

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

In the Matter of the Accusation  
Against:

Jen-Kway Shen, M.D.

Physician's & Surgeon's  
Certificate No A44321

Respondent

Case No. 800-2018-043479

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 March 3, 2021.

IT IS SO ORDERED February 1, 2021.

MEDICAL BOARD OF CALIFORNIA

By: 

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

1 XAVIER BECERRA  
Attorney General of California  
2 JUDITH T. ALVARADO  
Supervising Deputy Attorney General  
3 REBECCA L. SMITH  
Deputy Attorney General  
4 State Bar No. 179733  
California Department of Justice  
5 300 South Spring Street, Suite 1702  
Los Angeles, CA 90013  
6 Telephone: (213) 269-6475  
Facsimile: (916) 731-2117  
7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:  
13  
14 JEN-KWAY SHEN, M.D.  
1629 Sialic Place  
La Habra Heights, CA 90631  
15  
16 Physician's and Surgeon's Certificate  
No. A 44321,  
17  
18 Respondent.

Case No. 800-2018-043479

**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

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

21 **PARTIES**

22 1. William Prasifka ("Complainant") is the Executive Director of the Medical Board of  
23 California ("Board"). He brought this action solely in his official capacity and is represented in  
24 this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith,  
25 Deputy Attorney General.

26 1. Jen-Kway Shen, M.D. ("Respondent") is represented in this proceeding by attorney  
27 Robert B. Packer, whose address is 505 North Brand Boulevard, Suite 1025, Glendale, California  
28 91203.





1           **A. PUBLIC REPRIMAND.**

2           This Public Reprimand, which is issued in connection with Respondent's care and  
3 treatment of Patient 1 as set forth in Accusation No. 800-2018-043479, is as follows:

4           In 2013, you committed acts constituting negligence in violation of Business  
5 and Professions Code section 2234, subdivisions (b) and (c), in your care and  
6 treatment of Patient 1, by failing to document a discussion of the risks and benefits  
7 of an elective Pitocin induction and timely recognize and treat Patient 1's severe  
8 blood loss following delivery.

9           **B. EDUCATION COURSE.**

10          Within sixty (60) calendar days of the effective date of this Decision, Respondent shall  
11 submit to the Board or its designee for its prior approval educational program(s) or course(s)  
12 which shall not be less than twenty (20) hours. The educational program(s) or course(s) shall be  
13 aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified.  
14 The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition  
15 to the Continuing Medical Education ("CME") requirements for renewal of licensure. Following  
16 the completion of each course, the Board or its designee may administer an examination to test  
17 Respondent's knowledge of the course. Respondent shall provide proof of attendance for twenty  
18 (20) hours of CME in satisfaction of this condition.

19          Respondent shall submit a certification of successful completion to the Board or its  
20 designee not later than fifteen (15) calendar days after successfully completing the educational  
21 program(s) or course(s), or not later than fifteen (15) calendar days after the effective date of the  
22 Decision, whichever is later.

23          If Respondent fails to enroll, participate in, or successfully complete the educational  
24 program(s) or course(s) within the designated time period, Respondent shall receive a notification  
25 from the Board or its designee to cease the practice of medicine within three (3) calendar days  
26 after being so notified. Respondent shall not resume the practice of medicine until enrollment or  
27 participation in the educational program(s) or course(s) has been completed. Failure to  
28 successfully complete the educational program(s) or course(s) outlined above shall constitute

1 unprofessional conduct and is grounds for further disciplinary action.

2 ACCEPTANCE

3 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully  
4 discussed it with my attorney, Robert B. Packer. I understand the stipulation and the effect it will  
5 have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and  
6 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the  
7 Decision and Order of the Medical Board of California.

8  
9 DATED: 12/30/2020

  
10 JEN-KWAY SHEN, M.D.  
11 Respondent

12 I have read and fully discussed with Respondent Jen-Kway Shen, M.D. the terms and  
13 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.  
14 I approve its form and content.

15  
16 DATED: 12/03/2020

  
17 ROBERT B. PACKER  
18 Attorney for Respondent

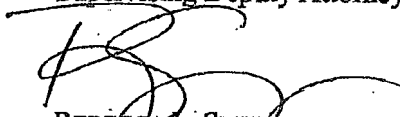
19 ENDORSEMENT

20 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully  
21 submitted for consideration by the Medical Board of California.

22 DATED: 12/23/2020

23 Respectfully submitted,

24 XAVIER BECERRA  
25 Attorney General of California  
26 JUDITH T. ALVARADO  
27 Supervising Deputy Attorney General

  
28 REBECCA L. SMITH  
29 Deputy Attorney General  
30 Attorneys for Complainant

LA2020501354/63787392.docx

**Exhibit A**

**Accusation No. 800-2018-043479**

1 XAVIER BECERRA  
Attorney General of California  
2 JUDITH T. ALVARADO  
Supervising Deputy Attorney General  
3 REBECCA L. SMITH  
Deputy Attorney General  
4 State Bar No. 179733  
California Department of Justice  
5 300 South Spring Street, Suite 1702  
Los Angeles, California 90013  
6 Telephone: (213) 269-6475  
Facsimile: (916) 731-2117  
7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:

Case No. 800-2018-043479

13 JEN-KWAY SHEN, M.D.  
14 1629 Sialic Place  
La Habra Heights, California 90631-8088  
15 Physician's and Surgeon's Certificate  
16 No. A 44321,

**A C C U S A T I O N**

17 Respondent.

18  
19 **PARTIES**

20 1. Christine J. Lally ("Complainant") brings this Accusation solely in her official  
21 capacity as the Interim Executive Director of the Medical Board of California, Department of  
22 Consumer Affairs ("Board").

23 2. On or about December 14, 1987, the Medical Board issued Physician's and Surgeon's  
24 Certificate Number A 44321 to Jen-Kway Shen, M.D. ("Respondent"). That license was in full  
25 force and effect at all times relevant to the charges brought herein and will expire on January 31,  
26 2021, unless renewed.

27 ///

28 ///



JURISDICTION

1  
2       3. This Accusation is brought before the Board under the authority of the following  
3 provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4       4. Section 2004 of the Code states:

5             The board shall have the responsibility for the following:

6             (a) The enforcement of the disciplinary and criminal provisions of the Medical  
7 Practice Act.

8             (b) The administration and hearing of disciplinary actions.

9             (c) Carrying out disciplinary actions appropriate to findings made by a panel or  
10 an administrative law judge.

11            (d) Suspending, revoking, or otherwise limiting certificates after the conclusion  
12 of disciplinary actions.

13            (e) Reviewing the quality of medical practice carried out by physician and  
14 surgeon certificate holders under the jurisdiction of the board.

15            (f) Approving undergraduate and graduate medical education programs.

16            (g) Approving clinical clerkship and special programs and hospitals for the  
17 programs in subdivision (f).

18            (h) Issuing licenses and certificates under the board's jurisdiction.

19            (i) Administering the board's continuing medical education program.

20       5. Section 2227 of the Code states:

21            (a) A licensee whose matter has been heard by an administrative law judge of  
22 the Medical Quality Hearing Panel as designated in Section 11371 of the Government  
23 Code, or whose default has been entered, and who is found guilty, or who has entered  
24 into a stipulation for disciplinary action with the board, may, in accordance with the  
25 provisions of this chapter:

26            (1) Have his or her license revoked upon order of the board.

27            (2) Have his or her right to practice suspended for a period not to exceed one  
28 year upon order of the board.

            (3) Be placed on probation and be required to pay the costs of probation  
monitoring upon order of the board.

            (4) Be publicly reprimanded by the board. The public reprimand may include a  
requirement that the licensee complete relevant educational courses approved by the  
board.

            (5) Have any other action taken in relation to discipline as part of an order of  
probation, as the board or an administrative law judge may deem proper.

1 (b) Any matter heard pursuant to subdivision (a), except for warning letters,  
2 medical review or advisory conferences, professional competency examinations,  
3 continuing education activities, and cost reimbursement associated therewith that are  
4 agreed to with the board and successfully completed by the licensee, or other matters  
5 made confidential or privileged by existing law, is deemed public, and shall be made  
6 available to the public by the board pursuant to Section 803.1.

7 6. Section 2234 of the Code, states:

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

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

13 (b) Gross negligence.

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

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

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

26 (d) Incompetence.

27 (e) The commission of any act involving dishonesty or corruption that is  
28 substantially related to the qualifications, functions, or duties of a physician and  
surgeon.

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

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

7. Section 2266 of the Code states:

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

///

///

///

1 **FACTUAL ALLEGATIONS**

2 8. Patient 1,<sup>1</sup> a then 33-year-old gravida 2, para 1 woman, arrived in California from  
3 China on February 20, 2013, in the late second/early third trimester of her pregnancy. She sought  
4 obstetrical care with Respondent on February 25, 2013, at which time she was approximately 27-  
5 weeks gestation with an estimated date of delivery of May 28, 2013. Patient 1 provided  
6 Respondent with some prenatal records from China, including an ultrasound performed on  
7 February 15, 2013, consistent with 25-weeks, 2-days gestation. Patient 1 saw Respondent for  
8 prenatal care approximately every two weeks for the next three months during which time,  
9 Respondent documented the progress of Patient 1's pregnancy, including blood pressure readings  
10 and laboratory studies. On April 26, 2013, Respondent diagnosed Patient 1 with gestational  
11 diabetes. He documented that he instructed her on diet, exercise and blood sugar monitoring and  
12 that she refused blood sugar monitoring treatment.

13 9. On May 20, 2013, Patient 1 presented to Respondent's office complaining of  
14 contractions. Respondent performed a cervical examination which revealed that Patient 1 was  
15 one centimeter dilated, 80% effaced and at minus one station. Respondent stated that Patient 1  
16 requested an induction of labor in order to hasten her return to China. He suggested that the  
17 patient wait until she passed her due date to be induced, but did not advise against induction at  
18 that time. The patient's request for induction and Respondent's recommendation to wait was not  
19 documented nor was there any documentation of any discussion with the patient regarding the  
20 risks associated with induction of labor.

21 10. On May 21, 2013 at 8:24 a.m., Patient 1 presented to PIH Health Hospital in Whittier  
22 (hereinafter referred to as "hospital") for induction of labor at 39-weeks gestation. Respondent  
23 admitted the patient to labor and delivery and gave telephonic admission orders at approximately  
24 9:25 a.m., including the administration of intravenous Pitocin.<sup>2</sup> There was no documentation of  
25 any discussion between Respondent and Patient 1 of the risks and benefits of an elective Pitocin  
26 induction. Pitocin was started at 10:32 a.m. From 7:00 p.m. to 8:24 p.m., Patient 1's pain level

27 <sup>1</sup> For privacy purposes, the patient in this Accusation is referred to as Patient 1.

28 <sup>2</sup> Pitocin is a medication that causes the uterus to contract and is used to induce labor.

1 induction. Pitocin was started at 10:32 a.m. From 7:00 p.m. to 8:24 p.m., Patient 1's pain level  
2 was noted to have increased from 4 out of 10 to 8 out of 10. A cervical examination was  
3 performed at 8:28 p.m. at which time Patient 1 was noted to be 1.5 cm dilated, 80% effaced and at  
4 minus two station. At 8:55 p.m., the patient's blood pressure was 121/73, heart rate was 93 and  
5 oxygen saturation rate was 98%. At 9:20 p.m., a cervical examination revealed that the patient  
6 was 4.5 cm dilated, 90% effaced and at minus one station; the Pitocin was turned off. Deep  
7 variable fetal decelerations developed at approximately 9:32 p.m. and a Category III Fetal Heart  
8 Rate tracing was noted.<sup>3</sup> At 9:39 p.m., the patient had a spontaneous rupture of membranes with  
9 scant clear fluid prior noted at 9:36 p.m. A cervical examination revealed that the patient was 10  
10 cm dilated and at station one. Anesthesiologist, Dr. S.L. was notified of the patient's request for  
11 an epidural and at 9:40 p.m., Respondent was notified of the patient's status. The hospital's  
12 resident physician, Dr. P.M., was at the patient's bedside. Crowning was noted at 9:54 p.m. and a  
13 male infant weighing 3,175 grams was delivered at 9:56 p.m. by Dr. P.M. with APGARS of 9 at  
14 both 1 and 5 minutes. Both Dr. P.M. and Nurse R.S. documented that there was a large "gush of  
15 blood" during the delivery of the infant. An estimated blood loss of 2,100 cc was noted on the  
16 Delivery Report.

17 11. At 10:01 p.m., Respondent was present in the delivery room. At 10:02 p.m., the  
18 patient's blood pressure was 96/56 and pulse was 157. Respondent documented that he observed  
19 a normal amount of vaginal bleeding and the placenta, which was already separated, was  
20 delivered easily at 10:04 p.m. For 6 minutes following the delivery of the placenta, Respondent  
21 noted that the patient was slowly oozing blood. In response, he ordered Methergine and Pitocin  
22 to stop the uterine bleeding.

23 ///

24 ///

25 ///

26 \_\_\_\_\_  
27 <sup>3</sup> From approximately 8:53 p.m. to 9:00 p.m., the patient had a Category I fetal heart rate tracing.  
28 A Category I fetal heart rate tracing is normal and not associated with fetal asphyxia. A Category III fetal  
heart rate tracing is abnormal and indicative of hypoxic risk to the fetus.

1           12. Respondent ordered packed red blood cells at 10:15 p.m., Hemabate<sup>4</sup> at 10:17 p.m.  
2 and laboratory studies, including a DIC panel<sup>5</sup> at 10:18 p.m. He performed a bimanual  
3 examination and massage for uterine tone/bleeding. He placed the patient in a dorsolithotomy  
4 position and examined her perineum, vagina and cervix for lacerations. The patient's blood  
5 pressure was 54/31 and heart rate was 139 at 10:30 p.m. In further effort to control the  
6 postpartum bleeding, Respondent placed a Bakri balloon with ultrasound confirmation by  
7 obstetrician, Dr. P.R., who was called in to assist. Vaginal packing was done and the fundus was  
8 noted to be firm.

9           13. Anesthesiologist, Dr. S.L. arrived to the patient's bedside at 10:35 p.m. and began  
10 giving intravenous Neo-Syneprine in order to maintain an adequate blood pressure during  
11 anesthesia and for treatment of vascular failure, and Hespan to treat hypovolemia. The patient's  
12 blood pressure was 48/27 at 10:35 p.m., and 100/36 at 10:41 p.m. Two units of uncross-matched  
13 blood, O Negative, were in the room at 10:43 p.m. The patient's blood pressure was 81/46 at  
14 10:45 p.m., 106/50 at 10:50 p.m. and 96/52 at 10:55 p.m. A second dose of Methergine and rectal  
15 Cytotec were given at 10:55 p.m. to stop the uterine bleeding. The patient's blood pressure was  
16 82/45 at 11:01 p.m., 86/49 at 11:09 p.m. and 85/42 at 11:15 p.m.<sup>6</sup>

17           14. Following the administration of the rescue medications by Dr. S.L., Patient 1's  
18 peripheral capillary oxygen saturation was maintained at 100% and the bleeding appeared to be  
19 more controlled with systolic blood pressure improvement between 80 and 100. Rather than  
20 administer the two units of uncross-matched blood, the decision was made to wait for the cross-  
21 matched blood.<sup>7</sup> Dr. S.L. documented that it was anticipated that the cross-matched blood would

22           <sup>4</sup> Hemabate is a medication administered to treat severe postpartum bleeding.

23           <sup>5</sup> Disseminated intravascular coagulation (DIC) is a condition in which blood clots form  
24 throughout the body, blocking small blood vessels. A DIC panel is a group of laboratory tests used to  
determine the presence of DIC.

25           <sup>6</sup> From 10:30 p.m. to 11:15 p.m., the patient's heart rate ranged between 131 to 151.

26           <sup>7</sup> Respondent stated that Dr. S.L. stopped the nurse from hanging the uncross-matched O Negative  
27 blood and there was no discussion regarding the decision to wait for cross-matched blood; however,  
Respondent also stated that he and Dr. S.L. jointly made the decision to wait for cross matched blood.  
28 There was no documentation in the medical records reflecting that Respondent did not participate in the  
decision to wait for the cross-matched blood.

1 be available in 30 minutes. Nursing documented that the cross-matched blood would be available  
2 in 10 minutes. Although not documented, Respondent stated that he believed the cross-matched  
3 blood would be available in 2 minutes. The first unit of cross-matched blood was administered at  
4 11:20 p.m., 37 minutes after the uncross-matched blood was available, and the second unit was  
5 administered minutes later.

6 15. Nurse R.S. noted that the patient was pale, had labored respirations and a distended  
7 abdomen. Dr. S.L. also noted that the patient had become incoherent. Respondent stated that a  
8 nurse told him that she heard a "pop". Respondent documented that he observed Patient 1's  
9 abdomen distending and called for an exploratory laparotomy for a possible uterine rupture from  
10 the Bakri balloon. Estimated blood loss since he arrived to the patient's bedside was 900 cc.  
11 This was not documented however. The hospital's Rapid Response Team was present at the  
12 bedside at 11:21 p.m.

13 16. At 11:43 p.m., Patient 1 was taken to the operating room. Dr. S.L. performed a rapid  
14 sequence IV induction. Dr. S.L. was unable to intubate and called intensivist, Dr. N.C., who then  
15 successfully intubated the patient. At approximately 12:03 a.m. on May 22, 2013, the patient  
16 went into sinus tachycardia with no pulse. A Code Blue was called and the patient was  
17 successfully resuscitated. Respondent performed a supracervical hysterectomy. Bleeding was  
18 found in the left lower uterine segment and an extensive hematoma was found in the left adnexal  
19 area. During surgery, the abnormal results of the patient's DIC panel were reported to  
20 Respondent and the patient received multiple units of packed red blood cells. The Surgical  
21 Record of Operation reflected an estimated blood loss of 2,500 cc. Respondent's Operative  
22 Report noted that the estimated blood loss was undetermined.

23 17. Patient 1 was transferred to the ICU. At 4:13 a.m., a Code Blue was called. Patient 1  
24 could not be resuscitated. She expired at 4:26 a.m. At autopsy, the coroner concluded that  
25 Patient 1 died of postpartum hemorrhage due to complications of a normal vaginal delivery and  
26 the manner of death was deemed natural.<sup>8</sup>

27 <sup>8</sup> The Autopsy Report did not show evidence of a uterine rupture, but there were findings of 300  
28 cc of blood in the peritoneal cavity, 200 cc of blood in the right lung, 150 cc of blood in the left lung, and  
the heart had endocardial hemorrhages.



1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 23. Respondent is subject to disciplinary action under section 2234, subdivision (c), of  
4 the Code in that he committed repeated negligent acts with respect to his care and treatment of  
5 Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through  
6 22, above, as though fully set forth herein.

7 24. In addition, Respondent was negligent in his care of Patient 1 when he failed to  
8 recognize the severity of Patient 1's blood loss and delayed transfusion by failing to use the  
9 uncross-matched O Negative blood that was available at 10:43 p.m. Respondent waited until  
10 11:20 p.m. to start transfusing Patient 1 with cross-matched blood.

11 25. Respondent also failed to document in Patient 1's medical records that he discussed  
12 the risks and benefits of an elective Pitocin induction.

13 26. Respondent's acts and/or omissions as set forth in paragraphs 8 through 25, above,  
14 whether proven individually, jointly, or in any combination thereof, constitute repeated negligent  
15 acts pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

16 **THIRD CAUSE FOR DISCIPLINE**

17 **(Failure to Maintain Adequate and Accurate Records)**

18 27. Respondent's license is subject to disciplinary action under section 2266 of the Code  
19 in that he failed to maintain adequate and accurate records concerning the care and treatment of  
20 Patient 1. Complainant refers to and, by this reference, incorporates Paragraphs 9 through 10, 14  
21 through 15, 19 and 25, above, as though set forth fully herein.

22 **PRAYER**

23 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
24 and that following the hearing, the Medical Board of California issue a decision:

25 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 44321,  
26 issued to Jen-Kway Shen, M.D.;

27 2. Revoking, suspending or denying approval of Jen-Kway Shen, M.D.'s authority to  
28 supervise physician assistants and advanced practice nurses;

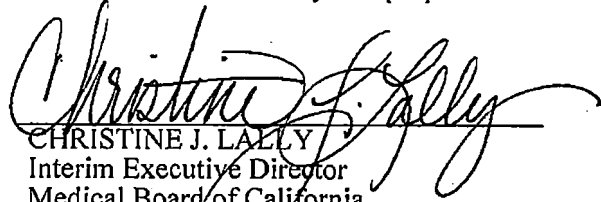


1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

3. Ordering Jen-Kway Shen, 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: APR 29 2020



CHRISTINE J. LALLY  
Interim Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

LA2020501354  
63208254.docx