

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

In the Matter of the Accusation Against:

Nerissa C. Safie, M.D.

**Physician's & Surgeon's
Certificate No. A 77806**

Respondent.

Case No. 800-2018-050681

DECISION

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

This Decision shall become effective at 5:00 p.m. on June 15, 2023.

IT IS SO ORDERED: May 16, 2023.

MEDICAL BOARD OF CALIFORNIA



**Richard E. Thorp, M.D., Chair
Panel B**

1 ROB BONTA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 TRINA L. SAUNDERS
Deputy Attorney General
4 State Bar No. 207764
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 269-6516
6 Facsimile: (916) 731-2117
Attorneys for Complainant
7

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 NERISSA C. SAFIE, M.D.

14 25485 Medical Center Drive, Suite 200
15 Murrieta, California 92562

16 Physician's and Surgeon's Certificate A 77806,
17 Respondent.
18

Case No. 800-2018-050681

OAH No. 2022040581

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

19
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
24 California (Board). He brought this action solely in his official capacity and is represented in this
25 matter by Rob Bonta, Attorney General of the State of California, by Trina L. Saunders, Deputy
26 Attorney General.

27 2. Respondent Nerissa C. Safie, M.D. (Respondent) is represented in this proceeding by
28 attorney Raymond J. McMahon, whose address is 5440 Trabuco Road, Irvine, California 92620.

3. On January 30, 2002, the Board issued Physician's and Surgeon's Certificate No. A 77806 to Nerissa C. Safie, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2018-050681, and will expire on December 31, 2023, unless renewed.

JURISDICTION

4. A First Amended Accusation in Case No. 800-2018-050681 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on June 2, 2022. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of the First Amended Accusation No. 800-2018-050681 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2018-050681. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

///

///

///

1 **CULPABILITY**

2 9. Respondent understands and agrees that the charges and allegations in First Amended
3 Accusation No. 800-2018-050681, if proven at a hearing, constitute cause for imposing discipline
4 upon her Physician's and Surgeon's Certificate.

5 10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case
6 or factual basis for the charges in the First Amended Accusation, and that Respondent hereby
7 gives up her right to contest those charges.

8 11. Respondent does not contest that, at an administrative hearing, Complainant could
9 establish a prima facie case with respect to the charges and allegations in First Amended
10 Accusation No. 800-2018-050681, a true and correct copy of which is attached hereto as Exhibit
11 A, and that she has thereby subjected her Physician's and Surgeon's Certificate, No. A 77806 to
12 disciplinary action.

13 12. Respondent agrees that her Physician's and Surgeon's Certificate is subject to
14 discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the
15 Disciplinary Order below.

16 **CONTINGENCY**

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

27 ///

28 ///

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

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND.

IT IS HEREBY ORDERED THAT Physician's and Surgeon's Certificate No. A 77806 issued to Respondent Nerissa C. Safie, M.D., shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand is issued in connection with the care and treatment of a single patients, as set forth in First Amended Accusation No. 800-2018-050681, and is as follows:

“In 2016, you were grossly negligent in that you exercised poor judgment in attempting a third endometrial ablation to address abnormal uterine bleeding in a patient, who had suffered perforations of her uterus after each of your prior two attempts of performing the same procedure, as more fully described in First Amended Accusation No. 800-2018-050681.”

B. EDUCATION COURSE. In addition, within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours. The educational program(s) or course(s) shall be aimed at endometrial bleeding and procedures and surgeries to address such conditions and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40

1 hours were in satisfaction of this condition.

2 C. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
3 ordered to reimburse the Board its costs of investigation and enforcement, including, but not
4 limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena
5 enforcement, as applicable, in the amount of \$8,242.50 (Eight thousand two hundred and forty-
6 two dollars and fifty cents). Costs shall be payable to the Medical Board of California. Failure to
7 pay such costs shall be considered a violation of this Order.

8 Payment must be made in full within 30 calendar days of the effective date of the Order, or
9 by a payment plan approved by the Medical Board of California. Any and all requests for a
10 payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with
11 the payment plan shall be considered a violation of this Order.

12 The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility
13 to repay investigation and enforcement costs."

14 Any failure to fully comply with the terms of this Disciplinary Order shall constitute
15 unprofessional conduct and will subject Respondent's Physician's and Surgeon's Certificate to
16 further disciplinary action.

17 ACCEPTANCE

18 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
19 discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect
20 it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement
21 and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
22 Decision and Order of the Medical Board of California.

23
24 DATED: 11/20/22


NERISSA C. SAFIE, M.D.
Respondent

26 ///

27 ///

28 ///

1 I have read and fully discussed with Respondent Nerissa C. Safie, M.D. the terms and
2 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
3 I approve its form and content.

4
5 DATED: November 21, 2022


6 RAYMOND J. MCMAHON
Attorney for Respondent

7
8 **ENDORSEMENT**

9 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
10 submitted for consideration by the Medical Board of California.

11 DATED: November 22, 2022

12 Respectfully submitted,

13 ROB BONTA
Attorney General of California
14 ROBERT MCKIM BELL
Supervising Deputy Attorney General

15
16 
TRINA L. SAUNDERS
17 Deputy Attorney General
Attorneys for Complainant
18
19
20

21 LA2020603923
Safie Stipulation - SDAG Reviewed.docx
22
23
24
25
26
27
28

Exhibit A

First Amended Accusation No. 800-2018-050681

1 ROB BONTA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 TRINA L. SAUNDERS
Deputy Attorney General
4 State Bar No. 207764
300 South Spring Street, Suite 1702
5 Los Angeles, California 90013
Telephone: (213) 269-6516
6 Facsimile: (916) 731-2117
Attorneys for Complainant
7

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2018-050681

13 **NERISSA C. SAFIE, M.D.**

14 **25485 Medical Center Drive, Suite 200**
15 **Murrieta, California 92562**

FIRST AMENDED ACCUSATION

16 Physician's and Surgeon's Certificate A
No. A 77806,

17 Respondent.
18

19
20 **PARTIES**

21 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity
22 as the Executive Director of the Medical Board of California (Board).

23 2. On January 30, 2002, the Board issued Physician's and Surgeon's Certificate Number
24 A 77806 to Nerissa C. Safie, M.D. (Respondent). That license was in full force and effect at all
25 times relevant to the charges brought herein and will expire on December 31, 2023, unless
26 renewed.

27 //

28 //

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

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.

1 (2) When the standard of care requires a change in the diagnosis, act, or
2 omission that constitutes the negligent act described in paragraph (1), including, but
3 not limited to, a reevaluation of the diagnosis or a change in treatment, and the
4 licensee's conduct departs from the applicable standard of care, each departure
5 constitutes a separate and distinct breach of the standard of care.

6 (d) Incompetence.

7 (e) The commission of any act involving dishonesty or corruption that is
8 substantially related to the qualifications, functions, or duties of a physician and
9 surgeon.

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

11 (g) The failure by a certificate holder, in the absence of good cause, to attend
12 and participate in an interview by the board. This subdivision shall only apply to a
13 certificate holder who is the subject of an investigation by the board.

14 6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain
15 adequate and accurate records relating to the provision of services to their patients constitutes
16 unprofessional conduct.

17 **COST RECOVERY**

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

24 **FIRST CAUSE FOR DISCIPLINE**

25 (Gross Negligence)

26 8. Respondent Nerissa C. Safie, M.D. is subject to disciplinary action under section
27 2234 (b) of the Code, in that she was grossly negligent in her care and treatment of Patient A¹.
28 The circumstances are as follows:

9 Patient A, a then 39-year-old female, presented to Trinity Women's Health Group in
10 March 2015, with complaints of abnormal uterine bleeding. Her intake form from March 26,

¹The patients herein are identified by letters to protect their privacy.

1 2015, indicated that she had undergone a bilateral tubal ligation at the time of her last Cesarean
2 section in March 2010.

3 10. Respondent ordered an ultrasound due to Patient A's history of pelvic pain. A pelvic
4 ultrasound was performed at Loma Linda University Medical Center-Murrieta on April 4, 2015,
5 and showed a 4-millimeter endometrial stripe and a uterus measuring 8.1 x 5.3 x 3.9, cm. The
6 patient was placed on Microgestin, a combination low-dose oral contraceptive pill, in April 2015
7 and switched over to NuvaRing, a combination vaginal contraceptive ring, in November 2015,
8 and finally to MonoNessa, another combination low-dose oral contraceptive pill, in December
9 2015.

10 11. On January 13, 2016, Patient A met with Respondent to discuss her treatment options.
11 Patient A indicated her desire to proceed with endometrial ablation. Respondent noted the
12 patient's prior surgical history of three Cesarean sections and a normal uterus on examination.
13 Respondent discussed the risks of the procedure including damage to surrounding organs and
14 mentioned alternatives such as medical therapy. Respondent did not document presenting
15 intrauterine devices, such as the levonorgestrel IUD, as an alternative. Patient A signed a
16 hysteroscopy informed consent form, which mentioned the risk of perforation and bowel injury.

17 12. On January 25, 2016, Patient A underwent a hysteroscopy, and dilation and curettage
18 with failed endometrial ablation with Respondent at Loma Linda University Medical Center. An
19 industry representative was present at the time of the procedure. The operative report, which was
20 dictated and signed on the same date, indicates a fluid deficit of 150 cc. Respondent indicated in
21 her operative report that three separate attempts of assessing cavity integrity with NovaSure², all
22 failed. Respondent then abandoned the NovaSure. She inspected the cavity with a hysteroscope.
23 She noted a left-sided perforation. Patient A was observed in the post-anesthesia care unit from
24 8:32 p.m. to 10:05 p.m., and was discharged with normal vital signs.

25 13. On February 11, 2016, Respondent met with Patient A and discussed the results of the
26 pathology from her surgery, which were benign, and indicated the uterine perforation was the
27 reason for the failed NovaSure. Respondent documented that Patient A wanted to proceed with a

28 ² An endometrial ablation procedure that removes the lining of the uterus.

1 second attempt of NovaSure endometrial ablation. Respondent documented telling the patient
2 that she would need four weeks to heal from the perforation before safely proceeding with
3 NovaSure endometrial ablation.

4 14. On March 8, 2016, Respondent documented a pre-operative history and physical which
5 reiterated the risks of the procedure, including the risk of damage to surrounding organs and
6 alternatives such as medical therapy, but did not document informing the patient of levonorgestrel
7 IUDs, or other surgical procedures.

8 15. A contemporaneous telephone note from March 8, 2016, written by L. M. indicated that
9 Respondent did not see the patient in her office and instead, on March 11, 2016, generated the
10 history and physical and dated it March 8, 2016.

11 16. On April 4, 2016, Patient A underwent her second attempt at a NovaSure endometrial
12 ablation. An industry representative was again present during the surgery. During this second
13 operation, Respondent described sounding the uterus to 9 cm. The cavity integrity assessment
14 failed twice with a first NovaSure device. A second NovaSure device was used and also failed.
15 Respondent did not specifically examine the endometrial cavity to assess for any perforation
16 during the surgery. She noted that her sound passed "back and forth" without any "break to the
17 integrity of the cavity." Respondent noted using two tenacula on the cervix as well as a Xeroform
18 dressing to minimize CO2 escaping from the cervix without success. Patient A was observed in
19 the post-anesthesia care unit from 8:10 a.m., until 9:25 a.m., and discharged home with normal
20 vital signs.

21 17. On April 25, 2016, Respondent signed a surgery request for Patient A, which was
22 generated by L. M. The request was for HerOption endometrial ablation. It indicated that
23 Respondent indicated that Patient A did not need a pre-operative visit. There is no documented
24 discussion in the aftermath of the second procedure between Respondent and Patient A, and no
25 discussion of her alternatives.

26 18. On May 20, 2016, Patient A presented to Respondent's office at 9:30 a.m. Respondent
27 documented in the progress note that an informed consent was given and that the procedure and
28 risks were explained in detail. No discussion of alternatives to the procedure were documented.

1 In the procedure note, Respondent described sounding the uterus under ultrasound guidance. She
2 used a cryoprobe to ablate the endometrium along the right cornu for 5 minutes, along the left
3 cornu for 5 ½ minutes, and along the midline for 5 minutes. Per the note, the patient tolerated the
4 procedure well. The note was signed at 10:59 a.m.

5 19. On the evening of May 20, 2016, Patient A was brought to Loma Linda University
6 Medical Center emergency room by ambulance, with severe lower abdominal pain. Patient A was
7 seen by an obstetrician/gynecologist. A CT scan of the abdomen and pelvis without contrast
8 showed a collapsed distal ileum consistent with a small bowel obstruction and mesenteric edema
9 with induration of the pelvic fat and fascia.

10 20. On May 21, 2016, in the early morning, Patient A was taken emergently to the
11 operating room for an exploratory laparotomy. A general surgeon was called in for an
12 intraoperative consultation. It was determined that two loops of small bowel had been injured
13 and were close together, including a gangrenous and pre-gangrenous loop amounting to
14 approximately 1 foot of small bowel. The affected bowel was resected and re-anastomosed. In
15 addition, an appendectomy was performed. The operative note described a posterior uterine wall
16 perforation and small bowel injury. The pathology showed an appendix with peri-appendicitis
17 and gangrenous small bowel measuring 14.5 cm in length with bowel necrosis, acute serositis and
18 abscess, but with viable margins. Patient A was discharged home on post-operative day number
19 three.

20 21. Patient A was seen by Respondent on May 21, 23, and 24, 2016.

21 22. Respondent's privileges to perform endometrial ablations at Loma Linda University
22 Medical Center in Murrieta were suspended pending a Focus Professional Practice Evaluation
23 (FPPE). The FPPE began on September 8, 2016. Respondent was to complete six endometrial
24 ablation cases by September 8, 2017. An extension was granted until September 2018.
25 Respondent was unable to complete the required cases and her clinical privileges for endometrial
26 ablations were rescinded in 2018. Respondent's conditional privileges were reinstated in
27 February 2020 under the condition that she complete her FPPE.
28

23. On July 22, 2020, Respondent appeared for an interview conducted as part of the Board's investigation into her practices. During that interview, Respondent admitted that the January 25, 2016, perforation to the patient's uterus was too small to pass a hysteroscope.

24. Respondent committed an extreme departure from the standard of care, in offering a third attempt at an endometrial ablation after the two preceding ones failed, presumably for the same reason, a uterine perforation.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

25. Respondent Nerissa C. Safie, M.D. is subject to disciplinary action under section 2234 (c) of the Code, in that she committed repeated negligent acts. The circumstances are as follows:

26. Paragraphs 8 through 24 are incorporated by reference as though fully set

27. Respondent further departed from the standard of care by proceeding with a second endometrial ablation without offering the patient alternatives, such as watchful waiting, placement of a progesterone IUD, or a hysterectomy.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

28. Respondent Nerissa C. Safie, M.D. is subject to disciplinary action under section 2266 of the Code, in that she failed to maintain complete and adequate records. The circumstances are as follows:

29. Respondent failed to accurately document her interaction with Patient A in preparation for her second endometrial ablation, and generated a note for a clinic visit that did not take place.

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 77806, issued to Nerissa C. Safie, M.D.;

- 1 2. Revoking, suspending or denying approval of her authority to supervise physician
2 assistants and advanced practice nurses;
- 3 3. Ordering her to pay the Board the costs of the investigation and enforcement of this
4 case, and if placed on probation, the costs of probation monitoring; and
- 5 4. Taking such other and further action as deemed necessary and proper.

6
7 DATED: JUN 03 2022



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

Complainant

12 LA2020603923
13 Copy of Safie First Amended Accusation - SDAG Reviewed.docx.docx