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

In the Matter of the Accusation Against:

VALERIE JANE EBEL, M.D.,

Physician's and Surgeon's Certificate No. A 132130

Respondent.

Agency Case No. 800-2018-050993

OAH No. 2023020264

DECISION AFTER NON-ADOPTION

Administrative Law Judge (ALJ) Karen Reichmann, State of California, Office of Administrative Hearings, heard this matter on June 5, 6, and 16, and July 6, 2023, by telephone and videoconference.

Deputy Attorney General David Carr represented Complainant Reji Varghese, Executive Director of the Medical Board of California (Complainant).

Attorney Ian Scharg represented Respondent Valerie Jane Ebel, M.D., (Respondent) who was present.

The record closed and the matter was submitted for decision on July 6, 2023.

A proposed decision was issued on August 2, 2023. On September 6, 2023, Panel A of the Board issued an Order of Non-Adoption of Proposed Decision.

Oral argument on the matter was heard by Panel A on November 29, 2023, with ALJ Wim van Rooyen presiding. Supervising Deputy Attorney General Greg W. Chambers appeared on behalf of the Complainant. Respondent was present and was represented by Ian Sharg, Attorney at Law. Panel A, having read and considered the entire record, including the transcript and the exhibits, and having considered the written and oral argument, hereby enters this Decision After Non-Adoption.

FACTUAL FINDINGS

Jurisdictional Matters

1. On August 14, 2014, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 132130 (Certificate) to Respondent Valerie Jane Ebel, M.D. The Certificate was in full force and effect at all times relevant to the charges in the Accusation. The Certificate will expire on March 31, 2024, unless renewed. There has been no prior discipline against Respondent's Certificate.

2. On December 10, 2021, the Board's former executive director, acting solely in his official capacity, filed the Accusation. Complainant Reji Varghese is now the Board's Executive Director. Complainant seeks to discipline Respondent for gross negligence and/or repeated negligent acts, alleging that she failed to identify and respond to changes in fetal heart rate monitoring during a labor and delivery in August 2017, and failed to provide adequate resuscitation to the newborn infant, who subsequently died.

3. Respondent filed a timely Notice of Defense.

Respondent's Background

4. Respondent graduated college with a degree in English. She then served in the Peace Corps in Azerbaijan, where she decided she could better fulfill her goal of helping others by becoming a physician. After completing a post-baccalaureate pre-medical program, she attended medical school in Chicago, graduating in 2013. Respondent completed a three-year residency in family medicine at Sutter Santa Rosa Medical Center, where she was selected chief resident. During her residency,

Respondent had six months of obstetrics training and delivered 100 babies. Respondent has been board certified in family medicine since 2016.

5. In November 2016, Respondent went to work for Open Door Community Health Centers, a federally qualified health clinic in Humboldt County, providing primary care, prenatal care, and obstetrics. Respondent had hospital privileges at Mad River Community Hospital, a small rural hospital in Arcata. Respondent was on call for labor and delivery at the hospital a minimum of seven days each month.

Labor and Delivery at Mad River Community Hospital

6. Respondent discovered differences in the patient populations she served in Santa Rosa and Humboldt County, and differences between the hospitals' resources. Most patients in Santa Rosa wanted to follow professional guidelines on inducing labor, but most patients in Humboldt County were resistant to induction and preferred minimal interventions. The quality of the labor and delivery registered nurses was much higher at Sutter Santa Rosa. Mad River had high nursing staff turnover and many travel nurses with varying levels of experience. There was central monitoring of the fetal heart monitor data at the nursing station at Sutter Santa Rosa, but not at Mad River. At Mad River, fetal monitoring is done with an analog monitor that prints out the data on paper strips; the hospital does not have this information available digitally for monitoring outside of the laboring patients' rooms. At Sutter Santa Rosa, there was a neonatal intensive care unit with specialists on call and specially trained nurses always present. This care was not available at Mad River.

7. Respondent is trained in obstetrics but is not trained in performing obstetric surgery. When delivering a baby, if Respondent determined that surgical intervention was necessary, she would call for consultation from an on-call obstetrician or family practice physician trained in obstetric surgery. Respondent is trained to assist in surgery and has done so. Mad River also has a pediatrician or pediatric nurse

practitioner on call at all times for pediatric emergencies in the emergency room or in labor and delivery. The surgically-trained obstetrics and pediatric specialists on call are expected to arrive at the hospital within 20 minutes.

Fetal Monitoring

8. Fetal monitors used during labor provide data regarding fetal heart rate and uterine contractions. Fetal heart rate monitoring data is referred to as "tracings" and is categorized as Category I, II, or III. To be classified as Category I, the baby's baseline heart rate must be within normal range with moderate variability[1] and no late or variable heart rate decelerations[2]. Category III is an "ominous" abnormal tracing, consisting of either a sinusoidal pattern or absent heart rate variability with recurrent late decelerations, recurrent variable decelerations, or bradycardia (heart rate below 110 beats per minute). A Category III fetal heart tracing requires immediate action.

Category II is a broad category of indeterminate tracings that fit neither Category I nor Category III. Most babies will have a combination of Category I and Category II tracings during labor. It is rare for a baby to be in Category I the entire duration of labor. Category II requires surveillance and reevaluation, especially if it persists and does not return to Category I.

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[1] Fetal heart rate variability refers to fluctuations in heart rate. Minimal variability is defined as less than 5 beats per minute; moderate variability is defined as 6 to 25 beats per minute; and marked variability is defined as more than 25 beats per minute.

[2] A deceleration is a temporary decrease of the fetal heart rate. Decelerations are classified as early, late, or variable, based on when they occur relative to uterine contractions. Late decelerations are concerning because they reflect a decrease in blood flow to the placenta, which can reduce the amount of oxygen flowing to the fetus. Variable decelerations are concerning because they indicate umbilical cord compression, which can reduce blood flow to the fetus.

Most fetal heart monitoring is done with an external monitor that is attached to the patient's abdomen. If the external monitor is not providing adequate data, or if the provider believes more detailed information is needed, an internal monitor (intrauterine pressure catheter or fetal scalp electrode) can be used.

Patient 1's Labor and Delivery, August 2017

9. Patient 1 was 28 years old and pregnant for the first time. Respondent had seen her one time for a routine prenatal appointment. Respondent was the on call attending physician for labor and delivery on August 4, 2017, when Patient 1 arrived at the hospital with uterine contractions. Respondent was working that day in the prenatal clinic, which is adjacent to the hospital. Respondent saw the patient before 8:13 a.m., performed an examination, and wrote a detailed chart note. The cervix was dilated to 4 centimeters, and the baby's station[3] was -1. Contractions were every five minutes. The baby was post-date at 41 weeks and 4 days. Patient 1 had gestational hypertension that was well-controlled. The patient expressed her desire for natural labor. Respondent documented in the chart that she explained to Patient 1 that the typical practice when a mother has gestational hypertension is to induce at 39 weeks, and that she would be recommending augmenting labor if labor was not progressing over the next few hours. Patient 1 was continuously monitored by a registered nurse once she was admitted to the hospital.

10. Respondent again checked in with the patient during the lunch hour and performed another examination. The patient had progressed to 5.5 centimeters dilation. Contractions were every three minutes. The fetal heart tracings were Category 1. The patient consented to have Respondent rupture the membrane. By this time, there was another patient in active labor at the hospital, also under Respondent's care.

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[3] The baby's station during labor and delivery refers its location in relation to the pelvis. The station indicates how labor is progressing.

11. Respondent next came to see Patient 1 after her shift at the prenatal clinic and documented the encounter at 5:47 p.m. Patient 1's mother, aunt, and two friends were present, as was the father of the baby. Patient 1 was in the birthing tub when Respondent arrived. Respondent performed another examination. Labor was progressing. The cervix was now dilated at 9 centimeters. Contractions were every three minutes. The fetal heart tracings remained Category I.

12. Respondent's next chart note is at 6:30 p.m. Respondent performed another examination which revealed no progress since the prior examination. The baby's heart tracings remained in Category 1. Respondent recommended that labor be augmented with Pitocin (an intravenous medication to increase uterine contractions), and Patient 1 agreed. This is the last note that Respondent made in Patient 1's chart until after the delivery. There are handwritten notes on the fetal monitoring strip made by the nurse reflecting the administration of Pitocin, on Respondent's orders, over the next several hours.

13. Respondent spent the next few hours going back and forth between Patient 1's room and the room of the other patient in labor.

14. By 7:00 p.m., Coral Snook was the registered nurse assigned to Patient 1. Respondent testified that she frequently checked in with Snook about the fetal heart tracings, and that Snook always responded that everything was fine or that it was Category 1. Respondent did not recall personally reviewing the strip during the last three or more hours of labor.

15. At 9:00 p.m., Patient 1's cervix was fully dilated. She began pushing in the birthing tub. After about 90 minutes pushing in the birthing tub, Respondent encouraged her to get out of the tub and try pushing in another position, and Patient 1 agreed. Beginning at 9:00 p.m., there are many gaps in the monitoring data, possibly due to Patient 1's movements. There are also incomplete tracings that cannot be interpreted and Category II tracings. Respondent was not aware of the gaps in the fetal monitor data or the irregular tracings that occurred between 9:00 and delivery shortly after

midnight. She was unaware that the monitor was not getting adequate data, and did not consider using alternate means of monitoring the fetus. There is no documentation of the baby's station during the last several hours of labor.

16. At midnight, everybody in the delivery room sang "Happy Birthday" to Patient 1, whose birthday was August 5.

17. Shortly before delivery, a second registered nurse was summoned into the labor room to assist, per hospital protocol.

18. A male baby weighing over nine pounds was born at 12:04 a.m. and was placed on Patient 1's abdomen. The baby was limp and nonresponsive. Attempts to stimulate the baby were unsuccessful, and after one to two minutes, the baby was removed to the warmer and resuscitation efforts (chest compressions and bag/mask ventilation) commenced. The initial mask selected was too small and was replaced with a larger mask. Respondent directed that pediatric back up and a respiratory therapist be called for assistance. A respiratory therapist was on site at the hospital and arrived quickly to assist with the resuscitation. A pediatric nurse practitioner was the on call back up pediatric provider that night. She arrived approximately 10 minutes after the baby was born and took over the resuscitation. After one unsuccessful attempt, she successfully intubated the baby at approximately 20 minutes after birth.

19. Respondent attended to Patient 1 to deliver the placenta, then left to assist the other patient deliver her baby. Respondent returned to provide follow up care to Patient 1, and later in the morning discharged her from the hospital so that she could stay with her infant.

20. The infant was transferred by air to UCSF for more advanced care once the fog lifted at around 9:00 a.m. The infant died six days later due to hypoxic ischemic encephalopathy (brain injury resulting from a lack of oxygen).

21. Respondent testified that she found out after the incident that Snook was an inexperienced nurse who was supposed to have been supervised by another

nurse at all times because she was still completing her orientation. Respondent believes that the nurse responsible for supervising Snook was fired. Respondent explained that she trusted Snook to report any unusual tracings and that she was taught in her residency that she could rely on labor and delivery registered nurses, who are trained in reading fetal heart tracings. Respondent reported that Snook consistently told her that the tracings were normal and never notified her that there were gaps or incomplete or irregular tracings. Respondent testified that if Snook had informed her that the tracings were incomplete or hard to get, she would have placed an intrauterine pressure catheter, in order to obtain more detailed readings. Respondent testified that she did announce the baby's station during Patient 1's labor, but that Snook failed to document it.

22. Respondent reviewed the strips afterwards. She does not believe there were any Category III tracings or repeated late decelerations, or that the strip would require a physician to have a pediatrician present during delivery. Respondent explained that it was not possible to have a pediatrician present at the birth of all babies when there was a mother with a risk factor.

23. Although Respondent does not believe she could have done anything differently and believes she acted within the standard of care, she testified that the experience caused her to change her practice while working labor and delivery at Mad River. She was clearer in her communication with nurses and "micromanaged" their work. She would stay at the hospital overnight when she was on call so that she could personally review the strips. She lowered her threshold for having a pediatrician present at birth and would call ahead to touch base with the on call pediatric provider while a patient was in labor.

24. Respondent reported that the case was subject to peer review at the hospital and there were no adverse findings about her care. Respondent continued to attend to deliveries at Mad River for four more years after this incident, delivering

more than 150 babies without complications. Respondent was uncomfortable with many issues at the hospital and decided to stop delivering babies there in August 2021.

Expert Witnesses

COMPLAINANT'S EXPERT, OGO MBANUGO, M.D.

25. Complainant retained Ogo Mbanugo, M.D., as its expert witness. Dr. Mbanugo has been a licensed physician for more than 40 years and is board certified in family practice. She has been an attending physician in obstetrics at Contra Costa Regional Medical Center, a large county hospital, for 30 years and has served on its credentialing committee. Her role includes teaching obstetrics to family medicine residents.

26. Dr. Mbanugo reviewed the fetal heart monitoring strips. She opined that Respondent's failure to recognize, acknowledge, consider, discuss and document alternatives, and act on decelerations constitute a simple departure from the standard of care and likely contributed to the poor outcome. She believes that hospital system issues were also to blame.

27. Dr. Mbanugo explained that the standard of care requires a physician to document incomplete or Category II tracings and explain what he or she is doing to address the situation, and that when Pitocin is being used, the physician must be able to assess uterine contractions and the baby's reaction to them. Dr. Mbanugo explained that Respondent deviated from the standard of care because there was no documentation that the tracings had become Category II and that there appeared to be some late decelerations. She saw no evidence in the medical record that Respondent was aware of the Category II tracings or tried to correct the poor data. Dr. Mbanugo noted that because of the gaps in data and incomplete tracings, it is hard to determine the fetus's baseline heartrate after Pitocin was started, and that Respondent possibly should have discontinued Pitocin to see if the heart rate returned to Category I.

28. Dr. Mbanugo observed that there is no documentation of the progress of the descent of the baby during the last several hours of labor, either in the chart or handwritten on the strips, and no documentation of the intensity of the uterine contractions. Dr. Mbanugo found it hard to evaluate Respondent's treatment of Patient 1 because it is unclear where the baby was in the birth canal as time progressed. In her experience, a doctor will announce the station and the nurse will document this on the strip or chart. She doubts that a nurse would fail to document the station when it is announced. She added that a physician would usually be able to see whether the nurse is writing notes on the strip or making entries into a patient's chart and would be aware of a nurse who was not doing as directed.

Dr. Mbanugo noted that the baby's station guides the treatment plan and is important clinical data that must be documented. Dr. Mbanugo cannot determine whether interventions (such as a caesarian section) would have been warranted because of the inadequate documentation of the baby's station.

29. Dr. Mbanugo agreed that it is the hospital's responsibility to hire competent nurses, and that doctors can assume a labor and delivery nurse is competent and trained in reading fetal monitoring strips. She believes that the physician and nurse are both responsible for making sure that effective monitoring of labor is taking place.

30. Dr. Mbanugo explained that given Patient 1's risk factors (post date pregnancy; gestational hypertension; prolonged Category II or indeterminate tracing; and length of time Patient 1 was pushing) the standard of care required that Respondent anticipate the possibility that the baby would need resuscitation and arrange to have someone present at birth who was capable of intubating a neonate if necessary. She believes that Respondent's failure to call for pediatric back up 30 to 60 minutes prior to delivery, given these risk factors, constituted an extreme departure from the standard of care.

RESPONDENT'S EXPERT, MARVIN KAMRAS, M.D.

31. Respondent retained Marvin Kamras, M.D., as an expert witness. Dr. Kamras has been licensed by the Board since 1975 and is board certified in obstetrics and gynecology. He is affiliated with Dignity Mercy San Juan Hospital, a large hospital in the Sacramento area, where he is the lead physician for high-risk obstetrics patients. Dr. Kamras is on the peer review committee and has served as the chair of the OB/GYN department at Dignity Mercy.

32. Dr. Kamras reviewed documents including the accusation, medical records from Mad River, Dr. Mbanugo's expert report, and the transcript of the investigative interview of Respondent. Dr. Kamras authored a report and testified at the hearing. Dr. Kamras does not believe that Respondent departed from the standard of care in any respect in her treatment of Patient 1 and her newborn infant.

33. Dr. Kamras agreed that there are gaps in the fetal monitoring strip, but opined that the amount of monitoring was adequate and that when monitoring was occurring the strip did not raise concerns. He agreed that all discernible tracings from 9:30 p.m. onward were Category II, but he views this as normal. Dr. Kamras did not identify any episodes of Category III in his review of the strips, and did not identify any repeated late decelerations. Dr. Kamras assumed that Respondent reviewed the strips because she was in the room at the patient's bedside.

34. Dr. Kamras stated that the "character" of the fetal heart tracings changed at 11:41 p.m., showing a decrease in variability. He explained that the standard of care in this situation is to observe the strip for the next "5 to 8 to 10 minutes" to see if it returns to a normal reading. Dr. Kamras believes that because Respondent was with the patient during that time frame and could tell that delivery was imminent, it was within the standard of care to proceed with the delivery. He believes that there was no indication that baby would be born limp and not breathing.

35. Dr. Kamras testified that it was not Respondent's responsibility to know the availability or competency of staffing when providing care, and that it is within the

standard of care for a physician to rely on nurses to review and interpret tracings and reasonable to accept the nurse's interpretation as accurate.

36. Dr. Kamras agreed that there are deficiencies in the medical records, but attributed these to nursing staff and not to Respondent. He believes that the absence of documentation of the baby's station is the nurse's fault and not Respondent's fault.

37. Dr. Kamras does not believe that Respondent departed from the standard of care in relation to the resuscitation of the infant. He believes Respondent was not required to call for pediatric back up prior to delivery, because he does not believe there was any reason to suspect that the baby would be hypoxic, noting that it was unusual for a baby to be born in this condition with these fetal heart tracings. Dr. Karmas explained that an obstetrics provider must be competent in only basic neonatal resuscitation, such as evaluating the baby, drying the baby, stimulating the baby, clearing the airway, and using bag/mask ventilation. It is the hospital's responsibility to provide personnel skilled in taking care of the baby because the physician delivering the baby's primary responsibility is taking care of the mother.

Other Evidence

38. Respondent completed a physician acupuncture course in 2019, and has been providing medical acupuncture since that time. In October 2021, Respondent began a two-year fellowship in integrative medicine. She plans to seek board certification in this field when she becomes eligible, in 2024.

39. In July 2022, Respondent joined West County Health Centers, a federally qualified health clinic in Sonoma County. She provides primary care for patients of all ages, including many migrant agricultural workers and indigent patients. She provides medical care and acupuncture for homeless patients at a weekly half-day clinic. Respondent no longer attends to deliveries and has no plan to resume doing so. Her

plan is to continue practicing outpatient medicine, medical acupuncture, and integrative medicine. She finds managing and preventing pain and chronic illness and developing personal relationships with patients to be a better fit for her than obstetrics.

40. Respondent submitted letters and testimony from numerous individuals who all are aware of the allegations in the Accusation.

41. The following individuals worked with Respondent while she was at Open Door Health in Humboldt County and delivering babies at Mad River:

a. Tara Vu, M.D., met Respondent when Respondent came to work for Open Door Health in 2016, where Dr. Vu already worked. Dr. Vu testified and wrote a letter in support of Respondent. Dr. Vu and Respondent worked together providing primary care, prenatal care, and labor and delivery, and collaborated frequently. Dr. Vu noted that Respondent had a good reputation for obstetrics, was easy to work with, and always prioritized patient care. Respondent was the physician on call who delivered Dr. Vu's second child in February 2018, and Dr. Vu had confidence in Respondent's medical care and judgment. Dr. Vu noted that Mad River is a small, rural hospital with limited resources, and that adverse outcomes are not always preventable. Dr. Vu is trained in performing caesarean sections, and wrote that Respondent sought appropriate consultation when medically indicated.

b. Carrie Griffin, D.O., is a family practice physician who provides high risk obstetrics services at three clinics, including Open Door Health, and who worked with Respondent beginning in 2018. Dr. Griffin testified that Respondent is a gifted, knowledgeable, and trustworthy physician who was excellent at anticipating the need for back up. Dr. Griffin described Respondent as a personable, unparalleled in compassion, and striving to use medicine to better humanity.

c. Danielle Cooksie served as a medical assistant and doula to Respondent in Humboldt County for six years, and was also her primary care patient. Cooksie wrote that Respondent always showed up early, worked hard, was polite,

made sure her patients were comfortable and well-informed, and provided excellent care. As a patient, Cooksie found Respondent was an attentive, well-educated physician who listened to her concerns and helped her achieve her health goals.

d. Ellen Drury, CNM, is a nurse midwife who worked with Respondent at Open Door Health. Drury has 40 years' experience. She wrote that Respondent is equitable, kind, generous, skilled, and well-rounded in her interests. Drury has complete trust in Respondent as a physician. Drury wrote that the hospital where the incident occurred is a challenging place to work, akin to a third-world hospital, due to the diminishment in the quality of the nursing staff and the outdated equipment.

e. Marissa Kummerling, M.D., M.P.H., was a colleague of Respondent in Humboldt County who also provided obstetrical care, including surgical consultation. Dr. Kummerling wrote that Respondent was a valuable member of the team and provided superior care and bonded easily with patients. Dr. Kummerling was impressed by Respondent's integrity, compassion, grace, and dedication to the practice of medicine. Dr. Kummerling reported that Respondent reached out to specialists to bring the highest level of care to a vulnerable patient population. Dr. Kummerling found Respondent's requests for surgical consultation for delivery were always well timed and appropriate. She believes that Respondent is an excellent physician and would entrust Respondent with the care of her own family. Dr. Kummerling finds the disciplinary action against Respondent "baffling" and believes that disciplining Respondent would be a disservice to the residents of California.

f. Molly Jacobs, N.P., is a certified family nurse practitioner who worked with Respondent providing prenatal care in Humboldt County. Jacobs found Respondent to be warm, kind, and professional. Respondent earned a reputation as an extremely hardworking, dedicated, and caring physician. Many who worked at the clinic chose Respondent for their own care and referred family and friends to her. Jacobs has not worked with a more capable medical provider than Respondent during her two decades working at the clinic. Jacobs urges the Board to consider the lack of

resources available at Mad River. She believes Respondent performed to the best of her abilities and continues to have complete confidence in her.

g. Maya Zwerdling, M.D., met Respondent in 2015 when Respondent was the chief resident and Dr. Zwerdling was an intern in family medicine at Sutter Santa Rosa Regional Medical Center. Dr. Zwerdling was impressed with Respondent's knowledge, skills, and humanity, especially during obstetrics rotation. Dr. Zwerdling joined Respondent at Open Door Community Health in 2018, and was on the same team performing primary care, prenatal care, and labor and delivery call at Mad River. Dr. Zwerdling reports that Respondent was well-loved by patients, committed to evidence-based care, and regarded by hospital staff as a kind and competent physician. Dr. Zwerdling wrote that the patient population in Humboldt County was challenging due to high rates of poverty, substance abuse, co-morbid physical conditions, and a strong local culture of rejecting obstetric interventions. Dr. Zwerdling described Mad River as a challenging environment for labor and delivery, due to old and poorly functioning fetal heart monitors and a chronic nursing shortage resulting in the use of inexperienced new graduates and traveling nurses. Due to these factors, Dr. Zwerdling stopped performing obstetrics at Mad River after nine months and would not herself choose to give birth there. Dr. Zwerdling finds Respondent to be an inspiring person and talented physician who is always seeking new opportunities to learn and increase her knowledge to better care for patients.

42. The following three patients submitted letters:

a. John Schmidt met Respondent in late 2016, when his long-time primary care physician retired and he became a patient of Respondent. He wrote that Respondent is the best doctor he has ever had. He described her as a warm and patient listener, empathetic, encouraging, and providing detailed information. He noted that he always felt heard and respected, and that she inspired him to take better care of himself.

b. Hunter-Paige Pennick Maccorkle wrote that she met Respondent when Respondent provided her with prenatal care six years ago. Respondent subsequently was the primary care provider for Maccorkle and her husband and children. Maccorkle feels blessed to have been able to get to know Respondent, and has found her to have great competence, compassion, diligence, honesty, and kindness. Maccorkle has found Respondent's care of her medical conditions "exemplary." Maccorkle believes that Respondent was heartbroken by the incident involving Patient 1 and has been deeply impacted. Maccorkle continues to have 100 percent faith in Respondent's ability to provide the greatest care possible.

c. Charles Chamberlin, Ph.D., is an emeritus professor of environmental resources engineering at California State Polytechnic University, Humboldt. Respondent became his primary care physician in early 2017, when his long-time physician retired. Dr. Chamberlin wrote that Respondent has carefully and thoroughly managed his numerous medical conditions and has been a compassionate and supportive listener as he has been faced with his wife and daughter's cancer diagnoses. Dr. Chamberlin has found Respondent to be compassionate, hardworking, honest, and highly competent, and would recommend her to family and friends without reservation.

43. Two letters were submitted from friends:

a. Kathy Altglibers met Respondent when they were college roommates, more than 20 years ago. She wrote that Respondent is the kindest and most moral and ethical person she knows, and described her as a smart, dedicated, honest, and hardworking physician.

b. Diane Korsower, M.D., is a retired family medicine physician in Humboldt County. She met Respondent when Respondent first moved to the area and joined Korsower's book club. They have not worked together professionally. Dr. Korsower admires Respondent's courage, strength, ability to connect with people, compassion, and dedication to serving the less affluent. Dr. Korsower echoed others in describing

Mad River as struggling to maintain adequate staffing and often utilizing temporary traveling nursing staff.

44. Rain Moore, M.D., is a family practice physician and Chief Medical Officer of West County Health Center in Sonoma County, where Respondent now works. Dr. Moore was on the committee that hired Respondent, who was upfront about this pending disciplinary matter. Dr. Moore is in frequent contact with Respondent and has regularly reviewed her charts. Dr. Moore reported that staff have been happy working with Respondent, who has been a good addition to their team. Dr. Moore described Respondent as outgoing, honest, and open. The agency serves a large number of Medi-Cal patients, and Dr. Moore is concerned that Respondent will not be able to serve these patients if she is placed on probation by the Board. The agency hopes to retain Respondent on staff, but is uncertain whether this would be feasible.

Ultimate Findings re: Causes for Discipline

45. The first cause for discipline pertains to Respondent's acts or omissions regarding fetal heart monitoring data during the final hours of labor. The expert opinions of Dr. Mbanugo regarding Respondent's failure to recognize, acknowledge, consider, discuss and document alternatives, and act on decelerations was more persuasive that the opinions of Dr. Kamras. Respondent admitted that she never personally reviewed the fetal heart tracings during the three hours that Patient 1 was pushing and was unaware that there were significant gaps in data and non-Category I tracings. Respondent further testified that had she been aware, she would have acted differently to obtain better data, possibly through use of another monitoring device. Respondent's reliance on the registered nurse was unreasonable. Clear and convincing evidence established that Respondent's acts and omissions regarding the fetal heart monitoring data constituted a simple departure from the standard of care.

46. The second cause for discipline pertains to Respondent's role in overseeing and ensuring resuscitative care of the newborn infant. Dr. Mbanugo persuasively opined that given the risk factors of a post date pregnancy, gestational

hypertension, gaps in fetal heart monitoring coupled with non-Category I tracings including some late decelerations, and the three-hour duration of pushing, the standard of care required that Respondent prepare for the possibility that the infant would need resuscitation by calling for back up prior to delivery. Dr. Kamras conceded that the character of the tracings changed at 11:41 p.m., and his opinion that calling at that time for back up was unnecessary was unpersuasive. Clear and convincing evidence established Respondent's failure to call for pediatric back up prior to delivery constituted an extreme departure from the standard of care.

47. It is possible that Respondent's negligence contributed to the infant's fatal injury, but it was not proven by clear and convincing evidence.

Costs

48. Complainant seeks to recover $10,298.75 for legal services provided by the Department of Justice through May 31, 2023. These costs are supported by declarations in compliance with the requirements of California Code of Regulations, title 1, section 1042, and are reasonable.

LEGAL CONCLUSIONS

1. It is Complainant's burden to demonstrate the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of Respondent's Certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Business and Professions Code section 2227 authorizes the Board to take disciplinary action, including public reprimand, against licensees who have been found to have committed violations of the Medical Practice Act. Business and Professions Code section 2234, included in the Medical Practice Act, provides that a licensee may be subject to discipline for committing gross negligence (Bus. & Prof. Code, § 2234, subd. (b)) or for repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)).

3. Clear and convincing evidence established that Respondent committed gross negligence and repeated negligent acts in her care and treatment of Patient 1 and the patient's newborn infant. Cause for discipline was established for violations of Business and Professions Code section 2234, subdivisions (b) and (c), in light of the matters set forth in Factual Findings 45 and 46.

4. In exercising its disciplinary functions, protection of the public is the Board's highest priority. (Bus. & Prof. Code, § 2229, subd. (a).) The Board is also required to take disciplinary action that is calculated to aid the rehabilitation of the physician whenever possible, as long as the Board's action is not inconsistent with public safety. (Bus. & Prof. Code, § 2229, subds. (b), (c).)

5. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016; Cal. Code Regs., tit. 16, § 1361) provide for a minimum discipline of five years' probation and a maximum discipline of revocation for licensees who have committed gross negligence or repeated negligent acts.

6. Respondent's violations occurred during her first year of practice after residency, while practicing obstetrics at a rural facility with limited resources. Respondent failed to realize and properly respond to indeterminate and incomplete fetal heart tracings and failed to ensure that appropriate staff was present at delivery in light of the risk factors present. Respondent's negligence may have contributed to the tragic outcome. Respondent altered her practices and continued to provide valued labor and delivery services at the hospital for four more years without any further allegations of negligence. In the fall of 2021, Respondent decided to switch her practice focus and began a two-year fellowship in integrative medicine. She stopped providing obstetrics at this time and does not plan to resume. Respondent relocated to Sonoma County in 2022 and is providing much needed primary care to the underserved population there, including migrant workers and the homeless community. Respondent presented letters and testimony from colleagues and patients establishing that she enjoys a strong reputation as a compassionate and competent practitioner with sound clinical judgment. It is unlikely that Respondent will

engage in any further similar acts of negligence in her practice.

Considering the record as a whole, a period of probation is not necessary to protect patients or the public. A public reprimand will provide adequate public protection and is the appropriate discipline in this case. (Bus. & Prof. Code, § 2227, subd. (a)(4).

7. Business and Professions Code section 125.3 authorizes the Board to recover its reasonable costs of investigation and enforcement if the licensee is found to have committed a violation of the licensing act. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth standards by which a licensing board must exercise its discretion to reduce or eliminate cost awards to ensure that licensees with potentially meritorious claims are not deterred from exercising their right to an administrative hearing. Those standards include whether the licensee has been successful at hearing in getting the charges dismissed or reduced, the licensee's good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate to the alleged misconduct. The Board has determined that Respondent did not establish a basis to reduce or eliminate the costs in this matter. As a result, Respondent shall pay the Board's costs totaling $10,298.75.

ORDER

1. Physician's and Surgeon's Certificate No. A 132130, issued to Respondent Valerie Jane Ebel, M.D., is hereby reprimanded within the meaning of Business and Professions Code section 2227, subdivision (a)(4).

2. Respondent shall pay to the Board costs associated with its enforcement of this matter, pursuant to Business and Professions Code section 125.3, in the amount of $10,298.75.

The Decision shall become effective at 5:00 p.m. on February 2, 2024

IT IS SO ORDERED this 5th day of January, 2024.



Laurie Rose Lubiano, J.D.
Chair, Panel A
Medical Board of California