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

In the Matter of the First Amended Accusation Against: Elias N. Moukarzel, M.D. Physician's and Surgeon's Certificate No. C 50303 Respondent.	Case No.: 800-2017-034242

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 January 14, 2022.

IT IS SO ORDERED: December 15, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D. , Chair
Panel B

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

In the Matter of the First Amended Accusation Against:

ELIAS N. MOUKARZEL, M.D.,

Physician's and Surgeon's Certificate No. C 50303,

Respondent

Case No. 800-2017-034242

OAH No. 2020060920

PROPOSED DECISION

Adam L. Berg, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by telephone/videoconference on August 2 through 5, 2021.

Karolyn M. Westfall, Deputy Attorney General, Department of Justice, State of California, represented complainant, William Prasifka, Executive Director, Medical Board of California, Department of Consumer Affairs, State of California (board).

Robert W. Frank, of Neil, Dymott, Frank, McCabe & Hudson, represented respondent Elias N. Moukarzel, M.D.

Oral and documentary evidence was received, and the matter submitted on August 5, 2021.

FACTUAL FINDINGS

Background

1. On September 16, 1999, the board issued Physician's and Surgeon's Certificate No. C 50303 to respondent. There is no history of discipline imposed against respondent's certificate.

2. On May 12, 2021, complainant signed the First Amended Accusation (accusation) alleging respondent committed gross negligence and repeated negligent acts with regards to the care of Patient A and Patient B; demonstrated incompetence in the care for Patient A; and failed to maintain adequate/accurate records regarding Patient B. Complainant seeks the revocation or suspension of respondent's certificate.

3. Respondent timely filed a notice of defense. This hearing ensued.

Respondent's Background

4. Respondent obtained his medical degree from the State University of New York at Stony Brook in 1986. He completed two years of a general surgical residency followed by a one-year clinical fellowship in urology at Montefiore Medical Center. He worked one year in an emergency room and returned to Montefiore where he completed 3.5 years of a urology residency program. However, he was not permitted to complete the program in order to sit for the boards. He worked one year in the emergency room before completing a four-year residency program in obstetrics and gynecology (OB-GYN) at Bronx Lebanon Hospital, within the Albert Einstein

School of Medicine. Following residency, he was recruited to join a medical group of two other OB-GYNs in El Centro who would be retiring soon. He ended up taking over the practice. In 2002, he became board certified in OB-GYN and has maintained his certification. In 2014 he became board certified in female pelvic medicine and reconstructive surgery. In 2007, respondent became chairman of the OB-GYN department at El Centro Regional Medical Center (ECRMC). Since then, he has held various leadership positions including chair of the bioethics committee, two terms as Vice Chief of Staff, and two terms of Chief of Staff. He is currently on the Medical Executive Committee. He is a member of several national and local professional organizations. He has held leadership positions with the California Medical Association and Imperial County Medical Society.

The Board's Expert Douglas Fenton, M.D.

5. Douglas Fenton, M.D., received his medical degree from the University of Colorado in 1982. He completed an internship and residency OB-GYN at the University of California, San Diego (UCSD). He is board certified in OB-GYN. After completing his residency in 1986, he founded an OB-GYN medical group, which he ran until 2010. In 2010, he joined Scripps Coastal Medical Center and has served as OB-GYN department head, laboratory director, and sits on the board of directors. He also works at Scripps Memorial Hospital Encinitas and has served as medical director for several departments including maternal child health, advanced gynecologic surgery, and the hospitalist program. Since 2015, he has been chairman of the OB-GYN department. He also holds hospital privileges at UCSD as an assistant clinical professor. His full-time practice is split evenly between obstetrics and gynecology patients. He sees approximately 80 patients and performs from 2 to 10 deliveries per week. He has served on several quality improvement committees for various hospitals and

institutions. He is a member of several national and local medical associations and has served on several committees for the American College of Obstetrician-Gynecologists (ACOG). He has been involved in multiple clinical research studies. For the past four years, Dr. Fenton has been an expert reviewer for the board. He has reviewed approximately 15 cases for the medical board.

Respondent's Expert Stephen DiMarzo, M.D.

6. Stephen DiMarzo, M.D., received his medical degree from the University of Rochester in 1980. In 1984, he completed an internship and residency in OB-GYN at UCSD, where he was chief resident. Since then, he has worked for Scripps as a general OB-GYN. He has hospital privileges at Scripps La Jolla Hospital and Green Hospital, where he has served on multiple committees and held leadership positions, including Vice-Chair of OB-GYN at Green Hospital. He is also an assistant clinical professor and holds privileges at UCSD. Dr. DiMarzo is board certified in OB-GYN. He is a member of several national and local medical associations, and has served on several committees and leadership positions, including for ACOG. He has served as an expert reviewer for the board many years ago.

Patient A

7. The following summary is based on the patient's medical records: Patient A was 41 years old and 36-and 2/7-weeks' gestational age when she was admitted to ECRMC on January 30, 2014, by the on-call physician, Stephen Gocke, M.D. Dr. Gocke had concerns of pregnancy-induced hypertension and preeclampsia.[1] Dr. Gocke's plan

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[1] Preeclampsia is the onset of hypertension in pregnancy associated with proteinuria (protein in the urine). A blood pressure in excess of 140 mm Hg systolic

was to monitor the patient overnight, whose blood pressure on several readings was recorded over 160 systolic. Labs revealed a normal platelet count of 162,000.

8. The following morning, Patient A's care was assumed by Marisel Chibas, M.D. Throughout the day, the patient's blood pressure remained labile, ranging from 137/78 to 183/91. Urinalysis indicated proteinuria. Dr. Chibas ordered continued observation and repeated labs. Multiple blood pressure readings measured a systolic pressure greater than 170. Dr. Chibas did not provide any treatment for the patient's hypertension. Instead, she ordered repeat labs and observation. When Dr. Chibas met with the patient, she discussed the possibility of inducing labor if there was a worsening of her preeclampsia.

9. On February 1, 2014, at 6:06 a.m., the patient's blood pressure was 160/79. Labs ordered by Dr. Chibas showed a platelet count of 130,000. At approximately 8:30 a.m., respondent assumed care of Patient A. Respondent documented the following: "Patient has been here for two days being evaluated for pre-eclampsia!! Today, her pre-eclampsia is getting worse since her platelet count is getting low indicating worsening pre-eclampsia." Respondent ordered induction of labor due to "intrauterine growth retardation; preeclampsia-PIH-eclampsia." The

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and/or 90 diastolic confirmed by another pressure reading four hours after the first. Preeclampsia "with severe features" (severe preeclampsia) occurs when a blood pressure is greater than 160 systolic and/or 110 diastolic on two occasions or any of the following: platelet count below 100,000, impaired liver function greater than twice normal, renal insufficiency, severe upper right quadrant abdominal pain; and neurological symptoms such as headache unresponsive to medication or visual disturbance.

patient's blood pressure was 190/96 at 9:56 a.m., 171/98 at 10:02 a.m., 185/92 at 10:06 a.m., 166/82 at 10:11 a.m., 159/83 at 10:16 a.m., 153/82 at 10:20 a.m., and 153/84 at 10:30 a.m.

10. At 10:26 a.m., the patient was administered medication for cervical ripening (i.e. dilation). At 11:01 a.m., the blood pressure was 166/87, and at 11:17 a.m., was 155/84. Her blood pressure remained in the high 150s systolic and high 80s diastolic until 1:57 p.m., when it was 174/93. The pressure was 165/87 at 2:26 p.m., 176/96 at 2:55 p.m., but dropped to 154/85 at 3:26 p.m., and remained elevated but not severe.

11. A nursing note at 4:53 p.m., indicated that a telephone report was given to respondent reporting the blood pressure trend, lab results, patient status, and medication administration. Respondent ordered 25 mcg of Cytotec,[2] a medication used to further ripen the cervix. The nurse also reported the patient complained of a frontal headache, for which respondent ordered Tylenol. At 5:26 p.m., the nurse confirmed the order to administer Cytotec because uterine contractions were every four to seven minutes. Respondent confirmed the order to administer 25 mcg of Cytotec. At 7:15 p.m., respondent was present at the nurses' station and reviewed the fetal monitor and urine output.

12. The patient's blood pressure was recorded at 144/84 at 6:44 p.m., 160/91 at 7:56 p.m., 161/91 at 8:25 p.m., 165/86 at 8:55 p.m., 164/87 at 9:26 p.m., 155/83 at 9:56 p.m., and 161/89 at 10:25 p.m.

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[2] Cytotec, the trade name for misoprostol, is FDA-approved for the treatment of ulcers, but commonly used off-label as a cervix ripening agent.

13. At 10:20 p.m., contractions were noted at every two to six minutes and the fetal heart rate (FHR) was identified as "category 1." At that time, 50 mcg of Cytotec was administered and Tylenol administered soon after for headache. Blood pressure was measured at 158/88 at 10:55 p.m., 167/91 at 11:27 p.m., 168/93 at 11:55 p.m., 178/92 at 12:25 a.m., 146/78 at 12:55 a.m., 141/79 at 1:25 a.m., and 147/81 at 1:56 a.m.

14. At 1:46 a.m., the nursing notes indicated an FHR with minimal to undetectable variability and prolonged deceleration. At 2:05 a.m., respondent was notified of the deceleration and at 2:08 a.m., respondent was with the patient and ordered her taken to the delivery room for emergency cesarian section (C-section). At 2:27 a.m., the anesthesiologist arrived, but the patient was completely dilated and ordered to push. The patient delivered at that time, with the placenta delivered minutes later.

15. Respondent massaged the patient's fundus and ordered 250 mcg of Hemabate[3] at 2:30 a.m. At 2:53 a.m., it was noted that the patient continued to bleed heavily despite continued fundus massage. Respondent ordered additional Hemabate. At 3:00 a.m., it was noted that the fundus massage was done, but the patient continued to bleed heavily, including from the mouth and teeth. Respondent ordered to type and crossmatch four units of packed red blood cells and ordered hematology labs. The patient continued to bleed heavily despite continued fundus massage. At 3:30 a.m., respondent ordered the patient transfused with three units of red blood

[3] Hemabate, is a hormone-like substance, is used to treat postpartum bleeding.

cells. Labs showed platelets of 113,000, fibrinogen at 130, and an INR of 4.2.[4] At 3:54 a.m., respondent ordered Methergine.[5] A nurse from the emergency room came to assist with the transfusion. At 3:55 a.m., respondent informed the patient that because she continued to bleed heavily vaginally and from her mouth, she needed a hysterectomy, for which the patient consented. At 4:00 a.m., one unit of red blood cells was transfused. Respondent, who was present with the anesthesiologist, ordered the operating room team to be called. Respondent ordered the hysterectomy to be performed in the delivery room because the patient was unstable to move to the operating room (OR).

16. At 4:35 a.m., respondent began a laparotomy and supracervical hysterectomy. According to respondent's operative report, over one liter of blood was found in the abdominal cavity and her uterus was boggy. Respondent estimated that approximately two liters of blood had been lost. Respondent indicated that

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[4] The medical records are not clear regarding what time the labs were reported. The laboratory records submitted into evidence were unorganized, with many pages apparently missing. A summary of the patient's lab results during her hospitalization indicates the fibrinogen and INR were measured at 3:44 a.m. (Exh. 10, p. A167.) There is no corresponding lab report in evidence showing whether this was the time the sample was obtained, or the results reported. The same report shows a platelet count of 113,000 at 2:55 a.m. (*Id.* at p. A172.) However, a corresponding lab report indicates that the sample was collected at 2:55 a.m., "received" at 3:23 a.m., and the report printed at 4:08 a.m. (*Id.* at p. A1212.) Thus, it appears that the identified times are the collection times and not when this information was reported.

[5] Methergine is an oxytocic used to treat postpartum hemorrhage.

disseminated intravascular coagulation (DIC)[6] was suspected to be a factor. The operating room team arrived at 5:25 a.m., shortly before the procedure was finished at 5:39 a.m.

17. After the procedure, the patient was transferred to the intensive care unit (ICU) where she developed hemorrhagic shock, severe leukocytosis secondary to sepsis, and abdominal compartmental syndrome. She was airlifted to UCSD Medical Center on February 5, 2014, for higher level of care.

18. The board's investigation report was not submitted as evidence; however, based on respondent's deposition and subject interview, the board was informed of the allegations regarding Patient A pursuant to a report of settlement as required under Business and Professions Code section 801.01.

DR. FENTON'S REPORT AND TESTIMONY

19. The board requested Dr. Fenton review the care provided for Patient A and determine whether there were any departures from the standard of care. Dr. Fenton prepared a report summarizing his findings and testified at hearing. The following is a summary of Dr. Fenton's report and testimony:

20. Dr. Fenton defined the standard of care as the skill and knowledge of care of other reasonably prudent physicians in similar circumstances. He described an extreme departure from the standard of care as the "want of scant care." Anything short of this constitutes a simple departure.

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[6] DIC is a series of processes that occur resulting in the depletion of the coagulation system, which can result in system wide bleeding, deteriorating into hypovolemic shock.

21. Dr. Fenton is very familiar with the treatment of preeclampsia. The standard of care in treatment of preeclampsia is gestational-age dependent. Currently, the recommendations are to induce labor at a gestational age greater than 37 weeks. For preeclampsia with severe features, the patient should be managed until 34 weeks and then delivered. The standard of care requires treatment of preeclampsia with severe features with antihypertensive medication within minutes of a blood pressure exceeding 160 systolic. There is significant association with severe hypertension and hemorrhagic stroke, requiring immediate treatment. The standard of care requires treatment of preeclampsia with severe features by administering blood pressure medication. Inducing delivery, without treating the hypertension, is not within the standard of care.

22. Dr. Fenton believed respondent lacked skill and knowledge in diagnosing severe preeclampsia. For the previous 24 hours, where the patient had been under the care of Dr. Chibas, she had multiple blood pressure readings greater than 160 systolic, meeting the criteria for severe preeclampsia. In reviewing respondent's note upon assuming care of the patient, respondent indicated the patient's preeclampsia was worsening because of a decreasing platelet count. Respondent, in a deposition taken in conjunction with a civil suit brought by Patient A, also stated that the indication for delivery was a falling platelet count.[7] Dr. Fenton noted that the patient's platelet count fell from 150,000 to 130,000. However, the definition of severe preeclampsia requires a platelet count less than 100,000. Thus, while respondent acted appropriately to induce

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[7] The deposition transcript was received as evidence. Respondent was asked why the patient's treatment for preeclampsia required delivery. He responded that her platelet counts were going down, which was a sign of worsening preeclampsia, her advanced maternal age, and she was almost at term at 36 weeks.

the patient due to severe preeclampsia, it was due to the blood pressures exceeding 160 systolic in addition to proteinuria, not the platelet count. Accordingly, Dr. Fenton believed that by only indicating a decrease in platelet count (which was not in the range for extreme preeclampsia) and not documenting that the patient's blood pressures were in the severe range, respondent lacked skill and knowledge in diagnosing severe preeclampsia.

On cross-examination, Dr. Fenton agreed that Dr. Chibas should have induced the patient. Dr. Fenton agreed that respondent's initial note containing two explanation points reflected that respondent was displeased that the patient had not already been induced. The first step respondent took when assuming care of the patient was to begin inducing labor. In his report, Dr. Fenton opined that respondent appropriately ordered induction because of severe preeclampsia; however, he lacked knowledge, i.e., was incompetent, because he only documented the decreasing platelets and not the blood pressures, which were the basis for the severe preeclampsia diagnosis. Dr. Fenton testified that his opinion that respondent lacked knowledge about the treatment of preeclampsia was also based on respondent's failure to order blood pressure medication to treat the patient's severe preeclampsia. Dr. Fenton agreed that this was not included in his report, and he could have been more specific.

23. Dr. Fenton believed that respondent's failure to administer blood pressure medication after multiple indications to do so constituted an extreme departure from the standard of care because respondent provided no care or treatment for the condition. He had multiple opportunities to order medication but did not. At multiple point throughout his care of the patient, the patient had systolic blood pressures exceeding 160, with several greater than 180. Two readings of systolic

pressures exceeding 160, ideally taken within 15 minutes apart, constitute a hypertensive emergency, and the standard of care is to treat it with blood pressure medication. In his admission orders, respondent did not write for blood pressure parameters to treat with blood pressure medication. This would provide nursing staff with the ability to immediately administer blood pressure medication when the patient's blood pressure reached an extreme level. Respondent should have been aware of the patient's high blood pressures and made appropriate orders for treatment with medication. At no time before delivery did Patient A receive any blood pressure medication despite sustained and elevated blood pressures. Failing to treat this condition created a significant risk for cerebral hemorrhage, infarction, and maternal death. Additionally, the patient developed a headache, which could be a harbinger of impending hemorrhagic stroke.

Dr. Fenton reviewed the report prepared by respondent's expert, Dr. DiMarzo. Dr. Fenton and Dr. DiMarzo are friends and colleagues at Scripps. Dr. Fenton highly respects Dr. DiMarzo but disagreed with him that this was a simple departure from the standard of care. Dr. Fenton believed it was more than a simple departure because respondent provided no treatment and rendered no care in terms of treating the hypertension.

24. Dr. Fenton believed that the administration of 50 mcg of Cytotec at 10:20 p.m. was an extreme departure from the standard of care. Cytotec is associated with uterine hyperstimulation. If contractions become too frequent, then the fetus cannot obtain enough oxygen, a condition called tachysystole, which can lead to fetal acidosis. Tachysystole is defined as five or more contractions in a 10-minute period. Dr. Fenton believed that the first administration of 25 mcg of Cytotec was within the standard of care. However, at 10:20 p.m., contractions were every two to six minutes,

which required vigilance to ensure the fetus was not compromised. Dr. Fenton reviewed the fetal heart monitor strips and believed the fetus was already showing signs of tachysystole. At 10:40 p.m., 50 mcg of Cytotec was administered. This resulted in prolonged decelerations and placed the fetus at high risk for compromise. A little more than an hour later, the patient was placed on 10 liters of oxygen to assist with perfusion to the fetus.

Doubling the dose of Cytotec, where contractions were every two to six minutes, constituted an extreme departure from the standard of care. Dr. Fenton disagreed with Dr. DiMarzo that this was a simple departure from the standard of care because no reasonably prudent specialist would double the dose of Cytotec when the fetus had tachysystole. Had respondent administered 25 mcg instead of 50 mcg, he might have found it to be a simple departure. The fact that he doubled the dose led him to conclude that it was an extreme departure.

On cross-examination, Dr. Fenton admitted that the fetal heart tracing at 10:10 p.m. was not reflected in the nursing notes, which reflected contractions every two to six minutes, which is not tachysystole. Additionally, the nursing notes indicate a category 1 fetal heart tracing, indicating the fetus was obtaining enough oxygen. However, the actual fetal heart tracing strips showed in fact the fetus was in tachysystole and was not a category 1 strip. Dr. Fenton agreed that it was reasonable for respondent to rely on the information he was being provided by the nursing staff. Based on the information indicated in the nursing notes, if respondent had been provided this information, and he was assured that respondent inquired about the fetal heart monitor status, he would categorize it as a simple departure because it was still not reasonably prudent to order 50 mcg where contractions were every two to six minutes.

25. Finally, Dr. Fenton concluded that respondent's handling of the patient's postpartum hemorrhage was an extreme departure from the standard of care. In his career, Dr. Fenton has treated over 1,000 patients with postpartum hemorrhage. It is a relatively common condition, and Dr. Fenton would expect respondent to provide appropriate treatment, even in a resource-limited facility such as ECRMC. Dr. Fenton noted that rapid labor and preeclampsia were significant risk factors for postpartum hemorrhage, which is a leading cause of maternal death. In response to the hemorrhage, respondent provided uterine massage and administered oxytocin, Hemabate, and Methergine. All of these were appropriate measures. However, Dr. Fenton believed respondent should have undertaken additional measures prior to surgery such as uterine packing, bimanual compressions, and using a Foley catheter balloon to attempt a tamponade of the bleeding.[8]

However, Dr. Fenton's primary criticism of respondent was that respondent elected to perform an exploratory laparotomy and subsequent hysterectomy without adequately assessing and addressing the patient's clotting ability. Dr. Fenton believed that surgery should have been deferred until the patient's coagulopathy (impaired ability of blood to clot) was addressed. Respondent did request labs, which showed a low platelet count of 113,000 (taken at 2:55 a.m.), fibrinogen of 130, and an INR[9] of 4.2 (taken at 3:44 a.m.). Dr. Fenton believed the labs and clinical picture at the time

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[8] Dr. Fenton also cited the use of a Bakri balloon, which is designed to assist with postpartum bleeding. However, Dr. Fenton accepted respondent's assertion that in 2014, ECRMC did not have this product.

[9] INR stands for International Normalized Ratio, a measure to determine blood clotting. A value of 1.0 is normal.

showed the patient was coagulopathic. At 3:00 a.m., the patient continued to bleed, including bleeding from the mouth. Bleeding from the mouth is another indicator of coagulopathy. Respondent appropriately ordered three units of red blood cells, but he did not order fresh frozen plasma (FFP), cryoprecipitate, or platelets. These are blood products that aid with clotting. Dr. Fenton believed that respondent should have received three units of FFP along with the red blood cells, and the failure to administer additional blood products was a departure from the standard of care. Dr. Fenton acknowledged that FFP requires approximately 30 minutes to thaw before it can be administered.

Dr. Fenton believed respondent should not have been surgically treated until the coagulopathy was addressed because by its nature, surgery causes increased bleeding and increased coagulopathy. There is a simple bedside test for assessing coagulation, which involves collecting a blood sample in a "red cap" tube, taping it to the wall, and seeing if it coagulates. He believed that respondent departed from the standard of care in proceeding with surgery without first addressing the coagulopathy. Dr. Fenton noted that ultimately, a hysterectomy might have been the appropriate intervention, but respondent should have first addressed the coagulopathy by administering additional blood products. In this case, performing a hysterectomy was not appropriate because of the associated blood loss.

Finally, Dr. Fenton criticized respondent's use of a Pfannenstiel incision instead of a midline incision. He explained that a Pfannenstiel incision, which is a horizontal incision, is the preferred incision in a normal patient without coagulopathy. However, this incision is associated with more bleeding, and in a coagulopathic patient, a vertical midline incision is preferable because of the decreased bleeding. Dr. Fenton also believed that other procedures, such as uterine artery ligation could have been

attempted before performing a supracervical hysterectomy, which itself can result in significant blood loss.

Dr. Fenton disagreed with Dr. DiMarzo's belief that there is a different standard of care for a rural community hospital such as ECRMC and a metropolitan tertiary care facility. There is one standard of care. Working in a resource-limited area requires the physician to be even more vigilant. Postpartum hemorrhage is a common problem, and it is important for physicians in low-resource areas to understand how to properly manage it and provide proper transfusion protocols. In this case, platelets would have been available.

In sum, Dr. Fenton believed that there were a cascade of multiple deficiencies including failure to address the patient's coagulopathy by administering FFP and platelets; the failure to attempt other physical measures such as uterine packing or the use of a Foley balloon; proceeding with a laparotomy and hysterectomy before addressing coagulation; and the type of incision used warranted his conclusion that respondent committed an extreme departure from the standard of care in his management of respondent's postpartum hemorrhage.

TESTIMONY AND REPORT BY DR. DIMARZO

26. Respondent requested Dr. DiMarzo review the case documents and address the findings in Dr. Fenton's report. Dr. DiMarzo prepared a report summarizing his findings and testified at hearing. The following is a summary of Dr. DiMarzo's report and testimony.

27. Dr. DiMarzo identified the standard of care as the care rendered by a reasonably trained physician under similar situations. Preeclampsia is a very common condition. Dr. DiMarzo identified the same criteria indicated by Dr. Fenton for the

diagnosis of preeclampsia and preeclampsia with severe features. Dr. DiMarzo does not believe that respondent had a lack of knowledge about the condition, as stated by Dr. Fenton. Instead, when respondent assumed care of the patient, he immediately identified her as having preeclampsia and needing to be delivered. Although respondent noted the decreased platelet count, this was just one factor. Respondent immediately ordered the patient to be induced, which is the standard of care. Dr. DiMarzo believed that respondent had a complete understanding of the clinical picture, including the severe blood pressure ranges, the proteinuria, drop in platelet count, and that the fetus was growth restricted, which is also common in preeclampsia.

28. Dr. DiMarzo agreed with Dr. Fenton that respondent's management of the patient's hypertension fell below the standard of care, but it was a simple, not extreme departure. Dr. DiMarzo noted that approximately half of the patient's blood pressures were in the severe range. He agreed that systolic pressures greater than 160 constituted a hypertensive emergency that required treatment. He agreed with Dr. Fenton that respondent departed from the standard of care by not treating the condition with blood pressure medication. However, he did not believe it was an extreme departure because in a preeclamptic patient, the goal is to keep the systolic pressure between the 140 to 159 range. Lowering the pressure below these levels in a preeclamptic patient can produce hypoperfusion in the placenta and fetal hypoxia. In this case, respondent noted that the fetus was growth restricted. Respondent's reasoning for not treating the patient's severe hypertension was that because approximately half the blood pressure readings were in the non-severe range, he did not want to cause hypoperfusion to the fetus. Dr. DiMarzo understands respondent's concern; however, the standard of care would have been to provide standing orders for the nursing staff to immediately treat blood pressure levels in the severe range with blood pressure medication. At the time, ECRMC did not have prepared order sets

for automatic treatment of severe hypertension during pregnancy. Notwithstanding, respondent should have ordered blood pressure parameters for the nurses to immediately treat the patient's hypertension. Otherwise, by the time a nurse reports to the doctor the elevated condition, the blood pressure could have dropped below a treatable level, as occurred in this case.

Dr. DiMarzo disagreed with Dr. Fenton that this was an extreme departure from the standard of care. He does not see this as a situation where respondent had a lack of even scant care. Instead, he believed respondent provided a lot of care for the patient, and respondent's failure to treat the hypertension was based on a clinical concern for hypoperfusion and half the readings being in a non-severe range.

29. Dr. DiMarzo agreed with Dr. Fenton that the administration of 25 mcg of Cytotec at 4:53 a.m. was appropriate and within the standard of care. Dr. DiMarzo also agreed with Dr. Fenton that the 50 mcg of Cytotec should not have been administered at approximately 10:40 p.m. because the fetal heart tracing showed periods of tachysystole with occasional decelerations. However, Dr. DiMarzo believed this constituted a simple departure from the standard of care. He noted that respondent ordered the second dose of Cytotec from home, after the nurse reported category 1 fetal heart tracing. The information provided by the nurse was inaccurate, as the fetal heart tracing was not category 1, and there were periods of tachysystole. Dr. DiMarzo believed respondent should not have ordered the 50 mcg dose based solely on the nurse's report alone, without himself reviewing the fetal heart strips. While it is within the standard of care for a doctor to rely on the nurse's assessment, respondent should have verified the information before doubling the dose. Dr. DiMarzo disagreed with Dr. Fenton that this constituted an extreme departure because it was not a case where respondent delivered no care and because respondent obtained a status from the

nurse prior to ordering the second dose of Cytotec. An extreme departure would have occurred had respondent been aware of the periods of tachysystole when he ordered the additional Cytotec. However, because he was provided erroneous information by a trusted Labor and Delivery (L&D) nurse, the departure did not rise to the level of extreme.

30. Regarding respondent's treatment of the patient's postpartum hemorrhage, Dr. DiMarzo believed respondent acted within the standard of care. Postpartum hemorrhage is common and is the cause of approximately 30 percent of maternal deaths. Dr. DiMarzo agreed with Dr. Fenton that respondent appropriately treated the patient's continued bleeding with uterine massage and uterotonic agents. In this case, it appears that uterine massage was intermittently successful. However, uterine bleeding is extremely dangerous because half of the mother's blood flow is delivered to the uterus in four minutes. Dr. DiMarzo described a bleeding uterus as a big hose, by which the patient can lose half her blood volume within four minutes. The OB-GYN doctor has to act fast and make quick clinical decisions. ECRMC was not equipped with a Bakri balloon. Dr. DiMarzo disagreed with Dr. Fenton that a Foley balloon could have been used because it is not big enough to provide much of a tamponade for the lower uterine segment. Uterine packing sometimes works, however Dr. DiMarzo has never obtained good results from it. Moreover, all of these interventions take time, which one does not have when the uterus is continuing to hemorrhage. Thus, Dr. DiMarzo believed respondent's decision to proceed with a hysterectomy was appropriate and his decision saved the patient's life.

Dr. DiMarzo disagreed with Dr. Fenton that respondent should have addressed respondent's coagulation status before initiating the hysterectomy. The hysterectomy needed to be performed regardless of the coagulation status because it was the cause

of the hemorrhage. Dr. DiMarzo did not believe that the patient was in DIC at the time he began the surgery. Some bleeding from the gums does not constitute a diagnosis of DIC. Even if the patient had coagulopathy, there is no choice but to get the uterus out. Pregnant women can tolerate up to 50 percent blood loss, after which they crash, and fast.

During the procedure it became apparent that the patient had DIC due to massive blood loss and fluid resuscitation. However, postpartum hysterectomies are difficult procedures requiring the OB-GYN's full attention to the surgery. The OB-GYN is literally "between the patient's legs." It is the anesthesiologist's responsibility to direct blood and blood product replacement. The anesthesiologist has the time to calculate the amount and type of replacement blood products.

Dr. DiMarzo further disagreed with Dr. Fenton's criticism of respondent's use of a Pfannenstiel incision. The clinical decision respondent made was what would give him the best exposure, which is the Pfannenstiel incision.

Dr. DiMarzo believed the case should be viewed considering the limited resources of ECRMC and respondent cannot be held to the same standards as a large tertiary hospital. Dr. DiMarzo was emphatic that respondent's handling of the postpartum hemorrhage was within the standard of care. He noted that he and Dr. Fenton have been friends for 40 years. They both have similar training and experience and enjoy good reputations. However, the fact that they disagree on this issue demonstrates there is variation in clinical decision-making. Postpartum hemorrhage is a critical situation that requires a clinician's on-the-spot assessment. Even if the patient had been in DIC before the operation, respondent did not have a choice but to operate. In sum, respondent acted appropriately under the circumstances.

RESPONDENT'S TESTIMONY

31. Respondent's testimony is summarized as follows: On February 1, 2014, respondent assumed care of Patient A. At 8:30 a.m., a nurse reported concerns that the patient had been in the hospital for two days with preeclampsia based on elevated blood pressures and proteinuria. This condition is very common in El Centro, where many patients do not obtain adequate prenatal care. Respondent was very surprised to find the patient had been hospitalized for two days with significantly elevated blood pressures, and the only plan was to repeat preeclampsia labs. Respondent believes the patient should have been induced by the evening of her admission. In Patient A's case, delivery was indicated even though the fetus had intrauterine growth restriction and was approximately five weeks behind. Respondent immediately ordered the patient be induced because of the preeclampsia. The decreasing platelet count simply demonstrated that the preeclampsia was worsening, and the baby needed to be delivered. Respondent's reference to the platelet count was not the reason for his diagnosis of preeclampsia. It was simply an indicator that the preeclampsia was worsening requiring intervention.

32. Most of the time, the patient's blood pressure was less than 160/90. She did have higher levels intermittently. In 2014, ACOG guidelines defined severe preeclampsia with elevated blood pressures persisting for more than 15 minutes. Except for once or twice, Patient A's pressure did not persist higher than 160 systolic for more than 10 or 12 minutes. Thus, by the time the order could be made, and the nurses ready to administer medication, the patient's pressure would have fallen below 160 systolic. Treating a pressure below this would cause risk of hypoperfusion to the fetus. Thus, respondent was attempting to reach a "balanced management" between the mother and baby. Because the patient likely had elevated blood pressures before

coming into the hospital, reducing pressures to a normal limit could lead to decreased blood diffusion to the baby. Instead, respondent wanted to deliver the baby as soon as possible.

33. Respondent ordered the administration of a cervical ripening agent, but six hours later, there was no significant change. He ordered Cytotec, another cervical ripening agent. When he called four or five hours later, the baby was doing well but there was no significant cervical change. The patient was not contracting properly so he ordered 50 mcg of Cytotec to continue induction. Nurses are well-trained to monitor fetal heart monitors. He routinely instructs them to report any problems. The nurse who provided him the update was one of the unit's most experienced and knowledgeable nurses. During the phone conversation, she did not advise respondent that the fetus was undergoing tachysystole. Respondent understands the danger of tachysystole to a fetus. He maintained that the nurse never reported tachysystole or an abnormal fetal heart rate.

34. Subsequently, the nursing staff called respondent and informed him the baby's heart rate was dropping and the patient was contracting more frequently. Respondent ordered medication to slow down contractions. He lives minutes from the hospital and was immediately onsite with the patient. Respondent ordered an emergency C-section, but the patient delivered, followed by the placenta.

35. Respondent began uterine massage as is standard post-delivery. The uterus appeared to be contracting and bleeding subsided. Respondent suspected hemorrhage was a risk because the patient had previous deliveries, a fast delivery, and preeclampsia. Respondent noticed continued bleeding. He re-examined the patient and felt the lower segment of the uterus was "boggy" or hypotonic. He explained that the muscles of the lower uterus were not contracting, which serves to clamp down on

the natural bleeding that follows a delivery. Respondent was concerned that postpartum hemorrhage could develop into DIC. Uterine massage and medication were not effective at stopping the bleeding. The patient's platelet count and Fibrinogen were still in a "reasonable range," greater than 100,000 each, so he decided to perform a hysterectomy. The patient was not in DIC when decided to perform the surgery. Respondent did not want her to go into DIC, which is why he elected to proceed with surgery.

36. Respondent did not believe there were other methods he should have exhausted before performing the hysterectomy. Neither uterine packing nor a Foley balloon would have stopped the bleeding, at most they slow down bleeding. Once it appeared that the bleeding had stopped, respondent left the patient to attend to a precipitous delivery in the emergency room. The nurse informed respondent that the patient continued to bleed, so he instructed her to contact anesthesiology and prepare for a hysterectomy.

Respondent maintained that the patient was not in DIC at the time of the hysterectomy. Not all the labs had then been reported to him. He noticed the patient had some bleeding from her mouth, but the bleeding had stopped and the labs he received were not in the diagnostic range for DIC. The hysterectomy proceeded quickly, and there were no complications. He performed it in the L&D room because he did not believe the patient was stable enough to move to the OR. He performed a Pfannenstiel incision because it is a quicker incision, and time was of the essence. The patient had very little bleeding from the incision.

In 2014, ECRMC staffed the ICU with hospitalists who were only trained in internal medicine. Respondent ordered the patient be transferred to the ICU, and he stayed with the patient because the on-duty hospitalist did not want to be involved.

The patient's pressure dropped and at one point, she did not have a pulse. Respondent managed her post-surgical care until he was relieved.

37. After this incident, respondent was instrumental in implementing protocols for the treatment of preeclampsia, including standing orders for treatment of severe hypertension. The hospital has also improved its protocols for treating postpartum hemorrhage and the need for blood replacement.[10] Respondent believes he exercised reasonable judgment in attempting to deal with an emergency at the time, with the resources available to him, and he did what he could to save the patient's life. Today, the hospital is much better equipped, there is greater availability of blood products, nurses and technicians are better trained, and there is a new policy that C-sections are to be performed in the OR.

38. On cross-examination, respondent admitted that he did not document the baby's intrauterine growth restriction as a reason for withholding blood pressure medication. Respondent again maintained that the patient's pressure was rarely in the severe range for more than 15 minutes, but when shown the records, admitted that the patient's blood pressure was in the severe range for nearly an hour at 1:51 p.m. and more than an hour-and-a-half from 7:56 p.m. Respondent was not aware that it was measured 18 times in the severe range, which is half of all recordings for the patient. When asked if he agreed with Dr. DiMarzo that his failure to treat the patient's hypertension departed from the standard of care, respondent initially answered that it was not his "opinion to say." He again explained his concern that treatment could result in hypoperfusion to the baby, and because the severe blood pressure readings

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[10] Respondent submitted ECRMC protocols for hypertension during pregnancy created in October 2014.

were intermittent, it made it difficult to treat the condition without risking hypoperfusion. Thus, he made the decision to closely monitor her by making sure her condition did not worsen while keeping an eye on the baby's profusion. Ultimately, he agreed that his failure to treat the patient with blood pressure medication departed from the standard of care.

39. Respondent is aware of the risks of hyperstimulation of the uterus. When he ordered the second round of Cytotec, contractions were every two to six minutes, which is irregular. The nurse reported the fetus was category 1, and contractions every six minutes is not a contraindication for continued cervical ripening and continued induction. When he ordered the additional Cytotec, there had been no significant cervical change and the fetus was reported as category 1. Had he known the fetus was in fact in Category 2 and in tachysystole, he would have ordered a C-section. He believed at the time that this was an appropriate decision based under the conditions. He doubled the dose because labor was not progressing, the patient had elevated blood pressure, the baby was very small, and it needed to be delivered.

40. Respondent was concerned that DIC would develop with the patient. He ordered labs at 3:00 a.m., which were not reported until 4:03 a.m. The INR was 4.2, but he did not have that result at the time of the surgery. Only the platelet count was reported before the surgery at 3:23 a.m., which was still greater than 100,000. When referred to his postoperative report indicating "suspected DIC," respondent testified that it was clear that her condition could develop into DIC.

EVALUATION

41. The accusation alleges respondent committed gross negligence in the care of Patient A by:

(A) Failing to provide antihypertensive medication to the patient despite repetitive and sustained elevated blood pressure readings;

(B) Ordering 50 mg [*sic*] Cyotec when the patient's contractions were approximately every two minutes and the fetal heart rate strip suggested tachysytole [*sic*]; and

(C) Failing to adequately manage the patient's postpartum hemorrhage.

42. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

43. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reason upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923.) Relying on certain portions of an expert's opinion is entirely appropriate. A 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 pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 767.) The fact finder may also reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.)

44. Both experts were well qualified based on their knowledge, training, and experience to provide an expert opinion on respondent's care of Patient A. Indeed, both experts underwent the same residency program, around the same time, and worked together as colleagues at Scripps their entire careers. They both offered detailed and thoughtful analysis of this case. They were both credible and unbiased.

45. Both experts and respondent (albeit reluctantly) agreed that respondent's failure to treat Patient A with blood pressure medication fell below the standard of care. They disagree, however, as to what extent respondent's behavior departed from that standard. Both experts conflated the concepts of a "want of even scant care" with an "extreme departure from the standard of care." Instead, gross negligence is defined as "want of even scant care" *or* "an extreme departure from the ordinary standard of conduct" – the use of the disjunctive in the definition indicates alternative elements of gross negligence. (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-197.) Regardless, Dr. Fenton believes that it is an extreme departure because respondent provided no treatment; Dr. DiMarzo believes that respondent was reasonably concerned about hypoperfusion to the fetus but should have had standing orders to treat severe hypertension. In addition, respondent's testimony that the patient's severe blood pressure readings did not last for more than 15 minutes was belied by the medical records, which showed several sustained periods for more than an hour.

Ultimately, it is complainant's burden to prove an extreme departure by clear and convincing evidence. While Dr. Fenton's opinion that respondent's failure to treat

the patient with blood pressure medication is an extreme departure is slightly more persuasive than Dr. DiMarzo's classification as a simple departure, the degree of such persuasion does not reach the level of clear and convincing. Although respondent did not document the fetus's intrauterine growth restriction as a factor for deciding not to treat the patient with blood pressure medication, he is credited with it being a factor in his decision-making process.

46. Similarly, clear and convincing evidence did not establish that respondent lacked the knowledge, skill, or training to assess and treat preeclampsia or severe preeclampsia. Rather, it is clear that respondent appreciated that the patient had preeclampsia, which is why he initiated induction.

47. Both experts agree that respondent departed from the standard of care in administering 50 mcg of Cytotec to the patient when the fetus was experiencing tachysystole. Again, the experts disagree on the degree of departure. Dr. Fenton based his opinion on the fact that the fetal heart tracing showed the fetus was in distress at the time the second dose was ordered. He also criticized the doubling of the dose, which was what differentiated it between a simple and extreme departure. Dr. DiMarzo believes it is a simple departure because the nursing staff did not correctly inform respondent of the fetus's condition when the second dose was ordered. Nevertheless, Dr. DiMarzo believed respondent should have himself reviewed the fetal heart tracing before making a decision to double the dose. Respondent maintained that he acted reasonably under the circumstances by relying on the information reported to him by an experience nurse.

As with the previous issue, Dr. Fenton's opinion is slightly more persuasive; however, it does not rise to the level of clear and convincing such that the departure rises to the level of an extreme departure. Moreover, respondent testified about his

concerns about the patient's failure to deliver and the need to deliver the baby. Thus, it is not an instance of the want of scant care. Rather, respondent should have verified the fetus's condition before doubling the dose, especially since it was reported that contractions were from two to six minutes.

48. Both experts disagree on respondent's handling of the patient's postpartum hemorrhage. Dr. Fenton believes that respondent's failure to assess and treat the patient's coagulopathy by administering FFP and platelets; the failure to attempt other physical measures to stop the bleeding such as uterine packing or the use of a Foley balloon; proceeding with a laparotomy and hysterectomy before addressing coagulation; and the use of a Pfannenstiel incision support his opinion of an extreme departure from the standard of care. Dr. DiMarzo believes that respondent reasonably and appropriately handled an emergency situation, which saved the patient's life.

As previously noted, the opinions of both experts were well-reasoned and thoughtful. That they disagree shows that reasonable clinical judgment can differ regarding respondent's handling of the situation. The primary point of contention is whether respondent should have treated the patient's coagulopathy prior to initiating a hysterectomy. Dr. Fenton believed the standard of care was for respondent to treat the coagulopathy with additional blood products, such as FFP, which was available at ECRMC at the time. Dr. DiMarzo believed the situation was critical, the patient continued to hemorrhage from the uterus, and any delay in a hysterectomy could be life-threatening.

Clear and convincing evidence did not establish that proceeding with a hysterectomy as he did, departed from the standard of care. While Dr. Fenton maintains that respondent could have attempted uterine packing or using a Foley

balloon, Dr. DiMarzo and respondent both noted that neither would have likely proven effective and would have only caused further delay. Additionally, it was not established that the use of a Pfannenstiel incision was unreasonable under the circumstances.

However, clear and convincing evidence established that failure to provide the patient with additional blood products, such as FFP, was a simple departure from the standard of care. It is not clear from the medical records when the results of the platelet count, fibrinogen, and IDR were actually reported to respondent. However, respondent himself expressed concern about impending DIC as justification for the hysterectomy and was aware of the patient's coagulopathy. Both experts agree that the patient should have been treated with additional blood products to control the coagulopathy. The question remains, however, who was responsible? Dr. DiMarzo contends that it was the anesthesiologist's responsibility to manage the patient's blood loss once the hysterectomy was initiated. Dr. Fenton believes respondent should have addressed it himself, well before the hysterectomy was started, when he first had an indication of coagulopathy. Ultimately, respondent ordered the administration of three units of blood at 3:30 a.m. The infusion began at 4:00 a.m., a half-hour before respondent started the hysterectomy. Considering that FFP requires a period of thawing, respondent should have foreseen its future necessity and ordered it at the time he obtained the patient's consent for a hysterectomy (a half-hour before the procedure was initiated). Thus, clear and convincing evidence established that respondent committed a simple departure from the standard of care by failing to address what he believed to be likelihood of imminent DIC by ordering administration of FFP or other blood products, well before he began surgical intervention.

Patient B

49. The following summary is based on the medical records and testimony of Patient B,[11] Paola Montejano, and Esther Stuber, R.N.: Patient B was 36 years old at that time and was living in Mexicali, Mexico. She has a college degree. She testified that she had previously received prenatal care by an OB-GYN in Mexico, who diagnosed her with placenta previa.[12] Her previous OB-GYN in El Centro was no longer practicing, but a friend recommended respondent. On February 14, 2019, Patient B presented to respondent's clinic to initiate prenatal care and was seen by a nurse practitioner. She reported a history of two prior cesarean sections in 2007 and 2012, a first trimester miscarriage in 2010, and a laparotomy for a right tubal pregnancy in 2013.

50. On February 21, 2019, Patient B presented for a follow-up visit and was seen by respondent. At this visit, respondent performed an ultrasound that revealed a complete anterior placenta previa. Respondent highly suspected the patient had a placenta accreta[13] and considered this a high-risk pregnancy due to her advanced maternal age, two prior cesarean sections, a laparotomy for a prior ectopic pregnancy, and complete placenta previa. Respondent documented, "Patient's risks are discussed at length. Risk of hemorrhage, blood transfusion, PTL and birth; hysterectomy and

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[11] Patient B, who was respondent's witness, testified with the assistance of a court-certified Spanish language interpreter.

[12] Placenta previa is a condition where the placenta covers the opening of the cervix.

[13] Placenta accreta is a condition where the placenta grows into the uterine wall.

other unknown complications are discussed." Respondent noted that the patient requested sterilization. Respondent prescribed a corticosteroid to enhance fetal lung maturity, which the patient planned on obtaining in Mexico. Patient B testified that she received the injections in Mexico as prescribed.

51. On March 5, 2019, Patient B presented to respondent for a follow-up. At this visit, respondent performed another ultrasound that revealed continued presence of complete placenta previa. At the conclusion of this visit, respondent scheduled the patient for a repeat cesarean section and bilateral partial salpingectomy (partial removal of fallopian tubes) at ECRMC on April 11, 2019, at 38 weeks' gestation.

52. On or about March 14, March 21, and April 9, 2019, respondent saw the patient for follow-up visits. On these visits, respondent documented discussing precautions for placenta previa with the patient, provided labor instructions to the patient, and documented discussing the risks of placenta accreta, hemorrhage, blood transfusion, and hysterectomy.

53. Patient B testified that respondent told her about placenta previa, that she had the condition, she might possibly need a blood transfusion, and that she might lose the uterus. He said the baby could be born premature, so he prescribed her a steroid injection to help develop the baby's lungs. She testified that respondent's demeanor was very positive compared to that of her doctor in Mexico. Respondent made her feel more confident because he was positive. She understood after speaking to him how dangerous her condition was for her and her baby. On more than one occasion, they discussed her having her baby in San Diego. Respondent always recommended it because the hospitals there were better equipped. However, Patient B told him she thought it best for her to have the baby in El Centro. She explained that she was crossing the border daily and not driving. Respondent repeated several times

about going to San Diego. However, this was not an option for her. Respondent also told her about placenta accreta and the possibility of a hysterectomy. When asked why Patient B felt safe in her decision to stay in El Centro and not go to San Diego, Patient B said respondent always showed himself to be confident "as far as the issues." She said he knew what was happening, which is why she trusted him. She repeated multiple times that she felt she could trust him.

54. When asked if respondent told her whether he was capable of handling her condition, Patient B said he provided her with many possibilities for going forward. During her first few months of pregnancy, her doctor in Mexico did not give her any "possibilities," and instead, wanted to "bury the condition." She said, "He buried me alive. I felt dead." Respondent told her that she could die, but "his face was different and I felt he was giving me hope." Patient B reiterated that respondent explained everything to her from the beginning. She believed ECRMC was well-equipped for her delivery. She came to the hospital the morning of April 11, 2019, for her scheduled C-section. She was not having contractions, and nobody said anything about the procedure being an emergency.

55. Paola Montejano was respondent's medical assistant at the time. Ms. Montejano testified that she is a native Spanish speaker and served as an interpreter for respondent and Patient B during her visits. Ms. Montejano remembers that Patient B was of late maternal age with the risk of placenta accreta. Ms. Montejano recalled respondent telling Patient B that she was high-risk, and she had the option of delivering in San Diego. Respondent explained she should deliver in San Diego because she was at risk for a pre-term labor, hemorrhage, and hysterectomy. She said respondent strongly recommended she deliver in San Diego because there was also a neonatal ICU. Patient B mentioned the inconvenience of travelling to San Diego and

the cost. Delivering in El Centro was more convenient because it was closer to her home in Mexicali. Respondent had more than one conversation with Patient B about the risks. He always took the time to explain things to patients so they could understand.

56. On April 10, 2019, L&D nurses at ECRMC noted Patient B's repeat cesarean section scheduled for the next morning at 5:00 a.m. One of the nurses, Esther Stuber, R.N., testified at the hearing as follows: Ms. Stuber began as a licensed practical nurse in 2005 and obtained her registered nurse license in 2012. She has spent almost her entire career as a travel nurse. On this date, she was nearing the end of a 13-week assignment at ECRMC. At the time, ECRMC did not have a neonatal ICU (NICU) unit. Ms. Stuber had worked with respondent multiple times during her assignment and assisted him with approximately 15 to 20 C-sections. Ms. Stuber was on a shift beginning at 7:00 p.m. and ending at 7:30 a.m. the next morning. A new travelling nurse was assigned to Patient B's C-section, scheduled for 5:00 a.m. Ms. Stuber was reviewing the patient's chart with her when she noticed that the patient had a suspected placenta accreta. They brought this to the attention of the charge nurse, who expressed concern that the procedure would be done at 5:00 a.m., when there was only a skeleton staff working at the hospital. The charge nurse called respondent to express her concern and ask that the surgery be moved back until 6:00 a.m. or 7:00 a.m., when more staff would be at the hospital. Ms. Stuber was present during the phone conversation but could not hear what respondent was saying to the charge nurse. However, respondent did not want to postpone the surgery and ordered four units of packed red blood cells to be type-crossed and held.

57. On April 11, 2019, at 1:25 a.m., Patient B presented to the hospital for the planned C-section. At 5:00 a.m., the patient was brought to the OR and the surgery

commenced. Ms. Stuber testified that there were four nurses to assist, along with an anesthesiologist and OR scrub technician. Respondent always used an OR technician as his first assistant, rather than another surgeon. At some point, the patient required transfusion. The rapid infuser had to be brought from the ER and was operated by an ER nurse, who knew how to use it. During the procedure, Ms. Stuber's role was to provide extra support. In her time at ECRMC, Ms. Stuber noted that respondent always scheduled his C-sections for 5:00 a.m. in the OR. Ms. Stuber did not believe respondent said anything to the staff prior to commencing the surgery.

58. Respondent delivered the baby by C-section. He noted the placenta could not be removed from the lower uterine segment, so he closed the uterus and performed a supracervical hysterectomy and bilateral salpingectomy on the patient. During the operation, the patient had significant blood loss of approximately 3,500 ml and received 6 units of packed red blood cells, one unit of FFP, one bag of platelets, and cryoprecipitate. The patient had no further complications and was discharged on April 14, 2019. Post-surgical pathology confirmed placenta accreta.

DR. FENTON'S REPORT AND TESTIMONY

59. The board requested Dr. Fenton review the care provided for Patient B and determine whether there were any departures from the standard of care. The following is a summary of his testimony and report:

60. Dr. Fenton believed that respondent committed an extreme departure in the standard of care for his prenatal care of Patient B. Based on Patient B's history, and presentation of placenta previa, respondent suspected placenta accreta. A patient with placenta previa has a 40 percent chance of having placenta accreta. Placenta accreta is a very serious condition because the placenta has invaded the uterine wall, which

poses a high risk of hemorrhage. Like with placenta previa, C-section is required for placenta accreta. The diagnosis of placenta accreta can be made through ultrasound, doppler flow, and many would recommend an MRI (however, an MRI is not required within the standard of care).

The standard of care for a suspected placenta accreta is to ensure a correct diagnosis and engage a multidisciplinary team with providers experienced with handling the condition. It was appropriate for respondent to have prescribed antenatal corticosteroids to advance fetal lung development. However, respondent prescribed it at almost 30 weeks gestational age, and there was no documentation of when the patient should (or did) receive the steroids. An injection lasts from 7 days to 2 weeks. Respondent should have documented when and where she received the injections.

Respondent scheduled the C-section for 38 weeks gestational age. The standard of care with a patient with suspected placenta accreta is to deliver between 34 through 35 and 6/7 weeks. Respondent in his interview indicated that he did not want to deliver before 38 weeks because ECRMC does not have a neonatal ICU able to support a premature birth. Dr. Fenton did not believe this was a sound reason because if the patient were to go into labor prior to 38 weeks, the mother would have increased risk of losing blood volume.

From respondent's interview, Dr. Fenton learned that respondent recommended to Patient B that she deliver at a tertiary care center in San Diego. There is no documentation in the medical records that such a referral was made. The standard of care is to provide written documentation of such counseling events and the risks of refusal. Respondent also failed to document any comprehensive management plan for the delivery, any discussions with other specialists, any request for additional assistance by an OB-GYN, anesthesia, general surgery, or nursing support. From his

records, respondent had no plan for dealing with the placenta accreta other than performing a repeat C-section and "sterilization." Dr. Fenton explained it is appropriate to have additional staff present during a placenta accreta delivery. It is likely that a patient would have massive hemorrhaging and require massive transfusion.

Patient B should simply not have had her surgery at ECRMC. The literature is quire robust about the importance of delivering these patients in a tertiary care setting. There are several facilities in San Diego equipped to handle these cases, including having available an interdisciplinary team. In addition to the care of the mother, these hospitals are equipped with NICUs, which allow for a preterm delivery between 34 and 36 weeks. The risk to baby and mother is exceptionally high if the mother goes into labor prior to the planned C-section because loss of blood volume can lead to death. In this case, waiting until 38 weeks placed the mother at significant risk for early delivery, which is especially concerning since she lived in Mexico. If she were unable to get across the border, her condition could have been fatal.

Of course, not all patients with placenta accreta have access to a tertiary care center. Patients often present with the condition unexpected. If in fact Patient B refused to go to San Diego, respondent could have taken additional steps before performing the planned procedure at ECRMC. These steps, along with the patient's refusal, should have been documented. Dr. Fenton believed the prenatal care constituted an extreme departure because of the multiple deficiencies. In addition to other literature, ACOG has published guidelines regarding the treatment of placenta accreta that recommends multidisciplinary management at a tertiary care facility.

61. Dr. Fenton also believed that respondent's perioperative and intraoperative care constituted an extreme departure from the standard of care. Respondent scheduled the procedure as a routine surgery. The patient's hemoglobin

should have been optimized prior to surgery. There was no evidence this occurred. Respondent elected to operate at 5:00 a.m., a time when there are fewer staff members available to assist in an emergency. The nurses' concern about performing this surgery at that time was sound. Respondent himself was not experienced in handling a placenta accreta surgery. He had no surgical support other than an OR scrub technician. He made no arrangements for ensuring availability of additional support form anesthesia, critical care, another surgeon, neonatology, senior nursing leadership, or blood bank personnel in the event of a mass transfusion protocol.

Once respondent opened the patient, he observed that the placenta was visible through the lower uterine segment, which is highly suggestive of placenta accreta. He did not believe that respondent should have entered through the placenta because the adherence to the uterine wall increased the risk of bleeding. Instead, Dr. Fenton believed that the fetus should have been delivered through a fundal uterine incision (an area unassociated with high bleeding), the umbilical cord replaced, the incision closed, and the patient transferred to a tertiary care center. Instead, respondent delivered the fetus through the anterior placenta, resulting in massive hemorrhage. In sum, Dr. Fenton did not believe respondent should have performed the procedure at ECRMC.

On cross-examination, Dr. Fenton agreed that there were not complications associated with the surgery because of a lack of adequate staffing. Instead, Dr. Fenton believed that the loss of blood requiring transfusion of four liters was a complication resulting from respondent's decision to enter through the placenta. Dr. Fenton agreed that the patient's blood loss and postoperative care were appropriately managed.

RESPONDENT'S TESTIMONY

62. Respondent's testimony about his treatment of Patient B is summarized as follows: The patient presented late in pregnancy after being diagnosed by her OB-GYN in Mexico with placenta previa. Respondent explained that she had a 40 percent risk of placenta accreta, had risk of hemorrhage, hysterectomy, and pre-term birth. He explained that ECRMC could handle the surgery and blood transfusions, but it did not have a neonatal ICU. He recommended that she go to San Diego and would have referred her. She did not want to go. Respondent does not ask why she did not want to go; it is the patient's decision. If the patient had other associated problems that would have complicated her delivery, he would have referred her to at least one consult in San Diego. She had no other health problems other than two previous C-sections, which put her at risk for placenta accreta. Respondent performed an ultrasound that showed features of placenta accreta. Respondent discussed this with her. Every time she came for an appointment, he reiterated the risks and recommended that she would be better off in San Diego. He also noted that the baby would most likely be premature, and there is a NICU in San Diego. Respondent explained the risk of hemorrhage could be life-threatening if labor started. She understood these risks. He scheduled her for an elective C-section at 38 weeks because he wanted to maximize the chance of having fetal lung maturity since ECRMC does not have a NICU or pediatrician.

63. Respondent repeated an ultrasound and again confirmed features of placenta accreta. He gave her a prescription for steroids to help in lung maturity. The patient told him she took the steroids. The steroids were in case she went into preterm labor.

64. This was the first time respondent ever scheduled a C-section for a patient with suspected placenta accreta. He has handled three placenta accreta deliveries in the past. When asked what he did differently than with a typical C-section, respondent said he made sure blood products were available, made sure the anesthesiologist knew what to expect, and spoke to the L&D nurse the night before. When the patient arrived at the hospital, she was contracting. The nurse called respondent asking to delay the surgery. Respondent schedules his surgeries for 5:00 a.m. to ensure that they go on time and are not bumped by any other surgeries. By delaying the surgery, there was the risk that the surgery would not go on time. By the time the patient presented at the hospital, the case was urgent because he did not know how quickly the labor would progress. They had five nurses working that night. The unit is never staffed with five nurses. Regarding the need for the transfusion machine from the ER, it is right next door to the OR.

65. Respondent was able to handle his previous placenta accreta deliveries without complications. He did not attempt to forcibly removed the placenta. Once he tested it, he knew it would not come off, and proceeded with the hysterectomy. The patient did not require any additional blood products than what had been available.

66. Respondent did not chart that he recommended the patient deliver in San Diego. The documentation of this does not improve patient care. He documented discussing the risk and complications. In hindsight, he agrees he should have documented his recommendation. He routinely refers patients to San Diego. The patient was adamant about not being transferred to San Diego.

67. On cross-examination, respondent admitted he never documented that the ultrasound confirmed features of placenta accreta. It was also not documented when the patient took her steroids, but the patient informed her she received them.

Respondent agreed that the patient was at risk of going into labor before 38 weeks. When asked if he was concerned about a high-risk delivery occurring in Mexico, respondent said that was Patient B's decision, and he cannot help that. It would be safer for her to deliver in Mexico than attempt to wait and cross the border. He discussed the risks with her several times. He told her the surgery and blood transfusion were not the issue, the issue was if she needed to stay in the ICU. When asked if he recommended that she go to San Diego, he said, "Of course." When asked if her decision to deliver in El Centro was against medical advice (AMA), he said she did not refuse medical care, so it was not an AMA. He did not document his recommendation or her refusal to follow his recommendation.

His three prior placenta accreta deliveries were all emergent. None of them were his patient prior to delivery. He noted that the ACOG guidelines recommend the presence of a vascular surgeon or female reconstructive surgeon, which respondent is. When it was noted that the ACOG recommendations also recommend a team accustomed to dealing with the conditions, respondent admitted he had no knowledge about the team's experience, but he was well-qualified to deal with it. The team is qualified to deal with hemorrhage and there was an on-call general surgeon if it came to it. Respondent had the qualifications of the two most important components. Respondent does not believe that the patient almost died. She had hemorrhaging just like any obstetrical patient. He did not try to remove the placenta. She did bleed a lot, but that was the risk.

When asked about any preparations he made before the surgery, he said he made sure the on-call surgeon was available, although he does not remember who this was, and it was not documented. Respondent did not consult with any other specialists. He did not request another OB-GYN to assist. There was only one

anesthesiologist available during the night shift. The anesthesiologist was aware of the procedure. They had adequate nursing coverage, although respondent admitted that there just happened to be five nurses working that night, and it was not something prearranged. He had no knowledge of who would be on duty or their experience with placenta accreta. He said it would not have made a difference. When respondent scheduled the C-section, he asked his staff to schedule a repeat C-section with the hospital. He does not remember if he asked to put down that it was a placenta accreta. The nurse called respondent before he could call her. He asked that blood be available. When asked why he did not think it necessary to make arrangements with the blood bank earlier, respondent said that the blood bank at ECRMC had tremendously improved since 2014, they had adequate product, and did not need any additional time to type and cross four units.

68. When asked if he would have done anything differently, respondent said he would have refused to handle the case because he does not want to go through this process again.

TESTIMONY AND REPORT OF DR. DIMARZO

69. Dr. DiMarzo also prepared a report addressing respondent's care of Patient B and Dr. Fenton's report. The report, along with his testimony, are summarized as follows: Once respondent confirmed the presence of a complete placenta previa, he appropriately managed treatment by assuming the presence of placenta accreta. Placenta accreta have a higher tendency for preterm labor and earlier gestation. It is usual to schedule delivery of the baby from 34 up to 36 weeks if the hospital is able to manage a premature infant. In placenta previa/accreta, it is important to deliver the baby before the mother goes into labor or has uterine contractions, which can lead to massive hemorrhage very quickly. However, this must

be balanced against the risk to the baby if it is born premature and there is not a nursery that can provide appropriate care. Dr. DiMarzo delivers all of his placenta previa patients during this time because his hospital is equipped with an advanced-care nursery. Because ECRMC did not have an advanced-care nursery, it was within the standard of care for respondent to schedule the patient for delivery at 38 weeks. This ensured that the baby's lungs would be fully mature. Respondent appropriately prescribed steroids at the appropriate time.

Dr. DiMarzo agreed that respondent failed to document when respondent actually received the steroid injection. Dr. DiMarzo was under the impression that the patient returned to respondent and informed him that she had received the injection. Respondent agreed it would have been a good idea for respondent to have documented this. However, documentation is not a standard of care issue.

70. Dr. DiMarzo agreed that delivery at a tertiary care facility is the preferred location because of the availability of critical care specialists, an interventional radiologist, and on-call OB-GYNs. The standard of care is to refer a patient to a tertiary care center. In this case, based on the statements by respondent and his medical assistant, Dr. DiMarzo believes that respondent referred Patient B to UCSD. For financial and other reasons, the patient refused. Thus, respondent had an obligation to care for the patient using the resources that he had. If the patient refused to go to San Diego, respondent had no other choice than to schedule the patient for delivery at ECRMC. The ACOG guidelines recommending delivery of placenta accreta in a tertiary care center are recommendations, and explicitly state they are not intended to constitute a standard of practice.

Dr. DiMarzo agreed that it "would be a good idea" for respondent to have documented his recommendation and referral of the patient to UCSD. He believed the

recommendation occurred but was not documented. He believed respondent's documentation was not a standard of care issue since it did not affect patient care.

Dr. DiMarzo also believed that respondent strongly recommended to the patient that she be delivered at a tertiary facility, but the patient understood the risks. Dr. DiMarzo believes it would have been unethical for a physician to refuse to treat the patient based on her informed refusal.

71. Dr. DiMarzo agreed that most OB-GYNs do not have the experience to handle a placenta accreta case. However, Dr. DiMarzo stated that respondent was well-qualified to perform the delivery since he had two years of general surgery training, 3.5 years of urology training, and completed a fellowship and certification in pelvic medicine and reconstructive surgery. Respondent was an experienced and capable pelvic surgeon who was qualified to perform a supracervical postpartum hysterectomy. When asked if handling three past cases of placenta accreta constituted a sufficient level of experience, Dr. DiMarzo said it is a "fair amount" of cases for an OB-GYN. His practice group delivers approximately 12 or 13 per year. Dr. DiMarzo was aware that prior to this procedure, respondent had never performed a planned placenta accreta delivery. A previously undiagnosed placenta accreta is more complicated because it involves performing a C-section without having cross-matched blood products. A planned procedure allows for the opportunity to mitigate risks.

72. Dr. DiMarzo also believed that respondent prepared for the surgery appropriately, and it was reasonable for him to have performed it at 5:00 a.m. First, respondent diagnosed the patient as going into latent stage labor based on the fetal heart monitor showing periods of regular uterine contraction. Contractions at 38 weeks with a placenta previa/accreta raises a very real concern of impending delivery, and respondent was justified in declining to delay the procedure until later in the

morning as requested by the L&D nurse. Moreover, respondent reasonably explained his concern that postponing the procedure risked conflicting with other scheduled procedures in the OR.

Respondent was aware that there was adequate nursing staff, he spoke to the anesthesiologist, and ensured blood components were available. Respondent was assisted by an experienced OR scrub technician, who respondent felt would provide better surgical assist than another OB-GYN. It is not Dr. DiMarzo's experience to have more than one anesthesiologist present during the procedure. The most important factor is ensuring that everyone on the operating team knows what they are doing and has the proper resources available to them. In this case, they ended up having the staffing needed, available blood products, a trained pelvic surgeon (respondent), and the patient went home healthy with a healthy baby. In sum, "they pulled it together and got it done." Dr. DiMarzo did not believe respondent acted inappropriately by waiting until the night before to request blood products. So long as the hospital was aware of the procedure ahead of time, there was sufficient time to cross-type blood.

73. Dr. DiMarzo also disagreed with Dr. Fenton's criticism of the surgical procedure itself. Respondent reasonably believed that a low traverse incision would give him better exposure. Often, with an anterior placenta previa, going through the placenta is the only way to get to the baby. In this case, the placenta went from the cervix to the top of the uterus. Thus, he disagreed with Dr. Fenton that a fundal incision would have avoided the placenta. It was then appropriate to gently test the placenta to see if it separated. In this case, because it did not, which confirmed the diagnosis of placenta accreta, respondent appropriately left the placenta and proceeded with the hysterectomy. Dr. DiMarzo does not believe that respondent forcibly tried to remove the placenta. There is no question that the patient experienced

a high amount of blood loss, but this was typical in such a situation. The team appropriately managed the blood loss with replacement blood products.

Dr. DiMarzo understands that the standard of care is not dependent on outcome. He does not think that respondent was reckless in his treatment decisions of the patient. He believes it would have been unethical for respondent to have terminated care of the patient, even if performing the delivery in El Centro posed the patient significantly higher risk.

EVALUATION

74. The accusation alleges respondent committed gross negligence and repeated negligence in the care and treatment of Patient B by:

> (A) Providing deficient prenatal care, including but not limited to, failing to schedule delivery between 34-35 6/7 weeks gestation; failing to administer or verify and document Patient B's receipt of corticosteroids; failing to discuss and/or document a discussion with Patient B regarding the limitations of delivery at ECRMC, his recommendation or referral to a tertiary care center, or the patient's informed refusal to obtain treatment elsewhere; and failing to obtain consultation from a maternal fetal medicine specialist or gynecologic oncologist to create a management plan for delivery;
>
> (B) Providing deficient perioperative and intraoperative care, including but not limited to, failing to provide extensive delivery planning and coordination of care with

necessary additional clinical support, and failing to deliver the fetus through a fundal uterine incision and performing a cesarean hysterectomy.

75. Dr. Fenton opined that respondent's prenatal care was an extreme departure from the standard of care because of the multiple deficiencies he identified. However, he did not identify any single one of these deficiencies as constituting an extreme departure from the standard of care; rather it was the culmination of all of the deficiencies that determined his opinion that respondent's prenatal care was an extreme departure. Dr. DiMarzo believed that respondent's prenatal care of Patient B was within the standard of care. Dr. DiMarzo did not believe that any deficiencies in documentation were related to the standard of care.

Both experts and respondent agree that with Patient B's history and presentation of placenta previa, referral to a tertiary care center was the standard of care. Respondent, Patient B, and Ms. Montejano all testified that respondent recommended that Patient B be delivered in San Diego, where there are several tertiary care facilities equipped with handling the associated risks of a placenta previa/accreta delivery. Their testimony was credible, even if respondent did not document the recommendation and referral. However, what is less clear is how forceful respondent was in his recommendation. Suspected placenta accreta poses significant risk to both mother and baby. There is no question that tertiary care centers are better equipped to handle such a delivery, where there is great risk of severe postpartum hemorrhage, premature delivery, or other complications. The forcefulness of respondent's recommendation to seek care at a tertiary care facility instead of ECRCMC must be commensurate with the risk. Put another way, because of the

extreme risk to mother and baby, the standard of care requires his medical recommendation to be unequivocal. The evidence did not show this.

Respondent testified that he explained that ECRMC could handle the surgery and blood transfusions, but it did not have ICU or NICU capabilities of those in San Diego. Once Patient B told respondent she did not want to go, respondent did not press the issue. Nor did respondent refer her for a consult in San Diego, to at least provide the patient with another opinion. Clearly, respondent felt he was highly competent as an OB-GYN and pelvic surgeon to handle the procedure himself. He was also confident in ECRMC's ability to provide transfusion in case of emergency.

Patient B's testimony was consistent with respondent providing warnings about the risk of death and the limitations of ECRMC, but Patient B also repeatedly testified how respondent was optimistic, appeared confident, and gave her hope. Thus, instead of a dire warning about the risks of delivering in ECRMC, Patient B came away from her interactions with a belief that everything would be okay. Her testimony was not consistent with someone who had been informed that her decision to have her baby in El Centro instead of San Diego, placed her and her baby in considerably more risk.

Finally, it is not clear that Patient B understood the risks if she went into labor before the 38-week planned C-section. Again, the risk of death to mother and child of a placenta accreta going into labor is exceptionally high. Respondent elected to postpone delivery until 38 weeks, two weeks beyond the recommended delivery time. While it is understood that respondent was attempting to balance the risk to mother in delaying delivery with the risks associated with ECRMC not being able to care for a premature baby, there was a very real possibility that Patient B would go into labor before 38 weeks. Indeed, according to respondent and Dr. DiMarzo, the patient had already begun to go into labor when she checked into the hospital for the planned C-

section. Had she begun contractions in Mexico the day before, and was unable to get across the border in time, the results could have been catastrophic. Even if she were to make it to ECRMC, the placenta accreta delivery would have been unplanned and hospital staff completely unprepared for the delivery. Respondent, in his testimony, appeared to be indifferent to this risk, instead, accepting it as a consequence of the patient's decision to have her baby in El Centro. In sum, the evidence shows that respondent, while cautioning the patient about the risks associated with a placenta previa/accreta, and recommending that she deliver in San Diego, also expressed to Patient B that he was fully capable of performing the procedure in El Centro. Thus, his decision to schedule a C-section for a suspected placenta accreta under these circumstances was a simple departure from the standard of care.

76. Respondent's failure to document his recommendation and referral and document when the patient received her steroid injection also constitutes a simple departure from the standard of care. Although Dr. DiMarzo believed it would have been prudent for respondent to have documented these, he did not believe it was a standard of care issue because it only related to documentation not affecting patient care. Business and Professions Code section 2266 requires a physician to maintain adequate and accurate records relating to the provision of services to their patients. Here, the standard of practice applicable to medical records has been established by law. A physician's failure to maintain adequate and accurate medical records would (in addition to being a violation of Section 2266) be a departure from this legislatively-created standard of practice, if the records were indeed deficient.

77. Dr. Fenton believed the decision to schedule delivery at 38 weeks departed from the standard of care, which is to deliver between 34 up to 36 weeks. Dr. Fenton did not believe respondent's justification to wait in order to allow for fetal lung

development justified such delay. Dr. DiMarzo believed that delivery at 38 weeks was appropriate considering that ECRMC does not have a nursery to provide appropriate support for a premature baby.

Dr. Fenton's opinion is slightly more persuasive than Dr. DiMarzo's and respondent's. However, it is not significantly more persuasive to meet the clear and convincing standard required to establish a departure from the standard of care. Accordingly, complainant did not meet his burden on this issue.

78. Dr. Fenton believed that respondent did not create an appropriate management plan for delivery, including coordination of care with necessary additional clinical support. Dr. DiMarzo believed that respondent was an experienced OB-GYN and pelvic surgeon who appropriately handled the delivery.

This case does not involve patient harm or an adverse outcome, making it comparatively rare for board disciplinary matters for the simple fact that positive outcomes rarely generate complaints to the board. However, professional licensing laws are designed to protect the public before a licensee harms a patient rather than after harm has occurred. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 771-772.) Thus, the fact that the patient had a positive outcome does not necessarily mean that respondent exercised the degree of care required. Here, respondent had almost no planning and coordination. Although respondent ordered blood be available, and perhaps ensured the availability of the on-call surgeon, he took no steps in coordinating a plan with the care team. Both Dr. DiMarzo and respondent rely heavily on the fact that respondent and his team "got the job done." But, as much as the successful outcome can be attributed to respondent's skill as a surgeon, much of the success of the outcome can also be attributed to chance. The case was not identified to the nursing staff ahead of time as being noteworthy, and although the L&D unit

was overstaffed at the time, this was happenstance. Overall, although the procedure was planned, respondent went into it essentially as if the patient had arrived at the hospital without prior notice, and the staff who happened to be present dealt with the situation. The gist of his testimony was that because he felt he was highly qualified and capable of performing the surgery, little else mattered. In sum, while it was not established that respondent's approach to the procedure rose to the level of an extreme departure from the standard of care his actions were not consistent with a reasonably prudent physician in similar circumstances. The reason that the standard of care is to recommend these procedures be performed in a tertiary care facility is because there is a high probability that something will go wrong, and these facilities have the resources to address complications. Put another way, there were plenty of factors beyond respondent's control that could have led to a different outcome. Respondent took almost no steps to mitigate against this risk. If respondent acted similarly in the future, the outcome likely would not be as fortuitous.

79. Finally, Dr. Fenton believed that respondent departed from the standard of care by entering the abdomen through a lateral incision and breaching the placenta. Dr. Fenton also believed that once respondent visualized that it was a placenta accreta, he should have delivered the baby, closed the patient, and transferred the patient to a tertiary care facility for a hysterectomy. Dr. DiMarzo believes that respondent's approach was reasonable because regardless of the incision point, the placenta would have had to have been breached. He believed respondent had the training and experience to perform the postpartum hysterectomy.

80. Clear and convincing evidence did not establish that respondent departed from the standard of care during the operation. Having decided to perform the surgery at ECRMC, respondent's actions and care for the patient were within the

standard of care. Respondent appropriately managed the patient's blood loss with blood replacement products.

Respondent's Additional Evidence

TESTIMONY OF CHRISTIAN TOMASZEWSKI, M.D.

81. The testimony of Christian Tomaszewski, M.D., and his letter to the board are summarized as follows: Dr. Tomaszewski is the Chief of Staff for UCSD Health, which manages ECRMC. Since 2016, Dr. Tomaszewski has also been the Chief Medical Officer (CMO) of ECRMC. In that position, he supervises hospital operations. Dr. Tomaszewski specializes in emergency medicine and has served as an attending physician in emergency medicine, medical toxicology, and hyperbarics at UCSD since 2008. From 2010 to 2016, Dr. Tomaszewski was the medical director of UCSD's Department of Emergency Medicine. Dr. Tomaszewski has known respondent professionally since he became CMO of ECRMC. Dr. Tomaszewski spends two to three days per week at ECRMC. He worked with respondent directly when respondent was ECRMC's Chief of Staff. Respondent is well-respected, an excellent clinician, and has demonstrated leadership in the hospital's management. Dr. Tomaszewski was unequivocal in his belief that respondent is an asset to the hospital and not a "problem physician." Respondent has been active and integral in improving ECRMC's quality of care and health delivery. Dr. Tomaszewski expressed concern about what would happen if respondent were placed on probation and removed from insurance panels. This would essentially prevent him from serving the El Centro community because there are few private-pay patients. When Dr. Tomaszewski wrote his letter of support he was aware of the allegations pertaining to Patient A. He has not reviewed the amended accusation as it relates to Patient B. He was not aware of the specific

allegations related to Patient B. Nevertheless, Dr. Tomaszewski believes respondent is a valued member of the medical community and not a danger to the public.

TESTIMONY OF DR. ADOLPHE EDWARD

82. The testimony of Dr. Adolphe Edward and his letter to the board are summarized as follows: Dr. Edward holds several advanced degrees including a Doctorate in Healthcare Administration and Healthcare Policy and Master of Business Administration. Dr. Edward is a retired Air Force colonel who was hired by UCSD in 2016 as ECRMC's Chief Executive Officer. During his first board meeting, he met respondent, who was transitioning from the OB-GYN department chair to Chief of Staff. Respondent has had a critical impact in improving the quality of healthcare at ECRMC over the past five years. Respondent enjoys an excellent clinical reputation in the community. He is also a valued and demonstrated leader in the hospital and El Centro community. Dr. Edward provided his testimony at midnight from the United Arab Emirates (on a recruiting trip) because he wanted to make sure he could impress upon the board the impact that respondent has had on the hospital. Dr. Edward noted that El Centro is an underserved population, and there is already a shortage of qualified practitioners. Since Dr. Edward joined ECRMC, the hospital has vastly improved in its ratings. Respondent has been instrumental in this reversal. Removing respondent from insurance panels would have a "devastating impact" on the community. In a small community like El Centro, word travels fast. Respondent is not a problem physician. If Dr. Edward were rating OB-GYN's in the area, respondent would be number one, with second place far behind. Dr. Edward is aware of the allegations against respondent but fully supports his ability to practice with an unrestricted license.

ADDITIONAL DOCUMENTS

83. Respondent submitted a letter dated June 23, 2020, addressed to the board and signed by eight department chairs and executive committee physicians from ECRMC. The letter stated that respondent has a stellar reputation amongst his patients and peers and has been a valuable leader in the medical community.

84. Respondent submitted proof that he has maintained continuing education requirements for ACOG membership.

85. Respondent submitted a letter from Cigna Care designating him as a Tier 1 provider, which is the highest ranking based on quality and claims information.

86. Respondent submitted a letter from ECRMC establishing that for reappointment with the hospital, he has received two "excellent" professional peer references for each evaluation period.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (Evid. Code § 115.) The standard of proof in an administrative action seeking to suspend or revoke a professional license is "clear and convincing evidence." (*Ettinger, supra,* at p. 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; it requires sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Relevant Statutory Authority

2. Business and Professions Code section 2227, subdivision (a), provides:

> 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.

3. Under Business and Professions Code section 2234, the board shall take action against a licensee charged with unprofessional conduct. Grounds for unprofessional conduct include:

(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.

4. It is also unprofessional conduct for a physician and surgeon to fail to maintain adequate and accurate records relating to the provision of services to his or her patients. (Bus. & Prof. Code, § 2266.)

Simple Negligence, Gross Negligence, and Incompetence

5. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.)

6. Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

7. Incompetence generally is defined as a lack of knowledge or ability to discharge professional obligations. (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) "Incompetence" is distinguished from simple negligence in that one may be competent or capable of performing a given duty, but negligent in performing it. A single negligent act is not equivalent to incompetence. While a single negligent act may reveal a general lack of ability to perform licensed duties and support a finding of incompetence, a single honest failing in performing those duties - without more - does not constitute the functional equivalent of incompetence. (*Kearl, supra,* at p. 1055.)

8. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore, supra,* at pp. 195-198; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

> Negligence and gross negligence are relative terms. "The amount of care demanded by the standard of reasonable conduct must be in proportion to the apparent risk. As the

danger becomes greater, the actor is required to exercise caution commensurate with it." (*Id.* at pp.184,198.)

9. A physician's failure to complete or maintain patient records can constitute gross or simple negligence, depending on the circumstances. (*Kearl, supra,* at p. 1054.)

Cause Exists to Discipline Respondent's Certificate

10. Cause does not exist to discipline respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), as alleged in the first cause for discipline. Clear and convincing evidence did not establish respondent committed an extreme departure from the standard of care or provided "want of even scant care" required to establish gross negligence (Factual Findings 45, 47, 48, 75-80).

11. Cause exists to discipline respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), as alleged in the second cause for discipline. Respondent committed repeated negligent acts, which is unprofessional conduct, based on the findings that respondent committed multiple departures from the standard of care in his treatment of Patient A and Patient B (Factual Findings 45, 47, 48, 75, 76, 78).

12. Cause does not exist to discipline respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (d), as alleged in the third cause for discipline. Clear and convincing evidence did not establish respondent demonstrated incompetence in his care of Patient A (Factual Finding 46).

13. Cause exists to discipline respondent's certificate, pursuant to Business and Professions Code section 2266, as alleged in the fourth cause for discipline.

Respondent failed to maintain adequate and accurate records relating to the provision of services for Patient B (Factual Finding 76).

Appropriate Level of Discipline

14. "Protection of the public shall be the highest priority" for the board in exercising its disciplinary authority. (Bus. & Prof. Code, § 2229, subd. (a).) The main purpose of disciplinary licensing schemes is protection of the public through the prevention of future harm and the improvement and rehabilitation of the licensee. (*Griffiths v. Sup. Ct.* (2002) 96 Cal.App.4th 757, 772.) The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Administrative proceedings before the board are not designed to punish but to afford protection to the public upon the rationale that respect and confidence of the public is merited by eliminating from the ranks of practitioners those who are dishonest, immoral, disreputable, or incompetent. (*Fahmy v. Medical Bd. of California* (1995) 38 Cal.App.4th 810, 817.)

15. California Code of Regulations, title 16, section 1361, subdivision (a), provides that when reaching a decision on a disciplinary action, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). The guidelines state:

> In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.
>
> [¶] . . . [¶]

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

16. Under the Disciplinary Guidelines, the minimum discipline for repeated negligence and failure to maintain adequate medical records is a stayed revocation for five years.[14] The maximum discipline is revocation. Among the conditions of probation, the guidelines recommend coursework, a clinical competence assessment program, a practice monitor, solo practice prohibition, and prohibited practice.

17. Complainant requests a term of probation with the recommended optional conditions except for a solo practice monitor and prohibited practice. Respondent argues that a public letter of reprimand with a requirement that he complete a recordkeeping course is sufficient for public protection. He further argues that placing him on probation will jeopardize his ability to remain on insurance panels, which in turn, could prevent him from continuing to provide much needed care in El

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[14] The guidelines provide that in cases of repeated negligence involving one patient, a "public reprimand may, in appropriate circumstances, be ordered."

Centro, a highly underserved community. In support of his argument, respondent notes that the simple negligence regarding the care of Patient A occurred seven-and-a-half years ago, and respondent has since implemented new policies and procedures to address the treatment of preeclampsia and postpartum hemorrhage. There has not been a repeat of a similar incident. While respondent did not admit any wrongdoing with his care of Patient B, respondent maintained that probation would not advance public protection but would instead, limit his ability to practice in a community in need of qualified OB-GYNs.

18. Respondent has been licensed for over 20 years and has no history of prior discipline. The allegations relating to Patient A occurred in early 2014, and respondent has helped establish uniform policies for the treatment of preeclampsia and postpartum hypertension at ECRMC. Had the issues in this case solely been matters of simple negligence related to Patient A, a public letter of reprimand would have been appropriate. Regarding Patient B, even though gross negligence was not established, respondent was negligent in several areas. Although he acknowledged some deficiencies in recordkeeping, he did not accept that he acted imprudently in his patient care. His statement that the only thing he would do differently would be to refuse the patient due to fear of board discipline does not reflect genuine introspection about his handling of the case. Respondent has not undergone any education courses addressing any of the issues raised in the accusation.

On the other hand, both the CEO and CMO of ECRMC praised respondent's skills as a clinician and leadership in improving the quality of care at the hospital. Both expressed concern that probation would force respondent out of El Centro. While their opinion might be jaded by self-interest in retaining an experienced OB-GYN at their

hospital, they both appeared genuine in their belief that respondent is not a "problem physician" who poses a risk to his patients (and in turn, liability by the hospital).

Respondent asks that the board consider the consequences that probation (and being dropped from insurance carriers) could have on the community of El Centro, an underserved population, and maintains that probation would not advance public protection. It is true that probation can have disparate effects on physicians depending on their location and type of practice. However, neither the legislature, nor the board, have expressed that the impact of probation on a physician's ability to practice in an underserved population should be considered as a criterion in rendering a disciplinary decision.

19. Upon the above findings and consideration of all the evidence in this matter, deviation from the disciplinary guidelines is warranted. Regarding specific conditions, the evidence established that respondent is not deficient in his skills and knowledge such as to require restricted practice, a practice monitor, enrollment in a clinical assessment competency program (PACE), or prohibition of solo practice. However, he would benefit from the requirement of certain education courses. While these courses could be imposed as a condition of a public letter of reprimand, a greater level of discipline is required in the absence of significant evidence of rehabilitation. A one-year period of probation is sufficient to meet this objective. While this is considerably less than the recommended five years, it bears noting that the findings of negligence and deficient recordkeeping in this case are significantly less serious than in cases warranting the recommended discipline. It is also important that the allegations related to Patient A occurred over seven years ago. Because it is determined that heightened monitoring (such as PACE or a practice monitor) is not warranted, public protection would not be enhanced by a longer term of probation.

ORDER

Certificate No. C 50303 issued to respondent, Elias N. Moukarzel, M.D., is revoked pursuant to Legal Conclusions 11 and 13, separately and for all of them. However, revocation is stayed, and respondent is placed on probation for one year 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. Medical Record Keeping Course. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record

keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole

discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Notification. Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Supervision of Physician Assistants and Advanced Practice Nurses. During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

6. 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.

7. 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.

8. General Probation Requirements. Compliance with Probation Unit: Respondent shall comply with the board's probation unit.

Address Changes: Respondent shall, at all times, keep the board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event respondent should leave the State of California to reside or to practice respondent shall notify the board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. 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.

10. Non-practice While on Probation. Respondent shall notify the board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

11. 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.

12. Violation of Probation. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. 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 or her license. The board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. 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.

DATE: September 7, 2021

Adam Berg (Sep 7, 2021 16:17 PDT)

ADAM L. BERG
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **ELIAS N. MOUKARZEL, M.D.** **2109 W. Ross Avenue** **El Centro, CA 92243** **Physician's and Surgeon's Certificate No. C 50303,** Respondent.	Case No. 800-2017-034242 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 17, 1999, the Medical Board issued Physician's and Surgeon's Certificate No. C 50303 to Elias N. Moukarzel, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2021, unless renewed.

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JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation that was filed on May 22, 2020, 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states, in pertinent part:

> 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:
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> ...
>
> (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.
>
> ...
>
> (d) Incompetence.
>
> ...

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 has subjected his Physician's and Surgeon's Certificate No. C 50303 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patients A and B, as more particularly alleged hereinafter:

PATIENT A[1]

8. On or about January 30, 2014, Patient A was admitted to El Centro Regional Medical Center (ECRMC) by S.G., M.D. (Dr. S.G.) with concerns of pregnancy induced hypertension and preeclampsia. Patient A was forty-one-years-old at the time and 36 2/7 weeks gestational age. Labs taken upon admission revealed a normal platelet count of 162,000. The patient's blood pressure over the course of a ten hour period was labile, ranging between 135/67 to 167/81. Dr. S.G.'s plan at that time was to monitor the patient overnight.

9. On or about January 31, 2014, Patient A's care was assumed by M.C., M.D. (Dr. M.C.) Throughout that day, the patient's blood pressure remained labile, ranging between 137/78 to 183/91. Dr. M.C. ordered continued observation and repeat labs. Between approximately 8:00 p.m. and 8:17 p.m., the patient's blood pressure was measured to be 170/84, and 178/82. At approximately 9:00 p.m., Dr. M.C. met with the patient and informed her that induction would need to be initiated if there was any worsening of her preeclampsia.

10. On or about February 1, 2014, at approximately 6:06 a.m., Patient A's blood pressure was measured to be 160/79. Labs ordered by Dr. M.C. revealed a platelet count of 130,000.

11. At approximately 8:30 a.m., Patient A's care was assumed by Respondent. Respondent noted the patient had been in the hospital for two days and that her preeclampsia was worsening due to her lowered platelet count. Because of the lowered platelet count, Respondent ordered an induction of labor, and magnesium therapy to protect against seizures.

12. Between approximately 9:56 a.m. and 10:16 a.m., Patient A's blood pressure was measured to be 190/96, 171/98, 185/92, 166/82, and 159/83. Respondent did not order antihypertensive medication at that time, or anytime thereafter during his course of treatment of this patient.

13. At approximately 10:26 a.m., the patient was given Prepidil[2] for cervical ripening.

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[1] To protect the privacy of the patients involved, the patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

[2] Prepidil (name brand for dinoprostone) is a medication used to dilate the opening of the uterus.

14. At approximately 2:55 p.m., Patient A had still not delivered and her blood pressure was measured to be 176/95.

15. At approximately 4:53 p.m., Respondent ordered the patient be immediately given Cyotec[3] 25 mcg vaginally and Tylenol for her complaints of a frontal headache.

16. At approximately 5:39 p.m., Respondent was advised by a nurse that the patient was experiencing uterine contractions every four to seven minutes and questioned his order for Cyotec. Respondent confirmed his order of Cyotec 25 mcg vaginally at that time.

17. At approximately 8:25 p.m., Patient A had still not delivered and her blood pressure was measured to be 161/91.

18. At approximately 10:10 p.m., when the patient was experiencing uterine contractions every two to six minutes, Respondent ordered Cyotec 50 mcg vaginally.

19. At approximately 10:30 p.m., Patient A was provided another dose of Tylenol for her headache.

20. At approximately 11:27 p.m. Patient A's blood pressure was measured to be 167/91. At approximately 11:43 p.m., oxygen was initiated.

21. On or about February 2, 2014, at approximately 12:25 a.m., Patient A had still not delivered and her blood pressure was measured to be 178/92. Five minutes later, the fetal heart rate tracings were noted to be minimal to undetectable variability.

22. At approximately 2:03 a.m., Patient A's fetal heart rate tracings were noted to be minimal to undetectable variability and a prolonged deceleration. At approximately 2:19 a.m., Respondent was bedside and ordered an emergent cesarean section.

23. At approximately 2:25 a.m., while in the delivery room, Patient A was found to be completely dilated and Respondent ordered her to push. At approximately 2:27 a.m., Patient A delivered a female infant weighing four pounds two ounces. Approximately two minutes later, her placenta was delivered intact.

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[3] Cyotec (brand name for misoprostol) is a medication used for the treatment of ulcers, but has been widely used for the effective induction of labor. Cyotec is not FDA approved for that process and contains a warning label that its use in pregnant woman can cause birth defects, abortion, premature birth, and uterine rupture.

24. At approximately 2:30 a.m., Patient A was bleeding abnormally, and Respondent massaged her uterus and ordered Hemabate[4] 250 mcg.

25. At approximately 2:53 a.m., Patient A continued to bleed heavily. Respondent continued to massage her uterus at that time and ordered another dose of Hemabate 250 mcg.

26. At approximately 3:00 a.m., Patient A continued to bleed heavily vaginally but was also noted to have blood in her mouth. At that time, Respondent continued to massage her uterus and ordered her to be transfused with three units of red blood cells. Respondent did not order or administer frozen plasma, cryoprecipitate, or platelets to Patient A at that time or anytime thereafter during his course of treatment of this patient.

27. At approximately 3:54 a.m., Patient A continued to bleed heavily vaginally and from her mouth despite continued uterine massage, and Respondent suspected she had developed disseminated intravascular coagulation. Respondent ordered the patient be given Merthergine[5] 2 mg and an emergent hysterectomy. Uterine packing and foley catheters were not utilized by Respondent, and he did not call for a general surgical consultation.

28. At approximately 4:35 a.m., Respondent performed a laparotomy and supracervical hysterectomy on Patient A without first assessing her clotting ability. During the procedure, Respondent found over one liter of blood in the patient's abdominal cavity and a boggy uterus. Respondent believed hemostasis was achieved in the peritoneal cavity, though he noted oozing in the subfascial space. After the procedure, the patient was transferred to the intensive care unit.

29. Between on or about February 2, 2014, through on or about February 5, 2014, Patient A developed hemorrhage shock, severe leukocytosis secondary to sepsis, and abdominal compartmental syndrome secondary to continuous bleeding and fluid resuscitation.

30. On or about February 5, 2014, the patient was emergently transferred by helicopter to UCSD Medical Center for a higher level of care, where she underwent an exploratory laparotomy and an extended course of treatment.

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[4] Hemabate (brand name for carboprost) is a hormone-like substance used to treat postpartum hemorrhage.

[5] Merthergine (brand name for methylergonovine) is an uterotonic and analgesic medication used to treat severe uterine bleeding.

31. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, the following:

(A) Failing to provide antihypertensive medication to the patient despite repetitive and sustained elevated blood pressure readings;

(B) Ordering 50 mg Cyotec when the patient's contractions were approximately every two minutes and the fetal heart rate strip suggested tachysytole; and

(C) Failing to adequately manage the patient's postpartum hemorrhage.

PATIENT B

32. On or about February 14, 2019, Patient B presented to Respondent's clinic to initiate prenatal care, and was seen by nurse practitioner, M.G., N.P. Patient B was thirty-six years old at that time and 28+ weeks' gestation with an estimated delivery date of April 25, 2019. Patient B had previously received prenatal care in Mexico, and had a history of two prior cesarean sections in 2007 and 2012, a first trimester miscarriage in 2010, and a laparotomy for a right tubal pregnancy in 2013.

33. On or about February 21, 2019, Patient B presented for a follow-up visit and was seen by Respondent. At this visit, Respondent performed an ultrasound that revealed a 33w0d pregnancy and a complete anterior placenta previa.[6] Respondent highly suspected the patient had a placenta accreta,[7] and considered this a high risk pregnancy due to her advanced maternal age, two prior cesarean sections, a laparotomy for a prior ectopic pregnancy, and complete placenta previa. Respondent discussed the risks at length with the patient, including but not limited to, risk of hemorrhage, blood transfusion, preterm labor and birth, hysterectomy, and other unknown complications. Respondent had never performed a cesarean section on a patient with placenta accreta at ECRMC, and did not discuss and/or document a discussion with Patient B at this visit or any visit thereafter, regarding the limitations of delivery at ECRMC, his recommendation or

[6] Placenta previa occurs when the placenta partially or totally covers the opening to the cervix.

[7] Placenta accreta is a serious pregnancy condition that occurs when the placenta grows too deeply into the uterine wall. Typically, the placenta detaches from the uterine wall after childbirth. With placenta accreta, part or all of the placenta remains attached. This can cause severe blood loss after delivery.

referral to a tertiary care center, or the patient's informed refusal to obtain treatment elsewhere. At the conclusion of this visit, Patient B requested sterilization, and Respondent prescribed a corticosteroid for fetal lung maturity that the patient planned to receive in Mexico.

34. On or about March 5, 2019, Patient B presented to Respondent for a follow-up. At this visit, Respondent performed another ultrasound that revealed continued presence of complete placenta previa. At the conclusion of this visit, Respondent scheduled the patient for a repeat cesarean section and bilateral partial salpingectomy[8] at ECRMC on April 11, 2019, at 38 weeks' gestation. Respondent did not at this visit or any visit thereafter, confirm and/or document whether or when the patient received the prescribed corticosteroid, obtain consultation from a maternal fetal medicine specialist or gynecologic oncologist to create a management plan for the patient's delivery, request additional clinical support for the patient's delivery at ECRMC, and/or document any attempts to coordinate her care with additional clinical support.

35. On or about March 14, 2019, Patient B presented to Respondent for a follow-up. At this visit, Respondent again discussed precautions for placenta previa with the patient.

36. On or about March 21, 2019, Patient B presented to Respondent for a follow-up. At this visit, Respondent provided labor instructions to the patient and discussed the risks of placenta accreta, hemorrhage, and hysterectomy.

37. On or about April 9, 2019, Patient B presented to Respondent for a follow-up. At this visit, Respondent noted the patient had a placenta accreta with a scheduled repeat low transverse cesarean section and sterilization on April 11, 2019. Respondent again discussed the risks with the patient, including but not limited to, hemorrhage, blood transfusion and hysterectomy.

38. On or about April 10, 2019, labor and delivery nurses at ECRMC noted Patient B's repeat cesarean section scheduled for the next morning at 5:00 a.m. The nurses reviewed the patient's prenatal chart and noted the patient had placenta accreta and became concerned about low staffing at 5:00 a.m. for a high risk surgery. At approximately 11:00 p.m., the labor and delivery charge nurse contacted Respondent by phone and asked if the surgery could be delayed

[8] Salpingectomy is the surgical removal of one (unilateral) or both (bilateral) fallopian tubes. A partial salpingectomy is the removal of only part of a fallopian tube.

until more staff was present at ECRMC. Respondent declined this request and the surgery remained as scheduled.

39. On or about April 11, 2019, at approximately 1:25 a.m., Patient B presented to ECRMC for her planned repeat cesarean section and sterilization. At approximately 5:00 a.m., the patient was brought into the operating room, prepared for surgery, and administered spinal anesthesia. Respondent then performed a repeat low transverse skin incision and noted the placenta was visible through the lower uterine segment. No gross vessels were seen coming through the wall of the lower uterine segment. Respondent then proceeded to make a low transverse uterine incision and entered the uterus through the placenta into the amniotic cavity. A viable male infant was delivered at approximately 5:58 a.m. Respondent then noted the placenta was not coming out and tried but failed to manually remove the placenta from the lower uterine segment, noting fragments of placenta within it. Respondent then closed the uterus quickly and performed a supracervical hysterectomy and bilateral salpingectomy on the patient. Intraoperatively, Patient B had a significant blood loss of approximately 3500 mL and received 6 units of packed red blood cells, one unit of fresh frozen plasma, one bag of platelets, and cryoprecipitate. The subsequent pathology report revealed findings consistent with placenta accreta.

40. Patient B was transferred to recovery in stable condition, had an uncomplicated postoperative course, and was discharged on or about April 14, 2019.

41. Respondent committed gross negligence in his care and treatment of Patient B, which included, but was not limited to, the following:

(A) Providing deficient prenatal care, including but not limited to, failing to schedule delivery between 34-35 6/7 weeks gestation; failing to administer or verify and document Patient B's receipt of corticosteroids; failing to discuss and/or document a discussion with Patient B regarding the limitations of delivery at ECRMC, his recommendation or referral to a tertiary care center, or the patient's informed refusal to obtain treatment elsewhere; and failing to obtain consultation from a maternal fetal medicine specialist or gynecologic oncologist to create a management plan for delivery;

(B) Providing deficient perioperative and intraoperative care, including but not limited to, failing to provide extensive delivery planning and coordination of care with necessary additional clinical support, and failing to deliver the fetus through a fundal uterine incision and performing a cesarean hysterectomy.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

42. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 50303 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A and B, as more particularly alleged in paragraphs 7 through 41(B), above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

43. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 50303 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated incompetence in his care and treatment of Patient A, as more particularly alleged in paragraphs 7 through 31(C), above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

44. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 50303 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient B, as more particularly alleged in paragraphs 32 through 41(B), above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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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 No. C 50303, issued to Respondent, Elias N. Moukarzel, M.D.;

2. Revoking, suspending or denying approval of Respondent, Elias N. Moukarzel, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, Elias N. Moukarzel, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: MAY 12 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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