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

In the Matter of the Accusation Against: Linda Adele Warren, M.D. Physician's and Surgeon's Certificate No. C 40079 Respondent.	Case No. 800-2017-034090

DECISION

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

This Decision shall become effective at 5:00 p.m. on October 31, 2020.

IT IS SO ORDERED AUG 14 2020.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
JONATHAN NGUYEN
Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **LINDA ADELE WARREN, M.D.** **6627 South Holt Avenue** **Los Angeles, CA 90056-2211** **Physician's and Surgeon's Certificate No. C 40079,** Respondent.	Case No. 800-2017-034090 OAH No. 2019110267 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Jonathan Nguyen, Deputy Attorney General.

2. LINDA ADELE WARREN, M.D. (Respondent) is represented in this proceeding by attorney Dennis R. Thelen, Esq., whose address is: 5001 E. Commercenter Drive, Suite 300, Bakersfield, CA 93309.

3. On or about October 5, 1981, the Board issued Physician's and Surgeon's Certificate

No. C 40079 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-034090 and will expire on October 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-034090 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 7, 2019. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2017-034090 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-034090. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2017-034090, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima

facie case with respect to the charges and allegations contained in the Accusation and that those charges and allegations constitute cause for discipline. Respondent hereby gives up her right to contest those charges and allegations.

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

RESERVATION

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

CONTINGENCY

12. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

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

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 40079, issued to Respondent LINDA ADELE WARREN, M.D., is surrendered and accepted by the Board effective on October 31, 2020.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2017-034090 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2017-034090 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

Decision and Order of the Medical Board of California.

DATED: 6-21-2020

Linda Adele Warren, MD

LINDA ADELE WARREN, M.D.
Respondent

I have read and fully discussed with Respondent LINDA ADELE WARREN, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 6-15-20

DENNIS R. THELEN, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 6/23/20

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

JONATHAN NGUYEN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-034090

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct. 7 20 19
BY A. Geremia ANALYST

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

In the Matter of the Accusation Against: **Linda Adele Warren, M.D.** **6627 South Holt Avenue** **Los Angeles, CA 90056** **Physician's and Surgeon's Certificate No. C40079,** Respondent.	Case No. 800-2017-034090 **ACCUSATION**

PARTIES

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

2. On or about October 5, 1981, the Medical Board issued Physician's and Surgeon's Certificate Number C40079 to Linda Adele Warren, 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, 2020, 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 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

5. Section 2227 of the Code states:

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

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

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

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

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

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

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

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

"(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.

"..."

7. 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

8. Patient 1,[1] then a 56-year-old female patient, presented to Respondent at Farid Medical Group with complaints of post menopausal vaginal bleeding. Patient 1 reported that her menses had ceased three years ago, but she was experiencing spotty brown vaginal bleeding accompanied by mucous, for about one year. The bleeding increased with exercise. Patient 1 also complained of urinary incontinence. Her past history was significant for diabetes and hypertension. Her physical exam revealed morbid obesity and atrophic pelvic changes involving the vagina and cervix. Respondent listed post-menopausal bleeding, incontinence, and obesity as her diagnoses. The plan was for a pap smear, testing for follicle-stimulating hormone (FSH) and estradiol levels, a pelvic ultrasound, and urinalysis.

9. On or about August 14, 2013, Respondent saw Patient 1 and ordered an ultrasound and lab work.

10. The ultrasound was completed on August 26, 2013. Evidence of bloodwork was not found in the clinical patient records.

11. The patient failed to show up for her scheduled September 9, 2013 visit with another doctor in the office. Office policy states that the chart of patients who missed their appointments are to be placed on the physician's desk.

12. The clinic had a practice of staff sorting all labs that come in, with normal tests being filed and abnormal tests being placed on the physician's desk to be reviewed by the physician. Once reviewed, the physician would initial and date the report to be filed or write further instructions.

13. The ultrasound was dated September 9, 2013 with a signature that looked like the signature of the Respondent. Per the clinic assistant, Respondent reviewed the chart with no further recommendations.

[1] For privacy purposes, the patient in this Accusation is referred to as Patient 1, with the identity of the patient disclosed to Respondent in discovery.

14. However, the ultrasound was grossly abnormal with uterine enlargement, including a 7cm heterogeneous mass. The endometrium was thickened at 27.6mm. The radiologist noted that the patient should be further evaluated with an MRI.

15. Respondent took no action to notify Patient 1 of her test results, directly or indirectly, or to refer her for a biopsy.

16. Patient 1 was not informed of the abnormal findings until she was seen by another physician the next year. She was eventually diagnosed with endometrial cancer.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Follow-up on Diagnostic Testing for Cancer)

17. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she engaged in gross negligence by failing to follow-up with the patient or with the clinical staff regarding the patient's ultrasound test results after referral for a possible diagnosis of endometrial cancer.

18. The standard of medical practice for a physician in the clinical setting includes ordering of laboratory tests with an obligation for follow-up. Physicians have a responsibility to monitor if the tests are completed by the patient and the laboratory. They then have an obligation to review the results, interpret the findings, notify the patient, and plan further treatment.

19. Respondent's acts and/or omissions, as set forth in Paragraphs 8 through 16 above, constitute an extreme departure from the standard of care.

20. Respondent's acts and/or omissions, as set forth in Paragraphs 8 through 16, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

21. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that she engaged in repeated acts of negligence in the care and treatment of Patient 1. Specifically, she was negligent in managing the patient's post-menopausal bleeding and in obtaining informed consent as to the diagnosis plan.

22. The allegations of the first cause for discipline are incorporated by reference as if fully set forth herein.

23. The standard of care when it comes to management of post-menopausal bleeding is that vaginal bleeding arising after menopause must be considered due to cancer, until proven otherwise. Although confirmatory testing may be warranted and initiated, a biopsy of the endometrium is required for diagnosis.

24. The standard of care in obtaining informed consent is to ensure that the patient is properly informed that vaginal bleeding is the only reliable warning sign of endometrial cancer. The patient should understand that accurate diagnosis requires tissue sampling via office endometrial biopsy or curettage under anesthesia. Ultrasound may be indicative of the diagnosis but is not always conclusive. Furthermore, the etiology of the bleeding requires treatment via hormonal therapy or surgical intervention, after the diagnosis has been made. A patient who is aware of the risk of cancer and the need for a biopsy and further treatment would be more likely to return for proper follow-up.

25. A physician's options in evaluating a patient for cancer include ultrasound examination with an endometrial biopsy, hysteroscopy, or dilation and curettage.

26. A normal ultrasound findings would still have required additional evaluation of the endometrial cavity to ascertain the origin of the uterine bleeding.

27. Respondent failed to initiate a diagnosis plan that involved acquiring a tissue sample using any procedures. Respondent did not attempt to obtain insurance authorization for the critical biopsy at the first visit, along with authorization for the ultrasound, to ensure timeliness and completeness of diagnosis.

28. Respondent also failed to properly communicate a diagnosis, treatment plan, and obtain consent from the patient. The critical need for follow-up on the ultrasound and tissue sample was not conveyed to the patient, along with stressing the importance of ruling out cancer. Making sure the patient understood that cancer was a possibility would have ensured compliance with the diagnosis plan. The brief chart note, documenting that patient was instructed to return

after her ultrasound, did not indicate that the urgency of follow up was properly communicated to Patient 1.

29. Respondent's acts and/or omissions as set forth in paragraphs 8 through 28 above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

30. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to her care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 29, above, as though fully set forth herein.

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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 C 40079, issued to Linda Adele Warren, M.D.;

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

3. Ordering Linda Adele Warren, 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: October 7, 2019

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

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