

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

In the Matter of the Accusation Against:

Alexandra Klikoff, M.D.

Physician's & Surgeon's
Certificate No. G 83647

Respondent.

Case No. 800-2015-016546

DECISION

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

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

JAN 14 2021

IT IS SO ORDERED DEC 15 2020

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

1 XAVIER BECERRA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 LAWRENCE MERCER
Deputy Attorney General
4 State Bar No. 111898
455 Golden Gate Avenue, Suite 11000
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Attorneys for Complainant
7

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

12 **Alexandra Klikoff, M.D.**
13 321 Highland Avenue
Santa Cruz, CA 95060-2662

14 Physician's and Surgeon's Certificate No. G 83647

15 Respondent.

Case No. 800-2015-016546

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

16
17 **IT IS HEREBY STIPULATED AND AGREED** by and between the parties to the above-
18 entitled proceedings that the following matters are true:

19 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
20 California. He brought this action solely in his official capacity and is represented in this matter
21 by Xavier Becerra, Attorney General of the State of California, by Lawrence Mercer.

22 2. Alexandra Klikoff, M.D. (Respondent) is represented in this matter by her attorneys
23 David M. Balfour, Esq. and Nossaman, LLP, 1925 Palomar Oaks Way, Suite 220, Carlsbad, CA
24 92008-6526.
25

26 3. On or about April 4, 1997, the Medical Board issued Physician's and Surgeon's
27 Certificate Number G 83647 to Respondent Alexandra Klikoff, M.D. The Physician's and
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1 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
2 herein and will expire on March 31, 2021, unless renewed.

3 **JURISDICTION**

4 4. On July 16, 2018, Complainant William Prasifka, in his official capacity as the
5 Executive Director of the Board, filed Accusation No. 800-2015-016546 (Accusation) against
6 Respondent. The Accusation was duly served upon Respondent and she timely filed a Notice of
7 Defense. A copy of the Accusation is attached hereto as Exhibit A.

8 **ADVISEMENT AND WAIVERS**

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10 5. Respondent has carefully read, fully discussed with counsel, and understands the
11 charges and allegations in Accusation No. 800-2015-016546.

12 6. Respondent has carefully read and fully understands the contents, force and effect of
13 this Stipulated Settlement and Disciplinary Order, and has fully reviewed and discussed same
14 with her attorney of record.

15 7. Respondent is fully aware of her legal rights in this matter including her right to a
16 hearing on the charges and allegations contained in Accusation No. 800-2015-016546 , her right
17 to present witnesses and evidence and to testify on her own behalf, her right to confront and
18 cross-examine all witnesses testifying against her, her right to the issuance of subpoenas to
19 compel the attendance of witnesses and the production of documents, her right to reconsideration
20 and court review of an adverse decision, and all other rights accorded her pursuant to the
21 California Administrative Procedure Act, the California Code of Civil Procedure, and all other
22 applicable laws, having been fully advised of same by her attorney of record. Respondent, having
23 the benefit of counsel hereby knowingly, intelligently, freely and voluntarily waives and gives up
24 each and every one of the rights set forth and/or referenced above.
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CULPABILITY

8. Respondent agrees that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2015-016546 and that she has thereby subjected her Physician's and Surgeon's Certificate to disciplinary action. Respondent further agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

9. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

10. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including electronic PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

11. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED: that Physician's and Surgeon's Certificate No. G 83647 issued to Respondent Alexandra Klikoff, M.D., shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code § 2227(a)(4). This Public Reprimand, which is issued in connection with Respondent's actions as set forth in Accusation No. 800-2015-016546, is as follows:

On and before April 26, 2014, you were the OB/GYN providing care and treatment for Patient A during her pregnancy, which was significant for monochorionic diamniotic twins and mild maternal preeclampsia. On April 26, 2014 you determined that delivery of Patient A's twins was appropriate. However, you encountered difficulties monitoring both twins, particularly Twin B. During this time, the intermittent fetal heart tracing showed variable decelerations for Twin B. You did perform an emergency cesarean section, but not until there had been substantial delay, which may have contributed to the adverse outcome for Twin B.

B. CLINICIAN-PATIENT COMMUNICATION COURSE: Within 60 calendar days

of the effective date of this Decision, Respondent shall enroll in a course in clinician-patient communication skills 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 clinician-patient communication skills course shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A clinician-patient communication skills 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

1 effective date of this Decision. Respondent shall submit a certification of successful completion
2 to the Board or its designee within 15 calendar days after completion of the course, or 15 days
3 after the effective date of this decision, whichever is later.

4 Respondent understands that failure to successfully complete the required course shall
5 constitute unprofessional conduct and grounds for further disciplinary action.
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ACCEPTANCE

I, Alexandra Klikoff, M.D., have carefully read this Stipulated Settlement and Disciplinary Order and, having the benefit of counsel, enter into it freely, voluntarily, intelligently and with full knowledge of its force and effect on my Physician's and Surgeon's Certificate No. G 83647. I fully understand that, after signing this stipulation, I may not withdraw from it, that it shall be submitted to the Medical Board of California for its consideration, and that the Board shall have a reasonable period of time to consider and act on this stipulation after receiving it. By entering into this stipulation, I fully understand that, upon formal acceptance by the Board, I shall receive this Public Reprimand from the Board and shall be required to comply with the terms and conditions of the Disciplinary Order set forth above. I also fully understand that any failure to comply with the terms and conditions of the Disciplinary Order set forth above shall constitute unprofessional conduct and that my Physician's and Surgeon's Certificate No. G 83647 will be subject to further disciplinary action.

Dated: 10/21/2020


ALEXANDRA KLIKOFF, M.D.

~~I have read and fully discussed with Respondent Alexandra Klikoff, M.D.~~
the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

Dated: 10/22/2020

NOSSAMAN, LLP


DAVID M. BALFOUR

Attorneys for Respondent

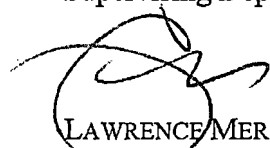
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ENDORSEMENT

The foregoing Stipulation is respectfully submitted for consideration by the Medical Board of California, Department of Consumer Affairs.

Dated: 10/23/2020

Respectfully submitted,
XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General



LAWRENCE MERCER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A
Accusation No. 800-2015-016546

1 XAVIER BECERRA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 LAWRENCE MERCER
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 16 2018
BY *[Signature]* ANALYST

7
8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 **Alexandra Klikoff, M.D.**
321 Highland Avenue
14 Santa Cruz, CA 95060-2662

15 Physician's and Surgeon's Certificate No. G 83647,

16 Respondent.

Case No. 800-2015-016546

ACCUSATION

17 Complainant alleges:

PARTIES

18 1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official
19 capacity as the Executive Director of the Medical Board of California.

20 2. On or about April 4, 1997, the Medical Board issued Physician's and Surgeon's
21 Certificate Number G 83647 to Alexandra Klikoff, M.D. (Respondent). The Physician's and
22 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
23 herein and will expire on March 31, 2019, unless renewed.

24 **JURISDICTION**

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

27 4. Section 2227 of the Code provides that a licensee who is found guilty under the
28 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed

1 one year, placed on probation and required to pay the costs of probation monitoring, or such other
2 action taken in relation to discipline as the Board deems proper.

3 5. Section 2234 of the Code states:

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

7 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
8 violation of, or conspiring to violate any provision of this chapter.

9 "(b) Gross negligence.

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

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

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

20 "(d) Incompetence.

21 "(e) The commission of any act involving dishonesty or corruption which is substantially
22 related to the qualifications, functions, or duties of a physician and surgeon.

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

24 "(g) The practice of medicine from this state into another state or country without meeting
25 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
26 apply to this subdivision. This subdivision shall become operative upon the implementation of the
27 proposed registration program described in Section 2052.5.

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

4 6. Section 2266 of the Code states:

5 “The failure of a physician and surgeon to maintain adequate and accurate records relating
6 to the provision of services to their patients constitutes unprofessional conduct.”

7 **CAUSE FOR DISCIPLINE**

8 **(Gross Negligence/Repeated Negligent Acts/Inadequate Records)**

9 7. Respondent Alexandra Klikoff, M.D. is subject to disciplinary action under section
10 2234 and/or 2234(b) and/or 2234(c) and/or 2266 in that Respondent was grossly negligent or
11 committed repeated negligent acts in her care and treatment of Patient A, was negligent in
12 arranging backup coverage for Patient B and failed to timely prepare and/or sign medical records
13 for Patient C. The circumstances are as follows:

14 **Patient A**

15 8. On and before April 26, 2014, Patient A was under Respondent’s care and treatment
16 related to her pregnancy. Patient A was a 32 year old gravida 2, paragravida 0, who had a twin
17 pregnancy significant for monochorionic, diamniotic twins. As a consequence, Patient A had been
18 followed by perinatologists, with alternating visits between Respondent’s office and the perinatal
19 diagnostic center. Delivery of the twins was recommended at 37 weeks.

20 9. Mild preeclampsia was first observed at the time of a nonstress test on April 15, 2014,
21 and on April 25, 2014, the patient was kept in the hospital for overnight observation. On April 26,
22 2014, Respondent determined that delivery was appropriate given the preeclampsia and this was
23 discussed with the patient. At 0945 hours the patient was having mild contractions every 7
24 minutes and was 4 cm dilated. At 1030 fetal heart rate monitoring was discontinued. She made
25 slow progress in labor and, at approximately noon was 6 cm. when monitoring was re-started.

26 10. Respondent encountered significant obstacles to monitoring both twins’ fetal heart
27 rates, but particularly as to Twin B. At 1230 hours, variable decelerations were noted for Twin B,
28 but the tracings were described as indeterminate. Late, variable decelerations were noted for Twin

1 B at 1300 hours. At approximately 1330 hours, Respondent attempted to remedy the problem
2 with fetal monitoring by breaking the bag of water on Twin A and placing a fetal scalp monitor.
3 However, difficulty monitoring Twin B persisted. Respondent later reported that Twin B could
4 not be located on the external monitor and that, at times, both monitors appeared to be monitoring
5 only one of the twins. The fetal scalp monitor on Twin A was not functioning properly, so that
6 neither fetal heart tone was heard for several minutes. An ultrasound was performed which
7 showed Twin B's fetal heart rate to have dropped to 100 and Respondent had Patient A taken to
8 the OR, where a repeat ultrasound showed Twin B's heart rate increased to the 130's at
9 approximately 1515. At approximately 1540, Twin B's heart rate again dropped. At 1600 the
10 heart rate was determined to be in the 80's. A emergent cesarean section was performed at 1612.

11 11. The outcome of the cesarean section included: "Twin A cephalic presentation, clear
12 fluid, viable female, Apgars 8/9, arterial cord pH 7.296/BE -6, venous cord pH 7.321/BE-4.2;
13 Twin B breech presentation, clear fluid, extremely pale, Apgars 0/0/0/2/3, arterial cord pH 6.878,
14 BE -16.9." Twin B subsequently died.

15 Patient B

16 12. Patient B was a 30 year old, gravida 1, paragravida 0, with a due date of June 26,
17 2015. On or about June 28, 2015, Patient B was admitted to the hospital by the midwife who
18 worked under Respondent's supervision. However, Respondent was covering two hospitals and
19 was attending another patient, whose care required her continuous in-hospital presence until
20 delivery. Respondent did not activate a back-up system to provide physician coverage for Patient
21 B, who eventually delivered by cesarean section the following morning by the oncoming
22 physician, with Respondent as an assistant.

23 Patient C

24 13. Patient C was a 33 year old, gravida 2, paragravida 1, who presented in labor at 39
25 weeks, 5 days on August 29, 2014. Patient C was eventually delivered by cesarean section for
26 fetal distress in labor. The infant's umbilical cord pH was 6.992 arterial and 7.014 venous. At the
27 time of the cesarean section, placental abruption was noted.

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1 14. Respondent's pre-operative note, explaining the patient's status and indication for the
2 cesarean section was not written until August 29 at 1536 hours. Similarly, a labor notation was
3 written four days after the event, on August 29, 2014.

4 15. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject
5 to disciplinary action based on her gross negligence and/or repeated negligent acts and/or
6 inadequate record keeping including, but not limited to, the following:

7 A. Respondent failed to expedite the delivery of Patient A's twins after being made
8 aware that the twins could not be monitored adequately;

9 B. Respondent failed to activate back-up coverage when she was unable to attend Patient
10 B in a timely manner;

11 C. Respondent unreasonably delayed four days before recording care earlier in the
12 course of Patient C's labor in the patient chart.

13 **PRAYER**

14 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
15 and that following the hearing, the Board issue a decision:

16 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 83647,
17 issued to Alexandra Klikoff, M.D.;

18 2. Revoking, suspending or denying approval of Alexandra Klikoff, M.D.'s authority to
19 supervise physician assistants and advanced practice nurses;

20 3. Ordering Alexandra Klikoff, M.D., if placed on probation, to pay the Board the costs
21 of probation monitoring; and

22 4. Taking such other and further action as deemed necessary and proper.

23
24 DATED: July 16, 2018


25 KIMBERLY KIRCHMEYER
26 Executive Director
27 Medical Board of California
28 State of California
Complainant

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