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

In the Matter of the First Amended Accusation Against: Kaylene Renee Carr, M.D. Physician's and Surgeon's Certificate No. A 124094 Respondent.	Case No. 800-2018-045698

DECISION

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

This Decision shall become effective at 5:00 p.m. on October 17, 2022.

IT IS SO ORDERED September 15, 2022.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the First Amended Accusation Against:

KAYLENE RENEE CARR, M.D., Respondent

Physician's and Surgeon's Certificate No. A 124094

Case No. 800-2018-045698

OAH No. 2021080068

PROPOSED DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by video/telephone conference on July 11 to 14, 2022.

LeAnna E. Shields, Deputy Attorney General, represented complainant, William J. Prasifka, Executive Director of the Medical Board of California (board).

Robert W. Frank, Attorney at Law, Neil, Dymott, Frank, McCabe & Hudson, APLC, represented respondent, Kaylene Renee Carr, M.D., who was present.

The matter was submitted on July 14, 2022.

SUMMARY

Complainant asserts that respondent's license should be disciplined because she committed gross negligence and repeated negligent acts and failed to adequately and accurately document her treatment of Patient A. Complainant proved by clear and convincing evidence only that respondent failed to adequately document her treatment of Patient A in one instance. Complainant failed to prove by clear and convincing evidence the remaining allegations in the first amended accusation and they are dismissed accordingly. Based on the evidence of record as a whole, a public reprimand will ensure public protection. Reasonable costs are awarded.

PROTECTIVE ORDER

A protective order has been issued on complainant's motion sealing Exhibits 4 to 11, and 13, and the confidential name list, without objection. It is impractical to redact the information from these exhibits. To protect the privacy and the confidential personal information from inappropriate disclosure, these exhibits are ordered sealed. A reviewing court, parties to this matter, and a government agency decision maker or designee under Government Code section 11517 may review materials subject to the protective order provided that this material is protected from disclosure to the public.

FACTUAL FINDINGS

Jurisdiction

1. On January 4, 2013, the board issued Physician's and Surgeon's Certificate No. A 124094 to respondent. The Physician's and Surgeon's Certificate was

in full force and effect at all times relevant to the charges in this matter and will expire on January 31, 2023, unless renewed. Respondent has no history of discipline.

2. On March 4, 2022, complainant filed the first amended accusation in this matter. Complainant alleges in this pleading that respondent committed gross negligence and repeated negligent acts when she removed the wrong Bartholin's gland from Patient A on September 25, 2017; when she failed to sign in a timely manner Patient A's July 28, 2017, September 18, 2017, and September 29, 2017, progress notes; when she failed to document the laterality[1] of which gland to remove on July 28, 2017, and September 18, 2017; and when she failed to document the laterality of the gland to remove in Patient A's consent forms. Complainant further alleges that respondent committed repeated negligent acts related to her care of Patient A and for failing to perform or adequately document an examination of the site where the gland was to be removed. Respondent is further charged with failure to adequately and accurately maintain records in her care and treatment of Patient A. Complainant seeks reasonable costs related to the enforcement of this matter.

Summary of Respondent's Care and Treatment of Patient A

3. The facts of Patient A's condition and respondent's treatment and care of her are found in the evidence of record in this matter. This evidence includes records from respondent's office and the Glenwood Surgery Center (surgery center) where respondent performed the surgery on Patient A, the transcript from respondent's October 22, 2020, interview with the Health Quality Investigation Unit (HQIU) of the Division of Investigation, respondent's summary of her treatment of Patient A, a

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[1] Laterality refers to the right and left side of the body.

portion of HQIU's Report of Investigation, and the testimony of both Patient A and respondent. These records document the following:

4. Patient A stated that in 2016 she started experiencing pain in her vaginal area while sitting and during intercourse. She went to Riverside Community Hospital on May 31, 2016, and was told she had a Bartholin cyst on her left Bartholin's gland and had an incision and drainage of the cyst. She went to Riverside University Health System on October 5, 2016, and was also told she had a Bartholin cyst on her left Bartholin's gland.[2]

5. After these visits, Patient A wanted to see a doctor who specializes in treating vaginal pain. She found respondent from a search she did on the internet. On July 28, 2017, respondent first saw Patient A at Raincross Women's Medical Group (medical office or office). The note from this date identifies the reason for her visit as an annual examination or Well Woman examination. Patient A complained of a right breast mass and a recurrent Bartholin cyst. Patient A testified that she identified at this visit the left gland as the gland giving her problems. Respondent testified that Patient A told her it was the right side and not her left. The laterality of the cyst was not identified in this note. Patient A told respondent she had a "Word catheter" placed there and it had fallen out. She reported normal periods. Patient A reported dyspareunia or pain during intercourse. Patient A identified that she did not have any known allergies to medications.

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[2] It is noted that in records from UCR above and Riverside University Health System, diagnoses of Bartholin's glands and cysts routinely do not identify laterality.

6. At the July 28, 2017, visit respondent conducted pelvic and breast exams of Patient A. She found the breasts and external genitalia vagina and uterus normal without masses.

7. In her assessment and treatment plan for Patient A, respondent referred Patient A for a right breast mammogram screening. Respondent also asked for authorization to proceed with the removal of recurrent Bartholin gland cyst. She advised Patient A to return in three weeks.

8. Respondent testified she completed the note on July 28, 2017, and signed it; however, she did not finalize the document electronically until October 9, 2017. The footer of this document records the date July 28, 2017, "Progress Note: Carr M.D." and the patient's name. The footer also identifies that eClinicalWorks, the electronic medical record (EMR) program, "generated" the "Note." It appears respondent did create the note on July 28, 2017, and no persuasive evidence contradicted her testimony.

9. Respondent stated that she did not finally sign the document until October 9, 2017, because billers at her office told her to leave the record unlocked to allow for billing insurance. Signing this document would "lock" the note per the eClinicalWorks program, and staff would be unable to bill the visit.

10. Respondent next saw Patient A on September 18, 2017, for a preoperative visit. Respondent had a "lengthy" discussion with Patient A regarding the risks and benefits of surgery. Respondent documented that Patient A wished to proceed with the procedure despite the risks.

Patient A told respondent she was here for the recurrent cyst removal due to Bartholin's gland infections and had "ward" [*sic*] catheters placed three times. Patient A

was referring to a "Word Catheter." The laterality of the gland was not identified. Respondent said she felt Patient A was a reliable historian because she knew what a Word Catheter is.

The note reports further that Patient A was "asymptomatic" but was "starting to feel something" regarding the Bartholin gland or cyst. Respondent did not examine the site of Patient A's Bartholin's gland.

Respondent recorded that she reminded Patient A to obtain a mammogram for her right breast. Patient A said she did not have this done because she could not afford the insurance. Respondent asked a person in her office to confirm whether Patient A needed to pay $350 for imaging.

11. In a telephone encounter note dated September 22, 2017, respondent's office assistant confirmed with Patient A's health plan that she had to pay $350 for imaging and it was also recommended she undergo an ultrasound.

12. As with the July 28, 2017, note respondent testified she completed the note on September 18, 2017, and signed it although she did not finalize the document electronically until October 9, 2017. The footer of this document identifies the date September 18, 2017 "Progress Note: Carr M.D." and the patient's name. The footer, in addition, identifies that eClinicalWorks "generated" the "Note." As with the earlier note, respondent did not complete it because billers in her office did not want her to lock it. Again, it appears the note was created on September 18, 2017, and no persuasive evidence contradicted respondent's testimony.

13. At this preoperative visit on September 18, 2017, respondent completed with Patient A the consent form from her office, an "H and P form" as it was referred to in the hearing and during her HQIU interview, and an admission order for the surgery

center. The admission order was faxed to the surgery center from respondent's office on September 19, 2017, at 10:29 a.m. The admission order indicates that a nurse at the surgical center documented and initialed she "noted" this procedure at 12:00 p.m. on September 25, 2017, the date of surgery, before the surgery as discussed below.

The consent form Patient A signed on September 18, 2017, does not identify the laterality of the Bartholin's gland. But both the "H and P form" and the admission order identifies the "right" Bartholin's gland as the gland to be excised. (The admission order was faxed to the surgery center on September 19, 2017, at 1:29 a.m. which means the original should have been in Patient A's chart.) The consent form identifies the procedure respondent was to perform as "Removal of Bartholin Gland." The form identifies the procedure "in common terms" as "Removing gland that keeps getting infected."

14. During this preop visit with Patient A at her office on September 18, 2017, respondent testified she read the "H and P form" with the "right Bartholin gland" excision procedure language with Patient A as written in the "consent to read" section. Respondent said it was her custom and practice to review these forms with a patient at the pre-op visit. She also reviewed the consent form with Patient A. Respondent said this paperwork was stapled together. As noted, respondent signed the "H and P form" and admission order later in the day at 5:45 p.m.

15. At her interview, respondent said she did not identify the laterality of the Bartholin's gland to be removed in the consent form because she identified the laterality in the "H and P form" and in the order for the surgery center. She added that all three documents (the informed consent, the "H and P form," and the admission order) were filled out at the same time.

16. The consent form Patient A signed does not identify, as a category, the benefits of the proposed procedure. But in a section termed "Alternative Methods of Treatment," the terms "watchful waiting" and "Marsupialization" are recorded. "Marsupialization" refers to the encasement of the infection by the cyst.

17. Patient A signed the consent form at 10:30 a.m. on September 18, 2017. She did not sign the "H and P form" at this time, but initialed and dated it before her September 25, 2017, procedure.

18. Patient A testified she did not recall whether she signed paperwork at her September 18, 2017, preop visit with respondent. But she recalled that she signed paperwork. She also could not recall whether she met respondent to go over this paperwork at that time.

19. On September 25, 2017, prior to the surgery, respondent was given a folder which contained the "H and P form," consent form, and admission order, among other documents. She took the folder with these documents to the surgery center. It was her practice to meet with the patient before the procedure and go over the forms with the patient before the surgery. She said she followed this practice with Patient A and went over the forms with her before the procedure.

20. At the September 25, 2017, meeting with Patient A, shortly before the surgery, respondent went over the forms with her and added additional language to the "H and P form" to reflect that Patient A wanted respondent to perform an endometrial biopsy. Respondent added this language as an additional procedure to be performed because Patient A told respondent she was having abnormal uterine bleeding and she wanted an endometrial biopsy. She also added "abnormal uterine bleeding" in the chief complaint/history of present illness section. Patient A affixed her

initials next to this language, dated it September 25, 2017, and identified the time as 12:50 p.m.

21. Patient A also signed her initials with the September 25, 2017, date to respondent's office's consent form and the surgery center consent form next to "endometrial biopsy." The surgery center consent form contains preprinted language for "Excision Bartholin Gland." Patient A initialed and signed her name at 12:05 p.m. to the surgery center consent form.

22. After Patient A initialed the "H and P form" and consent forms, per the nursing and operation room record, she was taken to the operating room at 12:52 p.m.

23. Patient A testified that she noticed that the form referred to the excision of the right side Bartholin's gland. She told respondent the left was to be excised not the right gland. She said respondent told her she would make the change. The surgical center records do not record this conversation.

24. In the operating room record, the nurse identified the procedure to be performed as "removal of right Bartholin gland/cyst." According to the Anesthesia Record, anesthesia was administered to Patient A starting at 1:00 p.m.

25. For unknown reasons, the "H and P form," admission records, and surgical center consent form records were part of the surgery center records but not part of Patient A's chart at her office. Respondent testified she thought these records were made part of the records at her office and were scanned into the EMR system.

26. Before the procedure was performed, as documented in a surgical center record, a nurse identified with Patient A the "procedure site and side." Before this as noted above at 12:00 p.m. on September 25, 2017, a nurse at the surgery center

documented and initialed the admission order which identified the procedure as excision of the right Bartholin gland/cyst.

Confirmation of the procedure site and side was done per the record before anesthesia was administered to Patient A as part of the pre-operation check list. Prior to the incision, another nurse confirmed the procedure site and side with Patient A. Surgery center records do not document that Patient A stated she wanted the left Bartholin's gland removed or that she expressed concern the right gland was identified for excision in the "H and P form" or that she relayed this concern to respondent.

27. Respondent performed the excision of the right Bartholin's gland procedure without complication.

28. In the Operative Report, respondent stated that she performed the procedure "[a]fter reviewing the consents and alternative options" with Patient A. Respondent also documented that "[a] time-out was conducted to confirm the patient and the procedure." Respondent did not perform the endometrial biopsy because the surgery center did not have a EMB Pipelle instrument. She did not document that she did not perform this procedure but informed patient at her post-op visit on September 29, 2017, that she did not perform it because she did not have this instrument.

29. Respondent documented that during the procedure she observed the right Bartholin's gland area had a "shiny substance underneath the subcutaneous tissue." She wrote in her report that this shiny substance was consistent with a deflated cyst wall.

30. The tissue specimen from the right Bartholin gland/cyst wall was sent to two different laboratories for analysis. The lab at Parkview Hospital confirmed that the tissue specimen was consistent with "mild chronic inflammation." The pathologist at

the hospital then consulted with Alistair Cochran, M.D., a pathologist at UCLA. Dr. Cochran diagnosed the specimen as "Bartholin gland with foci of patchy mild inflammation and fibrosis consistent with resolving infection." This confirmed that the right Bartholin's gland had been infected.

31. After the procedure, Patient A was discharged with a prescription for hydromorphone (generic name for Norco) for pain control.[3] The next day Patient A experienced pain on her right side and learned, to her surprise, that the procedure removed the right Bartholin's gland and not the left. Patient A called respondent's office on September 26, 2017, to complain respondent did a wrong side surgery. That day, respondent called Patient A and talked to her. Patient A wondered why the procedure removed the right Bartholin's gland and not the left since all the paperwork from the emergency room identified the left side. (It is noted Patient A for reasons that were not explained at the hearing did not provide this paperwork to respondent despite indicating she had these documents.) Respondent stated that the surgical consent form referred to the right Bartholin's gland and she excised the right side Bartholin's gland. She further noted Patient A planned to come to her office the next week for follow-up.

32. Patient A testified that during this call, respondent apologized and said that her left was Patient A's right.

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[3] Norco is an opioid used for the management of moderate to severe pain. Norco is a brand name for hydrocodone-acetaminophen. Both drugs are Schedule II opioid controlled substances pursuant to Health and Safety Code section 11055, and dangerous drugs pursuant to Business and Professions Code section 4022.

33. Respondent met with Patient A on September 29, 2017, for a post-operative visit, per a note she recorded. Patient A, however, denied she met respondent at this visit because she said she was too traumatized because of the procedure being performed on the wrong gland.

34. Per the September 29, 2017, record, respondent stated Patient A was upset the wrong gland was removed. Respondent said she removed the gland Patient A indicated at her initial visit with her. She offered Patient A options to manage the left Bartholin's gland including removal or waiting until a cyst forms and then removing it.

35. Respondent also advised Patient A she did not perform the endometrial biopsy because she did not have access to the EMB Pipelle instrument. Patient A asked about cleaning the surgical area and she said 800 mg of Motrin she was taking did not take care of her pain. Respondent recorded she wrote a script for Lidocaine gel; she commented that the pain appeared out of proportion to the surgery performed. Patient A reported no bleeding or discharge. Vital signs were recorded of her blood pressure and weight. Respondent reminded Patient A to follow up with breast imaging.

36. In the left column of the September 29, 2017, note, under Surgical History, the note incorrectly identifies the date of surgery as September 27, 2017, and not September 25, 2017, the date the surgery was performed. Complainant's expert, Victor Chan M.D., criticized respondent for this error and found it was a departure from the standard of care. Respondent testified that a medical assistant recorded the date. Respondent's expert, Stephen DiMarzo, M.D., testified he disagreed that this was a departure from the standard of care. Their opinions on this issue are discussed later in this decision.

37. As with the July 28, 2017, and September 18, 2017, notes, respondent signed this note although she did not finalize the document electronically until October 9, 2017, at the direction of billers in her office. The footer of this document identifies the date of September 29, 2017, "Progress Note: Carr M.D.," and the patient's name. The footer in addition identifies that eClinicalWorks "generated" the "Note." As with the other notes referenced above, it appears respondent created the note on the date of the visit and no persuasive evidence refuted her testimony.

Testimony of Complainant's Expert, Victor K. Chan, M.D.

38. Complainant called Victor K. Chan, M.D., as an expert. In addition to his testimony, Dr. Chan prepared a report, which was received in evidence.

39. Dr. Chan is board-certified in Obstetrics and Gynecology. He obtained his medical degree from the University of California Los Angeles in 1980, and completed an internship at Harbor General-UCLA Medical Center in internal medicine and a residency in obstetrics and gynecology at the University of Colorado Health Sciences Center in 1984. Dr. Chan presently works as an Obstetrical/Gynecological Hospitalist for Obstetrix Medical Group of Sacramento. He has served in various managerial and executive roles in the University of California Davis Health System in medical care including Director of Family Planning, Medical Director of Obstetrics Clinical Care Improvement, and as a member of the Utilization Management Committee and Utilization Review Committee. Since 1990, he has served as a Medical Reviewer and Examiner for the board, and since 2020, he serves as consultant to the board's Central Complaint Unit and as a District Medical Consultant.

40. Dr. Chan reviewed the materials which were admitted as evidence and prepared a report. His testimony was consistent with what he wrote in his report. He is

familiar with the definitions of standard of care and extreme departure from the standard of care. Dr. Chan characterized the differences between a simple departure and extreme departure this way: A simple departure is something that was not right but could happen to any doctor on any given day; an extreme departure is the lack of or scant care.

41. Dr. Chan identified the medical issues regarding respondent's care of Patient A as documentation and wrong site surgery.

42. Dr. Chan articulated the standard of care for documentation as follows in summary:

The standard of care in documentation of an office visit of a new patient includes a chief complaint if applicable and notation of past medical history, past surgical history, allergies, medications, and family history. When the history and presenting symptoms performed at the visit makes a surgical procedure an appropriate option, the record should clearly delineate and describe a physical examination of the anatomic location where the surgery is proposed. When there is laterality to the organs/structures, the side of the proposed surgery should be explicitly clear.

Assessment of problems should include subjective narratives supporting the assessment, and objective findings. The office notes and operative reports should be complete and accurate. When dictation is involved, the final records should be reviewed and signed off in a timely fashion.

If surgery is to be performed involving organs or structures that have laterality (left and right), direction (anterior and posterior), or spatial orientation (top to bottom levels) these descriptors must be precisely documented in all surgical consents.

43. Based on his review of the records Dr. Chan identified the following departures from the standard of care for documentation:

- Respondent failed to document on July 28, 2017, what Patient A told her as to the laterality of her recurrent infected left Bartholin cyst and therefore the side Patient A desired removal of. Dr. Chan believes that this departure constitutes an extreme departure from the standard of care.

- Respondent failed to document the characterization of the problems of the breast mass, pelvic pain, and dyspareunia. Each of these failures constitutes simple departures from the standard of care.

- Respondent failed to document at the September 18, 2017, preoperative visit an evaluation of the laterality of the proposed Bartholin gland excision. Dr. Chang believes that this failure is an extreme departure from the standard of care.

- Respondent failed to document a physical examination of the vaginal area to be operated upon. Dr. Chang believes that this failure is a simple departure from the standard of care.

- Respondent failed to document the laterality of the Bartholin's gland to be removed on the September 18, 2017, consent form. Dr. Chang believes that this failure is an extreme departure from the standard of care.

- Respondent failed to discuss the possible benefits from the proposed surgery with Patient A. He believes that this a simple departure from the standard of care.

- Respondent failed to document what the abnormal bleeding was and also failed to document on the operative report why an endometrial ablation was not done. Dr. Chang regards each of these failures as simple departures from the standard of care.

- Respondent failed to accurately type the September 25, 2017, date of the surgery at the office visit with Patient A on September 29, 2017. Dr. Chang views this failure as a simple departure from the standard of care.

- Respondent in her July 28, 2017, September 18, 2017, and September 29, 2017, notes did not sign and complete them until October 9, 2017, a date after all the interactions with Patient A occurred. Dr. Chang states in his report: "While the tardiness of each of these signoffs constitutes a simple departure, the totality of all of the records being completed so late is an extreme departure from the SOC."

44. In his testimony, Dr. Chan explained his analysis and reasoning for his conclusions on the various documentation issues he identified:

At the first visit respondent did not identify a problem with the right Bartholin's gland. Per the hospital records he reviewed, Patient A's problem was always identified on the left side although respondent did not have these records when she saw Patient A.

Dr. Chan criticized respondent because she examined Patient A's breast area but did not take a history; in his view most reasonably prudent doctors would talk about different aspects of the breast mass.

45. Regarding the pelvic pain Patient A described, respondent did not characterize the pain in terms of the nature of the pain. Dr. Chan commented that pain with intercourse may be related to the Bartholin's gland.

46. Dr. Chan noted that he could not tell whether respondent discussed with Patient A the endometrial biopsy or ablation.

Dr. Chan stated that in terms of respondent's pre-operative evaluation of Patient A, respondent should have performed a pelvic examination of Patient A because this exam needed to be done within a month of the procedure. At the September 18, 2017, respondent did not follow-up regarding the right breast mass, Patient A's pelvic pain, or her pain during intercourse.

47. Dr. Chan further noted that at this September 18, 2017, visit there was nothing in the notes about which Bartholin's gland was to be excised.

48. Regarding two consent forms Patient A signed (the surgical center completed form which Patient A signed on September 25, 2017, and the other form Patient A signed on September 18, 2017, at 10:30 a.m. with respondent), Dr. Chan found these forms lacking in terms of informed consent because they do not identify laterality and also because they do not identify the benefits of the procedure.

49. Dr. Chan disregarded the reference to "right Bartholin cyst" in "the "Proposed Procedure (consent to read)" section of the "H and P form," which respondent signed on September 18, 2017, and Patient A initialed on September 25,

2017. He parenthetically noted in his report that the form, despite its reference to "consent," is not a consent form. Dr. Chan however did not explain what he meant by this in his testimony. Dr. Chan did not consider as a matter of informed consent respondent's testimony that she went over this form when she met Patient A on September 18, 2017. He dismissed this form as documentation concerning the laterality of the Bartholin's gland to be removed because respondent signed it at 5:46 p.m. and not contemporaneously when she met Patient A.

50. Dr. Chan similarly disregarded the language in the admission order respondent signed on September 18, 2017, in which she identified under the "Consent" section of the form "removal of right Bartholin cyst" as the procedure to be performed. As with the other form she completed on September 18, 2017, respondent added the endometrial biopsy procedure to this section which Patient A initialed on September 25, 2017. He termed this a lapse of attention on respondent's part.

51. Dr. Chan in addition faulted respondent for not stating why she did not perform the endometrial biopsy in her operative report. He acknowledged respondent said she decided to not perform the procedure because the surgical center did not have a type of instrument she wanted to use. He commented that she still could have performed a "curettage procedure" using a different instrument.

52. Regarding the error in recording the correct date of surgery in the September 29, 2017, note Dr. Chan explained that he felt given Patient A's concerns about the surgery, respondent should have been careful to type the correct date of surgery. He termed her error a lapse of attention. He did not feel however it was a serious matter of misconduct but felt she still departed from the standard of care. When asked to assume that she did not complete the information in the left column of

the September 29, 2017, note Dr. Chan said she was still responsible for what is put in the chart.

53. With respect to signing the records after respondent interacted with Patient A, Dr. Chan admitted he is not familiar with eClinicalWorks EMR system. He said that two weeks is the time the standard of care requires to complete notes. He acknowledged that respondent completed her September 29, 2017, note on October 9, 2017, and this was within this two-week period. He acknowledged thus that she complied with the standard of care regarding completing this note.

In response to further questions on cross examination regarding locking the note for billing purposes, Dr. Chan said in general he does not testify regarding billing issues and could not say whether or not it was appropriate for respondent, per the billing procedure in her office, to delay locking her notes for billing purposes.

54. With regard to the Wrong Site Surgery issue Dr. Chan identified the standard of care this way:

The standard of care in surgery is to perform the consented procedure exactly as described in a properly executed consent. This includes specification of the laterality of the procedure when applicable as indicated in the consent. Consent involves not only a written piece of paper but includes a discussion with the patient as to understanding of the proposed surgery.

55. Dr. Chan, based on his review of the record, concluded that respondent performed a Wrong Site Surgery. He found the departure extreme.

56. In his analysis, as he states in his report and in his testimony, Dr. Chan credits fully Patient A's account of her discussions with respondent. Dr. Chan candidly

admitted he believes Patient A. He dismissed respondent's statement at the HQIU interview that Patient A "knew very well which side we were planning to remove" and she discussed performing the procedure on the right Bartholin's gland on September 18, 2017, and before the procedure on September 25, 2017. In his report, Dr. Chan does not cite respondent's statements at the HQIU interview.

57. Dr. Chan wrote the following in his report:

> This wrong site surgery resulted from not only documentation lapses, as described previously but also from not listening to [Patient A's] desires and exhortations including the day of surgery. The patient's account of her GSC experience describes an extreme departure from patient-centered care.

Testimony of Respondent's Expert Stephen V. DiMarzo, M.D.

58. Respondent called Stephen V. DiMarzo, M.D., as an expert. Dr. DiMarzo obtained his medical degree from the University of Rochester School of Medicine in 1980. He completed a residency in Obstetrics and Gynecology at the University of California San Diego (UCSD) Medical Center in 1981 and served as a junior and senior resident in Obstetrics and Gynecology at UCSD Medical Center in the Department of Reproductive Medicine from 1981 to 1983, and as Chief Resident from 1983 to 1984. He is Vice-Chair in the Department of Obstetrics and Gynecology at Scripps Clinic/Green Hospital, and also a senior staff member, attending physician at this facility, and member of the Supervisory Committee at the Department at this facility. Dr. DiMarzo is also a Voluntary Assistant Clinical Professor in the Department of Reproductive Medicine at UCSD Medical Center. Dr. DiMarzo has served in numerous

leadership capacities at the hospitals where he has worked. Dr. DiMarzo is board certified by the American Board of Obstetrics and Gynecology and a Fellow of the College of Obstetrics and Gynecology.

59. Dr. DiMarzo reviewed the materials of record in this matter and prepared a report, which has been admitted in evidence. Dr. DiMarzo is familiar with the definition of standard of care and what constitutes departures from a standard of care. In his testimony, however, he incorrectly stated that an extreme departure is the lack of or scant care resulting in a bad result. His definition is incorrect because outcome is irrelevant (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772.) His testimony is consistent for the most part with what he wrote in his report.

60. Based on his review of the record, Dr. DiMarzo found that respondent departed from the standard of care in one respect but in all other respects complied with the standard of care.

61. With respect to the documentation issues Dr. Chan identified, Dr. DiMarzo, as noted, found that respondent committed a simple departure from the standard of care when she failed to identify the Bartholin's gland laterality in her July 28, 2017, note. Otherwise, he disagreed with Dr. Chan that respondent departed from the standard of care for documentation.

62. First, with respect to Dr. Chan's opinion that respondent departed from the standard of care for failing to detail the problems with Patient A's complaint of a mass in her right breast mass, Dr. DiMarzo said respondent well-documented the record in this regard and met the standard of care. He termed Dr. Chan's criticism unreasonable. It was very clear to him respondent appropriately addressed and documented the breast mass and respondent met the standard of care. Dr. DiMarzo

added that respondent was on top of this issue and respondent documented the record fully even though she did not find a breast mass. She was very careful in ordering imaging and followed-up at the September 18, 2017, visit with respondent and her office in this regard. And her office confirmed on September 22, 2017, that respondent was required to pay the $350 for the imaging.

63. Regarding Dr. Chan's opinion concerning respondent's documentation of Patient A's pelvic pain, Dr. DiMarzo found that respondent met the standard of care. He similarly termed Dr. Chan's criticism unreasonable. Dr. DiMarzo noted that respondent described the pain as "vague pelvic pain" so, in fact, respondent documented the nature of the pain. She also documented that she examined Patient A's uterus and adnexa and no adnexa mass was found. Dr. DiMarzo testified he does not know what adjective or adjectives Dr. Chan expected respondent to use to describe "vague pelvic pain." He said a doctor reviewing this record would understand what was going on. The note was very clear. Dr. DiMarzo noted that in his practice he commonly uses the phrase.

64. Regarding Patient A's report of dyspareunia, Dr. DiMarzo also disagreed with Dr. Chan that the note of this condition fell below the standard of care. Dr. DiMarzo said it is well known that a gland infection or inflammation can cause pain during intercourse and the linkage should be obvious to the OB/GYN specialist. This also would be clear to any clinician taking over Patient A's care.

65. Concerning the issue of respondent's failure to document she performed a vaginal exam of the pelvic area, Dr. DiMarzo concluded that respondent did not depart from the standard of care, and he disagreed with Dr. Chan's contrary opinion. Dr. DiMarzo stated that because respondent found, based on the July 28, 2017, exam she performed, that the examination was normal, she did not have to perform an

additional exam on September 18, 2017, at the pre-op visit. Dr. DiMarzo reasoned that the plan to remove the right gland had not changed; the plan was always to remove this right gland. Dr. DiMarzo accepted respondent's statement at her HQIU interview that she was certain Patient A told her the right Bartholin's gland was the gland Patient A wanted excised. There was no need to reexamine the genital area because the plan was not going to change the original plan to remove the right Bartholin's gland.

66. With respect to respondent's documentation of informed consent regarding the benefits of the procedure with Patient A, Dr. DiMarzo disagreed with Dr. Chan that the documentation was not adequate. He said that respondent notated that she had a lengthy discussion with Patient A regarding the "risks and benefits of surgery" as she recorded it in her July 28, 2017, note and also in the informed consent form she identified alternative treatments. Dr. DiMarzo said that respondent clearly documented the record in the way residents are taught to document the record. Dr. DiMarzo uses this exact phraseology in his practice. He is not sure what Dr. Chan expects.

67. Concerning whether respondent departed from the standard of care when she failed to adequately record, as Dr. Chan found, Patient A's report of abnormal bleeding, Dr. DiMarzo testified that respondent did not depart from the standard of care here. Dr. DiMarzo stated that respondent, in fact, did adequately record in the surgery center records Patient A's report of abnormal bleeding to necessitate the endometrial biopsy. In the "H and P form" under the section "Chief Complaint/History of Present Illness" respondent wrote "Recurrent Bartholin gland infections abnormal uterine bleeding." Patient A then signed the form. Patient A complained of abnormal bleeding the day of the surgery. She initialed her acknowledgement of the diagnosis and the procedure. Respondent met the standard

of care because the standard only required respondent to document, as she did, Patient A's report of abnormal bleeding and did not require further documentation regarding the nature the bleeding and its circumstance in a pre-op setting. Further description would not help the evaluation. In an office setting, Dr. DiMarzo said it may be different in terms of management. Dr. DiMarzo added that abnormal bleeding is a common complaint of 30 percent of his patients.

68. Regarding Dr. Chan's opinion that respondent departed from the standard of care because she did not document in the operative report why an endometrial ablation was not done, Dr. DiMarzo found no departure. He testified that the purpose of an operative report is to document what was done not what was not done. At any rate, respondent told Patient A at the post operative visit why she did not perform the procedure because she did not have access to a Pippelle instrument. Dr. DiMarzo commented that her decision to not proceed with the surgery was correct because she was not comfortable performing this procedure without this instrument, contrary to Dr. Chan's view that she should have done a dilation and curettage procedure which is a substantially different procedure with its own potential risks.

69. On the issue of the incorrect surgery date in respondent's September 29, 2017, post operative visit note, Dr. DiMarzo found that respondent did not depart from the standard of care. In offering his opinion, Dr. DiMarzo pointedly criticized Dr. Chan for his opinion on this issue. He said his opinion was "absurd" because the correct date could easily be found in Patient A's record and the operative report was part of respondent's office record. Dr. DiMarzo said that anyone reviewing the record would know the date was a clerical error and it did not affect patient care in any way.

70. Dr. DiMarzo also criticized Dr. Chan for his "unreasonable" opinion that respondent committed an extreme departure from the standard of care for completing

on October 9, 2017, three notes relating to Patient A. (Dr. Chan conceded that respondent's September 29, 2017, note was completed timely despite his opinion in his report that it was not timely completed. Thus, there are two notes at issue not three.)

71. Dr. DiMarzo stated late completion of notes is a feature of the eClinicalWorks program which he is familiar with, as more fully explained below. Dr. DiMarzo opined that respondent's failure to complete the notes until October 9, 2017, did not constitute a lack of or scant care. He found no deviation from the standard of care.

72. Dr. DiMarzo elaborated on his opinion on this issue. He commented that failure to complete the notes is a common problem of the EMR system. Anyone using the EMR system knows that there will be delays in putting notes and billings through the system because of the multiple clicks the system requires to complete the notes for insurance billing purposes. The system "locks" the note so that no other changes can be made. Dr. DiMarzo stressed what is important is that the doctor documents when the encounter actually occurred as opposed to when the doctor signs off on the note. Respondent did that here.

Dr. DiMarzo noted that doctors often complain of this problem and a common term article on physician wellbeing use for this problem with EMRs is "death by a thousand clicks" because doctors must add clicks for diagnoses and medications to close out their notes. Dr. DiMarzo wrote in his report that even if the note is signed it does not register the note as closed. He said in his own practice the EMR system informs him of clicks he has missed. Recently Dr. DiMarzo cited an example where he was informed a note from December was not closed out because he failed to add one click.

73. Concerning the absence of laterality identification in the informed consent documents and the notes, Dr. DiMarzo disagreed with Dr. Chan's opinion that respondent committed extreme departures from the standard of care when she failed to document on July 28, 2017, what Patient A told her as to the laterality of her recurrent infected Bartholin's cyst, when she failed to document the laterality of the cyst in her September 28, 2017, note, and when she failed to adequately document laterality relating to the gland in the consent forms.

Dr. DiMarzo did agree respondent committed a simple departure from the standard of care in documenting laterality. He agreed that respondent should have identified the laterality of the Bartholin's gland in the July 28, 2017, note and her failure to do so constituted a departure from the standard of care. But he disagreed with Dr. Chan that this constituted an extreme departure, or that respondent departed from the standard of care in failing to document laterality in the September 18, 2017, note or the consent forms.

74. In his analysis regarding the laterality documentation issue, Dr. DiMarzo placed identification of laterality within the context of the wrong site surgery issue and records that identify the right side Bartholin's gland as the gland Patient A wanted excised. In his view, this was not a wrong site surgery case because the evidence of record as discussed below does not show that respondent operated on the wrong Bartholin's gland. Thus, once this is no longer considered a wrong site surgery case, the issue is whether respondent's failure to identify laterality in the July 28, 2017, and September 17, 2017, records and the consent forms represented a lack of or want of

care.[4] Dr. DiMarzo does not believe it does because another clinician reviewing the record could identify that the right side Bartholin's gland was removed. The "H and P form," the admission order, and respondent's operative report all document the right side. With this stated, Dr. DiMarzo agreed with Dr. Chan that at least regarding the July 28, 2017, note, respondent should have identified the right side Bartholin's gland.

75. In concluding that respondent did not operate on the wrong Bartholin's gland, Dr. DiMarzo stressed the documentation in the record that confirms Patient A wanted the right side Bartholin's gland removed. The "H and P form" and the admission order document that the procedure was to excise the right side Bartholin's gland, the surgery center conducted a time out to confirm the laterality of the procedure, and the operative report confirms that a time out was done.

Additionally, respondent recorded in her operative report she saw a substance consistent with a deflated cyst wall in the area of the right Bartholin's gland and lab results confirmed that the right side Bartholin's gland had a resolving infection. Further, Dr. DiMarzo recognized that respondent was certain Patient A told her she wanted the right side Bartholin's gland removed and respondent discussed removal of the right side Bartholin's gland with Patient A before the surgery.

76. Dr. DiMarzo emphasized that a wrong site surgery is a seminal event. Nurses are mandated to document an instance of wrong site surgery. If during the time out there is a question regarding the site's laterality, the procedure must be

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[4] It is noted here that the surgery center consent form is a preprinted surgery center form based on the consent form respondent prepared at her office.

stopped. Patient A's surgery center records does not indicate that Patient A expressed concern that the wrong Bartholin's gland was to be excised or was excised.

Patient A's Testimony

77. Patient A testified. Portions of her testimony have been incorporated in the above treatment summary. Her testimony is also summarized as follows:

Patient A is familiar with the Bartholin's gland and knows there are two glands. She always had problems with the left side Bartholin's gland; she was getting cysts on her left side. Three times about two years before she saw respondent she had cysts removed in the emergency room. She had a catheter placed there once. She obtained her records from her hospital visits to see as she explained "what I could get done attorney wise, if I could get some type of compensation due to this," and to get second opinions from other doctors.

78. At some point, Patient A wanted her left gland removed and, as noted, found respondent through an internet search she did and saw respondent on July 28, 2017. For reasons she did not explain, despite obtaining the records to get second opinions, Patient A did not give these records she obtained to respondent. This conflicts with her statement in her June 22, 2018, complaint to the board where she asserted respondent excised the right side Bartholin's gland after "showing all the reports of ER showing my left was my problem."

79. At her July 28, 2017, visit, she wanted an annual exam and also needed to be examined regarding the left gland issue. Respondent suggested she have surgery to have the left gland – not the right gland – removed. During the pelvic exam Patient A said respondent said she saw scarring on the left side.

80. At the September 18, 2017, visit, Patient A did not remember if she met respondent; she thinks she met one of the medical assistants. She could not recall if a pelvic exam was done; she remembers she went to the office and was given paperwork. The forms did not indicate which gland was to be removed.

81. Despite stating she did not remember meeting respondent at the September 18, 2017, visit Patient A said respondent suggested she have a mammogram. But she had to pay for the mammogram and she did not have the money at the time. She said she remembers telling respondent she had a little pain. She told respondent that the Bartholin's gland cysts were recurring; she always said her left side Bartholin's gland was the problem.

82. On the date of surgery September 25, 2017, Patient A testified respondent was running late. Patient A told the HQIU investigator that respondent "seemed disoriented and was not acting as she was in her previous appointments." She first saw the "H and P form" at the surgery center. She told respondent and a nurse the left gland – not the right – was to be removed and she grabbed her left leg to illustrate the side for respondent. Respondent told her that she would make the change. Patient A testified there were three to four persons from the surgery center in the room when she said the left side was to be excised and not the right. She said she does not remember signing the paperwork because she was dosing off from the anesthesia. Patient A further said that she was given anesthesia before she got to the operating room. Of note, this testimony conflicts with the anesthesia records. She said she thought she initialed the form to reflect the change "right" to "left." Patient A stated she had trouble initialing the form because of the anesthesia, and her husband had to hold the form for her because she was dosing off and it was hard to sign because she needed to use her right arm.

83. Patient A does recall that she discussed the endometrial biopsy with respondent; respondent told her it is a painful procedure and it is better to be performed while she was asleep.

84. After the surgery, Patient A said she was discharged with a prescription for Norco although she told respondent she was allergic to Norco. Respondent's office records, the surgery center records, and the hospital records indicate that Patient A reported she had no known allergies to medications. The hospital records indicate further that she was prescribed Norco after the May 31, 2016, procedure at Parkview Community Hospital and also after the October 5, 2016, procedure at Riverside University Health System. On November 7, 2017, she saw Bich-Van Tran, M.D. at UC Riverside Women's Health for the Bartholin's cyst. The records from that visit indicate for the first time that she said she was allergic to Norco.

85. Patient A said she was surprised she experienced pain on her right side and discovered that respondent excised the right-side Bartholin's gland. Patient A testified that after the procedure she remembered waking and felt pain on the right side and told the nurse at the surgery center. She said she asked to talk to respondent and was told she could not.

86. Patient A contacted respondent's office and respondent talked to her by phone. Patient A said respondent apologized and said your right side was my left.

87. Patient A stated she was traumatized the wrong gland was removed and suffered significant mental trauma. She testified she was supposed to have a post-operative visit with respondent but she did not go. She told the HQIU investigator she refused to see another physician regarding the left gland issue after the procedure. This is incorrect. In fact, on November 7, 2017, she saw Bich-Van Tran, M.D. at UC

Riverside Women's Health for the Bartholin's cyst and discussed with him the September 25, 2017, procedure.

Respondent's Testimony

88. Portions of respondent's testimony are summarized earlier in this decision. Respondent's testimony is otherwise summarized as follows:

89. Respondent obtained her medical degree from Albany Medical College in 2011 and completed her residency in OB/GYN at Loma Linda University Medical Center in 2015 where she served for four months as chief resident. She is board certified in Obstetrics and Gynecology and certified to perform laparoscopic surgery. Since 2018, she has worked at Inland Empire Women's Center. Since 2021, she has served as Vice-Chair of the OB-GYN Department at Community Hospital in San Bernardino and is Chair of the Cooperative American Physicians Risk Management Review Committee. Respondent is also a member of the Robotic Surgery Committee and she is an adjunct faculty member of Hope International University.

90. Respondent is familiar with Bartholin's gland cysts and had experience before she treated Patient A taking care of issues associated with them.

91. Respondent stated she did not operate on the wrong Bartholin's gland. She distinctly remembers treating Patient A. She specifically remembers discussing with Patient A the right side Bartholin's gland and Patient A had told her she had had a Word catheter placed. She said most patients would not know the type of catheter that was placed. Respondent is certain Patient A told her she wanted the right side Bartholin's gland removed because it was causing her pain during sex.

92. When respondent performed the exam on Patient A on July 28, 2017, she checked to see if there was an active cyst and would have recorded if there was. She denied she told Patient A during the exam that she saw scarring on the left side.

93. Respondent is also certain she went over the "H and P form" with the language "right Bartholin gland/cyst" with Patient A first at the September 18, 2017, visit. Respondent said she prepared the "H and P form" in the morning of September 18, 2017, and not at 5:46 p.m., per her custom and practice. And per her custom and practice, respondent would sit with the patient and go over the procedure or procedures and write them down with the patient in the room. Respondent said she wrote the document at 10:30 a.m. when she met Patient A after discussing with her which gland she wanted removed.

94. At the September 18, 2017, visit, Patient A told respondent she was starting to feel something on the right side. Consistent with Patient A's statement she was starting to feel something, respondent, during the September 25, 2017, procedure, saw in the area of the right Bartholin's gland underneath the subcutaneous tissue a shiny substance consistent with a deflated cyst wall. A lab report found that a tissue sample from this substance confirmed a resolving infection.

95. Respondent said she identified laterality in the "H and P form" and admission order; she thought both records were part of her office records. She thought these documents and other documents sent to the surgery center were scanned into her office's EMR system.

96. When respondent went to the surgery center on September 25, 2017, a medical assistant at her office made available for her a folder to take to the surgery center. This folder contained the "H and P form," the admission order, and the consent

form. Again, respondent stressed she understood that the documents were part of her office's records because her office retained custody of them. She first realized the "H and P form" and other records she sent to the surgery center were not part of her office's records when she saw the documents the board obtained as part of the investigation.

97. Respondent testified she is also absolutely certain she confirmed at the surgery center on September 25, 2017, with Patient A in the pre-operative area, what, as she put it, "we are doing today." She read to Patient A the language from the "H and P form" consent to read section which identified the right Bartholin's gland to be excised. She said Patient A was attentive and not drowsy. Respondent recalled that a nurse was with respondent and Patient A as they were doing pre-operative planning. She had no reason to think that a surgery center nurse did not review the pre-operative check list to further confirm the site of the procedure.

98. With respect to completing her notes, respondent testified she prepared the notes documenting her care of Patient A the date she saw Patient A; she was required to complete the notes every night before she went home. Per her contract with the medical group where she worked at the time - Raincross Women's Medical Group (Raincross) – she was required to do this. She explained that the reason the records at issue are dated as completed on October 9, 2017, is because that is how the eClinicalWorks system works. The signature is affixed when you lock the records and that is when the time stamp is placed.

99. Respondent explained that when she started working at Raincross, she was told not to lock the records until the biller told her to do so for insurance process issues. When the lock function is pressed, it locks the note and indicates the time the record is completed. With regards to the three notes at issue, respondent locked the

notes within minutes of each other as the biller at Raincross directed, although she completed the notes in each of the three records the dates she treated Patient A. The footers in each of the notes confirm she completed the notes on each of the days she treated Patient A.

100. Regarding the date of surgery recorded in the September 29, 2017, note, respondent said a medical assistant entered the date in the EMR system. The assistant also enters other information including whether the patient is allergic to medications and blood pressure and weight.

101. Patient A wrote "vague pelvic pain" in performing the pelvic exam because Patient A did not experience pain during the examination; if she had she would have recorded something like "tender" to describe the pain.

102. Respondent notated the record that she had "lengthy discussion of risks and benefits" because she, in fact, had a lengthy discussion with Patient A about both the risks and benefits of surgery. She would only have written "lengthy" if the discussion was "lengthy." Because removal of the gland would mean Patient A would not have recurrent infections, she did not believe it was necessary to identify this as the benefit of surgery in the consent form.

103. Regarding respondent's decision to not proceed with the endometrial biopsy because the surgery center did not have a Pippelle instrument, she testified that using a curette instrument would involve a completely different procedure that needed the patient's consent. Using the Pippelle is a very low risk, simple procedure. Respondent did not feel comfortable performing a biopsy of the cavity with a curette.

Respondent did not feel it was necessary to document why she did not perform the procedure in the operative report because she was taught to include what you did and not what you did not do in the operative report.

104. Respondent said she did not feel it was necessary to perform an examination on September 18, 2017, because Patient A reported she was starting to feel something in that area.

105. Respondent agreed she should have recorded that Patient A wanted the right side Bartholin's gland removed; in this respect, she admitted her record keeping was deficient.

To improve her record recording practices, respondent completed a medical record course at the University of California, Irvine School of Medicine on May 15, 2022.

Respondent believes she has worked to improve her record keeping and supplied redacted samples of her recent progress notes to show this.

Testimony of Joe Mawad, M.D.

106. Respondent called Joe Mawad, M.D. as a character witness. Dr. Mawad is Medical Director, President, and Lead Physician at Inland Empire Women's Center Medical Associates. He is also Chairman of the Department of Obstetrics and Gynecology at Dignity Health St. Bernardine's Medical Center. In addition to his testimony, Dr. Mawad wrote a letter which was admitted in evidence. His testimony is summarized as follows:

107. Respondent joined Inland Empire Women's Center three to four years ago. Dr. Mawad interviewed her for this position in 2016. The practice is a large group

practice that covers four outpatient offices and two hospitals. He described respondent as a very skilled and thorough practitioner and surgeon. He stated her skills are so advanced she became the Director of Advanced Robotic Surgery at the Center and sits on the Board of Robotic Surgery at St. Bernardine's Medical Center. She is one of the few doctors who can manage advanced laparoscopic techniques without assistance from other doctors. She frequently receives referrals from other doctors. Dr. Mawad is familiar with respondent's care of patients based on his interactions with her and his review of her records.

108. Dr. Mawad stated that respondent's ethics are unparalleled, and she cares for every patient with compassion and a listening attitude and offers extensive counseling.

Dr. Mawad has no doubt regarding respondent's honesty and straightforwardness and her commitment to patient safety and care.

Parties' Closing Arguments

109. Complainant argued that the allegations against respondent should be sustained based on Patient A's credible testimony and Dr. Chan's opinions. Complainant seeks the imposition of discipline consistent with the board's guidelines including the requirement that respondent have a practice monitor.

110. Respondent argued that if any discipline is to be imposed, the appropriate level of discipline should be a public reprimand. Respondent argued that the evidence of record does not meet the clear and convincing standard of proof required because Patient A's reliability as a witness is questionable for a number of reasons and Dr. Chan, as Dr. DiMarzo stated, was overcritical and unfair in his evaluation of respondent's treatment of Patient A and her documentation.

Respondent cited as a glaring example of the problem with Patient A's testimony her claim she never went back to see respondent after the surgery. Respondent pointed out that complainant did not charge respondent with creating a false record documenting that, in fact, Patient A saw respondent after the surgery. Respondent described Patient A's testimony here as a huge problem with her credibility which complainant ignored. Respondent asserted that Patient A was trying to make a case against respondent. Patient A also said she was allergic to Norco when all the records state otherwise. She said she was drowsy, and her husband had to hold the clipboard for her when she initialed the "H and P form"; the records, however, indicate that she was not given anesthesia until after she initialed the document.

Respondent argued further that respondent's testimony should be considered straightforward and honest and the evidence of record supports it. Respondent cited her practice of going over the "H and P form" with the patient, lab results showed a resolving infection in the right gland, and surgery center documentation confirmed the site of the surgery prior to the surgery.

Respondent stated that this is a case about documentation and the documentation confirms that respondent identified laterality. She thought that the surgery records were included in her office medical records. Respondent did not commit extreme departures due to the cumulative failure to complete the EMR notes as Dr. Chan claimed. Respondent said this did not constitute a lack or want of scant care.

Regarding the issues of documenting her examination of Patient A's reports of a breast mass pelvic pain and dyspareunia, respondent cited Dr. DiMarzo's testimony that there was adequate information in the record for another reviewing doctor. Respondent argued, similarly, that Dr. DiMarzo's testimony regarding documentation

of Patient A's report of abnormal bleeding the day of the procedure should be found persuasive.

In summary, respondent asserted that this case lacks the evidence by a clear and convincing standard to support the wrong site surgery allegation; respondent concedes however a record keeping violation has been established but a public reprimand should be issued for this violation.

Evaluation of Expert Testimony and Evidence

111. The decision in this matter requires resolving the conflict in the testimony of the experts. In this regard, consideration has been given to their qualifications and credibility, the factual bases of their opinions, the reasons for their opinions, and any biases that could color their opinions and review of the evidence. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

After giving due consideration to these factors, Dr. DiMarzo's opinions regarding the documentation and wrong site surgery issues are accepted over Dr. Chan's for these reasons:

112. A review of Dr. Chan's opinions makes clear he accepted Patient A's belief that respondent committed wrong site surgery and his opinions were influenced by his view that respondent performed a wrong site surgery. He echoed Patient A's complaint in his report where he wrote, as quoted earlier, the following:

> This wrong site surgery resulted from not only documentation lapses, as described previously but also

> from not listening to [Patient A's] desires and exhortations including the day of surgery. The patient's account of her GSC experience describes an extreme departure from patient-centered care.

113. But there are problems with Patient A's overall credibility based on her account of her interactions with respondent and her understanding of what took place at the time of her surgery. As found below, Patient A's testimony is not credible for a number of reasons; respondent's testimony that she was certain Patient A told her the right Bartholin's gland she wanted excised – not the left – is found credible also for reasons discussed below.

114. In terms of analyzing Dr. Chan's opinions, Dr. Chan was clearly influenced by his belief that respondent committed wrong site surgery based on Patient A's complaint and this colored his opinions in general. Once the wrong site surgery issue is taken out of the equation, a number of his criticisms of respondent's documentation and care of Patient A seem unfair and unreasonable, and he appeared overcritical of respondent. As one instance of this, Dr. Chan stated respondent departed from the standard of care for identifying the wrong date of surgery when he did not even consider it a serious matter in the first place; the date is clearly a typographical error; the date of surgery was not at issue and is documented in respondent's record in her operative report. Dr. Chan could only conclude that, in his view, this represented a lack of attention on respondent's part; he did not identify how this would impact how another doctor would review the record. Dr. Chan also opined that respondent committed an extreme departure for her cumulative departures from the standard of care when she signed and completed three records on October 9, 2017. But, he acknowledged respondent completed one of these within the two week time frame he

identified as the period to do so; she completed another record on September 18, 2017, which is not far past this two week time frame he identified as the time to complete the record. When asked to comment on whether respondent's office billers would request the EMR be left open Dr. Chan did not answer the question; he said he does not talk about billing matters. Dr. Chan also admitted he was not familiar with the EMR system used by respondent and complainant offered no evidence refuting respondent's explanation of how the record is kept "open" for insurance billing purposes.

115. Dr. Chan, in turn, seemed disinclined to accept evidence that even colorably could support respondent: He dismissed the "H and P form" identification of the right Bartholin's gland and the admission order which also identified the right Bartholin's gland in the context of his concern regarding informed consent. He also questioned whether respondent reviewed the document with Patient A on September 18, 2017, because she did not sign it until later in the day. The circumstances of both documents, per respondent's credible testimony, is that respondent reviewed the "H and P form" with Patient A and Patient A knew the document identified the right Bartholin's gland. This document can fairly be deemed confirmation that Patient A consented to have the right side Bartholin's gland removed. It, in fact, identifies the procedure to be performed as "Consent to Read."

116. In contrast, Dr. DiMarzo's opinions are soundly based on the record and his analyses were more dispassionate than Dr. Chan's. Dr. DiMarzo's statement relating extreme departure to outcome does not require discounting his overall well-reasoned and factually well-based opinions and analysis.

117. Regarding the specific issues, and Patient A's and respondent's credibility in terms of assessing their respective testimony, Patient A's testimony cannot be

credited over respondent's testimony for several reasons: As just noted, there is documentation which confirms respondent's testimony that she discussed performing an excision of the right Bartholin's gland with Patient A on September 18, 2017, and September 25, 2017, shortly before the procedure. The evidence of record does not support an inference, as Patient A suggested, there was a system break down at the surgery center where she told nurses and respondent the procedure was about to be performed on the wrong Bartholin's gland. In fact, preoperative documents establish that the site was confirmed. Respondent's operative report also confirms this fact.

118. There were also problems with Patient A's testimony that call into question her overall credibility as a witness: She said she did not return to see respondent on September 29, 2017. A record from this date records that respondent saw her and discussed with her the September 25, 2017, procedure. The record cannot be deemed a fabrication. Patient A said she signed the "H and P form" when she was under anesthesia when the records indicate that anesthesia was not administered until after she initialed the "H and P form." She said her husband had to help her sign the document because she was under the influence of anesthesia, but her husband, though identified as a witness, did not testify to support her testimony and no one form the surgery center confirmed her claim. Patient A said respondent and nurses at the surgery center all heard her say she wanted the left Bartholin's gland removed before the procedure and respondent told her she would change the form and operate on the left Bartholin's gland. The records from the surgery center do not in any way substantiate that a system wide breakdown at the surgery center for ensuring the correct site to be excised occurred. The records indicate that the site of the surgery was confirmed, and a time out was taken with informed consent confirmed. To believe Patient A's claim would require a finding that all staff at the surgery center conspired to hide a wrong site surgery, a finding that is completely unsupported by the evidence.

Patient A also told an HQIU investigator that respondent seemed "disoriented" when she was at the surgery center. There is no evidence of this. In fact, the record indicates that respondent acted professionally the day of surgery and declined to perform the endometrial biopsy because she did not have access to an instrument she was comfortable using. Patient A's characterization of respondent seems to be an effort on Patient A's part to portray respondent as somehow impaired. She also stated in her complaint that she showed the hospital records she allegedly obtained to get second opinions to respondent and respondent nonetheless operated on the wrong Bartholin's gland; in fact, she did not provide respondent with these records. She also said she obtained these records to see if she could get compensation for the problems she had. She said respondent prescribed her Norco when she was allergic to the medication when all the records before she saw respondent indicate she had no known allergy. This also appears to be an effort to portray respondent in as negative a light as possible.

119. Respondent's testimony is found credible and to the extent her testimony conflicts with Patient A, respondent's testimony is credited over Patient A's. Respondent testified she was certain she discussed with Patient A excision of the right Bartholin's gland. She stated at her HQIU interview that Patient A knew very well which side she was planning to remove. She discussed this with her before she was under anesthesia. Respondent's testimony is supported by the record: The "H and P form" and admission order specifically identify right Bartholin's gland as the gland to be excised. It is thus found, based on the record and respondent's testimony, she reviewed the "H and P form" with Patient A on September 18, 2017, even though she signed it later that day. In addition, Patient A admitted respondent reviewed the "H and P form" with her before the procedure on September 25, 2017. Patient A initialed the form next to the language regarding the right Bartholin's gland.

120. With the finding that respondent did not excise the wrong Bartholin's gland, the matter to be decided is whether respondent departed from the standard of care for documentation. In this respect Dr. DiMarzo's testimony is found fully persuasive and Dr. Chan's testimony and opinions to the contrary discounted. Dr. DiMarzo's testimony and opinions regarding the documentation issues and wrong site surgery issue are thus accepted over Dr. Chan's.

121. Accordingly, the following conclusions are reached concerning the issues identified in the first amended accusation:

122. Respondent committed a simple departure from the standard of care when she failed to record what Patient A told her regarding the laterality of the Bartholin's gland in the July 28, 2017, record. In his analysis of this issue, Dr. DiMarzo persuasively concluded that this was a simple departure from the standard of care and Dr. Chan's contrary opinion that the departure was extreme is not found persuasive.

123. Respondent did not depart from the standard of care when she failed to document laterality in the September 18, 2017, note or the consent forms for the reasons Dr. DiMarzo gave. The "H and P form" Patient A reviewed on September 18, 2017, and initialed before her surgery on September 28, 2017, supports the conclusion that Patient A consented to have the right Bartholin's gland excised.

124. Respondent did not remove the wrong Bartholin's gland as found above. The evidence of record supports respondent's credible testimony that Patient A wanted the right side Bartholin's gland removed.

125. Respondent did not depart from the standard of care when she did not complete her progress notes until October 9, 2017. Dr. DiMarzo persuasively opined that respondent did not depart from the standard of care due to the features of the

eClinicalWorks EMR system and the billing requirements of respondent's office. In any event, respondent completed the notes recorded in the record when she saw Patient A which, per Dr. DiMarzo's persuasive testimony, met the standard of care.

126. Respondent did not depart from the standard of care in documenting a narrative regarding the right breast mass in the July 28, 2017, note. Dr. DiMarzo persuasively opined that respondent met the standard of care documenting the breast mass on this date. Respondent, as Dr. DiMarzo put it, was on top of this issue and well documented the record even though she did not find a breast mass. Respondent carefully ordered imaging and followed-up at the September 18, 2017, visit with Patient A regarding whether she underwent the imaging and confirming with clinic staff what would be the cost of the imaging for Patient A.

127. Respondent did not depart from the standard of care in characterizing Patient A's pelvic pain or performing examination supporting or refuting the pelvic pain assessment in her progress note of July 28, 2017. Dr. DiMarzo persuasively testified that respondent met the standard of care documenting Patient A's report of pelvic pain in the July 28, 2017, note when she reported that Patient A had "vague" pelvic pain.

128. Respondent did not depart from the standard of care characterizing Patient A's dyspareunia in her progress note of July 28, 2017. Dr. DiMarzo persuasively testified that respondent adequately documented Patient A's report of dyspareunia because specialists in the area of OB/GYN care who would review the record would recognize dyspareunia is commonly a feature of a Bartholin's gland infection.

129. Respondent did not commit a departure from the standard of care when, as alleged, she failed to discuss and/or adequately document the benefits of the

proposed surgery to remove Patient A's Bartholin gland in her progress note of September 18, 2017. Dr. DiMarzo persuasively testified respondent met the standard of care when she documented she discussed at length the risks and benefits of the procedure with Patient A and identified in the consent form alternative treatments.

130. Respondent did not depart from the standard of care when, as alleged, she did not perform and/or failed to adequately document an examination of the surgical site where the Bartholin gland was to be removed. Dr. DiMarzo persuasively testified that the standard of care did not require respondent to perform an examination on September 18, 2017, because respondent found, based on the July 28, 2017, exam that the examination was normal appearing; she thus did not have to perform an additional exam on September 18, 2017, at the pre-op visit. The plan to remove the right gland had not changed; the plan was always to remove this right gland.

131. Respondent did not depart from the standard of care when, as alleged, when she failed to adequately document the abnormal uterine bleeding and endometrial biopsy in the "H and P form" or as part of the Operative Report and failed to document why the endometrial biopsy was not performed in the Operative Report. Dr. DiMarzo persuasively testified that respondent met the standard of care and adequately recorded Patient A's report of abnormal bleeding to necessitate the endometrial biopsy in the "H and P form" under the section "Chief Complaint/History of Present Illness." In this section, respondent wrote "Recurrent Bartholin gland infections abnormal uterine bleeding." Patient A initialed her acknowledgement of the diagnosis and the procedure. Respondent met the standard of care in the pre-op setting because the standard only required respondent to document, as she did,

Patient A's report of abnormal bleeding and did not require further documentation regarding the nature of the bleeding and its circumstance.

132. Respondent also did not depart from the standard of care when she did not explain in the operative report why she did not perform the endometrial biopsy. Dr. DiMarzo testified persuasively that the purpose of an operative report is to document what was done, not what was not done, and, further, respondent told Patient A at the September 29, 2017, visit that she did not perform the procedure because she did not have the correct instrument.

133. Respondent did not depart from the standard of care when, as alleged, she failed to adequately document the date of the surgery in her progress note of September 29, 2017. As Dr. DiMarzo noted this was a typographical error and any clinician reviewing the record would realize this because the operative report identified the date of surgery. Further, the error would have no impact on patient care. In any case, respondent did not record the incorrect date; a medical assistant wrote this date per respondent's credible testimony.

Costs of Enforcement

134. Complainant seeks recovery of enforcement costs in the total amount of $28,765 pursuant to Business and Professions Code section 125.3.

135. In support of the request for recovery of enforcement costs, the Deputy Attorney General who prosecuted the case signed a declaration on July 8, 2022, requesting $28,765 relating to the legal work performed in this matter, which includes $1,760 based on the good faith belief that eight additional hours will be incurred and billed from July 5, 2022, to the date of the hearing. Attached to the declaration is a document entitled "Master Time Activity by Professional Type." This document

identifies the tasks performed, the dates legal services were provided, who provided the services, the time spent on each task, and the hourly rate for the Supervising Deputy Attorney General, Deputies Attorney General, paralegals, and a program analyst from January 1, 2022, through July 5, 2022, for a total of $27,005 in prosecution costs. Additionally, in her declaration, as noted, the Deputy Attorney General identified $1,760 in good faith belief that 8 hours of additional work will be performed from July 5, 2022, to the date of the hearing.

136. California Code of Regulations, title 1, section 1042, subdivision (b), requires that this declaration must include "specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs."

137. The part of the declaration listing the actual tasks performed with the attachment complies with the requirements specificity of section 1042, subdivision (b), and are found to be reasonable. However, the estimated amount referenced in the declaration of $1,760 is disallowed. The description of the work to be performed is too general to allow for a finding that the costs are reasonable. Accordingly, the total reasonable costs of enforcement of this matter are $27,005. Respondent did not present any evidence regarding her ability to pay costs.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act (Chapter I, Division 2, of the Business and Professions Code) is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical*

Examiners (1978) 81 Cal.App.3d 564, 574.) The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Burden and Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the first amended accusation are true.

The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Applicable Statutes Regarding Causes to Impose Discipline

3. Section[5] 2227, subdivision (a), states:

> 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

[5] References are to the Business and Professions Code unless otherwise stated.

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 the discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

4. Section 2234 provides in part:

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

[¶] . . . [¶]

(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.

5. Section 2266 provides:

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

Decisional Authority Regarding Standard of Care

6. 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 involving the

acts of a physician 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.)

Case Law Regarding Gross Negligence

7. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

8. Courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. (*Id.* at 1054.)

Case Law Regarding Repeated Negligent Acts

9. A repeated negligent act involves two or more negligent acts or omissions. No pattern of negligence is required; repeated negligent acts means two or more acts of negligence. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

Cause Does Not Exists Under the First or Second Causes for Discipline to Impose Discipline Against Respondent's License for Gross Negligence or Repeated Negligent Acts

10. Complainant failed to prove by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), or repeated negligent acts pursuant to Section 2234, subdivision (c), in her care and treatment of Patient A based on the findings in this decision.

Dr. DiMarzo persuasively testified that respondent complied with the standard of care for documentation in all instances except in one instance of simple negligence. In that instance respondent failed to record the laterality of the Bartholin's gland Patient A wanted excised. Dr. Chan's testimony to the contrary is not found as persuasive as Dr. DiMarzo's for the reasons stated earlier in this decision. But, one simple departure is insufficient to merit discipline – there must be at least two negligent acts, and here, the evidence established there was only one.

In turn, complainant did not show by clear and convincing evidence that respondent operated on the wrong Bartholin's gland. Respondent's testimony is found credible she operated on the Bartholin's gland Patient A wanted excised and her testimony is supported by the evidence of record, specifically the "H and P form" and the admission order. Patient A's testimony to the extent it conflicts with respondent's testimony is found not credible.

Cause Exists Under the Third Cause for Discipline to Impose Discipline Against Respondent's License for Inadequate Record Keeping

11. Complainant proved by clear and convincing evidence that respondent violated Section 2266 when she failed to identify the laterality of the Bartholin's gland Patient A wanted excised at the July 28, 2017 visit. Dr. Chan and Dr. DiMarzo agreed that this failure represented inadequate record keeping.

The Board's Disciplinary Guidelines

12. With cause for discipline found, the determination now must be made regarding the degree of discipline and the terms and conditions to impose. In this regard, the board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016) states:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

13. For the cause of discipline for inadequate record keeping, the maximum penalty is revocation; the minimum penalty is stayed revocation and five years'

probation with terms and conditions. In cases charging repeated negligent acts involving one patient under the appropriate circumstances a public reprimand may be ordered.

Disciplinary Considerations and Disposition Regarding the Degree of Discipline

14. As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual, the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Fahmy, supra*, 38 Cal.App.4th at p. 817.) Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.)

15. The determination whether respondent's license should be disciplined includes an evaluation of the nature and severity of the conduct and rehabilitation and mitigation factors as set forth under California Code of Regulations, title 16, section 1360.1, which provides as follows:

> When considering the suspension or revocation of a license, certificate or permit on the ground that a person holding a license, certificate or permit under the Medical Practice Act has been convicted of a crime, the division, in evaluating the rehabilitation of such person and his or her eligibility for a license, certificate or permit shall consider the following criteria:
>
> (a) The nature and severity of the act(s) or offense(s).

(b) The total criminal record.

(c) The time that has elapsed since commission of the act(s) or offense(s).

(d) Whether the licensee, certificate or permit holder has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against such person.

(e) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(f) Evidence, if any, of rehabilitation submitted by the licensee, certificate or permit holder.

16. After considering the board's guidelines, and the factors under California Code of Regulations, title 16, section 1360.1, the evidence of rehabilitation, and mitigation, and the evidence of record as a whole, it is determined that a public reprimand will ensure public protection. It is not necessary to impose as condition of this reprimand the requirement that respondent take a medical record keeping course because respondent has successfully completed such a course. This conclusion is reached for these reasons:

17. The nature of respondent's misconduct was not so serious that a public reprimand would be contrary to the public interest. The serious allegation that respondent committed wrong site surgery has not been proven and the conduct that has been proven is a single act of inadequate record keeping. With this noted, respondent could have avoided this entire process had she documented laterality

when she first saw Patient A. The resulting allegations were due to respondent's failure to do this.

There are a number of factors in respondent's favor. Respondent accepts responsibility for this error and affirmatively took steps to improve her record keeping skills. The record shows that respondent attentively cared for Patient A and was responsive to her needs and concerns. Respondent appears to be a highly skilled doctor who cares for her patients in a conscientious manner and is concerned about their safety and well-being. Respondent demonstrated this when she decided to not proceed with the endometrial biopsy of Patient A surgery when an instrument she was comfortable using was not available to her. Her supervisor's testimony also supported this finding.

Costs of Enforcement

18. Under Business and Professions Code section 125.3, complainant may request that an administrative law judge "direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case." "A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case." (Bus. & Prof. Code, § 125.3, subd. (c).)

19. The Office of Administrative Hearings has enacted a regulation for use when evaluating an agency's request for costs under Business and Professions Code section 125.3. (Cal. Code Regs., tit. 1, § 1042.) Under the regulation, a cost request must be accompanied by a declaration or certification of costs. For services provided

by persons who are not agency employees, the declaration must be executed by the person providing the service and describe the general tasks performed, the time spent on each task, and the hourly rate. In lieu of the declaration, the agency may attach copies of the time and billing records submitted by the service provider. (Cal. Code Regs., tit. 1, § 1042, subd. (b)(2).)

20. Another consideration in determining costs is *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32. In *Zuckerman*, the California Supreme Court decided, in part, that in order to determine whether the reasonable costs of investigation and enforcement should be awarded or reduced, the administrative law judge must decide: (a) whether the licensee has been successful at hearing in getting charges dismissed or reduced; (b) the licensee's subjective good faith belief in the merits of his or her position; (c) whether the licensee has raised a colorable challenge to the proposed discipline; (d) the financial ability of the licensee to pay; and (e) whether the scope of the investigation was appropriate to the alleged misconduct. The scope of the investigation was appropriate to the allegations. The charges were sustained, and respondent provided no evidence regarding her ability to pay the costs.

21. After consideration of the factors under *Zuckerman, supra,* a substantial reduction in the reasonable costs of $27,005 as found is required to reflect that respondent successfully challenged most of the allegations against her and most of the allegations have been dismissed. Accordingly, reasonable costs are assessed at $1,500.

ORDER

The Decision in this matter constitutes the Public Reprimand in this matter. Costs in the amount of $1,500 are awarded.

DATE: August 10, 2022

Abraham M. Levy (Aug 10, 2022 14:06 PDT)

ABRAHAM M. LEVY

Administrative Law Judge

Office of Administrative Hearings

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

In the Matter of the First Amended Accusation Against: **KAYLENE RENEE CARR, M.D.** **1800 Western Avenue, Suite 204** **San Bernardino, CA 92411-1353** **Physician's and Surgeon's Certificate No. A 124094,** Respondent.	Case No. 800-2018-045698 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about January 4, 2013, the Medical Board issued Physician's and Surgeon's Certificate Number A 124094 to Kaylene Renee Carr, 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 January 31, 2023, unless renewed.

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JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on May 24, 2021, 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.

STATUTORY PROVISIONS

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

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.

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), in that she committed gross negligence in her care and treatment of Patient A,[1] as more particularly alleged hereinafter:

9. On or about May 31, 2016, Patient A, a then-41-year-old female, sought treatment at Parkview Community Hospital for a left-sided labial cyst where she had an incision and drainage of a left-sided Bartholin gland abscess.[2]

10. On or about October 5, 2016, Patient A sought treatment at Riverside University Health System (RUHS) for a recurrence of a left-sided cyst with an attempted incision and drainage that was not completed over concerns of procedure-related pain and inadequate anesthesia. According to Patient A, an RUHS physician recommended that she consider having her left Bartholin gland removed.

11. On or about July 2017, exact date unknown, Patient A sought treatment again for incision and drainage of the abscess and placement of a Word catheter, typically placed to allow continued drainage and restoration of a tract for future drainage.

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[1] The patient herein is identified as Patient A in order to maintain patient confidentiality.

[2] The Bartholin glands are located on each side of the vaginal opening and serve to secrete fluid that assists in lubricating the vagina. The openings of these glands may become obstructed causing fluid to back up in the gland which can cause a cyst or abscess. Treatment depends on the size of the cyst or abscess, the amount of pain, and whether the cyst or abscess is infected.

12. On or about July 28, 2017, Patient A had her first office visit with Respondent and presented for her annual examination. According to the progress note for this visit, the assessments were breast mass, right; screening for malignant neoplasm of breast; pelvic pain; dyspareunia (painful intercourse) due to medical condition in female; routine gynecological exam without abnormal findings; screening for malignant neoplasm of cervix; and screening for the human papillomavirus (HPV). Respondent documented that Patient A complained "of a right breast mass, vague pelvic pain and a recurrent Bartholin cyst" with a Word catheter placed about two weeks prior that had fallen out. The progress note for this visit was inadequate, because, among other things, there was no narrative concerning the right breast mass; there was no documentation characterizing the pelvic pain nor an examination supporting or refuting the pelvic pain assessment; there was no characterization of the dyspareunia; and there was no documentation of the laterality (which side on the patient, i.e., left or right) of the Bartholin cyst.

13. On or about September 18, 2017, at approximately 10:30 a.m., Patient A had her second office visit with Respondent which was a pre-operative visit for removal of her Bartholin gland. The progress note for this visit documented a patient history that included recurring Bartholin gland infections with Word catheters placed three times prior. Respondent documented that Patient reported she was "presently asymptomatic but was starting to feel something" and that the "Patient was supposed to undergo imaging for breast mass but has not done so because she can't afford it." Respondent documented that she discussed the risks and benefits of the upcoming surgery (with no benefits documented in the progress note) and that Patient A elected to proceed with the surgery to remove her Bartholin gland. As part of this visit, Respondent did not perform and/or failed to document on her progress note an examination of the surgical site pelvic where the Bartholin gland was to be removed which could have clarified laterality and/or any changes of the surgical site area. Patient A also signed a "Consent to Medical or Surgical Care and Treatment" form at 10:30 a.m. which identified the procedure of "Removal of Bartholin Gland" and "Removing gland that keeps becoming infected" with no laterality documented on the consent form.

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14. On or about September 18, 2017, at approximately 5:46 p.m., Respondent filled out a Glenwood Surgical Center [Pre-Procedure] Patient History and Physical form which identified the chief complaint and history of present illness as "Recurrent bartholin gland infections" and the "Proposed Procedure (consent to read)" documented as "Removal of right bartholin cyst." Respondent also filled out a Glenwood Surgical Center Admission Order, with the date of surgery listed as September 25, 2017, which also indicated "Removal of right bartholin cyst." According to Patient A, she had previously advised Respondent it was her left gland that was problematic.

15. On or about September 22, 2017, Glenwood Surgical Center made a "Pre-Op" call in which Patient A was told to arrive on the date of her surgery at 11:45 a.m. Patient A advised the staff her husband would transport her back home.

16. On or about September 25, 2017, Patient A went to Glenwood Surgical Center where the surgery to remove her Bartholin gland was scheduled with Respondent. According to Patient A, when she checked in, she was told to confirm she was there to have the right gland removed, at which point she became very concerned and adamantly told the staff she was there to have the left gland removed. Patient was "admitted" at 12:00 p.m. and her vital signs were obtained. Patient A was presented with a "Consent to Operation and Other Medical Services Including Transfusion(s)" which listed the "proposed procedure" as "Excision Bartholin Gland" with no documentation of the laterality, that she signed at 12:05 p.m. According to Respondent, the patient reported "abnormal bleeding," so an endometrial biopsy was added later to the consent form. Respondent reviewed and signed the Glenwood Surgical Center [Pre-Procedure] Patient History and Physical form at 12:50 p.m., and checked a box indicating there were no changes in the patient's condition from her previous visit of September 18, 2017. However, there was a change in her condition; a new report by the patient of abnormal uterine bleeding, which was the basis for the endometrial biopsy, that was not documented in the Glenwood Surgical Center [Pre-Procedure] Patient History and Physical form or as part of the Operative Report. The Operative Report also fails to document why the endometrial biopsy was not ultimately performed. Patient A was transported to the operating room at 12:52 p.m., placed under general anesthesia, and Respondent "[r]emoved portions of the right Bartholin gland and cyst wall" shortly thereafter.

Patient A was transferred to the recovery room at 1:46 p.m. and discharged from the Glenwood Surgical Center at 2:40 p.m.

17. On or about September 26, 2017, according to Patient A, she called Respondent and advised Respondent that she operated on the wrong side with Respondent apologizing, telling her that Patient A's left side was Respondent's right side, and offered to remove the other (left) gland.

18. On or about September 29, 2017, Patient A had her third and last office visit with Respondent for post-operative follow up. Respondent failed to document the date of the surgery in her progress note. Respondent's progress note for this visit indicates, in pertinent part:

> ". . . Patient's complaint that her cysts are on the left side is surprising and very concerning. She has never had a cyst at time of exam in my office so my surgical approach was based on her initial description of the location. I offered patient options for management of her left Bartholin gland including immediate removal, removal in the OR, wait until cyst forms and then remove it, or referral to another physician if she is not happy with her care. Patient opted to see if another cyst forms before further management...
>
> . . .
>
> ". . . Patient presents for post-op follow up. She is upset because she says that her Bartholin glad [sic] cysts have been on the left side, not the right side and she underwent surgery for a right Bartholin gland removal. On the day of her surgery, she asked for an endometrial biopsy to be done because she says she is having irregular bleeding. This was added to the surgical consent for the right Bartholin glad [sic] removal[3] but was not done because the EMB Pipelle was not available at the surgery center...."

19. Respondent committed gross negligence in her care and treatment of Patient A which included, but was not limited to, the following:

(a) Respondent failed to document the laterality of the recurrent Bartholin cyst in her progress note of July 28, 2017;

(b) Respondent failed to document the laterality of the recurrent Bartholin cyst and the laterality of the Bartholin gland to be removed in her progress note of September 18, 2017;

(c) Respondent failed to document laterality on the consent forms pertaining to Patient A's Bartholin gland;

[3] In actuality, the two consent forms did not indicate "right Bartholin gland removal" but instead "Removal of Bartholin Gland" and "Excision Bartholin Gland," with no laterality (right or left) documented on either consent form.

(d) Respondent removed the wrong Bartholin gland from Patient A; and

(e) Respondent failed to electronically sign her progress notes of July 28, September 18, and September 29, 2017, in a timely manner.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

20. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in her care and treatment of Patient A, as more particularly alleged herein.

21. Respondent committed repeated negligent acts in her care and treatment of Patient A, which included, but was not limited to, the following:

(a) Paragraphs 8 through 19, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to adequately document the laterality of the recurrent Bartholin cyst in her progress note of July 28, 2017;

(c) Respondent failed to adequately document the laterality of the recurrent Bartholin cyst and the laterality of the Bartholin gland to be removed in her progress note of September 18, 2017;

(d) Respondent failed to adequately document laterality on the consent forms pertaining to Patient A's Bartholin gland;

(e) Respondent removed the wrong Bartholin gland from Patient A;

(f) Respondent failed to electronically sign her progress notes of July 28, September 18, and September 29, 2017, in a timely manner;

(g) Respondent failed to adequately document a narrative concerning the right breast mass in her progress note of July 28, 2017;

(h) Respondent failed to adequately document a characterization of Patient A's pelvic pain or an examination supporting or refuting the pelvic pain assessment in her progress note of July 28, 2017;

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(i) Respondent failed to adequately document a characterization of Patient A's dyspareunia in her progress note of July 28, 2017;

(j) Respondent failed to discuss and/or adequately document the benefits of the proposed surgery to remove Patient A's Bartholin gland in her progress note of September 18, 2017;

(k) Respondent did not perform and/or failed to adequately document an examination of the surgical site where the Bartholin gland was to be removed which could have clarified laterality and/or any changes of the surgical site area in her progress note of September 18, 2017;

(l) Respondent failed to adequately document the abnormal uterine bleeding and endometrial biopsy in the Glenwood Surgical Center Patient History and Physical form or as part of the Operative Report and failed to document why the endometrial biopsy was not performed in the Operative Report; and

(m) Respondent failed to adequately document the date of the surgery in her progress note of September 29, 2017.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

22. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records in her care and treatment of Patient A, as more particularly alleged in paragraphs 8 through 21, above, which are hereby incorporated by reference and realleged as if 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 A 124094, issued to Respondent Kaylene Renee Carr, M.D.;

2. Revoking, suspending or denying approval of Respondent Kaylene Renee Carr, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Kaylene Renee Carr, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent Kaylene Renee Carr, M.D., to pay the Medical Board of California the reasonable costs of the enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

DATED: MAR 0 4 2022

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

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