



March 15, 2023

Senator Richard Roth, Chair  
Senate Committee on Business, Professions & Economic Development  
Assembly Member Marc Berman, Chair  
Assembly Committee on Business & Professions

Re: Medical Board Sunset Review

Dear Senator Roth and Assemblymember Berman:

The Medical Board of California's mission is to protect patient safety by disciplining dangerous doctors. For years, patients have flooded legislative hearings, board meetings and media headlines decrying what an investigation by the *Los Angeles Times* found was a "pattern of lenient discipline imposed by the board."<sup>1</sup>

These families' stories of injury and loss could have been prevented if the Medical Board did its job. **Medical Board Sunset Review legislation must guarantee patients' voice in the enforcement process, increase transparency of physicians' disciplinary histories, and ensure the board holds dangerous doctors accountable.**

The Board dismisses most complaints without discipline or explanation, takes years to investigate when it does act, and issues minor discipline for violations involving egregious harm or death, even when the doctor is a repeat offender. Doctors' histories are kept hidden from patients, and patients who are harmed and file a complaint with the Board are refused a voice in the enforcement process. These processes are failing to protect the public.

Patients and their family members are the Board's main source of information about potentially dangerous doctors. Yet the most common complaint we receive is about the Board's very first point of contact with the public. Once a patient files a complaint with the Board about harm they or a loved one suffered at the hands of a doctor, the board does not interview them before deciding whether to investigate or close their complaint.

In the last fiscal year, members of the public submitted 65% (6409) of the year's 9943 complaints. The Board closed 83% (8254) of pending cases at the Central Complaint Unit (CCU) without investigation (no interview).

---

<sup>1</sup> "Botched surgeries and death: How the California Medical Board keeps negligent doctors in business," *Los Angeles Times*, Jul. 14, 2021. <https://www.latimes.com/california/story/2021-07-14/how-california-medical-board-keeps-negligent-doctors-in-business>

→ **Sunset legislation must mandate that a patient or family member submitting a complaint be interviewed by the Board before a case is dismissed.**

It is inconceivable that the Medical Board would close a complaint involving potentially life-threatening negligence after a medical consultant gets only the doctor's side of the story. A member of the public who submits a complaint must have the chance to share facts the Board may otherwise never learn from interviewing the doctor, who can naturally be expected to defend their actions.

At last month's Board meeting, Board President Kristina Lawson acknowledged this problem, noting that the law the Board follows when triaging complaints (Business & Professions Code Section 2220.08) is biased in favor of physicians: "The balance is already in favor of a physician both being interviewed, providing an explanation, and then also providing expert testimony, literature etc. without the patient involvement there."

Board Vice President Dr. Randy Hawkins also said the Board should: "dig deeper, to see if we can get closer to what we are being asked to do by the public."<sup>2</sup>

The Central Complaint Unit is, however, only the start of the reforms needed at the Medical Board. **Sunset review legislation must also ensure the Board's focus on patient protection by:**

- **Mandating patients and their families have input at every stage of the enforcement process.**
- **Increasing transparency about a doctor's disciplinary history on the medical board website, and in the doctor's office.**
- **Strengthening the Board's enforcement tools so disciplinary actions are timely and match the offense.**

**Patients and their families must have input at every stage of the enforcement process.**

Once an injured patient or grieving family files a complaint with the board, they lose all rights.

If a case gets past CCU and is referred for investigation, Board investigators often refuse to accept new evidence from complainants, even if that evidence is an order issued by a state agency corroborating the events, or a test result that documents elements of a complaint.

---

<sup>2</sup> Quarterly Meeting of the Medical Board of California, Feb. 9, 2023. Agenda Item #10.  
<https://www.youtube.com/watch?v=7IX- auDswk>

Patients are prohibited from reviewing records submitted to the board about their own care for accuracy – resulting in decisions based on incomplete and even false information.<sup>3</sup> Complainants are not kept informed of the progress of investigations although they take 3-4 years on average to complete. And patients and family members are given no opportunity to address the board before a settlement or disciplinary decision is made.<sup>4</sup>

At every point, decisionmakers at the board are barred from hearing what happened from the patient’s point of view.

Sunset legislation should restore patients’ right to have a voice and role in the enforcement process. This must include, in addition to interviewing every complainant before their complaint is closed:

- A right to review records submitted about their own care and submit additional documentation during an investigation.
- A right to make an impact statement the Board will read or hear.
- And the right to be informed about the status of their case at every step.

### **Increase transparency about a doctor’s disciplinary history on the medical board website.**

Patients have little access to information about their doctors. Many report going to a doctor only to find out after the fact about their history of negligence leading to serious injury or a patient’s death.<sup>5</sup> This denies Californians the information they need to make an informed decision about their health care. Some of the most egregious stories of recent harm happened to patients who saw physicians that are repeat offenders as they were facing Medical Board discipline or criminal charges.<sup>6</sup>

When a consumer checks a doctor’s record at the Medical Board’s website, they must be able to trust the information they find is complete. Sunset legislation should require the physician profile on the site to clearly disclose, in language a lay person would understand:

- A doctor’s prior discipline, including license suspensions and revocations

---

<sup>3</sup> “Patient claims Pasadena surgeon ‘experimented’ on her and altered medical records to hide it,” *Pasadena Star-News*, Apr. 22, 2019. <https://www.pasadenastarnews.com/2018/12/17/patient-claims-pasadena-plastic-surgeon-experimented-on-her-and-altered-medical-records-to-hide-it/>

<sup>4</sup> “Patients are barred from doctor disciplinary hearings in California. That could change,” *Los Angeles Times*, Feb. 3, 2022. <https://www.latimes.com/california/story/2022-02-03/california-lawmakers-could-allow-patients-to-testify-at-doctor-disciplinary-hearings>

<sup>5</sup> “Orange County Plastic Surgeon Accused of Botching Procedures,” NBC 7, Jan. 6, 2023. <https://www.nbclosangeles.com/investigations/orange-county-plastic-surgeon-accused-of-botching-procedures/3067759/>

<sup>6</sup> “San Diego doctor and nurse not required to tell patients about involuntary manslaughter charges,” ABC 10, Dec. 24, 2021. <https://www.10news.com/news/local-news/san-diego-news/san-diego-doctor-nurse-not-required-to-tell-patients-about-involuntary-manslaughter-charges>

- If a doctor has lost hospital privileges
- Criminal charges

However, many patients never learn they can research a doctor's record at the Medical Board's website. In cases involving the most serious harm, the law must ensure that information reaches patients when they need it. Sunset legislation should require doctors to tell a patient before an appointment if they are:

- On probation for causing a patient serious injury or death. This is already the law for doctors disciplined for sexual misconduct and substance abuse under legislation passed in 2018.<sup>7</sup>
- Criminally charged with causing a patient serious injury or death.
- About to face practice restrictions, a license suspension, or revocation. Doctors are frequently granted a grace period by the Board before discipline takes effect, during which they continue to see patients. Patients are harmed in that interim.

### **Strengthen the Board's enforcement tools so discipline is timely and matches the offense.**

Unlike the state's other health care boards, the Medical Board does not investigate all complaints involving serious injury or death.<sup>8</sup> Doctors responsible for serious harm are slipping through the cracks.

When the board does discipline doctors, the punishment does not fit the crime. Public board member Eserick "TJ" Watkins has testified that disciplinary actions fall short of the board's own disciplinary guidelines more than 90% of the time.<sup>9</sup>

The standard of proof for the board to successfully discipline a doctor in California is higher than in 41 other states,<sup>10</sup> meaning cases are dropped that should be pursued. Without adequate funding, the Board is further hamstrung in its ability to protect the public or license doctors effectively.

To create more efficient, effective enforcement actions, sunset legislation must also:

---

<sup>7</sup> "California doctors must tell patients if put on probation for sexual misconduct under new law," *Los Angeles Times*, Sep. 20, 2018. <https://www.latimes.com/local/lanow/la-me-ln-doctor-probation-law-20180920-story.html>

<sup>8</sup> California Department of Consumer Affairs Complaint Prioritization & Referral Guidelines. [https://www.dca.ca.gov/enforcement/case\\_referral\\_guidelines.pdf](https://www.dca.ca.gov/enforcement/case_referral_guidelines.pdf)

<sup>9</sup> Testimony of Eserick "TJ" Watkins, Joint Sunset Review Hearing Senate Business, Professions and Economic Development and Assembly Business and Professions Committees, Mar. 19, 2021. <https://www.senate.ca.gov/media-archive/>

<sup>10</sup> Federation of State Medical Boards, "Standard of Proof." <https://www.fsmb.org/siteassets/advocacy/key-issues/standard-of-proof-by-state.pdf>

- Require the Board to meet its own minimum disciplinary guidelines or publicly justify why a decision deviates from the guidelines.
- Change the burden of proof from “clear and convincing” to “preponderance of evidence” so it is not harder to protect patients in California than in other states.
- Require the Board fully investigate every death and serious injury complaint, as other health care licensing boards are required to do.
- Raise licensing fees so the Board has the resources it needs to fully investigate and prosecute serious cases.

Many of these enforcement problems are exacerbated by the division between Board investigators at the Department of Consumer Affairs, and prosecutors who are housed in the Attorney General’s Office. The Initial Report of the Enforcement Monitor mandated during the last sunset review confirms this problem, and documents the delays, inefficiencies and rejected cases that result from this unnecessary split. We urge you to move complaint investigators and prosecutors under the same roof to help ensure meritorious cases involving the most egregious threats to public safety are prosecuted.

Finally, the success of reform will also hinge on a culture shift among board members to prioritize public protection. Rebalancing the Board so it has a public member majority would set it on the right track to do so.

Attached are the stories of some of the many patients and families who were failed by the Medical Board and are counting on the legislature to act. We look forward to working with you to hold doctors who cause harm accountable and keep patients safe.

Sincerely,

A handwritten signature in black ink that reads "Carmen Balber". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Carmen Balber

---

## Complaints to the board closed without an interview



**SHILPA AIRY** was a research scientist who ran a successful biotech consulting firm when she endured medical negligence at two separate hospitals in San Francisco that left her in two comas and ultimately cost her life. Seeking accountability, Shilpa's sister Alka filed a complaint with the Medical Board of California. Alka assumed when she filed her complaint that she would hear from a board investigator and be given the opportunity to explain the failures in her sister's care in detail. To her dismay, Alka was never contacted by the Board and her complaint was dismissed without action.



**MIKE BRADLEY of Menlo Park** was still working full time as a car salesman at 72 when a series of medical errors after surgery led to his death. Mike's wife Carol, an RN, filed a complaint with the Medical Board of California. She was never interviewed and after a few months Mike's case was dismissed, despite the fact that the California Department of Public Health had also investigated and issued a finding of their highest disciplinary level—level four immediate jeopardy.

---

## No interview denied the Board critical evidence



**JOSE IBARRA of San Jose** was having trouble breathing and was transported by ambulance to a local hospital. He died in the ER after being given a drug that could not be given with his medications. Jose's sister, Maria, filed a medical board complaint but it was dismissed at the Central Complaint unit with no interview and no contact. She later received Jose's toxicology report which provided evidence of the drug interaction. This information, which was not available at the time the complaint was filed, provided further evidence to support her complaint.

---

## No disclosure of past discipline, or current investigation, for patient harm



**DEMI DOMINGUEZ** was about to graduate college in Bakersfield and start her family at 23 when her life was cut short because her doctors failed to diagnose clear signs of a common pregnancy condition, preeclampsia. **Demi's baby Malakhi** was delivered by C-Section and also did not receive the care he needed to save his life. He lived for 18 hours before passing away in his father's arms.

Demi's family learned that the doctor responsible for her care at the hospital was under investigation by the Medical Board for the death of another mother when Demi saw him. That investigation was never disclosed to Demi or her family. Neither was the fact that he had lost hospital privileges, or multiple prior disciplinary actions for harming two other mothers and two other babies in his care. Ultimately the family learned he was connected to the injuries and deaths of fourteen other mothers and babies in Bakersfield. If they had known, or he had been sufficiently disciplined, Demi's and Malakhi's deaths could have been prevented.

---

## No disclosure of investigation or criminal manslaughter charges for patient harm



**MEGAN ESPINOZA** was a vibrant mother of two living in San Diego when she went to an ambulatory surgery center for a cosmetic procedure. When Megan stopped breathing on the operating table, her doctor tried unsuccessfully to resuscitate her for three hours before calling 911. Megan never regained consciousness. The investigation dragged on for three years before prosecutors filed criminal manslaughter charges against the doctor and nurse, and the Board filed an accusation the day later.

It was too late to protect **NATASSIA LOUIS**, who was left with a gaping hole in her stomach after surgery with the same doctor just months before charges were filed against him. He did not have to disclose the investigation to Natassia, or disclose when the criminal charges were filed. She did not learn of the manslaughter charges until she was tipped off just before she was about to return to the doctor for a third procedure to fix the errors.



The charges were also kept secret from a third patient, **PATRICIA PLASCENCIA**, who was left maimed and in serious pain when her surgery failed. She saw the doctor five months after he was charged with manslaughter but she was not informed of the charges, or the restrictions placed on his practice. Numerous other victims have since come forward.

---

## Board discipline fell well short of minimum guidelines



21-year-old **ALEX SMICK of Downey** died of an overdose of prescription medications given at the hospital where he sought relief.

Alex's parents turned to the Medical Board of California to hold his doctor accountable. The Medical Board took four long years to reach a decision. Tammy, Alex's mother, had to constantly call to make sure the case was still being investigated at all. During those years, the case was almost closed multiple times when the board lost documentation or the case got passed between multiple analysts and investigators. When the Attorney General's office finally filed an Accusation it recommended disciplinary action for Gross Negligence. The minimum penalty for gross negligence under the Board's Disciplinary Guidelines is a stayed license revocation with five years probation.

However, the AG's office negotiated a settlement behind closed doors, letting the doctor off with a Public Reprimand for repeated negligent acts – a slap on the wrist that went against the Medical Board's own disciplinary guidelines.

---

## Board failed to investigate case involving serious injury



**ANNETTE RAMIREZ of Manhattan Beach** entered the hospital for a routine hysterectomy. During the surgery her colon was nicked causing a severe sepsis infection. Annette was forced into a 4-month coma and woke with all four limbs amputated.

Annette submitted a complaint to the Medical Board of California to hold her doctor accountable for what happened to her. She never received a reply, so she called several times to follow up, but she was only put on hold, directed to different people, and hung up on. When she finally received a call back, they told her the case had been closed, as her complaint had been found “without merit.” She was never interviewed as part of an investigation and there had been no follow up despite the gravity of her injuries.