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

In the Matter of the Accusation Against: Vardui Asiryan, M.D. Physician's and Surgeon's Certificate No. A 128242 Respondent.	Case No.: 800-2019-062110

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 March 18, 2022.

IT IS SO ORDERED: February 16, 2022.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against:

VARDUI ASIRYAN, M.D.,

Physician and Surgeon's Certificate No. A 128242,

Respondent

Agency Case No. 800-2019-062110

OAH No. 2021040152

PROPOSED DECISION

Julie Cabos-Owen, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on December 13, 14, 15, 16, and 17, 2021. William Prasifka (Complainant) was represented by Vladimir Shalkevich, Deputy Attorney General. Vardui Asiryan, M.D. (Respondent) was represented by Nicholas Jurkowitz, Attorney at Law, with Fenton Law Group, LLC.

At the hearing, the ALJ was provided with Exhibits 7, 8, 12, F, G, H, I, J, and K, which all contained confidential information protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not provide adequate privacy protection. In order to prevent the disclosure of

confidential information, the ALJ issued a Protective Order providing that the Exhibits 7, 8, 12, F, G, H, I, J, and K, shall be placed under seal following their use in preparation of the Proposed Decision. These exhibits shall remain under seal and shall not be opened, except by order of the Medical Board of California (Board), by OAH, or by a reviewing court. A reviewing court, parties to this matter, their attorneys, or a government agency decision maker or designee under Government Code section 11517 may review the documents subject to this order provided that such documents are protected from release to the public.

Patients testified at the administrative hearing. In order to protect their privacy, they are referred to herein as Patient 1 and Patient 2.

Testimony and documents were received in evidence. The record closed and the matter was submitted for decision on December 17, 2021.

FACTUAL FINDINGS

Jurisdictional Matters

1. On December 27, 2013, the Board issued Physician's and Surgeon's Certificate Number A 128242 to Respondent. That license is scheduled to expire on October 31, 2023.

2. On February 5, 2021, Complainant filed the Accusation while acting in his official capacity as the Executive Director of the Board. Respondent filed a Notice of Defense, and this hearing ensued.

Respondent's Background and Training

3. Respondent was born in Armenia, and she graduated from medical school there before completing an obstetrics and gynecology (Ob-Gyn) residency in Russia. Thereafter, Respondent immigrated to the United States (US), passed the US Medical Licensing Examination, and completed another Ob-Gyn residency at Bronx Lebanon Hospital in New York. Since the beginning of residency, Respondent has had extensive training and experience in performing ultrasound examinations (both transvaginal and abdominal) on pregnant patients. In 2017, Respondent was certified by the American Board of Obstetrics and Gynecology.

4. Respondent moved to California and worked in Riverside for several years before obtaining hospital privileges at Glendale Adventist Medical Center (GAMC) in Glendale and at Providence St. Joseph Medical Center (St. Joseph) in Burbank. After resigning her privileges at GAMC, Respondent has maintained privileges at St. Joseph.

5. Respondent operates a solo Ob-Gyn practice in Burbank, and she shares office space with another Ob-Gyn. In her office, Respondent uses an ultrasound machine she leased brand-new in 2016, which is similar to prior machines she used, and on which she received training and orientation. Respondent sees mostly adult patients, with the rare patients aged 16 or 17. Respondent employs a front office staff person, a medical assistant, and billing staff, but does not employ any nurses.

Patient 1

JUNE 21, 2018 VISIT

6. On June 21, 2018, Patient 1, then 39 years old, visited Respondent's office for a gynecological exam and suspected pregnancy. Patient 1 had previously lived in Armenia, where she had trained and worked as a pharmacist.

7. Respondent's medical records for that date noted a last menstrual period (LMP) of "May 24 regular." (Exhibit 7, p. A52.) The patient also had a history of myomectomy, which is the surgical removal of uterine fibroids.

8. Respondent conducted a "Review of Systems" with Patient 1, asking about any abnormalities. In the chart, Respondent documented the following:

> Review of Systems:
>
> GENERAL: no weakness, no fatigue, no fever, no significant weight change
>
> SKIN: no rash, no lumps, no sores, no itching, no dryness, no color change, no changes in hair or nails
>
> HEENT: no headache, no head injury, no dizziness, no lightheadedness, no vision changes, no hearing problems, no tinnitus, no vertigo, no earaches, no nasal stuffiness, no nasal discharge, no nosebleeds, no sinus trouble, no dry mouth, no hoarseness
>
> NECK: no lumps, no lymphadenopathy, no goiter, no pain, no stiffness

BREASTS: no lumps, no pain or discomfort, no nipple discharge

CARDIOVASCULAR: no chest pain or discomfort, no palpitations, no dyspnea, no orthopnea, no paroxysmal nocturnal dyspnea, no edema

RESPIRATORY: no cough, no sputum, no hemoptysis, no dyspnea, no wheezing

GASTROINTESTINAL: no trouble swallowing, no heartburn, no nausea, no vomiting, no diarrhea, no rectal bleeding or tarry stools, no constipation, no abdominal pain, no food intolerance

URINARY: no polyuria, no nocturia, no urgency, no burning or pain on urination, no hematuria, no urinary infections, no kidney stones, no incontinence, no dribbling GENITAL: no dysmenorrhea, no menopausal symptoms, no postmenopausal bleeding, no vaginal discharge, no itching, no sores, no lumps, no dyspareunia

PERIPHERAL VASCULAR: no intermittent claudication, no leg cramps, no varicose veins MUSCULOSKELETAL: no muscle or joint pains, no stiffness, no arthritis, no gout, no backache, no swelling, no redness, no pain, no tenderness, no limitation of motion NEUROLOGIC: no fainting, no blackouts, no seizures, no weakness, no paralysis, no numbness or loss of sensation, no tingling, no tremors or

> other involuntary movements ENDOCRINE: no heat or cold intolerance, no excessive sweating, no excessive thirst or hunger, no polyuria, no change in glove or shoe size
>
> PSYCHIATRIC: no nervousness, no depression, no memory change

(Exhibit 7, pp. A52-A53.)

9. In the chart, Respondent documented the following findings from a physical examination:

> GENERAL: AAOx3, NAD, normal level of consciousness, good personal hygiene[;]
>
> SKIN: no lesions, no rash[;]
>
> NECK: Supple. No lymphadenopathy/tenderness (-) thyromegaly[;]
>
> CARDIOVASCULAR: RRR, no JVP, no carotid bruits, no murmurs, rubs or gallops, S1 S2 present, no S3, no S4[;]
> LUNGS: CTAB, no adventitious sounds[;]
>
> ABDOMEN: soft, non-tender, non-distended, no surgical scars, no trauma on inspection, normal bowel sounds all 4 quadrants, no masses noted on light or deep palpation, no CVA tenderness, no hepatosplenomegaly, no rebound tenderness[;]

> MUSCULOSKELETAL: normal muscle tone/bulk, no deformities, normal range of motion, normal spine alignment[;]
>
> BREASTS: no masses noted, no lymphadenopathy, no nipple discharge, no tenderness[;]
>
> EXTREMITIES: no varicose veins, no edema, no abnormal movements, no tremor, no rigidity, normal alignment, normal gait[.]

(Exhibit 7, p. A53.)

10. Respondent also documented a gynecological exam as follows: "[Sterile Speculum Exam (SSE)]: no abnormal discharges, no abnormal lesions, no [cyst, mass, tumor (CMT)], cervix closed uterus normal size, no adnexal masses palpated." (Exhibit 7, p. A53.)

11. Patient 1 testified at the administrative hearing that Respondent did not examine her breasts or reproductive system on June 21, 2018. Instead, Patient 1 recalled that, after taking her history, Respondent had her provide a urine sample, and she did not return to the examination table for further examination. Patient 1 recalled Respondent then gave her "a paper" to take to a laboratory, and she went to the laboratory that "same day." However, the documentation from the laboratory indicates Patient 1 went to the laboratory on June 27, 2018, not June 21, 2018. Given this discrepancy and the number of years that have passed since the June 21, 2018 visit, Patient 1's recollection of whether any examination occurred is given less weight than that of Respondent's documentation of the June 21, 2018 visit, set forth in Factual Findings 9 and 10.

12. Patient 1's urine test on June 21, 2018 came back as "light positive" for pregnancy, and Respondent's assessment was that Patient 1 was pregnant. To confirm the urine test, Respondent's plan was to have Patient 1 undergo a quantitative human chorionic gonadotropin (HCG) test, which determines the specific level of HCG in a patient's blood. If the HCG test was positive, Respondent would schedule a transvaginal ultrasound, also known as a transvaginal sonogram (TVS). As documented in the medical record, Respondent noted, "HCG [quantitative,] schedule for TVS if HCG also pos[itive], since [urine chorionic gonadotropin] was light positive." (Exhibit 7, p. A54.)

13. On June 27, 2018, Patient 1's HCG level was measured at 2,046 mIU/mL. (Exhibit 7, p. A59.) This confirmed Patient 1's pregnancy.

14. After June 27, 2018, Respondent did not check Patient 1's HCG levels to determine whether they were increasing because she does not do so unless she is "concerned about . . . ectopic pregnancy." (Exhibit 9, p. A418.)

JULY 5, 2018 VISIT

15. On July 5, 2018, Patient 1 returned to Respondent's office and began prenatal care. Respondent documented Patient 1's obstetrical history, noting she had one pregnancy carried to term in 2001, resulting in a normal vaginal delivery of a baby girl, and a prior miscarriage in 2007 at 10 weeks gestation. Respondent again noted Patient 1's prior myomectomy. No details were elicited about the myomectomy.

16. At the July 5, 2018, visit, Patient 1's LMP was incorrectly documented as May 10, 2018, and her estimated due date (EDD) was February 15, 2019, 40 weeks from the documented LMP. However, Patient 1's EDD based on her correct LMP

(5/24/18) was February 28, 2019. Consequently, at the July 5, 2018 visit, Patient 1 was at approximately six weeks estimated gestation based on her correct LMP and EDD.

17. Respondent did not conduct a full physical examination of Patient 1 on July 5, 2018. Nevertheless, Respondent's medical record for the July 5, 2018 visit documented the following findings from a physical examination:

> General and Pelvic Exam: HEENT: NORMAL, FUNDI: NORMAL, TEETH: NORMAL, THYROID: NORMAL, BREASTS: NORMAL, LUNGS: NORMAL, HEART: NORMAL, ABDOMEN: NORMAL, EXTREMITIES: NORMAL, SKIN: NORMAL, LYMPHNODE: NORMAL, VULVA: NORMAL, VAGINA: NORMAL, CERVIX: NORMAL, UTERUS SIZE: NORMAL, ADNEXA: NORMAL, RECTUM: NORMAL, DIAGONAL CONJUGATE: NORMAL, SPINES: NORMAL, SACRUM: NORMAL, SUBPUBICARCH: NORMAL, GYNECOD PELVIC TYPE: NORMAL

(Exhibit 7, p. A55.)

18. At the administrative hearing, Respondent explained the July 5, 2018 examination findings noted above were "auto-populated" by the electronic medical records program. However, Respondent never sought to correct the information that had been automatically populated to ensure the accuracy of the medical record.

19. Respondent's medical record for July 5, 2018, also included a separate notation of "Cervical exam l/c/p" which documented Respondent's examination of Patient 1's cervix to confirm it was long and closed.

20. At the July 5, 2018 visit, Respondent conducted a TVS to confirm Patient 1's pregnancy and to determine viability. Respondent documented her TVS findings, noting she could see a gestational sac and a yolk sac, and that the patient's ovaries were "normal." (Exhibit 7, p. A56.) Respondent's plan was to have Patient 1 return in two weeks for a follow-up visit and TVE "to confirm fetal pole and heartbeat." (*Ibid.*) (A fetal pole, also called an embryo, is the first TVS imaging of the fetus, manifesting as a thickening line, and appearing at about six weeks gestation.)

21. Respondent did not order quantitative HCG testing at the July 5, 2018, visit. She explained in a Board interview (on September 8, 2020) that, after previously noting the patient's HCG level at 2,000, she conducted the July 5, 2018, TVS and saw the gestational sac and the yolk sac. (Exhibit 9, p. A428.) Consequently, Respondent confirmed Patient 1 had an intrauterine pregnancy, and she was "not concerned about the ectopic pregnancy. That's what the whole point of my training was. We do quant[itive HCG testing] because we're concerned about the ectopic pregnancy. If I see the yolk sac then it's intrauterine pregnancy." (Exhibit 9, p. A425.)

22. Respondent estimated that once she sees the yolk sac, the patient is at about five to six weeks gestation. Respondent told Patient 1 to return July 19, 2018, to make sure they could see a fetal heartbeat to confirm a viable pregnancy. (Exhibit 9, p. A491.)

JULY 19, 2018, VISIT

23. On July 19, 2018, Patient 1 returned to Respondent's office for a follow-up visit. Respondent's medical record for this date contained identical documentation of Patient 1's obstetrical and gynecological history as the medical record from the July 5, 2018, visit. (See Factual Finding 15.)

24. At this visit, Respondent's medical record for Patient 1 documented the correct LMP of May 24, 2018, and the correct EDD of February 28, 2019. At this visit, Patient 1 was at approximately eight weeks estimated gestation.

25. Respondent did not conduct a full physical examination of Patient 1 on July 19, 2018, but instead conducted only a TVS. Nevertheless, Respondent's medical record for the July 19, 2018, visit documented the same inaccurate findings reflecting a physical examination as was documented in the July 5, 2018, record. (See Factual Finding 17.) However, Respondent never sought to correct the information that had been automatically populated to ensure the accuracy of the medical record.

26. For the July 19, 2018, visit, Respondent documented her TVS findings and plan as follows: "TVS done, enlarged yolk sac, no fetal pole identified, [patient] given option to go for second opinion, or expectant management, or medical [termination of pregnancy (TOP)] and [dilation and curettage (D&C)]. She wants to have an expectant management." (Exhibit 7, p. A58.)

27. At the July 19, 2018, TVS, 14 days after seeing the yolk sac, Respondent was seeking to confirm the fetal heartbeat because she was "supposed to" see a fetal pole and a fetal heartbeat beginning at "11 days minimum" from seeing the yolk sac. (Exhibit 9, p. A431.) However, Respondent did not see anything except an enlarged yolk sac. At that point, Respondent believed Patient 1 did not have a normally developing pregnancy.

28. Respondent did not order quantitative HCG testing at the July 19, 2018, visit because (as noted in Factual Finding 21, she does not order a quantitative HCG testing if she has already seen the yolk sac. (Exhibit 9, p. A436.)

29. After Respondent informed Patient 1 of the July 19, 2018 TVS findings, Patient 1 recalled Respondent explaining she had the option to consult with another Ob-Gyn to confirm her pregnancy was not developing. However, Respondent never mentioned the option of undergoing a "formal ultrasound."

30. At her Board interview and at hearing, Respondent explained that when offering Patient 1 the option of seeking a "second opinion," Respondent understood this to mean a "formal ultrasound." (Exhibit 9, p. A432.) Respondent did not specifically explain to Patient 1 that "second opinion" meant a "formal ultrasound." Respondent asserted that Patient 1 was "well educated" in what "second opinion" means. (Exhibit 9, p. A451.) However, Respondent did not clarify how Patient 1 had been "well educated" to know that "second opinion" meant "formal ultrasound."

31. Patient 1 was reluctant to accept her pregnancy was not progressing, so Respondent and Patient 1 finally agreed that Patient 1 would return in a few days so Respondent could perform another TVS.

JULY 24, 2018, VISIT

32. On July 24, 2018, Patient 1 returned to Respondent's office for a follow-up TVS. Respondent's medical record for this date contained identical documentation of Patient 1's obstetrical and gynecological history as the medical record from the July 5 and July 19, 2018, visits. (See Factual Findings 15 and 23.)

33. Respondent did not conduct a full physical examination of Patient 1 on July 24, 2018, but instead conducted only a TVS. Nevertheless, Respondent's medical record for the July 24, 2018, visit documented the same inaccurate findings reflecting a physical examination as was documented in the July 5 and July 19, 2018 records. (See Factual Findings 17 and 25.) However, Respondent never sought to correct the

information that had been automatically populated to ensure the accuracy of the medical record.

34. For the July 24, 2018, visit, Respondent documented her TVS findings and plan as follows:

> TVS enlarged yolk sac, no [fetal pole], [patient] given options to go for second opinion or have an expectant management[.] On my opinion she has most likely missed abortion and other options also provided[:] medical TOP and D&C, she wants to have a medical TOP, but states her blood type is neg[ative;] Will check CBC and type and screen and we will order RhoGAM[.] Bleeding precautions given.

(Exhibit 7, p. A68.)

35. After the July 24, 2018, TVS, Respondent reaffirmed her belief the pregnancy was not progressing normally. At the estimated eight and one-half weeks gestation, she should have seen a fetal heartbeat. Respondent provided Patient 1 her assessment of a nonviable pregnancy due to the lack of fetal heartbeat, and she gave alternatives to Patient 1. The alternatives given to Patient 1 included seeking a second opinion, waiting to see what happened by "expectant management," having medical TOP by oral medication, or undergoing surgical TOP by D&C. After their discussion, Respondent understood that Patient 1 selected medical TOP. (Exhibit 9, pp. A497-499.)

36. On July 24, 2018, Respondent provided Patient 1 with a prescription for misoprostol, also known by the brand name Cytotec.

37. Because Patient 1 mentioned she was Rh-negative, on July 24, 2018, Respondent ordered a blood test to determine whether Patient 1 would also need to be given Rho-GAM to prevent complications from bleeding during the pregnancy termination. The results of that blood test confirmed Patient 1 was Rh-negative.

38. On July 24, 2018, Respondent wrote a prescription for RhoGAM for intramuscular injection. There was no documentation in Patient 1's medical record that anyone at Respondent's office ever administered Patient 1 the RhoGAM.

39. In her Board interview, Respondent explained that her office sends the prescription for the RhoGAM, along with insurance authorization approval, to an approved pharmacy which then delivers the medication to Respondent's office. (Exhibit 9, p. A 439.) Once the medication is delivered, someone at Respondent's office will administer the intramuscular injection. Respondent asserted that Patient 1 was administered the RhoGAM in Respondent's office before taking the misoprostol. (Exhibit 9, p. A483.) Respondent insisted that it was administered by her "nurse" when Respondent was on vacation and "not in the city," (exhibit 9, p. A484), but acknowledged there was no documentation in Respondent's records of the RhoGAM injection. Respondent insisted it was her "nurse['s] fault," and the nurse does not work with her anymore. (Exhibit 9, p. A484.) In her testimony, Respondent confirmed she did not employ a nurse but instead had a certified medical assistant trained to document any injections given. Respondent did not remember who purportedly administered the injection.

40. During the July 24, 2018 visit, Patient 1 understood Respondent was about to leave on vacation, and she now recalls Respondent seeming rushed during the TVS. Patient 1 insisted Respondent did not advise her at this appointment that she could seek a second opinion, but instead just wrote the prescription for misoprostol

and ordered a blood test. Respondent credibly denied rushing through the June 24, 2018 TVS. She noted that she first focused on Patient 1's uterus to determine pregnancy viability and, after the focused examination, she also looked at the patient's ovaries as depicted in TVS images in Patient 1's medical record. However, Respondent admitted she conducted the July 24, 2018 TVS to make the patient "comfortable" with her assessment, but she did not believe she would find anything different from the July 19, 2018 TVS.

41. Respondent did not conduct any additional quantitative HCG testing between the July 19 and July 24 appointments. In her Board interview, she explained that she orders quantitative HCG testing "in the beginning when I'm not sure about the intrauterine pregnancy or not.]" (Exhibit 9, p. 502.) "I do bloodwork when I suspect something -- ectopic pregnancy. . . . [W]hen you see the yolk sac, we don't usually do the -- go by the quant[itative HCG]." (Exhibit 9, p. A500.) Once Respondent confirms intrauterine pregnancy, she will follow up with ultrasound only. Respondent noted she was not trained to order serial quantitative HCG testing after confirming an intrauterine gestational sac and yolk sac via ultrasound.

42. Respondent provided Patient 1 with verbal, but not written, instructions on how to take the misoprostol. However, Respondent did not document providing those verbal instructions. Respondent noted that Patient 1 was trained as a pharmacist in Armenia and was well educated regarding medications. (Exhibit 9, pp. A441.)

43. As documented in the July 24, 2018 medical record, bleeding precautions were given, and Respondent recalled she "usually" explains when to go to the emergency room for abnormally heavy bleeding, and "just those . . . instruction[s] I do provide before giving this type of medication and I don't give them so frequently[.]" (Exhibit 9, p. A443.)

44. Patient 1 testified Respondent explained about bleeding but did not explain how else the misoprostol would affect her, including cramping. However, in her complaint to the Board, Patient 1 noted, "I was told that the pill would cause cramping and that within 4-5 hours, the fetus would be discharged from the body." (Exhibit 6, p. A48.) Patient 1 also testified that, as trained pharmacist, she was familiar with pregnancy terminating medications like misoprostol and with their effects on pregnant women.

45. Patient 1 did not take the misoprostol immediately because she was not convinced her pregnancy was not developing. However, Patient 1 also testified somewhat inconsistently that she did not seek a second opinion from another Ob-Gyn at that time because she trusted Respondent, who told her "for sure" the pregnancy "did not develop."

46. Patient 1 took the misoprostol on July 26, 2018. (Exhibit 8, p. A304.) That night, she began experiencing severe cramping in her back and abdomen.

47. Patient 1's complaint to the Board asserted, "I began feeling horrific stomach cramping unlike what was described as a side effect of the drug. After approximately 8 hours of unbearable pain, on July 27, 2018, I begged my family to take me to the emergency room." (Exhibit 6, p. A48.) However, Patient 1's testimony at the administrative hearing contradicted the assertions in her Board complaint. Patient 1 testified that, as a pharmacist, she knew the effects of misoprostol, and the cramping and pain she experienced was at an expected level. Patient 1 also testified she decided to go to the emergency room so "they could do the abortion," because she had not begun bleeding yet to "clean out" the pregnancy.

JULY 27, 2018, VISIT TO GAMC

48. On July 27, 2018, Patient 1 went to the emergency room (ER) at GAMC complaining of abdominal pain after taking misoprostol the day prior. She denied bleeding or vaginal discharge. Patient 1 informed ER staff she was told to return to the doctor to get a Rho-GAM injection once the TOP was complete. (Exhibit 8, p. A304.)

49. Patient 1 was administered RhoGAM at GAMC. (Exhibit 8, p. A97.)

50. While at GAMC, Patient 1 underwent a TVS and transabdominal ultrasound with the following findings:

> Findings: [S]ingle intrauterine gestational pregnancy is seen in the fundal endometrium. The gestational sac measures 1.6 cm, corresponding to 5 weeks, 6 days gestation. Positive yolk sac and fetal pole are seen. The crown-rump length of the fetal pole measures 3.2 mm, corresponding to 6 weeks, 0 days gestation. Positive fetal heart tones are elicited at 118 bpm. Small subchorionic hemorrhage is noted. Trace free fluid is seen in the pelvis adjacent to the left ovary. Probable 1.2 cm corpus luteal cyst in the right ovary. Left ovary is unremarkable.
>
> Impression: Single living [intrauterine pregnancy] with estimated gestational age for ultrasound of 6 weeks, 0 days. Small subchorionic hemorrhage. No suspicious adnexal mass. Small free fluid in the pelvis.

(Exhibit 8, pp. A375 and A355.)

51. On July 27, 2018, Patient 1's HCG level was measured at 23,987 mIU/mL. (Exhibit 8, p. A387.)

52. An ER physician's chart note for July 27, 2018 documented the following discussion and plan prior to Patient 1's discharge:

> Patient's cramping resolved . . . Spoke to the patient's OB/GYN physician who is recommending the patient get progesterone 200 mg [three times per day] per vagina. I reviewed all findings with the patient. Patient states that she is a pharmacist from Armenia had actually done her research. She herself is requesting progesterone as well. Advise her that I'm not aware of the effects of progesterone on pregnancy or reversal of Cytotec. However patient, her husband, and her OB/GYN wished the patient to be on progesterone starting today. Patient was advised to follow with her OB/GYN as scheduled. Patient's OB/GYN actually spoke with her over the phone and set up an appointment with the patient. I had also spoken with on-call OB/GYN physician who advised me that there is no contraindication for progesterone and agrees with treatment plan.

(Exhibit 8, p. A305.)

53. Respondent recalled feeling confused and shocked upon receiving the telephone call from the ER physician about the ultrasound results and fetal heartbeat. Respondent asked to speak to Patient 1 and explained the ultrasound results. Patient 1 was very upset and hung up on Respondent. Respondent's staff set up a follow-up

appointment for five days later, on August 1, 2018, because Respondent was on vacation.

54. Respondent was unable to examine Patient 1 on August 1, 2018. Patient 1 was still very upset. She obtained a copy of her medical records and left.

AUGUST 5, 2018 VISIT TO GAMC

55. On August 5, 2018, Patient 1 returned to the GAMC ER due to abdominal pain, heavy vaginal bleeding, and the passage of some tissue. An ultrasound that day showed an empty uterine cavity with no intrauterine pregnancy, but with some retained products of conception. Patient 1's HCG level was measured at 6,022 mIU/mL. (Exhibit 8, p. A380.) The physician determined there was an abortion in progress, diagnosed an incomplete spontaneous abortion, and recommended a D&C. The D&C was completed, and Patient 1 was discharged.

56. Patient 1 has a malpractice lawsuit pending against Respondent.

RESPONDENT'S POSITION RE: PATIENT 1 TREATMENT

57. Respondent insists her diagnosis and prescription for misoprostol were correct. Respondent denies incorrectly estimating Patient 1's gestation. Respondent noted that gestational age is determined using the first day of a patient's LMP. Patient 1's LMP of May 24, her light positive urine test on June 21, her HCG level of 2,046 mIU/mL of on June 27, and Respondent's ability to see the yolk sac on July 5, 2018, all confirmed Patient 1's estimated gestational age. Respondent maintained that the absence of a fetal pole and the abnormally large yolk sac were enough evidence for her to understand that Patient 1 did not have normal pregnancy which included a missed abortion or a fetus not developing normally. She did not believe that changes

in management of the pregnancy would have resulted in normal fetus development. Respondent also denied the July 27, 2018 ultrasound indicated that the fetus was at a younger gestational age than she estimated. Instead, Respondent asserted the July 27, 2018 ultrasound results showed Patient 1 did not have a normally progressing pregnancy given the estimated size of the fetus; i.e., Patient 1 should have been at nine weeks gestation on July 27, 2018, and she was only estimated to be at six weeks. (Exhibit 9, p. A470.)

58. Respondent noted that she is required to, and did, follow the guidelines published by the American College of Obstetricians and Gynecologists (ACOG), and those guidelines indicate that a three-to-four-week delay in fetal development is abnormal.

59. Respondent explained that she provides patients with options, but they ultimately decide how to proceed, as happened in this case.

Patient 2

60. On April 17, 2019, Patient 2, then 21 years old, visited Respondent's office requesting a routine gynecological exam and pap smear. This was Patient 2's first gynecological exam and pap smear. Respondent understood that, since Patient 2 was 21 years old, she was at the age to begin undergoing pap smears.

61. Patient 2 had never had penetrative sex, and she relayed this information to Respondent.

62. Respondent reviewed Patient 2's social history and her family history which was negative for cervical cancer.

63. Respondent also conducted a "Review of Systems," asking Patient 2 about any abnormalities. In the chart, Respondent documented the following:

> Review of Systems:
>
> GENERAL: no weakness, no fatigue, no fever, no significant weight change[;] SKIN: no rash, no lumps, no sores, no itching, no dryness, no color change, no changes in hair or nails[;] HEENT: no headache, no head injury, no dizziness, no lightheadedness, no vision changes, no hearing problems, no tinnitus, no vertigo, no earaches, no nasal stuffiness, no nasal discharge, no nosebleeds, no sinus trouble, no dry mouth, no hoarseness[;] NECK: no lumps, no lymphadenopathy, no goiter, no pain, no stiffness[;] BREASTS: no lumps, no pain or discomfort, no nipple discharge[;] CARDIOVASCULAR: no chest pain or discomfort, no palpitations, no dyspnea, no orthopnea, no paroxysmal nocturnal dyspnea, no edema[;] RESPIRATORY: no cough, no sputum, no hemoptysis, no dyspnea, no wheezing[;] GASTROINTESTINAL: no trouble swallowing, no heartburn, no nausea, no vomiting, no diarrhea, no rectal bleeding or tarry stools, no constipation, no abdominal pain, no food intolerance[;] URINARY: no polyuria, no nocturia, no urgency, no burning or pain on urination, no hematuria, no urinary infections, no kidney stones, no incontinence, no dribbling[;] GENITAL: no dysmenorrhea, no menopausal symptoms, no postmenopausal bleeding, no

> vaginal discharge, no itching, no sores, no lumps, no dyspareunia[;] PERIPHERAL VASCULAR: no intermittent claudication, no leg cramps, no varicose veins[;] MUSCULOSKELETAL: no muscle or joint pains, no stiffness, no arthritis, no gout, no backache, no swelling, no redness, no pain, no tenderness, no limitation of motion[;] NEUROLOGIC: no fainting, no blackouts, no seizures, no weakness, no paralysis, no numbness or loss of sensation, no tingling, no tremors or other involuntary movements[;] ENDOCRINE: no heat or cold intolerance, no excessive sweating, no excessive thirst or hunger, no polyuria, no change in glove or shoe size[;] PSYCHIATRIC: no nervousness, no depression, no memory change

(Exhibit 12, pp. A534-A535.)

64. While discussing Patient 2's history, Respondent asked Patient 2 whether she had penetrative sex before. Patient 2 confirmed she had not.

65. Respondent recalled wondering why a 21-year-old who had never been sexually active was seeking a pap smear. Respondent understood that pap smears screen for cervical cancer which is primarily caused by the human papilloma virus (HPV), and since HPV is sexually transmitted, Patient 2 was not likely to have been exposed to it. Patient 2 also had no increased cancer risk from family history.

66. Respondent told Patient 2 there was no need for a pap smear because the chances of an abnormality were unlikely given that she was not sexually active. In a further effort to convince Patient 2 to defer a pap smear, she also asked Patient 2 if

she was sure she wanted to proceed with the pap smear because she would tear her hymenal ring and would not "be a virgin anymore." (Exhibit 13, p. A561.)

67. At hearing, Patient 2 did not recall Respondent telling her the pap smear portion of the examination was unnecessary and could be postponed. However, she recalled Respondent asking whether she had penetrative sex before and, when she confirmed she had not, Respondent asking why she was seeking a pap smear. Patient 2 also recalled Respondent then telling her that once the pap smear took place, she would no longer be a virgin.

68. Respondent's comment that Patient 2 would not be a virgin after the exam confused Patient 2. She viewed the visit as a medical examination rather than a sexual experience, and Respondent's comment did not comport with Patient 2's understanding. Patient 2 did not ask Respondent questions about the comment because she had never been to an Ob-Gyn before and "did not feel welcome by her to ask questions." (Patient 2 testimony.) However, Respondent never told Patient 2 she could not ask questions or that she could not stop the examination.

69. At hearing, Respondent explained that she did not intend to hurt Patient 2's feelings. Rather, she wanted to alert Patient 2 about the possibility of tearing of the hymenal ring because some patients want an intact hymenal ring for marriage.

70. Patient 2 confirmed with Respondent that she wanted to have a pap smear. Patient 2 believed the pap smear should proceed because that was why she scheduled the appointment.

71. Respondent understood that under ACOG guidelines, pap smears may be regularly performed on patients beginning at age 21. Since Patient 2 requested to proceed with the pap smear, Respondent did not feel she could deny her request.

72. Respondent conducted a physical examination and documented the following findings:

> GENERAL: AAOx3, NAD, normal level of consciousness, good personal hygiene[;] SKIN: no lesions, no rash[;] NECK: Supple. No lymphadenopathy/tenderness (-) thyromegaly[;] ABDOMEN: soft, non-lender, non-distended, no surgical scars, no trauma on inspection, normal bowel sounds all 4 quadrants, no masses noted on light or deep palpation, no CVA tenderness, no hepatosplenomegaly, no rebound tenderness[;] MUSCULOSKELETAL: normal muscle tone/bulk, no deformities, normal range of motion, normal spine alignment[;] EXTREMITIES: no varicose veins, no edema, no abnormal movements, no tremor, no rigidity, normal alignment, normal gait

(Exhibit 12, p. A535.)

73. Respondent did not palpate Patient 2's breasts to conduct a cancer screening examination.

74. Respondent then performed the gynecological exam and noted the following findings: "[Sterile speculum examination]: no abnormal discharges, no abnormal lesions, no CMT, cervix closed uterus normal size, no adnexal masses palpated." (Exhibit 12, p. A535.)

75. The gynecological examination entailed Respondent having Patient 2 lie face up on the examination table and placing her feet into stirrups, with her buttocks moved to the very edge of the examination table. Respondent then performed the

speculum examination. After applying lubricant, Respondent took her smallest sized speculum and inserted it into Patient 2's vagina. (Respondent stocks small, medium, and large speculums at her office, but does not have pediatric speculums since she does not treat children.) Respondent expanded the speculum to press and hold the vaginal walls open so she could view the cervix and use a long swab to take a sample of cervical cells for the pap smear. The speculum exam and pap smear lasted about one minute. After removing the speculum, Respondent performed a bi-manual examination wherein she inserted two gloved and lubricated fingers into Patient 2's vagina and pressed up while palpating the outside of the patient's abdomen with her other hand. This allowed Respondent to feel the uterus, fallopian tubes, and ovaries and to check for masses. The bi-manual portion of the examination typically lasts less than a minute.

76. Prior to the gynecological examination, Respondent did not ask Patient 2 if she ever experienced any pain in her genital area or if she experienced pain on penetration. Although Patient 2 had a history of pain on digital (finger) penetration, she did not mention this to Respondent because she had never gone to an Ob-Gyn before and was unsure of when to discuss it. Patient 2 did not recall Respondent forewarning her about any discomfort or pain from the examination.

77. Patient 2 recalled the speculum examination being incredibly painful, which she was not expecting. She was unaware of when Respondent conducted the pap smear portion of the examination because she felt the same pain through the entire speculum examination.

78. Patient 2 recalled groaning and having tears running down her face. Respondent acknowledged Patient 2's discomfort, saying, "I know. I know. It will be over soon." She did not do anything else to address Patient 2's pain.

79. Patient 2 never told Respondent to stop. She testified that "with the amount of pain I was in, I could not even think about speaking and requesting to stop."

80. Although Respondent noticed Patient 2 was uncomfortable, she did not perceive that Patient 2 was in excessive pain. Respondent did not see her tears, and Patient 2 did not convey to her that she was in excruciating pain. Respondent believed Patient 2's groaning was appropriate for a first speculum examination. At hearing, Respondent insisted that, if she had known Patient 2 was in excruciating pain or if Patient 2 had asked here to stop, she would have discontinued the examination.

81. After the examination, Patient 2 recalled still experiencing pain while walking. When she left the examination room and went to the waiting room, she told the person who accompanied her to the appointment that she had never experienced so much pain in her life.

82. In 2020, Patient 2 underwent a speculum examination with another Ob-Gyn to determine the cause of her prior pain. That Ob-Gyn made sure Patient 2 did not experience too much pain and only proceeded "as far as she needed to rule out conditions that might be causing [the pain]." (Patient 2 testimony.) Patient 2 did not experience the same amount of pain in 2020 as with Respondent's gynecological examination. The other Ob-Gyn did not have a diagnosis for Patient 2's prior pain but merely indicated Patient 2 was just not used to the stretching of her vaginal tissue.

The Experts

83. Complainant offered the testimony of Steven Freedman, M.D., to establish the standard of care in this case. Dr. Freedman received his medical degree from Eastern Virginia Medical School in 1978, and thereafter completed an Ob-Gyn

residency at Western Pennsylvania Hospital. Dr. Freedman is licensed to practice medicine in California and has been a medical expert reviewer for the Board for several years. He began private practice as an Ob-Gyn in 1982. Since 2020, he has served in a solely administrative role as Medical Director of a Federally Qualified Health Center in Lancaster, California.

84. Dr. Freedman's curriculum vitae indicates that he has board certification through the "American College of Obstetrics and Gynecology." This appears to be an error. The American College of Obstetricians and Gynecologists (ACOG) is a membership organization. Dr. Freedman's board certification would have to have been obtained through the American Board of Obstetrics and Gynecology, one of the specialty boards recognized by the American Board of Medical Specialties. Dr. Freedman testified he became board certified in 1984 and was "grandfathered-in" (i.e., he is not subject to the 10-year recertification requirements).

85. Respondent offered the testimony of Hindi E. Stohl, M.D., J.D., to establish the standard of care in this case. Dr. Stohl earned her medical degree from the University of Pennsylvania School of Medicine. She completed her internship and residency in Ob-Gyn at Johns Hopkins Medical Institutions, in Baltimore, Maryland. In 2013, she completed a fellowship in Maternal Fetal Medicine at the University of Southern California (USC). Dr. Stohl is board certified in General Obstetrics and Gynecology and has a subspecialty board certification in Maternal Fetal Medicine. She is licensed to practice medicine in California. Dr. Stohl is currently a clinical assistant professor at the UCLA David Geffen School of Medicine and an adjunct clinical assistant professor at the USC Keck School of Medicine. She currently serves as both the Director of the Division of Maternal Fetal Medicine in the Department of Ob-Gyn, and as the Associate Program Director of the Ob-Gyn Residency Program at Harbor

UCLA Medical Center. In her professorship and directorship roles, Dr. Stohl supervises residents and trainees. Dr. Stohl is a fellow of ACOG and has served in committee roles for ACOG and its education branch, the Council on Resident Education in Obstetrics and Gynecology (CREOG). Dr. Stohl's curriculum vitae is extensive and notes her many committee memberships, awards, presentations, and published peer-reviewed research papers and book chapters.

86. Drs. Freedman and Stohl were equally qualified to testify as experts on the standard of care in this case. Any additional weight given to one expert's testimony over the other's was based on the content of their testimonies and bases for their opinions, as set forth more fully below.

87. Dr. Freedman and Dr. Stohl provided expert reports setting forth their opinions regarding Respondent's care and treatment of Patients 1 and 2. Those reports were admitted into evidence at the hearing, and Drs. Freedman and Stohl testified in general conformity with their reports.

Standard of Care - Alleged Repeated Negligent Acts

FAILURE TO APPROPRIATELY EVALUATE PATIENT 1'S EARLY PREGNANCY

87. Complainant alleges in the Accusation, "Respondent's failure to appropriately evaluate Patient 1's early pregnancy was a departure from the standard of care." (Exhibit 1, p. A10, para. 21.)

88. In his report and testimony, Dr. Freedman is critical of Respondent's evaluation of Patient 1's early pregnancy. His report concluded that Respondent's "failure to properly evaluate this patient's early pregnancy was a simple departure from the standard of care." (Exhibit 15, p. A630.) However, much of Dr. Freedman's

criticism of Respondent's evaluation revolves around documentation (addressed in a separate section below). His main non-documentation criticism pertains to Respondent's failure to conduct serial HCG testing "to support or refute the diagnosis of threatened miscarriage." (Exhibit 15, p. A630.)

89. In his testimony, Dr. Freeman pointed out, if a patient wishes to continue a pregnancy, the Ob-Gyn should "err on the side of caution" and be certain of their diagnosis before "jumping into aborting a potentially healthy fetus."

90. In explaining how to verify such a diagnosis, Dr. Freedman noted that, in determining a pregnancy's progression, a TVS is used first to identify a gestational sac, which is a circular or elliptical image on the ultrasound. Thereafter, within that gestational sac, the physician should see the development of a fetus, referred to as a fetal pole, which will be a small structure which initially presents as a one-half centimeter or smaller line.

91. Dr. Freedman likened the search for the fetal pole to looking into a dark room with a flashlight, noting that what you find depends on where you point the flashlight, and if you fail to see something, this may mean you "could have been looking in the wrong place." Dr. Freedman insisted an inability to see a fetal pole does not mean it is not present, only that it was not visualized. Dr. Freedman opined finding a fetal pole is "confirmatory," but if it cannot be located, the physician must conduct a "more thorough" ultrasound examination. Dr. Freedman's assertion of the need for the physician to conduct a more thorough ultrasound apparently presumes either that an insufficiently trained Ob-Gyn performed the TVS or that the Ob-Gyn performed the TVS carelessly, neither of which was established in this case.

92. Dr. Freedman opined the inability to see a fetal pole would warrant "secondary confirmation." The secondary conformation could be either "a second opinion such as another Ob-Gyn doing the study" or "a radiologist performing a more detailed ultrasound." Secondary confirmation could also be obtained via blood tests to check progesterone levels or HCG levels to see how the pregnancy is progressing.

93. Regarding secondary confirmation through referral to radiology, Dr. Freeman maintained that the typical Ob-Gyn does not have the same quality machine as those present in a hospital or radiology center. He also maintained that a radiologist is trained and certified in ultrasound and that Ob-Gyns have training only through weekend seminars. However, Dr. Freedman conceded that a second opinion, while recommended, is not required by the standard of care to determine a fetus is not developing.

94. Regarding secondary confirmation via blood tests, Dr. Freedman asserted "HCG [levels] can age a pregnancy." Dr. Freedman explained that HCG levels in a pregnant woman's blood stream correlate with the gestational age of the pregnancy. Typically, laboratories determining HCG levels have their individual standards for testing and their reports indicate the HCG level as well as a corresponding gestational age range per the laboratories' parameters. In early pregnancy, HCG levels double every 48 hours, but HCG will "fall off with a miscarriage." Consequently, he opined that HCG levels taken 48 hours apart can confirm pregnancy if they double. He did not specify this serial blood testing was required by the standard of care.

95. Dr. Freedman acknowledged that, with an LMP of May 24, July 19, 2018 "would be around the time to see a fetal pole and heartbeat," so a TVS on July 19, 2018, was appropriate. Dr. Freedman never specifically stated the standard of care required Respondent to conduct HCG testing to confirm the July 19, 2018, TVS

findings. However, he testified that HCG levels should be used to assess the early growth of a pregnancy and that Respondent "could have conducted serial HCG testing" to indicate progress in the pregnancy and to "have a secondary form of confirmation" of her TVS findings and diagnosis. Dr. Freedman pointed out there would be a drop off in HCG levels as the pregnancy was compromised and the fetal pole was not developing.

96. Dr. Freedman also noted that, if the patient undergoes a series of "quality" ultrasounds that do not show a progression in the pregnancy, then further examinations would not be necessary. Dr. Freedman defined "quality" ultrasound to include "assessments that are measurable" such as measuring the size of the uterus, gestational sac, and "other aspects of pregnancy that are quantifiable," and correlating the ultrasound findings with a physical examination.

97. In her report and testimony, Dr. Stohl noted the standard of care for management of early pregnancy includes assessment of pregnancy dating as well as evaluation of the location of the pregnancy. She credibly noted that pregnancies are dated by LMP, so six weeks of gestation is six weeks from the first day of the LMP. For women who do not know their LMP, an ultrasound is used as the first dating criteria.

98. Although Dr. Freedman acknowledged that pregnancies are dated by the LMP, he insisted that a reported LMP of May 24 and a positive urine test on June 21 did not necessarily indicate a gestational age of four weeks. This assertion is contrary to the established method of dating of pregnancy using the LMP. Dr. Freedman also acknowledged that the finding of a yolk sac on ultrasound is indicative of a gestational age ranging from five to six weeks. However, he would not concede that despite the reported LMP of May 24, the positive urine test on June 21, and the finding of a

gestational sac and yolk sac on July 5, the gestational age on July 24 would have been about eight weeks.

99. Dr. Freedman's testimony vacillated regarding whether a fetal pole was identifiable in the July 19 and July 24 TVS's. In his report Dr. Freedman noted that during his review of the still images from the July 19 TVS, "there does appear to be an identifiable fetal pole." (Exhibit 15, p. A630.) During his testimony, Dr. Freedman reviewed the July 19 TVS images and initially testified he did not see "what he would call a fetal pole in this image" (Exhibit 7, p. A66). However, he later testified in conformity with his expert report and asserted that the July 19, TVS image "appeared to show a fetal pole." He was again shown a July 19 TVS image (Exhibit F), and he again equivocated and stated he did "not see a fetal pole in this image." He later confirmed that none of the images from the July 19 TVS showed a fetal pole. Dr. Freedman asserted this discrepancy is why "it is foolhardy" to rely on static ultrasound pictures to make an obstetrical diagnosis. He later testified that the July 24 TVS images "could potentially" show a fetal pole," but he "could not say [he] definitely saw a fetal pole" in the static images. Dr. Freedman conceded that the still images are snapshots of the overall TVS video, that the person performing the TVS has the best ability to see what is transmitted in real time, and that Respondent would have had "the greatest opportunity" to see any possible fetal pole.

100. Dr. Freedman agreed that on July 5, 2018, there appeared to be a viable pregnancy and that, on July 19, 2018, he did not see any fetal pole. He acknowledged that not seeing a fetal pole on July 19 is indicative of a problematic pregnancy. However, he maintained that the July 19 and 24 TVS examinations were insufficient to confirm the pregnancy was not developing.

101. Dr. Stohl noted, in early pregnancy there are two primary focuses. First is location, i.e., ascertaining if the pregnancy is in the uterus or outside the uterus, also known as an "ectopic" pregnancy. The second focus will then be viability, i.e., that the uterine pregnancy is normal and viable. To determine location, an Ob-Gyn will first use HCG levels which will indicate pregnancy before being able to visualize anything on ultrasound. The Ob-Gyn should later be able to see a pregnancy located in the uterus. If no pregnancy is visualized in the uterus despite HCG levels, then the possibility of ectopic pregnancy is explored. If the Ob-Gyn confirms an intrauterine pregnancy, the standard of care does not require continued use of HCG levels. Instead, the standard of care requires that intrauterine pregnancy be followed using TVS to establish viability which is determined by visualization of a fetal pole with a fetal heartbeat as expected for the specified stage of gestation.

102. Dr. Stohl explained that some of the early cells of conception become the placenta and amniotic sac to house the pregnancy and some of the cells become the baby itself. A yolk sac is part of placental cells; the yolk sac is a circular ring of tissue which confirms a pregnancy has placental tissue and that the pregnancy is in uterus. Visualization of the yolk sac confirms the pregnancy is intrauterine, but does not confirm the pregnancy is normal because the yolk sac is distinct from fetal tissue. Sometimes the placenta will grow but there will be no normally-growing fetus. A fetal pole is the term used to describe the length of a very early fetus, distinct from the yolk sac or placenta or amniotic membrane. It looks like a line and is measured from top to bottom to estimate weeks of gestation.

103. Dr. Stohl pointed to ACOG publications which set forth clinical management guidelines for Ob-Gyns. In a 2015 Practice Bulletin regarding Early Pregnancy Loss, updated in 2018, ACOG provided criteria for confirming early

pregnancy loss. ACOG's 2015 and 2018 practice bulletins note, "Early pregnancy loss is defined as a nonviable, intrauterine pregnancy with either an empty gestational sac or a gestational sac containing an embryo or fetus without fetal heart activity" within the first trimester. Both the 2015 and 2018 bulletins contained the same chart listing "Findings Diagnostic of Pregnancy Failure" to include: "Absence of embryo with heartbeat 2 weeks or more after a scan that showed a gestational sac without a yolk sac;" and "Absence of embryo with heartbeat 11 days or more after a scan that showed a gestational sac with a yolk sac." (Exhibit E, p. B47; Exhibit M, p. B73.) Dr. Stohl noted "Serum quantitative levels of HCG and serum levels of progesterone are not part of this algorithm supported by ACOG for diagnosing a failed pregnancy." (Exhibit B, p. B21.)

104. In addressing the AGOG guidelines, Dr. Freedman testified that the ACOG criterion of failure find a fetal pole or heartbeat after two weeks should rely on an ultrasound performed by a radiologist and that an Ob-Gyn does not have the same training. This assertion is not persuasive. The ACOG guidelines are intended for use by Ob-Gyns. Additionally, Dr. Stoh testified credibly that Ob-Gyns are "very well trained in ultrasound for early pregnancy," and Respondent credibly testified that she had been trained during residency in the use of ultrasound.

105. Dr. Stohl pointed out Respondent was able to visualize Patient 1's intrauterine pregnancy on July 5, 2018, which included visualizing a gestational sac and a yolk sac. Fourteen days later, on July 19, 2018, Respondent was unable to locate a fetal pole with a fetal heartbeat. At that point, Respondent could have, and did, diagnose a failed early pregnancy. However, Respondent had the patient return five days later, on July 24, 2018, 19 days after visualizing the gestational sac and yolk sac, and she remained unable to see a fetal pole with fetal heartbeat. With this TVS, the

ACOG criteria for diagnosis of a failed pregnancy were met again. The lack of a fetal pole and fetal heartbeat at almost nine weeks gestation would be, in itself, cause for concern. HCG levels and progesterone levels were not required in management of a pregnancy at this point and are notably not part of the ACOG ultrasound-based criteria for diagnosing a failed pregnancy. Additionally, Respondent was not required by the standard of care to take any TVS measurements at this time to diagnose a failed pregnancy.

106. Dr. Stohl opined Respondent committed no departure from the standard of care in the evaluating Patient 1's early pregnancy. She noted Respondent followed published ACOG criteria for diagnosis of a failed pregnancy and did not fail to properly evaluate Patient 1's early pregnancy. She also noted Respondent demonstrated proper knowledge and understanding of management of an early pregnancy as well as ultrasound-based criteria for diagnosing a failed pregnancy and the options available to a patient when such a diagnosis is made. Respondent offered Patient 1 the appropriate options upon TVS diagnosis of a failed pregnancy, including medical management through misoprostol that would complete the termination of an abnormal pregnancy. Respondent then prescribed medical therapy according to the patient's choice among the options presented.

107. Dr. Stohl maintained GAMC's July 27, 2018, finding of a fetal pole with a heartbeat on ultrasound does not automatically refute Respondent's July 24, 2018 TVS findings. She explained, "[A] pregnancy is consistently growing, and thus new findings may be present days after they were previously absent." (Exhibit B, p. B22.) Dr. Stohl also noted:

> [T]here is a distinct possibility that this pregnancy was not a normal one from the beginning (as evident by the absence

> of a fetal pole with a heartbeat earlier in pregnancy when it would have been expected as well as by the fact that when finally detected at [GAMC], the fetal pole only measured 6 weeks' gestation when [Patient 1] was, in fact, 9 weeks and 1 day in gestation).

(Exhibit B, p. B22.)

108. Dr. Freedman also acknowledged, since HCG levels double every 48 hours until about six to eight weeks gestation, and since Patient 1's HCG level on June 27 was 2,046, Patient 1 would have been expected to have a much higher HCG level on July 27 than the reported 23,987.

109. Complainant did not establish that the standard of care required Respondent to conduct HCG testing to confirm her diagnosis of early pregnancy loss, which she termed "missed abortion." (ACOG's 2015 and 2018 practice bulletins note, "[I]n the first trimester, the terms miscarriage, spontaneous abortion, and early pregnancy loss are used interchangeably." [Exhibit B, p. B45; Exhibit M, p. B71.]) Complainant also did not establish the standard of care required Respondent to arrive at a different diagnosis on July 24, 2018, or that she was required to offer Patient 1 options other than those she recommended given the information available to her at the time and pursuant to ACOG guidelines. In viewing Respondent's management of Patient 1's early pregnancy, the analysis of compliance with the standard of care must be viewed through the lens of what information was available, or should have been available, to Respondent at the time, and not a retrospective evaluation based on subsequent findings.

110. Regarding the evaluation of Patient 1's early pregnancy, Dr. Stohl's opinions are more persuasive than those of Dr. Freedman. Consequently, Complainant failed to establish by clear and convincing evidence that Respondent violated the standard of care by failing to appropriately evaluate Patient 1's early pregnancy.

FAILURE TO DOCUMENT DETAILS OF PATIENT 1 EVALUATION & TREATMENT AND FAILURE TO TAKE/DOCUMENT MEASUREMENTS FROM ULTRASOUNDS

111. Complainant alleges in the Accusation, "Respondent's failure to document the details of evaluation, treatment and follow up of Patient 1, including the significance of findings with regard to the viability of Patient 1's pregnancy, represents a departure from the standard of care." (Exhibit 1, p. A10, para. 21.)

112. Complainant also alleges in the Accusation, "Respondent's failure to take and/or document any measurements during the ultrasound performed on July 5, 2018, July 19, 2018, and on July 24, 2018, was a departure from the standard of care." (Exhibit 1, p. A10, para. 21.)

113. In his report and in his testimony, Dr. Freedman notes several criticisms of Respondent's documentation in general and pertaining specifically to TVS measurements.

114. Dr. Freedman noted, "Documentation of the usual [menstrual] cycle length or any factors which may have altered this cycle were absent." (Exhibit 15, p. A629.) Dr. Freedman explained that cycles vary among women and the length of Patient 1's menstrual periods and other information about her cycles are important to assess the validity of Patient 1's reporting of her LMP. However, Dr. Stohl noted that Respondent documented Patient 1's LMP as "regular," and it was not necessary for

Respondent to note details of the menstrual period since "it is reasonable to believe a woman when she provides a LMP which she believes is accurate and which she self-describes as regular." (Exhibit B, p. B23.) Ultimately, while Dr. Freedman described Respondent's documentation of the LMP as "a minimalist approach" which "could be more thorough," he conceded "it is not outside the standard of care."

115. Turning to the July 5, 2018, visit, which was the first prenatal visit, Dr. Freedman noted, in the obstetrical history, Patient 1's "previous miscarriage underscores her risks, especially if it required a D&C - which was not documented." (Exhibit 15, p. A630.) He opined that "more detail about the miscarriage could help in assessing the current pregnancy" since a prior D&C can impact the ability to conceive and increase the risk of miscarriage." However, he testified that, while the documentation of the previous miscarriage "is minimalist" and "ideally would go into much more detail," it is "the very least amount to satisfy" documentation requirements.

116. Dr. Freedman also criticized Respondent's documentation of the patient's prior myomectomy. He noted:

> The patient's previous myomectomy presents an increased risks of pelvic pain, uterine rupture, and abnormal placentation. The details of this procedure impact all future pregnancies and can, for example, be responsible for an abnormal progression in the growth of a pregnancy or HCG levels not rising on schedule. . . . These issues were not addressed, including a failure to mention when and how the myomectomy was performed[.]

(Exhibit 15, p. A629-A630.)

117. Dr. Freedman testified that details of a myomectomy should be documented because a myomectomy may scar the uterine lining which can affect implantation and growth rate of subsequent pregnancies. He acknowledged that obtaining this information may be "challenging" and that obtaining hospital records from Armenia where the myomectomy was performed may be "impossible." Dr. Freedman initially opined that Respondent's documentation of the myomectomy was not adequate because it contains no details to aide in future treatment. However, he conceded that the myomectomy documentation was "minimally" within the standard of care and that "the requirements for documentation are fairly minimalist."

118. Dr. Stohl credibly asserted the standard of care did not require Respondent to document details of Patient 1's myomectomy during early prenatal care. In her report, she noted:

> [A myomectomy] does, indeed, impact delivery planning, surgical approach to Cesarean section (or other uterine procedure), risk of uterine rupture and placentation. Thus, details related to [Patient 1's] myomectomy would be important to ascertain and discuss as the pregnancy progressed. However, at this early point in pregnancy, it is reasonable to avoid a detailed documentation of such history, as [Respondent] was not currently arranging for a delivery plan, performing a surgical procedure on [Patient 1's] uterus or concerned about uterine rupture.

(Exhibit B, p. 24.)

119. As further evidence of documentation failure, Dr. Freedman noted Respondent's inaccurate July 5 documentation of a May 10, 2018, LMP. Although it was a typographical error purportedly entered by Respondent's medical assistant, and Respondent entered the correct May 24 LMP in later records, the July 5, 2018, record remained uncorrected and constitutes an inaccurate medical record.

120. Dr. Freedman very credibly noted the dangers of electronic medical records and the automatic population of typical information in many categories. He also credibly opined it is incumbent on the physician to correct the automatically generated entries.

121. In his report, Dr. Freedman noted, "Symptoms of pregnancy, which may elucidate the timing of the pregnancy, were not elicited or documented. . . . The 7/5 office visit notes a pelvic exam which does not address any physical signs of pregnancy, or note the size and consistency of the uterus, or explain what a "normal" finding is in this context[.]" (Exhibit 15, p. A629-A630.) In his testimony, Dr. Freedman explained that a physical examination is critical during early pregnancy. The cervix should have a blue coloring indicative of pregnancy and supportive of gestational age. The uterus changes in size with the age of pregnancy, and it softens, beginning at the top, and starts to enlarge. Dr. Freedman opined an experienced Ob-Gyn can age a pregnancy by palpating the uterus. According to Dr. Freedman, a physical examination can be a physician's "secondary confirmation" following an ultrasound which raises concerns about pregnancy growth.

122. Regarding Respondent's documentation for the July 5, 19, and 24, 2018 general physical and pelvic examinations, Dr. Freedman noted none of the findings of an actual pelvic examination are recorded, but instead auto-populated findings of "NORMAL" were generated for numerous categories. Dr. Freedman credibly opined

that Respondent's July 5, 19, and 24, 2018 documentation for pelvic examination was inadequate and did not meet the standard of care.

123. Dr. Freedman also pointed out that the documentation for the July 19, 2018 visit did not follow standard SOAP format requiring subjective findings, objective findings, assessment, and a plan. Although there was a finding of a gestational sac and enlarged yolk sac, there was no documentation of the interpretation or assessment of what the enlarged yolk sac and lack of fetal pole meant. While an Ob-Gyn may be able to deduce what these findings meant, particularly in light of the plan options of getting a second opinion, expectant management, medical TOP or D&C, the actual assessment of "early pregnancy loss" was not documented. Consequently, the July 19, 2018 documentation was inadequate and did not meet the standard of care.

124. Dr. Freedman also noted documentation inadequacies violating the standard of care after July 24, 2018, when Respondent failed to document the purported administration of RhoGAM and also failed to document her July 27, 2018, conversation with GAMC ER personnel and Patient 1.

125. Dr. Freedman also criticized Respondent's documentation of TVS findings for July 5, July 19, and July 24. Dr. Freedman noted that on July 5, 2018, Respondent did not measure the gestational sac or the yolk sac. In his report, he opined, "Although measurement of these structures can be used to determine gestational age and viability, no measurements are documented." (Exhibit 15, p. A630.) During his testimony, Dr. Freedman reviewed still photographs taken during the July 5, 2018, TVS, and he opined that one of the images "appears to show an intrauterine sac with a possible yolk sac and a possible fetal pole." However, he noted the July 5, 2018, TVS was "confirmatory to confirm the presence of pregnancy, and it did so," and he

acknowledged the standard of care did not require measurements at this initial prenatal visit.

126. Regarding the July 19, 2018, visit, Dr. Freedman noted on TVS Respondent found an "enlarged sac without a fetal pole. [Respondent] described her visual impression of that sac, but did not take any measurements which would have objectively supported a diagnosis." (Exhibit 15, p. A630.) Dr. Freedman's testimony was ambiguous regarding whether the standard of care required measurements of the enlarged yolk sac on July 19, 2018. He acknowledged that when giving patient the option to terminate a pregnancy, measurements are not required because a patient can terminate a pregnancy at any time. However, he asserted that if an Ob-Gyn is recommending that a patient terminate a non-viable pregnancy, measurements are required. He testified the "standard of care is vague," but to determine the yolk sac is enlarged, measurements are required. He asserted, "the difference in size matters" and you can "get a vague idea of how the pregnancy is doing by measurement." He did not explain how the comparison would be done if measurements were not required on the July 5 TVS but required at the July 19 TVS.

127. Dr. Stohl credibly opined that the standard of care did not require Respondent to take measurements for the July 19 and July 24 TVS's and that no ultrasound measurements of the yolk sac would have been necessary to diagnose a failed pregnancy in this case. (See Exhibit B, p. B26.)

128. Regarding the documentation of the details of evaluation and treatment of Patient 1, Complainant established by clear and convincing evidence that Respondent violated the standard of care by failing to correct the inaccurate LMP entry on July 5, 2018, by inadequately documenting the July 5, July 19, and July 24, 2018 pelvic examinations, by failing to document a specific assessment on July 19,

2018, by failing to document the purported administration of RhoGAM after June 24, 2018, and by failing to document her July 27, 2018 conversation with GAMC ER personnel and Patient 1. The remainder of the documentation criticisms for Patient 1 were not proven by clear and convincing evidence.

129. Regarding the documentation of TVS measurements on July 5, July 19, and July 24, 2018, Dr. Stohl's opinions are more persuasive than those of Dr. Freedman. Consequently, Complainant failed to establish by clear and convincing evidence that Respondent violated the standard of care by failing to take and/or document any measurements during TVS's performed on July 5, 2018, July 19, 2018, and July 24, 2018.

FAILURE TO OBTAIN APPROPRIATE INFORMED CONSENT FOR TVS &

FAILURE TO OBTAIN APPROPRIATE INFORMED CONSENT FOR MEDICAL TOP

130. Complainant alleges in the Accusation, "Respondent's failure to obtain appropriate informed consent for serial transvaginal ultrasounds from Patient 1 was a departure from the standard of care." (Exhibit 1, p. A10, para. 21.)

131. Complainant also alleges in the Accusation, "Respondent's failure to obtain appropriate informed consent to perform a medical abortion of Patient 1's pregnancy, including but not limited to answering all of her questions and advising the patient about the effects of misoprostol, was a departure from the standard of care." (Exhibit 1, p. A10, para. 21.)

132. In his report, Dr. Freedman defined the standard of care for informed consent as follows:

> Informed consent is meant to provide the patient with sufficient information with which to make knowledgeable choices with regard to further treatment. That information begins with a clinical impression and includes a differential diagnosis of the condition. The risks and benefits of any procedure must be reviewed. Alternative courses of treatment must be explained. Anticipated results should be described in lay terms.

(Exhibit 15, p. A632-A633.)

133. Dr. Stohl's definition of the standard of care is similar, but also focuses on the informed consent required for medical interventions and prescribing medications as follows:

> Standard of care for informed consent requires a physician to discuss the indications, risks, benefits and alternatives to a given intervention. While some interventions require formalized consent, including both a verbal and written consent, other medical interventions simply require verbal consent or, even, verbal assent as demonstrated by willing participation in the procedure . . . or filling the prescription and taking it as prescribed.

(Exhibit B, pp. B26-B27.)

134. Dr. Stohl also explained the standard of care for informed consent as it specifically applied to TVS and prescription of medication for TOP as follows:

> Transvaginal ultrasound is an extremely common procedure in obstetrics. It is routinely used to establish pregnancy location and viability in the early stages of pregnancy. Transvaginal ultrasound is well tolerated by most women and has minimal associated risks. Obtaining written consent for a transvaginal ultrasound is not standard of care.
>
> [¶] . . . [¶]
>
> Misoprostol is a medication commonly used in obstetrics. In early pregnancy, it is a standard medication utilized for medical management of early pregnancy failure. As with all medications, a discussion between physician and patient regarding the prescribed medication is expected; however, a written consent is not required and is not standard of care in obstetrics.

(Exhibit B, pp. B26-B27.)

135. Dr. Freedman asserted Respondent should have obtained informed consent for the TVS's performed on Patient 1 as follows:

> Transvaginal ultrasounds, although performed routinely in office practice, must be considered a minimally invasive procedure requiring proper informed consent. This would entail that the patient understands the reason for the test, other diagnostic alternatives, and the findings of these exams. There is no evidence in the medical records that informed consent was given. Furthermore, as discussed, the

> patient was never educated about obtaining a more thorough exam at a radiology center or hospital ultrasound department.

(Exhibit 15, p. A633.)

136. Dr. Freedman also asserted Respondent should have obtained and documented informed consent when prescribing medication for medical TOP as follows:

> [Misoprostol] was being used to induce a medical abortion. This medication requires informed consent, which was not given or documented. The patient must be aware that her diagnosis of 'missed abortion' meant that her fetus was not alive. That by taking this medication she would experience cramps, often severe. That she would most likely go on to bleed vaginally and miscarry. Specifically, that after experiencing labor pains, she would expel the products of conception vaginally. And that the risk of bleeding is significant.

(Exhibit 15, p. A633.)

137. Dr. Freedman opined Respondent violated the standard of care and failed to provide proper informed consent because Patient 1 was not properly informed about the diagnostic tools used to date the pregnancy (i.e., TVS) and that better ultrasounds were available. Dr. Freedman further opined Respondent violated the standard of care and failed to provide proper informed consent because Patient 1 was "not well informed of the differential diagnoses" following the July 24 TVS and her

decision to terminate her pregnancy "was based on false premises," and because Patient 1 was not made aware of the possible side effects of the prescribed misoprostol.

138. Dr. Stohl opined that Respondent did not violate the standard of care when performing the TVS's on Patient 1. Specifically addressing the issue of informed consent for TVS, Dr. Stohl noted:

> Given [Respondent's] training and experience as an obstetrician, utilizing an ultrasound as part of her evaluation and management of an early pregnancy was within her scope of practice. Referral of such ultrasounds to a radiology unit is not required. There is no evidence in the medical records that [Respondent] did not obtain informed consent from [Patient 1] prior to performing the transvaginal ultrasounds. Written informed consent is not required for performance of a transvaginal ultrasound. Therefore, lack of a written consent in the medical record should not be assumed to indicate that informed consent was not obtained. On the contrary, [Respondent's] documentation of her conversation with [Patient 1] regarding her ultrasound findings suggests that she did, indeed, discuss the utility of ultrasound. Furthermore, the very fact that [Patient 1] returned multiple times to [Respondent's] office for follow-up ultrasounds strongly supports her consenting to the procedure. It is highly

> unlikely that [Patient 1] would voluntarily present to a clinic for an ultrasound to which she did not consent.

(Exhibit B, p. B27.)

139. Dr. Stohl also opined that Respondent did not violate the standard of care when prescribing misoprostol for Patient 1. Specifically addressing the issue of informed consent for such medication, Dr. Stohl noted:

> [Respondent] notes that she discussed management options with [Patient 1], highlighting that she did have an informed consent conversation with [Patient 1] about the findings, [Respondent's] concerns, and the possible next steps. [Respondent] documents that based on their conversation (aka informed consent), [Patient 1] elected for a "medical TOP." Accordingly, [Respondent] prescribed misoprostol and specifically notes that "bleeding precautions given." This note again highlights elements of informed consent - that risks related to the administration of misoprostol were reviewed. Neither written consent nor a detailed accounting of the physician-patient conversation are required by standard of care. A memorialization of the discussion with the basic components is all that is necessary; [Respondent's] documentation provides that: her findings, the options, risks/benefits and alternatives. Finally, in her complaint to the [Board], [Patient 1] notes that [Respondent] "prescribed me a drug called Misoprostol and instructed me to take one dose first, and then the second

> dose an hour later." She further notes that [Respondent] told her that "the pill would cause cramping and that within 4-5 hours, the fetus would be discharged from the body," Based on her own words, [Patient 1] highlights that [Respondent] had, in fact, discussed the administration and effects of misoprostol, including what result it would have on her symptoms and on the pregnancy.

(Exhibit B, p. B28.)

140. Dr. Stohl also opined Respondent met the standard of care for documenting informed consent. Dr. Stohl maintained written informed consent (i.e., consent form signed by the patient) is not required by the standard of care in the absence of very invasive procedures (such as delivery or surgery), nor is written informed consent required by the standard of care every time a physician prescribes medication. Additionally, she noted the substance of informed consent conversations "do not need to be documented in extensive detail," and since it is not feasible for busy physicians to document all details of complex conversations, the "[s]tandard of care simply requires a memorialization in the medical record of the discussion and its basic components." (Exhibit B, p. B23.) Dr. Stohl opined an Ob-Gyn could read Respondent's documentation and understand the conversation that occurred between Respondent and Patient 1. Respondent noted the discussion about the TVS findings and the options available, and the fact that Patient 1 chose an option indicates shared decision making.

141. Regarding Respondent's obtaining appropriate informed consent for serial transvaginal ultrasounds, the opinions of Dr. Stohl are more persuasive than those of Dr. Freedman. Consequently, Complainant failed to establish by clear and

convincing evidence that Respondent violated the standard of care by failing to obtain appropriate informed consent for serial transvaginal ultrasounds.

142. Regarding Respondent's obtaining appropriate informed consent to perform a medical TOP of Patient 1's pregnancy, including but not limited to answering her questions and advising the patient about the effects of misoprostol, Dr. Stohl's opinions are more persuasive than those of Dr. Freedman. Consequently, Complainant failed to establish by clear and convincing evidence that Respondent violated the standard of care by failing to obtain appropriate informed consent to perform the medical TOP of Patient 1's pregnancy.

NEGLIGENT PERFORMANCE OF PELVIC EXAM FOR PATIENT 2

143. Complainant alleges in the Accusation, "The manner in which the pelvic exam was performed for Patient 2 was a departure from the standard of care." (Exhibit 1, p. A10, para. 21.)

144. Dr. Freedman opined, "By the patient's account, the manner in which the pelvic exam was performed in this case, represents a simple departure from the standard of care." (Exhibit 16, p. A637.)

145. Dr. Freedman noted Patient 2 experienced tremendous amounts of pain, and a pap smear is not required for a 21-year-old who is not sexually active, so the pap smear could have been discontinued. Dr. Freedman also asserted: "Following a very traumatic speculum exam, it would be more painful or even cruel to even attempt to do a bi-manual exam." (Exhibit 16, p. A637.)

146. However, Dr. Freedman conceded that a painful examination does not necessarily indicate there was departure from the standard of care. He acknowledged

the typical pelvic exam can be stressful for the average woman, and pain is subjective. Dr. Freedman asserted a physician should "differentiate the pain" and "decipher the significance of a patient's report of pain." However, Patient 2 never actually reported to Respondent she was suffering from excessive pain. Additionally, Dr. Freedman conceded it would not necessarily be a departure from the standard of care for Respondent to have been aware of Patient 2's crying but merely replying, "I know. I know. It will be over soon." He explained, "It is the art of medicine to know how far you can push and the significance of the patient's complaint."

147. Despite his concessions above, Dr. Freedman maintained Respondent's performance of Patient 2's pelvic examination was a departure from the standard of care.

148. Dr. Freeman noted Ob-Gyns typically can select from three sizes of speculums for a pelvic examination and pap smear - small, medium, or large depending on a patient age, weight, and the number of times a woman has given birth. He asserted that a fourth option could be used: "For virginal patients and children, there are 'pediatric' speculums." (Exhibit 16, p. A636.) Dr. Freedman maintained:

> [T]he shorter blades of the pediatric instrument, allow for entrance into the vagina without any disruption of the hymen. That hymenal ring is a fibrous band of tissue that is less elastic than the surrounding vaginal mucosa. The ring runs circumferentially around the vaginal opening and extends as a membrane, like a drum head, over the opening to the vagina. The opening and the elasticity of the hymen varies from woman to woman. The hymen, itself, has little in

> the way of sensory nerve endings, but the surrounding tissue is well innervated. This means that the primary source of pain from the manipulation of the hymen is from traction on the vagina or from tearing or injuring the tissue. Pain, therefore, is dependent on the size of the opening of the hymen and the consistency and strength of the tissue. The hymen can usually be stretched with gentle slow traction. The tissue can be anesthetized, without risk, using OTC anesthetic creams. There is no evidence that such preventative measures were considered or implemented in this case.

(Exhibit 16, p. A637.)

149. Dr. Freedman further opined that Respondent's failure to use a pediatric speculum and anesthetic creams was below the standard of care and indicative of Respondent's lack of knowledge.

150. Dr. Stohl opined Respondent's care and treatment of Patient 2 met the standard of care, and Respondent did not violate the standard of care in her performance of Patient 2's pelvic examination. Dr. Stohl pointed out Patient 2 came to Respondent's office and requested a pap smear and was of the age where pap smears were recommended, so it was reasonable for Respondent to conduct the examination and pap smear. Dr. Stohl specifically noted:

> A first gynecologic examination is often uncomfortable for any woman - even for women who have had prior penetrative intercourse. . . . While using a smaller speculum

> can decrease the discomfort in some women, for many women, a pelvic exam is unpleasant regardless of the speculum used.
>
> [Patient 2] presented for her first gynecologic examination. A comprehensive evaluation of pelvic structures is recommended during an initial gynecologic examination of an adult woman. . . . [A]s an adult woman, she could have gynecologic abnormalities which would warrant further work-up. Finally, pap smears are recommended starting at the age of 21. Accordingly, it was reasonable for [Respondent] to complete a full evaluation and perform all elements of the gynecologic examination.

(Exhibit B, p. B29.)

151. Dr. Stohl credibly opined that use of a pediatric speculum on Patient 2 was not required by the standard of care, and she noted Respondent was not a pediatric gynecologist. Dr. Freedman explained:

> [Patient 2] was a virginal woman when she saw [Respondent] for her first gynecological exam at the age of 21. Physically, her pelvis was of adult size but her hymen would have been intact. Given her [history of no prior childbirth], she would not have undergone the vaginal stretching associated with pregnancy and vaginal delivery. Thus, the use of the smallest available speculum in the office would be appropriate. A pediatric speculum would

> not per se be required, as many adult gynecology clinics do not have pediatric speculums readily available. [¶] . . . [¶]
>
> [Respondent] utilized the smallest speculum available to her in her office to perform [Patient 2's] exam. Additionally, she used lots of lubricants on the speculum to further attempt to minimize the discomfort. In virginal women, the hymen is intact. Even the intact hymen, however, does not completely obscure the vaginal canal. The size of the opening of the hymen varies significantly between women. In many women, a speculum can be safely inserted past the hymen and into the upper vagina without tearing or disrupting the hymenal tissue.

(Exhibit B, p. B29 - B30.)

152. Dr. Stohl also credibly opined the standard of care did not require Respondent use analgesic or anesthetic cream when performing a pelvic examination.

153. Regarding Respondent's performance of the pelvic exam for Patient 2, Dr. Stohl's opinions are more persuasive than those of Dr. Freedman. Consequently, Complainant failed to establish by clear and convincing evidence that Respondent violated the standard of care in the manner in which she performed the pelvic exam for Patient 2.

NEGLIGENT DOCUMENTATION FOR PATIENT 2 VISIT

154. Complainant alleges in the Accusation, "Respondent's documentation of her patient encounter with Patient 2 was a departure from the standard of care." (Exhibit 1, p. A10, para. 21.)

155. Dr. Freedman noted in his report:

> The bi-manual exam requires that the patient relax her abdomen, in order to assess the adnexa and other pelvic structures. A woman in pain would reflex[ive]ly tense her abdominal musculature. This phenomenon known as 'guarding' makes an adequate exam impossible.

(Exhibit 16, p. A637.)

156. Dr. Freedman doubted that a bi-manual examination occurred because, if there was extreme pain during the speculum portion of the pelvic examination, Patient 2 "would not tolerate a bi-manual examination." He believed Patient 2 would be tensing her abdominal musculature which would make it unable for Respondent to palpate the abdomen. Dr. Freedman asserted Respondent's documentation (i.e., her notation of "uterus normal size, no adnexal masses palpated") "implies a bi-manual examination occurred without saying it," and "assuming no bi-manual examination" took place, this constitutes inaccurate record keeping and a violation of the standard of care. However, the evidence established (via Respondent's credible and uncontroverted testimony and accompanying documentation) that the bi-manual examination of Patient 2 occurred. Dr. Freedman conceded, if a bimanual examination did occur, "there would not be a problem with" Respondent's documented findings.

157. Dr. Freedman also asserted that Patient 2 "reported that she suffered intense pain during the examination," and that is the type of information required by the standard of care to be contained in the medical record." However, this presupposed that Respondent was made aware of Patient 2's intense pain, which was not established by the evidence.

158. Dr. Stohl opined that Respondent's documentation for Patient 2 met the standard of care. Dr. Stohl maintained, as a trained Ob-Gyn, she was able to understand what examination was performed and the findings. Dr. Stohl explained:

> [Respondent's] documentation includes findings consistent with both a sterile speculum exam as well as a sterile vaginal [bi-manual] exam. She notes normal uterine size and no adnexal masses - both of which are assessed via bi-manual exam and not via speculum. While she does not tease out in her records which findings is associated with which exam, she does note the constellation of findings consistent with a normal pelvic exam.

(Exhibit B, p. B30.)

159. Dr. Stohl disagreed with Dr. Freedman that Respondent needed to document Patient 2's pain. Dr. Stohl credibly opined such documentation would not be required unless Respondent was made aware of atypical pain.

160. Regarding the documentation of Respondent's patient encounter with Patient 2, Dr. Stohl's opinions are more persuasive than those of Dr. Freedman. Consequently, Complainant failed to establish by clear and convincing evidence that

Respondent violated the standard of care by failing to properly document her patient encounter with Patient 2.

FAILURE TO OBTAIN ADEQUATE INFORMED CONSENT FOR A PAP SMEAR

161. Complainant alleges in the Accusation, "Respondent's failure to obtain adequate informed consent for a pap smear for Patient 2 was a departure from the standard of care." (Exhibit 1, p. A10, para. 21.)

162. Dr. Freedman noted the most common cause of an abnormal pap smear is infection with HPV, which is typically spread through sexual intercourse. Consequently, he opined the standard of care is to defer "the psychological trauma and physical discomfort associated with a pelvic exam . . . until the woman is sexually active or over 21." (Exhibit 16, p. A639.) As Dr. Stohl credibly pointed out, Patient 2 "presented to [Respondent's] office at the age of 21, requesting a pap smear. Given her age, this was an indicated procedure and an appropriate one for [Respondent] to perform." (Exhibit B, p. B30.)

163. Dr. Stohl also credibly noted Patient 2 apparently consented to the examination and pap smear. Dr. Stohl pointed out, "The patient requested this evaluation; in fact, it was the primary reason [Patient 2] presented to [Respondent's] office." (Exhibit B, p. B30.) Additionally, since the patient removed underclothes and placed her feet into the stirrups, there is apparent consent to have procedure. Dr. Stohl noted:

> Although [Respondent] does not document specifically the informed consent, verbal consent is sufficient for a pap smear. Additionally, there is nothing in [Patient 2's] complaint that suggests that [Respondent] did not consent

> [Patient 2] prior to the pap smear. The fact that the examination was reportedly painful does not mean that consent was not obtained.

(Exhibit B, p. B30.)

164. While Patient 2 consented to the pelvic examination and pap smear, Dr. Freedman specifically took issue with the information Respondent provided to obtain consent, and he opined Respondent's informed consent fell below the standard of care.

165. Dr. Freedman opined "the fact that [Patient 2] was not given information about whether it was necessary to [undergo the pap smear] is a departure from the standard of care." However, Respondent did attempt to provide information about the necessity of the pap smear. The evidence established Respondent sought to inform Patient 2 a pap smear was unnecessary because abnormal results were unlikely in non-sexually active patients. Respondent asked Patient 2 why she was seeking a pap smear and told her she would tear her hymenal ring and would not "be a virgin anymore." Consequently, the inquiry turns to whether this information was adequate to meet the standard of care.

166. Dr. Freedman opined the information Respondent provided was inadequate. He asserted:

> Informed consent for the procedure must include insur[ing] the patient's understanding of what a pap smear is for, what it identifies, how it is performed, and the meaning of the results of this exam- all in lay terms. Visual aids are necessary for a proper explanation. In this case, informed

> consent must include an anatomy lesson, during which the patient learns the meaning of virginity and the specific structures involved. The location and significance of the hymen must be emphasized. Counseling regarding any applicable religious implications for virginity must be included. Finally, while detailing the exam itself and the insertion of the speculum in particular, the repercussions of the exam must be reviewed at length. The patient must be informed that she will have some pain with this exam. She should be assured that the physician will stop if the exam becomes too painful or simply if the patient wishes to stop. The patient must be informed that the pap smear can safely be left for a later date. . . . There is no evidence that the patient was aware that she did not need a pap at that time-that the exam could safely be postponed. Patient education regarding a navigation around the hymen in order to complete the pelvic examination, was required, but not completed[.]

(Exhibit 16, pp. A639-A640.)

167. Dr. Stohl opined that Respondent met the standard of care for informed consent of Patient 2. She noted Respondent "explained the procedure to the patient prior to performing the exam," and the information provided by Respondent was sufficient to obtain consent for a pap smear. Although Dr. Stohl believed Respondent "explained the procedure," she did not specify what information Respondent was required to provide. Additionally, the evidence did not establish Respondent explained

the procedure to Patient 2, but instead merely sought to dissuade her by noting she would not be a virgin afterward. Dr. Stohl conceded Respondent's "choice of words was not ideal."

168. Regarding Respondent's failure to provide adequate information to obtain informed consent for Patient 2's pap smear, the opinions of Dr. Freedman are more persuasive than those of Dr. Stohl. Consequently, Complainant established by clear and convincing evidence that Respondent violated the standard of care by failing to provide adequate information to obtain informed consent for Patient 2's pap smear.

Alleged Incompetence

169. Complainant alleges in the Accusation that Respondent "demonstrated a lack of knowledge and/or ability in the care and treatment of two patients" as follows:

> 1)Respondent's inaccurate reading of Patient 1's transvaginal ultrasounds, including her failure to record measurements, represents a lack of knowledge or ability.
>
> 2) Respondent's failure to obtain serial HCG testing, because she erroneously believed that such testing is only used to rule out ectopic pregnancies, represents a lack of knowledge or ability.
>
> 3) Respondent's failure to confirm the diagnosis of a presumptive abortion of Patient 1's pregnancy represents a lack of knowledge or ability.
>
> 4) Respondent's omission of the use of a pediatric-size speculum or another means to lessen the patient's pain

during her examination of Patient 2, represents a lack of knowledge or ability.

5) Respondent's failure to advise Patient 2 that a Pap smear examination could be safely postponed represents a lack of knowledge or ability.

(Exhibit 1, p. A11, paras. 22-24.)

INACCURATE READING OF TVS AND FAILURE TO RECORD MEASUREMENTS

170. As set forth above, Complainant failed to establish by clear and convincing evidence that Respondent inaccurately read Patient 1's TVS's or that she was required to record measurements from those ultrasound examinations. Consequently, Complainant has also failed to establish that Respondent demonstrated a lack of knowledge and/or ability in the care and treatment of Patient 1 by inaccurate reading of Patient 1's transvaginal ultrasounds, including failure to record measurements.

FAILURE TO OBTAIN SERIAL HCG TESTING

171. Dr. Freedman opined that Respondent's statements in her Board interview (that she does not check HCG levels unless she is concerned about ectopic pregnancy and that this is not a concern once she has confirmed an intrauterine pregnancy – [See Factual Findings 14 and 21]) represented a lack of lack of knowledge and/or ability. However, as set forth above, Complainant did not establish by clear and convincing evidence that the standard of care requires serial HCG testing to assess the growth of a pregnancy. Consequently, Complainant has also failed to establish that Respondent demonstrated a lack of knowledge and/or ability in the care and treatment of Patient 1 by failure to obtain serial HCG testing.

FAILURE TO CONFIRM DIAGNOSIS OF PRESUMPTIVE ABORTION

172. As set forth above, Complainant did not establish by clear and convincing evidence that the standard of care required Respondent to conduct further "secondary confirmation" after TVS to confirm her diagnosis of missed abortion. pregnancy. Consequently, Complainant has also failed to establish that Respondent demonstrated a lack of knowledge and/or ability in the care and treatment of Patient 1 by failure to confirm the diagnosis of a presumptive abortion of Patient 1's pregnancy.

FAILURE TO USE PEDIATRIC SPECULUM FOR PATIENT 2

173. As set forth above, Complainant did not establish by clear and convincing evidence that the standard of care required Respondent to use a pediatric speculum or another means to lessen Patient 2's pain during her examination. Consequently, Complainant has also failed to establish that Respondent demonstrated a lack of knowledge and/or ability in the care and treatment of Patient 2 by failure to use of a pediatric-size speculum or another means to lessen the patient's pain during her examination.

FAILURE TO ADVISE PATIENT 2 ABOUT POSTPONEMENT OF PAP SMEAR

174. As set forth above, Complainant established Respondent's inadequate provision of information to Patient 2 prior to her pap smear fell below the standard of care. However, while Complainant established Respondent's negligence, Complainant did not establish by clear and convincing evidence that Respondent's inadequate provision of information demonstrated a lack of knowledge or ability.

175. Incompetence has been defined as a lack of "qualification, ability or fitness to perform a prescribed duty or function." (*Kearl v. Bd of Med Quality Assur.*

(1986) 189 Cal.App.3d 1040, 1054, citing *Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837.) Negligence assumes that one is "competent or capable of performing a given duty, but negligent in performing that duty." (*Kearl, supra*, Cal.App.3d at p. 1055; *Pollack, supra*, 85 Cal.App.3d at p. 838.)

176. Respondent apparently understood she was required, and had the ability, to obtain informed consent from Patient 2, including providing information about the examination and possible postponement of the pap smear. However, Respondent was negligent in providing adequate informed consent. Consequently, Complainant has also failed to establish that Respondent demonstrated a lack of knowledge and/or ability in the care and treatment of Patient 2 by failing to adequately advise Patient 2 that a pap smear examination could be safely postponed.

Inadequate or Inaccurate Recordkeeping

177. As set forth above (see Factual Finding 128), Complainant established by clear and convincing evidence that Respondent failed to maintain adequate and accurate records for Patient 1 by: failing to correct the inaccurate LMP entry on July 5, 2018; inadequately documenting the July 5, July 19, and July 24, 2018 pelvic examinations; failing to document a specific assessment on July 19, 2018; failing to document the purported administration of RhoGAM after June 24, 2018; and failing to document her July 27, 2018 conversation with GAMC ER personnel and Patient 1.

Respondent's Character Evidence

178. Respondent has no record of prior Board discipline.

179. Respondent has the support of several colleagues who testified on her behalf and supported her continued licensure.

180. Marc Incerpi, M.D., a maternal fetal specialist to whom Respondent refers patients, has reviewed Respondent's medical records. He also sits on the peer review committee at St. Joseph. Dr. Incerpi opined that Respondent is a "good practitioner" with "strong clinical judgment" and "an asset to the medical staff" at St. Joseph.

181. Jose Aranez, M.D., an Ob-Gyn with a solo practice in Burbank, has known Respondent for about five years as a colleague at St. Joseph. He described her surgical competence as "superior," and opined "she is one of the best Ob-Gyns" at St. Joseph.

182. Sofya Tsyganovskaya, M.D., the Ob-Gyn who shares office space with Respondent, has worked "side-by-side" with Respondent for about three years. She described Respondent as a "good" and "very knowledgeable" physician with "excellent surgical skills," who is "getting better and better and more mature" as a physician.

LEGAL CONCLUSIONS

1. The standard of proof which must be met to establish the charging allegations is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

2. The Board has the authority to revoke or suspend a physician's license for engaging in unprofessional conduct. (Bus. & Prof. Code, §§ 2004, 2234.) Unprofessional conduct includes repeated negligent acts and incompetence. (Bus. & Prof. Code, § 2234, subds. (c), (d).)

3. Business and Professions Code section 2266 provides, "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."

4. Cause exists to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Respondent committed repeated acts of negligence in her care and treatment of Patients 1 and 2, by: failing to correct the inaccurate LMP entry for Patient 1 on July 5, 2018; inadequately documenting Patient 1's July 5, July 19, and July 24, 2018 pelvic examinations; failing to document a specific assessment for Patient 1 on July 19, 2018; failing to document the purported administration of RhoGAM to Patient 1 after June 24, 2018; failing to document her July 27, 2018 conversation with GAMC ER personnel and Patient 1; and failing to provide adequate information to obtain informed consent for Patient 2's pap smear. (Factual Findings 3 through 168.)

5. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (d), in that Complainant did not establish that Respondent demonstrated a lack of knowledge and/or ability in the care and treatment of Patients 1 and 2. (Factual Findings 3 through 176.)

6. Cause exists to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, in that Respondent failed to maintain adequate and accurate records in her care and treatment of Patient 1. (Factual Findings 3 through 168, and 177.)

7. Complainant established that Respondent engaged in a failure to maintain adequate and accurate records and in repeated acts of negligence in her

treatment of two patients. The remaining question is the nature of the discipline to be imposed against Respondent's certificate for her violations.

8. Business and Professions Code section 2229 provides, in pertinent part:

> (a) Protection of the public shall be the highest priority for the Division of Medical Quality . . . and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
>
> (b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel . . . shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.

9. Business and Professions Code section 2227, subdivision (a), provides:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, . . . and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the division.

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

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

(4) Be publicly reprimanded by the division.

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

10. Respondent's violations arise from her inadequate and inaccurate documentation along with her inadequate provision of information when obtaining consent for a first pap smear. Accurate and sufficient documentation is important to allow other practitioners to understand what occurred with a patient, and deficient documentation may make future treatment more difficult. Additionally, adequate provision of information when obtaining informed consent is essential to allow the patient the ability to make educated choices in their medical care.

11. Respondent's violations all apparently stem from her cursory approach to documenting and providing information. And this terse mindset did not go unnoticed by Patients 1 and 2, who perceived Respondent as hurried and insensitive. A detached demeanor is not below the standard of care in the evidence-based, clinical field of medicine, and succinctness does not always translate to negligence. However, as was evidenced in this case, approaching the practice of medicine with taciturn brevity can skirt the line between being within the standard of care and falling below it. While Respondent was able to stay just above the line in most instances, she crossed into inadequacy and negligence in others.

12. Given the foregoing, the Board has a duty to protect the public and ensure that no further violations occur. While outright revocation is not warranted, in weighing the goals of public protection and rehabilitation of the licensee, a short period of probation with education courses and a medical recordkeeping course will provide adequate public protection while working toward effective rehabilitation.

ORDER

Physician's and Surgeon's Certificate Number A 128242, issued to Respondent, Vardui Asiryan, M.D., is revoked. However, the revocation is stayed, and Respondent is placed on probation for two years upon 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.

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2. 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.

3. 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.

4. 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).

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Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

5. 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.

6. Non-practice While on Probation

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

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

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

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

7. 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.

8. 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 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.

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9. 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.

10. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance of the additional 40 hours of CME in satisfaction of this condition.

11. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment.

Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the 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.

12. Completion of Probation

Respondent shall comply with all financial obligations (i.e., 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.

DATE: 01/14/2022

Julie Cabos-Owen

JULIE CABOS-OWEN

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:	Case No. 800-2019-062110
Vardui Asiryan, M.D. **831 East Tujunga Avenue** **Burbank, CA 91501-1433** **Physician's and Surgeon's Certificate No. A 128242,** Respondent.	**A C C U S A T I O N**

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 December 27, 2013, the Medical Board issued Physician's and Surgeon's Certificate Number A 128242 to Vardui Asiryan, 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 October 31, 2021, unless renewed.

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JURISDICTION

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

4. Section 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.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

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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.

FACTUAL ALLEGATIONS

Patient 1[1]

7. On or about January 23, 2020, the Board received a complaint from Patient 1 who alleged that Respondent, who is engaged in the practice of medicine as an Obstetrician/Gynecologist, negligently induced an abortion of Patient 1's viable pregnancy.

8. Patient 1, a 39-year-old woman who believed that she was pregnant, presented to Respondent for prenatal care on June 21, 2018. Patient 1 gave a last menstrual period of May 24, 2018, with a history of regular cycles. Respondent did not elicit and did not record the specifics of that last period, nor the normal length of the patient's cycles, nor the usual characteristics or any other factors that could have affected the patient's cycle. Respondent performed a urine pregnancy test, which was read as a "light" positive, and the patient was sent for a blood test for confirmation of pregnancy. The HCG levels results were 2046, which was consistent with an early pregnancy.[2]

9. Patient 1 returned to see Respondent on July 5, 2018, for a complete prenatal exam. Her obstetrical history was significant for a vaginal delivery in 2001 and a miscarriage in 2007 at 10 weeks gestation. Respondent did not elicit and did not document details or treatment of the 2007 miscarriage. Patient 1 had a history of an abdominal myomectomy (surgical removal of fibroids from the uterus). For a woman of that age, a history of a myomectomy (rather than a hysterectomy) is indicative of her desire to have more children. However, the date of the myomectomy and its findings were not elicited or documented by Respondent. Patient 1 was also Rh negative. Pelvic examination, including examination of the cervix, uterine size, diagonal conjugate, and pelvic type were noted as

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[1] The patients are identified by number to protect their privacy. The patients' identities are known to the Respondent and/or will be provided to her in response to Request for Discovery.

[2] HCG refers to Human Chorionic Gonadotropin, a hormone excreted by a growing placenta after a fertilized egg implants in the woman's uterus. HCG levels tend to increase rapidly during the early stages of a normal pregnancy.

"normal" by Respondent. Respondent did not elicit and did not document any physical signs of pregnancy, including the size and consistency of the uterus. What "normal" represents in this case was not defined, particularly as it relates to pregnancy. A transvaginal ultrasound was reported as "pos. gest. sac" and "pos yolk sac". Respondent did not retain and did not document Patient 1's informed consent before performing a transvaginal ultrasound. Respondent failed to document ultrasound measurements. Respondent did not order another HCG sampling.

10. Patient 1 returned to see Respondent on July 19, 2018, where another transvaginal ultrasound was performed. Once again, Respondent did not obtain and did not document Patient 1's informed consent to perform a transvaginal ultrasound. The findings were reported as an enlarged sac with no fetal pole. Respondent did not take any measurements which would have objectively supported her diagnosis. Respondent's presumptive diagnosis of a missed abortion was not documented or discussed in Patient 1's records. Respondent did not take any steps to confirm her diagnosis. A differential diagnosis to include incorrect dating of the last menstrual period and reestablishment of abnormal placentation, were not considered, addressed or documented. Serial HCG levels or progesterone levels, a more thorough history and physical examination, or a radiologic consult could have confirmed or refuted Respondent's diagnosis, but Respondent failed to perform any of those. During her interview with the Board investigators Respondent explained, incorrectly, that HCG levels are only used to rule out ectopic pregnancies. Patient 1 was instructed to return for follow-up on July 24, 2018, when the ultrasound exam was repeated. The ultrasound was reported to demonstrate an increase in the size of the sac, although no measurements were taken or recorded. Respondent told Patient 1 that her baby had no heartbeat. Respondent then gave Patient 1 three options: to continue with expectant management awaiting a miscarriage, to medically induce a miscarriage, or to obtain a second opinion. Patient 1 had additional questions and attempted to question Respondent, who grew frustrated and became dismissive. The patient was given prescriptions for misoprostol[3] and RhoGAM. Respondent did not document when the patient

[3] Misoprostol, also known by brand name Cytotec, is a prescription medication that can be used to terminate a pregnancy.

received the RhoGAM injection. Respondent then left on vacation without making clear alternative coverage arrangements.

11. On or about July 27, 2018, Patient 1 presented to the E.R. at Glendale Adventist Hospital. She complained of severe cramping due to having taken misoprostol, as directed by Respondent. An ultrasound performed at that time demonstrated a viable intra-uterine pregnancy at 6 weeks gestation. The uterus was measured at 8.1 x 6.0 x 6.0 cm. A single intrauterine gestational pregnancy was noted in the fundal endometrium. The gestational sac measured 1.6 cm, corresponding to 5 weeks, 6 days gestation. Positive yolk sac and fetal pole were reported. The crown-rump length of the fetal pole measured 3.2 mm, corresponding to 6 weeks gestation. Positive fetal heart tones were elicited at 118 bpm. and a corpus luteum was noted in the right ovary. After consulting with Respondent over the phone, Patient 1 was discharged home on vaginal progesterone.

12. On or about August 5, 2018, Patient 1 returned to the hospital, bleeding, after having passed tissue at home due to a miscarriage.

Patient 2

13. On or about November 26, 2019, the Board received a complaint from Patient 2, a 21-year-old woman, who presented to Respondent on April 17, 2019 for her first gynecologic check-up and a Pap smear exam. The patient made several complaints, including that the examination was unduly painful, and that Respondent told Patient 1 that she would not be a virgin anymore after the Pap smear.

14. During her initial workup, Patient 2 stated that she had never had penetrative sex. Respondent elicited and documented no details of the patient's history of pain or discomfort and never questioned the patient about any other details of her history.

15. The size and length of the instrument necessary to appropriately perform a pelvic examination and Pap smear varies from patient to patient. An appropriate size of the instrument should be chosen so that the patient would not need to experience needless pain during the examination. A pediatric-size speculum may be used to reduce the patient's pain. Traction can be applied slowly to the tissues involved, and OTC anesthetic creams can be applied to prevent or lessen the pain associated with a speculum examination. Respondent did not take and did not

document taking any measures to reduce the patient's pain during the speculum examination. Respondent did not have a pediatric-size speculum available. The patient complained that she suffered severe pain during the examination, which caused Patient 2 to cry or weep, and have difficulty walking subsequently, but Respondent did not stop or change the manner of examination. Respondent documented that Patient 2's pain level was zero during the speculum exam and Pap smear. During her interview with the Board's investigators, Respondent stated that she did not use a pediatric speculum when examining Patient 2 because she would not be able to reach the patient's cervix.

16. Following a painful speculum exam, a bi-manual exam is generally even more painful. Respondent's medical record for Patient 2 indicates that a bi-manual exam was performed with normal findings, and does not comment on the patient's pain level or any precautions or techniques used to prevent pain during the bi-manual examination.

17. Pap smear screening can be started at age 21. However, an appropriate informed consent for a 21-year-old patient with no history of disease or penetrative sex should include information that the Pap smear may be safely postponed. During her interview with the Board's investigators, Respondent repeatedly stated that she performed the Pap smear on Patient 2 only because the patient asked for it. Respondent did not advise and did not document advising the patient that the Pap smear could be safely postponed.

18. Appropriate informed consent discussion preceding a Pap smear should include information about the location and significance of the hymenal ring and counseling regarding any applicable religious implications regarding virginity. Respondent told the patient that she would not be a virgin after a Pap smear, but Respondent did not perform, and did not document performing appropriate patient education as required by the standard of care to obtain informed consent from Patient 2.

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FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

19. Respondent Vardui Asiryan, M.D. is subject to disciplinary action under Code section 2234, subdivision (c), in that she engaged in repeated acts of negligence. The circumstances are as follows:

20. Allegations of paragraphs 7 through 18 are incorporated herein by reference.

21. Each of the following acts by Respondent constitute a departure from the standard of care:

1) Respondent's failure to appropriately evaluate Patient 1's early pregnancy was a departure from the standard of care.

2) Respondent's failure to document the details of evaluation, treatment and follow up of Patient 1, including the significance of findings with regard to the viability of Patient 1's pregnancy, represents a departure from the standard of care.

3) Respondent's failure to take and/or document any measurements during the ultrasound performed on July 5, 2018, July 19, 2018, and on July 24, 2018 was a departure from the standard of care.

4) Respondent's failure to obtain appropriate informed consent for serial transvaginal ultrasounds from Patient 1 was a departure from the standard of care.

5) Respondent's failure to obtain appropriate informed consent to perform a medical abortion of Patient 1's pregnancy, including but not limited to answering all of her questions and advising the patient about the effects of misoprostol, was a departure from the standard of care.

6) The manner in which the pelvic exam was performed for Patient 2 was a departure from the standard of care.

7) Respondent's documentation of her patient encounter with Patient 2 was a departure from the standard of care.

8) Respondent's failure to obtain adequate informed consent for a Pap smear for Patient 2 was a departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

22. Respondent Vardui Asiryan, M.D. is subject to disciplinary action under Code section 2234, subdivision (d), in that she demonstrated a lack of knowledge and/or ability in the care and treatment of two patients. The circumstances are as follows:

23. Allegations of paragraphs 7 through 18 are incorporated herein by reference.

24. Each of the following acts by Respondent demonstrated a lack of knowledge or ability:

1) Respondent's inaccurate reading of Patient 1's transvaginal ultrasounds, including her failure to record measurements, represents a lack of knowledge or ability.

2) Respondent's failure to obtain serial HCG testing, because she erroneously believed that such testing is only used to rule out ectopic pregnancies, represents a lack of knowledge or ability.

3) Respondent's failure to confirm the diagnosis of a presumptive abortion of Patient 1's pregnancy represents a lack of knowledge or ability.

4) Respondent's omission of the use of a pediatric-size speculum or another means to lessen the patient's pain during her examination of Patient 2, represents a lack of knowledge or ability.

5) Respondent's failure to advise Patient 2 that a Pap smear examination could be safely postponed represents a lack of knowledge or ability.

THIRD CAUSE FOR DISCIPLINE

(Record Keeping)

25. Respondent Vardui Asiryan, M.D. is subject to disciplinary action under Code section 2266 in that she kept inadequate and inaccurate records in the care and treatment of two patients. The circumstances are as follows:

26. Allegations of paragraphs 7 through 18 are incorporated herein by reference.

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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 128242, issued to Vardui Asiryan, M.D.;

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

3. Ordering Vardui Asiryan, 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: FEB 05 2021

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

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