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

In the Matter of the Accusation Against:

DAVID ARI BLOOM, M.D., Respondent

Case No. 800-2016-028979

OAH No. 2019031074

DECISION AFTER NON-ADOPTION

Marcie Larson, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter from March 9 through 13, 2020, in Sacramento, California.

Jannsen Tan, Deputy Attorney General (DAG), represented Complainant William J. Prasifka, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs (Complainant).

Lawrence Giardina, Attorney at Law, represented Respondent David Ari Bloom, M.D., (Respondent) who appeared at the hearing.

Evidence was received and the record remained open for submission of written closing arguments. Complainant's closing brief was filed on May 28, 2020, and marked as Exhibit 18. Respondent's closing brief was filed on June 30, 2020, and marked as

Exhibit T.[1] Complainant's reply brief was filed on July 9, 2020, and marked as Exhibit 19. The record closed and the matter was submitted for decision on July 10, 2020. The ALJ issued a proposed decision on August 7, 2020.

On November 19, 2020, Panel A of the Board issued an Order of Non-Adoption of Proposed Decision. Oral argument on the matter was heard by Panel A on February 3, 2021, with ALJ Heather Rowan presiding. DAG Jannsen Tan appeared on behalf of the Complainant. Respondent was present and was represented by Lawrence S. Giardina, Attorney at Law. Panel A, having read and considered the entire record, including the transcript and the exhibits, and having considered the written and oral argument, hereby enters this Decision After Non-Adoption.

FACTUAL FINDINGS

1. On November 16, 2015, the Board issued Respondent Physician and Surgeon's Certificate No. C 139300 (certificate). The certificate was current at all times pertinent to this matter and will expire on September 30, 2021, unless renewed.

2. On July 19, 2018, Kimberly Kirchmeyer, the former Executive Director of the Board, signed and thereafter filed the Accusation against Respondent. Complainant seeks to impose discipline on Respondent's certificate, based on his

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[1] Respondent's Motion to Strike portions of Complainant's closing brief is denied. The discussion of evidence in Complainant's brief was contained in evidence admitted at hearing without objection. However, evidence of allegations related to patients other than Patient A are not relevant and were not considered.

treatment of Patient A. Generally, Complainant alleged Respondent departed from the standard of care in his treatment and care of Patient A when performing a laparoscopic cholecystectomy, the surgical removal of the gallbladder, by failing to obtain a Critical View of Safety (CVS) before removing her gallbladder, resulting in a common bile duct injury. Complainant also alleged Respondent failed to adequately document the surgery in his operative report. Complainant alleged Respondent's conduct constituted gross negligence, repeated acts of negligence, and a failure to maintain complete and accurate medical records concerning the treatment he rendered to Patient A.

3. Respondent timely filed a Notice of Defense, pursuant to Government Code section 11506. The matter was set for an evidentiary hearing before an Administrative Law Judge of the OAH, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

Respondent's Background

4. Respondent completed a Bachelor of Arts degree in biology at Grinnell College, in Grinnell, Iowa in 1993. He obtained a Master's Degree in marine biology from Boston University in 1994. Respondent then completed a Ph.D. in marine, estuarine and environmental sciences from University of Maryland, Baltimore.

5. In 2003, Respondent obtained his medical degree from the Sackler School of Medicine, Tel Aviv University. Thereafter, he completed a one-year internship and four-year surgical residency at Brookdale University Hospital Medical Center in Brooklyn, New York, which he completed in 2010. Respondent learned how to perform laparoscopic cholecystectomy during his internship, and performed approximately 100

laparoscopic cholecystectomies during his residency. In 2010, Respondent obtained a New York medical license.

6. In 2011, Respondent opened a private practice in Long Beach, New York. He worked as a general surgeon covering shifts at the emergency room, as well as inpatient services and clinics at the Long Beach Medical Center. Within two years, a storm flooded the town and caused the medical center to close. Respondent closed his private practice and began performing locum work in various hospitals in the United States while he waited for Long Beach Medical Center to reopen. Locum positions are typically temporary.

7. In 2013, Respondent obtained his Oklahoma medical license. He worked at two hospitals in Oklahoma, performing general surgery. In 2015, he obtained medical licenses in Illinois, Washington, Iowa and California. The same year he obtained his Board certification in general surgery from the American College of Surgery. Respondent continued to perform laparoscopic cholecystectomies as part of his general surgeon duties.

8. In October 2016, Respondent was employed by Surgical Affiliates, in Sacramento, California. The practice consisted of three or four surgeons, nurse practitioners, medical assistants, and physician assistants. Respondent's duties included performing general surgery consultations and operations for emergency room patients at Sutter Medical Center, Sacramento (Sutter), including laparoscopic cholecystectomies. As of late October 2016, Respondent had worked at Sutter for less than a month.

Description of the Laparoscopic Cholecystectomy and CVS

9. Laparoscopic cholecystectomy is the minimally invasive removal of the gallbladder, an organ, located beneath the liver, that acts as storage for bile. The gallbladder is part of the biliary tract[2] which also includes the liver and bile ducts. A cystic duct and cystic artery branch off of the gallbladder. The cystic duct converges with the common bile duct which is the main tube that connects the liver to the intestines. The proximal part of the common bile duct is referred to as the common hepatic duct, which connects to the liver and carries bile from the liver to the intestine. The common hepatic duct bifurcates into the right and left hepatic ducts before it enters the liver. Bile flows from the liver into the intestines through the common hepatic duct.

10. Laparoscopic removal of the gallbladder requires the transection of the cystic duct and cystic artery. The CVS is a three-step process used by surgeons before a gallbladder is removed, to reduce the risk of biliary injuries. These steps include: (1) clearing the hepatocystic triangle[3] of fat and fibrous tissue; (2) separating the lower one-third of the gallbladder from the liver to expose the cystic plate;[4] and (3) confirming that only two structures are seen entering the gallbladder, the cystic duct and cystic artery.

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[2] The biliary tract is also referred to as the biliary tree.

[3] The hepatocystic triangle is also referred to as the Triangle of Calot. The triangle is formed by the cystic duct, the common hepatic duct, and the liver.

[4] The cystic plate is also referred to as the liver bed of the gallbladder.

Treatment of Patient A

11. On October 22, 2016, at approximately 10:14 p.m. Patient A, a 30-year-old woman, was admitted to the Sutter emergency room after complaining of pain in the right upper quadrant of her stomach. She reported having increased pain for approximately five hours. She also reported having the pain to some extent for the preceding month. An ultrasound of Patient A's abdomen was completed and blood was taken. The attending emergency room doctor diagnosed Patient A with possible biliary colic, pain caused by a gallstone, or early acute cholecystitis, which is inflammation of the gallbladder.

12. In the early morning of October 23, 2016, while working at Sutter as an on-call surgeon, Respondent was assigned to evaluate Patient A for a possible laparoscopic cholecystectomy. He obtained a history from Patient A, conducted a physical examination and obtained her vital signs. Respondent noted Patient A had a "positive Murphy's sign," which is a report of pain after Respondent put pressure on the upper right quadrant of her abdomen. Respondent also reviewed the laboratory results which revealed an elevated white blood cell count and ultrasound findings which was positive for pericholecystic fluid[5] and cholelithiasis[6]. Respondent diagnosed Patient A with acute cholecystitis.

13. Respondent recommended to Patient A that she undergo a laparoscopic cholecystectomy, and explained to her the risks and benefits of the procedure. She consented to the laparoscopic cholecystectomy and was prepared for surgery that

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[5] Pericholecystic fluid is fluid around the gallbladder.

[6] Cholelithiasis is gallstones.

afternoon. Patient A was sedated, intubated and administered general anesthesia. Respondent applied penetrating towel clamps on either side of Patient A's umbilicus to evaluate the abdominal wall away from the intestines. Respondent then incised the umbilicus with a blade scalpel. He next inserted a trocar through the incision into the abdomen to function as a portal to keep the incision open to allow the camera instrument to be inserted. The camera was hooked up to a monitor that allowed Respondent to view the gallbladder and surrounding structures. Respondent then made incisions in the epigastrium area, which is the upper abdomen over the stomach and the right lower quadrant, and inserted trocars to allow instruments to be inserted.

Respondent observed and documented in the operative report that Patient A's gallbladder was "greatly distended." Respondent guided a laparoscopic needle with attached syringe through one of the trocars to enter the gallbladder and aspirated bile fluid to make the gallbladder easier to grasp. Respondent used a tool to grasp the gallbladder. He identified what he believed was the cystic duct and cystic artery, which he circumferentially dissected free from the surrounding connective tissue. He then made another incision and inserted a second right lower quadrant trocar to "facilitate mobilization" of the gallbladder. Respondent "separately doubly ligated" the cystic duct and cystic artery with surgical clips. He then divided the cystic duct and cystic artery, in order to remove the gallbladder.

Respondent noted there was "no leakage of bile or ongoing bleeding from the cystic duct or artery." He then took the gallbladder off the liver bed with electrocautery. Patient A had some bleeding from the liver bed, which stopped with the use of "cautery, surgicell and floseal." The gallbladder was placed in an Endocatch bag and removed through the umbilical port. The trocars were removed and the

incisions were closed. Respondent noted that Patient A was stable and there appeared to be "no apparent complications."

14. The surgical pathology diagnosis for Patient A included: severe acute necrotizing and ulcerative cholecystitis; superimposed on subacute and chronic cholecystitis; benign cystic duct with cautery artifact; cholesterolosis; and cholelithiasis.

EVENTS AFTER OCTOBER 23, 2016

15. On October 24, 2016, the day after the surgery, Patient A complained of sharp chest pain and shortness of breath. She described her pain as a "10" on a scale of one to 10. Patient A also had tachycardia.[7] An electrocardiography (ECG) was administered. Patient A was diagnosed with pericarditis[8] and administered anti-inflammatory medication.

16. Patient A continued to have chest pain. A computerized tomography (CT) scan was ordered and revealed fluid around Patient A's liver, gallbladder fossa[9] and mid-abdomen which suggested there was an active bile leak. A hepatobiliary (HIDA) scan was also performed which revealed a probable common bile duct obstruction and ongoing bile leak. On October 28, 2016, an endoscopic retrograde cholangiopancreatography (ERCP) of Patient A was performed. The findings were

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[7] Tachycardia is an increased heart rate.

[8] Pericarditis is inflammation of the membrane surrounding the heart.

[9] The gallbladder fossa is the area where the gallbladder was removed from the liver.

"suggestive of [a] common bile duct transection as attempts to pass a guidewire through the common duct were unsuccessful as [surgical] clips precluded passage."

17. On October 29, 2016, Dr. Graves, a hepatobiliary surgeon specialist evaluated Patient A. He ordered a magnetic resonance cholangiopancreatography (MRCP) to be performed, which confirmed Patient A had a bile leak from the proximal common bile duct, with a complete obstruction of the distal common bile duct. Dr. Graves opined Patient A sustained a common bile duct transection and clipping. Patient A was stable and a drain was inserted into her abdomen to remove bile. Dr. Graves recommended Patient A delay surgery to repair the common bile duct and to allow the inflammation from the bile peritonitis[10] to decrease. Patient A lived in Southern California. Once released from Sutter, she intended to return home to continue her treatment.

18. On October 31, 2016, Patient A began complaining of pain. She had nausea, vomiting, and bloody drainage from her abdominal drain. At one point a "code blue" was called on Patient A due to a syncopal episode.[11] Patient A was breathing and had a pulse but was not "verbally responsive." She was also tachycardic. Supplemental oxygen was administered and she improved. Patient A was transferred to the Intensive Care Unit (ICU) for continued care. Lab tests revealed Patient A had an elevated white blood cell count. She was diagnosed with sepsis, which is an infection in the blood stream. A CT scan was performed of Patient A's abdomen and pelvis,

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[10] Bile peritonitis is the peritoneal lining of the organs and abdomen.

[11] Syncopal episode is unresponsiveness or unconsciousness.

which revealed heterogeneous perihepatic and perisplenic fluid[12] caused by an intra-abdominal acute hemorrhage, that had not been drained. Dr. Andrea Crowley and Dr. Graves recommended Patient A undergo a diagnostic laparoscopy to wash out bile and clotting in the abdomen and determine the cause of her condition.

19. On November 1, 2016, Dr. Crowley and Dr. Graves performed a laparoscopy on Patient A. During the procedure, the doctors identified that the common hepatic duct had been transected and discovered bile draining from the liver in her abdomen. A surgical clip was located on the distal part of the common bile duct. The doctors irrigated the abdomen and were able to remove most of the clot and bile. The doctors inserted a pediatric feeding tube into the open common hepatic transected duct to allow the bile to drain. Patient A was in the hospital for 11 more days before she was released on November 12, 2016. However, Patient A needed additional surgery to repair the common bile duct injury.

Investigation Conducted by Sutter

20. In late October or early November 2016, a Patient Safety Report (PSR) was initiated at Sutter to review quality of care concerns regarding Respondent's treatment of Patient A. Michael Beneke, M.D., Chief of the Department of Surgery at Sutter at the time, participated in the review and investigation. Dr. Beneke testified at hearing that his duties as Chief of the Department of Surgery included overseeing monthly meetings to address Department personnel issues. He also assisted with medical executive committee (MEC) meetings as a representative of the Department,

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[12] Heterogenous perihepatic and perisplenic fluid is irregular looking fluid near the liver and spleen.

and assisted with any other impromptu issues that might indirectly affect the function of the Department of Surgery.

21. As part of the PSR investigation, on November 7, 2016, Dr. Beneke spoke to Respondent concerning the circumstances of Patient A's treatment. Dr. Beneke documented the conversation in a memorandum he prepared the same day. Respondent explained the circumstances of the procedure and stated there was "'lots of inflammation and gnarlyness" referring to the condition of Patient A's gallbladder, but that he "thought he saw everything clearly." Dr. Beneke understood Respondent to mean that Patient A had an inflammatory condition, making the procedure a higher risk. Dr. Beneke explained that "[t]hose things do happen, and so [his] goal was to try to understand [Respondent's] understanding of circumstances and what options are available during those difficult circumstances."

Dr. Beneke asked Respondent if he "thought it would've been prudent to do a cholangiogram," which is a procedure using x-ray imaging and contrast dye that is injected into the bile duct to delineate the anatomy. Dr. Beneke explained that a cholangiogram is a standard intervention used when there is uncertainty about what the surgeon is seeing during the procedure. Respondent told Dr. Beneke that he had not considered a cholangiogram, and that he did not have privileges to perform a cholangiogram. Dr. Beneke informed Respondent he could have done the "cholangiogram with radiology shooting a flat plate image." Respondent stated that he "has never done that before."

During the discussion, Respondent informed Dr. Beneke that he was "adhering to the principles that his attending physicians impressed upon him during his training with respect to a cholecystectomy which was to cut in 'one fell swoop' so if there was an injury there would be a nice clean transection to repair." Dr. Beneke interpreted

Respondent's statement to mean that a "cavalier cut is sometimes better than chewing through small little pieces trying to whittle away at the anatomy." Dr. Beneke found Respondent's statement "alarming," because if Respondent could not see a patient's anatomy, then he could not know what he was cutting through.

After Respondent's statement, Dr. Beneke asked Respondent about the CVS, because cutting in "one fell swoop" is not part of the CVS. Respondent "discussed seeing things from the gallbladder down onto the bile duct and back up," which Dr. Beneke explained is not the CVS. Respondent appeared to be unfamiliar with the CVS, which Dr. Beneke found "strange for a general surgeon who does cholecystectomies," because the CVS is a "known standard surgeons try to achieve to limit complications" and is part of a surgeon's standard training.

Dr. Beneke concluded that Respondent's "knowledge was suboptimal because he did not appear to "know some of the techniques to minimize complications during laparoscopic cholecystectomy nor does he have a high enough index of suspension for potential injuries."

22. On November 9, 2016, Respondent provided Dr. Beneke a written response to the PSR. Respondent explained he reviewed Patient A's case with Dr. Graves, Dr. Crowley and Dr. Scherer, the Chief Medical Officer for Surgical Affiliates. Respondent wrote that "given the severity" of Patient A's "complication" and Respondent's status as a new member of Sutter's Department of Surgery, he "volunteered to proceed with proctoring on all cholecystectomy surgeries until further notice."

Respondent also explained that "[i]n retrospect, [he] failed to recognize the anatomy of the cystic and common bile duct, however at the time of surgery, [he] felt

[he] had obtained the critical view." He also stated that if he had "been concerned about the anatomy, [he] would have called in one of [his] partners to assist, as well as consider an intraoperative cholangiogram or conversion to open cholecystectomy."[13] This was the first time Respondent referenced obtaining a "critical view."

23. MEC reviewed the PSR findings, and determined the care Respondent gave to Patient A was inappropriate. The committee ultimately recommended revocation of Respondent's medical staff membership and privileges. On December 15, 2016, while under investigation, Respondent resigned his Sutter membership and privileges.

Investigation Conducted by Investigator Stacie Barrera

24. On December 29, 2016, the Board received an "805 Report" from Sutter. Sutter also provided a brief statement explaining that Sutter MEC initiated an investigation "based on serious concerns regarding [Respondent's] clinical care and Respondent resigned his membership and privileges while the investigation was pending."

25. On December 30, 2016, Stacie Barrera, an Investigator for the Department of Consumer Affairs, was assigned to investigate the 805 Report filed by Sutter. As part of her investigation, Ms. Barrera obtained, in part, Respondent's employment records and Patient A's medical records from Sutter. Ms. Barrera issued a report dated May 11, 2018, regarding her investigation.

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[13] An open cholecystectomy involves making a larger incision in the abdomen to view the anatomy and remove the gallbladder.

On March 6, 2018, Ms. Barrera and Kevin Mitchell, M.D., the Board's Medical Consultant, interviewed Respondent. The interview was recorded and transcribed. Respondent explained that he did not have specific recollection of Patient A. However, he described how he typically performs a laparoscopic cholecystectomy. Respondent explained that he "always" identifies the CVS during the procedure. He explained that is why he "strip[s] the duct" with an instrument to make sure that he can pass the instrument behind the cystic duct, meaning he has "cleared the window behind it." Respondent does not perform any confirmatory studies, such as a cholangiogram, to identify the cystic duct.

26. On March 22, 2018, Ms. Barrera sent a cover letter, and "Electronic Case Binder" containing the 805 Report, transcript of Respondent's March 6, 2018 interview, the Sutter PSR and MEC documents and Patient A's Sutter medical records, to Board expert reviewer Ninad Dabadghav, M.D.

Complainant's Expert Ninad Dabadghav, M.D.

27. Dr. Dabadghav is board-certified in general surgery, with the American Board of Surgery. In 1985, Dr. Dabadghav graduated from Rush Medical College. In 1986, he became licensed by the Board to practice medicine in California. In 1989, he completed his residency at Mt. Zion Hospital and Medical Center, which merged with Kaiser Permanente Medical Center, in San Francisco.

Since 1991, Dr. Dabadghav has worked as a staff surgeon for the Department of Surgery, at Kaiser Hospital in Santa Clara, California. There are two branches to Dr. Dabadghav's medical practice, which includes general surgery and surgical oncology. He has worked as the primary hepatobiliary surgeon for over 25 years. Dr. Dabadghav is also a Clinical Associate Professor of Surgery at Stanford University. Dr. Dabadghav

has performed approximately 1,200 laparoscopic cholecystectomies, as a primary, assistant, or teaching surgeon.

28. Following a March 22, 2018 referral from Ms. Barrera, Dr. Dabadghav authored a report dated April 18, 2018, concerning his evaluation of Respondent's conduct related to the treatment of Patient A. In the report, Dr. Dabadghav lists the documents he reviewed to reach his opinions and conclusions, including Patient A's medical records, the Sutter PSR and MEC investigation documents and a transcript of Respondent's interview with the Board's investigator. Dr. Dabadghav also reviewed several articles and literature concerning the use of CVS in laparoscopic cholecystectomies. Dr. Dabadghav testified at hearing consistent with his report.

29. Dr. Dabadghav explained laparoscopic cholecystectomy is a very common, high volume procedure in the United States. Close to 800,000 laparoscopic cholecystectomies are performed every year. The rate of bile duct injuries is 0.3 or 0.4 percent, which amounts to 3 or 4 injuries in every 1,000 patients. A laparoscopic cholecystectomy with no complications generally takes one and one-half hours to perform. The patient is typically released from the hospital the same day and is back to normal activity within 10 days to two weeks. However, when a major bile duct injury occurs, the patient's hospitalization increases dramatically and multiple surgeries are often required to fix the injury. Even when the bile duct is repaired, problems can continue, including lifelong infection.

30. Dr. Dabadghav explained that the standard of care is what a reasonably prudent and careful physician in a similar time and circumstance would do as part of a laparoscopic cholecystectomy. Here, he opined the standard of care requires a surgeon who performs laparoscopic cholecystectomies to be experienced in "standard laparoscopic techniques," to have performed multiple laparoscopic and open

cholecystectomies and "should know and adhere to the basic principles of safe laparoscopic techniques and maneuvers specifically established for laparoscopic surgery of the gallbladder." One of the most "basic but very important and well-established principles" is the verification of the CVS at the time of the laparoscopic procedure.

Dr. Dabadghav explained that the CVS, "has been recognized for over 20 years among surgeons performing gallbladder surgery." The CVS was initially described in 1995, by Steven Strasberg, M.D. and Michael Brunt, M.D., as a technique to be used by surgeons to reduce the risk of bile duct injuries. Between 2000 and 2002, the CVS was "established into surgical training and laparoscopic training programs." In 2010, the Society of Gastrointestinal and Endoscopic Surgeons adopted the CVS "as one of the most critical steps in avoiding bile duct injury during a laparoscopic."

31. Dr. Dabadghav explained that successfully establishing the CVS during a laparoscopic cholecystectomy has three main requirements. The first requirement is to clear the hepatocystic triangle of fat and fibrous tissue. Clearance of the hepatocystic triangle is different from the standard dissection performed by Respondent using the infundibular approach, which is the dissection of the liver all the way to the base of the gallbladder down towards the cystic duct. Rather, clearance of the hepatocystic triangle is a specific dissection a surgeon must perform to gain a critical view, because most aberrant structures run in the anterior-superior aspect of the triangle.

Dr. Dabadghav explained the second requirement to separate the lower one-third of the distal part of the gallbladder from the liver to expose the cystic plate, is a "critical part of the CVS because this is the location where most surgeons greatly increase the possibility of an injury to a high riding common hepatic duct during the dissection of the gallbladder off the liver bed." Furthermore, "[i]t also allows the

surgeon to more confidently and more safely confirm that the structure that was felt to the cystic duct is actually the cystic and not part of the common bile duct."

The third requirement is the surgeon confirms that only two structures, the cystic duct and cystic artery, are entering the gallbladder. Dr. Dabadghav explained that when the surgeon confirms there are no abnormalities, "nothing suspicious" and is confident of the CVS, the cystic duct and cystic artery may be clipped and cut.

32. Dr. Dabadghav further explained that the CVS is not a dissection process, meaning it is not a process of removing the gallbladder off the liver bed. Rather the CVS is a target identification technique to hone in on only the hepatocystic triangle between the cystic duct and the liver. He also explained that adherence to the CVS and "other safe principles of doing a laparoscopic cholecystectomy will not completely eliminate, but has proven to significantly reduce, the number of common bile duct injuries that occur every year."

33. Dr. Dabadghav also opined that "[i]f there is any concern about the anatomy or proper visualization of the hepatocystic triangle, an intraoperative cholangiogram should always be done." Dr. Dabadghav explained a cholangiogram provides the surgeon with a visualization of where the bile anatomy should be. Once the surgeon confirms the location of the cystic duct, he can proceed. If the cholangiogram does not provide a clear visualization, then the surgeon has other options including removing part of the gallbladder, converting the procedure to an open cholecystectomy or calling in another surgeon with more experience, such as a hepatobiliary surgeon.

34. Dr. Dabadghav opined that Respondent never obtained a "proper" CVS prior to "taking the cystic artery and cystic duct." Respondent dissected out what he

"assumed was the cystic duct and artery, but did not clearly describe (in his operative report) that he made an effort to mobilize the lower third of the gallbladder away from the liver to expose the cystic plate." He failed to mention any dissection of the cystic plate and made no mention of the clearance of the cystic plate. Dr. Dabadghav opined that after Respondent grasped the gallbladder and dissected the cystic duct and artery free of the surrounding, he should have performed a CVS, declared that a CVS had been found, and then doubly ligated and clipped the cystic duct and cystic artery. Dr. Dabadghav found no evidence that Respondent performed the CVS between the dissection and the clipping. Rather, Respondent went straight from identifying the cystic duct and cystic artery to isolating them, clipping and cutting the structures.

35. Additionally, Respondent failed to utilize an intraoperative cholangiogram to better delineate the biliary anatomy during the procedure. Dr. Dabadghav explained that Respondent was not aware that he cut the common bile duct. As a result, he did not consider using an intraoperative cholangiogram.

36. Dr. Dabadghav further opined that based on his review of Respondent's operative report, the memorandum prepared by Dr. Beneke concerning his November 6, 2016, discussion with Respondent and Respondent's March 6, 2018 interview with Ms. Barrera, Respondent did "not make any effort to get a [CVS] during the performance of the laparoscopic cholecystectomy" on Patient A. Further, Respondent "seemed to be lacking in knowledge in performing a [CVS] during the performance of a laparoscopic cholecystectomy."

Dr. Dabadghav also opined that there is no situation in which a surgeon should make a cut in "one fell swoop" so that if there was an injury, there would be a nice, clean transection to repair, as described by Respondent. Dr. Dabadghav opined this

technique does not comply with the standard of care for performing laparoscopic cholecystectomies.

37. Dr. Dabadghav further opined that Respondent's conduct was an extreme departure from the standard of care because Respondent "not only failed to get an adequate [CVS] during the performance of an uncomplicated laparoscopic cholecystectomy resulting in a bile duct injury, but mainly because he also seemed to have a suboptimal knowledge in performing a [CVS] during the performance of that laparoscopic cholecystectomy."

Respondent's Experts

EXPERT MICHAEL BAKER, M.D.

38. Dr. Baker is board-certified in general surgery, with the American Board of Surgery. In 1975, he obtained his medical degree from Pennsylvania State University. Dr. Baker then completed an internship at Mary's Help Hospital in Daly City, California. In 1979, Dr. Baker completed a four-year general surgery residency at the United States Public Health Service Hospital in San Francisco, California. Thereafter, he completed a one-year fellowship in cardiovascular surgery at the Methodist Medical Center. Dr. Baker served in the military for 30 years, in both active duty and the Navy Reserves. He retired with the rank of Rear Admiral.

Dr. Baker is licensed to practice medicine in California. He currently works in the Department of Surgery at John Muir Hospital in Walnut Creek and Concord, California. Dr. Baker has served as the chair of Department of Surgery at John Muir for seven years. He has performed approximately 2,000 to 3,000 cholecystectomies during his career.

39. Dr. Baker reviewed several documents to reach his opinions concerning Respondent's treatment of Patient A including the Accusation, Patient A's medical records from Sutter, transcript of Respondent's interview with the Board's investigator, and several articles and literature concerning the use of CVS in laparoscopic cholecystectomies. Dr. Baker did not review the Sutter PSR investigation records prior to hearing. Dr. Baker prepared a report dated January 24, 2020, and testified at hearing consistent with his report.

40. Dr. Baker opined that Respondent met the standard of care in his treatment of Patient A and that his care of Patient A did not "rise to the level of gross negligence." Dr. Baker also opined that Respondent's care in establishing the CVS was not substandard. Dr. Baker defined the standard of care as how a surgeon with the same training and experience would carry out an operation in a safe manner. Dr. Baker did not define the standard of care for performing a laparoscopic cholecystectomy, nor did he define or explain his use of the term "gross negligence."

41. Dr. Baker opined that it is not below the standard of care for a surgeon to injure the bile duct of a patient during performance of a laparoscopic cholecystectomy, explaining that the "best surgeons" have complications at a very low rate. He also opined that acute cholecystitis increases the rate of bile duct injuries due to the associated inflammation adhesions, gallbladder wall thickening and increased bleeding. As a result, it may be more difficult for the surgeon to identify the structures during the laparoscopic cholecystectomy.

42. Dr. Baker further opined there are "six or seven ways you attack a difficult gallbladder." Ultimately, the surgeon is trying to get to the final result of clearly seeing the cystic duct, cystic artery and all the structures. Dr. Baker opined that, based on Respondent's operative note, he grasped the gallbladder and circumferentially

dissected the cystic duct and artery free from the surrounding connective tissue. He identified what he believed was the cystic duct and cystic artery. Dr. Baker admitted the approach Respondent describes does not identify the "standard" Respondent followed for this procedure and is not a recognized technique such as the CVS.

43. Dr. Baker agreed that there are three requirements to obtain the CVS. He opined that the CVS is one of several techniques a surgeon can use to identify the crucial structures and that a surgeon does not have to "use the classic three-step process," but needs to get to the same end point in this process, which is proper identification of the structures. Dr. Baker did not know if Respondent used the CVS during laparoscopic cholecystectomy. He admitted that Respondent did not document the second step of the CVS which requires "visualization, freeing the gallbladder and raising it to view the cystic duct." However, he believes Respondent was attempting to obtain the CVS in "a broad general sense," because he was attempting to correctly identify the structures of "major concern" during the procedure.

44. Dr. Baker also opined Respondent's operative note for Patient A does not represent "substandard care" and complies with the standard of care. The note reflects what Respondent observed during the procedure and does not represent an entire summary of every step he took during the procedure. Rather it is a "global picture" of what Respondent saw, the steps he took and the outcome of the procedure.

45. Dr. Baker noted that an intraoperative cholangiogram is a tool a surgeon can use during a laparoscopic cholecystectomy to identify the structures, and he expected Respondent to have been trained to perform a cholangiogram as part of his surgery training. Dr. Baker also explained that seeking out a colleague for assistance to "get over the hump of whatever is making the case so difficult" is also an option.

46. Prior to hearing, Dr. Baker was not aware of Respondent's statement to Dr. Beneke that he was adhering to the principles his attending physicians impressed on him to cut in "one fell swoop" so if there was an injury there would be a nice clean transection to repair. Dr. Baker explained that he had never heard such terminology used in training, nor had he trained anybody to use such a technique.

EXPERT KRISTIN MEKEEL, M.D.

47. Dr. Mekeel is board-certified in general surgery, with the American Board of Surgery. In 1999, Dr. Mekeel obtained her medical degree from the University of Wisconsin. In 2004, she completed a five-year general surgery residency at the University of Colorado. She then completed a two-year transplant and hepatobiliary fellowship at the University of Florida in Gainesville. Dr. Mekeel thereafter worked as a transplant and hepatobiliary surgeon for four years at the Mayo Clinic in Arizona.

Dr. Mekeel is licensed to practice medicine in California. Since 2000, Dr. Mekeel has worked as the transplant and hepatobiliary surgeon at the University of California, San Diego. Currently, she is the Division Chief for transplant and hepatobiliary surgery. She is also the Program Director for the liver and kidney transplant program, and the Vice Chair of quality and patient safety for the Department of Surgery. Dr. Mekeel is also a Professor of Surgery at the University of San Diego. Dr. Mekeel has performed approximately 500 to 1,000 laparoscopic cholecystectomies during her career.

48. Dr. Mekeel reviewed several documents to reach her opinions concerning Respondent's treatment of Patient A including the Accusation, Patient A's medical records from Sutter, and a transcript of Respondent's interview with the Board's investigator. Dr. Mekeel did not review the Sutter PSR investigation records prior to

hearing. Dr. Mekeel prepared a report dated January 28, 2020, and testified at hearing consistent with her report.

49. Dr. Mekeel opined that Respondent met the standard of care in his treatment of Patient A and that the care did not constitute "gross negligence." Dr. Mekeel agreed that the standard of care is defined as what a reasonably prudent surgeon would do in the same or similar circumstances. However, she did not define the standard of care for performing a laparoscopic cholecystectomy, nor did she define or explain her use of the term "gross negligence."

50. Dr. Mekeel opined the laparoscopic cholecystectomy Respondent performed on Patient A was "complex due to a massively distended gall bladder." She further opined that he "clearly identified what he thought from his experience and training to be the cystic duct and artery prior to ligation." While it was "very clear" that Respondent was not trained on the CVS, Dr. Mekeel contended Respondent did perform the CVS based on the language he used in the operative note. She explained Respondent documented that he "clearly identified both the artery and the ducts going towards the gall bladder, missing some of the dissection," which she opined is "standard for the verbiage of the [CVS]." She further opined he described the "infundibular technique" or CVS, which met the standard of care.

51. Dr. Mekeel opined the CVS has been proposed as a way to clearly identify the cystic artery and cystic duct before ligating them to prevent common bile duct injury. She agreed that the CVS has three requirements that must be fulfilled by the surgeon in order to attain the CVS. However, she asserted that the CVS is not the only option for identifying structures, is not accepted by all surgeons and is not universally accepted or taught as the standard of care. Rather the CVS is considered to

be one of the standards of care for identifying the cystic artery and cystic duct. She further opined that utilizing the CVS does not completely prevent bile duct injury.

52. Dr. Mekeel also agreed surgeons can use cholangiography, which she opined "used to be considered standard of care." However, she opined that cholangiography is no longer considered the standard of care because if not done correctly the surgeon can get "inferior results."

53. Prior to hearing, Dr. Mekeel was not aware of Respondent's statement to Dr. Beneke that he was adhering to the principles his attending physicians impressed on him to cut in "one fell swoop" so if there was an injury there would be a nice clean transection to repair. Dr. Mekeel stated that this was "obviously" not the standard of care. She attributed this statement to her belief that Respondent was not trained to perform cholangiograms or the CVS. Dr. Mekeel opined that this demonstrated that the CVS is "not the standard of care because it is not taught everywhere across the country."

Additional Evidence from Respondent

54. Respondent explained, prior to the Accusation filed against him, he had never been trained or told the CVS had three requirements. As a result, Respondent does not complete the three requirements of the CVS during the laparoscopic cholecystectomies he performs. He utilized the CVS as a "view" of the clear hepatocystic triangle through to the liver and be able to pass an instrument cleanly behind the cystic duct and cystic artery. Respondent contends the steps he takes give him the "view" of the CVS.

55. Respondent also contended the requirement to dissect a part of the gallbladder from the liver before dissecting the cystic duct "seems wrong" and

"overbearing" because not all gallbladders are attached to the liver to the same extent. Respondent further contended the CVS is not the standard of care and there is no "consensus" the CVS is the only effective method.

56. Respondent also explained that during Patient A's laparoscopic cholecystectomy, he utilized his definition of the CVS to obtain the view of the hepatocystic triangle through to the liver and what he thought was the cystic duct and cystic artery. He had no doubt about the anatomy and therefore did not believe he needed to perform any diagnostic testing to identify the bile duct such as a cholangiogram. However, "[g]iven the injury" that occurred to Patient A, he must have made a mistake. Respondent has not changed his approach and still uses the CVS based on his definition of the "view."

57. Respondent also explained what he meant with his statement to Dr. Beneke regarding cutting in "one fell swoop." He was taught that once he identified the structures to cut, he cut them with one pass of the scissors rather than "taking little nibble bits across them." If the wrong structure is cut, repairing the structure is easier if there is a clean cut.

58. Respondent contends that he has the required knowledge of anatomy, surgical techniques and options available to him to perform safe laparoscopic cholecystectomies. He has successfully performed many of these procedures and was even initially proctored at Sutter to confirm his level of competence.

59. Since resigning his privileges at Sutter, Respondent completed a fellowship in surgical critical care at Wayne State University School of Medicine, through the Detroit Medical Center, that will enable him to become employed as an

attending physician in surgical care, intensive care units, and adjunct to a surgical practice and wound care and hyperbaric practice.

Analysis

60. Complainant alleged Respondent failed to obtain a CVS when he performed a laparoscopic cholecystectomy on Patient A, had a lack of understanding of the significance of the CVS when interviewed by Dr. Beneke, and failed to document in Patient A's operative report the steps he took to obtain a CVS, including the dissection of the cystic duct and artery after he obtained his version of the CVS and that he mobilized the lower third of the gallbladder away from the liver to expose the cystic plate. Complainant contends that, collectively, Respondent's conduct constitutes an extreme departure from the standard of care, repeated acts of negligence, and failure to maintain adequate and accurate records.

61. Dr. Dabadghav was the only expert to opine regarding the standard of care for the performance of a laparoscopic cholecystectomy. He persuasively opined a surgeon should know and adhere to the basic principles of safe laparoscopic techniques and maneuvers, including verification of the CVS. All the experts agree the CVS is standard of care for performing laparoscopic cholecystectomies, and that the CVS has three requirements that must be performed by the surgeon in order for the CVS to be considered to have been properly completed.

62. Clear and convincing evidence established Respondent's conduct constituted an extreme departure of care, repeated acts of negligence and failure to maintain adequate and accurate medical records. Respondent failed to obtain an adequate CVS during the performance of Patient A's laparoscopic cholecystectomy, resulting in a common bile duct injury, and demonstrated suboptimal knowledge of

performing a CVS. Specifically, Respondent failed to perform the three CVS requirements during the laparoscopic cholecystectomy procedure he performed on Patient A. Dr. Dabadghav persuasively opined Respondent never obtained a CVS prior to transecting the cystic artery and cystic duct. Respondent dissected what he what he believed was the cystic duct and artery, without mobilizing the lower third of the gallbladder away from the liver to expose the cystic plate.

The standard of care required Respondent grasp the gallbladder and dissect the cystic duct and artery free of the surrounding, perform the three requirements of the CVS, declare that a CVS had been found, and then doubly ligate and clip the cystic duct and cystic artery. Adherence to the three requirements of the CVS is important to ensure the cystic duct is actually the cystic and not part of the common bile duct. Respondent's failure to perform an adequate CVS resulted in transection of the common bile duct, causing significant harm to Patient A.

Additionally, when questioned by Dr. Beneke about obtaining a CVS, Respondent discussed seeing things from the gallbladder down onto the bile duct and back up during the procedure, which is not a CVS. Respondent's statements to Dr. Beneke and written response to the PSR evidenced his lack of understanding of the significance of the CVS, or the requirements that must be met to properly obtain a CVS. Respondent continued to demonstrate his lack of understanding in the March 6, 2018 interview with Ms. Barrera.

63. Both of Respondent's experts opined Respondent's treatment of Patient A met the standard of care and did not constitute "gross negligence." However, neither of the experts' opinions were persuasive. Notably, Dr. Baker admitted that based on his review of Respondent's operative note, the approach Respondent described did not explain the "standard" he followed for performing the laparoscopic

cholecystectomy and is not a recognized technique such as the CVS. Dr. Mekeel inexplicably opined that is was "very clear" that Respondent was not trained on the CVS, but that he nonetheless obtained the CVS based on the language he used in the operative note.

64. The Board's Disciplinary Guidelines provide that the minimum discipline that should be imposed, for an extreme departure from the standard of care, repeated acts of negligence, and failure to keep complete and accurate records, is stayed revocation, with five years of probation. Respondent has been licensed to practice medicine for 10 years. He has no record of prior discipline with the Board. The Accusation involves a single patient, however, Respondent has not changed his practice and still does not appear to fully understand the standard of care required when performing laparoscopic cholecystectomies. As a result, public protection requires that be monitored and undergo additional training to ensure he possesses the requisite knowledge and skill to safely treat patients.

65. Based on the totality of the evidence, public protection would be served by imposing a five-year term of probation, which includes a clinical competence assessment program, practice monitor or in the alternative completion of a professional enhancement program approved in advance by the Board, completion of a medical record keeping course and appropriate education courses approved by the Board.

LEGAL CONCLUSIONS

Burden of Proof

1. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence is evidence that leaves no substantial doubt and is sufficiently strong to command the unhesitating assent of every reasonable mind. (See, *In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.)

Cause for Discipline

2. Business and Professions Code section 2234 provides that the Board shall take action against any licensee found to have engaged in unprofessional conduct, which includes but is not limited to the following:

> (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.

3. Business and Professions Code section 2266 provides that 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. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care applicable in a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052. Simple negligence is merely a departure from the standard of care.

5. Complainant established by clear and convincing evidence that Respondent's treatment Patient A constituted gross negligence as it was an extreme departure from the standard of care, as set forth in Findings 11 through 37, and 60 through 63. Therefore, cause was established to discipline Respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (b).

6. Complainant established by clear and convincing evidence that Respondent's treatment Patient A constituted repeated acts of negligence, as set forth in Findings 11 through 37, and 60 through 63. Therefore, cause was established to impose discipline on Respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (c).

7. Complainant established by clear and convincing evidence that Respondent failed to maintain adequate and accurate records related to his treatment of Patient A, as set forth in Findings 11 through 37, and 60 through 63. Therefore, cause was established exists to impose discipline on Respondent's certificate pursuant to Business and Professions Code section 2266.

Conclusion

8. The objective of an administrative proceeding relating to licensing is to protect the public. Such proceedings are not for the primary purpose of punishment. (See *Fahmy v. Medical Bd. of California* (1995) 38 Cal.App.4th 810, 817.) When all the evidence is considered, Respondent's certificate should be placed on probation, for a period of five years, with appropriate terms and conditions to protect the public.

ORDER

Physician's and Surgeon's Certificate No. C 139300 issued to Respondent David Ari Bloom, M.D., is REVOKED, but the revocation is STAYED, and Respondent is placed on probation for five (5) years, upon the following terms and conditions:

1. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program no later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after Respondent has successfully completed the clinical competence assessment program, Respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

2. 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 for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. Medical Record Keeping Course

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

4. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of title 16, California Code of Regulations, section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. Monitoring – Practice

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are

valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee. Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of

providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

7. 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.

8. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

9. 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.

10. 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 no later than 10 calendar days after the end of the preceding quarter.

11. Compliance with Probation Unit

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

a. Address Changes: Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a

post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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

c. License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

d. 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.

12. 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.

13. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a

calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 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; and General Probation Requirements.

14. Completion of Probation

Respondent shall comply with all financial obligations (e.g., probation costs) no later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. 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.

16. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his 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.

17. 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.

The Decision shall become effective at 5:00 p.m. on March 31, 2021.

IT IS SO ORDERED this 1st day of March, 2021.

Ronald H. Lewis, M.D., Chair
Panel A
Medical Board of California

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 19 20 18
BY D. Richards ANALYST

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

In the Matter of the Accusation Against: **David Ari Bloom, M.D.** **136 Beach 117th St Apt 513** **Rockaway Park, NY 11694-2077** **Physician's and Surgeon's Certificate No. C 139300,** Respondent.	Case No. 800-2016-028979 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about November 16, 2015, the Medical Board issued Physician's and Surgeon's Certificate No. C 139300 to David Ari Bloom, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2019, 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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated 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."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent David Ari Bloom, M.D., is subject to disciplinary action under section 2234, subdivision (b), in that his care and treatment of Patient A was grossly negligent. The circumstances are as follows:

8. On or about October 22, 2016, Patient A, a thirty-year-old female, came to the Sutter Medical Center Sacramento Emergency Room, with a 4 to 5 hour history of right upper quadrant and epigastric abdominal pain. The patient also complained about nausea. She had a prior history of similar but milder abdominal pain intermittently over the past month. In the Emergency Room (ER), Patient A had an elevated white blood cell count (WBC) of 13.7K, with a left shift but normal liver function tests and no fever. An ultrasound of Patient A showed her gallbladder had stones with some pericholecystic[1] fluid.

9. The ER physician treating Patient A felt that this patient suffered from either biliary colic (abdominal pain usually caused by a stone) or early acute cholecystitis (inflammation of the gallbladder usually caused by bacterial infection). The ER physician called Respondent, who

[1] Near an inflamed gallbladder.

was the on-call surgeon to evaluate Patient A for possible laparoscopic cholecystectomy (surgical removal of the gallbladder).

10. In the early morning of October 23, 2016, Respondent examined Patient A, then reviewed her labs and imaging studies, and concluded that Patient A likely suffered from acute cholecystitis. Respondent recommended to Patient A that a laparoscopic cholecystectomy be done, and with the patient's consent, Respondent performed this procedure that same afternoon.

11. As stated in Respondent's operative report, at the time of surgery, Respondent found a distended, slightly inflamed, gallbladder that needed to be partially drained to assist in retracting it. Respondent identified the cystic duct and artery, then triply clipped and transected it. Respondent did not mention any significant inflammation, anatomical variance or difficulty in identifying the cystic duct and artery. He reported that he saw no bile leak or bleeding. Respondent then dissected the gallbladder from the liver bed with cautery and removed it through the larger umbilical port site.

12. On the first postoperative day, Patient A was tachycardic, (fast heart rate), and complained of shortness of breath and chest pain. A cardiology workup found that the patient had mild pericarditis[2] and the patient was started on anti-inflammatory medication. A CT chest scan revealed a significant amount of fluid around the patient's liver, gallbladder fossa, and mid-abdomen. Patient A's lab work showed an elevation in her total bilirubin (1.5 from 0.7) and WBC (12.2K from 8.5). A hepatobiliary (HIDA) scan revealed an intra-abdominal bile leak and a probable common bile duct obstruction.

13. On or about October 26, 2016, an ERCP (endoscopic retrograde cholangiopancreatography) of Patient A, showed that the distal common bile duct (CBD) was completely obstructed by surgical clips. The surgeons taking care of Patient A concluded that this patient had suffered some sort of common bile duct injury during her laparoscopic cholecystectomy performed by Respondent. A Hepato-Pancreato-Biliary (HPB) surgeon, Dr. G, was called in for a consultation and he evaluated Patient A on or about October 29, 2016. Dr. G.

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[2] Inflammation of the pericardium or the membrane surrounding the heart.

confirmed through an MRCP (magnetic resonance cholangiopancreatograophy) that the patient had a bile leak from the proximal CBD, with a complete obstruction of the distal CBD, likely caused by a CBD injury. Dr. G. advised that as long as the bile drained from the IR catheter, it would be best to defer any follow-up surgery in order to allow the acute inflammation from the bile peritonitis to decrease.

14. On or about October 31, 2016, Patient A complained of abdominal pain, her previous bilious drainage became bloody, and she appeared to have had a syncopal episode (loss of consciousness due to insufficient blood flow to the brain). A CT scan of the abdomen and pelvis showed a heterogenous perihepatic[3] and perisplenic[4] fluid collection caused by intra-abdominal hemorrhage that was not being drained. A perihepatic angiogram showed a pseudo-aneurysm of the cystic stump that was embolized. On or about November 1, 2016, a diagnostic laparoscopy was done and a feeding tube was placed with direct drainage from the proximal CBD. A larger 19 French Blake drain was also placed in the gallbladder fossa. Patient A was finally discharged on or about November 12, 2016 with a planned return in a few weeks for corrective hepatobilliary surgery.

15. Bile duct injuries are most common in laproscopic surgeries of the gallbladder when surgeons fail to gain the Critical View of Safety (CVS), which involves clearing the hepatocystic triangle[5] of fat and fibrous tissue, separating the lower one-third of the gallbladder from the liver to expose the cystic plate and only two structures are seen entering the gallbladder. If there is any concern by the surgeon about anatomy or proper visualization of the hepatocystic triangle, an interoperative cholongiogram (IOC) should always be done. In his operative report, Respondent fails to mention the hepatocystic triangle (also known as the triangle of Calot), nor does he mention any steps he had taken to get a Critical View of Safety at any time. Respondent told Dr. B., when interviewed as part of the Sutter Hospital investigation, that he never considered doing an Intraoperative cholangiogram and that he likes to "cut in one fell swoop." When Respondent

[3] Near the liver
[4] Near the spleen
[5] Consisting of the cystic duct, the common hepatic duct and the inferior edge of the liver.

was asked about the Critical View of Safety by Dr. B., he did not appear to understand what that was. Later, at the interview that was part of the Medical Board investigation on March 6, 2018, Respondent had no recollection of the Patient A case, but stated in general that he now looks for the CVS but does not document it. When Respondent was asked by the Board consultant what he has changed in his practice since the Patient A case, Respondent said he tries to stay even further away from the cystic duct and CBD connection, but made no mention of the CVS.

16. Respondent's failure to get a CVS when performing the laproscopic cholecystectomy of Patient A, combined with an apparent lack of understanding of the significance of the CVS when interviewed by Dr. B., along with Respondent's failure to document in his operative report the following: what steps he took to get the CVS, that the dissection of the cystic duct and artery only occurred after he got the CVS, and the fact that he mobilized the lower third of the gallbladder away from the liver to expose the cystic plate, collectively constitute an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

17. Respondent David Ari Bloom, M.D., is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in his care of Patient A. The circumstances are as follows:

18. Complainant re-alleges paragraphs 8 through 16.

19. Respondent's care and treatment of Patient A was repeatedly negligent in the following respects:

a. Respondent failed to get a CVS when performing the laproscopic cholecystectomy of Patient A.

b. Respondent failed to document in his operative report what steps he took to get the CVS, failed to mention that the dissection of the cystic duct and artery only occurred after he got the CVS, and failed to mention the fact that he mobilized the lower third of the gallbladder away from the liver to expose the cystic plate.

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THIRD CAUSE FOR DISCIPLINE

(Failure To Maintain Adequate and Accurate Records)

20. Respondent David Ari Bloom, M.D., is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records. The circumstances are as follows:

21. Complainant re-alleges paragraphs 8 through 16.

22. Respondent failed to document in his operative report what steps he took to gain the CVS when performing the laproscopic cholecystectomy of Patient A, failed to mention that the dissection of the cystic duct and artery only occurred after he got the CVS, and failed to mention that he mobilized the lower third of the gallbladder away from the liver to expose the cystic plate. These constitute failures to maintain adequate and accurate records.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. C 139300, issued to David Ari Bloom, M.D.;

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

3. Ordering David Ari Bloom, 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: July 19, 2018

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

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