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

In the Matter of the Accusation Against: ARTHUR M. PARK, M.D. 2502 Tiverton Drive Bakersfield, California 93311 Physician's and Surgeon's Certificate No. A 44597, Respondent.	Case No. 800-2016-026837 **A C C U S A T I O N**

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 (Board).

2. On March 21, 1988, the Board issued Physician's and Surgeon's Certificate Number A 44597 to Arthur M. Park, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. 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.

"(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."

5. 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 any 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.

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

6. 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)

7. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code for gross negligence in the care and treatment of Patient 1.[1] The circumstances are as follows:

8. Respondent was the on-call Obstetrician / Gynecologist at the Adventist Health Joaquin Community Hospital (hospital) on September 6, 2016. Patient 1 was 23 years old at the time. She already had two children and was about to have her third. At approximately 38.5 to 41.1 weeks gestation, Patient 1 came to the hospital, at approximately 3:00 a.m. on September 6, 2016, reporting that she had a spontaneous rupture of membranes approximately 54 hours previously. She was leaking amniotic fluid and was having mild intermitted labor contractions. Patient 1 had a history of limited prenatal care during this pregnancy. She was admitted to Respondent's care in the hospital's labor and delivery department.

9. Patient 1's initial triage assessment by the labor and delivery nurse revealed that she was progressing appropriately. Respondent was notified by phone of the patient's status and he gave admission orders, which included prenatal lab assessment and group B strep antibiotic prophylaxis. The nursing staff reassessed the patient's cervical exam within an hour of admission and found that her labor was steadily progressing, and her baby showed no signs of distress. Contractions were reported to be moderate in intensity. Approximately one hour later, the patient received an epidural for labor analgesia and a Foley catheter was inserted. The patient's vital signs remained stable and within a normal range; her labor continued to steadily progress, and her baby had no complications.

10. Respondent first examined Patient 1 at approximately 8:06 a.m. He recorded her history and physical examination on a handwritten form. Respondent recorded a history of no prenatal care, two normal spontaneous vaginal deliveries and a history of spontaneous rupture of membranes. The physical exam showed a fundal height of 37 cm, estimated fetal weight of 7.5

[1] The patient is referred to as Patient 1 to protect her privacy. The true identity of the patient is known to the Respondent or will be made known to him in response to a Request for Discovery.

pounds, fetal heart rate 140 beats per minute and uterine contractions five minutes apart. Respondent's history and physical examination were inadequate, as he left many portions of the form blank. The patient's history and physical examination, as recorded by Respondent, lacked appropriate detail and documentation concerning the patient's present clinical situation, such as duration of ruptured membranes, the color of amniotic fluid, onset of contractions, intensity of contractions, presence of fetal movement, or his assessment of gestational age. The document also lacked an assessment and documentation of the patient's past obstetric history. Respondent did not inquire about and/or did not record information about past complications such as postpartum hemorrhage or retained placenta, a record of any prenatal care, or maternal drug or alcohol use. The assessment document prepared by Respondent also lacked a record of a complete physical exam and omitted vital signs, a detailed assessment of abdominal findings such as uterine tenderness, baseline fetal heart tones, fetal heart rate variability, periodic decelerations, frequency, duration and intensity of uterine contractions. Respondent's history and physical form also lacked detailed information concerning clinical pelvimetry and cervical examination. Respondent did not consider and/or made no note of the fact that admitting laboratory studies were available for review and showed that the patient was anemic with a hemoglobin of 8.4 gm/dL. Respondent's handwritten history and physical form also lacked proper assessment and a detailed plan of the patient's management and did not address prolonged rupture of membranes, unknown group B strep carrier status and maternal anemia. Respondent then left the hospital.

11. At approximately 11:00 a.m., the patient was noted to have a category II fetal heart rate tracing. The nursing staff appropriately performed uterine resuscitative measures, and the problem resolved. The nursing staff notified Respondent by telephone, but he made no record of this event and did not come to the hospital to monitor the patient's fetal heart rate more closely.

12. At noon, the patient was fully dilated, with 100% effacement and at zero station. Respondent was notified that Patient 1 was ready to deliver her baby by a telephone call to his home. Respondent arrived at the patient's bedside at 12:21 p.m., and helped deliver a healthy baby girl by normal spontaneous vaginal delivery at 12:28 p.m. On Respondent's orders, Pitocin infusion was started after the delivery. The placenta remained in Patient 1's uterus.

13. Respondent then extracted the placenta. He dictated a procedure note, which described the removal of the placenta as follows:

> "The patient's umbilical cord was noted to be coming loose from the placenta after a gentle pull; therefore, no further pulling is done at this time. Before this, cord blood was obtained. The patient's fundus is massaged, but the patient is complaining of tenderness, and then there is moving in her tummy from the umbilicus to the right side of her abdomen freely without any further bleeding. After gentle massaging, there is noted to be bleeding from what was thought to be placental attachment. The ring forceps were used to grasp the lower part of the placenta with no avail. After approximately 10 minutes, the patient was informed that I would do manual removal. After this was attempted, the placenta is not reachable at this time and the procedure is promptly discontinued. Further massaging of the fundus is performed. After several attempts to grasp the placenta with ring forceps which the patient was not tolerating very well because the patient appeared agitated, this was discontinued. After further bleeding, the patient was informed sometime later that an additional attempt at manual extraction would be attempted. The second attempt was successful. The lower part of the placenta was grasped and pulled, resulting in delivery of a complete placenta which did not appear to have any abnormalities. The fundus is firm with minimal bleeding thereafter with a total blood loss of approximately 150 ml."

The labor and delivery nurse recorded that the placenta was delivered by manual extraction at 12:36 p.m.

14. Thus, Respondent, within several minutes after the delivery of the baby, attempted to deliver the placenta without observing or documenting the usual signs of placental separation. Respondent's initial attempts at placental delivery were by increased cord traction and uterine massage. Respondent incorrectly managed this patient as if she had a retained placenta, with attempts at manual and instrument removal of placenta. Respondent removed the placenta less than 30 minutes after the delivery of the baby when there was no indication of, or a recorded reason for, the need for the placenta to be rapidly extracted.

15. Respondent did not wait for 30 minutes prior to attempting to extract the placenta, nor did he stop the Pitocin infusion or give the patient medication to relax the myometrium and cervix to facilitate placental delivery. During an attempt to manually remove the placenta, Respondent noted that the cervix was contracted, an indication to consider stopping the Pitocin infusion or giving medication to relax the patient's myometrium and cervix, yet Respondent did not consider doing so, or record any such consideration. The nursing staff documented that during the placental extraction, the patient was screaming in pain and moving around in bed, and in his note

Respondent described her as "agitated," and did not consider or record consideration summoning the anesthesiologist to add medication to the patient's epidural infusion prior to attempting to extract the placenta. Respondent proceeded to attempt an instrument delivery of the placenta, despite the patient having a contracted cervix, without adequate pain control, and without ultrasound guidance. Respondent did not perform and did not document a thorough post extraction examination of the patient's uterus, cervix, vaginal or perineum tissue for injuries.

16. Within approximately a half hour after Respondent removed the placenta, the patient's vital signs began to deteriorate, and she began to show signs of shock. At approximately 12:50 p.m., she had a pulse of 100 and blood pressure of 65/34, with pulse oximetry of 98%. Respondent was notified of the low blood pressure and was asked to come to the patient's bedside by the nursing staff. Respondent did not observe frank vaginal bleeding and made no orders at that time. His uterine examination revealed the uterus to be firm and in the midline with minimal lochia rubra. At approximately 12:55 p.m., the nurse recorded that she had difficulty assessing the patient's blood pressure and was unable to record a reading. After the blood pressure cuff was readjusted, the patient's blood pressure was noted to be 68/33 with a pulse rate of 90 and pulse oximetry of 98%. At 1:06 p.m., Respondent was notified by telephone of the decreased blood pressure, the patient's pallor and her decreased level of consciousness. Respondent made no orders at that time. At 1:07 p.m, Respondent was at the nurse's station and was again informed of the patient's low blood pressure by the nursing staff who asked him to come to the patient's room to reevaluate her. At 1:09 p.m., Respondent reevaluated the patient with fundal massage with the fundus noted to be firm and at the umbilicus and noted scant vaginal bleeding. Respondent made no orders at this time. At 1:14 p.m., the patient's blood pressure remained low, and the patient was noted to be pale; Respondent who was at the nurse's station was asked to come back once again and reevaluate the patient. Within one minute, Respondent was at the bedside reevaluating the patient, whose pulse was 93, blood pressure was 50/26, and pulse oximetry was 100%. She was conscious but pale and denied difficulty with breathing; fundal exam was recorded as firm with scant vaginal bleeding. Seeing no blood, Respondent did not order ultrasound imaging of the patient's abdomen, did not order any blood transfusions or any other life-saving resuscitative

measures. He ordered that a one-liter LR bolus be administered. At a later interview with the Board's investigators, he explained that he did not believe that the patient was hemorrhaging at all, and based on the procedure that he did, he had no reason to believe that he perforated the patient's uterus in any manner.

17. At 1:23 P.M., the patient's pulse rate was 88, blood pressure was 73/37, pulse oximetry was 98%, her temperature was 97.6. Repeat evaluation at 1:30 p.m. revealed her pulse at 100, blood pressure 74/39, and pulse oximetry 97% with the fundal exam unchanged. The patient's medical record notes that the charge nurse was at the patient's bedside at 1:29 p.m. The labor and delivery nurse noted at 1:30 p.m., "M.D. out of the room, per M.D. bleeding is fine."

18. Respondent failed to take appropriate notice of clinical signs suggestive of ongoing hemorrhage when he was or should have been, aware of the patient's tachycardia, hypotension, and changes in the patient's level of consciousness. The standard of care dictates that hemodynamic instability in any postpartum patient, with or without observed vaginal bleeding, should have prompted Respondent to consider uterine rupture and/or intra-abdominal bleeding. Respondent did not perform a proper historical assessment, physical exam or laboratory studies to aid in the diagnosis of this patient's hypovolemic hemorrhagic shock. Respondent failed to recognize that he had inadvertently perforated the uterus at the time of instrument delivery of the placenta. In the immediate postpartum Respondent did not recognize that the patient was in shock with deterioration of maternal vital signs out of proportion to the vaginal bleeding that he observed. Respondent failed to rule out intraperitoneal or retroperitoneal bleeding. Respondent did not perform and/or document a thorough physical examination of the patient that would have aided in differentiating the type of shock the patient was suffering. Despite his lack of a diagnosis, Respondent did not initiate immediate life-saving resuscitative measures or emergent laboratory studies and did not perform any further diagnostic assessment such as an ultrasound evaluation.

19. At 1:44 p.m., a rapid response team was called by the nursing staff, and immediately responded to the patient's bedside. Respondent, who at the time was downstairs talking to his partner, trying to figure out what might be happening to Patient 1, was notified by telephone by

the ICU nurse who suggested that an intensivist should be called to assist in the care of this patient. The intensivist arrived at Patient 1's bedside at 1:53 p.m. and immediately ordered aggressive resuscitation.

20. The intensivist spoke to Respondent, who informed him that there was no excessive bleeding at the time of the delivery, and Respondent could not explain the source of the patient's severe anemia. The intensivist's note, which was written at 2:43 p.m., indicated that the "patient could be suffering from amniotic fluid embolism since as per the report, the patient did not lose much blood during vaginal delivery, no amniotic fluid was seen and there was a problem with placenta removal." At 3:12 p.m., Respondent wrote a progress note, which describes that the patient had been transferred to the ICU and care had been accepted by the intensivist. He reported that the patient's condition had deteriorated and her presumptive diagnosis was amniotic fluid embolism. The notation does not include any further history, physical examination, laboratory studies, assessment or suggested management plan.

21. After Patient 1 was transferred to the intensive care unit, despite aggressive attempts to resuscitate her, she suffered two cardiac arrests and was eventually pronounced dead at 7:50 p.m. The patient's autopsy revealed extensive laceration of the lower uterine segment and cervix and concluded that she died of postpartum hemorrhage due to traumatic laceration of uterus and cervix during forceps application and manual extraction during labor and removal of the placenta, though trauma caused during childbirth and delivery could not be excluded.

22. Each of the following, taken together or separately, constitutes an extreme departure from the standard of care by Respondent:

(a) Respondent did not wait the appropriate 30 minutes before attempting removal of the patient's placenta.

(b) Respondent did not stop the Pitocin infusion or give the patient medication to relax the myometrium and cervix to facilitate placental delivery despite noting that the patient's cervix was contracted.

(c) Respondent inappropriately proceeded to attempt an instrument delivery of the placenta without ultrasound guidance.

(d) Respondent inappropriately proceeded to attempt to deliver the placenta without appropriate pain management.

(e) Respondent did not perform and/or document a thorough post extraction examination of the issue uterine, cervix, vagina or perineum for lacerations or bleeding.

(f) In the immediate postpartum, Respondent did not recognize that the patient was in shock with deterioration of maternal vital signs well out of proportion to the observed vaginal bleeding.

(g) Respondent did not perform and/or document an appropriate assessment, physical exam or laboratory studies to aid in the diagnosis of the shock symptoms apparent in Patient 1.

(h) Respondent made an incorrect presumptive diagnosis of amniotic fluid embolism, a rare condition, without ruling out more common causes of shock.

(i) Respondent did not initiate immediate life-saving resuscitative measures despite the patient's symptoms consistent with post-partum hemorrhage.

(j) Respondent improperly delayed calling the hospital's rapid response team.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

23. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts in the case and treatment of Patient 1. The circumstances are as follows:

24. The allegations of paragraphs 8 through 22 are incorporated herein by reference. In addition to the allegations in paragraph 22 (a) through (j), the respondent further departed from the standard of care as follows:

(k) Respondent inadequately documented the patient's history and physical examination and the patient's progress through labor.

(l) Respondent incorrectly diagnosed a retained placenta.

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THIRD CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

25. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section 2266, in that failed to keep adequate or accurate medical records of his care and treatment of Patient 1. The circumstances are as follows:

26. Allegations of paragraphs 8 through 22 and paragraph 24 are incorporated herein by reference.

DISCIPLINARY CONSIDERATIONS

27. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about October 18, 2000, in a prior disciplinary action entitled In the Matter of the Accusation Against Arthur M. Park, M.D. before the Medical Board of California, in Case Number 08-1997-76654, Respondent's license was revoked, but the revocation was stayed, and Respondent's license was placed on probation for a period of three years, with various terms and conditions. That decision was based on Respondent's admission that in delivering obstetrical care to two patients in 1996 and 1997 he committed repeated negligent acts in violation of Business and Professions Code section 2234, subdivision, (c). That decision is now final and is incorporated by reference as if fully set forth herein.

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 44597, issued to Arthur M. Park, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advance practice nurses;

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

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

DATED: August 14, 2019

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

Complainant

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