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

In the Matter of the Accusation Against:	)	
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	)	
	)	
FRANCISCO S. PARDO, M.D.	)	**File No. 10-2008-191248**
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	)	
	)	
Physician's and Surgeon's Certificate No. G57474	)	
	)	
	)	
Respondent.	)	
	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 18, 2011.

IT IS SO ORDERED October 21, 2011.

MEDICAL BOARD OF CALIFORNIA

By: _____
Hedy Chang, Chair
Panel B

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

In the Matter of the Accusation Against: FRANCISCO S. PARDO, M.D. Physician's and Surgeon's Certificate No. G57474, Respondent.	CASE No. 10-2008-191248 OAH No. 2010100630

PROPOSED DECISION

This matter came on regularly for hearing before Roy W. Hewitt, Administrative Law Judge, Office of Administrative Hearings, in San Diego, California on September 12, 13, and 14, 2011.

Deputy Attorney General Abraham M. Levy represented complainant.

Dr. Francisco S. Pardo (respondent) personally appeared and was represented by Steven H. Zeigen, Esq.

Oral and documentary evidence was received and the matter was submitted on September 14, 2011.

FACTUAL FINDINGS

1. The Accusation against respondent was filed by Linda K. Whitney (complainant), while acting in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California (the Board).

2. On June 16, 1986, the Board issued respondent Physician's and Surgeon's Certificate No. G57474. Respondent's certificate was in full force and effect at all times relevant to the instant proceedings.

The Allegations Against Respondent

3. A listing of the allegations against respondent will aid in the focus of the factual findings. The Accusation alleges the following bases for disciplinary action against respondent's license:

> 7. Respondent committed gross negligence in his care and treatment of patient R.G. which included, but was not limited to, the following:
>
> (a) On or about January 29, 2004, respondent performed the incorrect procedure on patient R.G.
>
> * * *
>
> 10. Respondent committed repeated negligent acts in his care and treatment of patients F.C. and A.M. which included but was not limited to, the following:
>
> (a) Respondent failed to obtain consent for radiation therapy of patient F.C.'s right hip.
>
> (b) On or about July 1, 2004, respondent acquiesced to the division chief's adjusted fields and treated patient A.M. with radiation therapy based on the improperly designed fields.

The Facts Relevant to Assessing the Validity of the Allegations Against Respondent.

Respondent's care and treatment of patient R.G.

4. During December of 2003, respondent, a radiation oncologist, began treating R.G., a 45 year-old female, who had been diagnosed with cervical cancer. Patient R.G. began receiving radiation therapy. The therapy was provided pursuant to respondent's prescriptions.

5. The radiation oncology prescription sheet for R.G. reveals that respondent began prescribing brachytherapy using tandem and ovoids[1] (T&O) in

[1] Tandem is a small metal tube, which is placed inside the uterus to provide treatment to that area. Ovoids are round hollow metal holders that are placed adjacent to the cervix.

December of 2003. R.G. received approximately three T&O brachytherapy treatments prior to January 29, 2004.

6. On January 29, 2004, patient R.G. appeared at the University of California, San Diego Medical Center Radiation Oncology Division (UCSD) for a simulation.[2] Respondent had been on medical leave from UCSD for two weeks immediately preceding R.G.'s scheduled simulation. Consequently, respondent was not the doctor assigned to perform R.G.'s simulation on January 29, 2004. Respondent had returned to work a couple days prior to January 29, 2004, however, he was not made aware of the fact that Dr. S., the hospital Division Chief, was scheduled to perform a simulation on R.G. Respondent had nothing to do with the scheduling of R.G.'s brachytherapy on January 29, 2004. Unbeknownst to respondent, R.G. had been erroneously scheduled for a simulation using a vaginal cylinder, as opposed to the correct procedure, the procedure she had been receiving, utilizing a T&O.

7. The simulation room was "set up" with the instruments and equipment necessary to perform a vaginal cylinder simulation, not a T&O. Dr. S. could not be located when it was time to perform the simulation on R.G. so respondent became unexpectedly involved. Respondent entered the simulation room. R.G. had catheters placed and was ready for the scheduled vaginal cylinder simulation. The simulation room was set up for a vaginal cylinder simulation and respondent was presented with an instrument tray for a vaginal cylinder procedure. Consequently, respondent performed a bi-manual examination of R.G. during which respondent thought he felt a cervix. Upon feeling the cervix respondent thought to himself, "well, you know, if this is a vaginal cylinder case, why would she have a cervix?" (Exh. 23) Nonetheless, respondent placed the vaginal cylinder and the simulation went forward, i.e., films were taken. It is unclear who first noted that a vaginal cylinder simulation had been performed as opposed to a T&O, but respondent recognized that he had made a mistake by not having read R.G.'s chart prior to commencing the placement of a vaginal cylinder.

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[2] The common custom and practice at UCSD concerning brachytherapy is as follows: a patient undergoes a simulation. If the procedure involves a T&O then after the simulation, the patient receives high dose rate (HDR) radiation brachytherapy treatments to the treatment site(s). The brachytherapy treatment(s) when a T&O is used occurs on the same date as the T&O because of the invasive nature involved in the use of a T&O and the necessity of anesthesia during the T&O procedure. Unlike T&O, however, if the treatment involves the use of a vaginal cylinder, the vaginal cylinder is placed in the vaginal vault, xray "films" are taken, the films are read, the vaginal cylinder is removed, the patient is scheduled three to four days from the date of the simulation for the actual brachytherapy procedure, and the patient goes home until the scheduled brachytherapy date.

During respondent's testimony before the UCSD Judicial Review Panel, the following exchange occurred:

> Q And is it a typical procedure for you to proceed with the procedure without reviewing that prescription for [sic] your notes?
> A Actually, it's not.
> Q So did you review your prescription or notes prior to inserting the vaginal cylinder?
> A No, I don't believe I did when I put the cylinder in. I did afterwards.
> Q So if you had reviewed your prescription, even though it doesn't say T and O versus vaginal cylinder, you would have - - would you have been able to realize that it should not have been a vaginal cylinder?
> A I think there's a good chance that I would have - - it would have made me focus on the actual prescription, and I probably would have noticed it before I did the bimanual exam, which is when I noticed there was a cervix.
> Q So is it considered acceptable practice to perform that procedure without looking at your prescription or without referring to your notes on that patient?
> A No. I think that I should have looked at it, and I think it's the right thing to do. (Exh. 23, AGO-02691)

8. Respondent's expert, Leslie Botnick, M.D., of Vantage Oncology, reviewed the matter concerning respondent's care and treatment of R.G. In a June 10, 2010 letter to respondent's counsel, Dr. Botnick stated: "I do believe that patient (R.G.)['s] chart should have been reviewed more carefully. Though no harm was done, I do believe this represents a minor departure from the standard of care." (Exh. 24)

9. Complainant's expert, Dr. Jeffrey V. Kuo, M.D., agreed that respondent's care and treatment of patient R.G. was below the standard of care, but, based on his belief that a "radiation safety recordable event . . . a misadministration" of high dose radiation was going to follow the simulation, Dr. Kuo concluded that respondent's "performance of an incorrect procedure on this pt, . . . represents an extreme departure from the standard of care." However, during the hearing Dr. Kuo testified that he would modify his opinion that respondent's actions with regard to patient R.G. represented an extreme departure from the standard of care, and conclude that the departure was only a simple departure, if respondent had been the person who

discovered the mistake.[3] As it turned out, R.G. was not scheduled for high dose radiation after the simulation had been performed; rather, pursuant to hospital protocol, if the mistake had not been immediately discovered, the vaginal cylinder would have been removed after the simulation, patient R.G. would have been scheduled for brachytherapy three to four days from the simulation and she would have gone home until the scheduled radiation therapy date. In all likelihood, the vaginal cylinder error would have been discovered during this hiatus and the correct procedure would have been scheduled. In sum, although patient R.G. was subjected to an unnecessary procedure, the danger of harm was *de minimus*.

10. Based on all of the evidence presented during the hearing concerning patient R.G., it is found that respondent's performance of an incorrect procedure on R.G. was precipitated, in large part, by the errors of other professionals; however, the error on respondent's part, i.e., not reviewing R.G.'s chart prior to performing the procedure on R.G., represented a simple departure from the standard of care.

Respondent's care and treatment of patient F.C.

11. Patient F.C., an adult female, with a diagnosis of metastatic squamous cell carcinoma, originally of urethral origin, began treatment with respondent in October of 2002. On July 21, 2003, F.C. presented to respondent because "the patient has developed marked left hip pain . . . . Recent bone scan indicates uptake in the left acetabular area." (Exh. 4, AGO 00589) Respondent examined F.C. and the resulting assessment/plan states, in pertinent part: "A patient with metastatic involvement of the left hip region for consideration of palliative radiation therapy. . . . The benefits and risks of radiation therapy were explained to the patient, she understands these, and wishes to proceed. Informed consent was obtained." (Exh. 4, AGO 00589) The informed consent signed by F.C. states that F.C. understood the treatment was for metastatic urethra cancer and that the areas to be treated were, the "(L) acetabulum and ilium." (Exh 4, AGO 00569)

12. Some time prior to commencement of palliative radiation therapy to F.C.'s left hip, which was scheduled for July 24, 2003, F.C. complained of pain in her right hip area. Consequently, "In spite of the greater symptomatology of the left side, the right side was simulated first and started treatment prior to simulation and treatment of the . . . left side." (Exh. 4, AGO 00397) Respondent testified that because of F.C.'s complaint of right hip pain, he decided to "treat most of the bony pelvis, sequentially, with a palliative course of radiation therapy." Respondent testified that he informed F.C. of this change in the treatment plan and that F.C. consented to expanding the treatment area. Respondent's testimony in this regard was corroborated

[3] The record is unclear as to who discovered that a T&O should have been scheduled and performed. It appears, however, that it was a technician who discovered the mistake.

by the testimony of Christine Romero, a Nurse Case Manager, who was assisting respondent with F.C. Romero's testimony is paraphrased as follows: F.C. was the last patient of the day. She was accompanied by her daughter or niece and was taken to treatment room #3. . . . The patient told respondent three times that she really hurt in the area of her right hip. F.C. was taken to the simulator. Respondent decided to treat her entire pelvis but not both sides at the same time. Instead, respondent decided to begin treatment on the right side of F.C.'s pelvis and then transition to the left side. Respondent told F.C. two times about this change in the treatment plan, F.C. seemed to understand the change and she received treatment to her right hip area later that day[4]. Although oral authorization for the treatment to F.C.'s right hip area appears to have been given, respondent failed to obtain a signed, written informed consent form, such as that obtained on July 21, 2003 for the left hip area.

13. F.C. received radiation therapy to her "Rt. Hip" on July 24, 25, 28, 29, 30, 31, and August 1, and 4, 2003. Then, on August 6 and 7, 2003, her left and right hip were treated and on August 8, 2003, respondent transitioned to F.C.'s left hip area and treated her left hip on August 8, 11, 12, 13, 14, 18, 19, and 20, 2003.

14. Respondent testified that he did not obtain a written consent from F.C. for treatment of her right hip because he was treating the "same boney structure," i.e., the pelvis, and he did not believe a new consent form was necessary.

15. The consent form obtained from F.C. on July 21, 2003 was specific to her left hip area, not the right hip area or total pelvic area. This evidences that the hospital's custom and practice is to obtain very specific written informed consents from patients. Additionally, respondent's reasoning would be more persuasive if, he had commenced treatment to the total pelvic area. He did not. Instead he treated only the right hip area on nine separate treatment dates before involving the left hip in the treatment process. Consequently, complainant's expert's testimony is credited over that of respondent's expert. Complainant's expert was aware of the fact that "[Respondent] and Nurse Gibson [a.k.a. Romero] report counseling about treatments to the right side;" however, "absence of a consent for radiation therapy to the right hip does constitute a simple departure from the standard of care." (Exh 17, Ago 03991) Consequently, respondent's failure to obtain an appropriate written consent form for treatment of F.C.'s right hip constituted an act of negligence. Since respondent did inform F.C. about the change in treatment plan the failure to obtain the written

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[4] Since the medical records reveal that F.C.'s first radiation treatment occurred on July 24, 2003, it is reasonable to conclude that July 24, 2003 was the date F.C. first complained of right hip pain and the date that respondent changed the treatment plan to begin treating F.C.'s right hip area instead of commencing treatment on her left hip area, as originally contemplated on July 21, 2003, when the written, signed informed consent was obtained from F.C.

consent form for treatment of F.C.'s right hip is considered to be a technical, *de minimus*, violation of the standard of care.[5]

Respondent's care and treatment of patient A.M

16. On June 1, 2004, patient A.M., a then 45 year-old male, was evaluated by respondent. A.M. had a past medical history consisting on an orhiectomy at age 17 for testicular cancer and a 2004 abdominoperineal resection for rectal cancer. Respondent staged A.M.'s rectal cancer as "T3, N1, MO adenocarcinoma of the rectum post abdominoperineal resection" and recommended postoperative radiation therapy. (Exh 6, AGO 01025) Respondent obtained A.M.'s consent for treatment and during a subsequent simulation process on June 15, 2004, determined the size of the treatment field. The treatment field determined to be appropriate by respondent adequately covered A.M.'s postoperative surgical scar.

17. On June 21, 2004, A.M. began curative radiation treatment to the treatment field delineated by respondent.

18. On July 1, 2004, Dr. S., the hospital Division Chief, adjusted the treatment field for A.M. by increasing the field by 3.5 cm inferiorly. Presumably, this was done to ensure that A.M.'s perineal scar was included in the treatment area. Prior to treatment of the newly designated treatment field respondent became aware of the change and discussed the matter with Dr. S. The two disagreed and Dr. S. directed that the treatment be given to the expanded area. Respondent testified that he "argued with [Dr. S.] about the treatment." However, Dr. S. "took over the case," "adjusted the wire [setting out the treatment field]" and treatment was done pursuant to the treatment field, as adjusted by Dr. S. Respondent was in a tough spot. He disagreed with Dr. S.'s assessment and decision, A.M. was respondent's patient and respondent was primarily responsible to A.M. Respondent believed that Dr. S.'s decision was "sub optimal" but not below the standard of care. The increased radiation to A.M. would only be approximately one percent, so respondent allowed A.M. to be treated according to Dr. S.'s direction instead of raising a ruckus with his Division Chief. By acquiescing to Dr. S.'s treatment field change respondent's actions, as A.M.'s treating physician, fell below the standard of care. Again, as in the other two cases concerning patients R.G. and F.C., respondent's deviation from the standard of care was *de minimus*.

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[5] It was a clerical error, that in certain circumstances not present here, could subject respondent and/or the hospital to legal exposure, as opposed to a treatment error. Thus, F.C.'s health, safety and/or welfare were not jeopardized.

The Hospital Environment

19. Actions do not occur in a vacuum; thus, it is necessary to evaluate the environment surrounding each situation to determine the magnitude of any departures from the standard of care and the magnitude of any resulting, remedial, disciplinary action(s). In respondent's case, it became readily evident via the documents and witness testimony that the environment at the hospital during the relevant time-frame, late 2002 through 2004 was, as one of the witnesses phrased it, "toxic." The environment and atmosphere was "less than congenial" and the physicians, nurses, technical staff and clerical staff were not working as a team. Oncology is a team oriented area of practice. Physicians rely heavily on their teammates to help ensure that mistakes are minimized or eliminated. Here, there was a system error; the team had broken down and the dictatorial atmosphere at the hospital became a breeding ground for discontent and patient care errors. This does not excuse respondent or any reasonably prudent physician in the same or similar circumstances from their duty to cause no harm and ensure quality care for their patients. Ultimately, it is the treating physician who is responsible for ensuring patient errors do not occur and that patients receive quality care. Respondent fell short in this regard, as concerns the three patients in this case; however, the mitigating circumstances somewhat ameliorate his relatively minor shortcomings.

Respondent's Lack of Prior or Subsequent Discipline

20. Except for the three cases described here, R.G., F.C. and A.M., respondent has no record of any disciplinary actions against his license. All three of these cases occurred within a two-year time span, at the same location. This indicates that respondent's negligent acts were more situational in nature, and are not indicative of fundamental flaws in respondent's clinical knowledge or skills; rather, the acts were isolated in time and place, without likelihood of reoccurrence. Additionally, a review of complainant's expert's report reveals that the expert evaluated a great number of allegations against respondent and concluded that the majority of the allegations were unfounded; respondent's actions were within the standard of care.

LEGAL CONCLUSIONS

1. Cause does not exist for discipline pursuant to Business and Professions Code section 2234, subdivision (b) because, as set forth in Findings 4 through 10, respondent was not grossly negligent in his care and treatment of patient R.G.

2. Cause exists for discipline pursuant to Business and Professions Code section 2234, subdivision (c) because it was established by clear and convincing evidence that respondent committed repeated negligent acts in his care and treatment of patients R.G., F.C., and A.M.

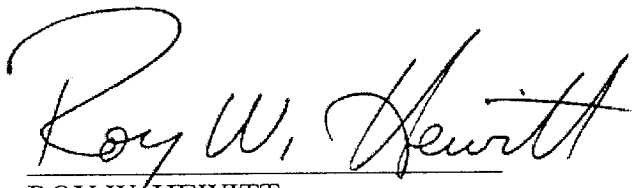
3. Considering the *de minimus* nature of the departures from the standard of care in conjunction with the passage of time since the events in question occurred (seven years), and the fact that respondent's violations were situational in nature, no valid administrative purpose would be served by any action other than issuing a public letter of reprimand to respondent. A public letter of reprimand serves to impress upon respondent and other practitioners the fact that patient care is paramount; physicians may not succumb to pressures that in any way compromise the care and treatment of their patients.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Respondent shall receive a written public reprimand for his actions. Should the Board so elect, this decision shall serve as that reprimand.

Dated: September 26, 2011.



ROY W. HEWITT
Administrative Law Judge
Office of Administrative Hearings