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

In the Matter of the Accusation Against: Connie S.L. Chein, M.D. Physician's and Surgeon's Certificate No. G 31986 Respondent.	Case No.: 800-2021-074735

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 20, 2025.

IT IS SO ORDERED: May 21, 2025.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

Michelle A. Bholat, M.D., Chair
Panel A

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

In the Matter of the Accusation Against:

CONNIE S.L. CHEIN, M.D.,

Physician's and Surgeon's Certificate Number No. G 31986,

Respondent.

Case No. 800-2021-074735

OAH No. 2024030480

PROPOSED DECISION

Ji-Lan Zang, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter by videoconference from January 27 to January 31, 2025.

Rebecca L. Smith, Deputy Attorney General, represented Reji Varghese, (complainant), Executive Director, Medical Board of California (Board), Department of Consumer Affairs.

Philip W. Boesch, Jr. and Annie Ksadzhikyan, Attorneys at Law, represented Connie S.L. Chein, M.D. (respondent), who was present throughout the hearing.

Oral and documentary evidence was received. The record was held open until February 28, 2025, for complainant's closing brief; until March 28, 2025, for respondent's closing brief; and until April 11, 2025, for complainant's reply brief. Parties timely filed all briefs. Complainant's closing and reply briefs were marked for identification as Exhibits 30 and 31, respectively. Respondent's closing brief was marked for identification as Exhibit S.

A separate protective order was issued placing Exhibits 7-9, 20-23, and O-R under seal to protect confidential information. On April 11, 2025, the ALJ closed the record, and the matter was submitted for decision.

SUMMARY

Complainant seeks to revoke respondent's license based on allegations that respondent is not able to practice medicine safely because she suffers from severe disruptive sleep apnea. Complainant did not prove cause to discipline respondent's license based on this allegation, as respondent presented evidence from her treating sleep specialist showing her sleep apnea is well under control. However, complainant also charged respondent with gross negligence, repeated acts of negligence, incompetence, and improper medical record keeping in connection with her treatment of Patient #1 and Patient #2. (Patients are identified by numbers to protect their privacy). These four additional causes for discipline were established by clear and convincing evidence. Respondent did not admit to any wrongdoing in her testimony at the hearing and presented little rehabilitative evidence. However, considering respondent's history of approximately 50 years of practice with no prior discipline,

placing respondent on five years of probation will be sufficient to protect the public health, interest, and welfare.

FACTUAL FINDINGS

Jurisdictional Matters

1. On July 1, 1976, the Board issued Physician's and Surgeon's Certificate Number G 31986 to respondent. This license is scheduled to expire on January 31, 2026.

2. On January 16, 2024, complainant filed the Accusation in his official capacity. Respondent filed a Notice of Defense requesting a hearing. All jurisdictional requirements have been met.

Respondent's Background

3. Respondent is 77 years old. She received her undergraduate degree from the University of Southern California and her medical degree from UCLA Medical School. Respondent completed her residency and internship at LAC+USC Hospital (now known as Los Angeles General Medical Center). After her graduation from LAC+USC in 1979, respondent joined a group obstetrician/gynecologist (OB/GYN) practice. Since 1981, she has had her own private practice in Beverly Hills, California.

4. From 1979 to 2009, respondent was on staff at Cedar Sinai Hospital (Cedar Sinai). From 2006 to 2009, she served as the chief of Cedar Sinai's OB/GYN Department. From 2009 to 2023, respondent was on staff Saint John's Hospital (St. John's) in Santa Monica. Respondent currently works at her private practice clinic,

where she sees approximately 15 patients a day, four days a week. Although respondent currently performs minor gynecological outpatient surgeries, she does not deliver any babies as she does not have any hospital privileges. However, respondent plans on delivering babies again in the future after the resolution of this matter.

5. Respondent has been certified by the American Board of Obstetrics and Gynecology since 1981. She has delivered over 9,000 babies throughout her career. She has no record of prior Board discipline.

Respondent's Sleep Apnea

SUSPENSION OF HOSPITAL PRIVILEGES AT ST. JOHN'S

6. On September 30, 2020, St. John's suspended respondent's privileges based on two witness' report that respondent fell asleep when a patient was delivering a baby, most notably during the second stage of labor when the patient was pushing. St. John's Medical Executive Committee required respondent to undergo a Comprehensive Diagnostic Evaluation (CDE) to assess her fitness to practice before it would lift the suspension. St. John's CDE team referred respondent for a sleep study, which respondent completed on November 19, 2020. Daniel Norman, M.D., a board-certified sleep disorder specialist at Sleep Disorders Center, performed the sleep study and diagnosed respondent with "severe obstructive sleep apnea" due to her "apnea/hypopnea, oxygen desaturation and fragmented sleep" which he deemed "clinically significant, warranting treatment." (Ex. 9, p. A252.) Dr. Norman prescribed a Continuous Positive Airway Pressure (CPAP) machine to treat respondent's sleep apnea. On December 7, 2020, St. John's CDE team issued a report that respondent was "fit to return to duty as long as she continues follow-up with her sleep disorder specialist and that reports continue to be favorable." (*Id.*, p. A271.) On a date not

established by the record, sometime in mid-December 2020, St. John's lifted respondent's suspension.

7. However, respondent's sleep apnea was initially not well controlled because the CPAP machine did not fit well. Dr. Norman testified at the hearing that between December 2020 and January 2021, respondent's CPAP machine experienced "high leak," and control of respondent's sleep apnea was "okay but not perfect."

8. On December 29, 2020, St. John's received another report that respondent had fallen asleep during a delivery. On January 6, 2021, Saint John's notified Dr. Chein that she was suspended for a second time because she had fallen asleep during deliveries on September 12, 2020, and December 29, 2020. On January 13, 2021, Saint John's extended respondent's suspension and filed a Health Facility/Peer Review Report to the Board regarding its suspension of respondent's hospital privileges.

9. In January 2021, after finding that the CPAP machine was not working effectively due to leaks, Dr. Norman changed respondent's prescription for a CPAP machine to a Bilevel Positive Airway Pressure (BIPAP) machine. At a follow-up visit on March 2021, Dr. Norman confirmed that respondent was using the BIPAP machine more frequently due to a better fit, and her sleep apnea had improved significantly. On April 6, 2021, Saint John's lifted respondent's second suspension.

BOARD INVESTIGATION AND EVALUATIONS

10. After its receipt of St. John's Health Facility/ Peer Review report on January 13, 2021, the Board initiated an investigation on January 31, 2021.

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11. On August 15, 2023, respondent voluntarily agreed to undergo mental and physical examinations by Board-appointed evaluators to determine whether her ability to practice medicine safely is impaired due to a mental or physical illness.

12. On September 22, 2023, David Taylor, M.D. conducted a Psychiatric Clinical Diagnostic Evaluation of respondent. After administering several different psychiatric tests, Dr. Taylor found that respondent did not suffer from depression, anxiety, alcoholism, or any other psychiatric conditions. Dr. Taylor opined that respondent is not a danger to public health, safety, or welfare. Dr. Taylor testified at the hearing and submitted a report dated September 27, 2023. Dr. Taylor's testimony was consistent with his written report, which concluded:

> . . . [Respondent] is able to continue to practice medicine safely at this time without restrictions or accommodations on a psychiatric basis. She does not have a psychiatric diagnosis, and no additional testing is necessary.
>
> However[,] the Board should require that [respondent's] sleep physician provide documentation to ensure that her diagnosis of severe obstructive sleep apnea is well-controlled and that she is compliant with recommended treatments.

(Ex. 15, p. A604.)

13. On October 13, 2023, Surasak Phuphanich, M.D. conducted a physical examination of respondent. At the time of her evaluation with Dr. Phuphanich, respondent was working at her out-patient clinic four days a week. She did not

perform any surgeries and referred her patients to UCLA Medical Center for deliveries. In a report dated October 13, 2023, Dr. Phuphanich found that respondent does not have a physical illness that impacts her ability to practice medicine, and she is able to practice medicine safely without restrictions or conditions. (Ex. 13, p. A582.)

14. However, in answering a question about whether respondent's continued practice of medicine poses a present danger or threat to the public health, Dr. Phuphanich wrote: "No for out-patient clinical practice. I would like to defer this specific question about delivery to an obstetrician specialist because of the possible late-night deliveries that may interrupt sleep pattern and can affect individual performance, especially older physician." (Ex. 13, p. A582.) Additionally, in answering a question about whether respondent has a physical illness or condition which requires monitoring to practice medicine safely, Dr. Phuphanich wrote, "Yes, she should be examined with sleep study and follow up annually." (*Id.*, p. A583.)

15. At the hearing, Dr. Phuphanich testified consistently with the content of his written report. Dr. Phuphanich further explained that sleep apnea is a serious condition which requires aggressive treatment. According to Dr. Phuphanich, sleep apnea causes oxygen desaturation, which, cumulatively over the years, can lead to permanent damage to the brain. Severe outcomes include stroke, early Alzheimer's Disease, and dementia. Although Dr. Phuphanich believes respondent can practice safely in an outpatient setting, he was concerned about respondent's ability to function during late night deliveries. Dr. Phuphanich also opined that even if respondent's sleep apnea is well controlled, it can still present some danger given respondent's age and her OB practice. Thus, he recommended the annual follow-up and the deference to an OB specialist regarding late-night deliveries.

16. No expert evidence was presented at the hearing from an OB specialist about how respondent's sleep apnea may impact any late-night deliveries.

RESPONDENT'S CURRENT CONDITION

17. Dr. Norman, respondent's treating sleep disorder specialist, testified at the hearing regarding respondent's current condition. Dr. Norman opined respondent's sleep apnea is clinically significant and requires treatment. He recalled that after respondent's switch to the BIPAP machine, her sleep apnea had improved significantly. According to Dr. Norman, the BIPAP machine can lose effectiveness, if the mask is not fitting well, if the patient gains significant weight, or experiences major change in health. Thus, if respondent experiences no major changes and is compliant with treatment, BIPAP therapy should continue to be effective in controlling respondent's sleep apnea. Dr. Norman recommended that respondent have annual follow-ups with his office if her sleep apnea is well-controlled and stable. Dr. Norman also opined that respondent may practice without restriction and poses no risk to patient safety if her sleep apnea is well-controlled.

18. Dr. Norman reported respondent had her last annual follow-up visit at the Sleep Disorder Center on March 20, 2024. At that follow-up visit, a nurse practitioner saw respondent. Respondent reported she was consistently using the BIPAP machine without any issues and she was sleeping well. However, Dr. Norman noted that the last data download, which shows respondent's compliance and control of sleep apnea, from respondent's BIPAP machine had occurred on November 8, 2022. The ALJ then ordered respondent to provide her BIPAP machine for Dr. Norman to download the most recent data from respondent's BIPAP machine and submit a brief report on the results.

19. Dr. Norman reported on those results in an email dated January 30, 2025:

> Enclosed are the data downloads you requested from the patient's BIPAP device for the past month and the past year.
>
> They both show excellent adherence to BIPAP therapy (100% of nights showing use >4/h, minimal acceptable adherence for Medicare coverage of BIPAP therapy is considered at least 70% of nights), with average nightly usage of 6h and 36 min in the past year.
>
> The control of sleep apnea appears to be excellent, with residual apnea / hypopnea index of 1.2/h over the past year, and 0.7/h in the past month (AHI < 5/h is considered. The leak numbers are a little higher than I would like - so I will ask the patient to return to the office with her mask to assess /address mask fit, but otherwise, I think this is data that indicates great adherence and great control of severe sleep apnea.

(Ex. P, p. B112.)

Respondent's Treatment of Patient #1 and #2

Background on Labor and Delivery

20. Childbirth consists of three phases, which are referred to as 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.

21. Fetal station refers to fetal descent down the birth canal relative to the ischial spine. When the baby's head is even with ischial spine, fetal descent is described as at 0 station. Some obstetricians describe fetal descent after 0 station 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. However, other obstetricians divide the birth canal into thirds, and +1 may refer to one third way down the birth canal until delivery at +3 station.

22. Fetal position refers to the fetus' position in the uterus at the time of the delivery. Fetal positions include occiput posterior, in which the fetus is head down, facing the mother's belly, and transverse, where the fetus is lying across the uterus on its back.

23. Operative vaginal delivery (OVD) is a method of delivery where a physician uses operative instruments such as forceps or vacuum. A vacuum-assisted vaginal delivery, also known as a vacuum extraction, is a method of delivery where a physician 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 physician gently pulls to help deliver the baby.

BACKGROUND ON FETAL MONITORING

24. 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.

25. Nomenclature and interpretation of FHR tracings were standardized in 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. (EFM Article.) (Ex. 25.) According to this article, FHR variability, or fluctuations from the baseline FHR of 100 to 160 beats per minute (bpm), is measured within a 10-minute window. (Ex. 25, p. A1508.) Variability is classified as absent (undetectable), minimal (less than 5 beats bpm), moderate (6 to 25 bpm), or marked (greater than 25 bpm). (*Ibid.*)

26. FHR decelerations are classified as late, early, or variable, based on specific characteristics. (Ex. 25, p. A1508.) An early deceleration is a visually apparent, usually symmetrical, gradual decrease and return of the FHR associated with a uterine contraction. (*Id.*, p. A1509.) A variable deceleration is a visually apparent, abrupt decrease in FHR. (*Ibid.*) A late deceleration is a visually apparent, gradual decrease in FHR below the baseline, typically following a uterine contraction. (*Ibid.*) FHR decelerations over certain periods of time are defined separately. For example, a prolonged deceleration is a visually apparent decrease in FHR from the baseline that is greater than or equal to 15 bpm, lasting more than 2 minutes, but less than 10 minutes. (*Ibid.*)

27. FHR patterns are categorized into a three-tier system. (Ex. 25, p. A1509.) 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. (*Ibid.*) 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.*) 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. (*Ibid.*)

28. Managing Category II tracings, or deciding when to proceed to a Cesarean section or an OVD in the face of Category II tracing, was not standardized until the publication of Clark et. al., *Intrapartum Management of Category II Fetal Heart Rate Tracings: Towards Standardization of Care* (August 2013) American Journal of Obstetrics & Gynecology 89 (Category II Article). This Category II Article provided an algorithm-based decision tree (Category II Algorithm) to assist obstetricians in making decisions about expediting delivery with Category II tracings. (Ex. 24.) The article also clarified that some patterns of decelerations are "significant" for managing Category II tracings. (*Id.*, p. A1499.) Initiation of a Cesarean section or a OVD when Category II tracings are present depends on the correlation between "significant" decelerations and the number and frequency of contractions. For example, under the Category II Algorithm, if the FHR shows "significant" decelerations with greater than or equal to 50 percent of the contractions for 30 minutes, then the physician should proceed to Cesarean section or OVD. (*Id.*, p. A1498.)

PATIENT #1

Treatment History

29. Patient #1 was 38 years old when respondent served as her care provider during her pregnancy in 2020. This was Patient #1's first pregnancy. The allegation that

respondent had fallen asleep during the delivery of Patient #1's baby formed the basis for St. John's second suspension of respondent's privileges on January 6, 2021.

30. In a History and Physical (H&P) note dated December 31, 2020, respondent described the circumstances of Patient #1's admission into St. John's and the procedures respondent performed to deliver the patient's baby. (Ex. 20, pp. A649-A650.) According to the H&P note, Patient #1's delivery due date was December 25, 2020. On December 28, 2020, when Patient #1 was three days overdue, respondent performed a non-stress test, a prenatal test that assesses FHR and reaction to movement. The non-stress test showed Patient #1's cervix was dilated to four centimeters and "completely effaced" (i.e., thinned and shortened), indicating the cervix was preparing for labor and delivery. Respondent also noted that the FHR tracings displayed that "with every mild contraction she has a late deceleration very subtle . . ." (*Id.*, p. A649.) Patient #1 was admitted to St. John's for delivery on December 28, 2020.

31. In the H&P note, respondent also indicated "[Patient #1] was in the hospital for 7 hours with contractions, mild ones, somewhere between 2-6 minutes and her cervix only progressed by 1 cm, so suggestion to her is to rupture her membrane and internalize her and so we can find out how she is doing in terms of contraction and progression." (Ex. 20, p. A650.) At approximately 0300 hours on December 29, 2020, Patient #1's FHR tracing "[became] consistently late," prompting respondent to rupture Patient #1's amniotic sac, in a procedure known as Artificial Rupture of Membrane (AROM). (*Ibid.*) After the AROM, Patient #1's amniotic sac showed "no fluid," indicating possible birth complications.

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32. Respondent then performed additional procedures, which she described as follows:

> IUPC [Intrauterine Pressure Catheter] placed and [Patient #1] is having booming contraction, and her contractions became very strong and so epidural anesthesia was given, and then she went very quickly to complete efface with completely dilated, +2 station; however, with every pushing the baby's heart rate go down with deep decels and since she is already complete, complete +2 station, so I decided to use a vacuum, the Mityvac to assist me for retaining the baby's station of the head, but it was not successful times 3, so because of that finding, [Patient #1] was then taken to OR for emergency C-section.

(Ex. 20, p. A650.)

33. According to progress notes by the bedside nurse (RN) Austyn Bessette, Patient #1 began the second stage of labor of pushing at 0552 hours on December 29, 2020. (Ex. 20, p. A667.) RN Bessette wrote that respondent first applied the vacuum to the fetus at 0648 hours, "[o]ne pull for 10 seconds resulting in a pop off at 0648 [hours]." (*Ibid.*) Respondent reapplied the vacuum at 0650 hours, with "[t]wo pulls for 10 seconds each resulting in a second pop off at 0650 [hours]." (*Ibid.*) Respondent applied the vacuum for 10 seconds for the third time at 0651 hours, "resulting in a third pop off at 0651 [hours]." (*Ibid.*) According to RN Bessette, Patient #1 was transferred to the operating room for a Cesarean section at 0653 hours. (*Ibid.*)

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34. An anesthesia post-procedure evaluation by Kevin Miller, M.D. indicated that the Cesarean section was completed at 0711 hours. (Ex. 20, p. A686.) Respondent described the Cesarean section in an operative report that was dictated on December 29, 2020, and transcribed on the same date. She wrote, in relevant part:

> . . . . so a vacuum-assisted vaginal delivery was tried three times and was failed; so she was taken immediately to a primary low transverse C-section, delivered a male infant, Apgars were 8 at one minute and 9 at five minutes. No anomalies noted. Baby weighing 5 pounds 14 ounces.

(*Id.*, p. 663.)

35. Patient #1 was discharged from St. John's on January 1, 2021. (Ex. 20, p. A651.)

36. Although respondent completed the H&P and the operative report, she only entered a single progress note to document her treatment of Patient #1 from the time that Patient #1 was admitted at St. John's on December 28, 2020, to the time that Patient #1 delivered her baby on December 29, 2020. This single progress note was initiated on December 28, 2020, but was not electronically signed until six days later, on January 4, 2021. The progress note stated:

> 38 yo G1p0 IUP 401/2 weeks, when in office for nst [non stress test] for postdate eval[.] Was noted to have late dels with mild UC's Cx was C/4/O. Was admitted to L&D, covid test was negative[.] Then was given IV hydration and external monitoring[.] UC's were mild and q3-6 minutes

> [f]or the next 7 hours, Cervix unchanged discussed with pt my plan of management, [i.]e. AROM and internal monitoring and Pitocin augmentation pros and cons given[.] PT did not want any intervention for the next 2 hours[.] Cont obs and monitoring.

(Ex. 20, pp. A666-A667.)

37. Thus, respondent did not document in any progress note Patient #1's arrest of labor and respondent's performance of AROM showing no fluid, attempted vacuum extraction with three pop offs, and subsequent Cesarean section. Respondent also did not document the fetal circumstances at the time of the vacuum extraction, including fetal station, fetal position, type of Mityvac used, and the number of pulls per contraction. Respondent also did not document Patient #1's informed consent to the vacuum extraction, including any discussions regarding the risks and benefits of the procedure, such as subgaleal hemorrhage, a rupture of vessels below the galea, which is a serious complication of vacuum extractions.

Respondent's Interview with the Board

38. On June 2, 2023, respondent participated in a Board interview with Board Investigator Chris Jensen and David Plourd, M.D., the Board's medical consultant. Counsel for both parties also joined this Board interview. During this interview, respondent disclosed to Dr. Plourd that she had 12 pages of additional progress notes that she wrote, which was not a part of Patient #1's medical records from St. John's. (Ex. 7, p. A131.) Respondent never produced to the Board the 12 pages of progress notes that she purportedly wrote during Patient #1's labor and delivery from December 28, 2025, to December 29, 2025. At the hearing, respondent presented a

single additional progress note that she supposedly completed on December 29, 2020, at 2:20 a.m., that was written on her own clinic's letterhead, which was not a part of Patient #1's medical records from St. John's. (Ex. 9, p. A280.) She also presented two post operative progress notes dated January 12, 2021, and February 9, 2021. (Exs. Q & R.)

39. During her Board interview, respondent was asked to interpret Patient #1's FHR tracings. Respondent's interpretations of Patient #1's FHR tracings did not use standardized terminology to describe FHR variability and deceleration. Instead of using standardized classifications of absent, minimal, moderate, and marked variability, respondent used terms including "okay," "great," "fantastic," "slightly decrease," "a little bit sleepy," "good," "beautiful," and "nice" to describe FHR variability. (Ex. 7, pp. A172, A173, A174, A185, A189, A193, A200.) Even when offered multiple opportunities to describe the tracing using standardized terms, respondent was not able to do so. For example, when Dr. Plourd asked respondent to describe the degree of variability in Patient #1's FHR tracings between 0215 hours and 0245 hours, respondent answered: "It--it--when the tracing is present it--the variability is good, but then it's just spotty, you know? It's spotty." (*Id.*, p. A174.) When Dr. Plourd asked for a second time for respondent to describe the variability, this exchange followed:

> DR. PLOURD: And how would you describe this variability or can you not describe it because of the quality of the tracing?
>
> [RESPONDENT]: You know, spotty--it's spotty.
>
> DR. PLOURD: The variability is best described and spocky [sic], is that what I'm hearing?

[RESPONDENT]: No--no, the tracing is spotty, so, very few--where it shows--does show up is okay.

(*Id.* p. A175.)

40. In another exchange, Dr. Plourd asked respondent to make a comment about the quality of variability in an FHR tracing panel from Patient #1's records, respondent answered as follows:

> [RESPONDENT]: That sounds a--it sounds a little bit sleepy, you know, like the kid is going to sleep or something because it--it's not associated with any significant uterine constructions--contractions.
>
> DR. PLOURD: Okay. Next panel.
>
> DR. PLOURD: How long is it allowable to say, oh, that's just the baby being asleep versus that's a baby with minimal to absent variability for an unacceptable period of time?
>
> [RESPONDENT]: For an hour. Baby is allowed to sleep an hour.

(Ex. 7, p. A185-186.)

41. Moreover, during her Board interview, respondent did not use the standard classification of early, variable, and late to describe decelerations. Notably, respondent described some decelerations as "major" decelerations, when it is not a standard term. She also provided an incorrect definition of prolonged deceleration (i.e. a visually apparent decrease in FHR from the baseline that is greater than or equal to

15 bpm, lasting more than 2 minutes, but less than 10 minutes. (Ex. 25, p. A1509.)) Respondent's exchange with Dr. Plourd is as follows:

> DR. PLOURD: Uh, and you used a term that I'm--I'm sorry, I'm not familiar with, you said major deceleration, uh, is that a--like a--are there criteria for a major versus a minor versus a moderate deceleration?
>
> [RESPONDENT]: You know, the major (INAUDIBLE) is that it a long--prolong deceleration and slow in recovery that's called major.
>
> DR. PLOURD: okay. And is there a time criterion for a prolonged versus a short or less than prolong deceleration?
>
> [RESPONDENT]: If it's less than--less than a minute, I will not be that concerned, but this one is lasted about--at least four, five minutes.
>
> DR. PLOURD: And is there a definition for prolonged? Is there like one minute is short, and more than a minute is prolonged? I guess that's what I'm trying to understand.
>
> [RESPONDENT]: No--no, we--we generally use this term very loosely, you know, one minute, you know, it came back, oh, that's nothing, but if it's more than five minutes, it's something significant.

(Ex. 7, p. A184.)

42. Additionally, respondent did not refer to FHR tracings as Category I, Category II, or Category III to describe FHR patterns. However, she used the term "head compression" several times to describe a certain FHR pattern. (Ex. 7, pp. A194-A200; A203-A204; A207.) Respondent defined "head compression" as follows:

> The decel--decel 'cause it's-- you notice the heartrate - heartrate is, uh (INAUDIBLE), uh--uh, opposite to the contraction and then when the contraction come, the heartrate goes up and come up. That means--that's what we call in our term called head compression, you know, so the baby is descending.

(Ex. 7, p. A194.)

43. Respondent also failed to use standard terms to describe fetal station. Instead of using terms such as +1 station, she used the terms "stage one," "stage two," and "stage three," which describe the stages labor, not fetal station. (Ex. 7, pp. A142, A145.) For example, she had the following exchange with Dr. Plourd:

> DR. PLOURD: So, do you know what the station of the fetal vertex was just prior to your initial application of the vacuum?
>
> [RESPONDENT]: I don't do, uh, less than stage two.
>
> DR. PLOURD: I'm sorry, I don't know what a stage two vacuum delivery is.

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[RESPONDENT]: Well, there's stage one, stage two, and stage three. The station of the -- the vaginal canal, okay? If it's high (INAUDIBLE) you cannot do high forecep[s] or high vacuum. It has to be right at the perineum, but it doesn't wanna come out, so, then you can rotate it. It's called outlet vacuums, okay? So, that's stage two to three, okay? So, that's the only time I will even contemplate at forcep[s] or vacuum. . . .

(*Id.*, p. A142.)

44. In another exchange, respondent also claimed that the Mityvac cannot hurt the baby and again used the term "stage" rather than "station" to describe fetal station, as follows:

[RESPONDENT]: Probably, yeah. I don't know, I don't have the whole thing with me. And, uh -- and so, you know, it's enough to say that after the whole night labor she went to completely (INAUDIBLE), completely dilated, and just doesn't wanna descend, okay? Uh, you know, come up to stage one, uh--uh--uh, 1, 2, 3, out you see? You don't wanna do that. So, that's why I was--attempted to do the vacuum thinking that, you know--by the way, my vacuum is not one of those horrible, uh, metal one. I use the Mityvac, it's very soft plastic, and if--if you use too much force it'll pop off and it will not hurt the baby's head, see?

(Ex. 7, p. A129.)

Respondent's Testimony

45. At the hearing, respondent testified about her treatment of Patient #1. She denied not providing informed consent to Patient #1 for the AROM and the Cesarean section. Respondent first claimed that that Patient #1's general consent (ex. 20, p. A1019) constituted her informed consent to the AROM, the vacuum extraction, and the Cesarean section. Respondent then blamed RN Bessette, asserting that RN Bessette was supposed to chart the case, but she was a traveling nurse and "did not know what's going on." Respondent stated that Charge Nurse (CN) Sarah Boomarito saw respondent provide informed consent to Patient #1 for the vacuum extraction. According to respondent, she did not advise Patient #1 about the possibility of subgaleal hemorrhage because "if the Mityvac is used properly, it's never a problem."

46. Respondent testified that the vacuum extraction was a medically necessary procedure. However, she claimed the vacuum has a soft cup and "does not hurt the baby." Respondent further testified that when the vacuum extraction was unsuccessful, St. John's obstetric hospitalist and neonatal team entered the delivery room. Respondent asserted she explained to the hospitalist that Patient #1 required a Cesarean section, and the hospitalist as well as the neonatal team witnessed Patient #1 giving her consent to the procedure. Respondent further asserted she documented Patient #1's informed consent to these procedures in her operative report, without specifying where in the operative report such documentation existed.

47. Respondent denied falling asleep during the delivery of Patient #1's baby. She claimed Patient #1 was happy with respondent's treatment and never complained about respondent's services. Respondent testified her management of Patient #1's labor and delivery resulted in "happy family, healthy baby, no problems."

48. Respondent insisted she appropriately documented Patient #1's case in the H&P note and the operative report. Respondent pointed to an additional progress note which she asserted she had entered into St. John's electronic recordkeeping system, Epix. However, this progress note is written on respondent's office letterhead and does not bear any of the parameters of an Epix entry, including author, service type (i.e. obstetrics), author type (i.e. RN or physician), date of service, creation time, status (i.e. signed or unsigned), and editor. This purported progress note reads:

> At around 12/29/2020 2:20 am
>
> Fetal heart tracing showed major decelerations again, both myself and Nurse Austyn [Bessette] went into the patient's room, Nurse Austyn tried to reposition the patient (sometimes it improved the baby 's heart rates), as a result, we lost the fetal heart rate by external monitors, so I pleaded to my patient, I must rupture the membrane to put on the internal monitor to make sure that the baby is OK. I ruptured the membrane at 03:10 am; after putting in the internal monitors; Nurse Austyn [Bessette] could not connect the electrodes to the computer screens; I called for help from Charge nurse, Sarah. The fetal tracing seemed ok; but her contractions became strong and frequent. So she was in pain, and asked for epidural anesthesia.

(Ex. 9, p. A280.)

49. As to the allegations that she does not use standardized terminology to interpret FHR tracings, respondent stated she was trained by the inventor of EFM and

insisted that she uses the standard terminology "every day, every single day." Later during her testimony, respondent also stated that the "new terminology" was introduced in 2008. According to respondent, she purposefully did not use such terminology with Dr. Plourd because she believed Dr. Plourd to be a layperson and thought he could understand her better using laymen terms. However, during cross-examination, respondent avoided the question of whether she used the standardized terminology for FHR tracings in Patient #1's medical records. Respondent also refused to agree to the proposition that medical documentation is a form of communication between healthcare providers and that it was necessary for her to use the standard terminology for FHR tracings.

50. Respondent's testimony regarding her treatment of Patient #1 is not credible for the following reasons. First, respondent's claims regarding her treatment of Patient #1 were rebutted by Patient #1's testimony at the hearing. Patient #1 testified she saw respondent fall asleep during the delivery of her baby. Patient #1 recalled that after laboring for approximately 24 hours, respondent told her she had to have the AROM, or the alternative is a "bad baby." Although Patient #1 asked respondent several times what "bad baby" means, respondent never gave her an explanation. According to Patient #1, she was also not informed about the risks and benefits of the vacuum extraction. Patient #1 denied providing an informed consent to the AROM or the vacuum extraction. Patient #1 stated she felt "confused and disappointed" during her birth process, and she expressed her dissatisfaction with respondent's treatment to respondent during a post-operative visit six weeks after the birth of her son. Patient #1's testimony is deemed to be credible as it is supported by the documentary evidence in this case. Patient #1's medical records do not reflect that respondent discussed the risks and benefits of the AROM and vacuum extraction with

Patient #1 or that Patient #1 provided informed consent to these procedures. Additionally, Patient #1 testified at the hearing in a measured, dignified manner that lends even more credibility to her testimony.

51. Second, the authenticity of the December 29, 2020 2:20 a.m. progress note is suspect. During cross-examination, respondent could not explain why this progress note is written on her office letterhead, if it was an Epix entry. Respondent also could not explain why this progress note was not electronically signed. Although respondent continued to insist she printed the progress note from the Epix system, she could not explain why all other notes she printed from the Epix system were stamped with her name, physician number, date and time of the printing, but this note was not.

52. Third, respondent's assertion that she did not use the standard terminology with Dr. Plourd because she was trying to make it easier for him as a layperson is nonsensical. Dr. Plourd identified himself as a physician and the Board's medical consultant at the commencement of the Board interview. (Ex. 7, p. A55.) Additionally, Dr. Plourd used terms such as "minimal to absent variability" and "prolonged deceleration" to describe FHR tracings during the interview, indicating that he is well-versed in the standard terminology to interpret FHR tracings. (*Id.*, pp. A184-A186.) However, respondent failed to recognize Dr. Plourd's familiarity with these terms and could not use such terms even when Dr. Plourd prompted her to do so. (*Id.*, pp. A185-186.) Finally, even assuming respondent purposefully did not use the standard terminology during her Board interview, it begs the question as why she would use nonstandard terminology such as "deep decles [decelerations]" in her medical documentation. (Ex. 20, p. A650.) Significantly, during cross-examination,

respondent avoided answering the question of whether she uses standard terminology in her medical documentation.

Complainant's Expert Opinion

53. 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 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. Dr. Chan has a solo practice in OB/GYN, and he has practiced as an obstetrical hospitalist since 1990. From April 2020 to the present, Dr. Chan worked as an OB hospitalist at Obstetrix/Pediatrix Medical Group. Dr. Chan delivered babies in 2020, when respondent treated Patient #1, and he is familiar with the standard of care for obstetricians at that time.

54. 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 St. John's, Patient #1's fetal monitoring strips, and transcript of respondent's June 2, 2023 Board interview. He set forth his opinions in an expert report (ex. 19), dated August 3, 2023, and in his testimony at the hearing.

55. Regarding the standard of care for OB/GYN physicians caring for patients in labor and delivery, Dr. Chan stated that important intrapartum events, including invasive procedures such as AROM and operative deliveries such as vacuum extraction and Cesarean section, must be documented by the physician in the form of progress notes, procedure notes, and surgical notes. Specifically, progress notes must be documented in a patient's medical records because they memorialize the sequence of care for the patient. Documentation of such progress notes should be

contemporaneous, if possible, though a late entry is acceptable if obstetric emergencies exist. Nursing staff are responsible for documenting some aspects of fetal status including heart baseline heart rate, uterine contraction pattern and strength, types of decelerations encountered, and corrective interventions. However, physicians must also document, through progress notes, their own acknowledgement and verification of important and critical events in fetal status and assessment.

56. According to Dr. Chan, in Patient #1's case, respondent entered only a single progress note between the time of Patient #1's admission on December 28, 2020, and the delivery of her baby on December 29, 2020. (Ex. 20, pp. A666-A667.) Dr. Chan opined that authoring only a single progress note for a patient who subsequently had a complicated intrapartum labor including arrest of labor, AROM showing no fluid, attempted vacuum extraction with three pop offs, and Cesarean section is an extreme departure from standard of care. According to Dr. Chan, this single progress note missed critical information regarding Patient #1's treatment, including fetal monitoring interpretation and indications for procedures such as vacuum extraction and Cesarean section. In Dr. Chan's opinion, although respondent's operative report addresses some of these issues, it is not sufficient to meet the standard of care because the operative report is retrospective, while progress notes must be contemporaneous. Furthermore, Dr. Chan noted that respondent claimed she had 12 pages of progress notes she wrote in Patient #1's medical records. However, Dr. Chan did not see 12 pages of progress notes written by respondent. Dr. Chan opined that respondent's failure to place all written progress notes into Patient #1's medical records is an extreme departure from the standard of care.

57. Furthermore, respondent also did not document anywhere in Patient #1's medical records the fetal circumstances when respondent attempted the vacuum

extraction. According to Dr. Chan, when arrest of labor and fetal descent occurred, respondent must document why she was proceeding with a vacuum extraction and describe the procedure itself. Although respondent wrote in the H&P note that Patient #1 had "booming contraction" and the "baby's heart rate [was going] down with deep decels [decelerations]" (ex. 20, p. A650), Dr. Chan opined that this description does not meet the standard of care because it does not use standard terminology and because it does not demonstrate what the status of the fetus is. Dr. Chan testified that "a booming contraction" is not standard terminology that accurately describes a contraction. The standard of care is to refer to the contraction's strength and frequency. "Deep Decels" is also not standard terminology, as decelerations are described as early, variable, or late. Furthermore, respondent did not document a correlation between the FHR and the contraction indicating concerns with the fetal status such that she was proceeding with a vacuum extraction.

58. Dr. Chan stated that RN Bessette documented some aspects of the vacuum extraction by noting the three vacuum applications at 0648, 0650, and 0651 hours. However, this note by the nursing staff is not sufficient to meet the standard of care required of physicians. According to Dr. Chan, when a vacuum extraction is performed, the standard of care requires the OB to document the fetal station, the fetal position, the type of Mityvac vacuum used (e.g. hand-held mushroom cup), placement and duration of vacuum use, and whether each attempt was successful. Dr. Chan opined that respondent's failure to document these elements of the fetal circumstances at the time of the vacuum extraction is an extreme departure from the standard of care.

59. Moreover, respondent did not document her informed consent discussion with Patient #1 for the vacuum extraction. Dr. Chan emphasized that Patient

#1's general consent (ex. 20, p. A1019) is not sufficient to meet the standard of care. According to Dr. Chan, while a general consent is obtained by the hospital upon admission, the informed consent for specific procedures in labor and delivery must be documented separately and individually. An informed consent discussion should include explanations of the proposed procedure itself, as well as indications for, risk and benefits of, and alternatives to the proposed procedure. The purpose of the informed consent is to provide information to the patient so that the patient understands the risks of the proposed procedure and contributes to the patient's decision-making process. For the vacuum extraction in particular, the standard of care requires the disclosure of the possibility of subgaleal hemorrhage, a life-threatening complication, because some patients may wish to proceed directly to a Cesarean section once they are informed of this risk. Dr. Chan opined that respondent's failure to document the informed consent discussion for the vacuum extraction and her failure to recognize subgaleal hemorrhage as a complication of vacuum extraction constitute extreme departures from the standard of care. Dr. Chan further opined respondent's statement during her Board interview, to the extent that her use of a soft cup vacuum cannot hurt the baby, demonstrates her lack of knowledge about subgaleal hemorrhage as a complication of vacuum extraction.

60. Finally, Dr. Chan opined that the standard of care for an obstetrician is to have command of the standard nomenclature used in describing aspects of fetal status including the description of fetal heart rate monitoring, fetal position, and fetal stations. Specifically, the EFM Article (ex. 25) is the seminal article that established a consensus among American, British, and Canadian physicians to standardize the language describing FHR monitoring. The Category II Article is an expansion of the EFM Article, using the standardized definitions in the EFM Article to discuss the

management of the most difficult part of FHR tracings, namely, Category II tracings. The standard of care is that every health care provider working in labor and delivery, including obstetricians, nurses, and medical students should be using the nomenclature in these articles to describe FHR tracings. Dr. Chan emphasized that obstetricians practice as a part of the labor and delivery team, and the use of standardized language allows the team members to communicate with each other. Use of non-standardized terminology leads to misinterpretation, confusion, misunderstandings, and disagreements about how to proceed. Therefore, obstetricians must use standardized terminology in both oral and written communications.

61. Dr. Chan cited many examples in Patient #1 medical records and respondent's Board interview where respondent did not use the standardized terminology to describe FHR variability, deceleration, and fetal station. Dr. Chan testified that respondent used outdated terminology from 40 to 45 years ago that is no longer in use. For example, in the H&P note, respondent described Patient #1 as having "deep decels" when she most likely means to describe, in modern terminology, a variable deceleration or a significant variable deceleration. (Ex. 20, p. A650.) In another instance, during her Board interview with Dr. Plourd, respondent used the term "head compression" several times. (Ex. 7, pp. A194-A201.) Dr. Chan stated that this is an outdated term from the 70's or the 80's. It describes, in modern terminology, an early deceleration, a symmetrical peak of FHR deceleration corresponding to a peak of contraction.

62. Dr. Chan testified that in his review of Patient #1's records and respondent's Board interview, he "did not see anywhere where [respondent] used standardized terminology." In her Board interview, respondent described FHR

variability as "okay," "great," "a little bit sleep," and "good," without using the standard terms of minimal, moderate, or marked. (Ex. 7, pp. A194-A201.) Respondent described FHR deceleration as "very subtle" in Patient #1's medical records and as "minor" and "major" during her Board interview. (Ex. 20, p. A649; ex. 7, p. A184). Respondent did not use Category I, Category II, or Category III to describe any of the FHR tracings. Moreover, Dr. Chan explained that the standard of care requires an obstetrician to accurately describe fetal descent using either the 0 to 5 or 0 to 3 classification terminology. However, respondent did not clarify which classification she was using and she used the term "stage," a term used for phases of labor, instead of "station," to describe fetal descent in her Board interview. (Ex. 7, p. A142.)

63. Dr. Chan concluded that respondent's use of non-standardized terminology to describe fetal heart rate variability and fetal heart rate decelerations and her use of incorrect terminology to describe fetal descent constitute a lack of knowledge as well as an extreme departure from the standard of care.

Respondent's Expert Opinion

64. Stephen C. Rabin, M.D., testified at the hearing as an expert witness on respondent's behalf. Dr. Rabin obtained his Doctor of Medicine degree from Rutgers University in 1974. He completed his internship and residency in OB/GYN at LAC + USC in 1975 and 1978, respectively. Dr. Rabin has been board-certified in OB/GYN since 1981. Dr. Rabin worked as an OB/GYN at Cedar-Sinai from 1978 to 2019. He currently serves as an emeritus member of the Cedar-Sinai OB/GYN department.

65. Dr. Rabin's opinions on respondent's treatment of Patient #1 are based on his review of records, including Patient #1's medical records from St. John's, Patient #1's fetal monitoring strips, and transcript of respondent's June 2, 2023 Board

interview. He set forth his opinions in an undated expert report (ex. O) and in his testimony at the hearing.

66. On direct examination and in his expert report, Dr. Rabin's opinions did not address many of the issues raised by Dr. Chan. For example, Dr. Rabin stated in his report that St. John's suspended respondent for "her sleeping at nurses' station, failure to recognize deteriorating fetal status, and a lack of documentation." (Ex. O, p. B110.) Dr. Rabin then proceeds to offer his opinions on the issue of respondent's sleep apnea and the propriety of respondent's decision to deliver Patient #1's baby by vacuum, without ever addressing the documentation issue. (*Ibid.*) However, Dr. Rabin is not qualified to render an opinion regarding respondent's sleep apnea, as he did not examine her and he is not an expert in sleep medicine. Moreover, Dr. Chan did not dispute that the vacuum extraction is clinically appropriate. Dr. Chan opined that respondent's failure to document the fetal circumstances at the time of the vacuum extraction and the informed consent discussion for the procedure were extreme departures from the standard of care. Nevertheless, Dr. Rabin did not address or attempt to refute these opinions in his direct examination and in his expert report. Similarly, with regard to respondent's interpretation of fetal monitoring during her Board interview, Dr. Rabin vaguely stated that respondent's descriptions were "done in a manner that a non-obstetrician could understand" and "enabled the Board to have a better idea." (*Ibid.*) However, Dr. Rabin avoided addressing the issue of whether respondent used the standard nomenclature to describe the FHR tracings.

67. During cross-examination, Dr. Rabin conceded that respondent did not use any of the terminology designated in the EFM Article and the Category II Articles in Patient #1's records or during her Board interview. Dr. Rabin further conceded that the information contained in the EFM Article and the Category II Article are reliable, as

they were written by experts in the field. However, Dr. Rabin asserted that these articles are not authoritative and serve only as guidelines. Yet, this assertion was undermined because Dr. Rabin himself used only the terminology designated in the EFM Article and the Category II Articles rather than any of the terminology used by respondent in Patient #1's medical records and during her Board interview.

68. Dr. Rabin admitted that documentation is an important aspect of patient care, as it serves as communication between health providers and ensures continuity of care for the patient. Dr. Rabin further acknowledged that the standard of care requires a physician to document informed consent in progress notes. Dr. Rabin admitted that he did not see any documentation of any informed consent in Patient #1's charts. Dr. Rabin testified that respondent's documentation of Patient #1's case "could have been better."

69. With respect to the lack of documentation for the vacuum extraction, Dr. Rabin conceded that based on respondent's documentation in Patient #1's charts, he could not determine what risks and benefits of the procedure were discussed with the patient. However, Dr. Rabin disagreed with Dr. Chan that it was necessary to discuss the risk of subgaleal hemorrhage with Patient #1 because the lethal condition "happens from pushing." Dr. Rabin did not offer any further explanations, and he did not refute Dr. Chan's opinion that subgaleal hemorrhage is a serious complication of vacuum extractions. Dr. Rabin also contended respondent presented alternatives to the vacuum extraction to Patient #1. Nevertheless, upon further questioning, Dr. Rabin admitted this contention was not based on the documentation in Patient #1's medical records, but based on his own assumption that such discussions always took place between physicians and patients.

Credibility Findings Re: Expert Opinions

70. Both Drs. Chan and Rabin are knowledgeable, experienced obstetricians who are well qualified to render opinions on respondent's care of Patient #1. However, Dr. Chan's opinions regarding respondent's treatment of Patient #1 are deemed more credible than those of Dr. Rabin for several reasons. First, Dr. Chan's opinions were detailed and well-reasoned. Dr. Chan clearly explained what the standard of care is in the obstetric field; offered support for the standard of care he articulated with scholarly articles such as the EFM Article and Category II Article; and elucidated how respondent failed to meet the standard of care in each instance. Dr. Rabin, on the other hand, proffered either opinions that did not address the issues at hand or on an issue, such as sleep apnea, in which he has no expertise. Dr. Rabin's testimony was also sometimes contradictory, as he asserted that the EFM Article and the Category II Articles did not set the standard of care, and yet he used the nomenclature set forth in these articles in his own descriptions of FHR tracings.

71. Second, Dr. Chan's opinions are consistent with both documentary and testimonial evidence. For example, Dr. Chan's opinion that respondent did not document Patient #1's informed consent to the vacuum extraction is supported by both Patient #1's medical records, as well as Patient #1's testimony that she did not have an informed consent discussion with respondent about the procedure. On the other hand, Dr. Rabin's opinion that such a discussion must have taken place was based on his assumptions that had no basis in fact.

72. Third, Dr. Rabin conceded during cross-examination that he does not deliver babies in his position as the emeritus member of the Cedar-Sinai OB/GYN department. Dr. Rabin admitted that the last time he delivered a baby was in 2019, at

least one year before Patient #1's delivery on December 29, 2020. Dr. Chan, on the other hand, was serving as an obstetric hospitalist and delivering babies in 2020. Under these circumstances, Dr. Chan's opinions on the obstetrical standard of care in 2020 are more reliable than those of Dr. Rabin.

73. Finally, Dr. Rabin made several concessions and admissions during cross-examination that further undermined his credibility. On the other hand, Dr. Chan, during cross-examination, did not waver from the opinions he expressed during direct examination. Considering these factors, Dr. Chan's opinions were afforded significant weight.

Summary Findings Regarding Patient #1

74. Based on the foregoing, clear and convincing evidence established that respondent committed the following acts constituting extreme departures from the standard of care:

- Authoring only a single progress note after Patient #1's admission to St. John's, who subsequently had a complicated delivery that included arrest of labor, AROM showing no fluid, attempted vacuum extraction with three pop offs, and a Cesarean section;
- Failure to place all written progress notes into the medical record;
- Failure to document the fetal circumstances at the time of vacuum extraction, including fetal station, fetal position, type of Mityvac used, and the number of pulls per contraction; and
- Failure to document an informed consent discussion with Patient #1.

75. Although in Dr. Chan's opinion, respondent committed certain acts which constituted both extreme departures from the standard of care and lack of knowledge, for reasons set forth below in Legal Conclusions 8 to 10, these are two distinct and mutually exclusive concepts. In this case, based on respondent's statements during her Board interview and her testimony at the hearing, clear and convincing evidence established that respondent committed the following acts demonstrating her lack of knowledge:

- Failure to recognize the possibility of a lethal subgaleal hemorrhage as a complication of the vacuum extraction;
- Failure to document FHR variability using standardized terminology in Patient #1's medical records and failure to use standardized terminology to describe FHR variability during her Board interview;
- Failure to document FHR decelerations using standardized terminology in Patient #1's medical records and failure to use standardized terminology to describe FHR decelerations during her Board interview; and
- Failure to properly describe fetal descent in Patient #1's medical records and failure to use standardized terminology to describe fetal descent during her Board interview.

PATIENT #2

Treatment History

76. Patient #2 was 30 years old when respondent served as her care provider during her pregnancy in 2020. This was Patient #2's first pregnancy. The allegation that

respondent had fallen asleep during the delivery of Patient #2's baby formed the basis for St. John's first suspension of respondent's privileges on September 30, 2020.

77. Patient #2's medical records reflect that she was admitted to St. John's hospital at 1930 hours on September 12, 2020. (Ex. 22, p. A1286.) Respondent authored a progress note on September 12, 2020, which stated, "30yo G1PO iup 38-39 weeks in labor cx was c/4-5/0 Because of pain Epidural given SROM clear Expectant management." (*Id.*, p. A1183.) However, respondent did not author an H&P note when Patient #2 was first admitted to St. John's.

78. By 2012 hours, a nurse examined Patient #2 and found her cervix was dilated to 4 centimeters, with 80 percent effacement, and the fetus at +1 station. (Ex. 22, p. A1287.) At 2228 hours, respondent was at Patient #2's bedside and examined her. (*Id.*, p. A1289.) Respondent's cervical examination found that Patient #2 was dilated to 9.5 centimeters, with 100 percent effacement, and the fetus at 0 station. (*Ibid.*) At 2308 hours, respondent examined Patient #2 again and found her cervix dilated to 10 centimeters, with 100 percent effacement, and the fetus at +2 station. (*Id.*, p. A1289.)

79. According to a delivery note dictated by respondent on September 13, 2020, and transcribed the same day, Patient #2's labor progressed as follows:

> This is a 30-year-old gravida 1, para 0, admitted to this hospital in active labor. Cervix was completely effaced, 4-5 cm, 0 station, bag of water intact, vertex presentation, and because of pain, epidural anesthesia was given. After epidural anesthesia, the patient had spontaneous rupture of the membranes, and then she progressed quickly to

> completely effaced, completely dilated, and 0 station; however, for the next 6 hours, she was pushing for 1 hour, resting for 2 hours, and 6 hours later, she finally delivered by Mityvac-guided vaginal delivery, and she had such a hard time putting out because the cord was extremely short. As a matter of fact, when the baby finally came out and was put on mother's abdomen for bonding, the cord snapped, but fortunately, we were able to clamp the cord snapping to decrease the bleeding, and the baby was delivered over a tiny episiotomy site. Baby is a normal male. Apgars were 9 at one minute and 9 at five minutes, no anomaly noted, baby weighing 8 pounds 10 ounces. Post-delivery, the episiotomy site was closed with 2-0 chromic and 3-0 chromic and no other lacerations.

(Ex. 22, p. A1179.)

80. The delivery note shows Patient #2 delivered by vacuum extraction. However, there is no progress note by respondent documenting the fetal circumstances at the time of the vacuum extraction including fetal station, fetal position, type of Mityvac used, number of pop offs, if they occurred, and the number of pulls per contraction.

81. On September 15, 2020, respondent dictated the following discharge summary, which was transcribed on the same day:

> The patient is a 30-year-old gravida 1, para 0, admitted to this hospital in active labor. Cervix was completely effaced,

4 cm, 0 station and because of pain epidural anesthesia and then after epidural anesthesia, the patient went quickly to completely effaced, completely dilated, +2 station; however, due to inadequate contraction with pushing, so we gave her 2 hours of rest and then started Pitocin for augmentation of labor and then she finally delivered a male infant over tiny episiotomy, 8 pound 12 ounce boy, Apgar was 9 at one minute, 9 at five minutes, no anomaly noted. Baby breastfeeding well right now postpartum. Postop she did well with the episiotomy site repaired and uterus contracted down nicely. Today, she is postoperative day #2, she is eating, ambulating well, had regular bowel movements. Incision at the episiotomy site healed well, so she is going home today. She will be seen in my office in 2 weeks for followup.

(Ex. 22, pp. a1169-1170.)

Respondent's Testimony

82. At the hearing, respondent testified that during Patient #2's delivery, she stayed in the patient's room and sat on a rocking chair to take a nap. Respondent asserted that Patient #2's family did not have any problems with respondent staying in the patient's room. According to respondent, Patient # 2 pushed for an hour with no success. Patient #2 took a break, and two hours later, she started pushing again. Respondent used the Mityvac to assist the delivery, and, in respondent's words, the

"baby came out without any [vaginal] tears." Respondent stated that the outcome of Patient #2's delivery was "perfect."

83. During cross-examination, respondent admitted that she did not prepare an H&P note for Patient #2 after her admittance at St. John's. Respondent also conceded she used vacuum extraction to assist Patient #2's delivery, but she did not document the fetal station or the fetal position. Respondent disputed the need to document the type of Mityvac, as she claimed there is only one type. Respondent asserted that she did not document any pop offs because there was none. Respondent also testified that she does not pull more than once on contraction when using the vacuum to assist a patient's delivery.

Complainant's Expert Opinions

84. According to Dr. Chan, the standard of care requires an obstetrician to record an H&P note, which must include a physical examination of the patient upon admission to the hospital for labor and delivery. Dr. Chan opined that neither respondent's progress note (i.e. "30yo G1PO iup 38-39 weeks in labor cx was c/4-5/0 Because of pain Epidural given SROM clear Expectant management"), nor the delivery note, nor the discharge summary can substitute for the H&P because these notes do not show a physical examination of the patient before admission. Dr. Chan explained the physical examination portion of the H&P must consist of more than just a cervical examination; it should include examination of the patient's abdomen, lungs, heart, etc. Dr. Chan testified that he did not see documentation of a physical exam in the H&P note in Patient #2's medical records, which constitutes an extreme departure from the standard of care.

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85. Dr. Chan also opined that respondent's delivery note describing the vacuum extraction did not meet the standard of care due to several omissions. Dr. Chan testified that when an obstetrician performs a delivery assisted by an instrument, certain information, such as indications for use of the instrument, how the procedure was performed, and the rationale for the procedure, must be documented. For Patient #2's vacuum extraction, respondent did not document the fetal station, the fetal position (e.g. occiput posterior, transverse etc.), the type of Mityvac used (e.g. hand-held mushroom cup), the number of pop offs, if any, and the number of pulls per contraction. Dr. Chan concluded that this lack of documentation constitutes an extreme departure from the standard of care.

Respondent's Expert Opinions

86. During direct examination and in his expert report, Dr. Rabin's opinions on respondent's treatment of Patient #2 did not address the issues raised by Dr. Chan. Dr. Rabin testified he did not find anything out of the ordinary for respondent to have rested on a rocking chair during Patient #2's delivery. He further asserted respondent's clinical decision to proceed to vacuum extraction for delivery was correct. Dr. Rabin stated that the "product of [respondent's] management [of Patient #2's delivery] was a healthy baby, and happy mom and dad." Dr. Rabin confirmed that in Patient #2's case, he "did not find any situation where [respondent's treatment] fell below the standard of care."

87. During cross-examination, when asked whether respondent described how she used the Mityvac in Patient #2's medical records, Dr. Rabin stated that he could not answer the question. When asked specifically about whether respondent's delivery note for Patient #2 contained information about the vacuum delivery, Dr.

Rabin conceded that respondent did not document the fetal station, the fetal position, the number of pop offs, if any, and the number of pulls per contraction. Although Dr. Rabin claimed that there is only one type of Mityvac for vacuum extractions, he also admitted that he did not delivery any babies in 2020 and thus does not know about the different types of vacuums available in 2020.

88. Dr. Rabin did not address the omission of the H&P note in Patient #2's case. He wrote in his report, "Notes in labor and delivery, prenatal as well as admitting progress note have been sufficient documentation for admission, but inductions are to have full history and physical." (Ex. O, p. B110.) However, he did not clarify this statement during his testimony at the hearing. Nevertheless, Dr. Rabin did admit during cross-examination that respondent's documentation in Patient #2's case "can be improved."

Credibility Findings Re Expert Opinions

89. Dr. Chan's opinions regarding respondent's treatment of Patient #2 is deemed to be more credible than those of Dr. Rabin. Dr. Chan's opinions were supported by Patient #2's medical records and by respondent's admission that she did not document an H&P note for Patient #2 and she did not document the fetal circumstances at the time of the vacuum extraction. Dr. Chan also did not waver from his opinions during cross-examination, lending even more credibility to his opinions. Dr. Chan also delivered babies in 2020, and thus his opinions on the obstetrical standard of care in 2020 are reliable. On the other hand, Dr. Rabin's opinions did not address the issues raised by Dr. Chan; Dr. Rabin's opinions are not supported by Patient #2's medical records; Dr. Rabin made numerous concessions during cross examination; and Dr. Rabin did not deliver babies in 2020, rendering his opinions on

the obstetrical standard of care in 2020 suspect. Considering these factors, Dr. Chan's opinions on respondent's treatment of Patient #2 were afforded significant weight.

Summary Findings Regarding Patient #2

90. Based on the foregoing, clear and convincing evidence established that respondent committed the following acts constituting extreme departures from the standard of care:

- Failure to document a physical examination in the H&P note after Patient #2 was admitted to St. John's for delivery; and
- Failure to document the fetal circumstances, including the fetal station, the fetal position, the type of Mityvac used, the number of pop offs, if any, and the number of pulls per contraction, for Patient #2's vacuum extraction.

Respondent's Character Evidence

91. Glenda Veasey, Commissioner of Los Angeles Superior Court, testified at the hearing on respondent's behalf as a character witness. Respondent has served as Commissioner Veasey's OB/GYN since 1979. Commissioner Veasey described respondent as "the best," a physician who "has great bedside manner, knows what she is talking about, [and] puts you at ease." Commissioner Veasey testified that in her forties, she was struggling with infertility, and respondent helped her through the process. After Commissioner Veasey became pregnant, respondent cared for Commissioner Veasey throughout her pregnancy and delivered her son via emergency Cesarean section in 2005. Commissioner Veasey has referred family and friends to respondent and would not hesitate to do so in the future. However, on cross-examination, Commissioner Veasey conceded that she has no knowledge of the

allegations in this matter, including any allegations about respondent's sleep apnea or her treatment of Patient #1 and Patient #2.

92. John Murdock, Attorney at Law, testified at the hearing on respondent's behalf as a character witness. Mr. Murdock represented respondent in a lawsuit opposing the acquisition of St. John's by Providence Medical Group. According to Mr. Murdock, respondent paid for his services out of her own pocket because she was concerned that the quality of care at St. John's would be diminished by the acquisition. Mr. Murdock stated that due in part to the lawsuit, Providence Medical Group agreed to certain conditions guaranteeing the quality of patient care at St. John's. Respondent also retained Mr. Murdock a second time to enforce orders that maintained the quality of care at St. John's. Mr. Murdock has the highest opinion of respondent, describing her as an "excellent physician" whom he would hire for his friends and family. However, on cross-examination, Mr. Murdock admitted he has a limited understanding of the allegations involved in this case. Although he recalled some allegations of respondent having fallen asleep, Mr. Murdock admitted he "can't remember the rest of the allegations."

Recovery Costs

93. Complainant requests the following in recovery costs: (1) costs of investigation totaling $12,680; (2) expert costs totaling $14,444; and (3) actual costs of prosecuting this matter by the Department of Justice (DOJ) totaling $69,230.75. (Ex. 29.) The total costs claimed are $96,350.75.

94. 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. (Bus. & Prof. Code, §§ 2000 et seq.) (All further references are to the Business and Professions Code, unless otherwise designated.) 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, repeated negligent acts,

which consist of two or more negligent acts or omissions, and incompetence. (*Id.*, subds. (a), (b), (c) & (d).)

First Cause for Discipline

5. The Accusation alleges respondent's certificate is subject to discipline under section 822 because respondent is suffering from a mental and/or physical illness, specifically sleep apnea.

6. It is undisputed that respondent has severe disruptive sleep apnea. However, Dr. Taylor, who conducted a psychiatric evaluation of respondent, found that respondent did not suffer from any psychiatric conditions and is safe to practice as long as she is compliant with her sleep specialist's treatment. Dr. Phuphanich, who conducted physical evaluation of respondent, found that respondent did not have any physical illness that impacts her ability to practice medicine, although she should follow up annually with her sleep specialist. Dr. Norman, who is respondent's treating physician for her sleep apnea, confirmed that respondent's adherence to BIPAP therapy and her control over her sleep apnea has been excellent after he evaluated data collected from respondent's BIPAP machine for the last year. However, Dr. Norman also recommended respondent to follow up with him annually.

7. Therefore, cause does not exist to discipline respondent's certificate based on a mental and/or physical illness pursuant to section 822. (Factual Findings 6-19.) Nevertheless, respondent will be required to follow up with a sleep specialist annually for the treatment of her severe disruptive sleep apnea.

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Second Cause for Discipline

8. 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 Patient #2. 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.)

9. Under section 2234, incompetence and negligence are two distinct and separate causes for discipline. (§ 2234, subds. (b) & (d).) In *Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 838 (*Pollak*), the Court of Appeal held, "a licensee may be competent or capable of performing a given duty but negligent in performing that duty." Incompetence is established only when respondent demonstrates a "general lack of present ability to perform a given duty." (*Id.* at p. 837; see also *James v. Bd. of Dental Examiners* (1985) 172 Cal.App.3d 1096, at 1109: ["Incompetence generally is defined as

a lack of knowledge or ability in the discharging of professional obligations"].) *Pollak* was followed in *Kearl v. Board of Medical Quality Assurance*, (1986) 189 Cal.App.3d 1040, 1054-1055 (*Kearl*). The Court of Appeal in *Kearl* upheld the trial court findings of incompetence against an anesthesiologist who exhibited flawed reasoning in his decisions and made several improper decisions in the treatment of a single patient, demonstrating "a general lack of knowledge, ability and skill in anesthesiology." (*Id.* at p. 1056.)

10. In this case, Dr. Chan testified that respondent's failure to recognize subgaleal hemorrhage as a complication of vacuum extraction and her failure to use standardized terminology for FHR tracing interpretation and fetal station in Patient #1's medical records and during her Board interview constitute both extreme departures from the standard of care and demonstrate respondent's lack of knowledge. However, as the caselaw cited above shows, an act cannot constitute both negligence and incompetence at the same time. One either knows how to do something but was negligent in performing the action, or one simply does not know how to do it. Here, the fact that respondent was not able to use standardized terminology in both her charting and during her Board interview shows she simply does not know the modern, standardized nomenclature. Respondent's testimony at the hearing that subgaleal hemorrhage is not a concern if the vacuum extraction is done properly also shows she is not aware of the lethality of the complication. Therefore, those acts constitute incompetence under section 2234, subdivision (d), rather than as gross negligence under section 2234, subdivision (b).

11. Cause exists to discipline respondent's certificate for gross negligence pursuant to section 2234, subdivision (b). Complainant established by clear and

convincing evidence respondent committed the following acts of extreme departures from the standard of care, constituting gross negligence:

- Authoring only a single progress note for after Patient #1's admission to St. John's, who subsequently had a complicated delivery that included arrest of labor, AROM showing no fluid, attempted vacuum extraction with three pop offs, and a Cesarean section;
- Failure to place all written progress notes into Patient #1's medical record;
- Failure to document the fetal circumstances at the time of Patient #1's vacuum extraction, including the fetal station, the fetal position, the type of Mityvac used, and the number of pulls per contraction;
- Failure to document an informed consent discussion with Patient #1 about the vacuum extraction;
- Failure to document a physical examination in the H&P note after Patient #2 was admitted to St. John's for delivery; and
- Failure to document the fetal circumstances at the time of Patient #2's vacuum extraction, including the fetal station, the fetal position, the type of Mityvac used, the number of pop offs, if any, and the number of pulls per contraction.

(Factual Findings 29-74; 76-90.)

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Third Cause for Discipline

12. 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 Patient #2.

13. Cause exists to discipline respondent's certificate for repeated acts of simple negligence pursuant to section 2234, subdivision (c). (Factual Findings 29-74; 76-90.) Each of the acts of gross negligence listed in Legal Conclusion 11 is also a negligent act.

Fourth Cause for Discipline

14. The Accusation alleges respondent's certificate is subject to discipline under section 2234, subdivision (d), because respondent was incompetent in her care and treatment of Patient #1.

15. Cause exists to discipline respondent's certificate for incompetence pursuant to section 2234, subdivision (d). Complainant established by clear and convincing evidence respondent committed the following acts demonstrating her lack of knowledge, which constitute incompetence:

- Failure to recognize the possibility of a lethal subgaleal hemorrhage as a complication of Patient #1's vacuum extraction;
- Failure to document FHR variability using standardized terminology in Patient #1's medical records and failure to use standardized terminology to describe FHR variability during her Board interview;

- Failure to document FHR decelerations using standardized terminology in Patient #1's medical records and failure to use standardized terminology to describe FHR decelerations during her Board interview; and

- Failure to properly describe fetal descent in Patient #1's medical records and failure to use standardized terminology to describe fetal descent during her Board interview.

(Factual Findings 29-75.)

Fifth Cause for Discipline

16. The Accusation alleges respondent is subject to disciplinary action because she failed to maintain adequate and accurate medical records for Patient #1 and Patient #2.

17. 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. A physician's memory does not constitute an adequate medical record. Accurate charting promotes skillful patient treatment and also protects a physician and institutions such as hospitals if any false claim arises.

18. Complainant established by clear and convincing evidence that respondent's medical recordkeeping was inadequate for Patient #1 and Patient #2. Cause therefore exists to discipline respondent's license for inadequate medical record keeping under section 2266. (Factual Findings 29-90.)

Disposition

19. The Board's Disciplinary Guidelines (Guidelines) recommend that for cases where cause for discipline was established based on gross negligence, repeated acts of negligence, incompetence, or inadequate medical record keeping, the minimum discipline is five years of probation, and the maximum discipline is revocation. (*Ibid.*)

20. In this case, the nature of respondent's misconduct was extremely serious. Respondent's documentation in both Patient #1 and Patient #2's cases was so inadequate that it constituted multiple acts of extreme departures from the standard of care. Respondent also demonstrated a lack of knowledge constituting incompetence when she did not recognize lethal subgaleal hemorrhage as a complication of Patient #1's vacuum extraction and could not use standardized terminology to describe FHR tracings and fetal station. Although Patient #1 and Patient #2 delivered healthy babies, Patient #1's testimony at the hearing showed that she suffered harm, as Patient #1 did not provide informed consent to the vacuum extraction and Patient #1 was left feeling confused and disappointed about her birth experience.

21. Concerningly, respondent admitted no wrongdoing on her part. She shifted blame for the failures in documentation to her nurses. She was not honest about providing informed consent to Patient #1 for the vacuum extraction, Patient #1's level of satisfaction with her treatment, and the provenance of the December 29, 2020 progress note written on her clinic's letterhead. She also did not concede that the terminology she used in Patient #1's medical records and during her Board interview with Dr. Plourd were outdated terms from well over 20 years ago.

Respondent's rehabilitative evidence also only consists of character evidence from two witnesses who are not aware of the magnitude of her misconduct. Nevertheless, respondent has practiced for almost 50 years with no prior record of discipline. Respondent's deficiencies in documentation and knowledge of modern obstetric terminology are remediable through education.

22. Under these circumstances, placing respondent on five years of probation, with additional terms ensuring her fitness to practice, should be adequate to protect the public. Such additional terms will include a clinical assessment program, practice monitor, education courses, professionalism program, and a medical recordkeeping course. Completion of the clinical assessment program must be a condition precedent to respondent's resumption of practice because she intends to deliver babies in the future. Dr. Phuphanich reserved his opinions on the impact of respondent's sleep apnea on any potential late-night deliveries to an OB specialist. However, no evidence from an OB specialist on this issue was presented at the hearing. Dr. Rabin did touch on the sleep habits of obstetricians during his testimony, but given he has not performed any deliveries since 2019, those opinions are discounted. A full clinical assessment program could address this issue before respondent performs late-night deliveries again. Additionally, as recommended by her treating sleep disorder specialist, Dr. Norman, respondent will be required to follow up with her sleep apnea treatment annually.

Costs

23. 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.)

24. Complainant requests reimbursement of $96,350.75 in actual costs of prosecution and enforcement. Although there was no evidence showing respondent lacks the financial resources to pay the Board's costs, complainant failed to establish one of the five alleged causes for discipline. It is therefore appropriate to reduce the amount of costs by 20 percent, for a total of $77,080.60.

ORDER

Physician and Surgeon's Certificate Number G 31986 issued to respondent Connie S.L. Chein is revoked pursuant to Causes for Discipline II, III, IV, and V, separately and for all of them. 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.

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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

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.

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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.

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12. Education Course

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

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.

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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. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

15. 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.

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.

Respondent shall not practice medicine until respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

16. 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.

17. Annual Follow-ups with Sleep Specialist

Respondent shall follow up with a sleep specialist regarding her severe disruptive sleep apnea annually to ensure compliance with treatment.

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18. Costs

Respondent shall pay $77,080.60 to the Board in reimbursement for its costs of investigation and enforcement based on a payment plan approved by the Board.

DATE:

Ji-Lan Zang

JI-LAN ZANG
Administrative Law Judge
Office of Administrative Hearings