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

In the Matter of the Accusation Against: ADRIENNE ELIZABETH LARA, M.D., Physician's and Surgeon's Certificate Number C 51906, Respondent.	Case No. 800-2013-001050 OAH No. 2016110033

DECISION AFTER NON-ADOPTION

Administrative Law Judge (ALJ) Carla L. Garrett heard this matter on May 15, 16, 17, 19, 22, and 23, 2017, at Los Angeles, California.

Vladamir Shalkevich, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board). Peter G. Bertling, Attorney at Law, represented Adrienne Elizabeth Lara, M.D. (Respondent), who was present at hearing.

During the hearing, Complainant amended paragraph 14 of the Accusation by deleting subparagraphs (a), (c), (d), and (e).

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on May 23, 2017. On June 22, 2017, The ALJ issued a Proposed Decision.

On August 3, 2017, Panel A of the Board issued an Order of Non-Adoption of Proposed Decision. Oral argument on the matter was heard by the Panel on October 25, 2017, with ALJ Heather Rowan presiding. Complainant was represented by Deputy Attorney General Vladamir Shalkevich. Respondent was present and was represented by Peter G. Bertling, Attorney at Law. Panel A, having read and considered the entire record, including the transcripts and the exhibits, and having considered the written and oral arguments presented by the parties, hereby enters this decision after non-adoption.

estimated date of delivery, and pre-pregnancy weight. Flowsheets also listed the dates of office visits, and included space to record information derived from each office visit, such as weeks of gestation, fundal height, presentation, fetal heart rate, fetal movement, preterm labor signs and symptoms, cervical exam and ultrasound length, blood pressure, weight, the presence of glucose or protein in urine, weeks in which Respondent wished to see the patient for the next visit, and pertinent comments for each visit.

7. Because Patient MT had suffered a high risk pregnancy with her first child, Respondent told Patient MT she wanted Dr. Daryoush Jadali to perform a comprehensive ultrasound screening for the purpose of monitoring Patient MT's current pregnancy for possible complications. . Dr. Jadali has been a board-certified obstetrician and gynecologist since 1996, and is also board-certified in the area of maternal and fetal medicine (i.e., a subspecialty of obstetrics concerned with the care of the fetus and complicated high-risk pregnancies, also known as perinatology), to whom Respondent sent her obstetrics patients for ultrasound scanning. As a perinatology specialist, Dr. Jadali and his technicians performed more comprehensive and detailed ultrasounds than the general ultrasounds performed by obstetricians and gynecologists.

8. Respondent instructed Patient MT to return in four weeks for her next visit.

B. INITIAL ULTRASOUND VISIT WITH DR. JADALI (AUGUST 6, 2013)

9. On August 6, 2013, Patient MT underwent a first trimester prenatal ultrasound screening at Dr. Jadali's office, which resulted in a written report prepared by Dr. Jadali, which he transmitted to Respondent on the same day. The report indicated that Dr. Jadali interacted with Patient MT for approximately 15 minutes "counseling and coordinating the care of [Patient MT's] pregnancy." (Exhibit 8, pages 89-90.) Dr. Jadali's staff obtained Patient MT's blood pressure twice, yielding readings of 134/80 and 122/74, which Dr. Jadali deemed high and diagnosed as chronic hypertension. Consequently, Dr. Jadali prescribed baby aspirin to Patient MT and instructed her to discontinue the aspirin when she reached 37 to 38 weeks of pregnancy. Dr. Jadali also ordered Patient MT to submit to a blood test for the California Prenatal Screening Program to assess her preliminary risk of Down Syndrome and Trisomy 18, which she did. The report listed the results of the ultrasound screening, which revealed that Patient MT's fetus measured 13 weeks and three days, yielding a due date of February 11, 2014. Dr. Jadali wrote a note on his report that was directed to Respondent, which stated that it was a pleasure "seeing [Respondent's] patient for a consultation and a first trimester prenatal screening," and recommended that, in addition to Patient MT taking baby aspirin, Patient MT should return to him in five weeks for a second trimester prenatal screening. (Exhibit 8, page 90.)

C. SECOND OFFICE VISIT WITH RESPONDENT (AUGUST 15, 2013)

10. At her second visit with Respondent on August 15, 2017, when she was 14 weeks and two days pregnant, Patient MT gave Respondent a copy of her medical records from Dr. Carter. Respondent recorded on Patient MT's flowsheet information she gleaned from those records as well as from history provided to Respondent from Patient MT, such as

noting that Patient MT had previously suffered from polycystic ovarian syndrome, gestational diabetes, and delivered a baby via c-section. She also noted Patient MT had suffered from hyperemesis and had received a prescription for Zofran, but did not note the start or stop date of this medication.

11. Additionally, Respondent reviewed the August 6, 2013 report prepared by Dr. Jadali and recorded on the flowsheet that Patient MT had chronic hypertension, and that she had been prescribed aspirin. Respondent did not note the start or stop date of this medication.

12. At this visit, Respondent prescribed acetaminophen with codeine, but recorded nothing in the flowsheet or in the progress notes indicating that she had prescribed the medication or the reason why.

13. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 166 pounds and her blood pressure was 120/69, which Respondent recorded on Patient MT's flowsheet.

14. Respondent instructed Patient MT to return in four weeks for her next visit.

D. THIRD OFFICE VISIT WITH RESPONDENT (AUGUST 26, 2013)

15. Although Patient MT was not scheduled to return to Respondent's office until mid-September, Patient MT returned to Respondent's office on August 26, 2013, when she was 15 weeks and six days pregnant, pursuant to Respondent's request. Specifically, four days prior, Patient MT called Respondent's office complaining of dizziness, lightheadedness, and near-fainting episodes, which she had been experiencing for three days. Respondent was out of town attending a conference, so Patient MT spoke with a member of Respondent's staff, Tina Godinas (Tina). Tina instructed Patient MT to proceed to the emergency room to undergo an examination. Tina recorded the substance of her telephone conversation with Patient MT in a progress note in Patient MT's records.

16. When Respondent returned from the conference, she spoke with the emergency room physician who treated Patient MT on August 26, 2013, and learned that Patient MT showed no signs of anemia, dehydration, or low blood sugar. Respondent recorded the substance of her telephone conversation with the emergency room physician in a progress note in Patient MT's records. Respondent also requested Patient MT to come into her office so she could examine Patient MT and assess how well Patient MT was doing since her emergency room visit.

17. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 166 pounds and her blood pressure was 128/75, which Respondent recorded on Patient MT's flowsheet. Respondent discussed with Patient MT her issues regarding lightheadedness. Respondent wrote a progress noted indicating that she was going to refer Patient MT to a Medi-Cal cardiologist to ensure that her lightheadedness was not related to potential heart problems. Respondent recorded in a

progress note that she wished for Tina to find a cardiologist that accepted Medi-Cal and then advise Patient MT accordingly. Patient MT never received any information or orders instructing her to see a cardiologist.

18. Respondent instructed Patient MT to return in four weeks for her next visit.

E. SECOND ULTRASOUND WITH DR. JADALI (SEPTEMBER 10, 2013) AND FOURTH OFFICE VISIT WITH RESPONDENT (SEPTEMBER 16, 2013)

19. On September 10, 2013, Patient MT underwent a second trimester ultrasound screening by Dr. Jadali. Dr. Jadali prepared a written report on the same day and transmitted it to Respondent. (Exhibit 8, pages 84-85.) The report indicated that Dr. Jadali spent approximately 15 minutes counseling Patient MT and coordinating the care of her pregnancy, and included updated information concerning Patient MT, such as her fainting and dizziness episodes. Dr. Jadali noted that the ultrasound did not visualize the baby's face, which Dr. Jadali opined at hearing was due to the baby possibly facing the spine of Patient MT, but it did show uterine artery notching (i.e., blood vessels in the placenta not enlarging or dilating as they should, causing resistance of blood flowing into the placenta), which could increase Patient MT's risk for preeclampsia, preterm birth placental abruption, intrauterine growth restriction, and intrauterine fetal death. Dr. Jadali also performed a fetal echocardiogram to check the baby's heart, and ordered Patient MT to submit to a second trimester blood test for the California Prenatal Screening Program's Integrated Screening, which she did. Dr. Jadali instructed Patient MT to return to his office in 10 to 12 weeks (December 2013) for an ultrasound to check her baby's fetal growth.

20. On September 16, 2013, when she was 18 weeks and six days pregnant, Patient MT arrived at Respondent's office for a regular office visit. At the visit, Respondent reviewed Dr. Jadali's report with Patient MT, and answered her questions. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 164 pounds and her blood pressure was 125/72, which Respondent recorded on Patient MT's flowsheet, as well as Respondent's instruction that MT return in four weeks.

21. When Patient MT returned home, she realized she had forgotten to ask Respondent a question. Consequently, Patient MT sent Respondent a September 16, 2013 email advising that she and her sister were born with a cleft palette, and wanted to find out if her baby had a cleft palette, without having to wait until December 2013 for her next ultrasound appointment with Dr. Jadali. Later that day, Respondent sent a reply to Patient MT's email, advising that she could undergo a repeat ultrasound, but Patient MT denies receiving Respondent's email. Consequently, Patient MT called Respondent's office on September 20, 2013, spoke with Tina, and advised she wanted a three or four dimensional ultrasound well before the scheduled December 2013 ultrasound appointment. Patient MT also asked in what hospital she would deliver her baby. Tina noted the substance of the conversation in Patient MT's progress notes. Respondent wrote a progress note in Patient MT's records indicating that Patient MT would deliver her baby at Saint John's Regional Medical Center (St. John's), and that Dr. Jadali knew of the cleft palette issues and would perform a three or four dimensional ultrasound, accordingly.

F. FIFTH AND SIXTH OFFICE VISITS WITH RESPONDENT (OCTOBER 17, 2013 AND OCTOBER 28, 2013)

22. Patient returned to Respondent's office on October 17, 2013, when she was 23 weeks and two days pregnant, for a routine visit. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 167 pounds and her blood pressure was 110/58, which Respondent recorded on Patient MT's flowsheet, as well as Respondent's instruction that MT return in four weeks. Also, because Patient MT was entering her 24th week of pregnancy, Respondent ordered that Patient MT undergo a glucose tolerance test at Foundation Laboratory, which she did on October 23, 2013.

23. Instead of returning in four weeks as Respondent had previously instructed, Patient MT returned 11 days later, on October 28, 2013, when she was 24 weeks and six days pregnant, after she had called Respondent's office and Respondent instructed Patient MT to come to her office that day. Patient MT told Respondent that she felt distressed, extremely anxious, and suffered panic attacks, one of which landed her in the emergency room. During her visit, Patient MT explained that her anxiety and panic attacks stemmed from adversity she faced at home and at work. Respondent prescribed Ativan (30 one-milligram tablets) to address Patient MT's anxiety, and instructed Patient MT to take it every six hours as needed. In her progress notes, Respondent stated that she told Patient MT that Ativan was "not for long-term use," a claim which Patient MT denies. Respondent did not prescribe any refills, but did not tell Patient MT exactly when she should discontinue the use of Ativan. Respondent did not record on Patient MT's medical record flowsheet that she had prescribed Ativan to Patient MT.

24. Respondent noted in Patient MT's chart that they discussed the need for Patient MT to receive therapy. Patient MT denies that Respondent told her that she needed to see a therapist. Respondent did not refer Patient MT to a therapist.

25. Also at the October 28, 2013 visit, Respondent advised Patient of the results of her glucose tolerance test. Specifically, Respondent told Patient MT that her glucose level was 197, which was considered high. Consequently, Respondent advised Patient MT that she would need to undergo a three-hour glucose screening to determine whether she was suffering from gestational diabetes, and noted the same on her flowsheet. Respondent instructed Patient MT to return in three weeks.

26. On October 30, 2013, Patient MT submitted to a three-hour glucose test at Foundation Laboratory. The results of the test, which Respondent's office received on November 1, 2013, indicated that Patient MT was suffering from gestational diabetes.

27. At hearing, Patient MT testified that on November 11, 2013, Patient MT called Respondent's office to get the results of her three-hour glucose test. Patient MT spoke with Tina, who promised to look up her results and call her back, but Tina never called back. Consequently, on November 12, 2013, Patient MT called Respondent's office again and spoke with Respondent, who told Patient MT to come into the office that day.

28. Respondent's testimony differed from Patient MT's, in that Respondent claimed to have called Patient MT to come in for a November 12, 2013 appointment, as a result of a issues that arose after Respondent received Patient MT's glucose results on Friday, November 1, 2013. Specifically, after reviewing Patient MT's glucose results, Respondent wished to get Patient MT into some diabetes care (i.e., a dietician, a teaching nurse to learn how to check glucose and inject insulin, and a general education on diabetes) at Magnolia Clinic (Magnolia). Magnolia would treat Patient MT on a consultation basis, while Respondent remained her obstetrician. Respondent directed her staff to make arrangements with Magnolia. Staff recorded in the progress notes that on November 1, 2013, they called Magnolia at 4:57, and was told it was too late to make an appointment, but would tell the doctor at Magnolia that it was urgent for Patient MT to get in to be seen. Six days later on Thursday, November 7, 2013, after consulting her tickler, Respondent discovered that Patient MT had not yet been seen at Magnolia for diabetes care. Respondent recorded instructions to her staff in the progress notes that Patient MT needed a referral and an appointment made immediately and that obtaining an appointment was a priority. On November 7, 2013, Respondent faxed Magnolia a letter of referral for Patient MT's gestational diabetes care, and included Patient MT's laboratory results. Respondent also made telephone calls to Magnolia and refaxed the referral letter and laboratory results to Magnolia on Friday, November 8, 2013. Monday, November 11, 2013, was a holiday.[2] On Tuesday, November 12, 2013, Respondent called Patient MT and asked her to come to Respondent's office to discuss a plan to address her diabetic care and to discuss her overall health.

G. SEVENTH OFFICE VISIT WITH RESPONDENT (NOVEMBER 12, 2013)

29. Patient MT returned to Respondent's office on November 12, 2013, when she was 27 weeks pregnant. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 164 pounds and her blood pressure was 110/70, which Respondent recorded on Patient MT's flowsheet. Respondent also indicated on the flowsheet that Patient MT "has not gone to Magnolia yet for diabetes care." (Ex. 8, page 36.)

30. Early during the visit, Patient MT expressed that she was still experiencing some depression and anxiety, and that she had suffered a panic attack at work. Patient MT also explained that she felt as though she lacked support, and she felt all alone.

31. Respondent told Patient MT about her glucose screening results, and advised Patient MT that she was suffering from gestational diabetes. According to Respondent, she discussed arrangements with Patient MT to obtain diabetes care from Magnolia; but after reflecting on Patient MT's overall health and potential complications stemming from Patient MT's gestational diabetes and her prior history of hypertension and c-section, Respondent concluded that Patient MT's pregnancy had become too high risk. Respondent also concluded that Patient MT's care and needs would be better served at Magnolia. Respondent

[2] Veterans' Day.

told Patient MT that she would be transferring Patient MT's care to Magnolia for the remainder of her pregnancy in order to address her complications, and instructed Patient MT to walk across the parking lot to the next building where Magnolia was located. Patient MT became upset and emotional when she heard this news, because she had just expressed how alone she felt and how she did not feel as though she had anyone's support, and now she no longer had a doctor. Patient MT stormed out of Respondent's office and attempted to locate Magnolia, but could not, which sparked another panic attack. Respondent had not given Patient MT any paperwork to take with her to Magnolia, and prescribed no insulin to address Patient MT's diabetes. Patient MT called Magnolia, and a Magnolia staff member talked to Patient MT, calming her down, and then scheduled an appointment for Patient MT to come to Magnolia the following day.

32. At hearing, Respondent testified that she told Patient MT that she would continue to care for Patient MT until the transfer was complete. Patient MT denies that Respondent ever told her that she could remain in Respondent's care during the transition to Magnolia.

33. Respondent recorded a three-page handwritten progress note dated November 12, 2013. She stated that her office had made an appointment for Patient MT for December 2, 2013, which Respondent stated was "not acceptable as we called 11/1 for apt." (Exhibit 8, page 44.) Respondent also stated that Patient MT had reported anxiety and panic attacks, particularly when going to work, and had used Ativan in the past. Respondent further stated that she would "transfer [Patient MT] to Magnolia Clinic for multiple social med issues making her high risk," citing Patient MT's "persistent and increased social stressors including but not limited to her boss at work, her husband at home and her claim re 'panic attacks' . . . in addition, her referral for diabetes care at Magnolia Clinic (across the parking lot from [Respondent's] office)." (Exhibit 8, pages 44-45.) Respondent wrote that she "explained to [Patient MT] that the best care for her would be at Magnolia where all of her medical, psychological and pregnancy needs could be taken care of at one place." (Exhibit 8, page 45.) Respondent stated that she "reassured [Patient MT] that she could continue with [Respondent] until the transfer to Magnolia and offered to call Dr. Lefkowitz[3] to ease the transition." (Id.) Additionally, Respondent stated that she informed Patient MT that she needed a hemoglobin A1C (Hgh A1C) test, that she needed to make an a appointment with Magnolia as soon as possible, and that Respondent had made her an appointment at Magnolia for December 2, 2013 to address her diabetic care. (*Id.*) Respondent further stated that "after discussing with [Patient MT] all of the above, [Patient MT] stormed angrily out of the office, refusing to take the written instructions [Respondent] had for her, [and] the lab order for an Hgh A1C. (*Id.* at page 46.) Respondent wrote that she "followed [Patient MT] and asked her to come back and let [Patient MT] know (again) she could stay with [Respondent's] practice until the transition was made . . . [Patient MT] left without acknowledging [Respondent's] offer, stating 'I can't count on anyone.'" (*Id.*)

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[3] Dr. Lefkowitz was the medical director at Magnolia.

34. Respondent also recorded on the flowsheet that on November 12, 2013, Patient MT was transferred to Magnolia due to social problems, gestational diabetes care, and because she was now high risk.

H. PATIENT MT'S MEDICAL CARE FROM NOVEMBER 13, 2013 THROUGH DELIVERY

35. On November 13, 2013, Patient MT went to Magnolia and met with Dr. Lisabeth Carlisle, when Patient MT was 27 weeks pregnant. When Patient MT and Dr. Carlisle discussed Patient MT's current medications, Dr. Carlisle told Patient MT to stop taking Ativan immediately, because it was not good for the baby. At the time, Patient MT had approximately one-quarter of a bottle of Ativan remaining. Dr. Carlisle also prescribed insulin to Patient MT, and set an appointment for Patient MT to return to Magnolia on November 20, 2013. A November 13, 2013 Magnolia medical record entry stated that Patient MT was a new patient transferring from another provider.

36. The following morning, November 14, 2013, Patient MT began contacting a number of doctors to request them to take her as a patient. However, Patient MT experienced great difficulty finding a doctor, because of her high risk status, combined with the advanced state of her pregnancy.

37. Also on November 14, 2013, Patient MT contacted Respondent's office, spoke with Respondent, and requested a copy of her medical records. Respondent told Patient MT that she could pick up her records on November 20, 2013, and would need to pay a $30 fee. Respondent asked Patient MT if she had gone to another doctor, to which Patient MT replied that she had gone to Magnolia, but that she was attempting to find a doctor with whom she was comfortable and who delivered at a hospital she liked. For reasons Patient MT could not explain, Respondent then told Patient MT that she felt that Patient MT was endangering her unborn child, because Patient MT was waiting to find a doctor she liked. Based upon the evidence, it is presumed Respondent did not hear Patient MT say that she had already gone to Magnolia. Respondent memorialized her version of the telephone discussion in Patient MT's progress notes and wrote that Patient MT was "refusing to go to Magnolia because she "wants to choose her own doctor." (Exhibit 8, page 46.) Respondent further stated that she "again reiterated that [she] would continue to see [Patient MT] and help her, and that Magnolia was in [Respondent's] opinion [Patient MT's] best option." (*Id.*) Respondent then stated that after she reinforced how important for Patient MT to be seen soon and to keep her December 2, 2013 appointment at Magnolia, the conversation ended. (*Id.* at page 47.)

38. Later that week, Patient MT wrote a negative review on Yelp regarding her experience with Respondent. She expressed that potential patients needed to do their research concerning Respondent, that somebody other than Respondent would be delivering their babies, and that Respondent was on medical probation for "negligence/malpractice," which was "why [Respondent did] not currently deliver at any hospitals." (Exhibit 6, page 2.)

39. On November 20, 2013, Patient MT retrieved her medical records from Respondent.

40. Patient MT returned to Magnolia for office visits on November 20 and 25, 2013.

41. On November 27, 2013, Patient MT began receiving treatment from Dr. Johannes Ramirez of Women's Care Center, who ultimately delivered Patient MT's son vaginally in February 2014, and provided post-delivery treatment.

42. Patient MT continued to receive ultrasound screenings from Dr. Jadali during the course of her pregnancy on December 3, 2013, January 13, 2014, and January 27, 2014.

43. Patient MT filed a complaint with the Board on December 26, 2013.

I. RESPONDENT'S TESTIMONY RE: PATIENT MT

44. Respondent proffered testimony as a percipient witness and as an expert witness. Respondent earned her associate's degree in nursing from Ventura College in 1975, and served as a nurse for 10 years. While working as a nurse, Respondent attended Chapman College and received her bachelor's degree in health science in 1982. She completed her pre-medical studies at the University of California at Santa Barbara in 1984, and earned her doctorate of medicine from Boston University School of Medicine in 1990. In 1995, Respondent completed her residency in obstetrics, gynecology, and reproductive biology at Beth Israel Deaconess Medical Center, which is a teaching hospital of Harvard Medical School. She served as chief resident in obstetrics and gynecology from 1994 to 1995. From 1995 through 2004, Respondent served as a clinical instructor of obstetrics, gynecology, and reproductive endocrinology at Harvard Medical School, where she conducted lectures to residents, taught them medical and surgical procedures related to obstetrics and gynecology, and taught them how to handle high risk patients. Respondent earned her board certification in obstetrics and gynecology in 1999. Respondent moved from Boston to California and set up her private practice in Oxnard in 2007.

45. In 2007, Respondent had admitting and attending privileges at St. John's. On July 27, 2007, while Respondent was delivering a baby at St. John's, the baby slipped through her hands and fell into the plastic bag used to collect blood and fluids from delivery, which was located under the buttocks of the patient. The incident caused the detachment of baby's umbilical cord. In a separate incident on January 7, 2008, Respondent delayed in delivering a breech baby at St. John's, performed an emergency c-section, and then cut the baby with her scalpel during delivery. Respondent also caused a separation of the uterine vessels of the mother, which resulted in massive bleeding that led to an urologist placing a stent in the patient's ureter. These two incidents resulted in the Board disciplining Respondent's license, effective September 25, 2012, for engaging in repeated acts of negligence. Specifically, the Board revoked Respondent's license, stayed the revocation, and placed Respondent on probation for a period of 35 months subject to certain terms and conditions, including

Respondent's completion of a clinical training program (i.e., Physician Assessment and Clinical Education Program [PACE]). As a result of the Board's discipline of Respondent, St. John's terminated Respondent's admitting and attending privileges.

46. In 2013, when Respondent treated Patient MT, Respondent still had no admitting or attending privileges at St. John's. Respondent testified that she explained to Patient MT, as was her custom and practice with all patients, that she "was not currently doing deliveries," but that she had previously made arrangements with certain medical entities to ensure her patients had coverage for medical emergencies and delivery. Specifically, Respondent arranged for physicians at Clinicas Del Camino Real (Clinicas) to care for her patients at St. John's as inpatients. In that regard, Respondent received regular monthly emails from Clinicas' setting forth its on-call schedule, so Respondent would know which one of Clinicas' physicians were on-call at a given time to deliver her patients' babies.

47. Respondent's custom and practice involved contacting the Clinicas physician on-call, and advising the Clinicas physician that her patient would be delivering at St. John's and that she had already sent the patient's medical records to St. John's labor and delivery department.

48. It was also Respondent's custom and practice to forward her patients' complete medical records, including the flowsheet, progress notes, laboratory results, and ultrasound reports, to St. John's at the patient's 35th week of pregnancy. Respondent expected the on-call physicians to review all of the records she sent, because she believed that everything she sent was pertinent to the patient's care. If an emergency arose where the patient could not provide any history because she was unconscious, Respondent expected the on-call physician to address the emergency first to protect the mother and the baby, and then go and review the medical records to figure out the course of treatment thereafter.

49. For patients she believed would require a c-section, it was Respondent's custom and practice to make a determination during the patient's 28th week of pregnancy of who would perform the c-section.

50. Finally, Respondent testified that it was her custom and practice to tell her patients that two obstetricians, meaning Respondent and Dr. Jadali, would be attending to their treatment during their pregnancies.

51. Patient MT emphatically denied that Respondent ever disclosed to her that she would not be delivering Patient MT's baby, until Respondent told Patient MT on November 12, 2013 that Patient MT's care would need to be transferred to Magnolia. Patient MT testified that the only other doctor Respondent discussed at the first visit was Dr. Jadali, who Respondent said would be performing ultrasound screenings. Patient MT testified that Respondent never mentioned anything to her about Clinicas, or that physicians from that facility would play a role in her treatment or delivery.

J. BOARD'S EXPERT WITNESS (DR. STEVEN FREEDMAN)

52. Dr. Steven Freedman provided expert testimony on behalf of Complainant. Dr. Freedman earned his bachelor's degree in biology and psychology from Northwestern University (Northwestern) in 1973, and completed graduate studies in psychology from Northwestern in 1974. Dr. Freedman received his doctorate in medicine in 1978 from Eastern Virginia Medical School, and completed his residency in the area of obstetrics and gynecology at Western Pennsylvania Hospital in 1982. He obtained his license to practice medicine in 1982, and his board certification from the American College of Obstetrics and Gynecology in 1985. Dr. Freedman has been in private practice since 1982, has served as Director at Women's Health Specialists of West Hills since 2001, and has held hospital privileges at West Hills Hospital and Medical Center since 1982. He also currently oversees an obstetrics program in Berkeley where he supervises 14 obstetricians and midwives. He has served as a physician expert reviewer with the Board since 2010, a risk management expert reviewer with the Cooperative of American Physicians (CAP) since 2009, and a risk management expert with the Southwest Consortium for Innovative Psychology in Education (SCIPIE) since 2009. Dr. Freedman has served as a principal investigator for clinical research studies for various pharmaceutical companies, and as part of the teaching faculty at the University of Southern California, Northridge Hospital, University of California at Los Angeles, and others.

53. Dr. Freedman has treated patients with pregnancies and health risks similar to those experienced by Patient MT. Dr. Freedman reviewed a number of materials in connection with Patient MT's care. Specifically, Dr. Freedman reviewed Patient MT's complaint filed with the Board, Patient MT's written statement, Patient MT's medical records provided by Respondent, Dr. Jadali, Dr. Ramirez, and Magnolia, CURES reports, Respondent's curriculum vitae, and the transcript of the Board's March 7, 2016 interview of Respondent. During cross-examination, Dr. Freedman disclosed that he did not review the documents from Magnolia "particularly carefully."

54. Dr. Freedman evaluated whether Respondent's treatment of Patient MT conformed to the standard of care, and prepared a written report setting forth his conclusions. At hearing, Dr. Freedman described standard of care as that which a reasonable obstetrician or gynecologist in similar circumstances would exercise when providing care to a patient. Dr. Freedman explained that when reviewing Respondent's treatment of Patient MT, he applied the standard of care or the community standard, as opposed to applying his own personal standard, which is higher than the community standard.

1. Complicated Obstetrics Patients

55. With respect to the care and treatment of complicated obstetrical patients, Dr. Freedman stated the following in his report regarding the standard of care:

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> A pregnancy is deemed complicated in the presence of maternal or fetal issues that may endanger the healthy continuation of that pregnancy. This may include maternal illness such as chronic hypertension. Pregnancy induced disease states such as gestational diabetes may complicate a pregnancy. Fetal factors also increase risk, such as uterine artery notching on ultrasound or a history of cleft palate. Maternal ingestion of drugs may also be considered.
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> (Exhibit 17, page 3.)

56. In his analysis regarding the care and treatment of complicated obstetrical patients, Dr. Freedman stated that Patient MT should have been considered high risk from the beginning, given her previous c-section for a pregnancy complicated by gestational diabetes and hypertension. At hearing, Dr. Freedman explained that a history of a prior c-section can complicate a patient's risk, because it could result in an uterine rupture in a subsequent pregnancy. He further explained that patients who have suffered from preeclampsia before are at risk for developing it again in a subsequent pregnancy, which generally presents itself at the beginning of the third trimester. Additionally, Dr. Freedman noted that Patient MT's current pregnancy was complicated by gestational diabetes, uterine notching, and Patient MT's medical prescriptions. Dr. Freedman noted that Respondent's practice was not appropriate for the care of complicated obstetrics patients, based on Respondent's interview with the Board. Specifically, Respondent stated that if she had it to do over again, she would not have accepted Patient MT in her practice, because "she may be brewing a high risk . . . [so, therefore] we're not going to take her in the practice 'cause we may not be the best practice for her." (Exhibit 15, page 49, lines 9-12.) Dr. Freedman stated that Respondent "[did] not have the capability at the hospital to evaluate, monitor, and treat high-risk issues that may arise during the pregnancy." (Exhibit 17, page 3.) Further, Dr. Freedman maintained that "[i]t is perfunctory that the physician who will ultimately perform the repeat cesarean section be involved and/or fully aware of the prenatal course and complications. That obstetrician must be able to identify complications and act expeditiously to deliver the infant at an appropriate facility." (Id.)

57. At hearing, Dr. Freedman explained that from the beginning, Respondent's lack of admitting privileges to hospitals raised a question of continuity of care for Patient MT, and how Patient MT would be given follow-up care after delivery. Dr. Freedman explained that, as such, Respondent should have documented a care plan of how Patient MT would receive such treatment. Dr. Freedman further explained the importance of continuity of care in obstetrics, because "the art of obstetrics is very nuanced and there is a need to anticipate problems before they develop." Therefore, by closely following any patient, the physician is better able to anticipate problems.

58. Overall, Dr. Freedman concluded that Respondent's care of Patient MT was "inappropriate and demonstrate[d] a lack of knowledge of complicated obstetrics." (Exhibit 17, page 3.) Dr. Freedman further concluded that for Respondent to see Patient MT at her facility "was a simple departure from the standard of care . . . mitigated by the continuing

involvement of a perinatologist [Dr. Jadali]." (*Id.*) At hearing, Dr. Freedman explained that if a perinatologist had not been involved, he would have concluded that Respondent had engaged in an extreme departure from the standard of care. If the perinatologist had served as more than a consultant or more than someone who conducted ultrasounds, such as serving as the physician designated to deliver the baby, Dr. Freedman would have concluded that no departure occurred.

2. Prescribing Ativan

59. With respect to prescribing Ativan, Dr. Freedman stated the following in his report regarding the standard of care:

> When prescribing psychotropic medications in pregnancy, the treating physician must determine that the benefits derived from the medication outweigh the risk that drug imposes to the mother and fetus.
>
> (Exhibit 17, page 3.)

60. Dr. Freedman acknowledged that Respondent prescribed Ativan to Patient MT to address her panic attacks and anxiety. At hearing, he explained that psychological stressors serve as risk factors for the patient, as anxiety levels increase steroid production, which can increase the mother's blood pressure, thereby affecting the blood-flow to the baby. Dr. Freedman noted that Ativan posed an increased risk of cleft lip when taken in the first trimester. He also noted that third trimester usage had been associated with withdrawal symptoms and hypotonia in the baby, commonly known as floppy baby syndrome, referencing the state of low muscle tone (the amount of tension or resistance to stretch in a muscle). As such, Dr. Freedman stated at hearing that Respondent should have erred on the side of caution and prescribed Patient MT fewer than 30 pills, as she was nearly 25 weeks pregnant, just three weeks shy of the commencement of her third trimester. Dr. Freedman also stated that Respondent should have made definitive arrangements for Patient MT to get help navigating through her stress, anxiety, and panic attacks.

61. Dr. Freedman also noted that Respondent had prescribed Ativan to Patient MT in the second trimester of her pregnancy, at one-milligram every six hours as needed, and that the quantity prescribed or the duration of usage had not been documented. Respondent indicated in a May 24, 2014 letter to the Board that the one-milligram dosage she had prescribed to Patient MT was the lowest available dosage. At hearing, Dr. Freedman explained that the lowest available dosage for Ativan was one-half of a milligram, not one milligram.

62. Dr. Freedman concluded that the usage of Ativan in the second trimester of pregnancy was within the standard of care. However, Respondent's failure to limit the frequency and duration of Patient MT's Ativan was a simple departure from the standard of care.

3. Termination of the Doctor-Patient Relationship

63. With respect to terminating the doctor-patient relationship, Dr. Freedman stated the following in his report regarding the standard of care:

> Termination of the doctor-patient relationship when the patient is unstable or in advanced pregnancy leaves the physician open to charges of abandonment. As stated in the Hippocratic Oath, 'I will not withdraw in time of need.'
>
> (Exhibit 17, page 4.)

64. Dr. Freedman noted in his report that, during Patient MT's third trimester, at approximately 27 weeks gestation, Respondent instructed her to continue care elsewhere, and that Patient MT had not found another qualified physician. Dr. Freedman noted that there was no written letter of termination included in Patient MT's records, and that the records reflected that Respondent's reason for withdrawing was due to Patient MT becoming high risk. Dr. Freedman additionally noted that Respondent failed to "spell out" Patient MT's medical problems at the time of withdrawal, and that Respondent had provided Patient MT "only one alternative clinic." (Exhibit 17, page 4.) Dr. Freedman further noted that at that time, Patient MT had been newly diagnosed with gestational diabetes, and therefore, required "immediate diabetic counseling, dietary consultation, continued home glucose monitoring, follow-up fetal surveillance via ultrasounds and testing, and a planned delivery by cesarean section." (*Id.*)

65. Dr. Freedman noted at hearing that Respondent did not advise Patient MT that she had gestational diabetes for 12 days after learning that Patient MT had gestational diabetes. Dr. Freedman explained that time is of the essence to get diabetic patients on insulin as soon as possible, as consequences exist for both the mother and the baby, such as the child growing disproportionately larger and faster, and the placenta undergoing changes that could increase chances of uterine abruption.

66. At hearing, Dr. Freedman questioned why Respondent did not refer Patient MT to Dr. Jadali to address her gestational diabetes, especially given Respondent's representation to her patients that she had two doctors taking care of them: Respondent and Dr. Jadali. Dr. Freedman explained that perinatologists, like Dr. Jadali, by definition treated high risk patients, including ones with gestational diabetes. Additionally, Dr. Freedman disclosed that he had independent knowledge that Dr. Jadali treated patients with gestational diabetes, because at one time, Dr. Jadali applied for privileges at West Hills Hospital where Dr. Freedman served as the chairman of the committee of the obstetrics and gynecology department, and participated in the decision granting Dr. Jadali privileges. Dr. Freedman had worked with Dr. Jadali at West Hills Hospital and sent patients to Dr. Jadali.

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67. At hearing, Dr. Freedman explained that when transferring a patient to a new facility, the transferring physician must communicate with the facility receiving the transferred patient and the receiving facility must agree to the transfer. The onus must be on the physician to make arrangements for transferring care to a new physician, not on the patient. Dr. Freedman testified that Respondent's progress notes were vague regarding the formalization of formal transfer arrangements to Magnolia. Specifically, Dr. Freedman explained that while Respondent's progress notes showed an apparent decision to transfer Patient MT's care to Magnolia, the standard of care required that the patient know and consent to the transfer, that the physician make arrangements to transfer the patient, and that the receiving facility agrees to accept the patient, all of which were not done. It was important that the patient consent to the transfer so that she would be aware of the transfer and comfortable with the decision to transfer. Finally, Dr. Freedman explained that a seamless transfer of care was required for continuity of care, and that the manner in which Respondent terminated the doctor-patient relationship constituted a simple departure from the standard of care.

68. During cross-examination, Dr. Freedman disclosed that he did not know whether Magnolia accepted the transfer. Additionally, Dr. Freedman was unaware that Patient MT was seen at Magnolia one day after Respondent advised that she was transferring Patient MT to Magnolia. Moreover, Dr. Freedman was unaware of Magnolia's medical records concerning Patient MT dated November 13, 2013 stating that Patient MT was a new obstetrics patient "transferring from other provider."

4. Obstetric Practice

69. Dr. Freedman stated the following in his report regarding the standard of care for obstetricians:

> [Standard of Care] dictates that the obstetrician provide complete care of the mother and infant from conception through the puerperium. Further, obstetrics requires 24/7 on call status for maintenance of thorough medical care as well as the delivery of the infant. Specifically, a board certified OB/GYN must maintain the ability to identify, treat, counsel, and follow gestational diabetics in both the office and hospital settings.
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> (Exhibit 17, page 4.)

70. At hearing, Dr. Freedman explained that the obstetrician is the "captain of the ship" for a patient's care from conception through the first six weeks of the infant's life; therefore, if the obstetrician will not be the one delivering the baby, the obstetrician must have already made arrangements for another physician to deliver the baby, which includes providing the delivering physician with all medical records and making sure that physician knows the needs of the patient.

71. Dr. Freedman noted that Respondent offered obstetric care although she had no admitting privileges at any hospitals. As such, she was unable to deliver the babies or to treat complicated obstetric cases. Although Respondent represented that she told her patients that she would be their primary obstetrician, that Dr. Jadali would perform ultrasounds and consult them regarding concerns that arise during their pregnancy, and that she verbally informed patients during their first visit that the "on call" doctor at the hospital would deliver their baby, "obstetric coverage entails the availability of prenatal records as well as a 'sign-out' process that familiarizes the treating obstetrician with the entire patient history." (Exhibit 17, page 5.) Dr. Freedman wrote in his report that "the delivering obstetrician is not specifically identified and there is no procedure in place for the transfer of medical records to insure continuity of care." (*Id.*)

72. Dr. Freedman wrote in his report that Respondent engaged in "an extreme departure from the standard of care to see patients antenatally and then having the patient simply present to an emergency room of the hospital to be delivered by a panel doctor who has minimal knowledge of their medical history." However, at hearing, after learning that Respondent had coverage arrangements with Clinicas, whose physicians provide care for Respondent's patients at St. John's, Dr. Freedman withdrew his conclusion that Respondent had engaged in an extreme departure from the standard of care. Instead, Dr. Freedman opined that a simple departure occurred because Respondent was dealing with a high risk patient, but lacked hospital privileges to address her high risk factors, and because the coverage arrangement did not fully set forth how the patient's high risk factors would be addressed or covered.

5. Documentation

73. With respect to documentation, Dr. Freedman stated the following:

> The [Standard of Care] dictates complete contemporaneous notes regarding past and current medical history, along with all medications and testing prescribed.
>
> (Exhibit 17, page 5.)

74. At hearing, Dr. Freedman explained that the standard of care requires physicians to document each visit with a patient, and would expect to see all pertinent information about the patient listed on the flowsheet.

75. Dr. Freedman noted that the medical records prepared by Respondent concerning Patient MT "contain[ed] the sparse obstetrics flow sheet and additional hand written notations." (Exhibit 17, page 5.) The records "lack[ed] proper documentation ofthe E.R. visits, syncopal episodes, and complaints related to anxiety." (*Id.*) He noted that there was "no record of the prescription of Ativan 1 mg, the rational, time frame, or the duration of its intended usage." (*Id.*) He stated that Respondent did not document a discussion of risks concerning the drug. Additionally, Dr. Freedman noted the flowsheet did "not document the

referral to the cardiologist and his findings . . . [and] [a]lthough Dr. Jidali (*sic*) was described as the second OB, his visits, findings, and treatment plans [were] not documented." He also noted that Dr. Jadali identified increased risks during multiple ultrasound exams, but the findings were not noted in the records. Dr. Freedman noted that the records did not mention which physician would deliver Patient MT's baby, or the mode of delivery or of the timing of the repeat c-section. Finally, he noted that the records lacked documentation of the "social problems" Patient MT experienced.

76. Dr. Freedman concluded that the prenatal flowsheet "quite probably represent[ed] the only communication between [Respondent] and the delivering obstetrician." (Exhibit 17, page 5.) At hearing, Dr. Freedman expressed that if Respondent sent pertinent lab reports to labor and delivery, along with her progress notes, it would not be a deviation from the standard of care. However, because the labor and delivery department can be busy, receiving too many documents could cause confusion. Dr. Freedman therefore expressed how important it was for the flowsheet to be comprehensive, because it serves as a table of contents, in essence, for the other documents.

77. At hearing, Dr. Freedman explained that the flowsheet failed to mention on the flowsheet Patient MT's ER visit, her anxiety, all medication prescribed to her, Dr. Jadali's concern about uterine notching, or a treatment plan. Overall, Dr. Freedman concluded that Respondent's documentation failures, particularly the flowsheet, constituted a simple departure from the standard of care.

78. Dr. Freedman also noted at hearing that Patient MT's records failed to document as part of an initial birthing plan that a physician from Clinicas would be delivering Patient MT's baby, not Respondent. Additionally, there was no documentation of a contingency plan in place should Patient MT become high risk. Dr. Freedman explained at hearing that, as a Medi-Cal patient, Patient MT faced difficulties in obtaining appointments to address her needs. As such, Respondent should have put in place contingency plan so that Patient MT would not need to scramble to find a Medi-Cal physician who handles high-risk pregnancies.

K. RESPONDENT'S EXPERT WITNESS (DR. DARYOUSH JADALI)

79. Dr. Daryoush Jadali proffered testimony as a percipient witness and as an expert witness. Dr. Jadali earned his medical degree from Xochicalco University in Baja, California in 1986, and then completed his residency in obstetrics and gynecology at Lincoln Medical Center in Bronx, New York in 1994. He also completed a fellowship in maternal and fetal medicine at Albert Einstein College of Medicine in Bronx, New York in 1996. Dr. Jadali is licensed to practice medicine in California, New York, and New Jersey, and has been a Board-certified obstetrician/gynecologist since 1997. He has hospital privileges at Community Memorial Hospital, Los Robles Regional Medical Center, and West Hills Medical Center, but no longer delivers babies, and has not done so for approximately 10 years.

80. Dr. Jadali has known Respondent since she came to practice medicine in Ventura County. He considers Respondent a well-trained, conscientious, and skilled physician. Dr. Jadali sometimes serves as a consultant to Respondent, and other times they co-manage patients together.

81. Dr. Jadali declared that based on his experienced, combined with the fact that Respondent is a Board-certified obstetrician and gynecologist, he had no reason to believe Respondent should not have been treating Patient MT.

82. With respect to prescribing Ativan to Patient MT, Dr. Jadali explained that Respondent prescribed Ativan to Patient MT during her second trimester, which was within the standard of care. Because anxiety has been associated with mothers giving birth to underweight or maladjusted babies, it was important that Respondent reduce Patient MT's anxiety. Respondent prescribed 30 pills which could have lasted through a portion of Patient MT's third trimester, which Dr. Jadali declared "perfectly okay." Dr. Jadali explained that taking Ativan in the third trimester only becomes a problem at the time of delivery, because Ativan could cause hypotonia in the baby. Even then, the physicians could easily intubate the baby, according to Dr. Jadali.

83. Respondent did not offer Dr. Jadali an opportunity to treat Patient MT as her primary obstetrician after receiving the gestational diabetes diagnosis. At hearing, Dr. Jadali explained that he follows patients with gestational diabetes, but he does not manage those patients, because he does not have a dietician in his office.

L. CREDIBILITY FINDINGS[4]

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[4] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ." (Cont.)

84. Patient MT was a very credible witness, given the forthright and transparent manner in which she testified. Specifically, Patient MT answered questions in a sincere, straight forward manner, without a cloud of prevarication. Her recitation of the facts remained essentially the same in all areas of significance, and remained consistent from the time she filed her complaint with the Board on December 26, 2013, to the time of hearing. As such, Patient MT's testimony was afforded great weight.

85. Respondent's testimony, though more straightforward than not, appeared incredible at times and more self-serving than truthful. For example, Respondent recorded a three-page handwritten progress note dated November 12, 2013, which, in and of itself, appeared highly unusual for Respondent to do, given the skeletal and/or omission-prone manner in which she generally recorded notes in Patient MT's case and others. Respondent's recitation of events in her November 12, 2013 note, most of which Patient MT denied, appeared on its face to be manufactured because Respondent was unusually detailed and comprehensive, taking care to list all of her purported reasons underlying her decision to transfer Patient MT's case to Magnolia. In contrast, Respondent failed to demonstrate the same level of detail in her contemporaneous notes of previous Patient MT's office visits and examinations, evidenced by her failure to include pertinent information in Patient MT's flowsheet and progress notes. Additionally, she failed to demonstrate a penchant for detail when she failed to inform Patient MT, for 12 straight days, that she had developed gestational diabetes, despite the seriousness of the disorder. Such factors cast doubt on portions of Respondent's testimony, rendering her overall testimony less impactful than Patient MT's, even though more of Respondent's testimony than not was credible.

86. As such, Patient MT's version of events material to the Accusation, particularly the events occurring on November 12, 2013 during her final office visit with Respondent, as well as Patient MT's testimony that Respondent did not tell her at her initial visit that Respondent would *not* be delivering her baby, or that a physician at Clinicas would be delivering her baby, shall be deemed as true.

87. Dr. Freedman's expert testimony was more credible than not, though, at times, it suffered from his admitted failure to closely review the records from Magnolia, his

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The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

discovery of last minute information, and from the defensive, sarcastic, and brooding manner in which he delivered his testimony during cross-examination. As such, Dr. Freedman's opinion was not always weighted heavily or adopted. However, Dr. Freedman's wealth of experience during his 35 years of practice, combined with his years teaching, overseeing obstetrics programs, and serving as an investigator for research clinical studies, made him a more persuasive expert witness than both Respondent and Dr. Jadali. While Dr. Jadali testified in a clear and straightforward manner, and though he had significant experience in the area of obstetrics, his experience did not outweigh that of Dr. Freedman, who has been practicing for more than a decade longer than Dr. Jadali. Additionally, Dr. Jadali's opinion that it was safe for a pregnant patient to continue to take Ativan in her third trimester, contradicted that of Dr. Freedman's and was inconsistent with the actions of Dr. Carlisle at Magnolia, who immediately terminated Patient MT's use of Ativan. Such factors generated some doubt concerning Dr. Jadali's overall expert testimony, rendering his opinion less convincing than Dr. Freedman's.

M. OVERALL CONCLUSIONS REGARDING THE PATIENT MT MATTER

88. The Accusation listed various acts or omissions allegedly committed by Respondent, which Complainant contends constitute gross and/or repeated acts of negligence. Each alleged act or omission is discussed in more detail below:

1. Offering Obstetric Care Despite No Hospital Admitting Privileges

89. Although Dr. Freedman, when considering Respondent's lack of hospital admitting privileges, stated that Respondent "[did] not have the capability at the hospital to evaluate, monitor, and treat high-risk issues that may arise during the pregnancy," the evidence showed that Respondent's office was equipped with an ultrasound machine, a non-stress test machine, and a Doppler machine, all of which Respondent could use to monitor high-risk issues, and that Respondent had a pre-arranged agreement with Clinicas to address problems that required in-patient hospital care. Additionally, Respondent's co-management of her patients with Dr. Jadali provided an additional layer of expertise in evaluating, monitoring, and treating high risk pregnancies, despite Respondent's lack of hospital admitting privileges. While Respondent ultimately determined that Patient MT was too high risk to continue treating her, this factor did not necessarily render Respondent incapable of treating patients with high risks, despite her lack of hospital privileges. As such, Respondent's provision of obstetric care despite having no hospital admitting privileges did not constitute an act or omission of negligence, as alleged in the Accusation.

2. Seeing the Patient Antenatally

90. The Accusation alleged that Respondent treating Patient MT antenatally at Respondent's office, and then having "the patient simply present to the ER of the hospital to be delivered by a panel doctor who has minimal knowledge of the patient's medical history," constituted gross and repeated acts of negligence. While these factors did not occur in Patient MT's matter, as Patient MT did not present to the ER for the delivery of her baby while under the care of Respondent, Dr. Freedman asserted that such a situation raised

"continuity of care" concerns. However, the evidence shows, as set forth above, that Respondent had previously made arrangements with physicians at Clinicas to ensure her patients had coverage for medical emergencies and delivery as inpatients at St. John's. Additionally, it was Respondent's custom and practice to contact the Clinicas physician on-call and advise him or her that Respondent's patient would be delivering at St. John's. Moreover, the evidence shows that it was Respondent's custom and practice to forward her patients' complete medical records, including the flowsheet, progress notes, laboratory results, and ultrasound reports, to St. John's at the patient's 35th week of pregnancy, so that the delivering physician would have information about the patient at his or her disposal. These factors address continuity of care concerns raised by Dr. Freedman, as they show that the delivering physician would have access to the patient's medical history before and during delivery. As such, Respondent treating patients antenatally did not constitute an act or omission of negligence, gross or otherwise, as alleged in the Accusation.

3. Failing to Limit Ativan

91. The Accusation alleged Respondent's failure to adequately limit the frequency and duration of Patient MT's usage of Ativan constituted an act of negligence. The evidence shows that Ativan usage in the third trimester of pregnancy can pose a health risk in the baby, rendering him or her hypotonic. Despite this danger, Respondent prescribed 30 tablets of Ativan to Patient MT when she was one day shy of her 25th week of pregnancy and three weeks shy of the commencement of her third trimester, and gave no instruction to Patient MT to cease taking the medication when she entered her third trimester. Consequently, Patient MT had one-quarter of a bottle of Ativan left when she reached her third trimester, which Patient MT could have continued using as Respondent had directed had she not received instructions directing her otherwise from Dr. Carlisle. While Respondent prescribed no refills of Ativan, that act did not shield Patient MT's baby from potential harm; however, a clear directive from Respondent could have. Given these factors, Respondent's failure to issue such a directive to Patient MT constituted an act of negligence.

4. Failing to Ensure Continuity of Care

92. The Accusation alleged Respondent failed to adequately ensure continuity of care for Patient MT after the termination of the doctor-patient relationship. While the credibility findings have established as true Patient MT's version of events regarding the abrupt termination of the doctor-patient relationship on November 12, 2013, and that Respondent's only directive was that Patient MT go to Magnolia for her continued care, the evidence shows that Patient MT received treatment at Magnolia on the following day, November 13, 2013, and that Magnolia's medical records of November 13, 2013 acknowledged that Patient MT was received and accepted as a transfer patient. While Patient MT contends that making arrangements to treat at Magnolia fell squarely on her shoulders, it is reasonable to conclude that Patient MT would not have gone to Magnolia to seek treatment without Respondent's directive to do so. Such action, despite Respondent's questionable rationale for the abrupt and unilateral decision to transfer Patient MT to Magnolia, resulted in continuity of care. As such, Respondent committed no act of negligence here.

5. Failing to Adequately Document the Care and Treatment of Patient MT

93. The evidence is clear Respondent failed to adequately document the care and treatment she provided Patient MT. While Respondent routinely documented Patient MT's blood pressure and weight at every visit, Respondent failed to document in Patient MT's medical records that Respondent prescribed Ativan or acetaminophen with codeine, particularly on the flowsheet. Additionally, Respondent failed to include a reference on the flowsheet that Patient MT visited the emergency room, failed to mention Patient MT's anxiety, and failed to highlight Dr. Jadali's concern about uterine notching, or a treatment plan. Dr. Freedman expressed how important it was for the flowsheet to be comprehensive, because it serves as a table of contents, in essence, for the other documents contained in the patient's records. For these reasons, and as attested by Dr. Freedman, Respondent's documentation failures, particularly on the flowsheet, constituted a simple departure from the standard of care.

II. Patient CK

94. On June 1, 2013, Patient CK met with Respondent regarding Respondent performing liposuction on Patient CK's inner thighs. Specifically, Patient CK wished to achieve a "thigh gap" through the removal of fat on her upper, inner thighs. At the visit, Patient CK provided Respondent with a photo depicting the shape and size of inner thighs she wanted Respondent to achieve.

95. On June 15, 2013, Respondent performed liposuction on Patient CK's inner thighs, after Patient CK signed an informed consent form. The informed consent form did not list the specific area in which Respondent was to perform liposuction (i.e., inner thighs). During the surgery, Respondent prepared a liposuction calculation sheet documenting the lidocaine and fluid given to Patient CK during the surgery. Respondent prepared an operative note describing the procedure she performed on Patient CK, and noted that, while using a debulking cannula, her "manual assessment of the degree of debulking was done constantly throughout the case using the operator's fingers to pinch and assure that there remained at least a centimeter of fat between them."

96. On June 16, 2013 and June 22, 2013, during post-operation (post-op) visits, Respondent noted on Patient CK's chart that she was healing well. Respondent noted in Patient CK's progress notes that Patient CK was to return for a follow up visit in one week, and that Respondent would introduce "lipo foam" (i.e., padding used to apply on the treated area under the compression garment) at that visit.

97. On June 29, 2013, Patient CK appeared for her follow-up appointment, but Respondent did not show up. Patient CK sent Respondent an email on this date expressing her displeasure about Respondent failing to appear for her appointment.

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98. On June 30, 2013, Patient CK had become concerned about the unevenness of her thighs and emailed a photo of her thighs to Respondent. Respondent did not respond to Patient CK's email. On July 13, 2013, Patient CK emailed another photo of her "choppy/uneven" thighs to Respondent. Respondent responded as follows:

> You had your procedure on 6/15. It's only been 4 weeks. The fluid is still absorbing. 1. Continue to wear your garment for up to 6 weeks. 2. You need to exercise to build the muscle underneath the area up to meet the skin above. Remember: The full effect will not be seen until 6 months and No 2 body parts are ever symmetrical. Please call the office on Monday to schedule a follow up visit.

99. Patient CK's next post-op visit occurred on July 27, 2013. Respondent noted that Patient CK was "'happy' with results, no complaints, questioning 'loose' areas." Respondent recommended inner thigh exercises for Patient CK, and indicated that in six months, she would consider performing some "touchup" surgery.

100. Also on July 27, 2013, Patient CK requested Respondent to inject Juvederm into her nasolavial folds, also known as smile lines or laugh lines, into her marionette lines (i.e., lines that run straight downwards from the corners of the mouth), and into the oral commissure (i.e., corners of the mouth). Respondent used one syringe of Juvederm to inject in the areas requested by Patient CK. Juvederm is an injectable dermal filler used to provide nine months to one year of correction for moderate to severe facial wrinkles and folds.

101. On July 28, 2013, Patient CK noticed a lump that appeared in the right cheek in the area where Respondent injected the Juvederm, and emailed Respondent a photo of the lump. Respondent told Patient CK that the lump would settle and resolve.

102. At Patient CK's post-op visit of October 15, 2013, 16 weeks after surgery, Respondent noted a more pronounced indentation in Patient CK's right thigh.

103. In January 2014, Patient CK met with Respondent regarding the swollen area on her right cheek. Respondent advised Patient CK that she needed to dissolve the area with Vitrase, which is a hyaluronidase used as an aid in helping the body absorb other injected medications. However, Respondent had no Vitrase in her office. Respondent told Patient CK that she would need to purchase a vial of Vitrase and bring it to the office for Respondent to inject. Patient CK subsequently sought treatment from a cosmetic dermatologist to address the lump on her right cheek.

104. On January 18, 2014, Patient CK's post-op visit with Respondent included Dr. Ryan Khosravi, whom Respondent identified and consulted as a plastic surgeon. Respondent noted in Patient CK's chart that, per Dr. Khosravi, the plan to address Patient CK's indentation in her right thigh included Patient CK wearing her compression garment again. At hearing, the Board's expert and cosmetic surgeon, Dr. Michael Schwartz, explained that compression garments can improve the final outcome, assuming they are used immediately

following liposuction, and worn for six to twelve weeks. Failure to wear the compression garment can lead to swelling and bleeding. Dr. Khosravi also recommended that Patient CK wait one year post-op before considering any revision surgery. Respondent also noted that Dr. Khosravi concluded that "there [was] no more fat to remove from inner thighs." (Exhibit 19, page 25.)

105. On May 13, 2014, Patient CK emailed to Respondent photos of her thighs, stating there had been no change in their appearance at the one-year post-op mark.

106. At the next post-op visit on May 31, 2014, Patient CK complained of hanging skin in the left thigh, as well as the indentation in her right thigh. Respondent recommended fat transfer and noted that she may have asymmetry and may require more than one procedure to correct the appearance of Patient CK's thighs. Patient CK ultimately sought consultation with other cosmetic surgeons to correct the appearance of Patient CK's thighs. As of the date of the hearing, Patient CK had not undergone any procedures to correct the deformity on her thigh.

107. On February 27, 2015, in response to its request, Respondent supplied the Board with a copy of Patient CK's medical records; however, these records did not include a medical note indicating that Respondent had injected Juvederm on July 27, 2013.

A. *BOARD'S EXPERT WITNESS (DR. MICHAEL SCHWARTZ)*

108. Dr. Michael Schwartz provided expert testimony on behalf of Complainant. Dr. Schwartz earned his bachelor's degree in biochemistry from Lawrence University in 1978, and his doctor of medicine from Loyola Stritch School of Medicine in 1982. He received his postgraduate training (i.e., residencies in internal medicine and otolaryngology, and internships in internal medicine and general surgery) at Los Angeles County/USC Medical Center from 1982 to 1989. Dr. Schwartz completed fellowships in facial plastic and reconstructive surgery in 1989, 1990, and 2009. He is licensed in California and Arizona, and board certified by the American Board of Cosmetic Surgery, the American Board of Facial Plastic and Reconstructive Surgery, and the American Board of Otolaryngology. Dr. Schwartz has served as a clinical assistant professor in the division of facial plastic surgery at Los Angeles County/USC Medical Center, authored eight publications, and made presentations in the area of reconstructive cosmetic surgery. Dr. Schwartz is affiliated with six hospitals in Arcadia and Pasadena, California. His current practice is in Pasadena and approximately half of it is focused on liposuction. Dr. Schwartz performs liposuction on approximately 100 patients per year, including on patients' thighs, and administers Juvederm injections.

109. Dr. Schwartz reviewed a number of materials in connection with Patient CK's care. Specifically, Dr. Schwartz reviewed Patient CK's complaint filed with the Board, Patient CK's written statement, Patient CK's medical records, photographs, Respondent's curriculum vitae, and the CD and transcript of the Board's March 7, 2016 interview of Respondent, among other things.

110. Dr. Schwartz noted that during Respondent's interview, Respondent, with respect to liposuction, stated, "I call it a procedure. To me, it's not surgery. Surgery by definition enters a body cavity so to speak, you know, and I'm nowhere close."

111. Respondent also stated in her interview that it was not clear whether the depression in Patient CK's right inner thigh resulted from the liposuction, the compression or the lack of compression, the lack of follow-up, the lack of exercise, the lack of compliance, or the lack of Motrin.

112. With respect to the contour deformity of Patient CK's right inner thigh, Dr. Schwartz explained the following regarding the applicable standard of care:

> The standard of care dictates that caution be used when performing liposuction of all areas of the body, but especially the inner and outer thighs, which are more prone to contour deformities than other areas of the body. Although contour deformities are a known complication of liposuction, surgeons performing liposuction should have comprehensive knowledge of proper technique and cause and treatment options for potential complications.
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> (Exhibit 26, page 4.)

113. Dr. Schwartz's review of Patient CK's medical records revealed no evidence of infection, and thus, he opined that the only possible cause for the severe depression and irregularity of Patient CK's right inner thigh was Respondent's over-section of fat and uneven resection of fat in this area. Dr. Schwartz found Respondent's statement false that it could not be known whether the indentation was caused by the liposuction, the compression or the lack of compression, the lack of follow-up, the lack of exercise, the lack of compliance, or by the lack of Motrin.

114. Dr. Schwartz noted that Patient CK's severe contour deformity would be difficult to correct and more likely impossible to correct. Dr. Schwartz explained that the fact that Respondent did not know the cause of the deformity, and the fact that she did not consider liposuction to be surgery, confirmed that Respondent's treatment of Patient CK departed from the standard of care, specifically, a simple departure.

115. With respect to Juvederm, Respondent stated in her interview that she did not carry Vitrase in her office, but that "it could cause more problem than it might be worth." Respondent stated that Vitrase expires very quickly, and because each vial costs $500, it was "not cost effective to do it."

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116. Dr. Schwartz explained the following regarding the applicable standard of care concerning injectable fillers:

> The standard of care when injecting fillers into the face is to have a comprehensive understanding of facial anatomy, the characteristics of each filler, and potential complications and treatment of complications.
>
> (Exhibit 26, page 5.)

117. Dr. Schwartz stated that potential emergency situations could occur when injecting Juvederm or other fillers, such as inadvertently injecting the Juvederm into an artery or vein in the face. Dr. Schwartz noted that such a situation could result in occlusion of an artery and thus impact the blood supply to an area of the face, or more seriously, embolization of filler material from a periorbital vein, causing blindness. As such, Dr. Schwartz expressed the essentiality of physicians stocking Vitrase or another hyaluronidase in their offices in the event that one of these emergencies arise. Dr. Schwartz concluded that Respondent's failure to stock Vitrase or any other hyaluronidase represented a simple departure from the standard of care.

B. RESPONDENT'S TESTIMONY

118. Respondent received training in performing certain cosmetic procedures beginning in 2007. Specifically, Respondent received training on aesthetic injecting techniques in 2007, 2012, 2013, and 2015, from Allergan, which is a pharmaceutical company that produces Juvederm. She also received training on aesthetic injecting techniques in 2012, 2013, 2014, and 2015, from Merz, which is another pharmaceutical company that specializes in aesthetics. In 2012, Respondent received liposuction training by Inspiring Physicians and by Ciao Bella Medical Spa, both in Phoenix, Arizona. Respondent received further liposuction training by Ciao Bella Medical Spa in 2013.

119. During her interview, when Respondent stated that liposuction was not surgery, she meant that liposuction addressed the area under the skin and does not enter any body cavities. Respondent explained she does not take cavalierly the seriousness of performing liposuction.

120. Respondent was trained to constantly assess how much fat to leave under the skin. Specifically, she was trained to leave a minimum of one-centimeter of subcutaneous fat under the skin, which Respondent claimed she did in Patient CK's case.

121. At hearing, Respondent explained that the six weeks following liposuction are vitally important to achieving the desired result, and that there is much a patient can do to assist with the healing process, such as wearing the appropriately-sized compression garment and using lipo foam padding. Respondent claimed that Patient CK never came in for a follow-up visit until six weeks following her first follow-up appointment, when she was supposed to return one week following her June 22, 2013 appointment. Respondent

explained that, as such, Patient CK did not receive any lipo foam to try. However, in his review of the records, Dr. Schwartz found no noncompliance on Patient CK's part regarding Patient CK attending her appointments, and further found that Patient CK's deformity in her right thigh was not caused by any purported failure to appear at post-op visits, but rather from Respondent's over-resection and injudicious liposuction. Additionally, Respondent did not note in Patient CK's records that Patient CK had missed any appointments. On the contrary, Respondent, herself, missed Patient CK's June 29, 2013 appointment.

122. With respect to Juvederm and other fillers, Respondent explained that there was no known risk that made it necessary for her to stock Vitrase in her office in 2013. It was not until May 28, 2015 when the Federal Drug Administration (FDA) issued a safety communication advising that physicians who injected patients with facial soft tissue fillers should be aware of the possibility of rare, but serious injuries that may occur due to unintentional injection of soft tissue filler into blood vessels in the face. Specifically, the FDA safety communication advised that the unintentional injection of soft tissue fillers into blood vessels that could block blood vessels and restrict blood supply to tissues, causing vision impairment, blindness, stroke, and damage and/or death of the skin (necrosis) and underlying facial structures. The safety communication also advised that physicians should adopt a detailed plan on how they should treat a patient should the physician unintentionally inject filler into a blood vessel, which could include on-site treatment. Respondent began stocking Vitrase in her office on October 15, 2016.

C. CREDIBILITY FINDINGS

123. Dr. Schwartz was a very credible and persuasive expert witness, as he testified in a clear, concise, and forthright way, and demonstrated a wealth of pertinent knowledge in the areas of liposuction and facial dermal fillers. Additionally, Dr. Schwartz's nearly 30 years of practice, coupled with his years of experience as a clinical assistant professor, author, and presenter, rendered Dr. Schwartz's testimony convincing. Accordingly, Dr. Schwartz's testimony was afforded more weight than Respondent's expert testimony, whose knowledge and experience paled in comparison to Respondent's in the area of liposuction and facial dermal fillers.

D. OVERALL CONCLUSIONS REGARDING THE PATIENT CK MATTER

124. The Accusation listed various acts or omissions allegedly committed by Respondent, which Complainant contends constitute repeated acts of negligence. Each alleged act or omission is discussed in more detail below:

1. Over-Resectioning of Fat / Failing to Know Cause of Deformity/ Failing to Consider Liposuction as Surgery

125. The evidence showed, through the credible testimony of Dr. Schwartz, that no evidence of infection existed, and thus, the only possible cause for the severe depression and irregularity of Patient CK's right inner thigh was Respondent's over-section of fat and uneven resection of fat in this area. Respondent's statement that it could not be known

whether the indentation was caused by the liposuction, the compression or the lack of compression, the lack of follow-up, the lack of exercise, the lack of compliance, or by the lack of Motrin, lacked credibility, given the weight given to Dr. Schwartz' finding that the indentation occurred by the Respondent's injudicious liposuction of Respondent's inner thigh. Such over-resectioning, coupled with Respondent's failure to understand that her conduct caused the deformity, constituted a simple departure from the standard of care. Respondent's Board interview, on the other hand, in which she stated that she did not consider liposuction to be surgery, was easily clarified at hearing by Respondent, and not considered a weighing factor in determining whether Respondent's conduct departed from the standard of care.

2. Failing to Stock Hyaluronidase (Vitrase)

126. While Dr. Schwartz concluded that Respondent's failure to stock Vitrase to address potential emergencies stemming from an inadvertent injection of Juvederm into an artery or vein of the face represented a simple departure from the standard of care, the evidence does not support that conclusion. Respondent proffered convincing evidence that the potential dangers of Juvederm injections described by Dr. Schwartz were not communicated to the public by the FDA until 2015, long after Respondent performed Juvederm injections on Patient CK. As such, Complainant has not established that Respondent departed from the standard of care when she did not maintain Vitrase in her office.

III. Patient YC

127. Patient YC had seen Respondent as her gynecologist for approximately three years. During Patient YC's annual gynecological visit in 2014, Respondent told Patient YC that she was now performing liposuction services in her office.

128. On May 30, 2014, Respondent performed liposuction of Patient YC's outer thighs, buttocks, and flanks, after Patient YC signed an informed consent form. The informed consent form, however, did not list the specific areas in which Respondent was to perform liposuction.

129. On the pre-procedure note, Respondent noted that the procedure to be performed was "love handles/upper thighs," but did not mention flanks. On the operative note, however, Respondent stated that the procedure was liposuction of the love handles and flanks, but did not mention the thighs. Additionally, Respondent stated on the operative note that the pre-operative diagnosis was "[d]esires liposuction of outer thighs and underbuttocks, and love handles," (Exhibit 30, page 8), which Dr. Schwartz noted was not a diagnosis. Dr. Schwartz explained that a more accurate diagnosis would have been lipodystrophy or excess fat of flanks and lateral thighs.

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130. During the surgery, Respondent prepared a liposuction calculation sheet, but did not document the concentration of any medications added to the saline solution injected in Patient YC's fat compartments during the tumescent liposuction. Respondent also did not record Patient YC's vital signs before, during, or after the liposuction procedure.

A. BOARD'S EXPERT WITNESS (DR. MICHAEL SCHWARTZ)

131. Dr. Schwartz reviewed a number of materials in connection with Patient YC's care. Specifically, Dr. Schwartz reviewed Patient YC's complaint filed with the Board, Patient YC's medical records, Respondent's curriculum vitae, and the CD and transcript of the Board's March 7, 2016 interview of Respondent, among other things.

132. With respect to medical record-keeping in surgery, Dr. Schwartz explained the following regarding the applicable standard of care:

> The standard of care dictates when creating an operative note is to accurately record the preoperative and postoperative diagnosis, the procedure, and all pertinent details of the surgery. Vital signs should be recorded at the minimum of 15 minute intervals.
>
> (Exhibit 34, page 3.)

133. Dr. Schwartz noted that Respondent's pre-procedure and operative notes failed to list all of the areas from which Respondent was to liposuction, and failed to include an actual diagnosis.

134. Additionally, Dr. Schwartz noted that when Respondent performed tumescent liposuction on Patient YC, she prepared a liposuction calculation sheet, but did not document the concentration of any medications added to the saline solution injected in Patient YC's fat compartments. Dr. Schwarz explained that lidocaine toxicity is a well-known complication of tumescent liposuction, therefore it is important to document the concentration of lidocaine and volume infiltrated of the tumescent solution containing lidocaine, and to record the lidocaine dose in milligrams/kilograms.

135. Dr. Schwartz explained that the standard of care when performing surgical procedures was to document Patient YC's vital signs before, during, or after the procedure. Respondent did not document any vital signs before, during, or after she performed liposuction on Respondent.

136. Because of the foregoing, Dr. Schwartz concluded that Respondent's medical record keeping in surgery constituted a simple departure from the standard of care.

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137. Given Dr. Schwartz's persuasiveness as an expert witness, in light of his nearly 30 years of practice and experience, great weight was afforded Dr. Schwartz's testimony. As such, Dr. Schwartz's testimony was considered more credible as an expert than Respondent's (set forth below), given Dr. Schwartz's superior knowledge and experience in the area of cosmetic surgery.

B. RESPONDENT'S TESTIMONY

138. In response to Dr. Schwartz's criticism that Respondent should have recorded Patient YC's vital signs during the surgery a minimum of every 15 minutes, Respondent explained that it was not her practice to use general anesthesia or conscious sedation on her patients, both of which require intubation and IV therapy. Respondent explained that because those forms of sedation are more invasive and pose increased risk to the patient, it is reasonable to monitor the patients in the way described by Dr. Schwartz. However, it was Respondent's practice to give her patients a constellation of oral medications, such as Ativan, Zofran, Toradol, and Vicadin, and thus, was not required to record vital signs every 15 minutes. Respondent did, however, obtain a baseline reading of Patient YC's vital signs before surgery, and obtained her vital signs following surgery.

139. In response to Dr. Schwartz's criticism that Respondent failed to documentthe concentration of medications added to the saline solution injected in Patient YC's fat compartments, Respondent explained that although she did not record the lidocaine concentration, it would have been impossible to perform the liposuction procedure without completing the lidocaine calculation. As such, Respondent explained that although she did not record the calculations on the liposuction calculation sheet, she is certain she performed the calculations somewhere else, but failed to include the calculation in Patient YC's records.

C. OVERALL CONCLUSIONS REGARDING THE PATIENT YC MATTER

140. The Accusation alleged that Respondent engaged in repeated acts of negligence by (1) failing to adequately document Patient YC's liposuction procedure in the medical records; (2) failing to adequately mention on the informed consent form, on the pre-procedure note, and on the operative note all of the anatomic areas slated to undergo liposuction; (3) failing to adequately document the concentration of any medications, including lidocaine, added to the saline solution injected during Patient YC's liposuction procedure; and (4) failing to adequately document Patient YC's vital signs before, during, and after the liposuction procedure. The evidence firmly establishes that Respondent committed such acts, and Respondent proffered no persuasive evidence, testimonial or otherwise, sufficiently excusing or disputing this conclusion.

CONCLUSIONS OF LAW

1. Cause does not exist to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), for gross negligence acts, as set forth in Findings 3 through 93.

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), for repeated negligent acts, as set forth in Findings 3 through 140.

3. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2266, for failure to maintain adequate records, as set forth in Findings 3 through 140.

The Applicable Law

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

5. The purpose of the Medical Practice Act[5] 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 imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

6. The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.) (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

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[5] Business and Professions Code sections 2000 through 2521.

7. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

8. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board ofMedical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

9. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard ofcare." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th462.)

10. Business and Professions Code section 2266 states that that "[t]he failure of a physician and surgeon to maintain adequate and accurate recordsrelating to the provisions of services to their patients constitutes unprofessional conduct."

11. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

Analysis

12. While Complainant did not meet her burden of establishing that Respondent engaged in gross negligence, she firmly established that Respondent engaged in repeated acts of negligence, in violation of Business and Professions Code section 2234, subdivision (c) and/or inadequate record keeping, in violation of Business and Professions Code section 2266, in relation to her care and treatment of Patients MT, CK, and YC. Specifically, Respondent (1) failed to adequately limit the frequency and duration of Patient MT's usage of Ativan; (2) failed to adequately document the care and treatment provided to Patient MT; (3) over-resectioned fat and engaged in injudicious liposuction of Patient CK's inner right thigh; (4) failed to know the cause of deformity of Patient CK's inner thigh; (5) failed to adequately document Patient YC's liposuction procedure in the medical records; (6) failed to adequately mention on the informed consent form, on the pre-procedure note, and on the operative note all of the anatomic areas slated to undergo liposuction; (7) failed to adequately document the concentration of any medications, including lidocaine, added to the saline solution injected during Patient YC's liposuction procedure;and (8) failed to adequately document Patient YC's vital signs before, during, and after the liposuction procedure.

13. Of great concern is Respondent's commission of the above-referenced acts while actively serving a 35 month probation previously imposed by the Board on September 25, 2012, stemming from Respondent's engagement in repeated acts of negligence. The purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) In order to adequately protect the public, Respondent shall submit to an extended period of probation, with specific terms and conditions.

ORDER

Certificate No. C 51906 issued to Respondent, Adrienne Elizabeth Lara, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five years, upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, 20 hours of which shall include hands-on training in liposuction, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of California Code of Regulations, title 16 (CCR), section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully

understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified.

Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

5. Prohibited Practice

During probation, Respondent is prohibited from practicing obstetrics. After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from practicing obstetrics. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

6. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true and correct copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

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10. General Probation Requirements

Compliance with Probation Unit
Respondent shall comply with the Board's probation unit.

Address Changes
Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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

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

Travel or Residence Outside California
Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been

approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California, will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

13. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether

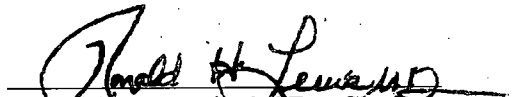
or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

The Decision shall become effective at 5:00 p.m. on December 15, 2017

IT IS SO ORDERED this 16th day of November 2017.



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

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

In the Matter of Accusation Against:	)	
	)	
ADRIENNE ELIZABETH LARA, M.D.	)	
	)	Case No.: 800-2013-001050
Physician's & Surgeon's	)	
Certificate No: C51906	)	OAH No.: 2016110033
	)	
Respondent	)	
	)	
	)	

ORDER OF NON-ADOPTION
OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed to the question of whether the proposed penalty should be modified. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Kennedy Court Reporters, 920 W. 17th Street, Santa Ana, CA 92706. The telephone number is (714) 835-0366

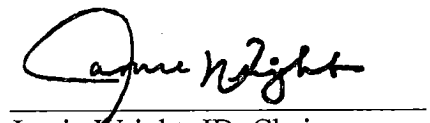
To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-8906
Attention: Richard M. Acosta

Date: August 3, 2017



Jamie Wright, JD, Chair
Panel A

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

In the Matter of the Accusation Against: ADRIENNE ELIZABETH LARA, M.D., Physician's and Surgeon's Certificate No C 51906, Respondent.	Case No. 800-2013-001050 OAH No. 2016110033

PROPOSED DECISION

Administrative Law Judge Carla L. Garrett heard this matter on May 15, 16, 17, 19, 22, and 23, 2017, at Los Angeles, California.

Vladamir Shalkevich, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board). Peter G. Bertling, Attorney at Law, represented Adrienne Elizabeth Lara, M.D. (Respondent), who was present at hearing.

During the hearing, Complainant amended paragraph 14 of the Accusation by deleting subparagraphs (a), (c), (d), and (e).

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on May 23, 2017.

FINDINGS OF FACT

1. Complainant made the Accusation in her official capacity as Executive Director of the Board.

2. The Board issued Physician's and Surgeon's Certificate Number C 51906 to Respondent on April 1, 2005. The certificate is renewed and current with an expiration date of November 30, 2018. Respondent is a Board-certified obstetrician and gynecologist.

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I. Patient MT[1]

3. In July 2013, when she was 10 weeks pregnant with her second child, Patient MT began treatment with Respondent for obstetric care, and saw Respondent until November 2013, for a total of seven office visits. Patient MT, who was a sales manager at Neiman Marcus, had no employer-sponsored health insurance. Consequently, Patient MT received health coverage from Medi-Cal. Respondent served patients covered by Medi-Cal.

4. In the earlier weeks of her pregnancy, Patient MT received treatment from Dr. Stephen Carter. Patient MT suffered from hyperemesis (i.e., intense morning sickness), so Dr. Carter prescribed Zofran to address her excessive vomiting. After two or three visits, Patient MT elected to leave Dr. Carter's care after developing concerns regarding the brevity of his examinations and the offensiveness of his bedside manner.

A. FIRST OFFICE VISIT WITH RESPONDENT (JULY 22, 2013)

5. On July 22, 2013, during her first visit with Respondent, Patient MT explained that she suffered complications during her first pregnancy in 2009, which she described as a high risk pregnancy. Specifically, during her first pregnancy, Patient MT developed gestational diabetes (i.e., unhealthily high blood glucose levels during pregnancy) and preeclampsia (i.e., high blood pressure and signs of damage to organ systems, most often the liver and kidneys). Patient MT delivered her first child, a boy, via cesarean section (c-section), after efforts to induce her labor failed. Her son was born with the umbilical cord wrapped around his neck. Respondent did not develop any concerns about her ability and capacity to treat Patient MT for her current pregnancy, despite Patient MT's previous pregnancy complications. Respondent was confident that should complications arise, she could address them accordingly. Respondent's office was equipped with an ultrasound machine, a non-stress test machine, and a Doppler machine to measure fetal heart rate.

6. As was her custom and practice, Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight at the first visit was 160 pounds and her blood pressure was 128/80, which were in the normal range. Respondent recorded this information on a medical record flowsheet. Flowsheets used by Respondent included space to record problems, plans, medications, medication start and end dates, estimated date of delivery, and pre-pregnancy weight. Flowsheet also listed the dates of office visits, and included space to record information derived from each office visit, such as weeks of gestation, fundal height, presentation, fetal heart rate, fetal movement, preterm labor signs and symptoms, cervical exam and ultrasound length, blood pressure, weight, the presence of glucose or protein in urine, weeks in which Respondent wished to see the patient for the next visit, and pertinent comments for each visit.

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[1] Patients are identified by their initials to protect their privacy.

7. Because Patient MT had suffered a high risk pregnancy with her first child, Respondent told Patient MT she wanted Dr. Daryoush Jadali to perform a comprehensive ultrasound screening for the purpose of monitoring Patient MT's current pregnancy for possible complications. Dr. Jadali has been a board-certified obstetrician and gynecologist since 1996, and is also board-certified in the area of maternal and fetal medicine (i.e., a subspecialty of obstetrics concerned with the care of the fetus and complicated high-risk pregnancies, also known as perinatology), to whom Respondent sent her obstetrics patients for ultrasound scanning. As a perinatology specialist, Dr. Jadali and his technicians performed more comprehensive and detailed ultrasounds than the general ultrasounds performed by obstetricians and gynecologists.

8. Respondent instructed Patient MT to return in four weeks for her next visit.

B. INITIAL ULTRASOUND VISIT WITH DR. JADALI (AUGUST 6, 2013)

9. On August 6, 2013, Patient MT underwent a first trimester prenatal ultrasound screening at Dr. Jadali's office, which resulted in a written report prepared by Dr. Jadali, which he transmitted to Respondent on the same day. The report indicated that Dr. Jadali interacted with Patient MT for approximately 15 minutes "counseling and coordinating the care of [Patient MT's] pregnancy." (Exhibit 8, pages 89-90.) Dr. Jadali's staff obtained Patient MT's blood pressure twice, yielding readings of 134/80 and 122/74, which Dr. Jadali deemed high and diagnosed as chronic hypertension. Consequently, Dr. Jadali prescribed baby aspirin to Patient MT and instructed her to discontinue the aspirin when she reached 37 to 38 weeks of pregnancy. Dr. Jadali also ordered Patient MT to submit to a blood test for the California Prenatal Screening Program to assess her preliminary risk of Down Syndrome and Trisomy 18, which she did. The report listed the results of the ultrasound screening, which revealed that Patient MT's fetus measured 13 weeks and three days, yielding a due date of February 11, 2014. Dr. Jadali wrote a note on his report that was directed to Respondent, which stated that it was a pleasure "seeing [Respondent's] patient for a consultation and a first trimester prenatal screening," and recommended that, in addition to Patient MT taking baby aspirin, Patient MT should return to him in five weeks for a second trimester prenatal screening. (Exhibit 8, page 90.)

C. SECOND OFFICE VISIT WITH RESPONDENT (AUGUST 15, 2013)

10. At her second visit with Respondent on August 15, 2017, when she was 14 weeks and two days pregnant, Patient MT gave Respondent a copy of her medical records from Dr. Carter. Respondent recorded on Patient MT's flowsheet information she gleaned from those records as well as from history provided to Respondent from Patient MT, such as noting that Patient MT had previously suffered from polycystic ovarian syndrome, gestational diabetes, and delivered a baby via c-section. She also noted Patient MT had suffered from hyperemesis and had received a prescription for Zofran, but did not note the start or stop date of this medication.

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11. Additionally, Respondent reviewed the August 6, 2013 report prepared by Dr. Jadali and recorded on the flowsheet that Patient MT had chronic hypertension, and that she had been prescribed aspirin. Respondent did not note the start or stop date of this medication.

12. At this visit, Respondent prescribed acetaminophen with codeine, but recorded nothing in the flowsheet or in the progress notes indicating that she had prescribed the medication or the reason why.

13. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 166 pounds and her blood pressure was 120/69, which Respondent recorded on Patient MT's flowsheet.

14. Respondent instructed Patient MT to return in four weeks for her next visit.

D. THIRD OFFICE VISIT WITH RESPONDENT (AUGUST 26, 2013)

15. Although Patient MT was not scheduled to return to Respondent office until mid-September, Patient MT returned to Respondent's office on August 26, 2013, when she was 15 weeks and six days pregnant, pursuant to Respondent's request. Specifically, four days prior, Patient MT called Respondent's office complaining of dizziness, lightheadedness, and near-fainting episodes, which she had been experiencing for three days. Respondent was out of town attending a conference, so Patient MT spoke with a member of Respondent's staff, Tina Godinas (Tina). Tina instructed Patient MT to proceed to the emergency room to undergo an examination. Tina recorded the substance of her telephone conversation with Patient MT in a progress note in Patient MT's records.

16. When Respondent returned from the conference, she spoke with the emergency room physician who treated Patient MT on August 26, 2013, and learned that Patient MT showed no signs of anemia, dehydration, or low blood sugar. Respondent recorded the substance of her telephone conversation with the emergency room physician in a progress note in Patient MT's records. Respondent also requested Patient MT to come into her office so she could examine Patient MT and assess how well Patient MT was doing since her emergency room visit.

17. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 166 pounds and her blood pressure was 128/75, which Respondent recorded on Patient MT's flowsheet. Respondent discussed with Patient MT her issues regarding lightheadedness. Respondent wrote a progress note indicating that she was going to refer Patient MT to a Medi-Cal cardiologist to ensure that her lightheadedness was not related to potential heart problems. Respondent recorded in a progress note that she wished for Tina to find a cardiologist that accepted Medi-Cal and then advise Patient MT accordingly. Patient MT never received any information or orders instructing her to see a cardiologist.

18. Respondent instructed Patient MT to return in four weeks for her next visit.

E. SECOND ULTRASOUND WITH DR. JADALI (SEPTEMBER 10, 2013) AND FOURTH OFFICE VISIT WITH RESPONDENT (SEPTEMBER 16, 2013)

19. On September 10, 2013, Patient MT underwent a second trimester ultrasound screening by Dr. Jadali. Dr. Jadali prepared a written report on the same day and transmitted it to Respondent. (Exhibit 8, pages 84-85.) The report indicated that Dr. Jadali spent approximately 15 minutes counseling Patient MT and coordinating the care of her pregnancy, and included updated information concerning Patient MT, such as her fainting and dizziness episodes. Dr. Jadali noted that the ultrasound did not visualize the baby's face, which Dr. Jadali opined at hearing was due to the baby possibly facing the spine of Patient MT, but it did show uterine artery notching (i.e., blood vessels in the placenta not enlarging or dilating as they should, causing resistance of blood flowing into the placenta), which could increase Patient MT's risk for preeclampsia, preterm birth placental abruption, intrauterine growth restriction, and intrauterine fetal death. Dr. Jadali also performed a fetal echocardiogram to check the baby's heart, and ordered Patient MT to submit to a second trimester blood test for the California Prenatal Screening Program's Integrated Screening, which she did. Dr. Jadali instructed Patient MT to return to his office in 10 to 12 weeks (December 2013) for an ultrasound to check her baby's fetal growth.

20. On September 16, 2013, when she was 18 weeks and six days pregnant, Patient MT arrived at Respondent's office for a regular office visit. At the visit, Respondent reviewed Dr. Jadali's report with Patient MT, and answered her questions. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 164 pounds and her blood pressure was 125/72, which Respondent recorded on Patient MT's flowsheet, as well as Respondent's instruction that MT return in four weeks.

21. When Patient MT returned home, she realized she had forgotten to ask Respondent a question. Consequently, Patient MT sent Respondent a September 16, 2013 email advising that she and her sister were born with a cleft palette, and wanted to find out if her baby had a cleft palette, without having to wait until December 2013 for her next ultrasound appointment with Dr. Jadali. Later that day, Respondent sent a reply to Patient MT's email, advising that she could undergo a repeat ultrasound, but Patient MT denies receiving Respondent's email. Consequently, Patient MT called Respondent's office on September 20, 2013, spoke with Tina, and advised she wanted a three or four dimensional ultrasound well before the scheduled December 2013 ultrasound appointment. Patient MT also asked in what hospital she would deliver her baby. Tina noted the substance of the conversation in Patient MT's progress notes. Respondent wrote a progress note in Patient MT's records indicating that Patient MT would deliver her baby at Saint John's Regional Medical Center (St. John's), and that Dr. Jadali knew of the cleft palette issues and would perform a three or four dimensional ultrasound, accordingly.

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F. FIFTH AND SIXTH OFFICE VISITS WITH RESPONDENT (OCTOBER 17, 2013 AND OCTOBER 28, 2013)

22. Patient returned to Respondent's office on October 17, 2013, when she was 23 weeks and two days pregnant, for a routine visit. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 167 pounds and her blood pressure was 110/58, which Respondent recorded on Patient MT's flowsheet, as well as Respondent's instruction that MT return in four weeks. Also, because Patient MT was entering her 24th week of pregnancy, Respondent ordered that Patient MT undergo a glucose tolerance test at Foundation Laboratory, which she did on October 23, 2013.

23. Instead of returning in four weeks as Respondent had previously instructed, Patient MT returned 11 days later, on October 28, 2013, when she was 24 weeks and six days pregnant, after she had called Respondent's office and Respondent instructed Patient MT to come to her office that day. Patient MT told Respondent that she felt distressed, extremely anxious, and suffered panic attacks, one of which landed her in the emergency room. During her visit, Patient MT explained that her anxiety and panic attacks stemmed from adversity she faced at home and at work. Respondent prescribed Ativan (30 one-milligram tablets) to address Patient MT's anxiety, and instructed Patient MT to take it every six hours as needed. In her progress notes, Respondent stated that she told Patient MT that Ativan was "not for long-term use," a claim which Patient MT denies. Respondent did not prescribe any refills, but did not tell Patient MT exactly when she should discontinue the use of Ativan. Respondent did not record on Patient MT's medical record flowsheet that she had prescribed Ativan to Patient MT.

24. Respondent noted in Patient MT's chart that they discussed the need for Patient MT to receive therapy. Patient MT denies that Respondent told her that she needed to see a therapist. Respondent did not refer Patient MT to a therapist.

25. Also at the October 28, 2013 visit, Respondent advised Patient of the results of her glucose tolerance test. Specifically, Respondent told Patient MT that her glucose level was 197, which was considered high. Consequently, Respondent advised Patient MT that she would need to undergo a three-hour glucose screening to determine whether she was suffering from gestational diabetes, and noted the same on her flowsheet. Respondent instructed Patient MT to return in three weeks.

26. On October 30, 2013, Patient MT submitted to a three-hour glucose test at Foundation Laboratory. The results of the test, which Respondent's office received on November 1, 2013, indicated that Patient MT was suffering from gestational diabetes.

27. At hearing, Patient MT testified that on November 11, 2013, Patient MT called Respondent's office to get the results of her three-hour glucose test. Patient MT spoke with Tina, who promised to look up her results and call her back, but Tina never called back. Consequently, on November 12, 2013, Patient MT called Respondent's office again and spoke with Respondent, who told Patient MT to come into the office that day.

28. Respondent's testimony differed from Patient MT's, in that Respondent claimed to have called Patient MT to come in for a November 12, 2013 appointment, as a result of a issues that arose after Respondent received Patient MT's glucose results on Friday, November 1, 2013. Specifically, after reviewing Patient MT's glucose results, Respondent wished to get Patient MT into some diabetes care (i.e., a dietician, a teaching nurse to learn how to check glucose and inject insulin, and a general education on diabetes) at Magnolia Clinic (Magnolia). Magnolia would treat Patient MT on a consultation basis, while Respondent remained her obstetrician. Respondent directed her staff to make arrangements with Magnolia. Staff recorded in the progress notes that on November 1, 2013, they called Magnolia at 4:57, and was told it was too late to make an appointment, but would tell the doctor at Magnolia that it was urgent for Patient MT to get in to be seen. Six days later on Thursday, November 7, 2013, after consulting her tickler, Respondent discovered that Patient MT had not yet been seen at Magnolia for diabetes care. Respondent recorded instructions to her staff in the progress notes that Patient MT needed a referral and an appointment made immediately and that obtaining an appointment was a priority. On November 7, 2013, Respondent faxed Magnolia a letter of referral for Patient MT's gestational diabetes care, and included Patient MT's laboratory results. Respondent also made telephone calls to Magnolia and refaxed the referral letter and laboratory results to Magnolia on Friday, November 8, 2013. Monday, November 11, 2013, was a holiday.[2] On Tuesday, November 12, 2013, Respondent called Patient MT and asked her to come to Respondent's office to discuss a plan to address her diabetic care and to discuss her overall health.

G. SEVENTH OFFICE VISIT WITH RESPONDENT (NOVEMBER 12, 2013)

29. Patient MT returned to Respondent's office on November 12, 2013, when she was 27 weeks pregnant. Respondent or her staff weighed Patient MT and took her blood pressure, among other things. Patient MT's weight was 164 pounds and her blood pressure was 110/70, which Respondent recorded on Patient MT's flowsheet. Respondent also indicated on the flowsheet that Patient MT "has not gone to Magnolia yet for diabetes care." (Ex. 8, page 36.)

30. Early during the visit, Patient MT expressed that she was still experiencing some depression and anxiety, and that she had suffered a panic attack at work. Patient MT also explained that she felt as though she lacked support, and she felt all alone.

31. Respondent told Patient MT about her glucose screening results, and advised Patient MT that she was suffering from gestational diabetes. According to Respondent, she discussed arrangements with Patient MT to obtain diabetes care from Magnolia; but after reflecting on Patient MT's overall health and potential complications stemming from Patient MT's gestational diabetes and her prior history of hypertension and c-section, Respondent concluded that Patient MT's pregnancy had become too high risk. Respondent also concluded that Patient MT's care and needs would be better served at Magnolia. Respondent

[2] Veterans' Day.

told Patient MT that she would be transferring Patient MT's care to Magnolia for the remainder of her pregnancy in order to address her complications, and instructed Patient MT to walk across the parking lot to the next building where Magnolia was located. Patient MT became upset and emotional when she heard this news, because she had just expressed how alone she felt and how she did not feel as though she had anyone's support, and now she no longer had a doctor. Patient MT stormed out of Respondent's office and attempted to locate Magnolia, but could not, which sparked another panic attack. Respondent had not given Patient MT any paperwork to take with her to Magnolia, and prescribed no insulin to address Patient MT's diabetes. Patient MT called Magnolia, and a Magnolia staff member talked to Patient MT, calming her down, and then scheduled an appointment for Patient MT to come to Magnolia the following day.

32. At hearing, Respondent testified that she told Patient MT that she would continue to care for Patient MT until the transfer was complete. Patient MT denies that Respondent ever told her that she could remain in Respondent's care during the transition to Magnolia.

33. Respondent recorded a three-page handwritten progress note dated November 12, 2013. She stated that her office had made an appointment for Patient MT for December 2, 2013, which Respondent stated was "not acceptable as we called 11/1 for apt." (Exhibit 8, page 44.) Respondent also stated that Patient MT had reported anxiety and panic attacks, particularly when going to work, and had used Ativan in the past. Respondent further stated that she would "transfer [Patient MT] to Magnolia Clinic for multiple social med issues making her high risk," citing Patient MT's "persistent and increased social stressors including but not limited to her boss at work, her husband at home and her claim re 'panic attacks' . . . in addition, her referral for diabetes care at Magnolia Clinic (across the parking lot from [Respondent's] office)." (Exhibit 8, pages 44-45.) Respondent wrote that she "explained to [Patient MT] that the best care for her would be at Magnolia where all of her medical, psychological and pregnancy needs could be taken care of at one place." (Exhibit 8, page 45.) Respondent stated that she "reassured [Patient MT] that she could continue with [Respondent] until the transfer to Magnolia and offered to call Dr. Lefkowitz[3] to ease the transition." (Id.) Additionally, Respondent stated that she informed Patient MT that she needed a hemoglobin A1C (Hgh A1C) test, that she needed to make an a appointment with Magnolia as soon as possible, and that Respondent had made her an appointment at Magnolia for December 2, 2013 to address her diabetic care. (*Id.*) Respondent further stated that "after discussing with [Patient MT] all of the above, [Patient MT] stormed angrily out of the office, refusing to take the written instructions [Respondent] had for her, [and] the lab order for an Hgh A1C. (*Id.* at page 46.) Respondent wrote that she "followed [Patient MT] and asked her to come back and let [Patient MT] know (again) she could stay with [Respondent's] practice until the transition was made . . . [Patient MT] left without acknowledging [Respondent's] offer, stating 'I can't count on anyone.'" (*Id.*)

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[3] Dr. Lefkowitz was the medical director at Magnolia.

34. Respondent also recorded on the flowsheet that on November 12, 2013, Patient MT was transferred to Magnolia due to social problems, gestational diabetes care, and because she was now high risk.

H. PATIENT MT'S MEDICAL CARE FROM NOVEMBER 13, 2013 THROUGH DELIVERY.

35. On November 13, 2013, Patient MT went to Magnolia and met with Dr. Lisabeth Carlisle, when Patient MT was 27 weeks pregnant. When Patient MT and Dr. Carlisle discussed Patient MT's current medications, Dr. Carlisle told Patient MT to stop taking Ativan immediately, because it was not good for the baby. At the time, Patient MT had approximately one-quarter of a bottle of Ativan remaining. Dr. Carlisle also prescribed insulin to Patient MT, and set an appointment for Patient MT to return to Magnolia on November 20, 2013. A November 13, 2013 Magnolia medical record entry stated that Patient MT was a new patient transferring from another provider.

36. The following morning, November 14, 2013, Patient MT began contacting a number of doctors to request them to take her as a patient. However, Patient MT experienced great difficulty finding a doctor, because of her high risk status, combined with the advanced state of her pregnancy.

37. Also on November 14, 2016, Patient MT contacted Respondent's office, spoke with Respondent, and requested a copy of her medical records. Respondent told Patient MT that she could pick up her records on November 20, 2013, and would need to pay a $30 fee. Respondent asked Patient MT if she had gone to another doctor, to which Patient MT replied that she had gone to Magnolia, but that she was attempting to find a doctor with whom she was comfortable and who delivered at a hospital she liked. For reasons Patient MT could not explain, Respondent then told Patient MT that she felt that Patient MT was endangering her unborn child, because Patient MT was waiting to find a doctor she liked. Based upon the evidence, it is presumed Respondent did not hear Patient MT say that she had already gone to Magnolia. Respondent memorialized her version of the telephone discussion in Patient MT's progress notes and wrote that Patient MT was "refusing to go to Magnolia because she "wants to choose her own doctor." (Exhibit 8, page 46.) Respondent further stated that she "again reiterated that [she] would continue to see [Patient MT] and help her, and that Magnolia was in [Respondent's] opinion [Patient MT's] best option." (*Id.*) Respondent then stated that after she reinforced how important for Patient MT to be seen soon and to keep her December 2, 2013 appointment at Magnolia, the conversation ended. (*Id.* at page 47.)

38. Later that week, Patient MT wrote a negative review on Yelp regarding her experience with Respondent. She expressed that potential patients needed to do their research concerning Respondent, that somebody other than Respondent would be delivering their babies, and that Respondent was on medical probation for "negligence/malpractice," which was "why [Respondent did] not currently deliver at any hospitals." (Exhibit 6, page 2.)

39. On November 20, 2013, Patient MT retrieved her medical records from Respondent.

40. Patient MT returned to Magnolia for office visits on November 20 and 25, 2013.

41. On November 27, 2013, Patient MT began receiving treatment from Dr. Johannes Ramirez of Women's Care Center, who ultimately delivered Patient MT's son vaginally in February 2014, and provided post-delivery treatment.

42. Patient MT continued to receive ultrasound screenings from Dr. Jadali during the course of her pregnancy on December 3, 2013, January 13, 2014, and January 27, 2014.

43. Patient MT filed a complaint with the Board on December 26, 2013.

I. RESPONDENT'S TESTIMONY RE: PATIENT MT

44. Respondent proffered testimony as a percipient witness and as an expert witness. Respondent earned her associate's degree in nursing from Ventura College in 1975, and served as a nurse for 10 years. While working as a nurse, Respondent attended Chapman College and received her bachelor's degree in health science in 1982. She completed her pre-medical studies at the University of California at Santa Barbara in 1984, and earned her doctorate of medicine from Boston University School of Medicine in 1990. In 1995, Respondent completed her residency in obstetrics, gynecology, and reproductive biology at Beth Israel Deaconess Medical Center, which is a teaching hospital of Harvard Medical School. She served as chief resident in obstetrics and gynecology from 1994 to 1995. From 1995 through 2004, Respondent served as a clinical instructor of obstetrics, gynecology, and reproductive endocrinology at Harvard Medical School, where she conducted lectures to residents, taught them medical and surgical procedures related to obstetrics and gynecology, and taught them how to handle high risk patients. Respondent earned her board certification in obstetrics and gynecology in 1999. Respondent moved from Boston to California and set up her private practice in Oxnard in 2007.

45. In 2007, Respondent had admitting and attending privileges at St. John's. On July 27, 2007, while Respondent was delivering a baby at St. John's, the baby slipped through her hands and fell into the plastic bag used to collect blood and fluids from delivery, which was located under the buttocks of the patient. The incident caused the detachment of baby's umbilical cord. In a separate incident on January 7, 2008, Respondent delayed in delivering a breech baby at St. John's, performed an emergency c-section, and then cut the baby with her scalpel during delivery. Respondent also caused a separation of the uterine vessels of the mother, which resulted in massive bleeding that led to an urologist placing a stent in the patient's ureter. These two incidents resulted in the Board disciplining Respondent's license, effective September 25, 2012, for engaging in repeated acts of negligence. Specifically, the Board revoked Respondent's license, stayed the revocation, and placed Respondent on probation for a period of 35 months subject to certain terms and

conditions, including Respondent's completion of a clinical training program (i.e., Physician Assessment and Clinical Education Program [PACE]). As a result of the Board's discipline of Respondent, St. John's terminated Respondent's admitting and attending privileges.

46. In 2013, when Respondent treated Patient MT, Respondent still had no admitting or attending privileges at St. John's. Respondent testified that she explained to Patient MT, as was her custom and practice with all patients, that she "was not currently doing deliveries," but that she had previously made arrangements with certain medical entities to ensure her patients had coverage for medical emergencies and delivery. Specifically, Respondent arranged for physicians at Clinicas Del Camino Real (Clinicas) to care for her patients at St. John's as inpatients. In that regard, Respondent received regular monthly emails from Clinicas' setting forth its on-call schedule, so Respondent would know which one of Clinicas' physicians were on-call at a given time to deliver her patients' babies.

47. Respondent's custom and practice involved contacting the Clinicas physician on-call, and advising the Clinicas physician that her patient would be delivering at St. John's and that she had already sent the patient's medical records to St. John's labor and delivery department.

48. It was also Respondent's custom and practice to forward her patients' complete medical records, including the flowsheet, progress notes, laboratory results, and ultrasound reports, to St. John's at the patient's 35th week of pregnancy. Respondent expected the on-call physicians to review all of the records she sent, because she believed that everything she sent was pertinent to the patient's care. If an emergency arose where the patient could not provide any history because she was unconscious, Respondent expected the on-call physician to address the emergency first to protect the mother and the baby, and then go and review the medical records to figure out the course of treatment thereafter.

49. For patients she believed would require a c-section, it was Respondent's custom and practice to make a determination during the patient's 28th week of pregnancy of who would perform the c-section.

50. Finally, Respondent testified that it was her custom and practice to tell her patients that two obstetricians, meaning Respondent and Dr. Jadali, would be attending to their treatment during their pregnancies.

51. Patient MT emphatically denied that Respondent ever disclosed to her that she would not be delivering Patient MT's baby, until Respondent told Patient MT on November 12, 2013 that Patient MT's care would need to be transferred to Magnolia. Patient MT testified that the only other doctor Respondent discussed at the first visit was Dr. Jadali, who Respondent said would be performing ultrasound screenings. Patient MT testified that Respondent never mentioned anything to her about Clinicas, or that physicians from that facility would play a role in her treatment or delivery.

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J. BOARD'S EXPERT WITNESS (DR. STEVEN FREEDMAN)

52. Dr. Steven Freedman provided expert testimony on behalf of Complainant. Dr. Freedman earned his bachelor's degree in biology and psychology from Northwestern University (Northwestern) in 1973, and completed graduate studies in psychology from Northwestern in 1974. Dr. Freedman received his doctorate in medicine in 1978 from Eastern Virginia Medical School, and completed his residency in the area of obstetrics and gynecology at Western Pennsylvania Hospital in 1982. He obtained his license to practice medicine in 1982, and his board certification from the American College of Obstetrics and Gynecology in 1985. Dr. Freedman has been in private practice since 1982, has served as Director at Women's Health Specialists of West Hills since 2001, and has held hospital privileges at West Hills Hospital and Medical Center since 1982. He also currently oversees an obstetrics program in Berkeley where he supervises 14 obstetricians and midwives. He has served as a physician expert reviewer with the Board since 2010, a risk management expert reviewer with the Cooperative of American Physicians (CAP) since 2009, and a risk management expert with the Southwest Consortium for Innovative Psychology in Education (SCIPIE) since 2009. Dr. Freedman has served as a principal investigator for clinical research studies for various pharmaceutical companies, and as part of the teaching faculty at the University of Southern California, Northridge Hospital, University of California at Los Angeles, and others.

53. Dr. Freedman has treated patients with pregnancies and health risks similar to those experienced by Patient MT. Dr. Freedman reviewed a number of materials in connection with Patient MT's care. Specifically, Dr. Freedman reviewed Patient MT's complaint filed with the Board, Patient MT's written statement, Patient MT's medical records provided by Respondent, Dr. Jadali, Dr. Ramirez, and Magnolia, CURES reports, Respondent's curriculum vitae, and the transcript of the Board's March 7, 2016 interview of Respondent. During cross-examination, Dr. Freedman disclosed that he did not review the documents from Magnolia "particularly carefully."

54. Dr. Freedman evaluated whether Respondent's treatment of Patient MT conformed to the standard of care, and prepared a written report setting forth his conclusions. At hearing, Dr. Freedman described standard of care as that which a reasonable obstetrician or gynecologist in similar circumstances would exercise when providing care to a patient. Dr. Freedman explained that when reviewing Respondent's treatment of Patient MT, he applied the standard of care or the community standard, as opposed to applying his own personal standard, which is higher than the community standard.

1. COMPLICATED OBSTETRICS PATIENTS

55. With respect to the care and treatment of complicated obstetrical patients, Dr. Freedman stated the following in his report regarding the standard of care:

> A pregnancy is deemed complicated in the presence of maternal or fetal issues that may endanger the healthy continuation of that

> pregnancy. This may include maternal illness such as chronic hypertension. Pregnancy induced disease states such as gestational diabetes may complicate a pregnancy. Fetal factors also increase risk, such as uterine artery notching on ultrasound or a history of cleft palate. Maternal ingestion of drugs may also be considered.
>
> (Exhibit 17, page 3.)

56. In his analysis regarding the care and treatment of complicated obstetrical patients, Dr. Freedman stated that Patient MT should have been considered high risk from the beginning, given her previous c-section for a pregnancy complicated by gestational diabetes and hypertension. At hearing, Dr. Freedman explained that a history of a prior c-section can complicate a patient's risk, because it could result in an uterine rupture in a subsequent pregnancy. He further explained that patients who have suffered from preeclampsia before are at risk for developing it again in a subsequent pregnancy, which generally presents itself at the beginning of the third trimester. Additionally, Dr. Freedman noted that Patient MT's current pregnancy was complicated by gestational diabetes, uterine notching, and Patient MT's medical prescriptions. Dr. Freedman noted that Respondent's practice was not appropriate for the care of complicated obstetrics patients, based on Respondent's interview with the Board. Specifically, Respondent stated that if she had it to do over again, she would not have accepted Patient MT in her practice, because "she may be brewing a high risk . . . [so, therefore] we're not going to take her in the practice 'cause we may not be the best practice for her." (Exhibit 15, page 49, lines 9-12.) Dr. Freedman stated that Respondent "[did] not have the capability at the hospital to evaluate, monitor, and treat high-risk issues that may arise during the pregnancy." (Exhibit 17, page 3.) Further, Dr. Freedman maintained that "[i]t is perfunctory that the physician who will ultimately perform the repeat cesarean section be involved and/or fully aware of the prenatal course and complications. That obstetrician must be able to identify complications and act expeditiously to deliver the infant at an appropriate facility." (Id.)

57. At hearing, Dr. Freedman explained that from the beginning, Respondent's lack of admitting privileges to hospitals raised a question of continuity of care for Patient MT, and how Patient MT would be given follow-up care after delivery. Dr. Freedman explained that, as such, Respondent should have documented a care plan of how Patient MT would receive such treatment. Dr. Freedman further explained the importance of continuity of care in obstetrics, because "the art of obstetrics is very nuanced and there is a need to anticipate problems before they develop." Therefore, by closely following any patient, the physician is better able to anticipate problems.

58. Overall, Dr. Freedman concluded that Respondent's care of Patient MT was "inappropriate and demonstrate[d] a lack of knowledge of complicated obstetrics." (Exhibit 17, page 3.) Dr. Freedman further concluded that for Respondent to see Patient MT at her facility "was a simple departure from the standard of care . . . mitigated by the continuing involvement of a perinatologist [Dr. Jadali]." (*Id.*) At hearing, Dr. Freedman explained that

if a perinatologist had not been involved, he would have concluded that Respondent had engaged in an extreme departure from the standard of care. If the perinatologist had served as more than a consultant or more than someone who conducted ultrasounds, such as serving as the physician designated to deliver the baby, Dr. Freedman would have concluded that no departure occurred.

2. *PRESCRIBING ATIVAN*

59. With respect to prescribing Ativan, Dr. Freedman stated the following in his report regarding the standard of care:

> When prescribing psychotropic medications in pregnancy, the treating physician must determine that the benefits derived from the medication outweigh the risk that drug imposes to the mother and fetus.
>
> (Exhibit 17, page 3.)

60. Dr. Freedman acknowledged that Respondent prescribed Ativan to Patient MT to address her panic attacks and anxiety. At hearing, he explained that psychological stressors serve as risk factors for the patient, as anxiety levels increase steroid production, which can increase the mother's blood pressure, thereby affecting the blood-flow to the baby. Dr. Freedman noted that Ativan posed an increased risk of cleft lip when taken in the first trimester. He also noted that third trimester usage had been associated with withdrawal symptoms and hypotonia in the baby, commonly known as floppy baby syndrome, referencing the state of low muscle tone (the amount of tension or resistance to stretch in a muscle). As such, Dr. Freedman stated at hearing that Respondent should have erred on the side of caution and prescribed Patient MT fewer than 30 pills, as she was nearly 25 weeks pregnant, just three weeks shy of the commencement of her third trimester. Dr. Freedman also stated that Respondent should have made definitive arrangements for Patient MT to get help navigating through her stress, anxiety, and panic attacks.

61. Dr. Freedman also noted that Respondent had prescribed Ativan to Patient MT in the second trimester of her pregnancy, at one-milligram every six hours as needed, and that the quantity prescribed or the duration of usage had not been documented. Respondent indicated in a May 24, 2014 letter to the Board that the one-milligram dosage she had prescribed to Patient MT was the lowest available dosage. At hearing, Dr. Freedman explained that the lowest available dosage for Ativan was one-half of a milligram, not one milligram.

62. Dr. Freedman concluded that the usage of Ativan in the second trimester of pregnancy was within the standard of care. However, Respondent's failure to limit the frequency and duration of Patient MT's Ativan was a simple departure from the standard of care.

3. *TERMINATION OF THE DOCTOR-PATIENT RELATIONSHIP*

63. With respect to terminating the doctor-patient relationship, Dr. Freedman stated the following in his report regarding the standard of care:

> Termination of the doctor-patient relationship when the patient is unstable or in advanced pregnancy leaves the physician open to charges of abandonment. As stated in the Hippocratic Oath, 'I will not withdraw in time of need.'
>
> (Exhibit 17, page 4.)

64. Dr. Freedman noted in his report that, during Patient MT's third trimester, at approximately 27 weeks gestation, Respondent instructed her to continue care elsewhere, and that Patient MT had not found another qualified physician. Dr. Freedman noted that there was no written letter of termination included in Patient MT's records, and that the records reflected that Respondent's reason for withdrawing was due to Patient MT becoming high risk. Dr. Freedman additionally noted that Respondent failed to "spell out" Patient MT's medical problems at the time of withdrawal, and that Respondent had provided Patient MT "only one alternative clinic." (Exhibit 17, page 4.) Dr. Freedman further noted that at that time, Patient MT had been newly diagnosed with gestational diabetes, and therefore, required "immediate diabetic counseling, dietary consultation, continued home glucose monitoring, follow-up fetal surveillance via ultrasounds and testing, and a planned delivery by cesarean section." (*Id.*)

65. Dr. Freedman noted at hearing that Respondent did not advise Patient MT that she had gestational diabetes for 12 days after learning that Patient MT had gestational diabetes. Dr. Freedman explained that time is of the essence to get diabetic patients on insulin as soon as possible, as consequences exist for both the mother and the baby, such as the child growing disproportionately larger and faster, and the placenta undergoing changes that could increase chances of uterine abruption.

66. At hearing, Dr. Freedman questioned why Respondent did not refer Patient MT to Dr. Jadali to address her gestational diabetes, especially given Respondent's representation to her patients that she had two doctors taking care of them: Respondent and Dr. Jadali. Dr. Freedman explained that perinatologists, like Dr. Jadali, by definition treated high risk patients, including ones with gestational diabetes. Additionally, Dr. Freedman disclosed that he had independent knowledge that Dr. Jadali treated patients with gestational diabetes, because at one time, Dr. Jadali applied for privileges at West Hills Hospital where Dr. Freedman served as the chairman of the committee of the obstetrics and gynecology department, and participated in the decision granting Dr. Jadali privileges. Dr. Freedman had worked with Dr. Jadali at West Hills Hospital and sent patients to Dr. Jadali.

67. At hearing, Dr. Freedman explained that when transferring a patient to a new facility, the transferring physician must communicate with the facility receiving the

transferred patient and the receiving facility must agree to the transfer. The onus must be on the physician to make arrangements for transferring care to a new physician, not on the patient. Dr. Freedman testified that Respondent's progress notes were vague regarding the formalization of formal transfer arrangements to Magnolia. Specifically, Dr. Freedman explained that while Respondent's progress notes showed an apparent decision to transfer Patient MT's care to Magnolia, the standard of care required that the patient know and consent to the transfer, that the physician make arrangements to transfer the patient, and that the receiving facility agrees to accept the patient, all of which were not done. It was important that the patient consent to the transfer so that she would be aware of the transfer and comfortable with the decision to transfer. Finally, Dr. Freedman explained that a seamless transfer of care was required for continuity of care, and that the manner in which Respondent terminated the doctor-patient relationship constituted a simple departure from the standard of care.

68. During cross-examination, Dr. Freedman disclosed that he did not know whether Magnolia accepted the transfer. Additionally, Dr. Freedman was unaware that Patient MT was seen at Magnolia one day after Respondent advised that she was transferring Patient MT to Magnolia. Moreover, Dr. Freedman was unaware of Magnolia's medical records concerning Patient MT dated November 13, 2013 stating that Patient MT was a new obstetrics patient "transferring from other provider."

4. OBSTETRIC PRACTICE

69. Dr. Freedman stated the following in his report regarding the standard of care for obstetricians:

> [Standard of Care] dictates that the obstetrician provide complete care of the mother and infant from conception through the puerperium. Further, obstetrics requires 24/7 on call status for maintenance of thorough medical care as well as the delivery of the infant. Specifically, a board certified OB/GYN must maintain the ability to identify, treat, counsel, and follow gestational diabetics in both the office and hospital settings.
>
> (Exhibit 17, page 4.)

70. At hearing, Dr. Freedman explained that the obstetrician is the "captain of the ship" for a patient's care from conception through the first six weeks of the infant's life; therefore, if the obstetrician will not be the one delivering the baby, the obstetrician must have already made arrangements for another physician to deliver the baby, which includes providing the delivering physician with all medical records and making sure that physician knows the needs of the patient.

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71. Dr. Freedman noted that Respondent offered obstetric care although she had no admitting privileges at any hospitals. As such, she was unable to deliver the babies or to treat complicated obstetric cases. Although Respondent represented that she told her patients that she would be their primary obstetrician, that Dr. Jadali would perform ultrasounds and consult them regarding concerns that arise during their pregnancy, and that she verbally informed patients during their first visit that the "on call" doctor at the hospital would deliver their baby, "obstetric coverage entails the availability of prenatal records as well as a 'sign-out' process that familiarizes the treating obstetrician with the entire patient history." (Exhibit 17, page 5.) Dr. Freedman wrote in his report that "the delivering obstetrician is not specifically identified and there is no procedure in place for the transfer of medical records to insure continuity of care." (*Id.*)

72. Dr. Freedman wrote in his report that Respondent engaged in "an extreme departure from the standard of care to see patients antenatally and then having the patient simply present to an emergency room of the hospital to be delivered by a panel doctor who has minimal knowledge of their medical history." However, at hearing, after learning that Respondent had coverage arrangements with Clinicas, whose physicians provide care for Respondent's patients at St. John's, Dr. Freedman withdrew his conclusion that Respondent had engaged in an extreme departure from the standard of care. Instead, Dr. Freedman opined that a simple departure occurred because Respondent was dealing with a high risk patient, but lacked hospital privileges to address her high risk factors, and because the coverage arrangement did not fully set forth how the patient's high risk factors would be addressed or covered.

5. DOCUMENTATION

73. With respect to documentation, Dr. Freedman stated the following:

> The [Standard of Care] dictates complete contemporaneous notes regarding past and current medical history, along with all medications and testing prescribed.
>
> (Exhibit 17, page 5.)

74. At hearing, Dr. Freedman explained that the standard of care requires physicians to document each visit with a patient, and would expect to see all pertinent information about the patient listed on the flowsheet.

75. Dr. Freedman noted that the medical records prepared by Respondent concerning Patient MT "contain[ed] the sparse obstetrics flow sheet and additional hand written notations." (Exhibit 17, page 5.) The records "lack[ed] proper documentation of the E.R. visits, syncopal episodes, and complaints related to anxiety." (*Id.*) He noted that there was "no record of the prescription of Ativan 1 mg, the rational, time frame, or the duration of its intended usage." (*Id.*) He stated that Respondent did not document a discussion of risks concerning the drug. Additionally, Dr. Freedman noted the flowsheet did "not document the

referral to the cardiologist and his findings . . . [and] [a]lthough Dr. Jidali (*sic*) was described as the second OB, his visits, findings, and treatment plans [were] not documented." He also noted that Dr. Jadali identified increased risks during multiple ultrasound exams, but the findings were not noted in the records. Dr. Freedman noted that the records did not mention which physician would deliver Patient MT's baby, or the mode of delivery or of the timing of the repeat c-section. Finally, he noted that the records lacked documentation of the "social problems" Patient MT experienced.

76. Dr. Freedman concluded that the prenatal flowsheet "quite probably represent[ed] the only communication between [Respondent] and the delivering obstetrician." (Exhibit 17, page 5.) At hearing, Dr. Freedman expressed that if Respondent sent pertinent lab reports to labor and delivery, along with her progress notes, it would not be a deviation from the standard of care. However, because the labor and delivery department can be busy, receiving too many documents could cause confusion. Dr. Freedman therefore expressed how important it was for the flowsheet to be comprehensive, because it serves as a table of contents, in essence, for the other documents.

77. At hearing, Dr. Freedman explained that the flowsheet failed to mention on the flowsheet Patient MT's ER visit, her anxiety, all medication prescribed to her, Dr. Jadali's concern about uterine notching, or a treatment plan. Overall, Dr. Freedman concluded that Respondent's documentation failures, particularly the flowsheet, constituted a simple departure from the standard of care.

78. Dr. Freedman also noted at hearing that Patient MT's records failed to document as part of an initial birthing plan that a physician from Clinicas would be delivering Patient MT's baby, not Respondent. Additionally, there was no documentation of a contingency plan in place should Patient MT become high risk. Dr. Freedman explained at hearing that, as a Medi-Cal patient, Patient MT faced difficulties in obtaining appointments to address her needs. As such, Respondent should have put in place contingency plan so that Patient MT would not need to scramble to find a Medi-Cal physician who handles high-risk pregnancies.

K. RESPONDENT'S EXPERT WITNESS (DR. DARYOUSH JADALI)

79. Dr. Daryoush Jadali proffered testimony as a percipient witness and as an expert witness. Dr. Jadali earned his medical degree from Xochicalco University in Baja, California in 1986, and then completed his residency in obstetrics and gynecology at Lincoln Medical Center in Bronx, New York in 1994. He also completed a fellowship in maternal and fetal medicine at Albert Einstein College of Medicine in Bronx, New York in 1996. Dr. Jadali is licensed to practice medicine in California, New York, and New Jersey, and has been a Board-certified obstetrician/gynecologist since 1997. He has hospital privileges at Community Memorial Hospital, Los Robles Regional Medical Center, and West Hills Medical Center, but no longer delivers babies, and has not done so for approximately 10 years.

80. Dr. Jadali has known Respondent since she came to practice medicine in Ventura County. He considers Respondent a well-trained, conscientious, and skilled physician. Dr. Jadali sometimes serves as a consultant to Respondent, and other times they co-manage patients together.

81. Dr. Jadali declared that based on his experienced, combined with the fact that Respondent is a Board-certified obstetrician and gynecologist, he had no reason to believe Respondent should not have been treating Patient MT.

82. With respect to prescribing Ativan to Patient MT, Dr. Jadali explained that Respondent prescribed Ativan to Patient MT during her second trimester, which was within the standard of care. Because anxiety has been associated with mothers giving birth to underweight or maladjusted babies, it was important that Respondent reduce Patient MT's anxiety. Respondent prescribed 30 pills which could have lasted through a portion of Patient MT's third trimester, which Dr. Jadali declared "perfectly okay." Dr. Jadali explained that taking Ativan in the third trimester only becomes a problem at the time of delivery, because Ativan could cause hypotonia in the baby. Even then, the physicians could easily intubate the baby, according to Dr. Jadali.

83. Respondent did not offer Dr. Jadali an opportunity to treat Patient MT as her primary obstetrician after receiving the gestational diabetes diagnosis. At hearing, Dr. Jadali explained that he follows patients with gestational diabetes, but he does not manage those patients, because he does not have a dietician in his office.

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L. CREDIBILITY FINDINGS[4]

84. Patient MT was a very credible witness, given the forthright and transparent manner in which she testified. Specifically, Patient MT answered questions in a sincere, straight forward manner, without a cloud of prevarication. Her recitation of the facts remained essentially the same in all areas of significance, and remained consistent from the time she filed her complaint with the Board on December 26, 2013 to the time of hearing. As such, Patient MT's testimony was afforded great weight.

85. Respondent's testimony, though more straightforward than not, appeared incredible at times and more self-serving than truthful. For example, Respondent recorded a three-page handwritten progress note dated November 12, 2013, which, in and of itself, appeared highly unusual for Respondent to do, given the skeletal and/or omission-prone manner in which she generally recorded notes in Patient MT's case and others. Respondent's recitation of events in her November 12, 2013 note, most of which Patient MT denied, appeared on its face to be manufactured because Respondent was unusually detailed and comprehensive, taking care to list all of her purported reasons underlying her decision to

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[4] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

transfer Patient MT's case to Magnolia. In contrast, Respondent failed to demonstrate the same level of detail in her contemporaneous notes of previous Patient MT's office visits and examinations, evidenced by her failure to include pertinent information in Patient MT's flowsheet and progress notes. Additionally, she failed to demonstrate a penchant for detail when she failed to inform Patient MT, for 12 straight days, that she had developed gestational diabetes, despite the seriousness of the disorder. Such factors cast doubt on portions of Respondent's testimony, rendering her overall testimony less impactful than Patient MT's, even though more of Respondent's testimony than not was credible.

86. As such, Patient MT's version of events material to the Accusation, particularly the events occurring on November 12, 2013 during her final office visit with Respondent, as well as Patient MT's testimony that Respondent did not tell her at her initial visit that Respondent would *not* be delivering her baby, or that a physician at Clinicas would be delivering her baby, shall be deemed as true.

87. Dr. Freedman's expert testimony was more credible than not, though, at times, it suffered from his admitted failure to closely review the records from Magnolia, his discovery of last minute information, and from the defensive, sarcastic, and brooding manner in which he delivered his testimony during cross-examination. As such, Dr. Freedman's opinion was not always weighted heavily or adopted. However, Dr. Freedman's wealth of experience during his 35 years of practice, combined with his years teaching, overseeing obstetrics programs, and serving as an investigator for research clinical studies, made him a more persuasive expert witness than both Respondent and Dr. Jadali. While Dr. Jadali testified in a clear and straightforward manner, and though he had significant experience in the area of obstetrics, his experience did not outweigh that of Dr. Freedman, who has been practicing for more than a decade longer than Dr. Jadali. Additionally, Dr. Jadali's opinion that it was safe for a pregnant patient to continue to take Ativan in her third trimester, contradicted that of Dr. Freedman's and was inconsistent with the actions of Dr. Carlisle at Magnolia, who immediately terminated Patient MT's use of Ativan. Such factors generated some doubt concerning Dr. Jadali's overall expert testimony, rendering his opinion less convincing than Dr. Freedman's.

M. OVERALL CONCLUSIONS REGARDING THE PATIENT MT MATTER

88. The Accusation listed various acts or omissions allegedly committed by Respondent, which Complainant contends constitute gross and/or repeated acts of negligence. Each alleged act or omission is discussed in more detail below:

1. OFFERING OBSTETRIC CARE DESPITE NO HOSPITAL ADMITTING PRIVILEGES

89. Although Dr. Freedman, when considering Respondent's lack of hospital admitting privileges, stated that Respondent "[did] not have the capability at the hospital to evaluate, monitor, and treat high-risk issues that may arise during the pregnancy," the evidence showed that Respondent's office was equipped with an ultrasound machine, a non-

stress test machine, and a Doppler machine, all of which Respondent could use to monitor high-risk issues, and that Respondent had a pre-arranged agreement with Clinicas to address problems that required in-patient hospital care. Additionally, Respondent's co-management of her patients with Dr. Jadali provided an additional layer of expertise in evaluating, monitoring, and treating high risk pregnancies, despite Respondent's lack of hospital admitting privileges. While Respondent ultimately determined that Patient MT was too high risk to continue treating her, this factor did not necessarily render Respondent incapable of treating patients with high risks, despite her lack of hospital privileges. As such, Respondent's provision of obstetric care despite having no hospital admitting privileges did not constitute an act or omission of negligence, as alleged in the Accusation.

2. SEEING THE PATIENT ANTENATALLY

90. The Accusation alleged that Respondent treating Patient MT antenatally at Respondent's office, and then having "the patient simply present to the ER of the hospital to be delivered by a panel doctor who has minimal knowledge of the patient's medical history," constituted gross and repeated acts of negligence. While these factors did not occur in Patient MT's matter, as Patient MT did not present to the ER for the delivery of her baby while under the care of Respondent, Dr. Freedman asserted that such a situation raised "continuity of care" concerns. However, the evidence shows, as set forth above, that Respondent had previously made arrangements with physicians at Clinicas to ensure her patients had coverage for medical emergencies and delivery as inpatients at St. John's. Additionally, it was Respondent's custom and practice to contact the Clinicas physician on-call and advise him or her that Respondent's patient would be delivering at St. John's. Moreover, the evidence shows that it was Respondent's custom and practice to forward her patients' complete medical records, including the flowsheet, progress notes, laboratory results, and ultrasound reports, to St. John's at the patient's 35th week of pregnancy, so that the delivering physician would have information about the patient at his or her disposal. These factors address continuity of care concerns raised by Dr. Freedman, as they show that the delivering physician would have access to the patient's medical history before and during delivery. As such, Respondent treating patients antenatally did not constitute an act or omission of negligence, gross or otherwise, as alleged in the Accusation.

3. FAILING TO LIMIT ATIVAN

91. The Accusation alleged Respondent's failure to adequately limit the frequency and duration of Patient MT's usage of Ativan constituted an act of negligence. The evidence shows that Ativan usage in the third trimester of pregnancy can pose a health risk in the baby, rendering him or her hypotonic. Despite this danger, Respondent prescribed 30 tablets of Ativan to Patient MT when she was one day shy of her 25th week of pregnancy and three weeks shy of the commencement of her third trimester, and gave no instruction to Patient MT to cease taking the medication when she entered her third trimester. Consequently, Patient MT had one-quarter of a bottle of Ativan left when she reached her third trimester, which Patient MT could have continued using as Respondent had directed had she not received instructions directing her otherwise from Dr. Carlisle. While Respondent

prescribed no refills of Ativan, that act did not shield Patient MT's baby from potential harm; however, a clear directive from Respondent could have. Given these factors, Respondent's failure to issue such a directive to Patient MT constituted an act of negligence.

4. *FAILING TO ENSURE CONTINUITY OF CARE*

92. The Accusation alleged Respondent failed to adequately ensure continuity of care for Patient MT after the termination of the doctor-patient relationship. While the credibility findings have established as true Patient MT's version of events regarding the abrupt termination of the doctor-patient relationship on November 12, 2013, and that Respondent's only directive was that Patient MT go to Magnolia for her continued care, the evidence shows that Patient MT received treatment at Magnolia on the following day, November 13, 2013, and that Magnolia's medical records of November 13, 2013 acknowledged that Patient MT was received and accepted as a transfer patient. While Patient MT contends that making arrangements to treat at Magnolia fell squarely on her shoulders, it is reasonable to conclude that Patient MT would not have gone to Magnolia to seek treatment without Respondent's directive to do so. Such action, despite Respondent's questionable rationale for the abrupt and unilateral decision to transfer Patient MT to Magnolia, resulted in continuity of care. As such, Respondent committed no act of negligence here.

5. *FAILING TO ADEQUATELY DOCUMENT THE CARE AND TREATMENT OF PATIENT MT*

93. The evidence is clear Respondent failed to adequately document the care and treatment she provided Patient MT. While Respondent routinely documented Patient MT's blood pressure and weight at every visit, Respondent failed to document in Patient MT's medical records that Respondent prescribed Ativan or acetaminophen with codeine, particularly on the flowsheet. Additionally, Respondent failed to include a reference on the flowsheet that Patient MT visited the emergency room, failed to mention Patient MT's anxiety, and failed to highlight Dr. Jadali's concern about uterine notching, or a treatment plan. Dr. Freedman expressed how important it was for the flowsheet to be comprehensive, because it serves as a table of contents, in essence, for the other documents contained in the patient's records. For these reasons, and as attested by Dr. Freedman, Respondent's documentation failures, particularly on the flowsheet, constituted a simple departure from the standard of care.

II. Patient CK

94. On June 1, 2013, Patient CK met with Respondent regarding Respondent performing liposuction on Patient CK's inner thighs. Specifically, Patient CK wished to achieve a "thigh gap" through the removal of fat on her upper, inner thighs. At the visit, Patient CK provided Respondent with a photo depicting the shape and size of inner thighs she wanted Respondent to achieve.

95. On June 15, 2013, Respondent performed liposuction on Patient CK's inner thighs, after Patient CK signed an informed consent form. The informed consent form did not list the specific area in which Respondent was to perform liposuction (i.e., inner thighs). During the surgery, Respondent prepared a liposuction calculation sheet documenting the lidocaine and fluid given to Patient CK during the surgery. Respondent prepared an operative note describing the procedure she performed on Patient CK, and noted that, while using a debulking cannula, her "manual assessment of the degree of debulking was done constantly throughout the case using the operator's fingers to pinch and assure that there remained at least a centimeter of fat between them."

96. On June 16, 2013 and June 22, 2013, during post-operation (post-op) visits, Respondent noted on Patient CK's chart that she was healing well. Respondent noted in Patient CK's progress notes that Patient CK was to return for a follow up visit in one week, and that Respondent would introduce "lipo foam" (i.e., padding used to apply on the treated area under the compression garment) at that visit.

97. On June 29, 2013, Patient CK appeared for her follow-up appointment, but Respondent did not show up. Patient CK sent Respondent an email on this date expressing her displeasure about Respondent failing to appear for her appointment.

98. On June 30, 2013, Patient CK had become concerned about the unevenness of her thighs and emailed a photo of her thighs to Respondent. Respondent did not respond to Patient CK's email. On July 13, 2013, Patient CK emailed another photo of her "choppy/uneven" thighs to Respondent. Respondent responded as follows:

> You had your procedure on 6/15. It's only been 4 weeks. The fluid is still absorbing. 1. Continue to wear your garment for up to 6 weeks. 2. You need to exercise to build the muscle underneath the area up to meet the skin above. Remember: The full effect will not be seen until 6 months and No 2 body parts are ever symmetrical. Please call the office on Monday to schedule a follow up visit.

99. Patient CK's next post-op visit occurred on July 27, 2013. Respondent noted that Patient CK was "'happy' with results, no complaints, questioning 'loose' areas." Respondent recommended inner thigh exercises for Patient CK, and indicated that in six months, she would consider performing some "touchup" surgery.

100. Also on July 27, 2013, Patient CK requested Respondent to inject Juvederm into her nasolavial folds, also known as smile lines or laugh lines, into her marionette lines (i.e., lines that run straight downwards from the corners of the mouth), and into the oral commissure (i.e., corners of the mouth). Respondent used one syringe of Juvederm to inject in the areas requested by Patient CK. Juvederm is an injectable dermal filler used to provide nine months to one year of correction for moderate to severe facial wrinkles and folds.

101. On July 28, 2013, Patient CK noticed a lump that appeared in the right cheek in the area where Respondent injected the Juvederm, and emailed Respondent a photo of the lump. Respondent told Patient CK that the lump would settle and resolve.

102. At Patient CK's post-op visit of October 15, 2013, 16 weeks after surgery, Respondent noted a more pronounced indentation in Patient CK's right thigh.

103. In January 2014, Patient CK met with Respondent regarding the swollen area on her right cheek. Respondent advised Patient CK that she needed to dissolve the area with Vitrase, which is a hyaluronidase used as an aid in helping the body absorb other injected medications. However, Respondent had no Vitrase in her office. Respondent told Patient CK that she would need to purchase a vial of Vitrase and bring it to the office for Respondent to inject. Patient CK subsequently sought treatment from a cosmetic dermatologist to address the lump on her right cheek.

104. On January 18, 2014, Patient CK's post-op visit with Respondent included Dr. Ryan Khosravi, whom Respondent identified and consulted as a plastic surgeon. Respondent noted in Patient CK's chart that, per Dr. Khosravi, the plan to address Patient CK's indentation in her right thigh included Patient CK wearing her compression garment again. At hearing, the Board's expert and cosmetic surgeon, Dr. Michael Schwartz, explained that compression garments can improve the final outcome, assuming they are used immediately following liposuction, and worn for six to twelve weeks. Failure to wear the compression garment can lead to swelling and bleeding. Dr. Khosravi also recommended that Patient CK wait one year post-op before considering any revision surgery. Respondent also noted that Dr. Khosravi concluded that "there [was] no more fat to remove from inner thighs." (Exhibit 19, page 25.)

105. On May 13, 2014, Patient CK emailed to Respondent photos of her thighs, stating there had been no change in their appearance at the one-year post-op mark.

106. At the next post-op visit on May 31, 2014, Patient CK complained of hanging skin in the left thigh, as well as the indentation in her right thigh. Respondent recommended fat transfer and noted that she may have asymmetry and may require more than one procedure to correct the appearance of Patient CK's thighs. Patient CK ultimately sought consultation with other cosmetic surgeons to correct the appearance of Patient CK's thighs. As of the date of the hearing, Patient CK had not undergone any procedures to correct the deformity on her thigh.

107. On February 27, 2015, in response to its request, Respondent supplied the Board with a copy of Patient CK's medical records; however, these records did not include a medical note indicating that Respondent had injected Juvederm on July 27, 2013.

A. BOARD'S EXPERT WITNESS (DR. MICHAEL SCHWARTZ)

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108. Dr. Michael Schwartz provided expert testimony on behalf of Complainant. Dr. Schwartz earned his bachelor's degree in biochemistry from Lawrence University in 1978, and his doctor of medicine from Loyola Stritch School of Medicine in 1982. He received his postgraduate training (i.e., residencies in internal medicine and otolaryngology, and internships in internal medicine and general surgery) at Los Angeles County/USC Medical Center from 1982 to 1989. Dr. Schwartz completed fellowships in facial plastic and reconstructive surgery in 1989, 1990, and 2009. He is licensed in California and Arizona, and board certified by the American Board of Cosmetic Surgery, the American Board of Facial Plastic and Reconstructive Surgery, and the American Board of Otolaryngology. Dr. Schwartz has served as a clinical assistant professor in the division of facial plastic surgery at Los Angeles County/USC Medical Center, authored eight publications, and made presentations in the area of reconstructive cosmetic surgery. Dr. Schwartz is affiliated with six hospitals in Arcadia and Pasadena, California. His current practice is in Pasadena and approximately half of it is focused on liposuction. Dr. Schwartz performs liposuction on approximately 100 patients per year, including on patients' thighs, and administers Juvederm injections.

109. Dr. Schwartz reviewed a number of materials in connection with Patient CK's care. Specifically, Dr. Schwartz reviewed Patient CK's complaint filed with the Board, Patient CK's written statement, Patient CK's medical records, photographs, Respondent's curriculum vitae, and the CD and transcript of the Board's March 7, 2016 interview of Respondent, among other things.

110. Dr. Schwartz noted that during Respondent's interview, Respondent, with respect to liposuction, stated, "I call it a procedure. To me, it's not surgery. Surgery by definition enters a body cavity so to speak, you know, and I'm nowhere close."

111. Respondent also stated in her interview that it was not clear whether the depression in Patient CK's right inner thigh resulted from the liposuction, the compression or the lack of compression, the lack of follow-up, the lack of exercise, the lack of compliance, or the lack of Motrin.

112. With respect to the contour deformity of Patient CK's right inner thigh, Dr. Schwartz explained the following regarding the applicable standard of care:

> The standard of care dictates that caution be used when performing liposuction of all areas of the body, but especially the inner and outer thighs, which are more prone to contour deformities than other areas of the body. Although contour deformities are a known complication of liposuction, surgeons performing liposuction should have comprehensive knowledge of proper technique and cause and treatment options for potential complications. (Exhibit 26, page 4.)

113. Dr. Schwartz's review of Patient CK's medical records revealed no evidence of infection, and thus, he opined that the only possible cause for the severe depression and irregularity of Patient CK's right inner thigh was Respondent's over-section of fat and uneven resection of fat in this area. Dr. Schwartz found Respondent's statement false that it could not be known whether the indentation was caused by the liposuction, the compression or the lack of compression, the lack of follow-up, the lack of exercise, the lack of compliance, or by the lack of Motrin.

114. Dr. Schwartz noted that Patient CK's severe contour deformity would be difficult to correct and more likely impossible to correct. Dr. Schwartz explained that the fact that Respondent did not know the cause of the deformity, and the fact that she did not consider liposuction to be surgery, confirmed that Respondent's treatment of Patient CK departed from the standard of care, specifically, a simple departure.

115. With respect to Juvederm, Respondent stated in her interview that she did not carry Vitrase in her office, but that "it could cause more problem than it might be worth." Respondent stated that Vitrase expires very quickly, and because each vial costs $500, it was "not cost effective to do it."

116. Dr. Schwartz explained the following regarding the applicable standard of care concerning injectable fillers:

> The standard of care when injecting fillers into the face is to have a comprehensive understanding of facial anatomy, the characteristics of each filler, and potential complications and treatment of complications.
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> (Exhibit 26, page 5.)

117. Dr. Schwartz stated that potential emergency situations could occur when injecting Juvederm or other fillers, such as inadvertently injecting the Juvederm into an artery or vein in the face. Dr. Schwartz noted that such a situation could result in occlusion of an artery and thus impact the blood supply to an area of the face, or more seriously, embolization of filler material from a periorbital vein, causing blindness. As such, Dr. Schwartz expressed the essentiality of physicians stocking Vitrase or another hyaluronidase in their offices in the event that one of these emergencies arise. Dr. Schwartz concluded that Respondent's failure to stock Vitrase or any other hyaluronidase represented a simple departure from the standard of care.

B. RESPONDENT'S TESTIMONY

118. Respondent received training in performing certain cosmetic procedures beginning in 2007. Specifically, Respondent received training on aesthetic injecting techniques in 2007, 2012, 2013, and 2015, from Allergan, which is a pharmaceutical company that produces Juvederm. She also received training on aesthetic injecting

techniques in 2012, 2013, 2014, and 2015, from Merz, which is another pharmaceutical company that specializes in aesthetics. In 2012, Respondent received liposuction training by Inspiring Physicians and by Ciao Bella Medical Spa, both in Phoenix, Arizona. Respondent received further liposuction training by Ciao Bella Medical Spa in 2013.

119. During her interview, when Respondent stated that liposuction was not surgery, she meant that liposuction addressed the area under the skin and does not enter any body cavities. Respondent explained she does not take cavalierly the seriousness of performing liposuction.

120. Respondent was trained to constantly assess how much fat to leave under the skin. Specifically, she was trained to leave a minimum of one-centimeter of subcutaneous fat under the skin, which Respondent claimed she did in Patient CK's case.

121. At hearing, Respondent explained that the six weeks following liposuction are vitally important to achieving the desired result, and that there is much a patient can do to assist with the healing process, such as wearing the appropriately-sized compression garment and using lipo foam padding. Respondent claimed that Patient CK never came in for a follow-up visit until six weeks following her first follow-up appointment, when she was supposed to return one week following her June 22, 2013 appointment. Respondent explained that, as such, Patient CK did not receive any lipo foam to try. However, in his review of the records, Dr. Schwartz found no noncompliance on Patient CK's part regarding Patient CK attending her appointments, and further found that Patient CK's deformity in her right thigh was not caused by any purported failure to appear at post-op visits, but rather from Respondent's over-resection and injudicious liposuction. Additionally, Respondent did not note in Patient CK's records that Patient CK had missed any appointments. On the contrary, Respondent, herself, missed Patient CK's June 29, 2013 appointment.

122. With respect to Juvederm and other fillers, Respondent explained that there was no known risk that made it necessary for her to stock Vitrase in her office in 2013. It was not until May 28, 2015 when the Federal Drug Administration (FDA) issued a safety communication advising that physicians who injected patients with facial soft tissue fillers should be aware of the possibility of rare, but serious injuries that may occur due to unintentional injection of soft tissue filler into blood vessels in the face. Specifically, the FDA safety communication advised that the unintentional injection of soft tissue fillers into blood vessels that could block blood vessels and restrict blood supply to tissues, causing vision impairment, blindness, stroke, and damage and/or death of the skin (necrosis) and underlying facial structures. The safety communication also advised that physicians should adopt a detailed plan on how they should treat a patient should the physician unintentionally inject filler into a blood vessel, which could include on-site treatment. Respondent began stocking Vitrase in her office on October 15, 2016.

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C. CREDIBILITY FINDINGS

123. Dr. Schwartz was a very credible and persuasive expert witness, as he testified in a clear, concise, and forthright way, and demonstrated a wealth of pertinent knowledge in the areas of liposuction and facial dermal fillers. Additionally, Dr. Schwartz's nearly 30 years of practice, coupled with his years of experience as a clinical assistant professor, author, and presenter, rendered Dr. Schwartz's testimony convincing. Accordingly, Dr. Schwartz's testimony was afforded more weight than Respondent's expert testimony, whose knowledge and experience paled in comparison to Respondent's in the area of liposuction and facial dermal fillers.

D. OVERALL CONCLUSIONS REGARDING THE PATIENT CK MATTER

124. The Accusation listed various acts or omissions allegedly committed by Respondent, which Complainant contends constitute repeated acts of negligence. Each alleged act or omission is discussed in more detail below:

1. OVER-RESECTIONING OF FAT / FAILING TO KNOW CAUSE OF DEFORMITY/ FAILING TO CONSIDER LIPOSUCTION AS SURGERY

125. The evidence showed, through the credible testimony of Dr. Schwartz, that no evidence of infection existed, and thus, the only possible cause for the severe depression and irregularity of Patient CK's right inner thigh was Respondent's over-section of fat and uneven resection of fat in this area. Respondent's statement that it could not be known whether the indentation was caused by the liposuction, the compression or the lack of compression, the lack of follow-up, the lack of exercise, the lack of compliance, or by the lack of Motrin, lacked credibility, given the weight given to Dr. Schwartz' finding that the indentation occurred by the Respondent's injudicious liposuction of Respondent's inner thigh. Such over-resectioning, coupled with Respondent's failure to understand that her conduct caused the deformity, constituted a simple departure from the standard of care. Respondent's Board interview, on the other hand, in which she stated that she did not consider liposuction to be surgery, was easily clarified at hearing by Respondent, and not considered a weighing factor in determining whether Respondent's conduct departed from the standard of care.

2. FAILING TO STOCK HYALURONIDASE (VITRASE)

126. While Dr. Schwartz concluded that Respondent's failure to stock Vitrase to address potential emergencies stemming from an inadvertent injection of Juvederm into an artery or vein of the face represented a simple departure from the standard of care, the evidence does not support that conclusion. Respondent proffered convincing evidence that the potential dangers of Juvederm injections described by Dr. Schwartz were not communicated to the public by the FDA until 2015, long after Respondent performed Juvederm injections on Patient CK. As such, Complainant has not established that

Respondent departed from the standard of care when she did not maintain Vitrase in her office.

III. Patient YC

127. Patient YC had seen Respondent as her gynecologist for approximately three years. During Patient YC's annual gynecological visit in 2014, Respondent told Patient YC that she was now performing liposuction services in her office.

128. On May 30, 2014, Respondent performed liposuction of Patient YC's outer thighs, buttocks, and flanks, after Patient YC signed an informed consent form. The informed consent form, however, did not list the specific areas in which Respondent was to perform liposuction.

129. On the pre-procedure note, Respondent noted that the procedure to be performed was "love handles/upper thighs," but did not mention flanks. On the operative note, however, Respondent stated that the procedure was liposuction of the love handles and flanks, but did not mention the thighs. Additionally, Respondent stated on the operative note that the pre-operative diagnosis was "[d]esires liposuction of outer thighs and under buttocks, and love handles," (Exhibit 30, page 8), which Dr. Schwartz noted was not a diagnosis. Dr. Schwartz explained that a more accurate diagnosis would have been lipodystrophy or excess fat of flanks and lateral thighs.

130. During the surgery, Respondent prepared a liposuction calculation sheet, but did not document the concentration of any medications added to the saline solution injected in Patient YC's fat compartments during the tumescent liposuction. Respondent also did not record Patient YC's vital signs before, during, or after the liposuction procedure.

A. BOARD'S EXPERT WITNESS (DR. MICHAEL SCHWARTZ)

131. Dr. Schwartz reviewed a number of materials in connection with Patient YC's care. Specifically, Dr. Schwartz reviewed Patient YC's complaint filed with the Board, Patient YC's medical records, Respondent's curriculum vitae, and the CD and transcript of the Board's March 7, 2016 interview of Respondent, among other things.

132. With respect to medical record-keeping in surgery, Dr. Schwartz explained the following regarding the applicable standard of care:

> The standard of care dictates when creating an operative note is to accurately record the preoperative and postoperative diagnosis, the procedure, and all pertinent details of the surgery. Vital signs should be recorded at the minimum of 15 minute intervals.
> (Exhibit 34, page 3.)

133. Dr. Schwartz noted that Respondent's pre-procedure and operative notes failed to list all of the areas from which Respondent was to liposuction, and failed to include an actual diagnosis.

134. Additionally, Dr. Schwartz noted that when Respondent performed tumescent liposuction on Patient YC, she prepared a liposuction calculation sheet, but did not document the concentration of any medications added to the saline solution injected in Patient YC's fat compartments. Dr. Schwarz explained that lidocaine toxicity is a well-known complication of tumescent liposuction, therefore it is important to document the concentration of lidocaine and volume infiltrated of the tumescent solution containing lidocaine, and to record the lidocaine dose in milligrams/kilograms.

135. Dr. Schwartz explained that the standard of care when performing surgical procedures was to document Patient YC's vital signs before, during, or after the procedure. Respondent did not document any vital signs before, during, or after she performed liposuction on Respondent.

136. Because of the foregoing, Dr. Schwartz concluded that Respondent's medical record keeping in surgery constituted a simple departure from the standard of care.

137. Given Dr. Schwartz's persuasiveness as an expert witness, in light of his nearly 30 years of practice and experience, great weight was afforded Dr. Schwartz's testimony. As such, Dr. Schwartz's testimony was considered more credible as an expert than Respondent's (set forth below), given Dr. Schwartz's superior knowledge and experience in the area of cosmetic surgery.

B. RESPONDENT'S TESTIMONY

138. In response to Dr. Schwartz's criticism that Respondent should have recorded Patient YC's vital signs during the surgery a minimum of every 15 minutes, Respondent explained that it was not her practice to use general anesthesia or conscious sedation on her patients, both of which require intubation and IV therapy. Respondent explained that because those forms of sedation are more invasive and pose increased risk to the patient, it is reasonable to monitor the patients in the way described by Dr. Schwartz. However, it was Respondent's practice to give her patients a constellation of oral medications, such as Ativan, Zofran, Toradol, and Vicadin, and thus, was not required to record vital signs every 15 minutes. Respondent did, however, obtain a baseline reading of Patient YC's vital signs before surgery, and obtained her vital signs following surgery.

139. In response to Dr. Schwartz's criticism that Respondent failed to document the concentration of medications added to the saline solution injected in Patient YC's fat compartments, Respondent explained that although she did not record the lidocaine concentration, it would have been impossible to perform the liposuction procedure without completing the lidocaine calculation. As such, Respondent explained that although she did

not record the calculations on the liposuction calculation sheet, she is certain she performed the calculations somewhere else, but failed to include the calculation in Patient YC's records.

C. OVERALL CONCLUSIONS REGARDING THE PATIENT YC MATTER

140. The Accusation alleged that Respondent engaged in repeated acts of negligence by (1) failing to adequately document Patient YC's liposuction procedure in the medical records; (2) failing to adequately mention on the informed consent form, on the pre-procedure note, and on the operative note all of the anatomic areas slated to undergo liposuction; (3) failing to adequately document the concentration of any medications, including lidocaine, added to the saline solution injected during Patient YC's liposuction procedure; and (4) failing to adequately document Patient YC's vital signs before, during, and after the liposuction procedure. The evidence firmly establishes that Respondent committed such acts, and Respondent proffered no persuasive evidence, testimonial or otherwise, sufficiently excusing or disputing this conclusion.

CONCLUSIONS OF LAW

1. Cause does not exist to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), for gross negligence acts, as set forth in Findings 3 through 93.

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), for repeated negligent acts, as set forth in Findings 3 through 140.

3. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2266, for failure to maintain adequate records, as set forth in Findings 3 through 140.

The Applicable Law

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

5. The purpose of the Medical Practice Act[5] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and

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[5] Business and Professions Code sections 2000 through 2521.

those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App. 3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

6. The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.) (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

7. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

8. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

9. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

10. Business and Professions Code section 2266 states that that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provisions of services to their patients constitutes unprofessional conduct."

11. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to

be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

Analysis

12. While Complainant did not meet her burden of establishing that Respondent engaged in gross negligence, she firmly established that Respondent engaged in repeated acts of negligence, in violation of Business and Professions Code section 2234, subdivision (c) and/or inadequate record keeping, in violation of Business and Professions Code section 2266, in relation to her care and treatment of Patients MT, CK, and YC. Specifically, Respondent (1) failed to adequately limit the frequency and duration of Patient MT's usage of Ativan; (2) failed to adequately document the care and treatment provided to Patient MT; (3) over-resectioned fat and engaged in injudicious liposuction of Patient CK's inner right thigh; (4) failed to know the cause of deformity of Patient CK's inner thigh; (5) failed to adequately document Patient YC's liposuction procedure in the medical records; (6) failed to adequately mention on the informed consent form, on the pre-procedure note, and on the operative note all of the anatomic areas slated to undergo liposuction; (7) failed to adequately document the concentration of any medications, including lidocaine, added to the saline solution injected during Patient YC's liposuction procedure; and (8) failed to adequately document Patient YC's vital signs before, during, and after the liposuction procedure.

13. Of great concern is Respondent's commission of the above-referenced acts while actively serving a 35 month probation previously imposed by the Board on September 25, 2012, stemming from Respondent's engagement in repeated acts of negligence. The purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) In order to adequately protect the public, Respondent shall submit to an extended period of probation, with specific terms and conditions.

ORDER

Certificate No. C 51906 issued to Respondent, Adrienne Elizabeth Lara, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five years, upon the following terms and conditions:

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1. **Education Course**

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. **Medical Record Keeping Course**

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. **Professionalism Program (Ethics Course)**

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of California Code of Regulations, title 16 (CCR), section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the

longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. **Monitoring - Practice**

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified.

Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

5. **Notification**

Within seven days of the effective date of this Decision, Respondent shall provide a true and correct copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. **Supervision of Physician Assistants**

During probation, Respondent is prohibited from supervising physician assistants.

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7. **Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. **Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. **General Probation Requirements**

Compliance with Probation Unit:

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

Address Changes:

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice:

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

License Renewal:

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

Travel or Residence Outside California:

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

10. **Interview with the Board or its Designee**

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. **Non-practice While on Probation**

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

12. **Violation of Probation**

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. **License Surrender**

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. **Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

15. **Completion of Probation**

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

DATED: June 22, 2017

DocuSigned by:
Carla L. Garrett
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CARLA L. GARRETT
Administrative Law Judge
Office of Administrative Hearings

KAMALA D. HARRIS
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
TAN N. TRAN
Deputy Attorney General
State Bar No. 197775
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-6793
Facsimile: (213) 897-9395
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Sept. 9 2016
BY: ANALYST

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

In the Matter of the Accusation Against: **Adrienne Elizabeth Lara, M.D.** **1801 Solar Drive, Suite 155** **Oxnard, CA 93030** **Physician's and Surgeon's Certificate No. C 51906,** Respondent.	Case No. 800-2013-001050 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about April 1, 2005, the Medical Board issued Physician's and Surgeon's Certificate Number C 51906 to Adrienne Elizabeth Lara, 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 November 30, 2016, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. 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.

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

"(d) Incompetence.

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

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

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

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the certificate holder and the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence- Patient M.T.)

8. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of patient M.T.[1] ("patient" or "M.T."). The circumstances are as follows:

9. M.T. was a patient who began treatment with respondent on or about July 2013 for obstetric care.[2] M.T. was due to deliver on February 2014. M.T. was a high-risk patient who had a pregnancy that had been complicated by hyperemesis,[3] gestational hypertension, and a prior cesarean section. The patient's past medical history was also significant for chronic hypertension, gestational diabetes and pre-eclampsia,[4] polycystic ovarian disease, and psychological stresses both at work and at home.

10. On August 13, 2013, the patient fainted at work and was seen in the Emergency Room (ER) with a diagnosis of dehydration. On September 13, 2013, the patient was seen by another physician who identified "bilateral uterine artery notching" which is associated with an increased risk of pre-eclampsia, pre-term birth, placental abruption, intra-uterine growth retardation, and intrauterine fetal demise. On August 22, 2013, telephone messages document repeated syncopal episodes, culminating in another visit to the ER on August 26, 2013.

11. At 23 weeks gestation, glucose screening for the patient was positive, and tests were consistent with gestational diabetes. The patient was placed on disability and respondent prescribed Ativan to the patient for "panic attacks."

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[1] In this Accusation, the patient is referred to by initial. The full name of the patient will be disclosed to Respondent in discovery.

[2] Respondent offered obstetric care although she had no admitting privileges at any hospital. Respondent was unable to deliver the babies or to treat complicated obstetric cases.

[3] A complication of pregnancy which is characterized by severe nausea and vomiting.

[4] A pregnancy complication characterized by high blood pressure and signs of damage to another organ system, often the kidneys.

12. Respondent terminated the doctor-patient relationship with M.T. at approximately 27 weeks gestation, and the patient was instructed to continue care elsewhere in the third trimester. The patient had not found another qualified physician, and there was no written letter of termination in the file.[5] Upon termination of the doctor-patient relationship with M.T., her current medical problems were not spelled out. Only one alternative clinic was provided. Medical records were provided to the patient a week later.[6]

13. The medical records contain the sparse obstetrics flow sheet and additional hand written notations. The records lack proper documentation of the ER visits, syncopal episodes, and complaints related to anxiety. There is no record of the prescription for Ativan, the rationale therefor, time frame, or the duration of its intended usage. The discussion of risks related to the drug was not documented. The flow sheet does not document a referral to a cardiologist and his findings. Although other physicians had identified complications with the patient's pregnancy, these visits with the other physicians were not well documented, including their findings, treatment plans, and the like. There is no mention of which doctor will deliver the patient, a discussion of mode of delivery, or of the timing of the repeat cesarean section. There is also a lack of documentation of the social problems with which the patient was dealing.

14. The following acts or omissions committed by Respondent in her care and treatment of Patient M.T. constitute an extreme departure from the standard of care:

a. Offering the patient obstetric care despite having no admitting privileges at any hospital;

b. Seeing the patient antenatally at respondent's facility, and then having the patient simply present to the ER of the hospital to be delivered by a panel doctor who has minimal knowledge of the patient's medical history;

c. Failing to adequately limit the frequency and duration of the patient's usage of Ativan;

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[5] The reason for the withdrawal was stated as "now high risk."

[6] At that time, the patient was a newly diagnosed gestational diabetic. She required immediate diabetic counseling, dietary consultation, continued home glucose monitoring, follow-up fetal surveillance via ultrasounds and testing, and a planned delivery by cesarean section.

d. Failing to adequately ensure continuity of care to this high-risk patient after the termination of the doctor-patient relationship with M.T.;

e. Failing to adequately document the care and treatment provided to M.T.

15. Respondent's acts and/or omissions as set forth in paragraphs 9 through 14, inclusive, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts- 3 Patients)

16. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that she committed repeated negligent acts in her care of patients M.T., C.K., and Y.C. The circumstances are as follows:

17. The facts and circumstances in the First Cause for Discipline, above, are incorporated by reference as if set forth in full herein.

18. Respondent also committed repeated negligent acts in her care of patients C.K. and Y.C. The circumstances are as follows:

Patient C.K.

19. C.K. visited respondent on or about June 1, 2013 for liposuction of the patient's inner thighs. On June 15, 2013, C.K. underwent surgery with respondent consisting of liposuction of the inner thighs with oral sedation and local anesthesia. Respondent also treated C.K. with injectable fillers in the patient's right cheek. Following the procedures, C.K. observed that there was a severe depression/deformity and irregularity in her right inner thigh, as well as a lump in her right cheek, which had been treated with Juvederm, an injectable filler. Respondent attempted to treat/repair the irregularities observed by C.K. during follow-up visits. Nevertheless, C.K. was left with a contour deformity in her right inner thigh due to over-resection and uneven resection of fat during the liposuction procedure.

20. Respondent was unable to remove the "lump" in C.K.'s cheek, likely caused by the filler being injected into a vessel in the face causing an occlusion, because she did not stock

hyaluronidase in her office. Hyaluronidase is an enzyme that dissolves filler material, such as Juvederm.

21. Respondent was interviewed by representatives of the Board. At her interview, respondent stated that she did not know the cause of C.K.'s thigh deformity. She also stated that she did not consider liposuction to be surgery.

Patient Y.C.

22. Y.C. visited respondent on or about May 30, 2014 for liposuction of the patient's outer thighs, buttocks, and "love handles." In her operative report, respondent's diagnosis is "desires liposuction of outer thighs...". This is not a proper diagnosis. In the procedure section, respondent stated the procedure as "liposuction of love handles and flanks." Respondent failed to mention the outer thighs. The operative report fails to describe any anatomical structures. Respondent also failed to document the concentration of any medications added to the saline solution that was injected into the patients fat compartments during the tumescent liposuction. This is important because the amount of lidocaine used is unknown. Respondent did not record the patient's vital signs before, during, or after the liposuction procedure.

23. The following acts or omissions committed by respondent in her care and treatment of patients M.T., C.K., and Y.C. constitute repeated negligent acts:

Patient M.T.

a. Offering the patient obstetric care despite having no admitting privileges at any hospital;

b. Seeing the patient antenatally at respondent's facility, and then having the patient simply present to the ER of the hospital to be delivered by a panel doctor who has minimal knowledge of the patient's medical history;

c. Failing to adequately limit the frequency and duration of the patient's usage of Ativan;

d. Failing to adequately ensure continuity of care to this high-risk patient after the termination of the doctor-patient relationship with M.T.;

e. Failing to adequately document the care and treatment provided to M.T.

Patient C.K.

a. Over –resectioning of fat and injudicious liposuction in the patient's inner thigh;

b. Failing to know the cause of the deformity in the patient's inner thigh;

c. Failing to consider liposuction to be surgery;

d. Failing to stock hyaluronidase in respondent's office to address potential complications which may occur when injectable fillers are used.

Patient Y.C.

a. Failing to adequately document the patient's liposuction procedure in respondent's medical records;

b. Failing to adequately mention the anatomic area which was being treated;

c. Failing to adequately document the concentration of lidocaine and to record the lidocaine dose in mg/kg;

d. Failing to adequately document the patient's vital signs.

24. Respondent's acts and/or omissions as set forth in paragraphs 17 through 23, inclusive, above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Records)

25. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of her care and treatment of patients M.T., C.K., and Y.C.

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DISCIPLINARY CONSIDERATIONS

26. To determine the degree of discipline, if any, to be imposed on Respondent Adrienne Elizabeth Lara, M.D., Complainant alleges that on or about October 25, 2012, in a prior disciplinary action entitled *In the Matter of the Accusation Against Adrienne Lara, M.D.* before the Medical Board of California, in Case Number 05-2010-207998, Respondent's license was placed on probation for 35 months with terms and conditions for her care and treatment of two patients. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 51906, issued to Adrienne Elizabeth Lara, M.D.;

2. Revoking, suspending or denying approval of Adrienne Elizabeth Lara, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Adrienne Elizabeth Lara, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: September 9, 2016

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

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