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

In the Matter of the Accusation Against: HAROLD T. PEART, M.D., Physician's and Surgeon's Certificate Number G 40523, Respondent.	Case No. 800-2015-016457 OAH No. 2018061078

DECISION AFTER NON-ADOPTION

Administrative Law Judge Carla L. Garrett heard this matter on March 12, 13, 14, and 15, 2018, at Los Angeles, California.

Claudia Ramirez, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board). Henry R. Fenton and Nicholas Jurkowitz, Attorneys at Law, represented Harold T. Peart, (Respondent), who was present at hearing.

During the hearing, Complainant amended the Accusation by deleting paragraph 11, with exception of "patient CJ, a 36-year-old female."

On February 26, 2018, Complainant moved for a protective order requesting that Exhibits 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 27 be placed under seal because the documents contain confidential information which is protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not have provided adequate privacy protection. The ALJ granted the motion, with the exception of Exhibits 3 and 14, which were withdrawn, and on her own motion, added Exhibits F, G, and H that included confidential information, and issued a Protective Order placing the above-referenced exhibits under seal. Those documents shall remain under seal and shall not be opened, except as provided by the Protective Order. 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 Protective Order, provided that such documents are protected from release to the public.

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on March 15, 2018.

Panel B of the Board (Panel or Panel B) declined to adopt the Proposed Decision (Decision) issued by Judge Garrett, and on April 30, 2018, issued an Order of Non-Adoption. Oral argument was scheduled for July 25, 2018, and on that date, oral argument was presented by both respondent's and complainant's counsel, and Respondent was present.

Panel B, having heard oral argument from the parties and having read and considered the administrative record and the written arguments submitted by both parties, hereby makes and enters the following as its decision in this matter.

FINDINGS OF FACT

1. Complainant made the Accusation in her official capacity as Executive Director of the Board.

2. The Board issued Physician's and Surgeon's Certificate Number G 40523 to Respondent on August 3, 1979. The certificate is scheduled to expire on August 30, 2018, unless renewed.

Respondent's Background

3. Respondent is a Board-certified obstetrician and gynecologist. He earned his bachelor's and master's degrees in zoology from Howard University in 1971 and 1973, respectively, and earned his doctorate of medicine from the College of Physicians and Surgeons at Columbia University in 1978. Respondent completed an internship and residency in the Department of Obstetrics and Gynecology at Martin Luther King, Jr. General Hospital in 1979 and 1982, respectively.

4. Since 1982, Respondent has been in private practice in obstetrics and gynecology, and since 1990, has served as a primary care physician. He has delivered 15,000 to 18,000 babies over the years. Respondent currently serves on Cedars Sinai's Foundation Physician Advisory and Integration Council, as well as on the Cedars Sinai Health Associated Medical Board. Respondent was awarded Physician of the Year in 2016 by Cedars Sinai's obstetricians and in 2007 by Cedars Sinai's labor and delivery nurses. Respondent has also been honored with a number of other awards and acknowledgements during his years as a physician.

Patient SD[1]

A. October 20, 2015 Visit

5. On October 20, 2015, Patient SD, a 24-year-old woman, sought prenatal care from Respondent after discovering through a home pregnancy test that she was pregnant. Patient SD had been Respondent's patient since 2011 and Respondent had delivered two of her children. Respondent screened Patient SD for chlamydia and gonorrhea, but ordered no prenatal blood tests at this visit or at any subsequent visit to screen for Rh factor, hepatitis, syphilis, HIV, and varicella.

[1] Patients are identified by their initials to protect their privacy.

At hearing, Respondent testified that Patient SD refused to take any prenatal blood tests because she was not sure whether she was going to keep the pregnancy, but Patient SD vehemently denied this claim, and credibly testified she told Respondent no such thing. It was her intention to keep the pregnancy, and engaged in behavior to increase the odds of delivering a healthy baby, such as abstaining from alcohol. Respondent recorded nothing in the medical notes indicating that Patient SD had refused to take any prenatal blood tests or that Patient SD had communicated anything indicating she was contemplating whether she was going to keep the pregnancy.

6. During Respondent's prenatal treatment of Patient SD's previous pregnancies, Respondent ordered prenatal blood panels and recorded Patient SD's blood type and the results of the Rh factor screening.

7. During the October 20, 2015 visit, Patient SD told Respondent that her last menstrual cycle began on September 8, 2015. After confirming Patient SD's pregnancy with a urine pregnancy test, Respondent performed a pelvic examination (i.e., a bimanual examination consisting of sliding fingers into the vagina with one hand while simultaneously pressing on the abdomen with the other hand) and noted that he felt a six to seven week sized uterus. Respondent performed a vaginal ultrasound which revealed "a structure in the uterus less than 6mm (6 weeks IUP)." (Exhibit 7, page 010.) At hearing, Respondent testified that he had been performing vaginal ultrasounds in his office for more than 10 years.

8. Respondent noted that Patient SD's body mass index (BMI) was 38, demonstrating that Patient SD was excessively obese. At hearing, Respondent testified that he has treated hundreds of excessively obese patients.

9 Respondent prescribed prenatal vitamins to Patient SD and instructed her to return in November 2015 for her next prenatal visit.

10. Patient SD failed to return for her November 2015 prenatal visit. At hearing, Patient SD explained that in November 2015, her life had become very hectic. Specifically, she experienced difficulties with her landlord that necessitated that she, her fiancé, and their two children move to a new residence. Additionally, she experienced a significant lack of energy, but still had to go to work to help support her family. These combined factors left her feeling overwhelmed and unable to complete the task of returning to Respondent's office for her November 2015 appointment. However, after missing her appointment, Patient SD scheduled a new appointment for December 8, 2015.

B. December 8, 2015 Visit

11. On December 8, 2015, 47 days after her initial visit, Patient SD returned to Respondent's office for prenatal care. At hearing, Respondent testified that, at this time, he believed Patient SD was approximately 12 weeks and five days pregnant.[2] While

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[2] In a September 1, 2016 letter he wrote to the Board, Respondent stated that Patient SD was 13 weeks pregnant.

Respondent did not state in Patient SD's medical records that he had performed a pelvic examination on December 8, 2015, Respondent testified that he performed a bimanual examination and concluded that the uterus was the same size as it was when he examined her on October 20, 2015. He explained that he expected to feel an increase in the size of the uterus since the last appointment. Respondent also performed a vaginal ultrasound and noted that it "reveal[ed] no evidence of an intrauterine pregnancy." (Exhibit 7, page 010.) Respondent told Patient SD that she had suffered a missed abortion (i.e., the death of the fetus without signs of miscarriage such as vaginal bleeding or abdominal pain). Patient SD told Respondent that she felt fluttering at the bottom of her abdomen, but Respondent told her that it was probably gas. Patient SD stated,

> [Respondent] checked the size of my uterus and claimed it hasn't grown at all, he did a vaginal ultrasound and he didn't see anything. I told him maybe he should use the ultrasound that goes over the belly, he suggested no. Nothing is in there. I asked him to use a doopler[3] (*sic*), he said there was no point to that.

(Exhibit 4.)

12. At hearing, Respondent explained that he did not typically perform abdominal ultrasounds or listen for fetal tones with a Doppler before the patient reached the third month of pregnancy. Respondent further testified that in Patient SD's case, when he believed her to be 12 or 13 weeks pregnant at the time of her December 8, 2015 visit, an abdominal ultrasound would not have been as accurate as a vaginal ultrasound, particularly given her obese size. He explained that a vaginal ultrasound at 12 or 13 weeks of pregnancy, no matter the size of the fetus, yields a clearer view than an abdominal ultrasound because the ultrasound instrument can get closer to the uterus.

13. Respondent ordered a HCG draw (i.e., a blood test to determine the level of the human chorionic gonadotropin hormone, which is produced during pregnancy). The result of the test showed that Patient SD's HCG level was 42,954 mIU/mL. Respondent instructed Patient SD to undergo another HCG blood draw on December 13, 2015, which yielded a result of 41,385 mIU/mL, and a final HCG blood draw on December 20, 2015, which yielded a result of 29,251 mIU/mL. Respondent testified at hearing that he expected the numbers to increase because Patient SD's pregnancy was in the first trimester. Respondent concluded that Patient SD's declining HCG levels established that the pregnancy was no longer growing and that Patient SD was suffering a miscarriage. Respondent told Patient SD that he needed to perform a D&C (i.e., a dilation and curettage), which is a surgical procedure consisting of the opening of the cervix (i.e., dilation) and the removal of the contents of the uterus (i.e., curettage). Respondent had performed thousands of D&Cs over the years of his practice. Patient SD reported to Respondent that she still experienced signs of pregnancy, like nausea and vomiting. Respondent nevertheless scheduled the D&C procedure for January 8, 2016.

C. January 8, 2016 D&C Procedure and Subsequent Medical Issues

14. On January 8, 2016, 17 weeks and six days after the reported date of her last menstrual cycle (i.e., September 8, 2015), Patient SD arrived at Respondent's office to undergo the D&C procedure. Patient SD signed a "CONSENT FOR DIAGNOSTIC D&C BY VACUUM ASPIRATION" form, which stated that "[Patient SD] hereby direct[s] and request[s] [Respondent]

[3] A Doppler is a hand-held fetal monitor that provides an audible simulation of the fetal heartbeat.

to perform a uterine aspiration procedure or Diagnostic D&C," and "[Patient SD] understand[s] that the procedure is carried out by suction aspiration of the contents of the uterus." (Exhibit 7, page 037.)

15. Respondent did not perform an ultrasound prior to performing the procedure. After performing the D&C procedure, Respondent noted in his medical records that Patient SD underwent a dilation and sharp curettage. During his testimony, Respondent stated that he also used a vacuum suction curettage, but he did not state the same in Patient SD's medical records, because the electronic medical records template used in his office did not include the reference. However, he stated that he used vacuum suction curettage in all D&C procedures he has performed. Following the procedure, the pathology department confirmed that Respondent had removed "products of conception" (i.e., fetal and/or placental tissue), which Respondent deemed consistent with a missed abortion.

16. Despite undergoing the D&C procedure, Patient SD still felt signs of pregnancy, such as vomiting, nausea, fatigue, and fluttering in the lower abdomen. Patient SD testified that the following day, she "started feeling weird." Specifically, Patient SD testified that her back hurt and she felt "more sick than [she felt] before."

17. On January 13, 2016, five days after the D&C procedure, Patient SD, while driving, experienced fluid coming out of her vagina. She pulled over and entered a Starbucks to use the restroom, as Patient SD believed she may have been hemorrhaging. When she discovered the fluid was clear, Patient SD returned home and rested. However, whenever she stood to walk, more fluid discharged from her vagina. Patient SD decided to go to Kaiser's Emergency Room (ER).

D. ER Visit and Subsequent D&C

18. While in the ER on January 13, 2016, Patient SD explained that she had undergone a D&C procedure five days prior. The ER physician performed a vaginal ultrasound, but could not see the entire uterus. The ER physician then ordered an abdominal ultrasound, which revealed a live 18-week size fetus with decreased amniotic fluid. The ER physician arranged for an obstetrician/gynecologist to consult with Patient SD, who concluded that there was a very low likelihood of a successful pregnancy due to the substantial lack of amniotic fluid, and explained the risks of attempting to maintain the pregnancy. Patient SD received information about termination option and facilities, and then left the ER.

19. Patient SD experienced difficulty in finding a facility that her health insurance would cover to remove the fetus, given the advanced state of her pregnancy. Patient SD ultimately located a Family Planning Association (FPA) facility that performed abortions for women in their second trimester. Patient SD, who was 20 weeks pregnant, explained that she wanted to keep the pregnancy if possible, but after the performance of an ultrasound that revealed that the fetus had virtually no amniotic fluid, the FPA physician recommended that she undergo an abortion. Patient SD followed the recommendation and permitted the FPA to perform a D&C procedure, which resulted in the successful termination of her pregnancy.

20. On January 19, 2016, Patient SD filed a complaint with the Board concerning Respondent's care and treatment.

21. At hearing, Respondent testified that if someone like Patient SD presented to him today, he would send her out to a radiologist or a perinatologist for a formal ultrasound to confirm or deny his suspicion of an abnormal fetus or pregnancy, and would not rely on HCG levels. As such, now, whenever he encounters something in a patient's pregnancy that is different from what he expects, Respondent sends them out for a second opinion.

Patient CJ

22. On August 6, 2015, Patient CJ, a 36 year-old woman, sought an abortion from Respondent after discovering she was pregnant through a positive home pregnancy test. Respondent had served as Patient CJ's primary care physician since 1999. Respondent confirmed the pregnancy and performed a pelvic examination which revealed a six to seven- week sized uterus. Respondent scheduled a D&C procedure for August 14, 2015.

23. On August 14, 2015, Respondent performed the D&C procedure in his office with local anesthesia and noted in Patient CJ's medical records that Patient CJ underwent a dilation and sharp curettage. Following the procedure, the pathology department confirmed that Respondent had removed products of conception.

24. On August 25, 2015, Patient CJ returned to Respondent's office complaining that she still felt pregnant. Respondent performed a pelvic examination which revealed a six to seven-week sized uterus. Respondent ordered a HCG draw, the results of which showed that Patient CJ's HCG level at 51,949 mIU/mL, thereby confirming Patient CJ's continued pregnancy. Respondent then authorized Patient CJ to undergo another D&C procedure, but this time, pursuant to Patient CJ's request, the procedure would be performed under general anesthesia. Respondent told Patient CJ he would be leaving for vacation on the following day, but did not provide Patient CJ with definitive information indicating when he would be performing the D&C procedure, and provided her with no instructions regarding her care in his absence.

25. On September 1, 2015, while Respondent was still on vacation, Patient CJ submitted a complaint to the Board stating that she was "not sure if [she was] waiting on [Respondent] to come back from vacation or what." (Exhibit 15, page 002.)

26. Respondent explained at hearing, as well as in his interview with the Board, that when he left for vacation, another physician covered his practice. Even though he was on vacation, he spoke with his office staff daily who then spoke with Patient CJ daily. He testified that the physician covering his practice could have performed the D&C procedure, but Patient CJ would have had to go to the emergency room to initiate the process. However, Patient CJ did not want to go to the emergency room, because she would have incurred additional costs. At hearing, Patient CJ explained that she was in no position to pay such costs as she had been experiencing financial difficulty.

27. Respondent made no arrangements with his backup physician to examine Patient CJ in his absence or to perform the D&C procedure in a hospital or surgical center that did not necessitate Patient CJ going through an emergency room. Respondent's staff told Patient CJ that

she should go to the emergency room if she experienced any life threatening symptoms or severe pain. Patient CJ experienced no intolerable pain or bleeding. Additionally, Respondent discovered nothing during his examination of Patient CJ on August 25, 2015 that suggested the D&C procedure needed to be performed sooner. As such, Respondent concluded that no emergency existed, and thus determined that Patient CJ's D&C procedure could wait until he returned from vacation.

28. On September 9, 2015, 15 days after Patient CJ's office visit, Respondent performed a D&C procedure on Patient CJ at Good Samaritan Hospital, and dictated medical notes at the hospital stating that he had performed a dilation and suction curettage on Patient CJ under general anesthesia. Following the procedure, the pathology department confirmed that Respondent had removed products of conception. Patient CJ signed out of the recovery room against medical advice and did not return for her post-operative examination.

Complainant's Expert (Dr. John C. Gustafson)

29. Dr. John Gustafson provided testimony as Complainant's expert witness. Dr. Gustafson earned his bachelor's degree in biochemistry from the University of California at Berkeley in 1973, and earned his medical degree from the University of Rochester School of Medicine in 1977. He completed his internship and residency in the Department of Obstetrics and Gynecology at University of Southern California / Los Angeles County Medical Center in 1978 and 1981, respectively. Dr. Gustafson is a licensed physician and board certified obstetrician and gynecologist.

30. Since 1981, Dr. Gustafson has been in private practice in Ventura, California, and is affiliated with Community Memorial Health Systems as an active staff member, the University of California at Los Angeles as an assistant clinical professor in the Department of Obstetrics and Gynecology, and the University of Southern California / Los Angeles County Medical Center as an assistant clinical professor in the Department of Obstetrics and Gynecology. He has held medical staff positions at Ventura County Medical Center and Community Memorial Heal Systems as chairman of the Department of Obstetrics and Gynecology, and maintains society memberships with the Ventura County Medical Society, the California Medical Association, the American Medical Association, and theAmerican College of Obstetrics and Gynecology. Dr. Gustafson has authored no publications in the field.

31. Dr. Gustafson's practice is currently 50 percent obstetrics and 50 percent gynecology, and he delivers approximately 250 babies per year. He has also performed thousands of D&C procedures over the course of his career. At one time, Dr. Gustafson performed ultrasounds in his office for a period of approximately 10 years, but he has not performed ultrasounds in his office in the last 15 years. Instead, Dr. Gustafson sends patients to specialized facilities for vaginal and abdominal ultrasounds. However, he does perform ultrasounds on patients in the hospital during labor and delivery.

A. Patient SD

32. Dr. Gustafson evaluated whether Respondent's treatment of Patient SD conformed to the standard of care, and prepared a written report setting forth his conclusions. At hearing, Dr. Gustafson described the standard of care as that which a reasonable obstetrician or gynecologist in

similar circumstances would exercise when providing care to a patient. Dr. Gustafson reviewed Patient SD's medical records prepared by Respondent and those prepared by Kaiser's ER department, and a transcript from Respondent's interview with the Board held on February 1, 2017, among other things. After Dr. Gustafson's review of the materials, he concluded Respondent deviated from the standard of care in three primary areas: (1) properly dating Patient SD's pregnancy prior to performing a D&C procedure; (2) preparing erroneous operative or procedure notes; and (3) failing to perform a prenatal blood panel.

1. Failing to Properly Date Pregnancy Before D&C Procedure

33. Dr. Gustafson stated in his report that the standard of care requires the physician to determine "the dating, estimated date of confinement of pregnancy, and viability of a pregnancy prior to a termination of a desired (wanted) pregnancy." (Exhibit 12, page 3.) Dr. Gustafson noted that Respondent only performed a vaginal ultrasound, and not an abdominal ultrasound, and that it was incumbent on Respondent to expose Patient SD to better testing, such as sending Patient SD to an outside facility specializing in ultrasounds before determining whether Patient SD had a viable pregnancy. At hearing, Dr. Gustafson testified that had Respondent performed an abdominal ultrasound, he would have seen the existence of a viable pregnancy before performing the D&C procedure on January 8, 2016.

34. Dr. Gustafson also testified that after Respondent performed a vaginal ultrasound on Patient SD on December 8, 2015, when Patient SD was 12 weeks and five days pregnant, and found "no evidence of an intrauterine pregnancy" (Exhibit 7, page 010), Respondent should have performed an abdominal ultrasound.

35. Dr. Gustafson additionally noted that Respondent assumed incorrectly that the HCG levels were diagnostic of a missed abortion in the first trimester, when, in fact, the HCG levels were declining because Patient SD's pregnancy had successfully progressed to the second trimester, when HCG levels naturally decrease. At hearing, Dr. Gustafson explained that, typically, HCG levels during the first trimester steadily increase and then begin falling beginning at approximately 10 weeks of pregnancy. Dr. Gustafson calculated that, based on Patient SD's reported date of her last menstrual cycle (i.e., September 8, 2015), Patient SD was 12 weeks and five days pregnant at the time of her December 8, 2015 HCG test, 13 weeks and four days pregnant at the time of her December 13, 2015 HCG test, and 14 weeks and four days pregnant at the time of her December 20, 2015 HCG test. Dr. Gustafson stated that Respondent's incorrect conclusion that the decreasing HCG levels evidenced a missed abortion in the first trimester, as opposed to the natural progression of her pregnancy in the second trimester, resulted in Respondent's attempt to terminate a viable pregnancy on January 8, 2016, when Patient SD was 17 weeks and six days pregnant.

36. Dr. Gustafson concluded that Respondent committed an extreme departure from the standard of care for performing a termination on a wanted pregnancy, as a result of his failure to properly determine the viability of the pregnancy.

2. Erroneous Operative or Procedural Notes

37. Dr. Gustafson stated in his report that the standard of care requires that medical records contain the proper documentation of a surgery or a procedure. Dr. Gustafson noted that Respondent performed a suction curettage during the D&C procedure of Patient SD, but

Respondent's note in Patient SD's chart mentioned nothing about suction curettage. At hearing, Dr. Gustafson testified that nearly all physicians use a suction curettage during D&C procedures, but that those who use the sharp curettage method only would still be operating within the standard of care. However, Dr. Gustafson explained that medical records are supposed to be correct and properly document what the physician did, so that someone, typically another physician, would know what the physician did.

38. Dr. Gustafson concluded that Respondent committed a simple departure from the standard of care by failing to include a complete and accurate operative note concerning the D&C procedure.

3. Failure to Perform a Prenatal Blood Panel

39. Dr. Gustafson stated in his report that the standard of care requires the execution of a prenatal blood panel, including a test of Rh factors, be completed within 17 weeks from the patient's last menstrual cycle. Dr. Gustafson explained that generally, such blood panels are performed early in the pregnancy, typically during the first prenatal visit, and ordering such panels has been the standard for decades. Dr. Gustafson noted that no prenatal blood studies were documented in Patient SD's medical records in connection with this pregnancy, and that the failure to do so constituted a simple departure from the standard of care. Dr. Gustafson further testified that it is important to order these blood panels with every pregnancy, because those studies can change from pregnancy to pregnancy, with the exception of blood type and Rh factor results.

B. Patient CJ

40. Dr. Gustafson evaluated whether Respondent's treatment of Patient CJ conformed to the standard of care, and prepared a written report setting forth his conclusions. Dr. Gustafson reviewed Patient CJ's medical records prepared by Respondent and by Good Samaritan Hospital, and a transcript from Respondent's interview with the Board held on February 1, 2017, among other things. After Dr. Gustafson's review of the materials, he concluded Respondent deviated from the standard of care in one pertinent area: delay in performing a repeat D&C procedure on Patient CJ.

41. Dr. Gustafson stated in his report that the standard of care required the diagnosis and treatment of the products of conception that were retained after the August 15, 2015 D&C procedure. In his testimony, Dr. Gustafson explained that the American College of Obstetricians and Gynecologists (ACOG), which provides a framework from which to practice, lists no clear guidelines regarding abortions, and sets forth nothing about how long a physician should reasonably wait to perform a D&C procedure. Consequently, Dr. Gustafson consulted other materials, including literature setting forth guidelines on performing safe abortions in third world countries, which state that evacuations of the uterus should be done in a prompt and timely manner. He also contacted a colleague in the family planning department of the University of Southern California / Los Angeles County Medical Center to inquire whether a 15-day delay in performing a repeat D&C procedure was within the standard of care.

42. Dr. Gustafson concluded that Respondent's delay in performing a repeat D&C procedure for 15 days to eliminate the products of conception retained after the August 15, 2015 D&C procedure was too long and constituted a simple departure from the standard of care, even

though Patient CJ ultimately fared well. At hearing, Dr. Gustafson explained that the fact that Patient CJ had suffered no pain or bleeding during the 15-day period did not absolve Respondent, because his delay exposed Patient CJ to risk of infection. Dr. Gustafson stated that the objective of the standard is to prevent complications.

Respondent's Expert (Dr. Howard Mandel)

43. Dr. Howard C. Mandel testified as Respondent's expert witness. Dr. Mandel earned his bachelor's degree in natural sciences from Johns Hopkins University in 1977, and earned his medical degree from New York University in 1981. He completed his residency at Cedars Sinai Medical Center in 1984, and served as its chief resident from 1984 to 1985. Dr. Mandel is a licensed physician and board certified obstetrician and gynecologist.

44. Since 1985, Dr. Mandel has been in private practice in Century City, California, a managing partner of the medical building of Century City Women's Health from 1992 to 2015, a principal of an association of medical practices in obstetrics and gynecology of Century City Women's Health since 1985, a consultant in student health services at the University of Southern California since 1985, a consultant at Saban Community Clinic since 1982, and a consultant at California Family Health Council since 1990. Dr. Mandel has served on dozens of boards and committees since 1985, and has received a number of honors, awards, and recognitions, nationally and internationally. He maintains society memberships with ACOG, the Johns Hopkins University Alumni Association, the American Association of Gynecologic Laparoscopists, the American Medical Association, California Medical Association, Los Angeles County Medical Association, and the Association of American Physicians and Surgeons. Dr. Mandel has authored dozens of publications in the field, and has served as an academic lecturer.

45. Dr. Mandel has delivered more than 10,000 babies over the course of his career, and has performed 1,800 to 2,000 D&C procedures. He regularly provides prenatal care to his patients and performs ultrasounds, both vaginally and abdominally.

46. Dr. Mandel reviewed Patient SD's and Patient CJ's medical records, Dr. Gustafson's written reports concerning Patient SD and Patient CJ, and a transcript from Respondent's interview with the Board held on February 1, 2017, among other things. Dr. Mandel prepared a written report.

A. Patient SD

47. Dr. Mandel disagreed with Dr. Gustafson in concluding that Respondent engaged in negligence, gross or otherwise, in his care and treatment of Patient SD. Dr. Mandel wrote:

> [T]he standard of care did not require that [Respondent] perform an abdominal ultrasound on [P]atient SD to confirm pregnancy. In this case, [Respondent] preformed an initial trans vaginal ultrasound on [P]atient SD which showed an abnormal size with size less than dates. [Respondent] then followed up that ultrasound on the next visit, in which no viable pregnancy was identified. [Respondent] then followed up by obtaining blood levels in order to confirm the pregnancy and its viability. Based upon the ultrasound results and the decrease in blood levels, it was not unreasonable for

[Respondent] to have concluded a missed abortion occurred.
(Exhibit 29.)

48. At hearing, Dr. Mandel testified that Respondent had provided care and treatment for Patient SD within the standard of care, and operated in a prudent manner and did everything a prudent physician would have done. Dr. Mandel stated that it was reasonable for Respondent to perform a D&C procedure after making a diagnosis of a missed abortion. He testified that there was nothing Respondent should have done differently.

49. Dr. Mandel's written report mentioned nothing about Patient SD's weight or her BMI of 38.17, however at hearing, Dr. Mandel testified that he considered Patient SD's morbid obesity a significant factor, because physical examinations are more difficult in obese patients, particularly when trying to feel the uterus. Thus, when Respondent examined Patient SD's uterus bimanually, Respondent felt a six millimeter fetus. Dr. Mandel testified that six millimeters is smaller than normal, but within the range for the early part of pregnancy.

50. Additionally, with respect to obesity, Dr. Mandel testified that ultrasounds in obese patients are notoriously distorted. Dr. Mandel explained that ultrasounds work by sending sound waves through the tissue, and because fat distorts soundwaves, the ultrasounds will likely miss more things.

51. Dr. Mandel testified that on December 8, 2015, during Patient SD's 12th week of pregnancy, specifically when Patient SD was 12 weeks and five days pregnant, Respondent practiced within the standard of care when he performed a vaginal ultrasound, and not an abdominal ultrasound. Dr. Mandel explained that at the 12-week mark, it is very difficult to see anything on an abdominal ultrasound, because the uterus is at the pubic bone at that time, and because the ultrasound cannot penetrate the pubic bone, a physician would have a better chance of seeing the uterus with a vaginal ultrasound, as the pubic bone does not obstruct vaginal ultrasounds. Dr. Mandel stated that before 14 weeks of gestation, only vaginal ultrasounds should be used. Dr. Mandel further stated that when Respondent performed the vaginal ultrasound on Patient SD on December 8, 2015, Dr. Mandel would have expected Respondent to find a structure the size of a large gummy bear. However, Respondent found no evidence of an intrauterine pregnancy, which Dr. Mandel attributed to Patient SD's obesity, thus Respondent, according to Dr. Mandel, appropriately performed HCG tests.

52. Dr. Mandel testified that Patient SD's HCG levels should have been increasing at the 12 week mark, and explained that the levels do not begin to decrease until the second trimester, which begins at 13 weeks and one day to 26 weeks, and not after 10 weeks as Dr. Gustafson testified. Respondent, who was also designated an expert witness in this matter, also testified that HCG levels typically level off after about 13 weeks, and also disagreed with Dr. Gustafson that levels begin to level off at 10 weeks. Respondent testified that HCG levels peak at the end of the first trimester and then level off in the second.

53. On January 8, 2016, when Patient SD arrived at Respondent's office for the D&C procedure, when she was 17 weeks and six days pregnant, Dr. Mandel explained that performing an abdominal ultrasound at this point, given the missed abortion diagnosis that Respondent had given previously, could have caused the patient emotional trauma, as the patient would have been forced to see the failed pregnancy.

54. Dr. Mandel disagreed that Respondent's medical records concerning Patient SD fell below the standard of care. Specifically, Dr. Mandel wrote:

> [The Board's] allegation that [Respondent's] operative report was inadequate because [Respondent] did not state that he performed a suction curettage is unfounded. The records identify the procedure that was performed, D&C, and the standard of care did not require that [Respondent] state 'suction curettage,' since that is the modern D&C that is virtually always performed in early pregnancy.

(Ibid.)

55. At hearing, Dr. Mandel reiterated that "everybodyis doing suction curettage in this day and age" and have been doing so "for the last 50 years." Consequently, according to Dr. Mandel, Respondent did not deviate from the standard of care for not writing in Patient SD's medical records that he applied suction curettage, because it was something "that is understood in the industry." Like Dr. Gustafson, Dr. Mandel also testified that physicians who use a sharp curettage only would be operating within the standard of care too, because that method had been used for years before the introduction of the suction curettage method. Dr. Mandel stated that Patient SD understood that Respondent was performing a suction curettage, because she signed a consent form stating so.

56. Dr. Mandel disagreed that Respondent's decision not to obtain prenatal blood studies fell below the standard of care, because Dr. Mandel asserted Patient SD was not certain that she would keep the pregnancy "and she regularly failed to return to the clinic as directed." (*Ibid.*) Dr. Mandel further stated, "[t]he standard of care does not require obtaining prenatal blood studies for unwanted pregnancies." (*Ibid.*)

57. At hearing, Dr. Mandel testified that once Respondent made the diagnosis of a missed abortion, there was no reason to order any blood panels, and Respondent did not deviate from the standard of care when he did not run such tests. According to Dr. Mandel, ordering blood panels under such conditions would have been a waste of money, and if the laboratory ended up sending the bill to the patient, the patient would be reminded of the failed pregnancy. Additionally, Dr. Mandel noted that Patient SD's prior records included Patient SD's blood type and Rh factor information.

B. Patient CJ

58. Dr. Mandel disagreed with Dr. Gustafson in concluding that Respondent committed a simple departure from the standard of care by delaying Patient CJ's D&C procedure for 15 days. Dr. Mandel wrote:

> The standard of care did not require that [Respondent] perform the D&C any sooner, since [P]atient CJ showed no signs of complications, including bleeding. Absent an emergency, it is within the standard of care of the physician to respect the wishes of his patients, including delaying non-emergency procedures. In this case, [Respondent] checked in on [Patient] CJ to make sure

there were no complications or that an emergency did not arise. All of this was within the standard of care.

(Ibid.)

59. At hearing, Dr. Mandel testified that on August 25, 2015, when Patient CJ presented to Respondent's office with retained products of conception, but was not infected or bleeding, Respondent had three choices: (1) do nothing and let Patient CJ's body eliminate the products of conception on its own; (2) perform a repeated D&C procedure; or (3) give Patient CJ medication to produce contractions to eliminate the products of conception. Dr. Mandel stated that the standard of care did not require that Respondent perform a D&C procedure at all, as the body could have expelled the tissue itself, and there was nothing wrong in Respondent performing the procedure 15 days after Patient CJ's August 15, 2015 office visit. In other words, Respondent did not deviate from the standard of care when he did not perform the repeat D&C procedure for 15 days, as there was no time limit to perform the D&C procedure, according to Dr. Mandel.

Credibility Findings[4]

60. Dr. Gustafson and Dr. Mandel, with their wealth of experience during their respective decades of practice, their impressive credentials, their years of teaching and overseeing obstetrics programs, as well as their respective delivery of testimony in a clear,

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[4] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code, § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

concise, straightforward manner, proved to be exceptional witnesses. However, as set forth in more detail in the Legal Conclusions below, Dr. Gustafson's opinions related to Respondent's care and treatment of Patient SD were deemed more persuasive than those of Dr. Mandel, and Dr. Mandel's opinions regarding the care and treatment of Patient CJ were deemed more persuasive than those of Dr. Gustafson.

Character Evidence

61. Dr. Samuel J. Porter, an obstetrician and gynecologist who has been practicing medicine since 1972, provided character testimony on Respondent's behalf. Dr. Porter and Respondent are colleagues, have known each other for more than 25 years, and have assisted each other in hundreds of surgeries. Dr. Porter testified that Respondent has a very good reputation, is highly regarded, and even delivered Dr. Porter's granddaughter. However, Dr. Porter admitted that he has not observed Respondent provide prenatal care to patients.

62. Dr. Regina Edmond, an obstetrician and gynecologist who has been practicing medicine for 10 years, also provided character testimony on Respondent's behalf. Dr. Edmond met Respondent during her residency and has assisted with many of Respondent's surgeries. Dr. Edmond described Respondent as a great surgeon and physician, as well-liked among residents and other doctors at Cedars Sinai Hospital, and takes care of some of the sickest patients with complicated pregnancies. Like Dr. Porter, she has not observed Respondent provide prenatal care to patients.

63. Respondent submitted various thank you notes from patients who described Respondent as calm, cool, caring, safe, and one who possesses a gift of knowledge.

CONCLUSIONS OF LAW

1. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), for gross negligence in relation to his care and treatment of Patient SD, as set forth in Findings 5 through 21, and 29 through 36.

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), for repeated negligent acts in relation to his care and treatment of Patient SD, as set forth in Findings 5 through 21, and 29 through 39. However, Complainant failed to establish that Respondent committed any negligence in relation to his care and treatment of Patient CJ, as set forth in Findings 22 through 28, 40 through 46, and 58 through 60.

The Applicable Law

3. The standard of proof which must be met to establish the charging allegations herein is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

4. The purpose of the Medical Practice Act[5] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

5. The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.) (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

6. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

7. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

8. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

9. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

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[5] Business and Professions Code sections 2000 through 2521.

Analysis

A. Gross Negligence

10. Complainant met her burden of establishing clearly and convincingly that Respondent engaged in gross negligence, in violation of Business and Professions Code section 2234, subdivision (b), by committing an extreme departure from the standard of care, according to the credible testimony of Dr. Gustafson, by failing to properly date and determine the viability of Patient SD's pregnancy prior to performing a D&C procedure on a wanted pregnancy. The evidence showed that after Respondent detected no intrauterine pregnancy after performing a vaginal ultrasound on Patient SD on December 8, 2015, he ordered HCG blood tests, and from those results, determined that Patient SD had suffered a missed abortion.

11. However, Respondent's own testimony established that he understood that HCG levels typically begin to taper off after 13 weeks of pregnancy. Patient SD, based on the date of her last period (i.e., September 8, 2015), was nearly 13 weeks pregnant at the time of her first HCG test (i.e., 12 weeks and five days) when the level was 42,954 mIU/mL, was more than 13 weeks pregnant at the time of the second HCG test (i.e., 13 weeks and four days) when the level had decreased to 41,385 mIU/mL, and was well into her 14th week of pregnancy at the time of the final HCG test (i.e., 14 weeks and four days) when the level dipped down to 29,251 mIU/mL. Yet it appears that Respondent failed to reasonably consider that Patient SD's HCG levels had decreased because she had reached a point in her pregnancy in which the levels were naturally expected to dip, and thus engaged in no further action to confirm his suspicion of a missed abortion.

12. While Dr. Mandel testified that performing an abdominal ultrasound during Patient SD's December 8, 2015 visit would not have yielded clear results because of a potential pubic bone obstruction, he did state that abdominal ultrasounds do yield clear results after 14 weeks gestation. By January 8, 2016, the date scheduled for the D&C procedure, it had been more than 17 weeks since Patient SD's last period, yet Respondent elected not to perform an abdominal ultrasound to confirm his missed abortion diagnosis, despite Patient SD's previous complaints of still feeling pregnant, including fluttering in her abdomen, and despite her previous request that Respondent perform one. Even the ER physician, who, like Respondent, experienced difficulty seeing the contents of Patient SD's uterus through a vaginal ultrasound, took the next reasonable step and ordered an abdominal ultrasound for further answers. Respondent, unfortunately, failed to do so, which yielded a tragic result for Patient SD.

13. In light of the above, Complainant clearly and convincingly established that Respondent failed to properly determine the viability of Patient SD's wanted pregnancy prior to his attempted termination of it. Thus, Respondent engaged in gross negligence in his care and treatment of Patient SD, in violation of Business and Professions Code section 2234, subdivision (b).

B. Repeated Acts of Negligence

14. Complainant met her burden of establishing clearly and convincingly that Respondent engaged in repeated acts of negligence in relation to his care and treatment of Patient SD, in violation of Business and Professions Code section 2234, subdivision (c). Complainant did

not establish clearly and convincingly that Respondent engaged in any negligent acts with respect to his care and treatment of Patient CJ.

15. With respect to Patient SD, in addition to the gross negligence set forth above, Respondent engaged in simple departures of the standard of care by failing to properly document Patient SD's records and by failing to perform prenatal blood panel studies on Patient SD. In regard to Respondent's medical notes, the evidence showed that Respondent admitted to using a suction curettage when he performed the D&C procedure on Patient SD, and that the consent form signed by Patient SD indicated that Respondent would be implementing suction aspiration during the procedure, but his medical notes prepared after the procedure failed to state that he had, in fact, used suction curettage. Rather, the note only mentioned his use of a sharp curettage. Dr. Gustafson credibly testified that the standard of care requires that medical records contain the proper documentation of a surgery or a procedure.

16. While Dr. Mandel convincingly testified that most physicians use suction curettage when performing D&C procedures, a fact to which Dr. Gustafson agreed, his testimony was not more persuasive than Dr. Gustafson's concerning the standard of care in this regard. Specifically, Dr. Mandel testified that because suction curettage has been used in the field for more than 50 years, the standard of care did not require that physicians write the words "suction curettage" in a patient's medical chart after performing a D&C procedure. However, like Dr. Gustafson, Dr. Mandel stated that those physicians who use a sharp curettage only during D&C procedures would still be operating within the standard of care. Because there are multiple ways to perform D&C procedures within the standard of care, it necessarily follows that physicians must accurately document the manner in which they perform such procedures. Indeed, Dr. Gustafson testified that the purpose behind requiring properly documented medical notes concerns an individual's ability, typically another physician, to know what a physician did in the care and treatment of a patient. Because Respondent noted that he used a sharp curettage, but nothing about using a suction curettage,he failed to properly document Patient SD's medical records, and thus committed a simple departure from the standard of care.

17. In regard to Respondent's failure to order prenatal blood panels on Patient SD, Dr. Gustafson persuasively testified that the standard of care requires the execution of a prenatal blood panel to screen for Rh factor, hepatitis, syphilis, HIV, and varicella, to be completed within 17 weeks from the patient's last menstrual cycle. However, the evidence showed that no prenatal blood studies were performed or documented in Patient SD's medical records in connection with this pregnancy, and thus, Respondent committed a simple departure from the standard of care. While Dr. Mandel testified that the standard of care did not require Respondent to order prenatal blood studies because Patient SD did not wish to keep her pregnancy, the evidence does not support Dr. Mandel's conclusion. Specifically, the record showed that Patient SD wished to maintain her pregnancy, evidenced by her acts of seeking prenatal care and abstaining from alcohol consumption.

18. Additionally, despite Dr. Mandel's assertion that Respondent committed no violation because Respondent included notations in Patient SD's prior records concerning her blood type and Rh factor in regard to her previous pregnancies, the evidence showed that this act did not eliminate Respondent's duty to order blood panel studies for this pregnancy. Specifically, Dr. Gustafson credibly testified that while blood type and Rh factor results do not change from pregnancy to pregnancy, the results of hepatitis, syphilis, HIV, andvaricella screenings can. As

such, Respondent committed a simple departure from the standard of care when he failed to order prenatal blood panels.

19. In light of the above, Complainant clearly and convincingly established that Respondent committed repeated negligent acts with respect to his care and treatment of Patient SD, in violation of Business and Professions Code section 2234, subdivision (c).

20. With respect to Patient CJ, Complainant failed to establish clearly and convincingly that Respondent deviated from the standard of care when he performed Patient CJ's repeat D&C procedure 15 days after she returned to his office with complaints of still feeling pregnant. In short, Complainant failed to persuasively identify and establish the prevailing standard of care in connection with repeat D&C procedures, and the acceptable period of time, if any, in which a physician must perform one. Dr. Gustafson admitted, in essence, that the standard of care in this area was not readily apparent, as ACOG, which provides a framework from which to practice, lists no clear guidelines regarding abortions, and sets forth nothing about how long a physician should reasonably wait to perform a D&C procedure. As a result, Dr. Gustafson relied on literature focused on safe abortions in third world countries, and a telephone call to a colleague in the family planning department of the University of Southern California / Los Angeles County Medical Center, to establish what he believed to be the standard of care in this area. Based on this literature and discussion, Dr. Gustafson determined that repeat D&C procedures should be done in a timely manner, and concluded that a 15-day delay in performing a repeat D&C procedure demonstrated a failure to perform the procedure in a timely manner. However, Dr. Mandel, who has been practicing medicine for more than 35 years, persuasively established that Respondent was not required to perform the D&C procedure any sooner, because Patient CJ showed no signs of complications or emergent conditions, such as infection or bleeding, and because Patient CJ's body potentially could eliminate the products of conception on its own, making another procedure unnecessary. Given the absence of a firmly established standard in this area, coupled with the divergent and reasonable view of Dr. Mandel, Complainant failed to clearly and convincingly establish that Respondent's care and treatment of Patient CJ deviated from the standard of care.

Appropriate Level of Discipline

21. A. Complainant seeks revocation of Respondent's license. While revocation falls into the range of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, particularly given the gross negligence involved, such discipline is not warranted in this matter. Respondent has enjoyed a long period of practice with no prior record of discipline, and the proven unprofessional conduct in this matter concerned only one patient (i.e., Patient SD). Additionally, Respondent has maintained a positive reputation in his field, which has earned him Physician of the Year in 2016 by Cedars Sinai's obstetricians and Physician of the Year in 2007 by Cedars Sinai's labor and delivery nurses. Moreover, in an effort to prevent a reoccurrence of the tragic events that arose in Patient SD's case, Respondent credibly testified that now whenever he encounters something in a patient's pregnancy that is different from what he expects, he sends the patient out for a second opinion.

B. At oral argument, Respondent credibly testified that he was responsible for his actions. Respondent was sincere in his statement that he had made a mistake and learned from it. He did not attempt to place blame on his patients.

22. Business and Professions Code section 2229 provides that protection of the public is paramount, but the Board should take action that will stress education to address deficiencies in practice. It is for this reason that Panel will impose the successful completion of a medical recordkeeping course as a condition of probation, as Respondent needs to improve in this area.

23. While the minimum period of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders* is five years' probation for gross and repeated acts of negligence violations, it is important to note that the purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) Respondent admitted the error, learned from it, and changed his practice. Accordingly, in this case, the public would be adequately protected by the imposition of a two- year period of probation, with specific terms and conditions, including a condition concerning education and a recordkeeping course.

ORDER

Certificate Number G 440523 issued to Respondent Harold T. Peart, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for two years, upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true and correct copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent.
Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

4. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

5. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. General Probation Requirements

Compliance with Probation Unit:

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes:

Respondent shall, at all times, keep the Board informed of Respondent's business and

residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice:

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal:

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California:

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

8. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

9. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years. Periods of non-practice will not apply to the reduction of the probationary term.
Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

10. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

12. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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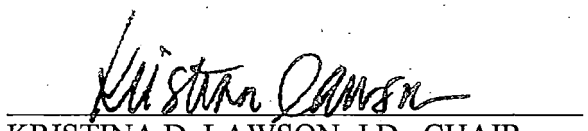
13. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

This Decision shall become effective at 5:00 pm on September 7, 2018.

IT IS SO ORDERED August 10, 2018.



KRISTINA D. LAWSON, J.D., CHAIR
PANEL B

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

In the Matter of the Accusation Against:	)	
	)	
HAROLD T. PEART, M.D.	)	
	)	Case No.: 800-2015-016457
Physician's & Surgeon's	)	
Certificate No: G 40523	)	OAH No.: 2017091058
	)	
Respondent	)	
	)	
	)	

ORDER OF NON-ADOPTION
OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed at whether the level of discipline ordered is sufficient to protect the public. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Jilio-Ryan Court Reporters, 14661 Franklin Avenue, Suite 150, Tustin, CA 92780. The telephone number is (714) 424-9902.

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 576-3216
Attention: Robyn Fitzwater

Date: April 30, 2018

Kristina D. Lawson, J.D., Chair
Panel B

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

In the Matter of the Accusation Against: HAROLD T. PEART, M.D., Physician's and Surgeon's Certificate Number G 40523, Respondent.	Case No. 800-2015-016457 OAH No. 2017091058

PROPOSED DECISION

Administrative Law Judge Carla L. Garrett heard this matter on March 12, 13, 14, and 15, 2018, at Los Angeles, California.

Claudia Ramirez, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board). Henry R. Fenton and Nicholas Jurkowitz, Attorneys at Law, represented Harold T. Peart, M.D. (Respondent), who was present at hearing.

During the hearing, Complainant amended the Accusation by deleting paragraph 11, with exception of "patient CJ, a 36-year-old female."

On February 26, 2018, Complainant moved for a protective order requesting that Exhibits 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 27 be placed under seal because the documents contain confidential information which is protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not have provided adequate privacy protection. The ALJ granted the motion, with the exception of Exhibits 3 and 14, which were withdrawn, and on her own motion, added Exhibits F, G, and H that included confidential information, and issued a Protective Order placing the above-referenced exhibits under seal. Those documents shall remain under seal and shall not be opened, except as provided by the Protective Order. 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 Protective Order, provided that such documents are protected from release to the public.

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on March 15, 2018.

FINDINGS OF FACT

1. Complainant made the Accusation in her official capacity as Executive Director of the Board.

2. The Board issued Physician's and Surgeon's Certificate Number G 40523 to Respondent on August 3, 1979. The certificate is scheduled to expire on August 30, 2018, unless renewed.

Respondent's Background

3. Respondent is a Board-certified obstetrician and gynecologist. He earned his bachelor's and master's degrees in zoology from Howard University in 1971 and 1973, respectively, and earned his doctorate of medicine from the College of Physicians and Surgeons at Columbia University in 1978. Respondent completed an internship and residency in the Department of Obstetrics and Gynecology at Martin Luther King, Jr. General Hospital in 1979 and 1982, respectively.

4. Since 1982, Respondent has been in private practice in obstetrics and gynecology, and since 1990, has served as a primary care physician. He has delivered 15,000 to 18,000 babies over the years. Respondent currently serves on Cedars Sinai's Foundation Physician Advisory and Integration Council, as well as on the Cedars Sinai Health Associated Medical Board. Respondent was awarded Physician of the Year in 2016 by Cedars Sinai's obstetricians and in 2007 by Cedars Sinai's labor and delivery nurses. Respondent has also been honored with a number of other awards and acknowledgements during his years as a physician.

Patient SD[1]

A. October 20, 2015 Visit

5. On October 20, 2015, Patient SD, a 24-year-old woman, sought prenatal care from Respondent after discovering through a home pregnancy test that she was pregnant. Patient SD had been Respondent's patient since 2011 and Respondent had delivered two of her children. Respondent screened Patient SD for chlamydia and gonorrhea, but ordered no prenatal blood tests at this visit or at any subsequent visit to screen for Rh factor, hepatitis, syphilis, HIV, and varicella. At hearing, Respondent testified that Patient SD refused to take any prenatal blood tests because she was not sure whether she was going to keep the

[1] Patients are identified by their initials to protect their privacy.

pregnancy, but Patient SD vehemently denied this claim, and credibly testified she told Respondent no such thing. It was her intention to keep the pregnancy, and engaged in behavior to increase the odds of delivering a healthy baby, such as abstaining from alcohol. Respondent recorded nothing in the medical notes indicating that Patient SD had refused to take any prenatal blood tests or that Patient SD had communicated anything indicating she was contemplating whether she was going to keep the pregnancy.

6. During Respondent's prenatal treatment of Patient SD's previous pregnancies, Respondent ordered prenatal blood panels and recorded Patient SD's blood type and the results of the Rh factor screening.

7. During the October 20, 2015 visit, Patient SD told Respondent that her last menstrual cycle began on September 8, 2015. After confirming Patient SD's pregnancy with a urine pregnancy test, Respondent performed a pelvic examination (i.e., a bimanual examination consisting of sliding fingers into the vagina with one hand while simultaneously pressing on the abdomen with the other hand) and noted that he felt a six to seven week sized uterus. Respondent performed a vaginal ultrasound which revealed "a structure in the uterus less than 6mm (6 weeks IUP)." (Exhibit 7, page 010.) At hearing, Respondent testified that he had been performing vaginal ultrasounds in his office for more than 10 years.

8. Respondent noted that Patient SD's body mass index (BMI) was 38, demonstrating that Patient SD was excessively obese. At hearing, Respondent testified that he has treated hundreds of excessively obese patients.

9. Respondent prescribed prenatal vitamins to Patient SD and instructed her to return in November 2015 for her next prenatal visit.

10. Patient SD failed to return for her November 2015 prenatal visit. At hearing, Patient SD explained that in November 2015, her life had become very hectic. Specifically, she experienced difficulties with her landlord that necessitated that she, her fiancé, and their two children move to a new residence. Additionally, she experienced a significant lack of energy, but still had to go to work to help support her family. These combined factors left her feeling overwhelmed and unable to complete the task of returning to Respondent's office for her November 2015 appointment. However, after missing her appointment, Patient SD scheduled a new appointment for December 8, 2015.

B. December 8, 2015 Visit

11. On December 8, 2015, 47 days after her initial visit, Patient SD returned to Respondent's office for prenatal care. At hearing, Respondent testified that, at this time, he believed Patient SD was approximately 12 weeks and five days pregnant.[2] While

[2] In a September 1, 2016 letter he wrote to the Board, Respondent stated that Patient SD was 13 weeks pregnant.

Respondent did not state in Patient SD's medical records that he had performed a pelvic examination on December 8, 2015, Respondent testified that he performed a bimanual examination and concluded that the uterus was the same size as it was when he examined her on October 20, 2015. He explained that he expected to feel an increase in the size of the uterus since the last appointment. Respondent also performed a vaginal ultrasound and noted that it "reveal[ed] no evidence of an intrauterine pregnancy." (Exhibit 7, page 010.) Respondent told Patient SD that she had suffered a missed abortion (i.e., the death of the fetus without signs of miscarriage such as vaginal bleeding or abdominal pain). Patient SD told Respondent that she felt fluttering at the bottom of her abdomen, but Respondent told her that it was probably gas. Patient SD stated,

> [Respondent] checked the size of my uterus and claimed it hasn't grown at all, he did a vaginal ultrasound and he didn't see anything. I told him maybe he should use the ultrasound that goes over the belly, he suggested no. Nothing is in there. I asked him to use a doopler[3] (*sic*), he said there was no point to that.

(Exhibit 4.)

12. At hearing, Respondent explained that he did not typically perform abdominal ultrasounds or listen for fetal tones with a Doppler before the patient reached the third month of pregnancy. Respondent further testified that in Patient SD's case, when he believed her to be 12 or 13 weeks pregnant at the time of her December 8, 2015 visit, an abdominal ultrasound would not have been as accurate as a vaginal ultrasound, particularly given her obese size. He explained that a vaginal ultrasound at 12 or 13 weeks of pregnancy, no matter the size of the fetus, yields a clearer view than an abdominal ultrasound because the ultrasound instrument can get closer to the uterus.

13. Respondent ordered a HCG draw (i.e., a blood test to determine the level of the human chorionic gonadotropin hormone, which is produced during pregnancy). The result of the test showed that Patient SD's HCG level was 42,954 mIU/mL. Respondent instructed Patient SD to undergo another HCG blood draw on December 13, 2015, which yielded a result of 41,385 mIU/mL, and a final HCG blood draw on December 20, 2015, which yielded a result of 29,251 mIU/mL. Respondent testified at hearing that he expected the numbers to increase because Patient SD's pregnancy was in the first trimester. Respondent concluded that Patient SD's declining HCG levels established that the pregnancy was no longer growing and that Patient SD was suffering a miscarriage. Respondent told Patient SD that he needed to perform a D&C (i.e., a dilation and curettage), which is a surgical procedure consisting of the opening of the cervix (i.e., dilation) and the removal of the contents of the uterus (i.e., curettage). Respondent had performed thousands of D&Cs over the years of his practice. Patient SD reported to Respondent that she still experienced signs of pregnancy, like nausea and vomiting. Respondent nevertheless scheduled the D&C procedure for January 8, 2016.

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[3] A Doppler is a hand-held fetal monitor that provides an audible simulation of the fetal heartbeat.

C. January 8, 2016 D&C Procedure and Subsequent Medical Issues

14. On January 8, 2016, 17 weeks and six days after the reported date of her last menstrual cycle (i.e., September 8, 2015), Patient SD arrived at Respondent's office to undergo the D&C procedure. Patient SD signed a "CONSENT FOR DIAGNOSITIC D&C BY VACUUM ASPIRATION" form, which stated that "[Patient SD] hereby direct[s] and request[s] [Respondent] to perform a uterine aspiration procedure or Diagnostic D&C," and "[Patient SD] understand[s] that the procedure is carried out by suction aspiration of the contents of the uterus." (Exhibit 7, page 037.)

15. Respondent did not perform an ultrasound prior to performing the procedure. After performing the D&C procedure, Respondent noted in his medical records that Patient SD underwent a dilation and sharp curettage. During his testimony, Respondent stated that he also used a vacuum suction curettage, but he did not state the same in Patient SD's medical records, because the electronic medical records template used in his office did not include the reference. However, he stated that he used vacuum suction curettage in all D&C procedures he has performed. Following the procedure, the pathology department confirmed that Respondent had removed "products of conception" (i.e., fetal and/or placental tissue), which Respondent deemed consistent with a missed abortion.

16. Despite undergoing the D&C procedure, Patient SD still felt signs of pregnancy, such as vomiting, nausea, fatigue, and fluttering in the lower abdomen. Patient SD testified that the following day, she "started feeling weird." Specifically, Patient SD testified that her back hurt and she felt "more sick than [she felt] before."

17. On January 13, 2016, five days after the D&C procedure, Patient SD, while driving, experienced fluid coming out of her vagina. She pulled over and entered a Starbucks to use the restroom, as Patient SD believed she may have been hemorrhaging. When she discovered the fluid was clear, Patient SD returned home and rested. However, whenever she stood to walk, more fluid discharged from her vagina. Patient SD decided to go to Kaiser's Emergency Room (ER).

D. ER Visit and Subsequent D&C

18. While in the ER on January 13, 2016, Patient SD explained that she had undergone a D&C procedure five days prior. The ER physician performed a vaginal ultrasound, but could not see the entire uterus. The ER physician then ordered an abdominal ultrasound, which revealed a live 18-week size fetus with decreased amniotic fluid. The ER physician arranged for an obstetrician/gynecologist to consult with Patient SD, who concluded that there was a very low likelihood of a successful pregnancy due to the substantial lack of amniotic fluid, and explained the risks of attempting to maintain the pregnancy. Patient SD received information about termination option and facilities, and then left the ER.

19. Patient SD experienced difficulty in finding a facility that her health insurance would cover to remove the fetus, given the advanced state of her pregnancy. Patient SD ultimately located a Family Planning Association (FPA) facility that performed abortions for women in their second trimester. Patient SD, who was 20 weeks pregnant, explained that she wanted to keep the pregnancy if possible, but after the performance of an ultrasound that revealed that the fetus had virtually no amniotic fluid, the FPA physician recommended that she undergo an abortion. Patient SD followed the recommendation and permitted the FPA to perform a D&C procedure, which resulted in the successful termination of her pregnancy.

20. On January 19, 2016, Patient SD filed a complaint with the Board concerning Respondent's care and treatment.

21. At hearing, Respondent testified that if someone like Patient SD presented to him today, he would send her out to a radiologist or a perinatologist for a formal ultrasound to confirm or deny his suspicion of an abnormal fetus or pregnancy, and would not rely on HCG levels. As such, now, whenever he encounters something in a patient's pregnancy that is different from what he expects, Respondent sends them out for a second opinion.

Patient CJ

22. On August 6, 2015, Patient CJ, a 36 year-old woman, sought an abortion from Respondent after discovering she was pregnant through a positive home pregnancy test. Respondent had served as Patient CJ's primary care physician since 1999. Respondent confirmed the pregnancy and performed a pelvic examination which revealed a six to seven-week sized uterus. Respondent scheduled a D&C procedure for August 14, 2015.

23. On August 14, 2015, Respondent performed the D&C procedure in his office with local anesthesia and noted in Patient CJ's medical records that Patient CJ underwent a dilation and sharp curettage. Following the procedure, the pathology department confirmed that Respondent had removed products of conception.

24. On August 25, 2015, Patient CJ returned to Respondent's office complaining that she still felt pregnant. Respondent performed a pelvic examination which revealed a six to seven-week sized uterus. Respondent ordered a HCG draw, the results of which showed that Patient CJ's HCG level at 51,949 mIU/mL, thereby confirming Patient CJ's continued pregnancy. Respondent then authorized Patient CJ to undergo another D&C procedure, but this time, pursuant to Patient CJ's request, the procedure would be performed under general anesthesia. Respondent told Patient CJ he would be leaving for vacation on the following day, but did not provide Patient CJ with definitive information indicating when he would be performing the D&C procedure, and provided her with no instructions regarding her care in his absence.

25. On September 1, 2015, while Respondent was still on vacation, Patient CJ submitted a complaint to the Board stating that she was "not sure if [she was] waiting on [Respondent] to come back from vacation or what." (Exhibit 15, page 002.)

26. Respondent explained at hearing, as well as in his interview with the Board, that when he left for vacation, another physician covered his practice. Even though he was on vacation, he spoke with his office staff daily who then spoke with Patient CJ daily. He testified that the physician covering his practice could have performed the D&C procedure, but Patient CJ would have had to go to the emergency room to initiate the process. However, Patient CJ did not want to go to the emergency room, because she would have incurred additional costs. At hearing, Patient CJ explained that she was in no position to pay such costs as she had been experiencing financial difficulty.

27. Respondent made no arrangements with his backup physician to examine Patient CJ in his absence or to perform the D&C procedure in a hospital or surgical center that did not necessitate Patient CJ going through an emergency room. Respondent's staff told Patient CJ that she should go to the emergency room if she experienced any life threatening symptoms or severe pain. Patient CJ experienced no intolerable pain or bleeding. Additionally, Respondent discovered nothing during his examination of Patient CJ on August 25, 2015 that suggested the D&C procedure needed to be performed sooner. As such, Respondent concluded that no emergency existed, and thus determined that Patient CJ's D&C procedure could wait until he returned from vacation.

28. On September 9, 2015, 15 days after Patient CJ's office visit, Respondent performed a D&C procedure on Patient CJ at Good Samaritan Hospital, and dictated medical notes at the hospital stating that he had performed a dilation and suction curettage on Patient CJ under general anesthesia. Following the procedure, the pathology department confirmed that Respondent had removed products of conception. Patient CJ signed out of the recovery room against medical advice and did not return for her post-operative examination.

Complainant's Expert (Dr. John C. Gustafson)

29. Dr. John Gustafson provided testimony as Complainant's expert witness. Dr. Gustafson earned his bachelor's degree in biochemistry from the University of California at Berkeley in 1973, and earned his medical degree from the University of Rochester School of Medicine in 1977. He completed his internship and residency in the Department of Obstetrics and Gynecology at University of Southern California / Los Angeles County Medical Center in 1978 and 1981, respectively. Dr. Gustafson is a licensed physician and board certified obstetrician and gynecologist.

30. Since 1981, Dr. Gustafson has been in private practice in Ventura, California, and is affiliated with Community Memorial Health Systems as an active staff member, the University of California at Los Angeles as an assistant clinical professor in the Department of Obstetrics and Gynecology, and the University of Southern California / Los Angeles County Medical Center as an assistant clinical professor in the Department of Obstetrics and Gynecology. He has held medical staff positions at Ventura County Medical Center and Community Memorial Heal Systems as chairman of the Department of Obstetrics and Gynecology, and maintains society memberships with the Ventura County Medical Society, the California Medical Association, the American Medical Association, and the American

College of Obstetrics and Gynecology. Dr. Gustafson has authored no publications in the field.

31. Dr. Gustafson's practice is currently 50 percent obstetrics and 50 percent gynecology, and he delivers approximately 250 babies per year. He has also performed thousands of D&C procedures over the course of his career. At one time, Dr. Gustafson performed ultrasounds in his office for a period of approximately 10 years, but he has not performed ultrasounds in his office in the last 15 years. Instead, Dr. Gustafson sends patients to specialized facilities for vaginal and abdominal ultrasounds. However, he does perform ultrasounds on patients in the hospital during labor and delivery.

A. Patient SD

32. Dr. Gustafson evaluated whether Respondent's treatment of Patient SD conformed to the standard of care, and prepared a written report setting forth his conclusions. At hearing, Dr. Gustafson described the standard of care as that which a reasonable obstetrician or gynecologist in similar circumstances would exercise when providing care to a patient. Dr. Gustafson reviewed Patient SD's medical records prepared by Respondent and those prepared by Kaiser's ER department, and a transcript from Respondent's interview with the Board held on February 1, 2017, among other things. After Dr. Gustafson's review of the materials, he concluded Respondent deviated from the standard of care in three primary areas: (1) properly dating Patient SD's pregnancy prior to performing a D&C procedure; (2) preparing erroneous operative or procedure notes; and (3) failing to perform a prenatal blood panel.

1. Failing to Properly Date Pregnancy Before D&C Procedure

33. Dr. Gustafson stated in his report that the standard of care requires the physician to determine "the dating, estimated date of confinement of pregnancy, and viability of a pregnancy prior to a termination of a desired (wanted) pregnancy." (Exhibit 12, page 3.) Dr. Gustafson noted that Respondent only performed a vaginal ultrasound, and not an abdominal ultrasound, and that it was incumbent on Respondent to expose Patient SD to better testing, such as sending Patient SD to an outside facility specializing in ultrasounds before determining whether Patient SD had a viable pregnancy. At hearing, Dr. Gustafson testified that had Respondent performed an abdominal ultrasound, he would have seen the existence of a viable pregnancy before performing the D&C procedure on January 8, 2016.

34. Dr. Gustafson also testified that after Respondent performed a vaginal ultrasound on Patient SD on December 8, 2015, when Patient SD was 12 weeks and five days pregnant, and found "no evidence of an intrauterine pregnancy" (Exhibit 7, page 010), Respondent should have performed an abdominal ultrasound.

35. Dr. Gustafson additionally noted that Respondent assumed incorrectly that the HCG levels were diagnostic of a missed abortion in the first trimester, when, in fact, the HCG levels were declining because Patient SD's pregnancy had successfully progressed to

the second trimester, when HCG levels naturally decrease. At hearing, Dr. Gustafson explained that, typically, HCG levels during the first trimester steadily increase and then begin falling beginning at approximately 10 weeks of pregnancy. Dr. Gustafson calculated that, based on Patient SD's reported date of her last menstrual cycle (i.e., September 8, 2015), Patient SD was 12 weeks and five days pregnant at the time of her December 8, 2015 HCG test, 13 weeks and four days pregnant at the time of her December 13, 2015 HCG test, and 14 weeks and four days pregnant at the time of her December 20, 2015 HCG test. Dr. Gustafson stated that Respondent's incorrect conclusion that the decreasing HCG levels evidenced a missed abortion in the first trimester, as opposed to the natural progression of her pregnancy in the second trimester, resulted in Respondent's attempt to terminate a viable pregnancy on January 8, 2016, when Patient SD was 17 weeks and six days pregnant.

36. Dr. Gustafson concluded that Respondent committed an extreme departure from the standard of care for performing a termination on a wanted pregnancy, as a result of his failure to properly determine the viability of the pregnancy.

2. Erroneous Operative or Procedural Notes

37. Dr. Gustafson stated in his report that the standard of care requires that medical records contain the proper documentation of a surgery or a procedure. Dr. Gustafson noted that Respondent performed a suction curettage during the D&C procedure of Patient SD, but Respondent's note in Patient SD's chart mentioned nothing about suction curettage. At hearing, Dr. Gustafson testified that nearly all physicians use a suction curettage during D&C procedures, but that those who use the sharp curettage method only would still be operating within the standard of care. However, Dr. Gustafson explained that medical records are supposed to be correct and properly document what the physician did, so that someone, typically another physician, would know what the physician did.

38. Dr. Gustafson concluded that Respondent committed a simple departure from the standard of care by failing to include a complete and accurate operative note concerning the D&C procedure.

3. Failure to Perform a Prenatal Blood Panel

39. Dr. Gustafson stated in his report that the standard of care requires the execution of a prenatal blood panel, including a test of Rh factors, be completed within 17 weeks from the patient's last menstrual cycle. Dr. Gustafson explained that generally, such blood panels are performed early in the pregnancy, typically during the first prenatal visit, and ordering such panels has been the standard for decades. Dr. Gustafson noted that no prenatal blood studies were documented in Patient SD's medical records in connection with this pregnancy, and that the failure to do so constituted a simple departure from the standard of care. Dr. Gustafson further testified that it is important to order these blood panels with every pregnancy, because those studies can change from pregnancy to pregnancy, with the exception of blood type and Rh factor results.

B. Patient CJ

40. Dr. Gustafson evaluated whether Respondent's treatment of Patient CJ conformed to the standard of care, and prepared a written report setting forth his conclusions. Dr. Gustafson reviewed Patient CJ's medical records prepared by Respondent and by Good Samaritan Hospital, and a transcript from Respondent's interview with the Board held on February 1, 2017, among other things. After Dr. Gustafson's review of the materials, he concluded Respondent deviated from the standard of care in one pertinent area: delay in performing a repeat D&C procedure on Patient CJ.

41. Dr. Gustafson stated in his report that the standard of care required the diagnosis and treatment of the products of conception that were retained after the August 15, 2015 D&C procedure. In his testimony, Dr. Gustafson explained that the American College of Obstetricians and Gynecologists (ACOG), which provides a framework from which to practice, lists no clear guidelines regarding abortions, and sets forth nothing about how long a physician should reasonably wait to perform a D&C procedure. Consequently, Dr. Gustafson consulted other materials, including literature setting forth guidelines on performing safe abortions in third world countries, which state that evacuations of the uterus should be done in a prompt and timely manner. He also contacted a colleague in the family planning department of the University of Southern California / Los Angeles County Medical Center to inquire whether a 15-day delay in performing a repeat D&C procedure was within the standard of care.

42. Dr. Gustafson concluded that Respondent's delay in performing a repeat D&C procedure for 15 days to eliminate the products of conception retained after the August 15, 2015 D&C procedure was too long and constituted a simple departure from the standard of care, even though Patient CJ ultimately fared well. At hearing, Dr. Gustafson explained that the fact that Patient CJ had suffered no pain or bleeding during the 15-day period did not absolve Respondent, because his delay exposed Patient CJ to risk of infection. Dr. Gustafson stated that the objective of the standard is to prevent complications.

Respondent's Expert (Dr. Howard Mandel)

43. Dr. Howard C. Mandel testified as Respondent's expert witness. Dr. Mandel earned his bachelor's degree in natural sciences from Johns Hopkins University in 1977, and earned his medical degree from New York University in 1981. He completed his residency at Cedars Sinai Medical Center in 1984, and served as its chief resident from 1984 to 1985. Dr. Mandel is a licensed physician and board certified obstetrician and gynecologist.

44. Since 1985, Dr. Mandel has been in private practice in Century City, California, a managing partner of the medical building of Century City Women's Health from 1992 to 2015, a principal of an association of medical practices in obstetrics and gynecology of Century City Women's Health since 1985, a consultant in student health services at the University of Southern California since 1985, a consultant at Saban Community Clinic since 1982, and a consultant at California Family Health Council since

1990. Dr. Mandel has served on dozens of boards and committees since 1985, and has received a number of honors, awards, and recognitions, nationally and internationally. He maintains society memberships with ACOG, the Johns Hopkins University Alumni Association, the American Association of Gynecologic Laparoscopists, the American Medical Association, California Medical Association, Los Angeles County Medical Association, and the Association of American Physicians and Surgeons. Dr. Mandel has authored dozens of publications in the field, and has served as an academic lecturer.

45. Dr. Mandel has delivered more than 10,000 babies over the course of his career, and has performed 1,800 to 2,000 D&C procedures. He regularly provides prenatal care to his patients and performs ultrasounds, both vaginally and abdominally.

46. Dr. Mandel reviewed Patient SD's and Patient CJ's medical records, Dr. Gustafson's written reports concerning Patient SD and Patient CJ, and a transcript from Respondent's interview with the Board held on February 1, 2017, among other things. Dr. Mandel prepared a written report.

A. Patient SD

47. Dr. Mandel disagreed with Dr. Gustafson in concluding that Respondent engaged in negligence, gross or otherwise, in his care and treatment of Patient SD. Dr. Mandel wrote:

> [T]he standard of care did not require that [Respondent] perform an abdominal ultrasound on [P]atient SD to confirm pregnancy. In this case, [Respondent] performed an initial trans vaginal ultrasound on [P]atient SD which showed an abnormal size with size less than dates. [Respondent] then followed up that ultrasound on the next visit, in which no viable pregnancy was identified. [Respondent] then followed up by obtaining blood levels in order to confirm the pregnancy and its viability. Based upon the ultrasound results and the decrease in blood levels, it was not unreasonable for [Respondent] to have concluded a missed abortion occurred.

(Exhibit 29.)

48. At hearing, Dr. Mandel testified that Respondent had provided care and treatment for Patient SD within the standard of care, and operated in a prudent manner and did everything a prudent physician would have done. Dr. Mandel stated that it was reasonable for Respondent to perform a D&C procedure after making a diagnosis of a missed abortion. He testified that there was nothing Respondent should have done differently.

49. Dr. Mandel's written report mentioned nothing about Patient SD's weight or her BMI of 38.17, however at hearing, Dr. Mandel testified that he considered Patient SD's morbid obesity a significant factor, because physical examinations are more difficult in obese patients, particularly when trying to feel the uterus. Thus, when Respondent examined

Patient SD's uterus bimanually, Respondent felt a six millimeter fetus. Dr. Mandel testified that six millimeters is smaller than normal, but within the range for the early part of pregnancy.

50. Additionally, with respect to obesity, Dr. Mandel testified that ultrasounds in obese patients are notoriously distorted. Dr. Mandel explained that ultrasounds work by sending sound waves through the tissue, and because fat distorts soundwaves, the ultrasounds will likely miss more things.

51. Dr. Mandel testified that on December 8, 2015, during Patient SD's 12th week of pregnancy, specifically when Patient SD was 12 weeks and five days pregnant, Respondent practiced within the standard of care when he performed a vaginal ultrasound, and not an abdominal ultrasound. Dr. Mandel explained that at the 12-week mark, it is very difficult to see anything on an abdominal ultrasound, because the uterus is at the pubic bone at that time, and because the ultrasound cannot penetrate the pubic bone, a physician would have a better chance of seeing the uterus with a vaginal ultrasound, as the pubic bone does not obstruct vaginal ultrasounds. Dr. Mandel stated that before 14 weeks of gestation, only vaginal ultrasounds should be used. Dr. Mandel further stated that when Respondent performed the vaginal ultrasound on Patient SD on December 8, 2015, Dr. Mandel would have expected Respondent to find a structure the size of a large gummy bear. However, Respondent found no evidence of an intrauterine pregnancy, which Dr. Mandel attributed to Patient SD's obesity, thus Respondent, according to Dr. Mandel, appropriately performed HCG tests.

52. Dr. Mandel testified that Patient SD's HCG levels should have been increasing at the 12 week mark, and explained that the levels do not begin to decrease until the second trimester, which begins at 13 weeks and one day to 26 weeks, and not after 10 weeks as Dr. Gustafson testified. Respondent, who was also designated an expert witness in this matter, also testified that HCG levels typically level off after about 13 weeks, and also disagreed with Dr. Gustafson that levels begin to level off at 10 weeks. Respondent testified that HCG levels peak at the end of the first trimester and then level off in the second.

53. On January 8, 2016, when Patient SD arrived at Respondent's office for the D&C procedure, when she was 17 weeks and six days pregnant, Dr. Mandel explained that performing an abdominal ultrasound at this point, given the missed abortion diagnosis that Respondent had given previously, could have caused the patient emotional trauma, as the patient would have been forced to see the failed pregnancy.

54. Dr. Mandel disagreed that Respondent's medical records concerning Patient SD fell below the standard of care. Specifically, Dr. Mandel wrote:

> [The Board's] allegation that [Respondent's] operative report was inadequate because [Respondent] did not state that he performed a suction curettage is unfounded. The records identify the procedure that was performed, D&C, and the standard of care did not require

> that [Respondent] state 'suction curettage,' since that is the modern D&C that is virtually always performed in early pregnancy.

(*Ibid.*)

55. At hearing, Dr. Mandel reiterated that "everybody is doing suction curettage in this day and age" and have been doing so "for the last 50 years." Consequently, according to Dr. Mandel, Respondent did not deviate from the standard of care for not writing in Patient SD's medical records that he applied suction curettage, because it was something "that is understood in the industry." Like Dr. Gustafson, Dr. Mandel also testified that physicians who use a sharp curettage only would be operating within the standard of care too, because that method had been used for years before the introduction of the suction curettage method. Dr. Mandel stated that Patient SD understood that Respondent was performing a suction curettage, because she signed a consent form stating so.

56. Dr. Mandel disagreed that Respondent's decision not to obtain prenatal blood studies fell below the standard of care, because Dr. Mandel asserted Patient SD was not certain that she would keep the pregnancy "and she regularly failed to return to the clinic as directed." (*Ibid.*) Dr. Mandel further stated, "[t]he standard of care does not require obtaining prenatal blood studies for unwanted pregnancies." (*Ibid.*)

57. At hearing, Dr. Mandel testified that once Respondent made the diagnosis of a missed abortion, there was no reason to order any blood panels, and Respondent did not deviate from the standard of care when he did not run such tests. According to Dr. Mandel, ordering blood panels under such conditions would have been a waste of money, and if the laboratory ended up sending the bill to the patient, the patient would be reminded of the failed pregnancy. Additionally, Dr. Mandel noted that Patient SD's prior records included Patient SD's blood type and Rh factor information.

B. Patient CJ

58. Dr. Mandel disagreed with Dr. Gustafson in concluding that Respondent committed a simple departure from the standard of care by delaying Patient CJ's D&C procedure for 15 days. Dr. Mandel wrote:

> The standard of care did not require that [Respondent] perform the D&C any sooner, since [P]atient CJ showed no signs of complications, including bleeding. Absent an emergency, it is within the standard of care of the physician to respect the wishes of his patients, including delaying non-emergency procedures. In this case, [Respondent] checked in on [Patient] CJ to make sure there were no complications or that an emergency did not arise. All of this was within the standard of care.

(*Ibid.*)

59. At hearing, Dr. Mandel testified that on August 25, 2015, when Patient CJ presented to Respondent's office with retained products of conception, but was not infected or bleeding, Respondent had three choices: (1) do nothing and let Patient CJ's body eliminate the products of conception on its own; (2) perform a repeated D&C procedure; or (3) give Patient CJ medication to produce contractions to eliminate the products of conception. Dr. Mandel stated that the standard of care did not require that Respondent perform a D&C procedure at all, as the body could have expelled the tissue itself, and there was nothing wrong in Respondent performing the procedure 15 days after Patient CJ's August 15, 2015 office visit. In other words, Respondent did not deviate from the standard of care when he did not perform the repeat D&C procedure for 15 days, as there was no time limit to perform the D&C procedure, according to Dr. Mandel.

Credibility Findings[4]

60. Dr. Gustafson and Dr. Mandel, with their wealth of experience during their respective decades of practice, their impressive credentials, their years of teaching and overseeing obstetrics programs, as well as their respective delivery of testimony in a clear,

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[4] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code, § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

concise, straightforward manner, proved to be exceptional witnesses. However, as set forth in more detail in the Legal Conclusions below, Dr. Gustafson's opinions related to Respondent's care and treatment of Patient SD were deemed more persuasive than those of Dr. Mandel, and Dr. Mandel's opinions regarding the care and treatment of Patient CJ were deemed more persuasive than those of Dr. Gustafson.

Character Evidence

61. Dr. Samuel J. Porter, an obstetrician and gynecologist who has been practicing medicine since 1972, provided character testimony on Respondent's behalf. Dr. Porter and Respondent are colleagues, have known each other for more than 25 years, and have assisted each other in hundreds of surgeries. Dr. Porter testified that Respondent has a very good reputation, is highly regarded, and even delivered Dr. Porter's granddaughter. However, Dr. Porter admitted that he has not observed Respondent provide prenatal care to patients.

62. Dr. Regina Edmond, an obstetrician and gynecologist who has been practicing medicine for 10 years, also provided character testimony on Respondent's behalf. Dr. Edmond met Respondent during her residency and has assisted with many of Respondent's surgeries. Dr. Edmond described Respondent as a great surgeon and physician, as well-liked among residents and other doctors at Cedars Sinai Hospital, and takes care of some of the sickest patients with complicated pregnancies. Like Dr. Porter, she has not observed Respondent provide prenatal care to patients.

63. Respondent submitted various thank you notes from patients who described Respondent as calm, cool, caring, safe, and one who possesses a gift of knowledge.

CONCLUSIONS OF LAW

1. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), for gross negligence in relation to his care and treatment of Patient SD, as set forth in Findings 5 through 21, and 29 through 36.

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), for repeated negligent acts in relation to his care and treatment of Patient SD, as set forth in Findings 5 through 21, and 29 through 39. However, Complainant failed to establish that Respondent committed any negligence in relation to his care and treatment of Patient CJ, as set forth in Findings 22 through 28, 40 through 46, and 58 through 60.

The Applicable Law

3. The standard of proof which must be met to establish the charging allegations herein is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance*

(1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

4. The purpose of the Medical Practice Act[5] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

5. The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.) (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

6. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

7. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

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[5] Business and Professions Code sections 2000 through 2521.

8. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

9. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

Analysis

A. Gross Negligence

10. Complainant met her burden of establishing clearly and convincingly that Respondent engaged in gross negligence, in violation of Business and Professions Code section 2234, subdivision (b), by committing an extreme departure from the standard of care, according to the credible testimony of Dr. Gustafson, by failing to properly date and determine the viability of Patient SD's pregnancy prior to performing a D&C procedure on a wanted pregnancy. The evidence showed that after Respondent detected no intrauterine pregnancy after performing a vaginal ultrasound on Patient SD on December 8, 2015, he ordered HCG blood tests, and from those results, determined that Patient SD had suffered a missed abortion.

11. However, Respondent's own testimony established that he understood that HCG levels typically begin to taper off after 13 weeks of pregnancy. Patient SD, based on the date of her last period (i.e., September 8, 2015), was nearly 13 weeks pregnant at the time of her first HCG test (i.e., 12 weeks and five days) when the level was 42,954 mIU/mL, was more than 13 weeks pregnant at the time of the second HCG test (i.e., 13 weeks and four days) when the level had decreased to 41,385 mIU/mL, and was well into her 14th week of pregnancy at the time of the final HCG test (i.e., 14 weeks and four days) when the level dipped down to 29,251 mIU/mL. Yet it appears that Respondent failed to reasonably consider that Patient SD's HCG levels had decreased because she had reached a point in her pregnancy in which the levels were naturally expected to dip, and thus engaged in no further action to confirm his suspicion of a missed abortion.

12. While Dr. Mandel testified that performing an abdominal ultrasound during Patient SD's December 8, 2015 visit would not have yielded clear results because of a potential pubic bone obstruction, he did state that abdominal ultrasounds do yield clear results after 14 weeks gestation. By January 8, 2016, the date scheduled for the D&C procedure, it had been more than 17 weeks since Patient SD's last period, yet Respondent elected not to perform an abdominal ultrasound to confirm his missed abortion diagnosis, despite Patient SD's previous complaints of still feeling pregnant, including fluttering in her abdomen, and despite her previous request that Respondent perform one. Even the ER

physician, who, like Respondent, experienced difficulty seeing the contents of Patient SD's uterus through a vaginal ultrasound, took the next reasonable step and ordered an abdominal ultrasound for further answers. Respondent, unfortunately, failed to do so, which yielded a tragic result for Patient SD.

13. In light of the above, Complainant clearly and convincingly established that Respondent failed to properly determine the viability of Patient SD's wanted pregnancy prior to his attempted termination of it. Thus, Respondent engaged in gross negligence in his care and treatment of Patient SD, in violation of Business and Professions Code section 2234, subdivision (b).

B. Repeated Acts of Negligence

14. Complainant met her burden of establishing clearly and convincingly that Respondent engaged in repeated acts of negligence in relation to his care and treatment of Patient SD, in violation of Business and Professions Code section 2234, subdivision (c). Complainant did not establish clearly and convincingly that Respondent engaged in any negligent acts with respect to his care and treatment of Patient CJ.

15. With respect to Patient SD, in addition to the gross negligence set forth above, Respondent engaged in simple departures of the standard of care by failing to properly document Patient SD's records and by failing to perform prenatal blood panel studies on Patient SD. In regard to Respondent's medical notes, the evidence showed that Respondent admitted to using a suction curettage when he performed the D&C procedure on Patient SD, and that the consent form signed by Patient SD indicated that Respondent would be implementing suction aspiration during the procedure, but his medical notes prepared after the procedure failed to state that he had, in fact, used suction curettage. Rather, the note only mentioned his use of a sharp curettage. Dr. Gustafson credibly testified that the standard of care requires that medical records contain the proper documentation of a surgery or a procedure.

16. While Dr. Mandel convincingly testified that most physicians use suction curettage when performing D&C procedures, a fact to which Dr. Gustafson agreed, his testimony was not more persuasive than Dr. Gustafson's concerning the standard of care in this regard. Specifically, Dr. Mandel testified that because suction curettage has been used in the field for more than 50 years, the standard of care did not require that physicians write the words "suction curettage" in a patient's medical chart after performing a D&C procedure. However, like Dr. Gustafson, Dr. Mandel stated that those physicians who use a sharp curettage only during D&C procedures would still be operating within the standard of care. Because there are multiple ways to perform D&C procedures within the standard of care, it necessarily follows that physicians must accurately document the manner in which they perform such procedures. Indeed, Dr. Gustafson testified that the purpose behind requiring properly documented medical notes concerns an individual's ability, typically another physician, to know what a physician did in the care and treatment of a patient. Because Respondent noted that he used a sharp curettage, but nothing about using a suction curettage,

he failed to properly document Patient SD's medical records, and thus committed a simple departure from the standard of care.

17. In regard to Respondent's failure to order prenatal blood panels on Patient SD, Dr. Gustafson persuasively testified that the standard of care requires the execution of a prenatal blood panel to screen for Rh factor, hepatitis, syphilis, HIV, and varicella, to be completed within 17 weeks from the patient's last menstrual cycle. However, the evidence showed that no prenatal blood studies were performed or documented in Patient SD's medical records in connection with this pregnancy, and thus, Respondent committed a simple departure from the standard of care. While Dr. Mandel testified that the standard of care did not require Respondent to order prenatal blood studies because Patient SD did not wish to keep her pregnancy, the evidence does not support Dr. Mandel's conclusion. Specifically, the record showed that Patient SD wished to maintain her pregnancy, evidenced by her acts of seeking prenatal care and abstaining from alcohol consumption.

18. Additionally, despite Dr. Mandel's assertion that Respondent committed no violation because Respondent included notations in Patient SD's prior records concerning her blood type and Rh factor in regard to her previous pregnancies, the evidence showed that this act did not eliminate Respondent's duty to order blood panel studies for this pregnancy. Specifically, Dr. Gustafson credibly testified that while blood type and Rh factor results do not change from pregnancy to pregnancy, the results of hepatitis, syphilis, HIV, and varicella screenings can. As such, Respondent committed a simple departure from the standard of care when he failed to order prenatal blood panels.

19. In light of the above, Complainant clearly and convincingly established that Respondent committed repeated negligent acts with respect to his care and treatment of Patient SD, in violation of Business and Professions Code section 2234, subdivision (c).

20. With respect to Patient CJ, Complainant failed to establish clearly and convincingly that Respondent deviated from the standard of care when he performed Patient CJ's repeat D&C procedure 15 days after she returned to his office with complaints of still feeling pregnant. In short, Complainant failed to persuasively identify and establish the prevailing standard of care in connection with repeat D&C procedures, and the acceptable period of time, if any, in which a physician must perform one. Dr. Gustafson admitted, in essence, that the standard of care in this area was not readily apparent, as ACOG, which provides a framework from which to practice, lists no clear guidelines regarding abortions, and sets forth nothing about how long a physician should reasonably wait to perform a D&C procedure. As a result, Dr. Gustafson relied on literature focused on safe abortions in third world countries, and a telephone call to a colleague in the family planning department of the University of Southern California / Los Angeles County Medical Center, to establish what he believed to be the standard of care in this area. Based on this literature and discussion, Dr. Gustafson determined that repeat D&C procedures should be done in a timely manner, and concluded that a 15-day delay in performing a repeat D&C procedure demonstrated a failure to perform the procedure in a timely manner. However, Dr. Mandel, who has been practicing medicine for more than 35 years, persuasively established that Respondent was

not required to perform the D&C procedure any sooner, because Patient CJ showed no signs of complications or emergent conditions, such as infection or bleeding, and because Patient CJ's body potentially could eliminate the products of conception on its own, making another procedure unnecessary. Given the absence of a firmly established standard in this area, coupled with the divergent and reasonable view of Dr. Mandel, Complainant failed to clearly and convincingly establish that Respondent's care and treatment of Patient CJ deviated from the standard of care.

Appropriate Level of Discipline

21. Complainant seeks revocation of Respondent's license. While revocation falls into the range of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, particularly given the gross negligence involved, such discipline is not warranted in this matter. Respondent has enjoyed a long period of practice with no prior record of discipline, and the proven unprofessional conduct in this matter concerned only one patient (i.e., Patient SD). Additionally, Respondent has maintained a positive reputation in his field, which has earned him Physician of the Year in 2016 by Cedars Sinai's obstetricians and Physician of the Year in 2007 by Cedars Sinai's labor and delivery nurses. Moreover, in an effort to prevent a reoccurrence of the tragic events that arose in Patient SD's case, Respondent credibly testified that now whenever he encounters something in a patient's pregnancy that is different from what he expects, he sends the patient out for a second opinion.

22. Business and Professions Code section 2229 provides that protection of the public is paramount, but the Board should take action that will stress education to address deficiencies in practice.

23. While the minimum period of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders* is five years' probation for gross and repeated acts of negligence violations, it is important to note that the purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) In this case, the public would be adequately protected by the imposition of a two-year period of probation, with specific terms and conditions, including a condition concerning education.

ORDER

Certificate Number G 440523 issued to Respondent Harold T. Peart, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for two years, upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true and correct copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

3. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

4. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

5. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

6. General Probation Requirements

Compliance with Probation Unit:

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes:

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice:

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal:

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California:

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

7. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

8. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

9. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee

and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

12. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

Date: April 16, 2018

DocuSigned by:
Carla L. Garrett
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CARLA L. GARRETT
Administrative Law Judge
Office of Administrative Hearings

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 21 2017
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Harold T. Peart, M.D.** **6091 W. Pico Blvd.** **Los Angeles, CA 90035** **Physician's and Surgeon's Certificate No. G 40523,** Respondent.	Case No. 800-2015-016457 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about August 3, 1979, the Medical Board issued Physician's and Surgeon's Certificate Number G 40523 to Harold T. Peart, 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 August 31, 2018, 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 unless otherwise indicated.

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

5. Section 2234 of the Code states, in pertinent part:

"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:

"....

"(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.

"...."

FACTUAL BACKGROUND

PATIENT S.D.

6. At all times relevant to the charges herein, Respondent was a licensed physician and surgeon practicing as an obstetrician-gynecologist (OB-GYN).

7. On October 20, 2015, patient S.D., a 24-year-old female at the time, presented to Pico Women's Medical Group (PWMG) with a chief complaint of a positive pregnancy test, desiring prenatal care. Her last menstrual period was on September 8, 2015. Respondent performed a pelvic exam, revealing a 6 to7 week sized uterus. A vaginal ultrasound revealed that she was 6 weeks pregnant. No prenatal labs were ordered.

8. S.D. returned on December 8, 2015. The prenatal record for this date states "vaginal ultrasound reveals no evidence of an intrauterine pregnancy. Will draw HCG." On December 9, 2015, the HCG test returned with a level at 42,954 mIU/mL. The test was repeated and, on December 14, 2015, returned with a level at 41,385 mIU/mL. The test was repeated again and, on December 21, 2015,returned with a level at 29,251 mIU/mL.

9. S.D. returned on January 8, 2016. The record for this date states "24 year old female had a missed abortion and is here for a D&C." Respondent performed on S.D. a dilatation and sharp curettage under a paracervical block. There is no mention of vacuum suction curettage being used.

10. On January 13, 2016, S.D. presented at a Kaiser Emergency Room ("ER") with a complaint of fluid coming out of her vagina. An abdominal ultrasound showed an 18-week sized live fetus with decreased amniotic fluid.

PATIENT C.J.

11. On July 20, 2015, patient C.J., a 36-year-old female at the time, presented to Respondent's office with a complaint of menorrhagia and dysmenorrhea for five months. Her last menstrual period was on June 21, 2015. No pregnancy test for this date appears in the records. A pelvic exam performed by Respondent revealed a 10 to 12 week retroflexed uterus. An ultrasound was ordered, but not performed.

12. On August 6, 2015, C.J. returned with a complaint of amenorrhea and a positive urine pregnancy test. A pelvic exam performed by Respondent showed a 6 to 7 week sized uterus and the positive pregnancy test was confirmed. She requested the pregnancy be terminated.

13. On August 14, 2015, Respondent performed on C.J. a dilatation and sharp curettage under a paracervical block. Products of conception were confirmed by pathology.

14. On August 25, 2015, C.J. presented with a complaint that she still felt pregnant. An examination performed by Respondent revealed a 6 to 7 week sized uterus. He then ordered a quantitative B-HCG, which returned with a level at 51,949 mIU/mL. Respondent authorized a dilatation and curettage under general anesthesia. There was a 15-day delay in having this procedure performed, however, because Respondent was out of town and did not consider this to be an emergency.

15. C.J. presented to Good Samaritan Hospital on September 9, 2015 and underwent a dilatation and suction curettage under general anesthesia. Pathology confirmed products of conception. She did not return for her post-operative examination.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of patient S.D. The circumstances are as follows:

17. The standard of care for an OB-GYN is to determine the dating, estimated date of confinement, and viability of a pregnancy prior to a termination of a wanted pregnancy.

18. Respondent's treatment of patient S.D., as set forth above in paragraphs 6 through 10, includes the following acts and/or omissions which constitute an extreme departure from the standard of care: Respondent only performed a vaginal ultrasound and not an abdominal ultrasound. When he reviewed the HCG titers, he incorrectly assumed they were diagnostic of a missed abortion in the first trimester. Instead, the HCG titers were falling because S.D. was further along in the second trimester, when HCG titers decrease. Respondent misdiagnosed and misunderstood the dating of S.D.'s pregnancy and performed a termination on a wanted pregnancy.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

19. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care and treatment of patients S.D. and C.J. The circumstances are as follows:

20. Complainant refers to and, by this reference, incorporates paragraphs 6 through 15, above, as though set forth fully herein.

21. The allegations of the First Cause for Discipline are incorporated by reference as if fully set forth herein.

22. The standard of care requires a surgery or procedure to be properly documented in the patient's medical record.

23. The standard of care requires that a prenatal blood panel (including Rh) must be drawn.

24. After a first trimester termination of pregnancy, the standard of care requires appropriate diagnosis and prompt treatment of retained products of conception.

25. Respondent's treatment of patients S.D. and C.J., as set forth above in paragraphs 6 through 15, includes the following acts and/or omissions which constitute repeated negligent acts:

A. Respondent only performed a vaginal ultrasound and not an abdominal ultrasound on S.D. When he reviewed the HCG titers, he incorrectly assumed they were diagnostic of a missed abortion in the first trimester. Instead, the HCG titers were falling because S.D. was further along in the second trimester, when HCG titers decrease. Respondent misdiagnosed and misunderstood the dating of S.D.'s pregnancy and performed a termination on a wanted pregnancy.

B. Respondent's operative note for patient S.D. is inaccurate. He performed a suction curettage on patient S.D., but his notes from her January 2016 visit make no mention of this.

C. Respondent failed to perform or order prenatal blood studies for patient S.D. at seventeen weeks from her last menstrual period and did not document her blood type or Rh in her

medical record.

D. Respondent failed to timely perform a dilatation and curettage on C.J. for retained products of conception after the first trimester termination that was performed in August 2015.

26. Respondent's acts and/or omissions as set forth in paragraphs 20 through 25, above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts, pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

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 40523, issued to Harold T. Peart, M.D.;

2. Revoking, suspending or denying approval of Harold T. Peart, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Harold T. Peart, 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 21, 2017

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

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