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

In the Matter of the Accusation Against: Carol Ann Gilmore, M.D. Physician's & Surgeon's Certificate No. C 41580 Respondent.	Case No. 800-2022-090165

DECISION

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

This Decision shall become effective at 5:00 p.m. on SEP 13 2024.

IT IS SO ORDERED: AUG 16 2024.

MEDICAL BOARD OF CALIFORNIA

Michelle A Bholat MD

Michelle Bholat, M.D., Interim Chair
Panel A

BEFORE THE
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DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

CAROL ANN GILMORE, M.D., Respondent

Agency Case No. 800-2022-090165

OAH No. 2023110172

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by videoconference and telephone on June 24, 2024.

Karolyn M. Westfall, Deputy Attorney General, represented complainant, Reji Varghese, Executive Director of the Medical Board of California (board), Department of Consumer Affairs, State of California.

Despite proper service of the notice of hearing this matter pursuant to Government Code section 11509, Carol Ann Gilmore, M.D., respondent, who represented herself, did not appear.

Complainant's request that respondent's default be entered, and that complainant be permitted to prove up the allegations set forth in the accusation was

granted. This matter proceeded as a default under Government Code section 11520. Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on June 24, 2024.

After the record was closed, complainant submitted an updated cost declaration for investigative activity and a request to re-open the record to include this updated cost declaration. The reason provided by complainant for failure to submit the document prior to the close of the record was that the complainant's investigator forgot to include it previously. Complainant's request to re-open the record is denied, that document is excluded, and it shall not be considered.

PROTECTIVE SEALING ORDER

The name of the patient in this matter is subject to a protective sealing order. No court reporter or transcription service shall transcribe the actual name of the patient but shall instead refer to the patient as Patient A, as set forth in a Confidential Names List admitted into evidence as Exhibit 27 and placed under seal. To protect privacy and confidential personal and medical information from inappropriate disclosure, a written Protective Order Sealing Confidential Records was issued. The order lists the exhibits ordered sealed and governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the order, provided that such documents are protected from release to the public.

FACTUAL FINDINGS

Jurisdictional Matters

1. On September 24, 1984, the board issued Physician's and Surgeon's Certificate Number C 41580 to respondent. Said certificate expired on November 30, 2023, and is in delinquent status. Respondent's certificate has no history of prior discipline.

2. On September 7, 2023, the board filed the accusation in this matter alleging two causes for discipline, namely: (1) gross negligence for respondent's care and treatment of Patient A by failing to appropriately medically manage Patient A on November 10, 2019, a pregnant patient in active withdrawal, and for respondent failing to perform an appropriate physical examination, work-up, and plan of treatment for Patient A, who had an undiagnosed acute medical condition on November 11, 2019; and (2) repeated negligent acts for respondent's care and treatment of Patient A as noted above. The accusation also sought cost recovery of costs of investigation and enforcement.

3. Respondent timely filed a notice of defense, and this hearing followed.

Patient A's Incarceration and Events Thereafter

4. The following factual findings were obtained from certified medical records regarding Patient A from the San Diego County Sheriff's Department. On November 6, 2019, at 12:21 a.m. Patient A, a 24-year-old female, was booked into the Las Colinas Detention facility on felony theft charges. At the time of her medical screening at intake, Patient A reported that she is pregnant, injects heroin daily, takes

Xanax[1] daily, and drinks alcohol daily. Patient A reported that she had experienced alcohol withdrawal symptoms, but she did not report having any seizures or hallucinations after periods of abstaining from alcohol. Patient A reported last taking heroin, alcohol, and Xanax about two hours before she was booked. Patient A also reported that she takes two Xanax pills every day.

5. Between November 6, 2019, and November 10, 2019, Patient A was housed in mainline housing at the Las Colinas Detention facility and was observed by staff and other inmates to be experiencing repeated intractable emesis, at times self-induced. On November 9, 2019, Patient A reported that she was experiencing "withdrawls [*sic*] and terminating prgnancy. [*sic*] been throwing up 3 days straight." Nursing notes indicate that Patient A was requesting termination of her pregnancy. Patient A was "encouraged to drink fluids as tolerated" and was taking Zofran by mouth.

6. On November 10, 2019, at 10:18 a.m., respondent entered a note in the medical records for Patient A wherein she noted as follows: "pt pregnant per her report about 5 weeks. She desires termination 'for sure'. She is WD from heroin and alcohol and c/o intractable vomiting." Respondent further diagnosed Patient A as follows: "IUP w vomiting and mild dehydration." Respondent noted that Patient A was "alert conversant" and "orthostatic.[2]" In respondent's note under the title "Plan"

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[1] Xanax is the trade name for alprazolam, a benzodiazepine, is a fast-acting tranquilizer used to treat anxiety and panic disorders.

[2] Further explanation of the meaning of the word "orthostatic" is provided below from expert testimony.

respondent wrote as follows: "Transfer to MOB obs for hydration, zofran 8TID referral to PP for termination." MOB means Medical Observation Beds located in the Las Colinas Detention Facility Medical Observation Unit. PP refers to Planned Parenthood.

7. On November 10, 2019, at 11:21 a.m., respondent entered a note in Patient A's medical records as follows: "CC pt was never TX for her WD, on Zofran now and will order Vistaril." This note means that Patient A was never treated for her withdrawal from alcohol, benzodiazepines, or heroin, and that Patient A is currently taking Zofran, an anti-nausea drug, and respondent will prescribe Vistaril.

8. On November 11, 2019, at 1:15 a.m., a nurses note in Patient A's medical records provides, in part, as follows:

> Emesis x1 clear liquid. Per other inmates IP continues to induce self to vomit in trash can and floor clear liquid. Skin pink & dry. Amb steady, normal gait, no SOB. Breathing even & unlabored. No shakes/tremors noted. Mood irritable, w/ episodes of agitation but cooperative.....IP was transferred from the ward to iso[3] cell d/t disruptive behavior. As IP was being escorted by deputies to cell ambulating w/ normal gait she was yelling excitedly, "I can't walk," although she was walking w/ bilateral strength in lower extremities & normal gait.

[3] ISO refers to the isolation unit of the facility.

9. On November 11, 2019, at 11:50 a.m. respondent wrote a note in Patient A's medical records as follows:

> Pt was not brought to clinic d/t her behavior. She wants TAB[4] and referral has already been made at PP.

Later that same day at 1:35 p.m. respondent wrote the following note in Patient A's medical records:

> Pt. not brought to OB clinic. She is in iso cell and had a spell not c/w seizure[5]. Pt was given 1 mg Ativan and evaluated by Dr. [V.L.]. Pt. desires TAB and that has been arranged.

10. On November 11, 2019, at 1:53 p.m. Dr. F.V. wrote a note in Patient A's medical records, in part, as follows:

> Seen in MOB for f/u. Finished SNP for ETOH/heroin WD, about 5 weeks pregnant, wants abortion (already has referral) was admitted to MOB for "fainting spells." According to Medical staff there has been high suspicion for I/P staging her "fainting spells" for second gain purposes. Doing better today, denies hx of seizures says has been vomiting all of her food and drinks, requesting IV hydration. Of note, I/P was witnessed self-inducing vomiting by putting fingers and at times whole hand into

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[4] TAB means therapeutic abortion.

[5] Not c/w means not consistent with.

mough [*sic*]. Denies other acute or chronic Medical issues. Agrees to go back to housing.

In that same note Dr. F.V. wrote as the assessment and plan to send Patient A back to mainline housing, instructed her to rest, ingest only small amounts of food and drink at a time, and refrain from self-induced vomiting. Dr. F.V. also placed Patient A on a full liquid diet for three days and noted that Patient A was already on Zofran.

11. On November 11, 2019, at 2:14 p.m. Dr. F.V. wrote another note in Patient A's medical records, in part, as follows:

> Emergency add-on. Was taken out of ISO room in MOB and placed into a wheelchair in order to be taken back to housing as discussed this AM, when I/P suddenly moved backward in wheelchair, stiffening up her entire body, and no longer responding. Was taken down to floor and placed back on mattress in her room. Apparently was holding her breath after ammonia was held under her nose for some time. O2 sat initially 87 with essentially otherwise normal VS. When I/P "woke up" she was A&O x3, breathing regularly, speaking in full sentences, but noted to have very cold hands and feet. Ativan 1 mg po had been ordered earlier by another provider upon arrival at the scene before this examiner arrived and it was eventually given to I/P who had no new complaints except for having felt weak again. Denies hx of WD seizures.

Dr. F.V. further wrote in this note under "assessment" and "plan" that Patient A suffered a "fainting spell" and "doubt true seizure and suspect second gain" and that "given risk for self-harm and unable to completely exclude Medical cause for claimed weakness and fainting spells, will keep in MOB for obs for one more day."

12. Video from November 11, 2019, beginning at 1:56 p.m. and ending at 2:16 p.m. from the Medical Isolation unit of the Las Colinas Detention facility shows Patient A in a wheelchair and stiff as described in the note above at paragraph 11. The video shows Patient A unresponsive at times and various nurses attempting to take her vital signs and give oxygen to Patient A. At one point respondent walks into the room and talks with the nurses while they are attending to Patient A. However, at no time during the video did respondent ever touch Patient A or even lean down to talk to Patient A while Patient A was laying on a mattress on the floor. A few minutes after respondent entered the room Dr. F.V. entered the room and began to attend to Patient A, who was laying on the floor. At 2:14 p.m. the video shows Patient A on the floor, moving and responding to nurses and guards, sitting up, taking a pill, and drinking water. Immediately thereafter, all people leave the medical isolation cell leaving Patient A alone. Patient A then lays back on the mattress on the floor.

13. A "Mandown Assessment" form in Patient A's medical records from the Las Colinas Detention Facility shows that on November 11, 2019, at 8:07 p.m. a nurse observed Patient A laying on her back in the medical isolation cell and was non-responsive, without pulse, and not breathing. Patient A was pale and cool to the touch with vomiting noted around her body. The nurses began cardio-pulmonary resuscitation (CPR) at 8:09 p.m. Patient A was given two doses of Narcan. Paramedics arrived at 8:16 p.m. and took over care of Patient A. Patient A was pronounced dead on scene at 8:23 p.m. by a physician from Grossmont Hospital.

Expert Testimony

14. James Arthur Rael, M.D., has been licensed to practice medicine in California since 1990. He is also licensed to practice medicine in the states of Hawaii, Oregon, Washington, Nevada, and Arizona. Dr. Rael is board certified in internal medicine. He attended San Francisco State University for his undergraduate degree and obtained his medical degree from University of California, San Francisco in 1989. He completed his residency in primary care internal medicine in 1992 at Highland General Hospital. Thereafter, Dr. Rael worked in private practice at Contra Costa Regional Medical Center (CCRMC), which is an umbrella for both hospitals and clinics, from 1994 to March 2023. Since March 2023, he has worked as the Medical Director for the West Territories of Aetna Health. Soon after beginning work at CCRMC, Dr. Rael took the position of Medical Director of CCRMC's five detention facilities. Thereafter, in addition to his position as Medical Director of detention facilities, Dr. Rael also took leadership positions at CCRMC at hospitals, including becoming Chair of the Patient Safety and Performance Improvement Committee, and Chair of the Utilization Management Committee. He also worked as the Chair of the Medical Quality Assurance Committee at CCRMC, where he oversaw quality care measures for hospitals and 11 clinics.

Dr. Rael worked as the Medical Director of the detention facilities for approximately 10 years, and in that role was responsible for oversight of physicians providing inmate care. During his time working as the Medical Director for the five detention facilities, he worked in the facilities for both male and female inmates. During that time, he also worked for the board and chaired the board's committee for credentialing detention facilities, which consisted of performing surveys of detention facilities throughout the State of California to ensure quality of care. Dr. Rael worked

on the committee for the board until the committee was disbanded. Additionally, Dr. Rael has worked for the board as an expert reviewer for over 20 years and opined on whether a physician's treatment or care was within the standard of care. The following factual findings are based on the testimony of Dr. Rael, as well as supporting documents received in evidence, such as his report.

15. Dr. Rael is familiar with the phrase "standard of care" and explained that the standard of care for a patient in a detention facility is the same as the standard of care for a patient in a hospital or clinic. He stated that the standard of care is the level of care, skill, and knowledge in the diagnosis and treatment ordinarily possessed and exercised by a prudent physician in the same or similar circumstances in the same time in question. Dr. Rael stated that there are varying degrees of departure from the standard of care, and that a simple departure from the standard of care involves a departure of a lesser degree than that of an extreme departure from the standard of care. An extreme departure from the standard of care constitutes gross negligence and is a want of even scant care.

16. Dr. Rael testified that he has treated hundreds of patients for alcohol withdrawal, and he has also treated hundreds of patients for benzodiazepine withdrawal during his career. He stated that patients withdrawing from alcohol and drugs is common in detention facilities. Dr. Rael explained that withdrawal means that once a person is dependent on drugs or alcohol, after stopping the use of those drugs or alcohol, then the person will experience physical symptoms from lack of the drug and alcohol. Specifically, withdrawal from alcohol use can be life-threatening, and withdrawal from benzodiazepines can be life-threatening. However, withdrawal from opioids is not life-threatening, but can make a person very ill. The standard of care of a patient experiencing withdrawal from drugs or alcohol will depend on the substance

they are withdrawing from. Additionally, if the patient is pregnant, then the standard of care will also be different because you are also concerned about the health of the unborn fetus. Any withdrawal can cause miscarriage of pregnancy or spontaneous abortion at any stage of the pregnancy.

Dr. Rael explained that for a pregnant patient experiencing withdrawal from alcohol, the standard of care requires the replacement of alcohol with benzodiazepines while also taking into account any other symptoms the patient may be having, such as fluid imbalances, dehydration or electrolyte imbalances. He explained that the typical alcohol withdrawal symptoms include vomiting, anxiety, shaking, high pulse, sweating, and potential seizures. Thereafter, the patient will experience delirium tremens, which is an acute issue and rapid onset of confusion caused by alcohol withdrawal that if not treated immediately will lead to death.

For a pregnant patient experiencing withdrawal from opioids, such as heroin, the standard of care requires that you replace the opioid with one that is easy to taper off. For example, with a pregnant patient withdrawing from heroin, you would replace the heroin with a low-level opiate such as Vicodin or Norco, which can be tapered over a three to four day period and for maintenance thereafter you can use methadone until the patient has no symptoms. He explained that the symptoms of opioid withdrawal include vomiting, dehydration from vomiting, sweating, body aches and pains, feeling sick, and not being able to eat or drink.

Dr. Rael explained that the standard of care for benzodiazepine in a pregnant patient requires the replacement of the benzodiazepine with another benzodiazepine that can be dosage controlled and slowly tapered. He explained that similar to alcohol withdrawal, benzodiazepine withdrawal has symptoms of nausea, vomiting, sweating, anxiousness, increased heart rate, and seizures if not treated.

17. Dr. Rael testified that the standard of care for a patient experiencing withdrawal from drugs or alcohol requires that the patient should be treated for withdrawal before symptoms manifest. Dr. Rael also reviewed the policy and procedures of the Sheriff's Department regarding the Las Colinas Detention facility, including the requirement that an inmate be provided medical screening prior to being booked into the facility to ensure that there are no acute medical or behavioral issues that needed to be addressed immediately, as well as the requirement that inmates with substance withdrawal must receive appropriate medical care. Dr. Rael stated that his opinions in this matter are consistent with the standards as set forth in those policies and procedures.

18. Dr. Rael reviewed respondent's care and treatment of Patient A in this matter and summarized his opinions regarding that care and treatment in a report and supplemental report, both of which were received in evidence. He testified that the medical screening of Patient A at the time of her booking into the facility showed that she was a daily user of heroin, alcohol, and alprazolam, with her last use of all those substances being only two hours prior to the booking. Patient A also indicated on that screening that when she had stopped taking those substances previously, she had withdrawal symptoms. As a result, Dr. Rael opined that Patient A was at a high risk of experiencing withdrawal from alcohol, opioids and alprazolam. Upon her booking at the facility, Patient A had been given a prescription for Zofran, also known as Ondansetron, which is an anti-nausea medication but does not treat withdrawal symptoms. Dr. Rael stressed that during Patient A's time at Las Colinas Detention Facility, Patient A was never given any medications to treat her withdrawal from benzodiazepines or from alcohol or from opiates.

Patient A was booked into the facility on November 6, 2019, and by November 9, 2019, Patient A signed a form requesting to see a physician because, as she wrote on the form, "withdrawls [*sic*]+ terminating pregnancy/been throwing up 3+ days straight." Dr. Rael noted that respondent entered a note into Patient A's medical records on November 10, 2019, at 10:18 a.m., wherein respondent writes that Patient A is five weeks pregnant, desires termination of the pregnancy, and is withdrawing from heroin and alcohol, and has intractable vomiting. Respondent also noted that Patient A is orthostatic, meaning that her blood pressure drops from moving from a laying position to a standing position, which Dr. Rael explains is caused by dehydration. Dr. Rael also noted that respondent did not complete a physical examination of Patient A. Under respondent's plan for Patient A in this note, respondent ordered that Patient A go to MOB to observe her for hydration, and also ordered Zofran, and referred her to Planned Parenthood for termination of the pregnancy.

Another note from respondent from November 10, 2019, at 11:21 a.m., shows that respondent noted that Patient A was never treated for her withdrawal and is on Zofran now. Respondent ordered Vistaril, which Dr. Rael explained is a medication that can treat low anxiety symptoms but is not a benzodiazepine and not a treatment for withdrawal. Dr. Rael opined that respondent's treatment and care of Patient A on November 10, 2019, was an extreme departure from the standard of care and constituted gross negligence because Patient A was experiencing acute withdrawal and respondent was aware of that but failed to treat or manage the withdrawal at all. He opined that the standard of care for treatment of Patient A on November 10, 2019, required respondent to do a physical examination, document it, order lab work for blood count levels and start an intravenous line for fluids to treat the dehydration, and order an EKG to monitor electrolyte abnormalities, as well as starting withdrawal medications for withdrawal from benzodiazepine, alcohol, and opiates. Respondent

simply did none of those things. If the facility did not have EKG equipment or ability to do intravenous treatment, then Patient A needed to be transferred to a hospital or a higher level of care. There were no such orders from respondent. Respondent's failure to do these things was an extreme departure from the standard of care.

19. Dr. Rael noted that Patient A was admitted to MOB on November 10, 2019, and was given hydration by mouth only with water, which Dr. Rael disagrees with because Patient A was vomiting as a result of her withdrawal and would not be able to keep water down as a result. Dr. Rael noted that early in the morning on November 11, 2019, Patient A was transferred to an isolation cell and her blood pressure was observed to be low. Nursing notes show that Patient A continued to vomit and was fainting. On November 11, 2019, Dr. F.V. also noted that Patient A was vomiting and fainting but failed to properly treat Patient A for withdrawal and ordered her moved to mainline housing. Later that day, when attempting to move Patient A to mainline housing, nurses observed Patient A to have a seizure by being verbally non-responsive, and having a stiff body while in a wheelchair (hereinafter referred to as the wheelchair incident). Patient A's oxygen level was low at 87 and was given oxygen. Dr. Rael testified that at this point, Patient A was in an acute situation and displaying abnormal behavior. Dr. Rael's review of respondent's testimony during the criminal trial of Dr. F.V., shows that after the wheelchair incident, respondent was contacted while she was in the OB/GYN clinic to respond to the MOB for Patient A because Dr. F.V. was not available. When respondent arrived, Patient A was laying on the floor and appeared angry and agitated. Respondent stated that due to the possibility of Patient A having a seizure, she ordered 1 mg of Ativan. However, Dr. Rael testified that while Ativan is a benzodiazepine, only 1 mg of Ativan is not appropriate for treatment of either a seizure or for withdrawal and is simply not enough. In the San Diego Sheriff's Department investigative report summarizing an interview with respondent,

respondent stated that there was no confirmation at the time of the wheelchair incident that Patient A had a seizure. However, Dr. Rael noted that respondent did not give the Ativan to treat withdrawal, so it is unclear why respondent gave the Ativan. During the time respondent goes to the MOB for Patient A on November 11, 2019, she does not touch the patient or even talk to the patient as shown on the video surveillance. A few minutes later Dr. F.V. arrives and takes over.

Dr. Rael opined that with regard to the November 11, 2019, wheelchair incident, respondent committed another extreme departure from the standard of care because this is another acute incident of Patient A exhibiting an acute problem consistent with withdrawal from benzodiazepine, alcohol, and opiates, namely seizure activity. Despite this, respondent did not come up with any assessment or treatment plan. Dr. Rael stated that because respondent first arrived on the scene of an acute incident with Patient A and ordered Ativan, this means she assumed care of Patient A. The standard of care requires that respondent perform an evaluation and create a treatment plan. By ordering Ativan, respondent ordered a form of treatment without first conducting an evaluation. Again Dr. Rael opined that respondent provided essentially no care to Patient A by failing to evaluate her and treat her, which is an extreme departure from the standard of care. Dr. Rael also stressed that the fact that Dr. F.V. subsequently arrived on the scene does not relieve respondent of her obligation to conduct an evaluation and treatment plan for Patient A in an acute situation.

Testimony of Board Investigator

20. Lucila Gojny is an acting supervising investigator for the Department of Consumer Affairs, Health Quality Investigation Unit (HQIU), in the San Diego Field office. She has worked for HQIU for eight years. Prior to working as a supervising investigator, she worked as an investigator at HQIU. Ms. Gojny is a California sworn

peace officer. She has received specialized training on conducting investigations with a focus on violations of the Medical Practice Act. Ms. Gojny investigates cases on behalf of the board and was assigned to investigate this matter in July 2022. The following factual findings are based on her testimony and supporting documents received in evidence, including her report.

21. Through her investigation of respondent, Ms. Gojny obtained all board certifications for respondent and learned that she is board certified in internal medicine. Ms. Gojny attempted to interview respondent as part of her investigation, but she was unable to do so. As part of her investigation, Ms. Gojny also obtained a compact disc (CD) from the San Diego District Attorney's office containing files and several hours of video surveillance from the Las Colinas Detention Facility and MOB and isolation cells where Patient A was located. Additional materials included on the CD were the policies and procedures from the facility, San Diego Sheriff Department's investigation report, and medical records for Patient A from the facility and other materials. Ms. Gojny reviewed all information on the CD including the surveillance video, which took weeks. Ms. Gojny testified that the time stamp on the video footage was one hour ahead of the actual time of the events.

22. Ms. Gojny testified that she is familiar with the physical appearance of respondent based upon her photograph from the Department of Motor Vehicles from her driver license, which she verified. Ms. Gojny testified and identified respondent on the video footage received into evidence from the surveillance footage and confirmed respondent's identity.

Costs of Enforcement and Investigation

23. Complainant seeks recovery of enforcement costs of $27,606.25 and investigative costs in an unknown amount, and expert reviewer costs of $2,000 pursuant to Business and Professions Code section 125.3.

24. In support of the request for recovery of enforcement costs, the Deputy Attorney General who prosecuted the case signed a declaration on June 18, 2022, requesting total enforcement costs of $27,606.25. Attached to the declaration is a document entitled "Master Time Activity by Professional Type." This document identifies the tasks performed, the dates legal services were provided, who provided the services, the time spent on each task, and the hourly rate of a Supervising Deputy Attorney General, four Deputies Attorney General, an analyst, and four paralegals from July 20, 2023, through June 18, 2024, for a total of $27,606.25 in prosecution costs for 126.75 hours of work.

25. In support of the request for recovery of investigation costs, a declaration of costs associated with the expert reviewer services from Dr. Rael was signed by Amy Cleveland, A.G.P.A. for the board certifying that Dr. Rael spent 10 hours reviewing the records, video and preparing his report in this case at a rate of $200 per hour for a total of $2,000. Additionally, a declaration signed by Joseph Vaugh, Commander, Department of Consumer Affairs, provided that Ms. Gojny began investigating this matter on July 1, 2022, and spent a total of 23.50 hours investigating this matter. The declaration included an "Investigator Log" providing the dates, number of hours, and tasks performed with a task description, for the work Ms. Gojny performed on this matter. However, the declaration included a column for hourly rate and total costs for Ms. Gojny's work, which was blank. Accordingly, no information was provided on the total costs incurred by Ms. Gojny and no information was provided on her hourly rate.

As noted above, after the record was closed, complainant submitted an updated cost declaration for investigative activity and a request to re-open the record to include this updated cost declaration. However, that request was denied.

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

27. The declaration of enforcement costs with the attachment complies with the requirements specificity of section 1042, subdivision (b), with regard to the attachment titled "Master Time Activity by Professional Type" for a total of $27,606.25. Accordingly, the enforcement costs are $27,606.25, which is found to be reasonable. The declaration of expert reviewer costs of investigation complies with the requirements specificity of section 1042, subdivision (b), for a total of $2,000, which is found to be reasonable. However, the declaration for other investigation costs was incomplete and does not comply with the requirements of section 1042, subdivision (b), and those costs are not allowed.

28. Accordingly, the total reasonable costs of enforcement and investigation of this matter are $29,606.25 This total is analyzed further below with respect to whether complainant established the causes for discipline as alleged in the accusation. Respondent did not present any evidence regarding her ability to pay costs or otherwise.

LEGAL CONCLUSIONS

The Purpose of Physician Discipline

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

2. Business and Professions Code section 2229 states: "Protection of the public shall be the highest priority" for the medical board."

Burden and Standard of Proof

3. Complainant bears the burden of establishing that the causes pled in the accusation are true. (*Martin v. State Personnel Medical Board* (1972) 26 Cal.App.3d 573, 582.)

4. The standard of proof in an administrative action seeking to suspend or revoke a physician and surgeon's certificate is "clear and convincing evidence." (*Ettinger v. Medical board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

5. Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.) The requirement to prove by clear and convincing evidence is a "heavy burden, far in excess of the preponderance sufficient in most civil litigation. [Citation.]" (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.) "The burden of proof by clear and convincing evidence 'requires a finding of high

probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind.' [Citation.]" (*Ibid.*)

Applicable Statutory Authority

6. Business and Professions Code section 2227 authorizes the board to discipline a licensee.

7. Business and Professions Code section 2234 states in part:

> The medical board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> [¶] . . . [¶]
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

Applicable Case Law

8. The standard of care requires that physicians exercise in diagnosis and treatment that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care is a matter peculiarly within the knowledge of experts; it presents the basic issue in a malpractice action and can only be proved by their testimony, unless the conduct required by the particular circumstances is within the common knowledge of the layman. (*Williamson v. Prida* (1999) 75 Cal.App.4th 1417, 1424; *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal. 4th 992, 1001.)

9. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.)

10. At one time, the standard of care required that a physician have the degree of learning and skill ordinarily possessed by practitioners in the same locality. But later the California Supreme Court formulated the standard of care as that of physicians in similar circumstances rather than similar locations. (*Borrayo v. Avery*

(2016) 2 Cal.App.5th 304, 310.) Geographical location may be a factor considered in making that determination, but, by itself, does not provide a practical basis for measuring similar circumstances. (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal. App. 4th 463, 470.) The essential factor is knowledge of similarity of conditions; geographical proximity is only one factor to be considered. (*Sinz v. Owens* (1949) 33 Cal.2d 749, 756.)

11. A physician is not necessarily negligent due to every "untoward result which may occur." (*Norden v. Hartman* (1955) 134 Cal.App.2d 333, 337.) A physician is negligent only where the error in judgment or lack of success is due to failure to perform any of the duties required of reputable members of the medical profession practicing under similar circumstances. (See *Black v. Caruso* (1960) 187 Cal.App.2d 195, 200-202.)

12. So far as the phrase has any accepted meaning, "gross negligence" is "merely an extreme departure from the ordinary standard of care." *(Franz v. Medical Board of Medical Quality Assurance* (1982) 31 Cal. 3d 124, 138, citing *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196 and *Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941.)

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

14. A repeated negligent act involves two or more negligent acts or omissions. No pattern of negligence is required; repeated negligent acts means two or

more acts of negligence. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

15. In determining the weight of each expert's testimony, the expert's qualifications, credibility and bases for the opinions were considered. California courts repeatedly underscore that an expert's opinion is only as good as the facts and reason upon which that opinion is based: "Like a house built on sand, the expert's opinion is no better than the facts on which it is based." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923.)

16. An expert's failure to consider all of the facts may make his opinions less persuasive (*People v. Coddington* (2000) 23 Cal.4th 529, 614) and the expert may be examined about whether the expert sufficiently took into account matters arguably inconsistent with the expert's conclusions. (*People v. Ledesma* (2006) 39 Cal.4th 641, 695.) An expert's opinion may be rejected if the reasons given for it are unsound. (*Kastner v. Los Angeles Metropolitan Transit Authority* (1965) 63 Cal.2d 52, 58.)

Evaluation

17. There is no other profession in which one passes so completely within the power and control of another as does the practice of medicine. The physician-patient relationship is built on trust. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 578-579.) The primary purpose of disciplinary action is to protect the public. (Bus. & Prof. Code, § 2229, subd. (a).) The Medical Practice Act emphasizes that the board should "seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies." (Bus. & Prof. Code, § 2229, subd. (c).) However,

"[w]here rehabilitation and protection are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

18. Dr. Rael credibly testified regarding his understanding of the definition and meaning of the phrases "standard of care," "gross negligence," and "simple negligence." Dr. Rael is particularly qualified to opine on the applicable standard of care for the treatment of Patient A in a detention facility, as he was the director of five such facilities for over ten years, and he is qualified to opine regarding the treatment of a pregnant patient experiencing withdrawal from alcohol, benzodiazepines, and opiates, and has treated hundreds of such patients during his career. Dr. Rael credibly testified that respondent's treatment and care of Patient A on November 10, 2019, and on November 11, 2019, each constituted independent acts of extreme departures from the standard of care because she simply provided no treatment for Patient A's withdrawal from alcohol, benzodiazepines, and opioids, which respondent had direct knowledge of based on Patient A's admissions of taking those drugs only two hours prior to her booking. Despite her knowledge and repeated notes indicating respondent was aware of Patient A's withdrawal from those substances, she simply provided absolutely no treatment for the withdrawals as required by the standard of care. Respondent also failed to provide any evaluation of Patient A with blood tests and EKG to evaluate her or provide any treatment plan for Patient A. As a direct result of those failures, Patient A died from a lack of treatment for withdrawal. Respondent committed these extreme departures from the standard of care on two occasions, specifically on November 10, 2019, and on November 11, 2019, constituting repeated negligent acts.

19. Respondent failed to appear at the hearing and failed to provide any evidence in mitigation or explanation. No evidence was presented to contradict Dr. Rael's credible and convincing testimony.

20. Accordingly, after consideration of all evidence presented, the only disciplinary measure that will ensure public protection is the revocation of respondent's license.

Cause Exists to Discipline Respondent's License

21. Cause exists under Business and Professions Code section 2234, subdivision (b), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in gross negligence with respect to her care and treatment of Patient A for failing to appropriately medically manage Patient A for her withdrawal from alcohol, benzodiazepine, and opiates on November 10, 2019, and for failing to perform a physical examination, work-up, and create a plan of treatment for Patient A on November 11, 2019.

22. Cause exists under Business and Professions Code section 2234, subdivision (c), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in repeated acts of negligence with respect to Patient A based upon respondent's failure to properly treat and care for Patient A on November 10, 2019, and on November 11, 2019.

Costs of Enforcement

23. Business and Professions Code section 125.3, subdivision (a), authorizes an administrative law judge to direct a licensee who has violated the applicable

licensing act to pay a sum not to exceed the reasonable costs of investigation and prosecution. The reasonable costs in this matter are $29,606.25.

24. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45, the California Supreme Court set forth five factors to be considered in determining whether a particular licensee should be ordered to pay the reasonable costs of investigation and prosecution under statutes like Business and professions Code section 125.3. Those factors are: whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Ibid.*)

25. Applying the *Zuckerman* factors to this case leads to the following conclusions: respondent failed to appear at the hearing, provided no defense to the allegations, and provided no evidence or argument to establish that she does not have the financial ability to pay costs; and the scope of the investigation was appropriate in light of the alleged misconduct.

26. After consideration of the *Zuckerman* factors in this case, a reduction of the costs of enforcement is not appropriate. Accordingly, an appropriate cost amount of $29,606.25 is deemed reasonable and respondent shall pay that amount to the board prior to any reinstatement of her license.

ORDER

IT IS HEREBY ORDERED that respondent Carol Ann Gilmore, M.D.'s Physician's and Surgeon's Certificate No. C41580 is revoked. Respondent shall pay the amount of

$29,606.25 of costs of investigation and enforcement to the board prior to any reinstatement of her Physician's and Surgeon's Certificate.

DATE: July 22, 2024

Debra D. Nye-Perkins

DEBRA D. NYE-PERKINS
Administrative Law Judge
Office of Administrative Hearings