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

In the Matter of the Accusation Against: **Donald Clyde Willis, M.D.** **P.O. BOX 10818** **San Bernardino, CA 92423-0818** **Physician's and Surgeon's Certificate No. G 35712,** Respondent.	Case No. 800-2017-036455 **A C C U S A T I O N**

PARTIES

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

2. On or about October 17, 1977, the Medical Board issued Physician's and Surgeon's Certificate Number G 35712 to Donald Clyde Willis, 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 June 30, 2021, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
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> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (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.
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> (b) Gross negligence.
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> (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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

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

6. 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)

7. Respondent's Physician's and Surgeon's Certificate Number G 35712 is subject to disciplinary action under section 2227, as defined by section 2234, subdivision (b), in that he committed act(s) and/or omission(s) constituting gross negligence. The circumstances are as follows:

8. At all times relevant to this Accusation, Respondent practiced at Family Planning Associates (FPA) at various clinics throughout California, including Bakersfield. Respondent's duties included performing surgical abortions. Respondent currently only practices gynecology in an office setting in Fresno and Modesto, and ceased the surgical side of his practice approximately three years ago. Respondent is Board Certified in obstetrics and gynecology.

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Patient A[1]

9. On or about February 3, 2017, Patient A presented to Respondent at approximately 28 years old, G2P1, desiring an abortion. An ultrasound examination revealed the gestational age to be approximately 17 3/7 weeks. Respondent placed three dilapan osmotic dilators, and scheduled Patient A for a dilation and evacuation procedure the following day.

10. On or about February 4, 2017, Patient A presented for her dilation and evacuation procedure. The procedure itself was uncomplicated, and Respondent placed a Nexplanon contraceptive device at the conclusion of the procedure. Postoperatively, Patient A's bleeding began to increase. Respondent took Patient A back to the operating room, re-aspirated, and under ultrasound, a small amount of additional tissue was removed. Postoperatively, ultrasound revealed additional bleeding outside Patient A's uterus measuring approximately 6x5x3 cm. Respondent believed that this was intraperitoneal bleeding from perforation or adnexal bleeding secondary to "stretching of tissue." Respondent transferred Patient A to the hospital. The hospital did not find any evidence of intraperitoneal bleeding, signs of perforation, or free air. Patient A's blood count and vital signs remained stable, and she was eventually discharged. Respondent failed to document numerous pertinent facts in the medical record of Patient A related to her dilation and evacuation procedure. Respondent did not document the size of the dilator or the curette used in the operation. Respondent did not document the type of forceps used for decompression. Respondent did not document a description of the fetal tissue removed in regards to fetal parts in a operation that involved respiration. Respondent did not document an operative note for Patient A's respiration. In addition to the missing documentation in the operative note, Respondent's medical records for Patient A include many blank spaces on the preprinted medical record forms. Respondent did not document the Nexplanon insert within the handwritten portion of the dilation and evacuation procedure, although it is electronically entered in a separate section of the medical record. Respondent repeatedly failed to document pertinent information in the medical record of Patient A, which constitutes gross negligence.

[1] To protect the privacy of the patient involved, the patient's name has not been included in this pleading. Respondent is aware of the identity of the patient referred to herein.

Patient B

11. On or about August 19, 2017, Patient B presented to Respondent at approximately 23 years of age, G2P1, seeking an abortion. Respondent determined her gestational age to be approximately 14 2/7 weeks. Towards the end of the procedure, Respondent noted that Patient B was suddenly jerking, and the tenaculum caused a tear of the cervix with subsequent blood loss of approximately 200 ml. Respondent determined that he could not obtain the needed exposure and visualization at the clinic to address the bleeding due to Patient B's morbid obesity. Respondent called an ambulance and transferred Patient B to the hospital. Respondent was uncertain if the calvarium was in Patient B's uterus or vagina at the time of transfer. At the hospital, the emergency room staff immediately requested an OBGYN consultation, and Patient B was taken to the operating room for completion of the surgery. Tissue was removed by suction curettage, and the pathology report stated that "fetal tissue" was part of the specimen recovered. Patient B recovered without complication, and was discharged from the hospital.

12. Respondent did not document was removed, and what was not removed ruing his incomplete dilation and evacuation surgery prior to transferring Patient B to the hospital. Respondent's failure to document these details, prevents subsequent physicians from knowing if the termination was completed. Respondent's failure to document what tissues were removed during surgery prior to transferring Patient B to the hospital constitutes gross negligence.

Patient C

13. On or about October 3, 2017, Patient C presented to Respondent for an abortion at 23 years of age, G4P3, with a history of two prior cesarean sections. Respondent estimated the gestational age to be approximately 11 1/7 weeks. Respondent performed the surgery using Hegar dilators to dilate the opening to 11 mm, and a #11 cannula vacuum for suction, despite not being able to clearly visualize the external os of the cervix. During surgery, no tissue passed, blood loss was estimated at 500 ml, but there was no bleeding observed from her vagina. Respondent did not document any fetal tissue removed from Patient C. Patient C's vital signs became unstable, 911 was called, and she was transferred to the hospital. Patient C was treated for hemorrhagic shock at the hospital, and imaging revealed a right adnexal mass consistent with

an intraperitoneal hematoma. Patient C received 4 units of blood and proceeded to surgery. In surgery, Patient C suffered a cardiac arrest, was successfully resuscitated. The surgeons conducted an exploratory laparotomy, total abdominal hysterectomy, right salpingo-oophorectomy for a right sided uterine perforation and extensive damage to the right ovary and right fallopian tube. Patient C's pregnancy was removed with the uterus, and she received 10 additional units of blood. Five days later, on October 8, 2017, Patient C was discharged from the hospital.

14. Respondent did not document an operative note for Patient C's surgery. Although there is a later entry in the medical record that Respondent suffered an injury, there is no documentation to correct or complete the operative note for Patient C's operation. Respondent's failure to document an operative note for Patient C's operation constitutes gross negligence

15. Respondent did not take into account potential risk factors for Patient C's surgery. Respondent should have considered any unstable vital signs, abnormal anatomy, medication use, or previously unspecified allergies. Respondent did not visual a normal cervical opening during Patient C's procedure, and was unable to perform the surgery safely without imaging or other assistance. Respondent could have rescheduled the surgery so that he could have the imaging assistance needed, but he elected to proceed by blindly dilating where he believed the cervical opening was located. Respondent perforated the uterus on the right side, causing major injury to the large vessels of the ovary and fallopian tube during the dilation, suction or both. Respondent characterized his error as causing the perforation, failing to recognize the error of proceeding blindly in surgery on a patient with distorted anatomy. Respondent's decision to proceed with Patient C's abortion, without the ability to discern the pathway to her uterus constitutes gross negligence.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

16. Respondent's Physician's and Surgeon's Certificate Number G 35712 is subject to disciplinary action under section 2227, as defined by section 2234, subdivision (c), in that he committed act(s) and/or omission(s) constituting negligence. The circumstances alleged in paragraphs 8 through 15, which are hereby incorporated by reference and realleged as if fully set forth herein, and as follows:

Patient B

17. Respondent documented the reason for transferring Patient B to the hospital, but he did not attempt to directly communicate with the receiving physician or the OBGYN, who ultimately completed the surgery. Respondent wrote in the record, "call me if needed" and left his cell phone number. Respondent's failure to adequately communicate with hospital staff regarding Patient B's transfer to the hospital constitutes negligence.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

18. Respondent's Physician's and Surgeon's Certificate Number G 35712 is subject to disciplinary action under section 2227, as defined by section 2266, in that he failed to maintain adequate and accurate records in the treatment of Patient A, Patient B, and Patient C. The circumstances alleged in paragraphs 8 through 15, which are hereby incorporated by reference and realleged as if fully set forth herein, and as follows:

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 G 35712, issued to Donald Clyde Willis, M.D.;

2. Revoking, suspending or denying approval of Donald Clyde Willis, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Donald Clyde Willis, 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: AUG 0 7 2020

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

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