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Abortion Patient's Death Shows License System Flaws : Medicine: Longtime O.C. resident, a convicted felon, kept practicing while state board inquiry was forgotten.

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SAN YSIDRO — It took a woman's death to breathe life into the essentially forgotten case against Dr. Suresh Gandotra.

Before Magdalena Ortega-Rodriguez bled to death last December from pelvic injuries suffered during an abortion attempt at Gandotra's clinic, the California Medical Board had launched two investigations against the doctor, one of them dating back to 1990.

The first investigation stemmed from his criminal conviction on 14 felonies and three misdemeanors, including grand theft and Medi-Cal fraud, for which he was sentenced to 16 months in prison, state documents show. Authorities had investigated, as well, a complaint that Gandotra--a longtime Anaheim resident who once practiced in Los Angeles County--botched an abortion attempt in 1991, seriously injuring a young woman who recovered after emergency surgery.

But the Medical Board's 4-year-old case against Gandotra, 45, was lost in the system, buried in a file that sat in the state attorney general's office for nearly two years. The case never even made it to a disciplinary hearing.

Ortega-Rodriguez, 23, apparently knew nothing of this when she traveled to Gandotra's San Ysidro clinic from Tijuana, just across the border, seeking to end her pregnancy. It was only after her death that authorities took decisive action against the physician, rushing to obtain a court order suspending his practice.

In January, Gandotra surrendered his license. While denying Gandotra was negligent, his attorney said the doctor could not afford a protracted legal battle and was too distraught to carry on. And last month, Gandotra, who made Orange County his home for at least 15 years and developed strong ties in the Indian community here, moved to India.

Behind him, however, he left some disconcerting questions, with implications far beyond the dusty border community where the doctor worked, performing up to 100 abortions per week.

As details of Gandotra's troubled history have unfolded in the past few months, the state's top licensing officials have found themselves hard-pressed to explain how the system they have worked so hard to reform let this case slide for so long.

The story comes to light after nearly four years of major legislative and administrative reform efforts, all aimed at improving a system long criticized for lengthy delays, laxity, secrecy and bureaucratic fumbling.

Yet an internal review ordered by the state attorney general's office, completed last month, found the state's disciplinary case against Gandotra was delayed by one of the Medical Board's own policies--since dropped--and then was held up in the attorneys' office by a string of mistakes.

"In this case, I think it could be said that a person might not have died" had the system worked properly, said Dixon Arnett, executive director of the Medical Board of California. "I think you have to conclude that."

Critics of the Medical Board consider the case exasperating as well as tragic.

"If they're not even handling our egregious cases competently, what are they doing with our everyday garden-variety negligence and incompetence cases?" said Julie D'Angelo, a supervising attorney with the Center for Public Interest Law, a San Diego-based consumer group that has had a hand in the state's reforms.

"This is not what happens in 99% of our cases," insisted Assistant Atty. Gen. Al Korobkin, who oversees prosecutors handling disciplinary hearings for the Medical Board.

But Arnett, who has pushed for reforms since taking the board's top administrative post in 1993, acknowledged the Gandotra case highlighted some of the system's remaining shortcomings. In particular, it underscored the need to give priority to serious complaints and keep better track of them, he said.

"It's one of those cases where you learn the hard way."

The Medical Board opened its first investigation against Gandotra by 1990, when he was convicted in Los Angeles Superior Court of 17 crimes, including Medi-Cal fraud and helping employees practice medicine without a license at his Huntington Park clinic.

The doctor was sentenced to 16 months in state prison and was fined \$347,000. He actually served five months and spent three months in a work-furlough program. The fine was later "substantially reduced" by an appellate court, said Evan Ginsburg, Gandotra's attorney, although he did not know by what amount.

The Medical Board then was stymied by its own rules. Before the board can take disciplinary action--such as restricting the doctor's license--it has to hold its own administrative hearings on the allegations. But the board's policy then--since changed--was not to proceed with such hearings until any criminal matters involving physicians were resolved, including any appeals, Arnett said.

That meant holding off on disciplinary action against Gandotra for two years. Gandotra appealed his criminal conviction and the appeals court--which reduced his fine--did not affirm the conviction until December, 1992, Korobkin said.

After serving his sentence, Gandotra resumed his practice unrestricted and, that same year, another complaint came to the Medical Board. This one was about an attempted abortion in May, 1991, at a clinic Gandotra operated in San Ysidro.

Anel Lopez, 22, like the vast majority of Gandotra's patients at the San Ysidro clinic, came from Mexico, where abortion is illegal. She traveled from Tijuana when she was about 18 weeks' pregnant.

According to allegations filed by the Medical Board in San Diego Superior Court three years later, Gandotra tried to perform the second-trimester abortion one day but was unable to complete it, so he sent Lopez home in hopes "the fetus would drop." She returned to the clinic the next day with an infection, making her uterus vulnerable to injury, according to the state filing that sought to suspend his license.

After Gandotra realized he had mistakenly cut the woman's uterus and removed part of her bowel, the state said in the court papers, he arranged to have her admitted at UC San Diego Medical Center, not the closest hospital.

When the patient arrived, she had lost 40% of her blood volume and she was in shock, said UCSD obstetrician Donna Johnson in a sworn declaration filed in court.

"The damage was so extensive it was difficult to identify the anatomy," said Johnson, who with other doctors repaired the cuts to Lopez's cervix, bladder and other organs. The patient survived.

Johnson concluded that Gandotra shouldn't have sent the patient home the first time he tried the abortion, because he left her vulnerable to infections and concealed bleeding. She also said that Gandotra provided substandard care by performing a second-trimester abortion, often riskier than one done in the first trimester, without specialized training and preparations for possible complications.

Gandotra is trained in emergency medicine, according to court papers; he is not an obstetrician-gynecologist. He lacked admitting privileges at any hospital.

"I guess I screwed up," Gandotra told Medical Board investigators looking into the Lopez case in August, 1992, according to the court papers filed in 1994.

Ginsburg, Gandotra's attorney, said that perforating a patient's uterus is a standard risk of a second-trimester abortion, and that Gandotra operated within the standards of care.

As for Gandotra's training, Ginsburg said "there is no real formal training to do abortions. You learn through residencies and practice. . . . He had been doing abortions for 18 years, exclusively."

In the Lopez case, Ginsburg said, "the tear was sewn up and she was fine."

It was only after Ortega-Rodriguez's death, when state investigators toured the San Ysidro clinic, that they noted a host of serious problems in its operations.

The doctor told investigators he had been performing more than 100 abortions a week for 20 years, according to state allegations filed in court. But, during their visit, authorities found Gandotra did not keep a blood supply on hand for transfusions; he did not have consent forms for anything but first-trimester abortions; he did not take after-hours calls; he did not keep appropriate records, and he did not speak Spanish, though 95% of his patients were Spanish-speaking, according to court papers.

Why did it take the state so long to act against the doctor? The attorney general's office--the Medical Board's prosecutor--offers some partial answers.

Based on an internal review he ordered, Korobkin determined authorities made a string of mistakes.

Both the 1991 abortion case and the 1990 fraud case were assigned to the attorney general's office in San Diego around February, 1993, after the Medical Board investigators had completed their probes. But neither case ever made it to hearing. The abortion case, in fact, was never written up in a formal accusation, required before a case can go to hearing.

The problem: Half the case was lost in a handoff between lawyers.

The attorney originally assigned to the case--busy with several lengthy hearings--had a second attorney file part of the case for him in September, 1993, Korobkin said. The idea was to split the case up, so that the formal accusation based on the 1990 criminal convictions, which could be handled quickly, was filed first, and the more time-consuming abortion allegations filed later, Korobkin said.

But the second attorney, who ultimately took over responsibility for the entire Gandotra case, never filed the abortion allegations.

"There is no justifiable reason why that first abortion case was not filed," said Korobkin, who refused to identify any of the employees involved or explain their actions, citing employee confidentiality restrictions.

After that, Korobkin said, the attorney who took over the case failed to request a hearing in response to Gandotra's notice that he would defend his license against the fraud accusation.

"A hearing should have been requested around the end of 1993," Korobkin said. "I don't believe the explanations are appropriate" for why it was not, he said.

Finally, Korobkin said, the office's tracking system that should have picked up the failure to request a hearing didn't work. That is because somehow it was incorrectly recorded in the system that a hearing *had* been requested. Korobkin would not say how that error occurred.

Arnett said the Medical Board's failure to assign separate numbers to the fraud and abortion issues contributed to the confusion.

The case was stashed away and all but forgotten when Ortega-Rodriguez traveled from Tijuana to Gandotra's clinic in December, seeking an abortion.

Ortega-Rodriguez told Gandotra she was 22 weeks' pregnant, in her second trimester, Ginsburg said. A medical examiner later determined she was 26 to 28 weeks along, in her third trimester, records show.

The doctor began the procedure at 10 a.m. Dec. 8, then stopped because he "was having trouble extracting all the fetal parts," according to Medical Board allegations, recounting circumstances eerily similar to the Lopez surgery in 1991. Gandotra resumed early that afternoon, but, within 10 minutes, realized he had perforated the uterus and removed parts of the bowel, court records say.

"I knew I screwed up," he told state investigators after Ortega-Rodriguez' death, almost echoing his statements in the earlier case.

Ginsburg said Gandotra tried to save the woman, giving her cardiopulmonary resuscitation and putting in a tube to help her breathe.

According to the Medical Board's court filing, at 3:24 p.m., the doctor called UCSD, asking for directions by car. He was told to summon an ambulance immediately. After trying and failing to get a private ambulance, he called 911.

Paramedics found Ortega Rodriguez at 4:33 p.m., bleeding, in cardiac arrest and with no pulse.

The patient arrived 40 minutes later at Scripps Chula Vista emergency room with no vital signs, according to the records. Though her pulse resumed, her condition deteriorated during emergency surgery, in which a "massive amount of blood gushed out" and doctors found a large uterine laceration, the records state.

Ortega-Rodriguez died after the surgery, at 10:17 p.m., from blood loss and shock caused by her injuries, according to the San Diego County medical examiner's office.

A medical expert for the board found that Gandotra had deviated from the standard of care in 10 significant ways, all of which "contributed to the death of this patient." He found, for example, "an extreme delay" in treating and transferring the patient following the surgical complication, according to court papers.

"There's no question that (Gandotra) caused her death," Ginsburg said. "He's terribly upset over it (but) she signed a waiver that the risks include . . . a perforated uterus. What he did was not below the standard of care."

Medical Board chief Arnett said the Gandotra case underscored the need for several changes in the way the board did business.

It provided another compelling argument for a planned "fast-track" system prioritizing the cases of doctors suspected of multiple or serious offenses. Such a system is being tested and is expected to be in place by early next year, he said.

In addition, the case hastened changes in the way the state tracks cases, Arnett said. Today, the Medical Board can better follow its own progress on cases through a new computerized tracking system, he said, and it is working on expanding the system so the complaints can be traced by the board after they are turned over to the attorney general.

A new coding method will make it clear when charges are added to an existing file, so more recent accusations are not lost, Arnett said.

"I'd eventually like to get to the point where (people) don't have to make calls asking, 'What took you so long?'" he said.