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

In the Matter of the Accusation Against: Jennifer May Chen, M.D. Physician's & Surgeon's Certificate No A 136036 Respondent.	Case No.: 800-2020-072233

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Matthew A. Brinegar, Esq. on behalf of Jennifer May Chan, M.D., and the time for action having expired at 5:00 p.m. on June 21, 2024, the petition is deemed denied by operation of law.

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

In the Matter of the Accusation Against: **Jennifer May Chen, M.D.** **Physician's & Surgeon's Certificate No. A 136036** **Respondent.**	**Case No. 800-2020-072233** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Respondent, Jennifer May Chen, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of June 13, 2024, at 5:00 p.m.

Execution is stayed until June 21, 2024, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: June 12, 2024

Reji Varghese
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against: Jennifer May Chen, M.D. Physician's and Surgeon's Certificate No. A 136036 Respondent.	Case No.: 800-2020-072233

DECISION

The attached Proposed Decision 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 June 13, 2024.

IT IS SO ORDERED: May 14, 2024.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the Accusation Against:

JENNIFER MAY CHEN, M.D.,

Physician's and Surgeon's Certificate Number No. A 136036,

Respondent.

Case No. 800-2020-072233

OAH No. 2023060385

PROPOSED DECISION

Ji-Lan Zang, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter by videoconference from February 20 to February 22, 2024.

Marsha E. Barr-Fernandez, Deputy Attorney General, represented Reji Varghese, (complainant), Interim Executive Director, Medical Board of California (Board), Department of Consumer Affairs.

Henry Fenton and Benjamin Fenton, Attorneys at Law, represented Jennifer May Chen, M.D. (respondent), who was present throughout the hearing.

The ALJ, on her own motion, redacted patient names from Exhibit 34 to protect the patients' privacy.

Oral and documentary evidence was received. The record remained open until March 8, 2024, for respondent to submit objections on portions of complainant's expert report she contends do not comply with Business and Professions Code section 2334 (any further references are to the Business and Professions Code, unless otherwise designated) for failure to state a basis for the expert opinion, and until March 22, 2024, for complainant to submit a response, if any. Respondent was granted leave until March 29, 2024, to submit a reply, if any.

Respondent timely filed her objections (marked for identification as Exhibit I) to complainant's expert's opinions on obstetric management of labor and delivery (opinions one through five) (Ex. 34, p. A6453). Complainant timely filed his response to these objections (marked for identification as Exhibit 44). In his response, complainant also requested the admission of the following documents: (1) discovery transmittal letter dated June 1, 2023 (Exhibit 40); (2) complainant's expert witness disclosure, dated June 13, 2023 (Exhibit 41); (3) complainant's Pre-Hearing Conference (PHC) statement dated October 17, 2023 (Exhibit 42); and (4) the ALJ's PHC Order, dated October 31, 2023 (Ex. 43). Exhibits 40 to 43 are excluded, as they are discovery documents and prehearing motions and orders that are a part of the administrative record, but not evidence. The ALJ's ruling on the admissibility of complainant's expert opinions on obstetric management of labor and delivery is set forth in Factual Findings 43 to 45.

On March 15, 2024, respondent submitted supplemental objections (marked as Exhibit J) to complainant's expert's opinions on documentation (opinions six through nine) (Ex. 34, p. A6454.). On March 18, 2024, complainant filed written objections

(marked as Exhibit 45) to respondent's supplemental objections contending that they were untimely. Respondent's supplemental objections were not considered, as they were filed seven days after the deadline set forth by the ALJ and therefore untimely.

On April 29, 2024, the ALJ, not having received any replies from respondent, closed the record, and the matter was submitted for decision.

SUMMARY

Complainant charged respondent with gross negligence, repeated acts of negligence, and improper medical record keeping in connection with her delivery of Patient 1's baby, C. (Baby C.) (patients and their family members are identified either by numbers or initials to protect their privacy), from March 29, 2019, to March 31, 2019. Complainant proved respondent committed acts of gross negligence and repeated acts of negligence because she failed to expedite the delivery of Baby C., resulting in the birth of the infant with severe brain damage caused by deprivation of oxygen during labor and delivery. Complainant also proved respondent kept inadequate medical records for her delivery of Baby C. Respondent presented some evidence of rehabilitation by acknowledging it was her mistake not to have expedited Baby C.'s delivery by 0050 hours on March 31, 2019. Considering respondent has practiced since 2019 without any further acts of negligence, placing respondent on five years of probation, with additional terms to ensure her fitness to practice, is sufficient to protect the public.

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FACTUAL FINDINGS

Jurisdictional Matters

1. On May 2, 2015, the Board issued Physician's and Surgeon's Certificate Number A 136036 to respondent. This license is scheduled to expire on May 31, 2025.

2. On May 5, 2023, complainant filed the Accusation in his official capacity. Respondent filed a Notice of Defense requesting a hearing. Jurisdiction to proceed with this hearing has been established.

Respondent's Background

3. Respondent obtained her undergraduate degree from Wellesley College in 2007 and her Doctor of Medicine degree from Drexel University in 2013. From 2013 to 2017, respondent trained as an obstetrics/gynecology (OB/GYN) intern at Cedars-Sinai Medical Center (Cedars). In August 2017, respondent began practicing at Rodeo Drive Women's Health Center (Rodeo), a private practice OB/GYN group located in Beverly Hills, California, as an associate. Three years later, in 2020, respondent was elevated as a partner at Rodeo.

Patient 1

4. In March 2019, Patient 1 was 42 years old. She was pregnant with her first child, Baby C., via in vitro fertilization (IVF) using a donor egg. Her estimated due date was April 5, 2019.

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Prenatal Care

5. Lily Lee, M.D., an OB/GYN with Manhattan Beach Women's Center, provided prenatal care for Patient 1 from September 19, 2018, until March 29, 2019. During this period, Dr. Lee assessed Patient 1 with several risk factors that affected her pregnancy. (Ex. 11, p. A347.) These risk factors included: (1) IVF pregnancy using a donor egg; (2) anemia due to beta thalassemia, a genetic blood disorder which causes a person's body to make less hemoglobin, the red blood cell that carries oxygen, than normal; (3) advance maternal age of 42; and (4) gestational diabetes. (*Id.*, p. A349.)

6. Due to these risk factors, respondent also saw a maternal-fetal specialist, Christina Han, M.D., once a week for fetal monitoring, and this frequency increased to twice a week closer to Patient 1's due date. The monitoring by Dr. Han, which included ultrasounds and fetal heart monitoring, revealed no issues with the baby or the placenta.

7. By her appointment on March 14, 2019, however, Patient 1 learned the baby's head circumference was at the 90th percentile, signifying the baby was measuring large for gestational age (LGA). There was also a concern Patient 1 had a tight pelvis, which was potentially a problem for delivery. Based on Patient 1's advanced maternal age and her gestational diabetes, Dr. Han and Dr. Lee recommended an induction at 39 weeks, on March 29, 2019. Patient 1 and Dr. Lee discussed a birth plan, though this birth plan was not documented in the medical records. According to Patient 1, the plan was to try for vaginal delivery, but if the delivery stalled, she would undergo a Cesarean section to deliver Baby C. Patient 1 never told Dr. Lee she would refuse a Cesarean section. According to Dr. Lee, she did not recall discussions of a possible Cesarean section with Patient 1, but Dr. Lee also did not recall Patient 1's absolute refusal of a Cesarean section.

8. On March 21, 2019, Dr. Lee submitted hospital admittance documents to Cedars, the hospital to which is she affiliated, in preparation for Patient 1's induction. On the same date, however, Dr. Lee informed Patient 1 she may be unavailable on the induction date due to a family commitment. On March 26, 2019, Dr. Lee informed Patient 1 she would not be available until April 1 due to her family commitment. Dr. Lee testified she gave Patient 1 the option of going forward with the induction on March 29, 2019, with a different, on-call OB/GYN, or she could wait a few days until Dr. Lee is available. Patient 1 opted to go forward with the induction with an on-call OB/GYN.

9. Although Dr. Lee's practice is based primarily in Manhattan Beach, California, she practices one day a week at Rodeo. Dr. Lee's practice also has a coverage arrangement with Rodeo, in which the physicians from both practices cover for each other in the event a physician is unavailable. Dr. Lee checked the on-call schedule, and on March 29, 2019, respondent was the physician on call. Dr. Lee called respondent as a courtesy and confirmed with respondent that she would cover Patient 1's induction on behalf of Dr. Lee.

10. On March 26, 2019, Dr. Lee wrote a History and Presentation (H&P) Note in Patient 1's medical records. This H&P Note indicates Patient 1 presented for induction of labor with issues including IVF pregnancy using donor egg, advanced maternal age, anemia due to beta thalassemia, gestational diabetes well controlled with insulin, and a baby measuring LGA. (Ex. 12, p. A398.)

Induction of Labor and Fetal Monitoring

11. Childbirth consists of three stages. The first stage consists of the onset of labor until the cervix is completely dilated to 10 centimeters. The second stage

consists of "pushing" the infant through the birth canal until delivery. The third stage consists of the delivery of the placenta.

12. A patient undergoing labor and delivery in a hospital is typically placed on electronic fetal monitor (EFM), which monitors both uterine contractions and fetal heart rate (FHR). The EFM transcribes its recordings onto graphs called tracings. The top part of the tracing shows FHR, while the bottom part of the tracing shows the duration of contractions and the intervals between them. At Cedars, a physician can view tracings either directly on a computer in the delivery room or on paper print out.

13. FHR tracings are classified into three categories. Category I FHR tracings are normal and are not associated with fetal acidosis, the accumulation of lactic acid in a baby due to oxygen deprivation. (Ex. 24, p. A6327.) Category III tracings are abnormal and indicate an increased risk of fetal acidosis. (*Ibid.*) Category II FHR tracings are considered "indeterminate" and cannot be classified as either reassuring or non-reassuring. (*Ibid.*)

14. In interpreting an FHR tracing, FHR variability, or fluctuations from the baseline FHR of 100 to 160 beats per minute (bpm), is measured within a 10-minute window. (Ex. 24, p. A6326.) Variability is classified as absent (undetectable), minimal (less than 5 beats bpm), moderate (6 to 25 bpm), or marked (greater than 25 bpm). (*Ibid.*) Among the three different types of decelerations, a late deceleration is a visually apparent, gradual decrease in FHR below the baseline, typically following a uterine contraction. (*Id.*, p. A6327.) While Category II tracings are characterized by recurrent late decelerations with moderate variability, Category III tracings are characterized by recurrent late decelerations and minimal or no variability. (*Id.*, p. A6328.)

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STAGE 1: FROM 1136 HOURS ON MARCH 29, 2019, TO 2121 HOURS ON MARCH 30, 2019

15. On March 29, 2019, at 1136 hours, Dr. Lee admitted Patient 1 into Cedars's labor and delivery unit. (Ex. 12, p. A425.) The admitting nurse indicated in her progress notes that respondent would perform the induction. (*Ibid.*)

16. At 1144 hours, the admitting nurse placed Patient 1 on an EFM. (Ex. 12, p. A899.) To induce labor, Patient 1's medical providers performed several procedures during the first stage to dilate her cervix to 10 centimeters. At 1331 hours on March 29, 2019, Lindsay Gubernick, M.D., a resident at Cedars, placed Cervidil, a medication delivered through a vaginal insert that softens the cervix, in Patient 1. (Ex. 12, p. A419.) On March 30, 2019, at 0335 hours, Certified Nurse Midwife (CNM) Miriam Michel manually placed in Patient 1 a Foley ballon, a cervical ripening ballon. (*Id.* at p. A417.) At approximately 0629, CNM Cindy McClain began administering Pitocin, an intravenous (IV) synthetic hormone that causes uterine contractions. (*Id.* at p. A416.) Patient 1 also received an epidural for pain management. (*Id.* at p. A417.)

17. At 1453 hours on March 30, 3019, approximately 26 hours after the induction of labor began, the medical records reflect that Patient 1 stated she was getting hungry and tired. (Ex. 12, p. 415.) Patient 1 also requested respondent's presence to discuss her labor progress. (*Ibid.*) By 1554 hours, respondent met with Patient 1 for the first time and answered her questions. (*Id.* at p. 423.) At 1601 hours, respondent also performed an artificial rupture of the membranes (AROM), where she intentionally broke Patient 1's amniotic sac in another effort to encourage the dilation of the cervix. (*Ibid.*) According to a nurse's progress note, when respondent performed the AROM, the amniotic fluid was clear, and FHR tracings were reassuring, remaining in Category I. (*Ibid.*)

18. Respondent then left Patient 1's bedside. Respondent, however, did not document a progress note of her first visit with Patient 1. She did not document her discussion with Patient 1 about the patient's labor progress, the pelvic exam she performed, and her performance of the AROM.

19. At 1900 hours, Paula Jacobs, R.N., came on to the shift and became Patient 1's one-on-one labor and delivery nurse. RN Jacobs performed an assessment of Patient 1 every 30 minutes. She noted that assessments of Patient 1 performed at 1930 hours, 2000 hours, 2030 hours, and 2100 hours all showed FHR was within the normal baseline range. (Ex. 12, pp. A706-707.) The tracings during each of these assessments were also in Category I, except for the assessment done at 2100 hours, which showed a Category II tracing. (*Id.*, pp. A705-707.)

20. At 2121 hours, CNM McClain performed a cervical examination of Patient 1 and determined that her cervix was fully dilated at 10 centimeters. (Ex. 12, p. A704.) Thus, the first stage of labor was complete. At this point, the baby's head is even with ischial spine, and fetal descent is described as at 0 station. Before the baby's head reaches the ischial spine, fetal descent is described as -2 station for two centimeters above the ischial spine, -1 station for two centimeters above the ischial spine, etc. Fetal descent after 0 station is described as +1 station for one centimeter below the ischial spine, +2 station for two centimeters below the ischial spine, until delivery at +4 or +5 station.

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STAGE 2: FROM 2244 HOURS ON MARCH 30, 2019, TO 0234 HOURS ON MARCH 31, 2019

Start of Pushing at 2244 Hours on March 30, 2019

21. According to the FHR tracings, Patient 1 began pushing at approximately 2244 hours on March 30, 2019. (Ex. 13, p. A1159.) As Patient 1 began pushing, respondent returned to Patient 1's bedside, and she stayed with the patient until delivery.

22. At 2244 hours, fetal station was documented in the medical records as at +2 station. (Ex. 13, p. A1159.) Respondent, however, disputes this assessment of fetal station. According to respondent, fetal station was at +1 at 2244 hours, but respondent did not document a cervical examination or her assessment of the fetal station in the medical records.

23. In an email addressed to the Board Investigator dated June 30, 2022, respondent interpreted the FHR tracings at 2244 hours as "moderate variability with variable decelerations," in Category II. (Ex. 15, p. A1194.)

Category II Tracings from 2310 Hours on March 30, 2019, to 0110 Hours on March 31, 2019

24. As RN Jacobs and respondent provided care to Patient 1 during the pushing process, they reviewed Patient 1's FHR tracings every 30 minutes. (Ex. 12, pp. A682-705.) From 2310 hours on March 30, 2019, to 0009 hours on March 31, 2019, the FHR tracings showed moderate variability and 11 late decelerations associated with 21 contractions. (Ex. 13, pp. A1162-A1168.) From 0010 to 0110 on March 31, 2019, the FHR tracings show 14 late decelerations associated with 19 contractions with

increasing periods of minimal variability. (*Id.*, pp. A1162-A1168.) There is no documentation in the medical records of the fetal station during this period.

25. In her June 30, 2022 email to the Board Investigator, respondent interpreted the FHR tracings at 2345 hours on March 30, 2019, as "moderate variability with late decelerations, periods of minimal variability," and at 0050 hours on March 31, 2019, as "minimal variability with late decelerations." (Ex. 15, p. A1194.) Respondent classified the FHR tracings during both times as Category II.

26. Although the FHR tracings remained in Category II, respondent and RN Jacobs were concerned due to the increasing number of late decelerations and periods of minimal variability. To increase oxygen delivery to the baby, RN Jacobs performed a number of intrauterine resuscitation measures, including increasing IV fluids, changing Patient 1's positions (left lateral to right lateral and then back to left lateral), and administering supplemental oxygen to Patient 1, in attempts to revert the FHR tracings to Category I. (Ex. 12, p. A683.) However, those attempts were unsuccessful.

Stopping and Restarting Pitocin from 0025 Hours to 0049 Hours on March 31, 2019

27. At 0025 hours, after Patient 1 had been pushing for approximately one hour and 40 minutes, respondent stopped the infusion of the Pitocin as an additional intrauterine resuscitation measure. (Ex. 12, p. A683.) Pitocin augments contractions, and contractions cause a decrease of blood and oxygen supply to the baby during labor. Therefore, turning off the Pitocin is a measure to give the baby a break from contractions and to increase oxygen supply to the baby.

28. However, 24 minutes later, at 0049 hours, respondent restarted the Pitocin, and the infusion of Pitocin continued past 0109 hours. (Ex. 12, at p. A682.)

Vacuum-Assisted Vaginal Delivery from 0125 Hours to 0216 Hours on March 31, 2019

29. RN Jacobs wrote in her progress notes that at 0125 hours: "[Respondent] discussing vacuum with [Patient 1] and husband, including risks and benefits. [Patient 1] verbally consents to vacuum assist. Charge RN informed." (Ex. 12, p. A424.) A vacuum-assisted vaginal delivery is a method of delivery where a healthcare provider uses a vacuum extractor to help move the baby through the birth canal. The vacuum extractor uses a soft plastic cup that attaches to the baby's head with suction. During a contraction, the patient is asked to push while the healthcare provider gently pulls to help deliver the baby. However, respondent did not document any discussion with Patient 1 of the risk and benefits of vacuum-assisted delivery, and she did not document Patient 1's consent to this procedure.

30. From 0125 hours to 0155 hours, the FHR tracings show 10 late decelerations associated with 11 contractions and more consistent minimal variability. (Ex. 13, pp. A1176-1180.) Although the tracings during this period remain in Category II, they were trending towards Category III.

31. At 0154 hours, respondent began applying a handheld vacuum extractor to the baby's head. (Ex. 12, p. A682; Ex. 13, p. A1180.) Between 0154 and 0216 hours, for approximately 22 minutes, respondent attempted 11 pulls with the vacuum extractor, with the vacuum popping off the baby's head three times at 0201, 0207, and 0216 hours. (Ex. 12, pp. A679-682.) The general guideline for vacuum-assisted vaginal delivery is to cease the procedure after three pop offs. Thus, respondent abandoned the vacuum-assisted vaginal delivery at 0216 hours.

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32. By her own admission in her June 30, 2022 email to the Board Investigator, by approximately 0200 hours, the FHR tracings show minimal variability to no variability and were in Category III. (Ex. 15, p. A1194.)

Continued Vaginal Delivery from 0216 Hours to 0234 Hours on March 31, 2019

33. Although not documented in the medical records, respondent reported the baby was crowning, meaning the head was visible through the vaginal opening, at 0216 hours. Respondent testified at the hearing that because the baby was crowning, she believed it would have been faster to deliver the baby vaginally rather than by Cesarean section. Therefore, instead of proceeding to a Cesarean section, respondent continued with the vaginal delivery. From 0216 hours until 0234 hours, the FHR tracings remained in Category III with no variability and significant decelerations. (Ex. 13, pp. A1182-1184.)

34. At 0234 hours, after Patient 1 had been pushing for three hours and 50 minutes, she delivered Baby C. (Ex. 12, p. A423.) Baby C. was immediately rushed to the Neonatal Intensive Care Unit (NICU). She was later diagnosed with severe hypoxic ischemic encephalopathy (HIE), a type of brain damage caused by deprivation of oxygen during labor and delivery.

35. Even though Patient 1's assigned labor and delivery room was next door to the operating room (OR), respondent never ordered Patient 1 to proceed to the OR for a potential Cesarean section. Although a maternal-fetal monitoring specialist was available for consult on a 24-hour basis at Cedars, respondent never consulted the specialist about Patient 1's FHR tracings. Neither did respondent consult another physician about issues she encountered during Patient 1's delivery.

Respondent's Documentation of Patient 1's Case

36. In the medical records, the only documentation of pelvic examinations performed on Patient 1, fetal stations, patient consent to procedures such as the AROM and the vacuum-assisted vaginal delivery, were in RN or CNM progress notes. The only documentation by respondent of her delivery of Baby C. in the medical records is a delivery summary respondent wrote four days later, on April 4, 2019. That summary stated, in relevant part:

> . . . [Patient 1] was induced with cervidil, Foley balloon, pitocin, and AROM. When she became completely dilated, she pushed for 2-3 hrs with good progress, despite a persistent Category 2 FHT. Due to the tracing, a vacuum was offered to the pt to expedite delivery. Risks were discussed, she verbally consented.
>
> [¶] .....[¶]
>
> Procedure: Position of the baby's head was palpated in OA position. The bladder was emptied with a red robin catheter. The kiwi vacuum was applied to the flexion point while the patient was not pushing. An exam was done to confirm that no vaginal tissue was trapped under the vacuum. The vacuum pressure was applied to 500mmHG. With each contraction the pt pushed while setting traction was used to pull the vacuum. Good descent was being made, despite three pop-offs. By the third popoff, the infant's head was crowning. The pt was encouraged to push

> and she delivered the infant over an intact perineum. Head in ROA position. Control delivery of head with 1x loose nuchal cord noted, which was easily reduced. Gentle downward traction to deliver the left anterior shoulder. Gentle upward traction to deliver the right posterior shoulder and body. Cord clamped x2 and cut immediately and infant handed to NICU team cord blood sent for gases....

(Ex. 12, p. A405.)

Baby C.'s Death

37. Baby C. was hospitalized from March 31, 2019, until June 10, 2019. Although Patient 1 originally planned to return to work after giving birth, she became Baby C.'s full-time caretaker, as Baby C. required assistance with her feedings and medications. Patient 1 also took Baby C. to see several specialists, including a neurologist, an occupational therapist, and a physical therapist. On November 30, 2020, Baby C. passed away. (Ex. 30.) Her death certificate lists "effect of perinatal hypoxia" and HIE as causes of her death. (*Ibid.*)

Civil Suit Against Respondent and Board Investigation

38. On May 29, 2019, Patient 1 filed a civil suit against respondent based on claims that respondent did not timely and appropriately respond to concerning FHR tracings during labor. (Ex. 6, p. A31.) On September 3, 2020, Patient 1 and respondent settled the civil suit. (*Id.*, p. A32.) On October 30, 2020, the Board's Central Complaint Unit received a report of the civil suit settlement from respondent's insurer, pursuant to section 801.01, which requires certain entities to report to the Board civil

settlements of $30,000 or more caused by a licensee's alleged negligence, error, omission, or rendering of unauthorized services. (Ex. 5, p. A25.) Based on this report of the civil suit settlement, the Board initiated its investigation of respondent, which eventually led to the filing of the Accusation in this case.

Expert Opinions

39. Victor K. Chan, M.D., testified at the hearing as an expert witness on complainant's behalf. Dr. Chan obtained his Doctor of Medicine degree from the University of California, Los Angeles (UCLA) in 1980. He completed his internship in internal medicine at UCLA in 1981 and his residency in OB/GYN at the University of Colorado. Dr. Chan has been board-certified in OB/GYN since 1987. He has taught as an instructor at the University of California Davis School of Medicine since 1985.

40. Dr. Chan has a solo practice in OB/GYN, and he has practiced as an obstetrical hospitalist since 1990. As such, Dr. Chan works in the hospital in 12-hour shifts, and he sees every pregnant patient who comes through the hospital, including those who do not have an OB/GYN. Dr. Chan estimated he has performed over 4,000 deliveries, and of those deliveries, approximately 800 are Cesarean sections. Dr. Chan is also familiar with vacuum extractions, which makes up more than five percent of his deliveries.

41. Dr. Chan's opinions on respondent's treatment of Patient 1 are based on his review of records, including Patient 1's medical records from Cedars, respondent's March 4, 2019 deposition during the civil suit, and respondent's June 8, 2022 Board interview. He set forth his opinions in an expert report (ex. 34), dated August 21, 2022, and in his testimony at the hearing.

42. Respondent did not present any expert witness evidence at the hearing.

ADMISSIBILITY OF DR. CHAN'S OPINIONS ON OBSTETRICAL MANAGEMENT OF LABOR AND DELIVERY

43. Respondent objected to the admission of Dr. Chan's opinions on respondent's obstetrical management of Patient 1's labor and delivery (Ex. 34, p. A6321). Specifically, Dr. Chan opined the following: (1) respondent's failure to initiate an operative vaginal delivery (OVD) (vaginal delivery assisted either by vacuum or forceps) or a Cesarean section by 0010 hours on March 31, 2019, is a simple departure from the standard of care; (2) continuing Pitocin augmentation after 0109 hours is a simple departure from the standard of care; (3) respondent's failure to initiate an urgent OVD or a cesarean section by 0110 hours is an extreme departure from the standard of care; (4) respondent's failure to move Patient 1 to the OR by 0155 hours for the vacuum-assisted vaginal delivery attempt is a simple departure from the standard of care; and (5) respondent's failure to initiate an emergency Cesarean section by 0216 hours is an extreme departure from the standard of care. (*Id.*, p. A6453.)

44. Respondent contends Dr. Chan failed to provide any analysis or explanation of his findings. (Ex. I.) Respondent further contends that that her ability to cross-examine Dr. Chan was prejudiced by this lack of analysis. (*Ibid.*) According to respondent, Dr. Chan's failure to provide an explanation of his opinions violated section 2334, which requires the exchange of a complete expert witness report, including "a complete statement of all opinions the expert will express and the bases and reasons for each opinion." (§ 2334, subd. (a)(2)(A).)

45. Complainant contends Dr. Chan provided more than a recitation of the medical records in his expert report and analyzed Patient 1's FHR tracings. (Ex. 44.) Complainant further contends respondent's objections are not timely, as they were

raised at the hearing, when Dr. Chan's expert report was exchanged twice with respondent, first as a part of discovery and then as part of complainant's expert disclosure, in June 2023, more than eight months prior to the hearing. (*Id.* at p. A6521.) Additionally, respondent failed to raise a motion *in limine* to exclude Dr. Chan's expert report or expert testimony five business days before the hearing in compliance with the ALJ's October 31, 2023 PHC order. (*Id.* at p. A6522.)

46. After considering both parties' briefs on this issue, the ALJ rules that all five of Dr. Chan's opinions on respondent's obstetrical management of Patient 1's labor and delivery are admissible. First, Dr. Chan's expert report contained analyses of Patient 1's FHR tracings. While the medical records of the FHR tracings show mere graphs (ex. 13), Dr. Chan's report analyzed the FHR tracings for FHR variability and the percentage of late or significant decelerations to contractions over certain period of time (ex. 43). He also provided the definitions of variability and decelerations in an attached scholarly article, Macones et. al., *The 2008 National Institute of Child Health and Human Development Workshop Report on Electronic Fetal Monitoring: Update on Definitions, Interpretations, and Research Guidelines* (Sept. 2008) 112 Obstetrics and Gynecology 661. (Ex. 24.)

47. Second, Dr. Chan also attached another scholarly article, Clark et. al., *Intrapartum Management of Category II Fetal Heart Rate Tracings: Towards Standardization of Care* (August 2013) American Journal of Obstetrics & Gynecology 89 (AJOG article), which provides an algorithm-based decision tree (Category II Algorithm) to assist obstetricians in making decisions about expediting delivery with Category II tracings. (Ex. 25.) As explained more fully below, Dr. Chan derived his opinions about when respondent should have proceeded to an OVD or a Cesarean section by inputting into the Category II Algorithm the FHR variability and the

percentage of significant decelerations to contractions. The AJOG article also discusses discontinuation of oxytocin (generic name for Pitocin) in the presence of excessive uterine activity and a persistent Category II FHR pattern. (Ex. 25, p. A6332.) Given Dr. Chan's report contained an analysis of FHR variability, the percentage of significant deceleration to contractions, and the Category II Algorithm which directs the obstetrician to OVD or Cesarean section based on these two factors, Dr. Chan set forth the bases upon which he formed his opinions. Consequently, his expert report complies with the requirements of section 2334, subdivision (a)(2(A).

48. Third, respondent, at the hearing, admitted she is aware of the AJOG article and the Category II Algorithm. She is also trained in interpretation of FHR tracings and understood what FHR variability and late decelerations are. Respondent also knows what Pitocin is and how it is used in induction of labor. Therefore, respondent's contention she was unable to properly cross-examine Dr. Chan due to purported deficiencies in his expert report is unconvincing.

49. Fourth, legislative history of section 2334 shows the Legislature explicitly rejected a previous version of the statute requiring the expert witness disclosures be made simply "in advance of the hearing," and, instead, enacted the statute to require disclosures to made "at least 30 calendar days prior to the commencement date of the hearing." (Sen. Bill No. 231 (2005-2006 Reg. Sess.) § 12, as amended in Assembly on August 30, 2005.) The intent of this legislation was to prevent litigation surprise. (See Initial Report, Medical Board of California Enforcement Program Monitor, prepared by Julianne D'Angelo Fellmeth and Thomas A. Papageorge, dated November 1, 2004, at pp. 160-161.) Here, even though complainant's expert report was exchanged with respondent well over 30 calendar days prior to the commencement date of the hearing, respondent failed to raise any objections to the expert report until the

hearing began. Waiting until the hearing to object to an expert report exchanged well in advance of the hearing defeats section 2334's legislative purpose of preventing litigation surprises. This practice also prejudices the complainant, as complainant was deprived of the opportunity to provide additional foundation or to supplement the expert's report to remedy any deficiencies in advance of the hearing. Under these circumstances, respondent's objections must be overruled, as there are no statutory or due process grounds to exclude Dr. Chan's opinions as respondent requests.

OBSTETRICAL MANAGEMENT OF LABOR AND DELIVERY

50. Dr. Chan opined the standard of care for an obstetrician is to assess laboring patients and their babies, monitor their well-being and employ diagnostic and therapeutic measures to ensure the best route of safe delivery while balancing the medical needs and risks of the mother and baby. (Ex. 34, p. A6450.)

Failure to Initiate OVD or Cesarean Section by 0010 Hours

51. Dr. Chan explained labor is extremely stressful for the baby, as contractions interrupt blood flow to the uterus and interrupt oxygenation to the baby. The purpose of FHR is to monitor how contractions are affecting the baby, thus allowing the obstetrician to detect fetal distress due to interruption of oxygen. Dr. Chan further explained that Patient 1's FHR tracings show late decelerations beginning at 2222 hours on March 30, 2019. (Ex. 13, p. A1170.) A late deceleration is evidence of interruption of oxygenation to the baby through the placenta. According to Dr. Chan, how often these interruptions occur determines whether an obstetrician needs to intervene in a vaginal delivery.

52. Dr. Chan noted that from 2310 hours on March 30, 2019, to 0009 hours on March 31, 2019, the FHR tracings showed moderate variability with 11 late

decelerations with 21 contractions, even though the tracings were in Category II. Thus, by 0010 hours on March 31, 2019, there were late deceleration with more than 50 percent of contractions for one hour. Dr. Chan clarified that at this point, there is still no serious risk of acidemia to the baby. However, Dr. Chan opined the baby was "slowly deteriorating" after intrauterine resuscitation measures have failed to improve the tracings from Category II to Category I. To assess the progress of labor, Dr. Chan relied on respondent's statement in her March 4, 2019 deposition during the civil suit that the fetal station at 0030 hours on March 31, 2019, is +2. (Ex. 34, p. A6452; ex. 8, p. A184.) Thus, based on respondent's recall that fetal station was +1 when Patient 1 first began pushing at 2244 hours on March 30, 2019, her progress of labor about one hour and half later, by 0010 hours on March 31, 2019, was at best +1. Based on the fetal station of +2 at 2244 hours on March 30, 2019, that is documented in the medical records, however, Patient 1 progress of labor about an hour and half later was zero.

53. Although Category II tracings are indeterminate, Dr. Chan pointed to the Category II Algorithm in the AJOG article as the standard of care for obstetricians managing Category II tracings. The Category II Algorithm shows that with moderate variability and significant decelerations (any late deceleration is considered significant) with more than 50 percent of contractions for one hour during the second stage of labor, the obstetrician should proceed with a Cesarean section or an OVD if the patient is not making normal progress. (*Id.* at p. A6330.)

54. Therefore, Dr. Chan concluded respondent's failure to initiate either an OVD or a Cesarean section by 0010 hours on March 31, 2019, is a simple departure from the standard care. He explained that at 0010 hours, it is not yet an emergency scenario as there is no evidence of acidemia. However, standard of care requires the

obstetrician at this point to intervene, either by OVD or Cesarean section, in the delivery of the baby.

Continuing Pitocin Augmentation After 0109 Hours on March 31, 2019

55. At 0025 hours, respondent stopped the Pitocin infusion, but at 0049 hours, respondent restarted the Pitocin infusion, which continued after 0109 hours. Dr. Chan noted that based on the FHR tracings, from 0010 to 0109 hours, there were recurrent late decelerations at 0013, 0015, 0017, 0021, 0023, 0028, 0031, 0042, 0054, 0059, 0103, 0105, and 0108 hours. (Ex. 34, p. A6452.) Additionally, there was a significant deceleration at 0026 hours. (*Ibid.*) Dr. Chan opined that by 0109 hours, with these recurrent late or significant decelerations, continuing the Pitocin augmentation would not have helped the baby to be delivered spontaneously, as the only safe pathway for delivery at this point was by OVD or Cesarean section. According to Dr. Chan, a reasonable obstetrician would have stopped the Pitocin infusion by 0109 hours because the Pitocin can only cause more fetal distress as it increases contractions and interrupts oxygen supply to the baby. Therefore, in Dr. Chan's opinion, continuing the Pitocin augmentation after 0109 is a simple departure from the standard of care.

Failure To Initiate an Urgent OVD or Cesarean Section by 0110

56. By 0110 hours, Patient 1 had been pushing for nearly two and a half hours. By respondent's own admission at the hearing, fetal station progress was at best +1 or +2. By respondent's own admission in her June 30, 2022 email to the Board

Investigator, the FHR tracings show periods of minimal variability by 2345 hours, and minimal variability by 0050 hours. (Ex. 15, p. A1194.)

57. According to Dr. Chan, from 0010 to 0110 hours, the FHR tracing showed 14 late or significant decelerations associated with 19 contractions. (Ex. 34, p. A6452.) Thus, the significant declarations comprised of more than 70 percent of the contractions. Periods of minimal variability are increasing, even though the tracings remained in Category II. (*Ibid.*)

58. The authors of the AJOG article cautioned against delaying the delivery of a baby with a deteriorating FHR pattern, in part because a baby suffering from severe acidemia with absent variability must pass through a stage of minimal variability. (Ex. 25, pp. A6334-6335.) Therefore, they consider persistent minimal variability the same as absent variability. (*Id.*, p.A6334.) According to the Category II Algorithm, when variability is persistently minimal or absent, significant decelerations comprise more than 50 percent of the contractions for 30 minutes, and intrauterine resuscitation measures have failed, the obstetrician should proceed to OVD or Cesarean section, regardless of the progress of labor. (*Id.*, p. A6330.)

59. Under these circumstances, Dr. Chan opined that by 0110 hours, the need to expedite the delivery of the baby by OVD or Cesarean section is now urgent, even though FHR tracings are still in Category II and the baby is not yet acidemic. Thus, respondent's failure to initiate an urgent OVD or Cesarean section by 0110 hours is an extreme departure from the standard of care.

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Failure to Move Patient 1 to the OR for Vacuum-Assisted Delivery Attempt at 0155 Hours

60. According to Dr. Chan, from 0125 to 0155 hours, the FHR tracings show 10 late decelerations associated with 11 contractions, with more consistent minimal variability. Thus, significant decelerations comprised more than 90 percent of the contractions. At this point, the status of the baby is extremely worrisome, as interruptions of oxygenation are increasing, and the baby is clearly not tolerating labor. In Dr. Chan's opinion, the standard of care by 0155 hours is for the obstetrician to move Patient 1 to the OR for an OVD attempt. Given the uncertainty of success with OVD attempts, the obstetrician should proceed quickly to a Cesarean section if such attempts fail. Dr. Chan opined that while not all vacuum-assisted vaginal delivery need to be performed in the OR, given the urgent nature of Patient 1's case, respondent's failure to move Patient 1 to the OR in preparation for a Cesarean section constitutes a simple departure from the standard of care.

Failure to Initiate an Emergency Cesarean Section at 0216 Hours

61. Dr. Chan explained that by 0216 hours, Patient 1 had been pushing for almost three and half hours, which is a prolonged second stage of labor. (Any second stage of labor lasting for three to four hours is considered prolonged.) Vacuum-assisted delivery had failed after three pop-offs. The FHR tracings were in Category III, with significant decelerations and no variability. Dr. Chan opined that the baby is now acidemic, and delivery must be accomplished as soon as possible in an emergency Cesarean section.

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62. Even though respondent cited to the baby's crowning at 0216 hours as the reason for her to continue with the vaginal delivery instead of an emergency Cesarean section, Dr. Chan does not believe that the baby's crowning at 0216 hours affects need for an emergency Cesarean section at this point. According to Dr. Chan, even after the baby has crowned, respondent would have no knowledge of how much longer it would take to delivery the baby vaginally. However, by 0216 hours, the Category III FHR tracings were indicating that the baby must be delivered immediately, and the only certain method for an immediate delivery is an emergency Cesarean section. Dr. Chan stated that even after a baby has crowned, it is a common procedure to push the baby up the birth canal to proceed with an emergency Cesarean section. Therefore, respondent's failure to initiate an emergency Cesarean section by 0216 hours constitutes an extreme departure from the standard of care.

DOCUMENTATION ISSUES

63. Dr. Chan wrote in his expert report: "The Standard of Care for obstetricians caring for patients he/she is responsible for on labor and delivery is to document important interactions with their patient, document procedures including consents performed on a patient, and document important critical temporal milestones in the hospital course when appropriate." (Ex. 34, p. A6453.)

64. Dr. Chan opined that respondent's failure to document her first encounter with Patient 1 on March 29, 2019, at 1554 hours constitutes a simple departure from the standard of care. In Dr. Chan's opinion, the standard of care required respondent to document her discussion with Patient 1 about her progress in labor and respondent's performance of a pelvic examination and the AROM at 1600 hours.

65. Dr. Chan also opined that respondent's failure to document her assessments of Patient 1's labor progress and procedures performed during the prolonged second stage of labor constitutes a simple departure from the standard of care. In Dr. Chan's opinion, the standard of care required respondent to document her performance of pelvic examinations, her assessments of the fetal station, her assessment of Patient 1's cervix, her discussions with Patient 1 of the risks and benefits of the vacuum-assisted vaginal delivery, and Patient 1's consent to the procedure.

66. Additionally, Dr. Chan opined that respondent's failure to document Patient 1's delivery of Baby C. four days after the fact is another simple departure from the standard of care. In Dr. Chan's opinion, even with a bad outcome, the responsibility is with the obstetrician to be a historian of record, which also serves to help other medical providers with information about Patient 1 and Baby C. Although it is understandable respondent was emotionally exhausted after Baby C.'s delivery, a delay of four days to provide any documentation is a deviation from the standard of care.

Credibility and Other Additional Findings on Expert Testimony

67. Dr. Chan is a well-qualified expert with extensive experience as an OB/GYN. His opinions are afforded significant weight as they were unrefuted, consistent with the medical evidence, and supported by the medical literature he cited. Additionally, during cross-examination, Dr. Chan did not waver from his opinions, adding to his credibility. Therefore, all of Dr. Chan's opinions were established by clear and convincing evidence.

68. It also should be noted that Dr. Chan addressed in his testimony the challenge of interpreting Category II tracings. He stated proper interpretation of

Category II tracings requires interobserver and intraobserver assessments. Interobserver assessment means the obstetrician needs to assess the FHR tracings retrospectively and reassess her interpretations multiple times. Dr. Chan pointed out that during her Board interview on June 8, 2022, respondent stated she was only able to view 10-minute snippets of the FHR tracings. (Ex. 9, p. A342.) However, Dr. Chan suggested respondent could have either used paper copies of the tracings or scrolled back electronically to assess tracings beyond the last 10 minutes. Dr. Chan wrote in his expert report: "Thoughtful essential analysis of evolving Category II tracings often requires multiple real-time retrospective reexaminations." (Ex. 34, p. A6454.) Intraobserver assessment means consultations with other providers or other on-site practitioners who could offer a different assessment. Dr. Chan wrote in his expert report: "Therefore consultation with another on-site practitioner would/might have assisted [respondent] in this clinical situation." (*Ibid.*)

Respondent's Evidence

69. Respondent testified that in 2019, she was adequately trained and prepared for Patient 1's labor and delivery. She estimated that as an intern at Cedars, she performed 700 to1,000 deliveries under the supervision of attending physicians, with a majority of those deliveries involving high risk patients who are over the age of 35. However, respondent also testified she was inexperienced at the time she agreed to take on Patient 1's case from Dr. Lee.

70. Respondent attributed the outcome of Patient 1's case to the fact that she wanted to show Patient 1 her support and stayed with Patient 1 for almost four hours of pushing without taking any breaks. Respondent testified she "lost sight of the time that passed" and "lost sight of the bigger picture." Respondent conceded she had read the AJOG article and was aware of the Category II Algorithm as a general

guideline for physicians. Nevertheless, respondent insisted there are no hard rules for how long to continue with a vaginal delivery before proceeding to a Cesarean section. According to respondent, as long as the patient is progressing, the attending physician has the discretion to continue with the vaginal delivery. Respondent insisted Patient 1 was progressing with her labor, albeit slowly. Based on her own recall, respondent believes the baby was at +1 station when Patient began pushing at 2244 hours. Respondent believes by 0155 hours, when the vacuum was applied, the baby was at +2.5 to almost +3. Respondent claimed it is not unusual for a patient to push three to four hours for one centimeter for descent, but when asked if such progress was "normal," she evaded the question by answering that whether labor progress was normal is a subjective assessment.

71. Respondent disagreed with Dr. Chan's opinion that continuing Pitocin at 0109 hours placed greater stress on the baby, and she disagreed with Dr. Chan's opinion that by 0109 hours, the only safe pathway for delivery of Baby C. was by OVD or Cesarean section. However, respondent offered no support for this opinion, other than stating that in the moment, as the provider who was treating Patient 1, she felt Patient 1 was making progress and Patient 1 could still have a spontaneous delivery.

72. Respondent disagreed with Dr. Chan's opinion that Patient 1 should have been moved to the OR at 0155 hours for the vacuum-assisted vaginal delivery attempt. However, respondent again offered no support for this opinion, other than stating at that time, she believed she had more time and did not feel the need to move Patient 1 to the OR.

73. Respondent disagreed with Dr. Chan's opinion that at 0216 hours, even if the Baby C. was crowning, the baby could have been pushed back into the birth canal for an emergency Cesarean section. Respondent asserted pushing the baby back into

the birth canal could result in greater morbidity for both mother and child. Respondent also testified that at 0216 hours, she made the decision to continue with vaginal delivery because she believed the baby could be delivered within a few minutes vaginally, whereas an emergency Cesarean section would have taken 15 to 20 minutes. However, this testimony is at odds with respondent's statements during her March 4, 2019 deposition during the civil suit. During that deposition, when asked what was her backup plan at 0216 hours in the event the vacuum-assisted vaginal delivery did not work, respondent answered: "Like I said, though she was—she was crowning, and so the—I—Obviously, I have no idea how long it takes from crowning to her pushing the baby out....." (Ex. 8, p. A225.) When cross-examined about this inconsistency at the hearing, respondent insisted while making decision in hindsight is easy, she was the only provider at Patient 1's bedside at that time and she believed it would have been faster to deliver Baby C. vaginally. Respondent also denied that the decision to proceed with vaginal delivery at 0216 hours was poor judgement.

74. Respondent did concede that she made a mistake in her treatment of Patient 1. According to respondent, she was only looking at 10-minute portions of the FHR tracing. Now, in retrospect, she believes she should have expedited delivery of Baby C. by 0050 hours on March 31, 2019. According to her June 30, 2022 email to the Board Investigator, respondent believes she should have tried the vacuum-assisted vaginally delivery first, but if delivery was not imminent with 10 minutes of the vacuum attempt, she should have proceeded to a Cesarean section. (Ex. 15, p. A1194.)

75. Although respondent admitted that the final clinical decision fell on her as the attending obstetrician, she believes she was "let down" by the labor and delivery team at Cedars. Respondent emphasized RN Jacobs and the CNM's were present during the labor and delivery; the nurse station was also monitoring FHR; and the

charge nurse was also reviewing the FHR tracings. However, no one on the labor and delivery team approached her to discuss any concerning tracings. Notably, respondent did not address why she did not consult with the maternal-fetal monitoring specialist at Cedars about Patient 1's FHR tracings, even though this specialist was on call around the clock at Cedars.

76. Regarding the documentation issues raised by Dr. Chan, respondent asserted it was impossible for her to document procedures simultaneously, as she was busy providing care to Patient 1. This assertion is disingenuous, as respondent is not expected to stop caring for a patient to do documentation. However, as Dr. Chan noted, respondent is expected to document important interactions with Patient 1; procedures, including consents, performed on Patient 1; and important critical temporal milestones, including labor progress and fetal stations, soon after the event. Respondent had no explanations about why she did not document her initial visit with Patient 1 on March 30, 2019, her performance of the AROM on the same date, and during the second stage of labor, her performance of pelvic examinations, her assessments of the fetal station, her assessment of Patient 1's cervix, her discussions with Patient 1 of the risks and benefits of the vacuum-assisted vaginal delivery, and Patient 1's consent to the procedure. Respondent reported she was devastated after Baby C.'s delivery and did not write the delivery summary until four days later, but this delay in documentation did not violate any Cedars rules or policies. Nevertheless, respondent offered no evidence to refute Dr. Chan's opinion that a delay of four days in documenting the delivery summary is a deviation from the standard of care.

77. Respondent's testimony during the hearing also displayed a lack of candor. Respondent claimed during direct examination that Cedars did not take any adverse action against her after Baby C.'s delivery, but on cross-examination, she

admitted Cedars required her to be proctored after undergoing a peer review process. Respondent claimed during direct examination she has not been the subject of any other malpractice suit, but on cross-examination, she admitted she is the defendant in a malpractice suit in case number 23SMCV01070 filed in 2023 (2023 Suit). (Exs. 37 & 38.) (The 2023 Suit is considered only as impeachment evidence of respondent's credibility, not as evidence of further acts of negligence.) Respondent then claimed she could not recall being served with the 2023 Suit but later testified she was only named in the 2023 Suit but was not "part of the care that led to the lawsuit." As an additional explanation of why she denied being sued again for malpractice during direction examination, respondent added "[she does] not know how legal things work." These explanations strain one's credulity, as respondent is a well-educated physician who should be able to recall and understand the significance of being a party to a malpractice suit.

78. Five years after Baby C.'s delivery, respondent believes she has learned valuable lessons from Patient 1's case. She reported she is now extremely vigilant about Category II tracings; she looks backs on the tracings 30 minutes at a time; she is more aware of the time that has passed during delivery; and she seeks out second opinions. Respondent reported she took a fetal monitoring course, but she did not submit any course certificates. There is no evidence respondent has taken any medical recordkeeping course.

79. Respondent submitted two character reference letters from her colleagues, Kathleen Valenton, M.D., and Peter Weiss, M.D. (Exs. G & H.) Drs. Valenton and Weiss, who both with respondent work at Rodeo, describe respondent as an outstanding, hard-working OB/GYN who is beloved by her patients. However, because

neither doctor acknowledged any awareness of the allegations contained in the Accusation, their character references carried little weight.

80. Respondent averred she was devastated by the outcome of Baby C.'s delivery, and she is heartbroken for the family. She believes it is an experience that will continue to shape her for the remainder of her career. However, respondent is passionate about and devoted to her job, and she wishes to continue practicing as an OB/GYN without restrictions.

Costs

81. Complainant requests the following in recovery costs: (1) costs of investigation totaling $2,938; (2) expert costs totaling $5,776; and (3) actual costs of prosecuting this matter by the Department of Justice (DOJ) totaling $45,463.75. The DOJ costs consist of the following: 195.75 hours of attorney time billed at $220 per hour; and 10.75 hours of paralegal time billed at $205 per hour. Total costs claimed are $54,177.75. (Ex. 32.)

82. Respondent did not present any evidence regarding her income or expenses.

LEGAL CONCLUSIONS

Standard and Burden of Proof

1. Complainant has the burden of proof in an administrative action seeking to suspend or revoke a professional license, and the standard is clear and convincing proof to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Governing Law and Legislative Intent

3. The Medical Practice Act governs the rights and responsibilities of the holder of a physician's and surgeon's certificate. (§§ 2000 et seq.) The state's obligation and power to regulate the professional conduct of its health practitioners is well settled. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 577.) Protection of the public is the highest priority for the Board in exercising its disciplinary authority and is paramount over other interests in conflict with that objective. (§ 2001.1.)

4. The Board is required to take action against any licensee who is charged with unprofessional conduct. (§ 2234.) Unprofessional conduct includes violation of any provision of the Medical Practice Act, gross negligence, and repeated negligent acts, which consist of two or more negligent acts or omissions. (*Id.,* subd. (a), (b), & (c).)

First Cause for Discipline

5. The Accusation alleges respondent's certificate is subject to discipline under section 2234, subdivision (b), because respondent was grossly negligent in her care and treatment of Patient 1 and Baby C. The Medical Practice Act does not define "negligence." Generally, negligence is conduct that falls below the standard established by law for the protection of others against unreasonable risk of harm. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997; Restatement (Second) of Torts § 282 (1965).) It is well settled that the standard of care

for physicians is the reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.) Importantly, a medical professional is held to the standard of care in their own "school" or specialty. Specialists are held to that standard of learning and skill normally possessed by such specialists in the same or similar locality under the same or similar circumstances. (*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Gross negligence includes "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Van Meter v. Bent Const. Co.* (1956) 46 Cal.2d 588, 594.)

6. Complainant established by clear and convincing evidence respondent committed extreme departures from the standard of care by failing to initiate an urgent OVD or a Cesarean section by 0110 hours on March 31, 2019, and by failing to initiate an emergency Cesarean section by 0216 hours. (Factual Findings 56-59; 61-62; 67.)

7. Cause therefore exists to discipline respondent's certificate for gross negligence pursuant to section 2234, subdivision (b).

Second Cause for Discipline

8. The Accusation alleges respondent's certificate is subject to discipline under section 2234, subdivision (c), because she committed repeated negligent acts in her care and treatment of Patient 1 and Baby C.

9. Complainant established by clear and convincing evidence respondent committed simple departures from the standard of care by failing to initiate an OVD or a Cesarean section by 0010 hours on March 31, 2019; continuing Pitocin augmentation

after 0109 hours; and failing to move Patient 1 to the OR for the vacuum-assisted vaginal delivery attempt. (Factual Findings 51-55; 60 & 67.) Complainant also established by clear and convincing evidence respondent committed simple departures from the standard of care by failing to document her first visit with Patient 1 that included a discussion of Patient 1's labor progress, a pelvic exam, and AROM; failing to document Patient 1's labor progress and assessments about Patient 1's prolonged second stage of labor, any pelvic exams, discussions with Patient 1 about the vacuum-assisted vaginal delivery, and Patient 1's consent to the procedure; and failing to document the delivery summary until four days after the fact. (Factual Findings 63-67.)

10. Cause therefore exists to discipline respondent's certificate for repeated acts of simple negligence pursuant to section 2234, subdivision (c).

Third Cause for Discipline

11. The Accusation alleges respondent is subject to disciplinary action because she failed to maintain adequate and accurate medical records for Patient 1.

12. 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. (§ 2266.) Accurate and adequate records promote a physician's skillful treatment of a patient, contain the essence of what the physician was told and what the physician observed, and trace the physician's medical decision-making process. Accurate and adequate records, in this case, could have permitted a review of the progression of Patient 1's labor and conveyed important information to Baby C.'s medical providers. A physician's memory does not constitute an adequate

medical record. Accurate charting promotes skillful patient treatment and also protects a physician if any false claim arises.

13. Complainant established by clear and convincing evidence that respondent's medical recordkeeping was inadequate for Patient 1. (Factual Findings 63-67; Legal Conclusion 9). Cause therefore exists to discipline respondent's license for inadequate medical record keeping under section 2266.

Disposition

14. Under the Board's Disciplinary Guidelines (Guidelines), a finding of repeated acts of negligence, unprofessional conduct, or inadequate medical record keeping warrants license probation to monitor a physician's activities. (Ex. 26, p. A6362.) The Guidelines recommend a minimum discipline of five years of probation and a maximum discipline of revocation. (*Ibid.*)

15. In this case, the nature of respondent's misconduct was extremely serious. Respondent failed to expedite Baby C.'s delivery due to a lack of thoughtful assessments of deteriorating Category II tracings. Respondent's conduct resulted in catastrophic harm to both Patient 1 and Baby C. Respondent also failed to properly document Patient 1's labor and delivery in the medical records, writing only a summary of a complicated delivery four days after the fact. Respondent's shifting of blame on the labor and delivery team for failing her demonstrates a minimization of her own responsibility. Her lack of candor about Cedar's imposition of adverse action against her and the 2023 Suit is also concerning and calls into question respondent's credibility and her rehabilitative efforts.

16. Most significantly, respondent averred she learned valuable lessons from the complicated delivery of Baby C. However, respondent's insistence that there are no

hard rules about when to proceed to an OVD or Cesarean section, despite her acknowledgment of the Category II Algorithm as a guideline, casts doubt on how much insight she has gained. At the hearing, respondent persisted in her belief that it is entirely up the clinical judgment of the attending obstetrician to determine whether to proceed with an OVD or a Cesarean section in the face of deteriorating Category II tracings. Respondent disputed many of Dr. Chan's opinion by merely asserting that as the attending obstetrician in the delivery room, she believed Patient 1 was progressing and could still have a spontaneous delivery by 0110 hours; she believed continuing Pitocin past 0109 hours did not put Baby C. under more stress; she believed Patient 1 had more time and did not need to be moved to the OR by 0155 hours; she believed a vaginal delivery would have been faster than a Cesarean section by 0216 hours. However, respondent presented no expert testimony and cited to no medical literature to support these beliefs. Indeed, it is respondent's misplaced confidence in her own clinical judgment, to the exclusion of relying on evidence-based medical literature or consulting with the on-call maternal-fetal monitoring specialist at Cedars or other physicians, that lead to the delivery of Baby C. with HIE and her death a year later.

17. However, respondent did acknowledge some responsibility by conceding she should have attempted an OVD by 0050 hours and if delivery was not imminent in 10 minutes, she should have proceeded to a Cesarean section. Respondent has also changed her practice to be more vigilante of Category II tracings, and she has practiced as an obstetrician in the last five years without evidence of other misconduct. Under these circumstances, placing respondent on five years of probation, with additional terms ensuring her general fitness to practice, should be adequate to protect the public. Such additional terms will include a clinical assessment program, practice monitor, solo practice prohibition, education courses, and a medical recordkeeping course.

Costs

18. The ALJ may direct a Board licensee found to have committed a violation or violations of the Medical Practice Act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. (§ 125.3, subd. (a).) In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 (*Zuckerman*), the Supreme Court set forth factors to be considered in determining the reasonableness of the costs sought. These factors include: 1) the licentiate's success in getting the charges dismissed or the severity of the discipline imposed reduced; 2) the licentiate's subjective good faith belief in the merits of his or her position; 3) whether the licentiate raised a colorable challenge to the proposed discipline; 4) the licentiate's financial ability to pay; and 5) whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Id.*, p. 45.)

19. Complainant requests reimbursement of $54,177.75 in actual costs of prosecution and enforcement. Complainant's request for reimbursement of $54,177.75 for actual costs is unreasonable under the *Zuckerman* factors. Although there was no evidence showing respondent lacks the financial resources to pay the Board's costs, the prosecution costs are not proportionate to a three-day hearing involving a single expert witness. It is therefore appropriate to reduce the amount of costs by 50 percent, for a total of $27,088.

ORDER

Physician and Surgeon's Certificate No. A136036 issued to Jennifer May Chen, M.D., is revoked. However, the revocation is stayed, and respondent is placed on probation for five years, upon the following terms and conditions:

1. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true 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.

2. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

3. 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.

4. 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.

5. General Probation Requirements

Compliance with Probation Unit.

Respondent shall comply with the Board's probation unit.

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(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

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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 thirty (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.

6. 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.

7. 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 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. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. 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 the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment 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 (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice for a respondent residing outside of California, 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; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

8. 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.

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, or 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 her 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. Education Course

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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.

13. 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.

14. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of three and no more than five days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

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At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction. If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the respondent did not successfully complete the clinical competence assessment program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

15. Monitoring – Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are

valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

16. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent

merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within five calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

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17. Costs

Respondent shall pay $27,088 to the Board in reimbursement for its costs of investigation and enforcement based on a payment plan approved by the Board.

DATE: 04/26/2024

Ji-Lan Zang

JI-LAN ZANG

Administrative Law Judge

Office of Administrative Hearings