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

In the Matter of the Accusation Against:	)	
NAKIA THERESA MAINOR-ROTH, M.D.	)	Case No. 800-2014-008912
Physician's and Surgeon's Certificate No. A87346	)	OAH No. 2017090259
Respondent	)	

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 November 9, 2018.

IT IS SO ORDERED: October 10, 2018.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson, JD, Chair
Panel B

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In the Matter of the Accusation Against: NAKIA THERESA MAINOR-ROTH, M.D., Physician's and Surgeon's Certificate Number A 87346, Respondent.	Case No. 800-2014-008912 OAH No. 2017090259

PROPOSED DECISION

Administrative Law Judge Carla L. Garrett heard this matter on August 13, 14, 15, and 21, 2018, in Los Angeles, California.

Rebecca Smith, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board). Paul Spackman, Attorney at Law, represented Nakia Theresa Mainor-Roth, M.D. (Respondent), who was present at the hearing.

During the hearing, Complainant amended the Accusation by changing 2011 to 2012 on page 4, at lines 8 and 12.

On August 24, 2018, Complainant moved for a protective order requesting that Exhibits 6, 7, 10, 11, 16, 17, 19, 20, 24, 25, 28, 29, B, and D be placed under seal because the documents contain confidential information which is protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not have provided adequate privacy protection. Respondent did not oppose Complainant's motion. The ALJ granted the motion and issued a Protective Order placing the above-referenced exhibits under seal. Those documents shall remain under seal and shall not be opened, except as provided by the Protective Order. A reviewing court, parties to this matter, their attorneys, and a government agency decision-maker or designee under Government Code section 11517 may review the documents subject to the Protective Order, provided that such documents are protected from release to the public.

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on August 21, 2018.

FINDINGS OF FACT

1. Complainant made the Accusation in her official capacity as Executive Director of the Board.

2. The Board issued Physician's and Surgeon's Certificate Number A 87346 to Respondent on May 26, 2004. The certificate is scheduled to expire on April 30, 2020, unless renewed.

Respondent's Background

3. Respondent is a Board-certified obstetrician and gynecologist. She earned her bachelor's degree in biology from Loyola Marymount University in 1997, and earned her doctorate of medicine from Loyola Stritch School of Medicine in 2002. Respondent completed her residency at the Kaiser Permanente Los Angeles Medical Center in 2006.

4. Since 2006, Respondent has served as a partner physician at Southern California Permanente Medical Group in the practice of obstetrics and gynecology. Her practice is comprised of approximately 50 percent of obstetrics patients and 50 percent gynecology patients. She supervises others as an attending physician, including nurse practitioners and midwives.

Patients JG and JB[1]

5. On May 17, 2012, at approximately 9:55 p.m., Patient JG, a full-term 40 year-old woman, was admitted to Kaiser Permanente South Bay Medical Center (Kaiser) in active labor. Approximately 30 minutes after her admission, Patient JG's cervix was nine centimeters dilated. Twenty minutes later, Respondent, who had not met Patient JG prior to admission, examined Patient JG and determined Patient JG's cervix was nine and one-half centimeters dilated. Respondent also noted that the estimated fetal weight was 3,000 grams (i.e., 6.61 pounds). Approximately 50 minutes later, Patient JG's "water bag" broke, revealing meconium-stained amniotic fluid.

6. Pursuant to Respondent's instructions, Patient JG began pushing, and 20 minutes later, delivered the baby's head. Respondent then discovered that the baby had encountered anterior shoulder dystocia. Shoulder dystocia occurs during delivery when the baby's shoulder gets stuck behind the mother's pubic bone, which is an obstetric emergency. In this case, the shoulder dystocia impacted the baby's right shoulder. Respondent instructed

[1] Patients are identified by their initials to protect their privacy.

Patient JG to stop pushing and called a "Code Pink" to obtain the assistance of additional personnel. Specifically, labor delivery nurses and eventually Respondent's backup physician entered the room to help.

7. Respondent and the additional personnel placed Patient JG into a McRoberts position. Specifically, Patient JG's legs were pulled tightly to her abdomen, and Respondent applied suprapubic pressure (i.e., pressure just above the pubic bone) in an attempt to dislodge the shoulder from behind the pubic bone. Respondent then applied downward traction (i.e., pulled the fetus in a downward motion) by the head and neck, and simultaneously encouraged Patient JG to push. However, Respondent was not successful in dislodging the shoulder from behind the pubic bone.

8. At the hearing, Respondent testified that in terms of the amount of traction she applied in the case, she could not quantify how hard she pulled, but had the sense that she pulled in a manner similar to her other deliveries, and had no recollection of "trying to strong-arm this baby out."

9. Respondent then began delivering the posterior arm (i.e., the baby's left arm), which she did, but caused a fracture to the humerus. After delivering the posterior arm, Respondent was able to dislodge the baby's right shoulder from behind the pubic bone, and delivered the baby, Patient JB, who was 3860 grams (i.e., eight pounds and eight ounces). At the hearing, Respondent testified that she would have performed an episiotomy (i.e., a surgical cut made at the opening of the vagina during childbirth) if she had insufficient room to fit her hand in Patient JG's vagina and deliver the posterior arm.

10. Upon initial assessment, Patient JB had no movement in the right arm. Patient JB had sustained right upper brachial plexus palsy. Brachial plexus palsy is the damaging of a network of nerves that extends from the spine through the neck, interrupting signals from the brain to the arm muscles, causing a limp arm. Patient JB's neurological deficit was later diagnosed as primarily involving cervical nerves 5 through 7 (i.e., C5 through C7), or cervical nerves 5 through 6 (i.e., C5 though C6), suggesting an avulsion (i.e., an injury in which a body structure is forcibly detached from its normal point) of the nerve root, and was determined to be a permanent injury.

Complainant's Expert (Dr. David M. Plourd)

11. Dr. David M. Plourd, who offered testimony as an expert on behalf of the Complainant, is a Board-certified obstetrician and gynecologist. He earned his bachelor's degree in natural and marine science from Pepperdine University in 1978, his doctorate of medicine from the University of California at Los Angeles School of Medicine in 1982, and completed his residency in 1986 at the University of California at Irvine.

12. Dr. Plourd, who has served as an expert reviewer for the Board since 2010, as well as for a period of time in 2007, also serves as a continuing education lecturer, and as a medical consultant. From 2009 through June 2017, Dr. Plourd served as an obstetric

hospitalist at Scripps Encinitas Hospital, and from 1995 through 2012, he served as an assistant professor of obstetrics and gynecology at the Naval Medical Center. Prior, from 2001 through 2015, Dr. Plourd served as a clinical instructor in the Department of Obstetrics and Gynecology at the University of California at San Diego. Dr. Plourd was an examiner for the American Board of Obstetrics and Gynecology from 2002 through 2017, an expert reviewer for the Alaska State Medical Board from 2006 through 2017, and for the Texas Medical Board from 2008 through 2014. He has also served as a medical consultant for the Board from 2008 through 2010, as a media representative for the American College of Obstetrics and Gynecology from 2002 through 2017, and has served as a staff obstetrics and gynecology physician at Tri-City Medical Center, at Santa Clara Valley Medical Center, and at the Naval Hospital in Oakland.

13. Dr. Plourd has been an American Board of Obstetrics and Gynecology diplomat since 1988, and a National Board of Medical Examiners diplomat since 1983. He has also been a fellow with the American College of Obstetrics and Gynecology since 2017. Dr. Plourd has published a number of articles from 1992 through 2005, though none pertaining to the issues set forth in the Accusation, and has served as a lecturer nationally from 1995 to the present.

14. Dr. Plourd reviewed medical records and materials in connection with Patients JG and JB. Specifically, Dr. Plourd reviewed Patients JG's and JB's medical records from Kaiser, audio recording of Respondent's January 24, 2017 Board interview, an 801 Report (i.e., Report of Settlement, Judgment or Arbitration Award) received by the Board on April 25, 2016, and deposition transcripts of Respondent, Patient JG, and JB's father.

15. Dr. Plourd, who has performed more than 5,000 deliveries, including 200 to 250 shoulder dystocia deliveries,[2] evaluated whether Respondent conformed to the standard of care in appropriately recognizing and managing the shoulder dystocia involving Patients JG and JB, and prepared a written report setting forth his conclusions. Dr. Plourd explained that the standard of care requires that an obstetrician promptly recognize or determine when the usual amount and duration of gentle downward traction on the fetal head fails to readily produce the delivery of the anterior fetal shoulder. Once the physician recognizes shoulder dystocia, the physician should immediately complete the following six steps: (1) stop pulling until measures have been undertaken to facilitate the release of the shoulder from behind the pubic bone; (2) instruct the patient to stop pushing; (3) discontinue oxytocin if infusing; (4) start the clock; (5) call for assistance; and (6) flatten the head of the bed.

16. Dr. Plourd further explained that following those steps, positioning the patient in the McRoberts position is a reasonable first step in an attempt to resolve the dystocia, because the McRoberts position changes the angle of the impact. At the hearing, Dr. Plourd explained that most shoulder dystocia situations are resolved through the McRoberts

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[2] Dr. Plourd testified that in one of those deliveries, specifically in 1983 as a second year resident, he caused injury to an infant who suffered shoulder dystocia, by applying too much force.

maneuver, but if execution of the McRoberts position does not dislodge the shoulder dystocia, suprapubic pressure is a next reasonable step. At the hearing, Dr. Plourd stated that if the application of suprapubic pressure is unsuccessful, the physician should apply a rotational maneuver where the physician "corkscrews the fetus' shoulder from underneath the pubic bone. However, in his report, he stated that "the order of additional steps after application of suprapubic pressure," such as rotating the anterior shoulder, or delivering the posterior arm, "is not strict, but the execution of each of them properly is of critical importance." (Exhibit 6, page 006.) At the hearing, Dr. Plourd stated that if the physician is unable to dislodge the fetus after applying a rotational maneuver, the physician should then deliver the shoulder and arm that are not impacted and then deliver the impacted shoulder.

17. Dr. Plourd also stressed that a tenant of management is to avoid applying excessive lateral downward and/or rotational traction to the fetal head and neck. In this context, "excessive" refers to force and duration.

18. Dr. Plourd explained that shoulder dystocia is most often unpredictable and unpreventable by any clinically meaningful predictors. Accordingly, the standard of care requires that the obstetrician be prepared to appropriately recognize and manage the complication of shoulder dystocia whenever it occurs.

19. During Dr. Plourd's review of the records and materials described in Factual Finding 14, he noted that Respondent correctly defined shoulder dystocia in her Board interview, and that she concluded her interview by explaining why did not attempt a rotational maneuver on the anterior shoulder and why she did not cut an episiotomy. Specifically, Respondent explained that she did not attempt a rotational maneuver on the anterior shoulder because there was not sufficient room anteriorly to do so, and did not cut an episiotomy because there was already adequate room posteriorly, such that she did not require additional room for her hand. While her experience with Patients JG and JB was not her first encounter with shoulder dystocia, as she had had two previous experiences during her residency and while she served as a staff physician, her encounter with Patients JG and JB was the first time she had to face either delivering the posterior arm or applying rotational maneuvers.

20. Dr. Plourd inferred from Patient JG's deposition testimony that she had been told, at some point, to stop pushing, and that Respondent did not pull continuously. Additionally, he noted that Respondent clearly called a "Code Pink." He found no reference to the positioning of the bed, but noted that both parents stated in their deposition that a nurse applied fundal and suprapubic pressure. He also found no notations in the records by Respondent describing how much traction force she used, but stated at the hearing that physicians do not generally state in the records how much traction they use during delivery.

21. Dr. Plourd noted that Patient JB's neonatal brachial plexus palsy was extensive and long-lasting enough to suggest a permanent injury, and stated at the hearing that such an injury generally occurs when "too much pressure or traction is placed on the neck during delivery." However, he stated in his report that permanent brachial plexus palsy was not

always due to excessive clinician-applied forces. Specifically, Dr. Plourd stated that other causes include the following conditions: (a) congenital absence of the plexus; (b) exostosis (i.e., outgrowth from the surface of the bone) of the first rib; (c) osteomyelitis (i.e., inflammation of the bone caused by infection) of the humeral head; (d) intrauterine infection such as varicella (i.e., chickenpox); (e) over-folding of scapular helix; (f) amniotic band syndrome (i.e., strands of the amniotic sac that separate and entangle digits, limbs, or other parts of the fetus); (g) uterine malformations; (h) intrauterine malpositioning; (i) neoplasms (i.e., abnormal growth of tissue in some part of the body) that compress the brachial plexus/roots; and (j) rapid labor, prolonged labor, and the intrauterine intrinsic forces of labor. With respect to (j), Dr. Plourd noted that while such conditions are mentioned in literature, they are accompanied by no high-quality clinical evidence.

22. Dr. Plourd found no evidence in the medical records of any of the alternative explanations described in Factual Finding 21. He stated in his report, "in the case of permanent brachial plexus palsies, >90% are not explicable by etiologies besides excessive clinician-applied traction." (Exhibit 16, page 007.) At the hearing, he explained that 0 to 10 pounds of force (i.e., traction) is typically applied for deliveries, and even force of up to 18 pounds can occur in normal deliveries; however a rupture of C5 and C6, which occurred in Patient JB, required at least 44 pounds of force. Dr. Plourd based these findings, in part, on research literature he read by R.H Allen, written in 1991 and 1994. R.H. Allen was not a physician, but rather a biomechanical engineer. Dr. Plourd also relied on literature by S.H. Deering, written in 2011, by J.F. Crofts, written in 2007, and by J.P. Metaizean, written in 1979.

23. Dr. Plourd further testified that the avulsion that Patient JB suffered was the most severe uprooting of the nerve that would not have come from the usual forces of a regular delivery, and not caused by maternal forces (i.e., pushing) for the permanent injuries that Patient JB sustained. Dr. Plourd testified that rather, the injuries were caused "by excessive forces or exertion applied by Respondent." Dr. Plourd further testified that he had read in Patient JG's deposition testimony that Respondent stood up two or three times after the head was delivered, "which raises concern that [Respondent] potentially applied more delivery force while standing than in a sitting position."

24. At the hearing, Respondent testified that, because of her short stature, she typically stood during deliveries, and recalled at no time sitting during Patient JG's delivery of Patient JB.

25. Dr. Plourd stated the following in his report:

> Also, 'excessive forces' applied to the fetal head/neck are occasionally (rarely) clinically appropriate and justified—e.g. when the time interval since the delivery of the fetal head is so long that there is imminent and grave concern for irreversible fetal hypoxic brain injury. However, there

> is no indication of such in the medical record or in any testimony/interview by [Respondent].

(Id., pages 007-008.)

26. With respect to the fractured humerus and its significance in relation to Patient JB's brachial plexus injury, Dr. Plourd stated the following:

> The contralateral (left-sided) humeral fracture . . . was likely the incidental (non-intentional) complication of [Respondent's] attempt to deliver the posterior shoulder. While, in and of itself, this type of injury is usually self-resolving without complication/ sequelae, it further speaks to the force exerted by [Respondent] in the conduct of this delivery. Mid humeral fracture can be an intentional maneuver to facilitate the delivery of the fetal posterior arm, however, nothing in the record, interview or testimony, entered by [Respondent] supports her having an intent to fracture the left (posterior) humerus.

(Id., page 008.)

27. At the hearing, however, Dr. Plourd acknowledged he could have worded his comments differently regarding excessive force as it related to the humerus fraction such that "it did not sound as strong, because a humerus break can occur as a part of being born." Dr. Plourd assigned no departures to the standard of care as it related to the humerus fracture.

28. Dr. Plourd rejected the notion that Patient JB's injuries could have been caused in a way analogous to what some call a "tractor-trailer theory," in which a high velocity vehicle like a tractor-trailer going through a tunnel and gets stuck, but the velocity of the tractor-trailer unsticks the tractor-trailer, permitting the tractor-trailer to get through the tunnel. Dr. Plourd explained at the hearing that maternal forces may produce transient injuries, but not permanent injuries, and stated that "it is highly medically improbable that maternal or intrauterine forces caused the permanent injury to [Patient JB], as the mother cannot cause the amount of stretch on the neck to cause such an injury with the head out." He testified that 20 to 25 percent stretch can cause a transient injury, and a permanent injury involves a stretch of more than 25 percent.

29. Additionally, Dr. Plourd testified that execution of the McRoberts maneuver could not have caused Patient JB's injury, because the maneuver reduces the strain on the neck, and does not increase it. Similarly, according to Dr. Plourd, neither the application of suprapubic pressure nor the delivery of the posterior arm would have increased the strain on the neck.

30. Dr. Plourd explained that 5.9 percent of brachial plexus palsy cannot be explained, 1 or 2 percent are due to other issues, and the remaining 92 percent is due to increased traction applied by the physician at the time of the delivery. He testified that in this case, there is a 90 percent chance that Patient JB's injury was caused by Respondent and

her excessive traction, in light of the xrays and MRI results of Patient JB, and the fact that Respondent stood up to apply traction.

31. Dr. Plourd concluded that Respondent's "failure to avoid applying excessive lateral and/or rotational traction to the fetal head and neck, to a degree to cause such injuries as sustained by [Patient JB], during the management of his delivery complicated by shoulder dystocia, represents an extreme departure from the standard of care." (*Ibid.*) Specifically, as he testified at the hearing, the extreme departure occurred when Respondent applied force that was so great, "in the order of 44 pounds, enough to avulse the nerve roots, as opposed to the standard and customary 10 pounds."

Respondent's Expert (Dr. Joseph G. Ouzounian)

32. Dr. Joseph G. Ouzounian, who offered testimony as an expert on behalf of Respondent, is a Board-certified obstetrician and gynecologist. He earned his bachelor's degree in biochemistry from the University of California at Los Angeles in 1986, his doctorate of medicine from the University of Southern California (USC) Keck School of Medicine in 1990, and completed his internship and residency in 1991 and 1994, respectively, at the Los Angeles County-USC Medical Center.

33. Dr. Ouzounian has served as a clinical instructor, an assistant clinical professor, an associate professor, and a full-time professor, in the Department of Obstetrics and Gynecology at USC Keck School of Medicine, from 1994 through 2007, from 2007 through 2008, from 2008 through 2014, and from 2014 to the present, respectively. He spends a majority of his practice in clinical medicine in which he trains medical students, residents, and fellows in maternal fetal medicine. He has served as Chief of the Division of Maternal-Fetal Medicine since 2011 at USC Keck School of Medicine. Dr. Ouzounian has taught students, residents, and fellows how to deliver babies with shoulder dystocia through the use of simulation drills utilizing mannequins, and has, himself, performed between 25 and 50 shoulder dystocia deliveries.

34. Dr. Ouzounian has published extensively. Specifically, he has published more than 60 peer-reviewed research publications, including the following articles: (1) *Permanent Erb palsy: A traction related injury?* in the American Journal of Obstetrics and Gynecology in 1997, which challenged the thinking in obstetrics that brachial plexus palsy injuries were due to physician traction; (2) *The McRoberts maneuver for relief of shoulder dystocia: How effective is it?* in the American Journal of Obstetrics and Gynecology in 1997, which found that the McRoberts maneuver worked about 42 percent of the time; (3) *Brachial plexus palsy associated with cesarean section: An in utero injury?* in the American Journal of Obstetrics and Gynecology in 1997, which highlighted children born with brachial plexus palsy injuries, but were delivered by Cesarean-section; (4) *Obstetrics maneuvers for shoulder dystocia and associated fetal morbidity* in the American Journal of Obstetrics and Gynecology in 1998; (5) *Brachial plexus palsy: An in utero injury?* in the American Journal of Obstetrics and Gynecology in 1999, which discussed more cases of children born with brachial plexus palsy injuries, despite delivery through Cesarean section; (6) *A comparison of shoulder-dystocia*

transient and permanent brachial plexus palsies, in the American Journal of Obstetrics and Gynecology in 2003; (7) *Shoulder dystocia: Are historic risk factors reliable predictors?* in the American Journal of Obstetrics and Gynecology in 2005; (8) *Posterior arm shoulder dystocia alleviated by the Zavanelli maneuver* in the American Journal of Perinatology in 2010, which discussed deliveries in which the physician pushed the head back into the vagina and then performed a Cesarean-section; (9) *Recurrent shoulder dystocia: Analysis of incidence and risk factors,* in the American Journal of Perinatology in 2012; (10) *Severe brachial plexus palsy in women without shoulder dystocia,* in the American Journal of Obstetrics and Gynecology in 2012, which discussed children who suffered brachial plexus palsy injuries, but suffered no shoulder dystocia at the time of delivery; (11) *Brachial plexus palsy and shoulder dystocia: Obstetrical risk factors remain* elusive, in the American Journal of Perinatology in 2013; (12) *Risk factors for neonatal brachial plexus palsy*, in the Seminars of Perinatology in 2014; and (13) *Shoulder Dystocia,* in the American College of Obstetricians and Gynecology (ACOG) Practice Bulletin No. 178 in 2017.

35. Dr. Ouzounian has also served as a presenter of more than 80 lectures, including a number of formal lectures discussing shoulder dystocia, beginning in 1996. His most recent lecture on shoulder dystocia occurred in Spring 2018.

36. Dr. Ouzounian reviewed medical records and materials in connection with Patients JG and JB. Specifically, Dr. Ouzounian reviewed Patients JG's and JB's medical records from Kaiser, the Board's investigative report, interrogatory responses, expert reports, an 801 Report, and deposition transcripts.

37. Dr. Ouzounian, after reviewing the medical records, noted that a vaginal delivery was reasonable, as Patient JG was well within the threshold of patients who should deliver vaginally. Specifically, Patient JG was not diabetic and the estimated fetal weight was 3,000 grams, much fewer than maximum of 5,000 grams stipulated by the American College of Obstetrics and Gynecology (ACOG). ACOG provides a framework and guidelines from which obstetricians and gynecologist to practice.

38. Dr. Ouzounian noted in his report that shoulder dystocia is unpredictable and unpreventable, and in this case, opined that once Respondent diagnosed shoulder dystocia, she implemented standard and well-accepted clinical maneuvers to deliver the child as quickly and safely as possible. He stated that in shoulder dystocia cases, a delay in delivery could result in permanent brain damage or even fetal death.

39. Dr. Ouzounian stated the following concerning Patient JB's brachial plexus palsy:

> The brachial plexus palsy sustained was an unpredictable event that occurred due to impaction of his anterior shoulder on the maternal pubic bone within the maternal pelvis. This, in turn causes stretch and damage to the brachial plexus at the moment of impaction, because the shoulder stops moving but the head

> and neck continue to be propelled forward. Subsequently, while normal delivery traction and standard shoulder dystocia maneuvers may exacerbate the injury, they are a necessary part of the shoulder dystocia drill and are required to deliver the child prior to hypoxic neurologic injury. All shoulder dystocia maneuvers, no matter how expertly performed, may increase stretch on the brachial plexus.

(Exhibit B, pages 3 and 4.)

40. Dr. Ouzounian testified that no clinical study or published literature has demonstrated that "the mere presence of a permanent brachial plexus injury equates with excess physician applied traction" (Exhibit B, page 4), particularly given the existence of children born with such an injury, but encountered no shoulder dystocia issues during delivery, and were delivered through the application of normal traction. Similarly, Dr. Ouzounian shared that even some babies born through Cesarean-section have suffered brachial plexus palsy injuries.

41. At the hearing, Dr. Ouzounian testified that the infant could have suffered an injury similar to the way someone suffers whiplash, in that when the baby's head came out and the shoulder got stuck, the baby's head, in light of the presence of maternal forces, whipped back, which could have caused the injury. He also testified that the presence of maternal forces exerted on a baby during delivery such as contractions that push the baby downwards, as well as the force from the mother pushing after her cervix becomes completely dilated, creates quite of bit of force on the baby. Dr. Ouzounian explained that studies have shown that maternal forces can be 5 to 9 percent higher than physician applied force (i.e., traction).

42. Dr. Plourd disagreed, and stated that a mother and her uterus cannot produce enough force to cause brachial plexus palsy, and disagreed with the overall notion of the "tractor-trailer" theory asserted by Dr. Ouzounian in Factual Finding 41.

43. Overall, Dr. Ouzounian concluded that "based on the evidence derived from the records provided to [Dr. Ouzounian], and to a high degree of medical probability, in [his] opinion, there was no deviation from the standard of care by [Respondent], and the brachial plexus palsy sustained by the infant was not due to inappropriate physician-applied traction." (Exhibit B, page 4.)

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Credibility Findings[3] *(Re: Patients JG and JB)*

44. Dr. Plourd and Dr. Ouzounian, with their wealth of experience during their respective decades of practice, their impressive credentials, their years of teaching and overseeing obstetrics programs, as well as their respective delivery of testimony in a clear, concise, straightforward manner, proved to be exceptional witnesses. Both proffered impressive theories and opinions concerning the brachial plexus palsy injury and whether Respondent was the cause of that injury. However, given the totality of the facts, the breadth of expertise on the topic, and the burden of proof in this case as defined in the Legal Conclusions below, Dr. Ouzounian's opinions were deemed more persuasive than those of Dr. Plourd.

45. Specifically, Dr. Ouzounian has published 13 peer-reviewed articles concerning shoulder dystocia and/or brachial plexus palsy over the years, while Dr. Plourd has published no articles on the topic, and he was persuasive in establishing that a child born with a brachial plexus palsy injury did not necessarily suffer the injury as a result of excessive traction on the part of the physician. Dr. Ouzounian's discussion of studies in

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[3] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code, § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

which infants sustained brachial plexus palsy injuries, but had suffered no shoulder dystocia issues during birth, and of which infants sustained brachial plexus palsy injuries, but were born via Cesarean-section, were credible in establishing that infants can also suffer these injuries for reasons unrelated to a physician's application of traction. Indeed, even according to Dr. Plourd's calculations, 5.9 percent of brachial plexus palsy cannot be explained, thereby buttressing Dr. Ouzounian's assertion that it is unfair to automatically assume that a physician is the cause of an infant's brachial plexus injury.

46. Additionally, while Dr. Plourd asserts that Patient JB's injuries were, in fact, caused by Respondent's application of excessive force when attempting to dislodge Patient JB's shoulder from behind the pubic bone, Dr. Plourd based his theory, in part, on deposition testimony of Patient JG, who, according to Dr. Plourd, stated that Respondent stood up repeatedly and applied downward traction to dislodge Patient JB. Specifically, Dr. Plourd stated that Respondent stood up two or three times after the head was delivered, "which raise[d] concern that [Respondent] potentially applied more delivery force while standing than in a sitting position." In other words, Dr. Plourd concluded that Respondent's act of standing was a way, in essence, to gain more leverage to apply traction to dislodge Patient JB, and contributed to at least 44 pounds of force that Respondent must have used that caused Patient JB's nerve avulsion.

47. However, Respondent credibly testified that, because of her short stature, she routinely stood during her delivery of babies, and that she applied no more traction in the delivery of Patient JB than she typically applied during the delivery of babies. These factors demonstrate that Dr. Plourd based his opinion, in part, on inaccurate information, and Complainant proffered no percipient witnesses to offer testimony on this point.

Patient BW

48. On August 19, 2011, Patient BW, who was 33 years-old, delivered a baby girl. The labor and delivery were uneventful in that Patient BW's blood pressure readings were normal, and remained normal throughout her postpartum course in the hospital. Patient BW and her infant daughter were discharged from the hospital on August 21, 2011, in stable condition.

49. Five days after her discharge, Patient BW returned to Kaiser on August 26, 2011 at approximately 2:22 p.m., and presented in the emergency department with complaints of high blood pressure, headache, and blurred vision. Her blood pressure and liver enzymes were markedly elevated upon initial evaluation and admission, despite having no known history of hypertension, including during her recent pregnancy. Specifically, her initial blood pressure was 177/102 at 1:22 p.m. and then 203/91 when hospital staff repeated her blood pressure at 2:28 p.m. Additionally, the results of a liver function test (LFT) administered to Patient BW showed that Patient BW's alanine aminotransferase level (ALT) was 709 and her aspartate transaminase level (AST) was 119. The normal range for ALT is between 14 and 54 and the normal range for AST is less than 31.

50. Hospital staff also found that Patient BW's glucose was high at 144. The normal range for glucose is between 70 and 140. Patient BW's platelets were normal at 171,000 and her urine was negative for proteinuria. Additionally, she had mild lower extremity edema (i.e., swelling caused by excess fluid trapped in the body's tissues).

51. Patient BW was assessed as having hypertension, headache, and possible preeclampsia. Preeclampsia is a condition that can occur when a woman has persistent high blood pressure of 140/90 or greater, and develops during pregnancy or during the postpartum period (typically during the first six weeks following delivery). It is associated with protein in the urine or the new development of decreased blood platelets, trouble with the kidneys or liver, fluid in the lungs, or signs of brain trouble such as seizures and/or visual disturbances. Severe preeclampsia occurs when a woman's blood pressure exceeds 160/110.

52. The emergency room physician administered 2 mg of magnesium sulfate to Patient BW to keep her from suffering a seizure, and administered two doses of an antihypertensive agent, hydralazine, 10 mg intravenously at 2:56 p.m. and 3:58 p.m., which reduced Patient BW's blood pressure to 150/90 in the emergency department.

53. Patient BW was admitted to the hospital's obstetrics unit, and continued to receive magnesium sulfate intravenously, as well as an oral antihypertensive agent, labetalol, 200 mg twice daily. By August 27, 2011, Patient BW's complaints of headache had diminished and her blood pressure had normalized. Specifically, Patient BW's blood pressure readings on April 27, 2011 were as follows:

Time	**Blood Pressure**
4:00 a.m.	131/80
5:07 a.m.	124/80
6:00 a.m.	105/62
7:00 a.m.	121/80
8:00 a.m.	135/85
9:00 a.m.	129/78
10:00 a.m.	121/86
11:00 a.m.	123/79
12:00 p.m.	120/76
1:00 p.m.	132/86
2:00 p.m.	121/80
3:00 p.m.	134/89
4:51 p.m.	139/90
10:27 p.m.	142/85

54. During this period on August 27, 2011, Patient BW's LFT's were trending towards normal, as her ALT had decreased to 518, and her AST had decreased to 67. Additionally, Patient BW's intake and output of fluids trended positively. Specifically, at 7:00 a.m., Patient BW's intake was 1,000 milliliters and her output was 900 milliliters.

55. At 3:58 p.m. on August 27, 2011, the staff physician discontinued Patient BW's magnesium sulfate.

56. On the morning of August 28, 2011, Patient BW's blood pressure readings were as follows:

Time	Blood Pressure
12:02 a.m.	150/81
4:00 a.m.	133/77
8:00 a.m.	168/91

57. Respondent, whose hospital shift began at 8:00 a.m. on August 28, 2011, assumed Patient BW's hospital care. Respondent had previously met Patient BW prenatally on two occasions when Respondent provided Patient BW with consultation services in relation to gestational diabetes.

58. Between 8:00 a.m. and 9:00 a.m., Respondent began reviewing Patient BW's medical chart through Kaiser's electronic medical records, including the physician's notes from the day prior, as well as nursing notes, laboratory reports, intake and output reports, and the last 24 hours of vital signs. At the hearing, Respondent stated that at the time of her review, the 8:00 a.m. reading of Patient BW's blood pressure (i.e., 168/91) had not been entered into Patient BW's chart by the nursing staff, and no one from the nursing staff alerted Respondent of the high blood pressure reading. Consequently, Respondent concluded that Patient BW's blood pressure during the 24 hour period between 4:00 a.m. on August 27, 2011 and 4:00 a.m. on August 28, 2011, had been decreasing and that her severe postpartum preeclampsia was improving, especially given the 4:00 a.m. blood pressure of 133/77. Additionally, Respondent noted that her diastolic readings had decreased after the magnesium sulfate was discontinued, and had decreased even more after she had received a dose of her antihypertension medication after the 4:51 p.m. blood pressure reading of 139/90 on August 27, 2011.

59. At the time of her review, the records showed that Patient BW had reported no further symptoms and her laboratory studies continued to trend towards normal with an ALT of 331 and an AST of 33. Additionally, Patient BW had been off of the magnesium sulfate for nearly 24 hours, had denied any complaints, and had remarked that it was "the first time she [felt] this good in days." Several nursing notes reflected the absence of headache or visual changes. Additionally, Patient BW's intake was 350 milliliters and output was 750 milliliters, and she had no more edema in her legs.

60. Respondent began making her rounds between 9:00 a.m. and 10:00 a.m., and spent time with Patient BW assessing her condition. Patient BW reported that she no longer had a headache, that she had been eating well, and that she was anxious to go home. Respondent told Patient BW that she would be discharging her. Respondent testified at the

hearing that she also told Patient BW that she would need to return to the nurse's clinic in two or three days for a blood pressure check.

61. At 9:32 a.m., a nurse entered the 8:00 a.m. blood pressure reading of 168/91 into Patient BW's electronic medical records. Respondent was not aware that this entry had been made.

62. After finishing her rounds that morning, Respondent, at approximately 1:12 p.m., wrote rounding notes concerning Patient BW. Respondent used the hospital's electronic medical record template in the preparation of these notes, which auto-populated Patient BW's most recent vital signs, including the 8:00 a.m. blood pressure reading of 168/91. Respondent did not notice the 168/91 blood pressure populated onto her note.

63. Respondent indicated on the note that Patient BW was "stable for discharge" and noted in her plan that Patient BW should follow up with her primary care physician in two to three weeks. (Exhibit 7, page 001432.) Respondent mentioned nothing in note stating that she had instructed Patient BW to return to the nurse's clinic in two or three days for a blood pressure check. Respondent then electronically signed the note at 1:12 p.m.

64. Patient BW was discharged at 2:07 p.m. The discharge instructions set forth Patient BW's future appointments scheduled for two and three weeks after discharge. Specifically, the discharge instructions stated that Patient BW would need to visit a Kaiser physician on September 12, 2011 at 10:40 a.m. for a blood pressure follow up, and then on September 23, 2011 with a different Kaiser physician. The discharge instructions also directed Patient BW to take one tablet of labetalol 200 mg twice per day, orally. The discharge instructions mentioned nothing indicating that Patient BW would need to return to the nurse's clinic in two or three days for a blood pressure check.

65. At the hearing, Respondent testified that had she noticed the 168/91 blood pressure reading, she would have requested the nursing staff to take Patient BW's blood pressure again to see if the blood pressure was accurate and sustained, which would have guided her next step. While she acknowledged that she made a "proofreading error" when she failed to notice the 168/91 blood pressure reading on her note, she stated that she was only as good as the weakest person on her team. In other words, Respondent reiterated that the nurse should have both entered the 8:00 a.m. 168/91 blood pressure reading immediately after taking it, and should have alerted Respondent of the abnormal reading. Notwithstanding the nurse's error, Respondent testified that she held herself responsible because the 168/91 blood pressure reading was in her note and she should have been aware of it.

66. Hours after discharge, Patient BW developed a headache that she rated 10 on a pain scale of 1 to 10. She also had an elevated blood pressure reading at home, which prompted her partner to take her back to the hospital. On the way to the hospital, Patient BW suffered multiple intracranial hemorrhages.

67. Patient BW was pronounced brain dead on August 31, 2018.

Complainant's Expert (Dr. Plourd)

68. Dr. David M. Plourd offered testimony as an expert regarding Respondent's care and treatment of Patient BW. Dr. Plourd reviewed medical records and materials in connection with Patient BW. Specifically, Dr. Plourd reviewed Patient BW's medical records from Kaiser, audio recording and transcript of Respondent's June 14, 2016 Board interview, summary of care from Respondent, Respondent's curriculum vitae, an 801 Report received by the Board on September 22, 2014, and deposition transcripts.

69. Dr. Plourd evaluated whether Respondent conformed to the standard of care in the evaluation, assessment, discharge, and follow-up care of Patient BW on August 28, 2011, with specific regard to Patient BW's severe postpartum preeclampsia.

70. Dr. Plourd explained that the standard of care requires that an obstetrician promptly and thoroughly evaluate and manage hypertensive disorders during pregnancy and the puerperal period (i.e., up to six weeks postpartum). While the actual incidence of stroke in the puerperium period is rare, the existence of preeclampsia is known to be one of the most significant risk factors on elevating that risk. Hence, in light of the morbidity and mortality surrounding such a rare likelihood, the standard of care requires strict vigilance as to prompt evaluation and immediate lowering of markedly elevated blood pressures, during pregnancy, particularly after 20 weeks of gestation, and even more so in the puerperium period. Dr. Plourd stated that approximately 15% of maternal deaths have been ascribed to hypertension and preeclampsia. Women with severe preeclampsia and elevated systolic blood pressure, more so than diastolic blood pressure, should be considered to be at particularly high risk of stroke.

71. Dr. Plourd further explained that clinical considerations are critical for discharging a patient diagnosed with severe preeclampsia, and require that the patient be symptom-improved or symptom-free, that the blood pressure be controlled, that her kidneys be diuresed (i.e., produce a good volume of urine), and that any abnormal laboratory results have returned to normal or sufficiently toward normal. The standard of care also requires that a follow-up blood pressure check be scheduled no later than seven days after discharge.

72. Dr. Plourd noted that when Respondent evaluated Patient BW on August 28, 2011, Patient BW's most recent blood pressure was severely elevated at 168/91.[4] Dr. Plourd explained that the standard of care required Respondent, at the very least, to repeat the blood pressure prior to her discharge of Patient BW. A more aggressive standard of care would have mandated the acute and immediate administration of an antihypertensive dose, within one hour of her noting the severely elevated blood pressure. Thereafter, the standard of care

[4] While Respondent denies seeing the 168/91 reading, the fact remains that Patient BW's blood pressure reading was 168/91.

would have required frequent monitoring and surveillance of Patient BW's blood pressures before considering discharging the patient.

73. Dr. Plourd concluded that Respondent's assessment, evaluation, discharge, and follow-up plan of Patient BW represented a "single aggregate extreme departure" from the standard of care, "rather than multiple departures," in that Respondent (1) failed to repeat the blood pressure prior to considering discharge; (2) failed to administer an acute dose of an antihypertensive agent; and (3) failed to arrange or document a follow-up blood pressure check within seven days of discharge. (Exhibit 6, page 011.)

Respondent's Expert (Dr. Michael Ross)

74. Dr. Michael Ross, who offered testimony as an expert on behalf of Respondent, is a Board-certified obstetrician and gynecologist. He earned his bachelor's degree in life sciences from Massachusetts Institute of Technology in 1973, his doctorate of medicine from Harvard Medical School in 1978, and completed his residency in 1982 at the Brigham and Women's Hospital.

75. Dr. Ross currently serves as a distinguished professor of obstetrics and gynecology, and of public health, at the David Geffen School of Medicine at the University of California at Los Angeles, and as a clinical professor at Charles Drew University of Medicine and Science. His clinical practice is comprised of a teaching practice, as well as an active research laboratory. Dr. Ross has treated hundreds of postpartum preeclampsia women over the years.

76. Dr. Ross has published extensively. Specifically, he has published more than 325 peer-reviewed research publications, more than 40 book chapters, six books, 43 letters to editors, and 731 abstracts. Dr. Ross has also presented lectures as local, national, and international conferences. He also reviews for 50 to 100 journals per year.

77. Dr. Ross reviewed medical records and materials in connection with Patient BW. Specifically, Dr. Ross reviewed Patient BE's medical records from Kaiser, the Board's investigative report, interrogatory responses, expert reports, an 801 Report, a transcript of Respondent's interview, and a report by Dr. Plourd.

78. Dr. Ross described the standard of care as what a prudent physician would do under similar circumstances. He also stated that an extreme departure from the standard of care would include an egregious or willful act in contradiction to what would be standard.

79. Dr. Ross contended that Dr. Plourd applied current and relatively new standards of care for the treatment of hypertension during pregnancy or postpartum periods which were not applicable during 2011. Specifically, Dr. Ross asserted that the standard of care during the pertinent period of this case was established through guidelines produced by ACOG, to wit, "Diagnosis and management of preeclampsia and eclampsia" that was issued in January 2002. Dr. Ross stated that within this ACOG bulletin, "antihypertensive therapy

is generally recommended for diastolic blood pressure levels of 105 to 110 mmHg or higher, and that the practice bulletin provides guidelines for treatment." (Exhibit D, page 3.) Dr. Ross further stated the following:

> This specific recommendation is repeated in the section of the summary of recommendations, without comment as to the need for treatment of systolic hypertension, in the absence of diastolic hypertension. During this period of time, clinical data indicated the importance of pregnancy diastolic as compared to systolic hypertension. Subsequent research publications following the ACOG bulletin have created a shift in clinical practice, to now address both systolic and diastolic hypertension.

(*Id.* at pages 3-4.)

80. Dr. Ross concluded that Respondent "fully complied with the standard of care guidelines for the management and treatment of patients, as no medical therapy was required for a diastolic pressure of 91 mmHg, and there was no specified indication for the treatment of systolic hypertension under this circumstance." (*Ibid.* at page 4.) At the hearing, Dr. Ross stated that during the 24 hour period from 4:00 a.m. on August 27, 2011 through 4:00 a.m. on August 28, 2011, there was no trend in the diastolic reading. He further stated that it was within the standard of care for Respondent to discharge Patient BW after reviewing the blood pressure readings taken during that 24 hour period, even though Respondent reached her decision to discharge Patient BW in the morning, but Patient BW was not officially discharged until the afternoon.

81. Dr. Ross further testified that in 2011, a blood pressure reading of 168/91 did not require any additional antihypertensive treatment, because the treatment, according to ACOG bulletins, focused only on the diastolic readings. However, Dr. Ross acknowledged in his testimony that "there was clearly an oversight in [Respondent] not seeing the auto-populated 168/91, but [Respondent] met the standard of care to discharge [Patient BW] at the time she made the decision to do so."

82. Dr. Plourd asserted that ACOG is not the standard of care and "does not hold a monopoly of what the standard of care is," but rather formulates guidelines. Additionally, he explained that, in fact, ACOG publications specifically state that ACOG does not define the standard of care. Notwithstanding Dr. Ross' reliance on ACOG bulletins for the standard of care in 2011, specifically his assertion that clinical data indicated the importance of pregnancy diastolic as compared to systolic hypertension, Dr. Ploud cited literature from the American Journal of Obstetrics and Gynecology, the Seventh Report of the Joint National Committee,[5] and from Obstetrics & Gynecology, which is the official journal of ACOG, for

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[5] The purpose of the *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* is to provide an evidence-based approach to the prevention and management of hypertension.

the period of 1995 through 2010, demonstrating that systolic pressure was the germane standard of care in 2011. Specifically, in 2011, if the systolic pressure exceeded 160, the standard of care required that the blood pressure be taken every 15 minutes and if it remained elevated, then to treat the high blood pressure. Dr. Plourd reiterated that it was not within the standard of care to discharge Patient BW when her systolic pressure exceeded 160.

83. Dr. Ross testified that he "[did] not have enough information to determine whether the discharge of [Patient BW] with blood pressure of 168/91 was outside of the standard of care."

84. Dr. Ross also testified that Respondent's failure to document the medical record of her instruction to Patient BW directing her to the nurse's clinic in two or three days to have her blood pressure checked, did not fall outside of the standard of care, because "the standard of care pertains to the treatment of patients, and not necessarily the documentation of medical records." However, on cross-examination, Dr. Ross conceded that the contents of medical records are important, and that it is the physician's responsibility to maintain adequate the accurate medical records. Notwithstanding this concession, Dr. Ross testified that Respondent's progress note was a reasonable documentation of what occurred, although "it would have been nice if [Respondent] had included the instruction that [Patient BW] must return in a few days." Dr. Ross then testified that Respondent's failure to include the instruction constituted no violation of the standard of care.

Credibility Findings (Re: Patient BW Matter)

85. While both Dr. Plourd and Dr. Ross have practiced medicine for decades and have a wealth of experience, Dr. Plourd's testimony was more persuasive than Dr. Ross', and was afforded great weight. Dr. Plourd provided credible testimony regarding the standard of care concerning the care and treatment of severe preeclampsia, and supported his testimony with peer-reviewed publications that established that, in 2011, blood pressure readings of greater than 160/110 established severe preeclampsia, and that the systolic pressure was a pertinent consideration in the care and treatment of severe preeclampsia. Dr. Plourd also credibly established that Respondent failed to conform to the standard of care in her care and treatment of Patient BW when she discharged Patient BW from the hospital with a blood pressure reading of 168/91. Dr. Plourd also convincingly testified that Respondent failed to conform to the standard of care relating to the documentation of the medical records, when she failed to include her instruction directing Patient BW to return in two to three days to have her blood pressure checked.

86. Dr. Ross' testimony, on the other hand, suffered from inconsistencies and/or a lack of intellectual integrity. Specifically, Dr. Ross attempted to limit his opinion to the 24 hour period of 4:00 a.m. on August 27, 2011 to 4:00 a.m. on August 28, 2011, completely ignoring the 8:00 a.m. blood pressure reading of 168/91 that is the subject of this case, and concluded that Respondent's actions conformed to the standard of care. When asked whether Respondent's decision to discharge Patient BW with a blood pressure reading of 168/91, Dr. Ross, who testified that he had reviewed all of the medical records, claimed,

incredibly, that he "[did] not have enough information to determine whether the discharge of [Patient BW] with blood pressure of 168/91 was outside of the standard of care."

87. Additionally, when questioned about the standard of care regarding documenting medical records, Dr. Ross testified that "the standard of care pertains to the treatment of patients, and not necessarily the documentation of medical records." But moments later, during cross-examination, Dr. Ross conceded that the contents of medical records are important, and that it is the physician's responsibility to maintain adequate the accurate medical records. Despite his declaration on cross-examination, as well as his statement that "it would have been nice if [Respondent] had included the instruction that [Patient BW] must return in a few days," Dr. Ross concluded that Respondent's failure to include the instruction constituted no violation of the standard of care, but offered no credible rationale or supporting data establishing why it equaled no violation.

Character Evidence

88. Dr. Rhonda Smalls, an obstetrician and gynecologist who has been practicing medicine since 1992, provided character testimony on Respondent's behalf. Dr. Smalls has worked at Kaiser since 2001, and has served as Chief of Obstetrics and Gynecology since 2010. Dr. Smalls has known Respondent since 2002, when Respondent was in the residency program. Dr. Smalls trained Respondent, and has kept in contact with Respondent over the years. Dr. Smalls has a high opinion of Respondent, and witnessed during Respondent's residency that she was dependable and reliable in the area of patient care.

89. Dr. William Wallace, an obstetrician and gynecologist who has been practicing medicine since 1995, provided character testimony on Respondent's behalf. Dr. Wallace has worked at Kaiser for 21 years, and crosses paths with Respondent one to two times per week. He frequently discusses patient care with Respondent, as he does with all of the other physicians at Kaiser, and performs surgeries with Respondent.

90. Dr. Wallace was peripherally involved in the shoulder dystocia case involving Patients JG and JB, in that he arrived in the room just before Respondent delivered the posterior arm, and noted that Respondent delivered Patient JB "with minimal traction." Dr. Wallace considers Respondent to be highly skilled and one who provides quality patient care. He said that he would feel comfortable having a member of his family treated by Respondent.

91. Dr. Janet Williams, an obstetrician and gynecologist who has been practicing medicine since 2003, provided character testimony on Respondent's behalf. Dr. Williams and Respondent completed their residency together, and subsequently began working together at Kaiser in 2005 or 2006. They have been office neighbors since 2007, they take care of each other's patients when the other is out, and they discuss their patients with each other on a frequent basis. They also assist each other during surgery. Dr. Williams wrote a letter of reference on Respondent's behalf, and described Respondent as one who "regularly demonstrates her motivation to do the right thing for her patients" and who "is organized and

stays abreast of the latest research, guidelines and recommendations relevant to our practice." (Exhibit F, page 3.) She also stated the following:

> From the intricate management of complex laboratory results to her Patient's social situations, whole care is important to [Respondent] and for this she is revered by her patients and colleagues alike. She is a trusted mentor to midwives and nurse practitioners who often prefer discussing cases because of her ease of insight. She is an excellent surgeon leader in emergent care situations and has often been commended by nursing staff for her skills in this area.

(*Id.*)

92. Dr. Mojan Gabbay, who has worked with Respondent for more than 16 years, wrote a letter of reference on Respondent's behalf. Dr. Gabbay stated the following:

> [Respondent] is loved by her patients and her colleagues, but this only scratches the surface of who she really is. [Respondent] is a wonderful human being, a humanitarian and a woman of ethics and morality. [Respondent] not only juggles a full load at work but . . . treats her patients like her own family. I would trust any of my loved ones in [Respondent's] capable hands.

(Exhibit F, page 1.)

93. Dr. Dana Kristin Loo, who has worked with Respondent since 2006, wrote a letter of reference on Respondent's behalf. Dr. Loo stated the following:

> Professionally, [Respondent] in her practice has always exhibited extremely competent medical skills—both in her knowledge base as well as her proficiency as a surgeon. She continually employs evidence based medicine as the foundation of her practice and is always striving to stay up to date with changes in her established field. Furthermore, her technical skills as a surgeon have always been excellent and she continues to assist in managing critically ill patients when the need arises with exemplary finesse.

(Exhibit F, page 2.)

CONCLUSIONS OF LAW

1. Cause does not exist to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), for gross negligence in relation to her management of shoulder dystocia in the delivery of Patient JB on May 17, 2012, as set forth in Factual Findings 5 through 47.

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), for gross negligence in relation to her evaluation, assessment, discharge, and follow-up plan concerning Patient BW's severe preeclampsia, as set forth in Factual Findings 48 through 87.

3. Cause does not exist to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), for repeated negligent acts in relation to her care and treatment of Patients JG and JB, as set forth in Factual Findings 5 through 47, or in relation to her care and treatment of Patient BW, as set forth in Findings 48 through 87.

4. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2266, for failing to maintain adequate and accurate records relating to her care and treatment of Patient BW, as set forth in Factual Findings 48 through 87.

The Applicable Law

5. The standard of proof which must be met to establish the charging allegations herein is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

6. The purpose of the Medical Practice Act[6] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

7. The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a

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[6] Business and Professions Code sections 2000 through 2521.

diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.) (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

8. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

9. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

10. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

11. Business and Professions Code section 2266 states that that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provisions of services to their patients constitutes unprofessional conduct."

12. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

Analysis

A. Gross Negligence

13. Complainant failed to meet her burden of establishing clearly and convincingly that Respondent engaged in gross negligence, in violation of Business and Professions Code section 2234, subdivision (b), in relation to her care and treatment of Patients JG and JB. Specifically, Complainant failed to establish that Respondent committed an extreme departure from the standard of care in her management of shoulder dystocia in the delivery of Patient JB. As set forth in Factual Findings 44 through 47, the testimony of Complainant's only witness, Dr. Plourd, who asserted that Respondent applied excessive force during her delivery of Patient JB and thus caused his brachial plexus injury, was not credited over the expert testimony of Dr. Ouzounian, who persuasively testified that such an

injury is not evidence that the physician applied too much force, especially given the presence of such injuries in babies that suffered no shoulder dystocia or who were born via Cesarean-section. With no percipient witnesses proffered by Complainant describing the amount of force applied by Respondent during the delivery, coupled with the reasonable potential for other possible causes for Patient JB's injury, Complainant has failed to meet her burden.

14. Complainant successfully met her burden of establishing clearly and convincingly that Respondent engaged in gross negligence, in violation of Business and Professions Code section 2234, subdivision (b), in relation to her care and treatment of Patient BW. Specifically, the uncontroverted evidence established that Respondent discharged Patient BW, who had been diagnosed with severe preeclampsia, from the hospital with a blood pressure of 167/91, which, as Dr. Plourd credibly testified, constituted an extreme departure from the standard of care, because that blood pressure reading placed Patient BW squarely in the severe preeclampsia range. Additionally, Dr. Plourd testified that other factors contributed to the extreme departure, such as Respondent's failure to repeat the blood pressure prior to discharge, Respondent's failure to administer additional medication, and her failure to document a follow-up blood pressure check within seven days of discharge. As a result of Respondent's gross negligence in discharging Patient BW, Patient BW suffered irreparable injury in the form of multiple intracranial hemorrhaging just hours after discharge, resulting in her death.

B. Repeated Acts of Negligence

15. Complainant failed to meet her burden of establishing clearly and convincingly that Respondent engaged in any acts of negligence in relation to her care and treatment of Patients JG and JB, as discussed in detail above. Complainant also failed to meet her burden of establishing that Respondent engaged in repeated acts of negligence as it related to her care and treatment of Patient BW, based on the conclusions of Complainant's expert. Specifically, Complainant's only witness, Dr. Plourd, stated very clearly that the following acts represented a "single aggregate extreme departure . . . rather than multiple departures": (1) failure to repeat the blood pressure prior to considering discharge; (2) failure to administer an acute dose of an antihypertensive agent; and (3) failure to arrange or document a follow-up blood pressure check within seven days of discharge. Because Dr. Plourd declined to find simple or "multiple departures," Complainant failed to establish that Respondent engaged in repeated acts of negligence.

C. Failure to Maintain Adequate and Accurate Records

16. Complainant persuasively established that Respondent failed to maintain adequate and accurate records of his care and treatment of Patient BW, in violation of Business and Professions Code section 2266. As established by the record, Respondent maintains that she instructed Patient BW to return in two or three days for a blood pressure follow-up reading, but failed to document those instructions in Patient BW's medical records. As such, Respondent violated Business and Professions Code section 2266.

Appropriate Level of Discipline

17. Complainant seeks revocation of Respondent's license or, in the alternative, seven years' probation. While revocation falls into the range of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, particularly given the gross negligence involved that resulted in the loss of a life, such discipline is not warranted in this matter. Respondent has enjoyed a long period of practice with no prior record of discipline, and the proven unprofessional conduct in this matter concerned only one patient (i.e., Patient BW), more than seven years ago. Additionally, Respondent has maintained a positive reputation in her field, evidenced by the character witnesses who testified or who provided letters of reference on Respondent's behalf.

18. Business and Professions Code section 2229 provides that protection of the public is paramount, but the Board should take action that will stress education to address deficiencies in practice.

19. Given these factors, and noting that the purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.), the public would be adequately protected by the imposition of a five-year period of probation, with specific terms and conditions, including a condition concerning education.

ORDER

Certificate Number A 87346 issued to Respondent Nakia Theresa Mainor-Roth, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five years, upon the following terms and conditions:

1. 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.

2. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true and correct 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.

3. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

4. 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.

5. 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.

6. General Probation Requirements

Compliance with Probation Unit:

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

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, subdivision (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 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.

7. 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.

8. 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 in California 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training 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 years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice 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; and General Probation Requirements.

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, 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 his 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. 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.

Date: September 20, 2018

DocuSigned by:
Carla L. Garrett
CARLA L. GARRETT
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 11, 20 17
BY Sara Passon ANALYST

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

In the Matter of the Accusation Against: NAKIA THERESA MAINOR-ROTH, M.D. 25965 South Normandie Avenue Obstetrics-Gynecology Second Floor Harbor City, California 90710 Physician's and Surgeon's Certificate No. A 87346, Respondent.	Case No. 800-2014-008912 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On May 26, 2004, the Board issued Physician's and Surgeon's Certificate number A 87346 to Nakia Theresa Mainor-Roth, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2018, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

"..."

5. Section 2227 of the Code states:

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

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

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

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

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

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

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

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

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7. Section 2266 of the Code states:

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence as to Patient J.B.)

8. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she engaged in gross negligence in her management of shoulder dystocia in the delivery of Patient J.B.[1] on May 17, 2011. The circumstances are as follows:

9. Maternal patient J.G., a then 40-year-old patient, began prenatal care on November 2, 2011 with Dr. D.L.[2] Her estimated date of delivery was May 17, 2012 based upon an early ultrasound performed on December 9, 2011.

10. On May 17, 2011 at approximately 9:55 p.m., J.G. was admitted to Kaiser Permanente South Bay Medical Center in active labor. At 10:10 p.m., J.G.'s cervix was noted to be dilated at 9 centimeters, 100% effaced and at minus three station.

11. At 10:30 p.m., Respondent examined J.G., at which time her cervix was noted to be dilated at 9½ centimeters, 100% effaced and at minus five station. Using Leopold's maneuvers, a method to determine fetus position, presentation and engagement, Respondent estimated fetal weight on admission to be 3,000 grams.

12. At 11:20 p.m., J.G.'s cervix was completely dilated at 10 centimeters. At 11:28 p.m., spontaneous rupture of the membranes occurred and meconium-stained amniotic fluid was noted. The baby's head was still at a high station and the fetal heart rate was not detectable on the external monitor. Respondent placed a direct fetal scalp electrode and noted that the heart rate was in the 90's. Shortly thereafter, J.G. began pushing. After approximately 20 minutes of pushing efforts, at around 11:48 p.m., Respondent delivered the fetal head.

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[1] Initials are used for privacy purposes.

[2] By way of history, J.G. was gravida 3, para 1, in her third pregnancy after one term pregnancy and one prior spontaneous miscarriage. J.G.'s first baby was born vaginally and weighed approximately seven pounds.

13. A shoulder dystocia was then encountered and Respondent called a "Code Pink" to seek the assistance of additional personnel, including labor and delivery nurses as well as Respondent's back up physician, Dr. W.W. A tight nuchal cord times one (umbilical cord once around the neck) was noted. J.G. was placed in McRoberts position, and suprapubic pressure was exerted. Repeated downward traction was applied on the fetal head and neck. Respondent then attempted to deliver the posterior arm. She did not attempt a rotational maneuver on the anterior shoulder; nor did she cut an episiotomy. The head-to-body delivery interval was approximately two to three minutes. The Vaginal Delivery Note reflects that the fetus was in the vertex left occiput anterior position, with the right shoulder being the anterior or "stuck" shoulder. It is further documented the maneuvers used were: McRoberts, suprapubic pressure and posterior arm. J.B. was born at 11:50 p.m. His birthweight was 3860 grams (8 pounds, 8 ounces), with APGAR scores of 6 and 9 at 1 and 5 minutes, respectively. Respondent noted that the infant's "right arm appears limp."

14. J.B. sustained a right upper brachial plexus palsy (neonatal brachial plexus palsy) and showed some improvement by two months of age, but as twenty-three months of age, he still had incomplete function of his right arm. He also sustained a fracture of the left humerus at the time of birth which healed by June 13, 2012.

15. The standard of obstetrical medical practice in California requires that a practitioner promptly recognize and manage shoulder dystocia. The occurrence of a shoulder dystocia is recognized when one's usual and customary duration, direction, and amount of gentle downward or axial traction on the fetal head fails to readily produce the delivery of the anterior fetal shoulder.

16. The standard of medical practice in California requires that once shoulder dystocia is recognized, the following steps be immediately undertaken by the practitioner or under the practitioner's direction: start a clock; stop pulling or applying traction on the fetal head (until measures have been undertaken to facilitate the release of the shoulder from behind the symphysis pubis); instruct the patient to stop pushing; discontinue oxytocin, if infusing; call for additional assistance; and flatten the head of the bed. Thereafter, the standard of medical practice

in California requires the practitioner to systematically embark upon a series of specialized additional obstetric maneuvers, in no particular sequence/order, until delivery has been effected. Such maneuvers include McRoberts (hips abducted and hyperflexed), suprapubic pressure, delivery of the posterior arm, and/or any of a number of named rotational maneuvers that entail reaching deep into the birth canal and applying pressure to either side of the fetal chest or scapula. Other maneuvers are also available should the aforementioned ones all fail with repeated efforts. In no case should the practitioner apply more than the his/her usual and customary amount of lateral and/or rotational traction to the fetal neck, in an attempt to effect delivery. The only exception to the aforementioned standard is the rare situation in which the shoulders have been stuck for so long as to pose an imminent threat of irreversible brain damage, unless delivery is effected within moments, at any cost to the brachial plexus and upper extremities.

17. During the management of J.B.'s delivery, complicated by shoulder dystocia, Respondent applied excessive lateral and/or rotational traction to the fetal head and neck.

18. Respondent's acts and/or omissions as set forth in paragraphs 8 through 17, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence as to Patient B.W.)

19. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she engaged in gross negligence in her evaluation, assessment, discharge, and follow up plan-of-care of B.W.'s postpartum severe preeclampsia on August 28, 2011. The circumstances are as follows:

20. On August 19, 2011, 33-year-old patient, B.W., had an uneventful delivery of a full-term female infant at Kaiser Permanente South Bay Medical Center. B.W.'s blood pressures were normal during labor, delivery, and throughout her post partum course in the hospital. B.W.

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and her infant were discharged home on August 21, 2011 in stable condition.[3]

21. Seven days after delivery, on August 26, 2011, B.W. presented to Kaiser Permanente South Bay Medical Center's emergency department at approximately 2:22 p.m. with complaints of high blood pressure, headache and blurred vision. Her review of systems was negative other than headaches. Upon physical examination she was noted to have mild lower extremity edema (pretibial and bilateral feet), rated as a +1. While she had no known history of hypertension, and more specifically, no known history of hypertension during the recent pregnancy, her initial blood pressure upon her evaluation was markedly elevated at 177/102 at 1:22 p.m. and 203/91 upon repeat at 2:28 p.m. She was assessed as having hypertension, headache and possible preeclampsia.[4]

22. Laboratory studies were performed. A Liver Function Test (LFT) revealed markedly elevated liver enzymes with an alanine aminotransferase (ALT) of 709 and aspartate transaminase (AST) of 119.[5] Her glucose was high at 144.[6] Her platelets were normal at 171,000 and her urine was negative for proteinuria.

23. B.W. received a 2 mg magnesium sulfate bolus at 3:10 p.m. as seizure prophylaxis. She was given two doses of antihypertensive agent, hydralazine, 10 mg intravenously at 2:56 p.m. and 3:58 p.m. which was reported by the emergency room physician to have brought her blood pressure down to 150/90 in the emergency department.

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[3] By way of history, B.W., gravida 2, para 1, arbortus 1, began her prenatal care with Kaiser Permanente Medical Group on December 31, 2010. She experienced complications of first-trimester bleeding, emotional stress at work and gestational diabetes, which was classified at GDM A1 (diabetes limited to pregnancy, not previously diagnosed; controlled by diet-alone, not requiring pharmacologic agents).

[4] Preeclampsia is a condition that can occur when a woman has persistent high blood pressure (140/90 or greater) that develops during pregnancy or during the postpartum period that is associated with protein in the urine or the new development of decreased blood platelets, trouble with the kidney or liver, fluid in the lungs, or signs of brain trouble such as seizures and/or visual disturbances. Severe preeclampsia is associated with blood pressure greater than 160/110.

[5] The normal range for ALT is 14-54. The normal range for AST is less than 31.

[6] The normal range for glucose is 70-140.

24. B.W. was admitted to the hospital's obstetrical service. She was maintained on a magnesium sulfate continuous intravenous infusion of 2 grams per hour and started on oral antihypertensive agent, labetalol, 200 mg twice daily.

25. By August 27, 2011, B.W.'s complaints of headache had improved. Her blood pressure had normalized. At 7:00 a.m., her blood pressure was 121/80. At 10:00 a.m., her blood pressure was 121/86. At 1:00 p.m., her blood pressure was 132/86 and at 3:00 p.m., it was 134/89. Her LFT's were trending towards normal with her ALT decreasing to 518 and AST decreasing to 67. In addition, B.W.'s intake and output was well-balanced. At 7:00 a.m., her intake was documented to be 1,000 milliliters and output was 900 milliliters. Over the ensuing 24 hours, her intake was 350 milliliters and output was 750 milliliters.

26. The magnesium sulfate was discontinued at 3:58 p.m. on August 27, 2011 pursuant to the order of Dr. D. L.

27. On August 28, 2011, Respondent assumed B.W.'s hospital care. At that time, B.W. had no further reported symptoms and her laboratory studies continued to trend towards normal with an ALT of 331 and AST of 33. B.W. had been off the magnesium sulfate for nearly 24 hours and denied complaints. Several nursing notes reflected the absence of headache, visual changes and epigastric pain. In her Progress Note however, Respondent documented that B.W.'s blood pressure was 168/91. Respondent did not document whether or not she checked the patient's deep tendon reflexes nor did she document that nursing notes noted normal reflexes on August 28, 2011. Respondent's assessment was postpartum preeclampsia status post 24-hours of intravenous magnesium sulfate for seizure prophylaxis and blood pressure normal on labetalol. Respondent documented that B.W. was stable for discharge. Respondent documented that it was her plan to discharge B.W. home with instructions to follow up with her primary care physician in 2-3 weeks. B.W. was discharged at approximately 2:07 p.m.

28. B.W.'s discharge instructions set forth her future appointments on September 12, 2011 at 10:40 a.m. with Dr. N. T. for blood pressure follow up and on September 23, 2011 with Dr. S. C. She was also instructed to take 1 tablet of labetalol 200 mg twice a day, orally.

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29. At the time of her interview with the Board on June 14, 2016, Respondent stated that it is her "standard of care" to have patients return in two days for a follow up blood pressure check by a nurse. There is no note in the chart reflecting any such instruction for B.W.

30. Later, that same night, at approximately 10:45 p.m., B.W. developed a headache, rated a 10 on a pain scale of 1 to 10. She also had an elevated blood pressure reading at home which prompted her significant other to take her back to the hospital. On the way to Kaiser Permanente South Bay Medical Center, B.W. experienced left-sided facial droop, right-sided weakness, confusion and disordered speech so they stopped at Long Beach Memorial Hospital as it was the closest hospital. She was diagnosed with a large intracranial hemorrhage and was transferred to K.P. Los Angeles Medical Center at approximately 3:00 a.m. on August 29, 2011 for neurosurgical management. At Kaiser Permanente Los Angeles Medical Center it was determined that B.W. had multiple large cerebral hemorrhages bilaterally with midline shift and surgical intervention would not be beneficial. Brain death was confirmed on August 31, 2011.

31. One of the most significant risk factors of stroke in the puerperal period, especially during the first two weeks, is preeclampsia.

A. Preeclampsia is defined as a blood pressure of greater than 140 systolic or greater than 90 diastolic, measured on two separate occasions at least four hours apart.

B. Severe preeclampsia is defined as a blood pressure of greater than 160 systolic or greater than 110 diastolic.

C. In addition to elevated blood pressure, other features associated with preeclampsia include protein in the urine or the new development of decreased blood platelets, trouble with the kidney or liver, fluid in the lungs, or signs of brain trouble such as seizures and/or visual disturbances.

32. Other risk factors of stroke in the puerperal period include headache, impaired consciousness and visual changes.

33. The standard of medical practice in California requires that the obstetrical practitioner promptly and thoroughly evaluate and manage hypertensive disorders during pregnancy and the puerperal period, up to six weeks postpartum.

34. The standard of medical practice in California requires the administration of antihypertensive agents, such as hydralazine, labetalol or nifedipine, within the hour of a severely elevated blood pressure reading, as defined by a systolic blood pressure greater than 160 or a diastolic blood pressure greater than 110.

35. The standard of medical practice in California requires prophylactic treatment with magnesium sulfate, for a minimum of 24-48 hours, in all patients with features of severe preeclampsia.

36. The standard of medical practice in California requires that prior to hospital discharge, a patient diagnosed with preeclampsia be symptom-improved or symptom-free, with blood pressure well-controlled, kidneys diuresed of any increased retained fluid and laboratory values in the normal range.

37. Following a severely elevated blood pressure reading, as defined by a systolic blood pressure greater than 160 or a diastolic blood pressure greater than 110, the standard of medical practice in California requires a repeat blood pressure reading prior to considering hospital discharge.

38. The standard of medical practice in California requires a follow up blood pressure check, scheduled no later than seven days after discharge, for patients diagnosed with preeclampsia.

39. Following the severely elevated blood pressure reading of 168/91, as documented in Respondent's August 28, 2011 Progress Note, Respondent failed to administer an antihypertensive agent, such as hydralazine, labetalol or nifedipine.

40. Prior to discharging B.W. on August 28, 2011, Respondent failed to order frequent surveillance of B.W.'s blood pressure and failed to obtain any repeat blood pressure reading.

41. Respondent's acts and/or omissions as set forth in paragraphs 19 through 40, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

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THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence: Patients J.B. and B.W.)

42. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that she engaged in repeated acts of negligence in her care and treatment of Patients J.B. and B.W. The circumstances are as follows:

43. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 41, above, as though fully set forth herein.

44. Respondent's acts and/or omissions as set forth in paragraphs 8 through 41, above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records as to Patient B.W.)

45. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to her care and treatment of B.W. Complainant refers to and, by this reference, incorporates herein, paragraphs 27, 28 and 29, above, as though fully set forth herein.

46. Respondent's acts and/or omissions as set forth in paragraphs 27, 28 and 29, above, whether proven individually, jointly, or in any combination thereof, constitute the failure to maintain adequate records pursuant to section 2266 of the Code. Therefore cause for discipline exists.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 87346, issued to Nakia Theresa Mainor-Roth, M.D.;

2. Revoking, suspending or denying approval of her authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. If placed on probation, ordering her to pay the Board the costs of probation monitoring; and

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

DATED: August 11, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

LA2017504200