

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

In the Matter of the Accusation Against:)

JAYSHREE MAHESH VYAS, M.D.)

**Physician's and Surgeon's)
Certificate No. A 37968)**

Respondent)

Case No. 8002014003471

DECISION AND ORDER

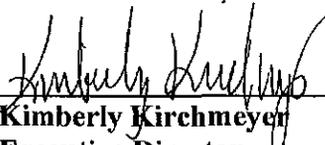
The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 5, 2017.

IT IS SO ORDERED April 28, 2017.

MEDICAL BOARD OF CALIFORNIA

By:


Kimberly Kirchmeyer
Executive Director

1 XAVIER BECERRA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 CHRISTINE R. FRIAR
Deputy Attorney General
4 State Bar No. 228421
California Department of Justice
5 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 897-6404
Facsimile: (213) 897-9395
7 Attorneys for Complainant

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

12 **JAYSHREE MAHESH VYAS, M.D.**
13 **8245 East Monte Vista Road, Suite 200**
Anaheim, CA 92808

14 **Physician's and Surgeon's Certificate No.**
15 **A37968,**

16 Respondent.

Case Nos. 800-2014-003471
800-2016-024861
800-2016-024336
800-2016-024298

OAH No. 2016090825

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

17
18 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
19 entitled proceedings that the following matters are true:

20 **PARTIES**

21 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board
22 of California (Board). She brought this action solely in her official capacity and is represented in
23 this matter by Xavier Becerra, Attorney General of the State of California, by Christine R. Friar,
24 Deputy Attorney General.

25 2. Jayshree Mahesh Vyas, M.D. (Respondent) is represented in this proceeding by
26 Raymond J. McMahon, Esq. of Doyle Schafer McMahon, LLP, located at 100 Spectrum Center
27 Drive, Suite 520, Irvine, California 92618.

28 //

1 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the
2 acceptance of the surrendered license by the Board shall constitute the imposition of discipline
3 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
4 of Respondent's license history with the Medical Board of California.

5 2. Respondent shall lose all rights and privileges as a Physician and Surgeon in
6 California as of the effective date of the Board's Decision and Order.

7 3. Respondent shall cause to be delivered to the Board her pocket license and, if one was
8 issued, her wall certificate on or before the effective date of the Decision and Order.

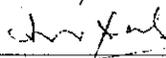
9 4. If Respondent ever files an application for licensure or a petition for reinstatement in
10 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
11 comply with all the laws, regulations and procedures for reinstatement of a revoked license in
12 effect at the time the petition is filed, and all of the charges and allegations contained in
13 Accusation No. 800-2014-003471 shall be deemed to be true, correct and admitted by Respondent
14 when the Board determines whether to grant or deny the petition. Respondent may petition for
15 reinstatement no earlier than two (2) years from the effective date of the Decision and Order.

16 5. If Respondent should ever apply or reapply for a new license or certification, or
17 petition for reinstatement of a license, by any other health care licensing agency in the State of
18 California, all of the charges and allegations contained in Accusation No. 800-2014-003471 shall
19 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of
20 Issues or any other proceeding seeking to deny or restrict licensure.

21 //
22 //
23 //
24 //
25 //
26 //
27 //
28 //

1 ACCEPTANCE

2 I have carefully read the above Stipulated Surrender of License and Order and have fully
3 discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect
4 it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of
5 License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the
6 Decision and Order of the Medical Board of California.

7
8 DATED: 1/27/17 
9 JAYSHREE MAHESH VYAS, M.D.
10 Respondent

11 //

12 I have read and fully discussed with Respondent Jayshree Mahesh Vyas, M.D. the terms
13 and conditions and other matters contained in this Stipulated Surrender of License and Order. I
14 approve its form and content.

15 DATED: January 27 2017 
16 RAYMOND MCMAHON
17 Attorney for Respondent

18 ENDORSEMENT

19 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
20 for consideration by the Medical Board of California of the Department of Consumer Affairs.

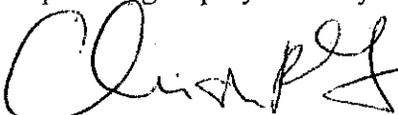
21 Dated: 1/30/2017 Respectfully submitted,
22 XAVIER BECERRA
23 Attorney General of California
24 ROBERT MCKIM BELL
25 Supervising Deputy Attorney General
26 
27 CHRISTINE R. FRIAR
28 Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2014-003471

1 KAMALA D. HARRIS
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 CHRISTINE R. FRIAR
Deputy Attorney General
4 State Bar No. 228421
California Department of Justice
5 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 897-6404
Facsimile: (213) 897-9395
7 *Attorneys for Complainant*

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 11, 2014
BY: *[Signature]* ANALYST

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 800-2014-003471

12 **JAYSHREE MAHESH VYAS, M.D.**
13 **8245 East Monte Vista Road, Suite 200**
Anaheim, CA 92808

ACCUSATION

14 **Physician's and Surgeon's Certificate**
15 **No. A37968,**

16 Respondent.

17 Complainant alleges:

18 **PARTIES**

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

22 2. On or about January 18, 1982, the Medical Board issued Physician's and Surgeon's
23 Certificate Number A37968 to Jayshree Mahesh Vyas, M.D. (Respondent). The Physician's and
24 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
25 herein and will expire on August 31, 2017, unless renewed.

26 **JURISDICTION**

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

1 4. Section 2227 of the Code provides that a licensee who is found guilty under the
2 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
3 one year, be placed on probation and required to pay the costs of probation monitoring, or such
4 other action taken in relation to discipline as the Board deems proper.

5 5. Section 2234 of the Code, states:

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

9 "...

10 "...

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

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

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

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

24 ///

25 ///

26 ///

27 ///

28 ///

1 **CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 7. Respondent Jayshree Mahesh Vyas, M.D. is subject to disciplinary action under
4 section Code section 2234, subdivision (c), in that she committed repeated negligent acts in the
5 care and treatment of Patient M.G.W.¹ The circumstances are as follows:

6 8. Respondent is Board certified in Obstetrics and Gynecology.

7 9. On or about April 2, 2012, Patient M.G.W., a sixty-six (66) year old female,
8 established care with Respondent.

9 10. Patient M.G.W.'s chief complaint was of a bladder infection.

10 11. Patient M.G.W. was post-menopausal and on oral hormone therapy. Patient M.G.W.
11 reported a past medical history that included two Cesarean sections and bladder suspension
12 surgery. M.G.W. also suffered from hypertension, hyperlipidemia and obesity.

13 12. At the April 2, 2012 appointment, Respondent took a complete history and performed
14 a physical exam. A urine culture was also performed. Her urinary tract infection was treated
15 with an injection of Rocephin, an antibiotic.

16 13. Patient M.G.W. was treated by Respondent numerous times over the course of the
17 next two and a half months. Patient M.G.W. was evaluated and treated for symptoms of urinary
18 incontinence and changes were made to her medications for hypertension.

19 14. On May 31, 2012, Respondent discussed treatment options with Patient M.G.W. for
20 her urinary incontinence. Several options were presented: observation (conservative therapy),
21 biofeedback, a bladder neck suspension, a bladder neck suspension with a hysterectomy and a
22 combination of surgery and behavioral therapy.

23 15. On or about July 17, 2012, Patient M.G.W. underwent a laparoscopic assisted vaginal
24 hysterectomy right salpingo-oophorectomy, extensive lysis of adhesions, bladder neck suspension
25 with transobturator sling, cystocele repair, rectocele repair, enterocele repair and

26 _____
27 ¹ In this Accusation, the patient is referred to by initial to protect her right of privacy. The
28 patient's full name will be disclosed to Respondent when discovery is provided pursuant to
Government Code section 11507.6.

1 cystourethroscopy. The surgery was performed by Respondent at St. Joseph Hospital in Orange,
2 California.

3 16. According to Respondent's notes, the surgery was complicated by extensive
4 adhesions throughout the pelvic area and "paper thin" tissue between the rectum and vaginal
5 mucosa. Despite the extensive adhesions noted, Respondent failed to check for a bowel
6 perforation, intra operatively.

7 17. Patient M.G.W. was then transferred to the recovery room and kept overnight at the
8 hospital to be monitored. Respondent discharged Patient M.G.W. the following day, July 18,
9 2012. Patient M.G.W.'s last complete blood count test before being discharged revealed an
10 elevated white blood cell count of 17.9 and a hemoglobin count of 11.0.

11 18. On July 19, 2012, Patient M.G.W. returned to the emergency department. She had a
12 fever of 102 degrees and complained of abdominal pain. At the emergency department, she was
13 noted to be in moderate distress with tachycardia (abnormally rapid heart rate), labored breathing
14 and an abdominal exam showed diffuse moderate tenderness.

15 19. The emergency room physician conducted numerous tests, including blood work, a
16 chest X-ray, a VQ scan (to rule out a pulmonary embolism), and an abdominal and pelvic CT
17 scan.

18 20. Patient M.G.W. was admitted for observation, placed on IV antibiotics and pain
19 medication.

20 21. While in the hospital, Patient M.G.W. was treated by several medical consultants,
21 including Respondent. While her respiratory status gradually improved, she increasingly
22 exhibited symptoms of a bowel obstruction – abdominal distention, nausea and vomiting and an
23 ever increasing white blood cell count.

24 22. On July 25, 2012, a surgery consultant performed an exploratory laparotomy which
25 showed extensive bowel adhesions and a rectal perforation with evidence of peritonitis and
26 sepsis.

27 23. A transverse loop colostomy was performed by the general surgeon. Following a
28 complicated post-operative course, Patient M.G.W. was discharged on August 8, 2012.

1 24. Patient M.G.W. has since had multiple surgeries and complications since the surgery
2 performed by Respondent, including another bladder suspension surgery to correct her persistent
3 urinary incontinence. Patient M.G.W. also now lives with a permanent colostomy bag.

4 25. According to Respondent's records, she recommended a hysterectomy based on a
5 mild uterine prolapse. The applicable standard of care in the medical community requires that
6 prior to making such a recommendation that a pelvic exam be performed and an appropriate
7 description of the pelvic prolapse be documented. Also, because pelvic prolapses can be
8 asymptomatic and, thus, not require repair, the patient's symptoms and dysfunctions caused by
9 the pelvic prolapse should be documented.

10 26. Respondent's notes do not indicate that Patient M.G.W. complained of symptoms
11 specifically related to the prolapse. Further, Respondent conducted one pelvic exam before the
12 pre-operative exam and only described the vagina as "relaxed." The prolapse is not mentioned
13 again in Respondent's records until the operative note. Respondent's recommendation of a major
14 surgery (the hysterectomy) for a minor problem (a mild prolapse) in a patient with multiple co-
15 morbidities constitutes a simple departure from the standard of care.

16 27. There are several methods of performing a hysterectomy and bilateral salpingo-
17 oophorectomy. Those methods include vaginal surgery, a laparoscopic procedure, a combination
18 of vaginal and laparoscopic surgery or an open hysterectomy with bilateral salpingo-
19 oophorectomy. The applicable standard of care in the medical community requires that the
20 appropriate method of surgery be selected based on the surgeon's training and skill, the patient's
21 desires, the patient's past medical and surgical history, the physical exam and the intra-operative
22 findings.

23 28. Respondent elected to perform a vaginal hysterectomy which is contraindicated given
24 the complicated and extensive pelvic adhesions she noted in Patient M.G.W., including possible
25 bowel adhesions to the uterus. Respondent's choice of an inappropriate surgical method and
26 failure to test for a bowel injury intra-operatively constitutes a simple departure from the standard
27 of care.

28 29. The applicable standard of care in the medical community requires that after surgery

1 a patient be adequately evaluated and cared for in the post-operative period and prior to
2 discharge. This post-operative care includes monitoring vital signs, subjective data, physical
3 findings and conducting any necessary laboratory studies to ensure that the patient is recovering
4 properly and ready for discharge at the appropriate time.

5 30. Prior to discharging Patient M.G.W., Respondent failed to properly evaluate her.
6 Specifically, Patient M.G.W.'s last complete blood count test revealed an elevated white blood
7 cell count of 17.9 and a hemoglobin count of 11.0. Respondent should have repeated the
8 complete blood count test to determine whether Patient M.G.W.'s white blood cell count was
9 increasing or decreasing prior to discharging Patient M.G.W. Respondent's failure to properly
10 evaluate Patient M.G.W. and repeat the blood test, in light of Patient M.G.W.'s elevated white
11 blood cell count, constitutes a simple departure from the applicable post-operative standard of
12 care.

13 31. The applicable standard of care in the medical community requires that when a
14 patient returns to the hospital after being discharged, that the patient be adequately evaluated such
15 that a diagnosis can be formulated of the presenting problem and the patient can be properly
16 treated.

17 32. When Patient M.G.W. returned to the hospital on July 19, 2012, she complained of
18 shortness of breath and abdominal pain. Numerous tests were conducted, however, Respondent
19 did not adequately consider and explore the possibility of a bowel injury. She then failed to
20 timely request a surgical consult. Instead, she observed Patient M.G.W. and kept her on
21 antibiotics, despite Patient M.G.W. rising white blood cell count and differential. The rectal
22 perforation was not discovered and treated by the consulting surgeon until July 25, 2012.
23 Respondent's evaluation and management of Patient M.G.W. constitutes a simple departure from
24 the standard of care.

25 33. Respondent's acts and/or omissions as set forth in paragraphs 8 through 32, inclusive
26 above, constitute repeated negligent acts in violation of section 2234, subdivision (c), of the
27 Code. As such, cause for discipline exists.

28 ///

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 A37968, issued to Jayshree Mahesh Vyas, M.D.;

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

3. Ordering Jayshree Mahesh Vyas, 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: August 11, 2016


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

LA2016501570
62038530.doc