Verducci described respondent as a hardworking and dedicated physician and intelligent and astute clinician, who always conducted himself in the utmost professional manner. He would refer patients, friends, or family to respondent without hesitation. Dr. Verducci is aware of the allegations in the Accusation.

PATIENTS

59. The following patients of respondent wrote letters and testified on his behalf. All were aware of the allegations in the Accusation.

a. Katharine Wright, an immigration attorney, has been a patient of respondent for about 10 years. She has received osteopathic manipulative treatment for injuries and chronic conditions. Prior to becoming an attorney, she worked as a sports massage therapist for about six years. Wright completely trusts respondent and finds him to be an effective practitioner and educator. She credits him with helping her keep in good shape. Respondent has never touched her inappropriately and she has never felt uneasy in his care. She has referred friends, her husband, and her daughter to respondent for treatment.

b. Maayan Greene, L.C.S.W., has been a patient of respondent for about 10 years. She sees him frequently for osteopathic manipulative treatment for chronic pain.

She trusts respondent, with whom she has developed a great relationship. She described him as supportive and having a balanced point of view. Respondent has never touched her inappropriately.

c. Rosa Lynley is a yoga teacher. She has been a patient of respondent for at least 10 years. She has sought treatment for a variety of conditions, including a shoulder injury, jaw pain, and wrist tendinitis, and she has found him to be professional, trustworthy, and compassionate. She noted that respondent asks for permission and explains his treatment as he touches her. Lynley has referred many people to respondent for care, and even brought her infant daughter for treatment. Respondent has never touched her inappropriately.

60. One patient, Marie Bourget, wrote a letter but did not testify. She has been treated by respondent for 13 years. She recently moved to St. Helena and continues to travel to San Francisco for treatment. She described respondent as an excellent physician who is open to discussing treatments and referring her to other providers. She has never had any concern for her safety and has never questioned the appropriateness of his treatment. In her experience, respondent has always been courteous and professional.

LEGAL CONCLUSIONS

1. It is complainant's burden to demonstrate the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's Certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Business and Professions Code section 2227 authorizes the Board to take disciplinary action against licensees who have been found to have committed violations of the Medical Practice Act. Business and Professions Code section 2234, included in the Medical Practice Act, provides that a licensee may be subject to discipline for committing unprofessional conduct, which includes conduct that is grossly negligent (Bus. & Prof. Code, § 2234, subd. (b)), repeatedly negligent (Bus. & Prof. Code, § 2234, subd. (c)), or incompetent (Bus. & Prof. Code, § 2234, subd. (d)). Business and Professions Code section 726 provides that a licensee may be subject to discipline for "the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer." Business and Professions Code section 2266 provides that a licensee may be subject to discipline for failing to maintain adequate and accurate records relating to the provision of services.

3. Complainant alleges that respondent's Certificate is subject to discipline for unprofessional conduct, gross negligence and/or sexual misconduct because he touched Patient 1's genital area without medical necessity. Cause for discipline was not established, in light of the matters set forth in Finding 53.

4. Complainant alleges that respondent's Certificate is subject to discipline for repeated negligent acts and/or incompetence and/or inadequate records. Cause for discipline for repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)) and inadequate records (Bus. & Prof. Code, § 726) was established, in light of the matters set forth in Finding 52. Cause for discipline for incompetence was not established.

5. In exercising its disciplinary functions, protection of the public is the Board's highest priority. (Bus. & Prof. Code, § 2229, subd. (a).) The Board is also required to take disciplinary action that is calculated to aid the rehabilitation of the

physician whenever possible, as long as the Board's action is not inconsistent with public safety. (Bus. & Prof. Code, § 2229, subds. (b), (c).)

6. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016; Cal. Code Regs., tit. 16, § 1361) provide for a minimum discipline of five years' probation and a maximum discipline of revocation for licensees who have committed repeated negligent acts or maintained inadequate medical records. In cases charging repeated negligent acts with one patient, a public reprimand may be appropriate in certain circumstances.

7. Respondent is highly regarded as a practitioner of osteopathic manipulative medicine and former hospitalist. He has many loyal patients who have benefited from his care. Respondent has been licensed for 15 years with no other discipline. The evidence did not establish the more serious allegations of gross negligence, sexual misconduct, or incompetence. It was established that respondent violated the standard of care by failing to document the requisite evaluation of Patient 1, failing to consider or document considering alternative treatments, failing to document obtaining informed consent, and failing to document the osteopathic manipulative techniques performed. Respondent's failings amounted to simple departures from the standard of care. Respondent demonstrated that he is a dedicated and caring physician and committed to practicing within the standard of care. He has improved his documentation. Revocation is not necessary for the protection of the public. The minimum recommended discipline of five years' probation is appropriate. Respondent will also be required to complete a medical record keeping course. No other special conditions are necessary.

ORDER

Physician's and Surgeon's Certificate No. A 93851, issued to respondent Matthew August Gilmartin, M.D., is revoked; however, revocation is stayed, and respondent is placed on probation for five years under the following terms and conditions.

1. Notification

Within seven 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.

2. Supervision of Physician Assistants and Advanced Practice Nurses

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

3. 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.

4. 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.

5. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

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).

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 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.

6. 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.

7. 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 in California 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 years.

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

Periods of non-practice for 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; and Quarterly Declarations.

8. 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.

9. 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.

10. 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 Certificate. 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.

11. 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.

12. Medical Record Keeping Course

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

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

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

DATE: 11/08/2021

Karen Reichmann

KAREN REICHMANN
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation Against: **Matthew August Gilmartin, M.D.** **2299 Post Street** **Suite 308** **San Francisco, CA 94115** **Physician's and Surgeon's Certificate No. A 93851,** Respondent.	Case No. 800-2018-050766 **ACCUSATION**

PARTIES

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

2. On or about January 25, 2006, the Medical Board issued Physician's and Surgeon's Certificate Number A 93851 to Matthew August Gilmartin, 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 August 31, 2021, unless renewed.

///

JURISDICTION

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

4. Section 2004 of the Code states:

> The board shall have the responsibility for the following:
>
> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
>
> (b) The administration and hearing of disciplinary actions.
>
> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.
>
> (d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.
>
> (e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.
>
> ...

5. Section 2227 of the Code provides 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.

6. 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.
>
> (d) Incompetence.
>
> ...

(f) Any action or conduct that would have warranted the denial of a certificate.

...

7. Section 726 of the Code states:

(a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this or under any initiative act referred to in this division.

8. 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.

9. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

...

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

...

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

RESPONDENT'S PRACTICE

10. Respondent lists his area of practice as Family Medicine and Complementary and Alternative Medicine. He describes his solo practice as outpatient osteopathic manipulation (OM) mostly for musculoskeletal pain.

FACTUAL ALLEGATIONS

11. Patient 1[1] first saw Respondent on November 20, 2018, because she was seeking help for pain in her left hip and leg. Patient 1 had prior care at Kaiser Permanente.

12. Patient 1 filled out a questionnaire for her first appointment with Respondent detailing her problems as: "left hip and knee pain (outer knee) and shin; left gluteal irritated; FAI [femoroacetabular impingement] and labral tear ..." The questionnaire included anatomical figures for marking physical pain where she noted pain in the left hip, left buttock; left knee and

[1] The patient is designated in this document as Patient 1 to protect her privacy. Respondent knows the name of the patient and can confirm her identity through discovery.

left shin. Patient 1 reported a prior evaluation that included a magnetic resonance image (MRI) of some part of her spine that was normal and provided an incomplete copy of a left hip MRI arthrogram documenting mild bony prominence at the femoral head/neck junction and a small tear of the anteriorsuperior labrum.

13. Patient 1 reported that since her pregnancy and delivery 3.5 years earlier, pain had limited her walking, hiking, jogging and yoga. Patient 1 shared that her vaginal delivery was complicated with a 68-hour labor. Patient 1 also said that she carried her child on her left hip which might be contributing to her problems. Patient 1 had a history of athletic activity over her life including gymnastics, field hockey, soccer, and lacrosse before college, then yoga and some dance.

14. To manage the pain, Patient 1 was taking 400 mg of ibuprofen and a variety of non-prescription herbal or other supplements. Over the years she had been dealing with this problem, Patient 1 had tried other treatments including physical therapy, acupuncture, ice, and topical agents.

15. Patient 1 only saw Respondent twice before terminating treatment with Respondent after the second visit, on December 6, 2018, when Respondent touched her vulva without medical necessity.

16. On December 6, 2018, during Patient 1's second visit to his office, Respondent placed his hand over Patient 1's vulvar structures without medical necessity while he was performing osteopathic manipulation treatment [OMT]. Patient 1 was wearing thin black leggings during the OM treatment when this occurred. Specifically, Patient 1 reported that, while she was lying face down on the treatment table, Respondent reached under her body and placed his hand on her "vagina." More specifically, she said one or more of his fingers pressed lightly on her vagina while, what felt like, his thumb applied pressure to her pubic bone right above her labia. This position was held for several minutes.

17. Respondent's records do not provide any medical basis or explanation for touching Patient 1 in the manner described (there is no discriminating detail about which OMT maneuvers were actually performed, upon which body structures or where his hands were placed to effect

those maneuvers). Further, the scant information Respondent does list in Patient 1's records does not provide any basis for the touching of the vulvar structures.

18. Patient 1, shocked at how she was being touched but confused about whether this was an appropriate medical procedure, did not object at the moment of the touching. When the treatment was over she managed to complain to Respondent about the work he did in her "pelvic area." Patient 1 said that Respondent told her that he was sorry he made her uncomfortable and that he then proceeded to explain the structures of the pelvis –"something about it being shaped like a Mercedes sign"- and apologized for making her uncomfortable. Patient 1, still shaken, pretended everything was normal and gave Respondent her credit card to pay for the appointment.

19. Respondent's December 6, 2018, case note has an addendum acknowledging Patient 1's complaint before she left his office:

> NOTE: Pt said at end of appointment that she had been taken aback by my work in her groin area without asking permission (I had asked for permission to palpate the area of her ischial tuberosities and pevlic [sic] floor earlier and she had said "it's fine"

Neither the work described in this addendum note, nor the referenced informed consent, were written in the earlier documentation of either visit.

20. Respondent's post-complaint addendum offers more detail on his treatment than any other note in Patient 1's file, but still gives no medical basis for the touching. All of the muscular structures named by the Respondent in his note and interview as potentially causing the Patient's symptoms lie outside of the pelvic outlet described by Patient 1, and except for the gluteus maximus, are all deep structures not easily directly palpated externally.

21. Upon leaving the office Patient 1, still shaken, immediately called her sister to report what had happened to her at the doctor's visit and she shared the conduct with her husband that evening. She also called a friend who is a medical doctor because she wanted to make sure that she was not misconstruing the touching that had felt so inappropriate and unnecessary.

22. On the evening of December 6, 2018, Patient 1 sent the Respondent an email repeating her prior complaint in his office, this time specifically accusing him of touching her vagina. Patient 1 wrote:

Dr. Gilmartin,
I'm requesting a full refund for the treatment provided earlier today, December 6th. I'm beyond unsatisfied. You informed me that you planned to touch my abdomen and buttocks and asked for my permission, I consented and relaxed on your table. I was nearly asleep when I noticed that your hand was touching my vagina. I quickly became extremely alert, tense and uncomfortable. My level of discomfort and lack of trust for you prevented the session from being effective. Frankly, I'm surprised that you asked me for my credit card after the session given that I told you about my discomfort at the completion of the session. Your speedy resolution of this matter is appreciated.
Thank you,
[Patient 1]

23. Respondent, despite being explicitly accused of touching Patient 1's vagina, did not deny or refute Patient 1's description. Respondent only wrote back:

[Patient 1],
Of course I will give you a full refund. I am so sorry for this misunderstanding. My goal is to always have my patients feel comfortable under my care, in addition to the resolution of the clinical problem that I am treating.
If you would like to, we can discuss this further by phone tomorrow. I can be available at lunch or at the end of the day.
I will also process the refund tomorrow. ...
Matthew Gilmartin

24. Within a week, on December 13, 2018, Patient 1 emailed a complaint to the Medical Board.

25. At the Board interview, Respondent conceded, for the first time, that there was no medical reason for him to touch her vulvar structure:

...The treatment that I did for her when she was prone you know, involved the treatment of the musculoskeletal system exclusively. Um – I treated her for --um—muscles that are in the region of the groin, in the pelvis. Including the iliopsoas, the tensor fascia lata, the adductor magnus.

Um – manipulation involves for the most part direct contact to those muscles. Um—and—uh—you know, frequently they will involve pressure in order to bring them back, bring about relaxation of muscles that are in spasm.

Um—you know, at no time would I have touched her genitals. Uh—at no time would I have –uh—touched an area close to the genital –uh—or genitals except –uh—the fact that some of those muscles are –um—anatomically close –umm... I mean, I –I certainly didn't touch her vagina. I didn't touch her clitoris. I didn't touch her –um—you know, I didn't touch her genitalia.

///

26. Respondent's general treatment of Patient 1, and the documentation of the treatment, were also below the standard of care.

27. Respondent's evaluation of Patient 1's areas of complaint were deficient. The standard of care for evaluating leg pain radiating from the gluteal (buttock) region to the shin is to perform enough of a physical examination to reasonably determine one or more potential causes of the patient's symptoms to justify that subsequent treatment is both germane to the postulated cause or causes and does not omit pertinent necessary interventions for those causes. To differentiate among the different possibilities, the standard of care is to perform, at a minimum, at least a cursory examination of the lumbar nerve root function encompassing the strength of the lower extremity joint flexion and extension, sensation of the overlying skin, and documentation of the hip and knee range of motion adequacy. Respondent either did not perform such examinations and/or did not document such examinations.

28. Not only was the examination incomplete and/or undocumented – to the extent Respondent did document his examination, such documentation was unintelligible to a reviewing medical doctor. Respondent documented with non-standard abbreviations that required clarification at the Board interview.

29. Respondent's case note for his physical examination and findings on the first visit, November 20, 2018, reads simply:

> **Objective**
> Extremities
> standing/seated flexion negative[2]
> S/S[3] intact bilateral LE
>
> L TFL [tensor facia lata], IP[4], OI[5], glut max spasm
> L femur IOS[6]
>
> L SI S pole restriction

[2] Per Respondent: "So that's the flexion of the sacroiliac joint –um—when it's -- it's a classic osteopathic physical exam. Where you assess the uh – the function of the sacroiliac joint from the seated position and from a standing position."
[3] Per Respondent: "S/S. So that's strain and sensation."
[4] Per Respondent: IP stands for "Iliopsoas"
[5] Per Respondent: OI stands for "Obturator internus"
[6] Per Respondent IOS stands for "Intraosseous strain"

Lfibular head restriction

a/p
hip pain – myofascial pain

30. Respondent's second case note for his physical examination and findings on December 6, 2018, was no more thorough or intelligible:

Objective
Extremities
Seated/standing tests negative
Step test negative[7]

L IP/piriformis/adductor magnus spasm
L immonimate IOS
L SI restriction
L femur IOS
L fibular head restricted
L anterior compartment tight
Anterior diaphragm restricted

a/p
L labral tear
Hip pain

31. Respondent's bills for the visits share slightly different, but equally vague, information:

Respondent's bill for the November 20, 2018, visit has checked boxes for:

Somatic Dysfunction: S.D. Lumbar; S.D. Sacral
Spine: Sciatica

Respondent's bill for the December 6, 2018, visit has checked boxes for:

Somatic Dysfunction: S.D. Pelvic; S.D. Lower Ext
Extremities: Hip Pain; Knee pain

32. Neither of the Respondent's examinations document hip or knee range of motion for deficits, nor strength of flexion and extension of the hip or knee. At Respondent's Board interview there was reference to an "intact" sensory examination of the legs but no description of the locations of the overlying skin where this was tested to adequately exclude nerve root

[7] Per Respondent "I did misstate that. But I noted her gait. Her gait, the step of her gait was negative. She had a normal gait." "Gait. It should have said "gait testing."

compression at any of the five lumbar vertebrae (bones of the spine). Such a minimal exam is warranted to confirm the unsubstantiated patient report of an antecedent normal lumbar spine MRI and to rule out bony joint disease that would be inappropriate for Respondent's OMT interventions.

33. Respondent acknowledged that he knew Patient 1 might need a referral to another specialist but still did not adequately document the diagnosis or treatment. When asked if he considered referring Patient 1 to orthopedics, rheumatology or any other specialty given the "left labral tear" Respondent replied:

> ...Uh--- you know, it always remains a conversation in my care of patients. That osteopathy may work for them. I --- as I recall, I discussed with her and I certainly discuss with every patient that comes to me with FAI and a labral tear that the prognosis is guarded for –um—uh—conservative management, which is what I consider my care part of. Given her extensive history, sports as a young person, and the length of time that she suffered for, absolutely. She –I –I was very guarded in my – my assessment of the role of osteopathy in resolving her issue.

None of these advisements, if given, were documented.

34. Respondent acknowledged in his interview that he does not document informed consent:

> I don't have a signed informed consent, but I do have standard things that I say to patients that include –um—you know, for example, if someone tells me that their labral tear, I would have mentioned that on her phone call to me. Um—that my experience with treat – labral tear is mixed. I can help some people, and they're satisfied. Other people after treatments may decide I cannot help them, and they need to move on.

35. There was no documentation that Patient 1 was given a description of the procedure he performed, alternatives to the procedure, risks of the procedure, or gave verbal or written consent to proceed (other than the retrospective addendum on the second visit addressed in paragraph 19 of this Accusation). Additionally, Respondent did not adequately document the treatment Patient 1 actually received.

36. The standard of care in documenting treatment is to provide an adequate account of the intervention allowing identification of the anatomic structures treated, the side of the body

treated, and a description of the treatment. The treatment description at a minimum should include terms having a standard definition in the medical literature or a step-by-step description of the actions performed in more complex treatment interventions subject to variation applied at the time of treatment determined by individual findings.

37. The case notes for both appointments documented the treatment given as "gentle omt" with no further detail. Respondent's billing record has slightly more detail since he checks off boxes for "OMT Procedures: OMT 7-8 areas." Missing from the documentation is what maneuvers were performed and to which body areas or structures.

38. Respondent's recording of "gentle OMT" and billing of "7-8 areas" does not permit identification of which bones, muscles, tendons, or ligaments were treated, the side treated, the duration, if pertinent, that the treatment was applied, the technique used for the manipulation if not described in terms having a standard definition in the medical literature, how the patient tolerated or responded to the treatment, or absence of immediate complications while in the office. No subsequent treating physician could review those records and understand in detail what treatment had been performed on Patient 1.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Sexual Misconduct)

39. Respondent is guilty of unprofessional conduct and his certificate is subject to discipline pursuant to sections 2234 (unprofessional conduct), 2234(b) (gross negligence), and/or 726(a) (sexual abuse or misconduct) of the Code, including but not limited to the following: Respondent touched Patient 1's genital area without medical necessity.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts and/or Incompetence and/or Failure to Maintain Adequate Records)

40. Respondent is guilty of unprofessional conduct and his certificate is subject to discipline pursuant to 2234(c) (repeated negligent acts), and/or 2234(d) (incompetence), and/or 2266 (inadequate records) of the code, including but not limited to the following:

A. Respondent failed to properly take and/or document a hip and knee range of motion and strength testing in assessment of pain spanning Patient 1's joints.

B. Respondent failed to consider and/or document other more appropriate interventions other than the osteopathic manipulation treatment provided.

C. Respondent failed to provide and/or document that Patient 1 was provided a description of the procedures, alternatives, risks, or gave consent to proceed (informed consent).

D. Respondent failed to describe with any detail the osteopathic manipulation treatments performed.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 93851, issued to Matthew August Gilmartin, M.D.;

2. Revoking, suspending or denying approval of Matthew August Gilmartin, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Matthew August Gilmartin, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent, if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: OCT 30 2020

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

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