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

In the Matter of the Accusation Against Allan Akerman, M.D. Physician's and Surgeon's License No. A91309 Respondent.	Case No. 800-2017-030133

DECISION

The attached Amended Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(C), to correct a clerical error that does not affect the factual or legal basis of the Amended Proposed Decision. The Amended Proposed Decision is amended as follows:

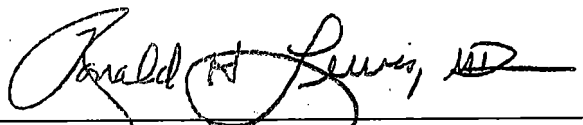
1. Page 4, paragraph 3, line 2: the license number is corrected to read "A91309."

The attached Amended 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 September 25, 2020.

IT IS SO ORDERED: August 27, 2020.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the Accusation against:

Allan Akerman, M.D., Respondent

Case No. 800-2017-030133

OAH No. 2019041007

AMENDED PROPOSED DECISION[1]

Vallera J. Johnson, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on October 8, 9, and 11, 2019, and February 5, 6, and 7, 2020.

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[1] Pursuant to Government Code section 11518.5, the Administrative Law Judge amends the Proposed Decision, issued on July 23, 2020, to correct a mistake and clerical error, that is, to rule on Exhibit 20 and to properly identify the exhibit numbers of closing arguments/briefs. All amendments are included in footnote 2 and indicated in bold font.

Tessa L. Heunis, Deputy Attorney General, Department of Justice, Office of Attorney General, represented the Executive Director of the Medical Board of California.

Dennis K. Ames, Attorney at Law, of La Follette, Johnson, De Haas, Fesler & Ames, APC represented Allan Akerman, M.D.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on May 22, 2020.[2]

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[2] On February 7, 2020, the hearing concluded. **Complainant offered Exhibit 20 (timeline of ultrasounds), and respondent objected; the administrative law judge reserved. Having considered the arguments of counsel, exhibit 20 is admitted.**

During the hearing on the same date, the administrative law judge set the schedule for filing closing arguments. Thereafter, each of the parties filed motions to extend the time to file closing argument. Without objection by the other party, the motions were granted.

On April 17, 2020, Complainant's Closing Argument was filed and marked exhibit **S**. On May 15, 2020, Respondent – Closing Argument was filed and marked exhibit. On May 22, 2020, Complainant's Reply was filed and marked exhibit **22**.

On May 22, 2020, the record was closed, and the matter was submitted.

FACTUAL FINDINGS

Jurisdictional Matters

1. Complainant filed Accusation, Case No. 800-2017-030133, against respondent.

In the Accusation, complainant alleged, among other things, that respondent provided care and treatment below the standard of care for Patient A in that he failed to identify and appropriately monitor a monochorionic twin pregnancy, to appropriately document ultrasounds performed and the findings, and failed to appropriately document a diagnosis of gestational diabetes and patient counseling regarding this diagnosis, and failed to maintain adequate and accurate records; further, complainant alleged that the foregoing facts constituted violations of the Medical Practice Act and therefore justified discipline.

Respondent filed a timely Notice of Defense, requesting a hearing in this matter.

In support of the charges, in addition to the documentary evidence, complainant offered the testimony of Jessica Kingston, M.D. (Dr. Kingston), complainant's expert witness. In response to the allegations, in addition to the documentary evidence, respondent testified and offered the testimony of Scott Serden, M.D. (Dr. Serden), his expert witness; in addition, he offered the testimony of Solomon Maya, M.D., and four letters of support.

Burden and Standard of Proof

2. Complainant bears the burden of proving the charges by clear and convincing evidence to a reasonable certainty. (*Ettinger* v. *Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This requires that she present evidence "of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth" of the charges (BAJI 2.62), and be "so clear as to leave no substantial doubt." (*In re Angelia P.* (1981) 28 Cal.3d 908, 919; *In re David C.* (1984) 152 Cal.App.3d 1189, 1208.) If the totality of the evidence serves only to raise concern, suspicion, conjecture or speculation, the standard is not met.

License History

3. On May 20, 2005, the board issued Physician's and Surgeon's Certificate Number G66777 to respondent. The certificate is current, with no history of discipline, and expired on May 31, 2019, unless it was renewed.

Background Information

4. Dr. Kingston and respondent agreed (and Dr. Serden did not dispute) that, generally, twin pregnancies (more than singletons) are at increased risk for potential pregnancy complications: pre-term birth, gestational diabetes, and hypertension; depending on the type of twin pregnancy, they can be at risk for placental function problems that can compromise the babies earlier in the pregnancy, including limiting the growth of the fetuses and can put the fetuses at risk for demise prior to birth.

5. There are three levels of risk, depending on the type of twins.

The lowest level of risk is dichorionic diamniotic (also known as di-di), which means there are two chorionic sacs, two amniotic sacs, two placentas, two fetuses and two umbilical cords. There are four layers of membranes between the babies.

The intermediate level of risk is monochorionic diamniotic (mo-di), which means the babies share a placenta and share a chorionic sac; they have two amniotic sacs and two umbilical cords; they have two layers of membranes, and one membrane surrounds the fetuses. The mo-di is higher risk because the sharing of the placenta can be uneven such that one baby essentially gives blood to the other baby (donor baby), and the recipient baby is getting more of the blood; they can grow disproportionately, and it can lead to problems.

The highest level of risk is monochorionic-monoamniotic (mo-mo), which means there is one chorionic sac and one amniotic sac; the fetuses share one placenta and share the same physical space; they can become entangled together, and their umbilical cords can tangle up. These twins should be managed by a high-risk pregnancy expert alone. These mothers tend to be hospitalized from 24 weeks-gestation (depending on the patient's preferences) and monitored continuously because the entanglement is hard to predict whether it will happen or not; they need to be potentially delivered emergently.

6. One of the risks of monochorionic pregnancy is that twin to twin transfusion syndrome (TTTS) can occur.

TTTS is a rare, serious condition that can occur in pregnancies when identical twins share a placenta. Abnormal blood vessel connections form in the placenta and allow blood to flow unevenly between the babies. One twin becomes the donor twin, where most of the blood supply will be donated from that twin's portion of the

placenta to the other twin, known as the recipient twin. If the syndrome is occurring, and it evolves and progresses, then the fluid levels will change such that the recipient twin develops polyhydramnios (excessive amniotic fluid), while the donor twin becomes dehydrated and has oligohydramnios (low amniotic fluid).

Clinicians do not know which monochorionic gestations will develop TTTS or which will not; so all need to be followed closely to assess for that risk. If the pregnancy develops TTTS, clinicians do not know which ones will stabilize and stay the same, which ones will get a little better as the pregnancy advances or which ones will continue to progress and worsen and go through the stages of the syndrome to the final stage, which is one or both babies dying in utero.

7. There are five stages of TTTS. Stage one is when there is a discordance in fluid levels such that one twin has excessive amniotic fluid and the other twin has low amniotic fluid. Stage two is when the donor twin's urinary bladder disappears, and it cannot be seen on ultrasound anymore. Stage three is when the clinician can appreciate changes in the blood flow patterns within the placenta with the Doppler ultrasound. Stage four is when the recipient twin becomes really swollen (hydrops). Stage five is when one or both of the babies die in utero.

If TTTS is going to develop, it tends to occur in the second trimester, typically not as early as 14 weeks but is more common to evolve after 16 to 18 weeks, typically in early second trimester. TTTS may occur in as short as a week but, typically, it progresses through the stages, from stage one to stage two etc.

If the physician sees stage one, the recommendation is to look again in a week. When the clinician looks in one week, it may be stage one still or may have evolved to stage 2 or stage 3.

The rate of progression of TTTS is unknown. However, it is better to identify and treat TTTS early, because, at that time, treatment is less risky, and there is less likelihood of irreversible damage to one or both babies.

8. Since 10 to 15 percent of all monochorionic pregnancies can develop TTTS, they should be managed in consultation with a high-risk pregnancy expert or by the high-risk pregnancy expert independently. For this reason, it is important to establish the chorionicity of a twin gestation as early as possible to determine the level of surveillance necessary.

9. It is undisputed that the best time to determine chorionicity is the first trimester; Dr. Kingston explained that the first trimester is "from the time you can clinically recognize a pregnancy on ultrasound, which is about five to six weeks, up to 14 weeks. In the cases that chorionicity is diagnosed prior to 14 weeks, the accuracy of the diagnosis approaches 100 percent." "And the further along in pregnancy that diagnosis was made, the less accurate that diagnosis became."

10. In most cases, ultrasounds will agree on chorionicity; however, if the ultrasounds are discordant, the one done prior to 14 weeks that established chorionicity is more reliable than the one performed after 14 weeks.

11. During the course of pregnancy, chorionicity is best established by ultrasound. In looking at an ultrasound image and determining chorionicity, there are accepted "clues" that can assist.

- One visual clue that can distinguish monochorionic pregnancy from a dichorionic pregnancy in the first trimester, is the presence or absence of the "twin peak" sign between the two fetuses and placentas. If

the peak is not there, it is a monochorionic pregnancy. The peak may be seen on ultrasound as early as 45-days gestation.

- Another distinguishing feature on a first trimester ultrasound can be the yolk sac. One yolk sac means one placenta. Two yolk sacs is more likely to be dichorionic. The yolk sac(s) can best be seen on ultrasound before or at 10 weeks.

- A further indication of chorionicity may be the babies' gender. If they are different genders, that will mean they are not identical twins and are dichorionic.

12. Gestational Diabetes occurs during pregnancy because the placental hormones impacting the maternal metabolism become relatively intolerant to glucose, or essentially insulin resistant. It is diabetes specific to pregnancy. If it is uncontrolled, it can lead to abnormal fetal growth (also known as macrosomia). If high levels of glucose are sustained and untreated, it increases risk for stillbirth. Women who have gestational diabetes are at risk for blood pressure problems during pregnancy.

When gestational diabetes has been diagnosed, the patient should begin glucose monitoring. If the patient is not able to keep her glucose levels within the targeted levels, medications such as insulin or oral diabetes medication may be recommended. In addition, the patient should be educated about her diagnosis and its implications for her and her baby. Women with gestational diabetes are also at higher

risk of becoming diabetic after pregnancy and should be followed once a year by her primary physician for diabetes screenings.

Patients who have been diagnosed with gestational diabetes in their previous pregnancy are at increased risk for developing it in subsequent pregnancies.

13. The State of California Department of Health operates the Genetics Disease Screening Program, offered to all pregnant women, to screen for certain birth defects. The prenatal screening program includes first trimester screening, which provides pregnant women a risk assessment for down syndrome and Trisomy 18 earlier in pregnancy and to provide more accurate risk assessment in the second trimester of pregnancy.

The screening may be performed in three different ways. The patient may opt to screen by blood tests alone; alternatively, she may elect a two-test panel with the first blood test occurring between 10 to 13 weeks six days, and the second one between 15 to 20 weeks; the third option is to have an integrated screening which includes two blood tests (the two previously described blood tests) and a nuchal translucency (NT) ultrasound, which is typically performed between 11 and 14 weeks.

All three versions of screening tests involve at least one blood test, possibly two. Each blood sample is sent to the state laboratory for testing, accompanied by a state test requisition form (or request for testing). The results are returned to the treating OB/GYN.

Patient A

14. On March 8, 2012, Patient A, then a 33-year-old female serving as a surrogate, underwent in vitro fertilization (IVF) of a single embryo, performed by Vicken Sahakian, M.D. (Dr. Sahakian) at Pacific Fertility Clinic.

Patient A's history was notable for two vaginal births (1996 and 2001) and one cesarean section delivery (2010). The cesarean delivery was for suspected macrosomia as a result of gestational diabetes.

15. On March 20, 2012, Patient A's pregnancy was confirmed with an estimated due date of November 26, 2012.

16. On April 2, and 16, and May 2, 2012 (six, eight and 10 weeks)[3], Dr. Sahakian performed an obstetric ultrasound on Patient A. On each of the ultrasounds, Dr. Sahakian charted one sac (monochorionic) and two fetal heart rates (identical twins). The chart notes from the fertility center do not reflect the amnionicity of the twins.

17. After experiencing vaginal bleeding, on May 1, 2012, Patient A presented to the emergency room at St. Joseph Hospital with a complaint of vaginal bleeding; on that date, an ultrasound was performed which revealed twin pregnancies with two fetal heart rates; both fetuses were viable.

18. On May 5, 2012, Patient A (10 weeks 6 days) presented again to the emergency room at St. Joseph Hospital with a complaint of vaginal bleeding. Dr. Robert Cho (Dr. Cho), the radiologist who performed an ultrasound, issued a report in

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[3] This reference (on this occasion and hereinafter) is to the gestational age.

which he stated: "No definitive separating membrane is noted. A single yolk sac is seen. Fetal heart rates are 170 beats per minute and 167 beats per minute. Large anterior subchorionic hemorrhage 9 x 3 x 4 cm." The radiologists impression was of a: "(1) Living uterine twin pregnancy . . . consistent with likely monochorionic monoamniotic twins. (2) Large subchorionic hemorrhage."

Prior to discharge, Patient A was advised to follow up with respondent within four days because he was taking over her care from Dr. Sahakian.

19. On May 7, 2012, Patient A (11 weeks 1 day) initiated prenatal care with respondent and presented with complaints of vaginal bleeding.

At Patient A's first prenatal visit, respondent performed an obstetrical ultrasound; the ultrasound report revealed, among other things, living intrauterine twin gestation with normal fetal heart rates, and an estimated delivery date of November 29, 2012. Respondent ordered prenatal lab work.

Though copied on the May 5 ultrasound report, there is no documentation in Patient A's chart that respondent reviewed this ultrasound report. Respondent did not discuss the ultrasound report with the radiologist.

Respondent had Patient A complete a medical release of authorization form consenting to the release of her medical records from Pacific Fertility Center. Respondent made no further effort to obtain these records. Neither did he receive the medical records from Pacific Fertility Center nor did he speak with Dr. Sahakian.

Patient A's chart notes for this visit do not identify chorionicity or amnionicity of the twins.

20. On May 15, 2012, Patient A had prenatal lab work performed; a lab report was issued. The results of the hemoglobin A1C and fasting glucose tests showed that Patient A was at increased risk for gestational diabetes. The report was forwarded to respondent's office and reviewed by Debbie Tobin, N.P. (Ms. Tobin), the nurse practitioner who worked in respondent's Orange office.

After reviewing this report, on May 23, 2012, Ms. Tobin referred Patient A to "Sweet Beginnings"[4] and arranged to have the report scanned into the computer record and the original of the report placed in Patient A's medical records.

21. Between May 23, 2012, and August 16, 2012 (Patient A's last visit in respondent's office), at no time was it documented in the chart notes for Patient A, that she had been counseled regarding the diagnosis of gestational diabetes, the potential risks for her and her fetuses, educated on diet, instructed to monitor home glucose values, whether she was attending regularly, being complainant and maintaining her glucose log

22. On May 21, 2012 (13 weeks), Patient A returned to respondent's office for a follow-up evaluation; she was seen by Ms. Tobin, who performed an ultrasound. In the chart, Ms. Tobin noted two fetal heart rates and the crown rump length (CRL) of each fetus but there was no ultrasound report. Ms. Tobin referred Patient A for the first

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[4] "Sweet Beginnings" is a program at St. Joseph Hospital with nurse practitioners who work under the supervision of a perinatologist; the nurse practitioners provide counseling for gestational diabetes, management and follow-up for gestational diabetes and nutritional counseling.

trimester screening as soon as possible. The chart notes for this visit do not mention chorionicity or amnionicity.

23. On the next day, May 22, 2012, Patient A presented at the Genetics Center. Her blood was drawn and the NT ultrasound performed. The test request form was completed, including information regarding the NT ultrasound and the collection of the blood sample, and sent to the State Lab along with Patient A's first trimester blood sample. The first trimester test request was completed by Liz Vargas. The sonographer was Zoe Chester (Ms. Chester).

On May 23, 2012, respondent's office received a 3-page facsimile from the Genetics Center, which included copies of the NT ultrasound report, the first trimester test request and a cover page from the Genetics Center. The first trimester test request included the NT exam date, crown rump and NT measurements of each fetus along with the NT practitioner license number. A box was checked that indicated twin pregnancy, and another box was checked indicating the chorionicity as dichorionic. The prenatal screening issued by the California Department of Public Health noted chorionicity to be dichorionic.

Respondent did not discuss the NT ultrasound findings or determination of chorionicity with Zoe Chester, the sonographer.

24. On May 24, 2012, Patient A (13 weeks three days) was seen by respondent for an unscheduled appointment with complaints of continued vaginal bleeding. Respondent performed an obstetric ultrasound and identified two fetal heart rates. The chart notes included a reference to the second trimester screening test but did not identify chorionicity or amnionicity of the twins.

25. On June 18, 2012, Patient A (17 weeks) was seen by respondent for a follow-up evaluation. Respondent performed an obstetric ultrasound that identified two fetal heart rates. The chart notes for this visit do not identify either chorionicity or amnionicity of the twins. The "comments" section of the note again noted the second trimester screening test to be done as well as the ultrasound to rule out anomalies.

26. On July 5, 2012, Patient A (19 weeks 3 days) returned for an anatomy scan[5], that was performed by Corinne Lentz (Ms. Lentz), a certified sonographer[6], who worked in respondent's office one day per week every two weeks. Thereafter Ms. Lentz issued a report, revealing two females with normal anatomy and normal amniotic fluid; the dividing membrane was visualized; the estimated weight of Fetus A was 376 grams and Fetus B was 350 grams; the gestational age of Fetus A was 20 weeks and five days and Fetus B was 20 weeks and two days; the estimated date of delivery of Fetus A was November 18 and Fetus B was November 20. The fetuses were concordant[7]. The ultrasound did not identify the chronicity of the twins.

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[5] Respondent explained that, the anatomy scan (level 2 ultrasound) is very detailed and includes detailed parts of the fetuses (if a multiple pregnancy), brain development, face features, limbs, cardiac, anatomy, kidney development, fluid, bladder, biometry, amniotic sac and placenta.

[6] A certified sonographer is also known as radiologic diagnostic medical sonographer (RDMS); the certified sonographer completes at least two years of education and is licensed by the State of California. Respondent did not describe the specific education and did not know the board or agency that issues the certification.

[7] Concordant means "approximately equal."

On July 18, 2012, respondent signed the report indicating that he had "reviewed that ultrasound report" (performed on July 5, 2012). He did not speak with Ms. Lentz about chorionicity.

27. On July 17, 2012, Patient A was seen by respondent for a follow-up evaluation. Respondent performed an obstetric ultrasound that identified two fetal heart rates. The chart notes for this visit do not identify either amnionicity or chorionicity of the twins.

28. On August 16, 2012, Patient A (25 weeks five days) was seen by respondent for a follow-up evaluation. On that date, Patient A requested a letter for her employer indicating that she could not work due to having irregular contractions. Respondent recommended that she continue "Sweet Beginnings," referred her for a growth ultrasound, and scheduled her for a cesarean section delivery on November 11, 2012.

29. On August 25, 2012, Patient A (26 weeks six days) had a 3D/4D ultrasound performed, not the ultrasound respondent ordered. The ultrasound technician noted one twin's heart rate was slow and irregular compared to the other twin and recommended Patient A follow-up with her doctor.

30. On August 27, 2012, Patient A (27 weeks two days) contacted respondent's office regarding the ultrasound technician's concerns [stated in the foregoing paragraph] and was informed that respondent was on vacation. Ms. Tobin scheduled Patient A for non-stress testing. On the same date, Patient A presented to St. Joseph Hospital, and an ultrasound was performed which revealed "stuck twin B with oligohydramnios, biophysical score 2/8 twin A with polyhydramnios, biophysical score 8/8 with ascites and pericardial fluid, poor ventricular contraction."

31. On the following day, August 28, 2012, Patient A (27 weeks 3 days) was seen by Afshan Hameed, M.D. (Dr. Hameed) at St. Joseph Hospital for a perinatology consultation. Dr. Hameed performed an ultrasound that revealed "deepest vertical pocket for twin A of 13 cm, and twin B without any fluid. No bladder was visualized for twin B, and absent end-diastolic flow was noted on Twin B as well. Twin B was stuck to the cellophane to the right side of the uterus. Twin A appeared normal with normal umbilical artery Doppler, however cardiomegaly was noted with depressed cardiac function, significant tricuspid regurgitation, 8 mm pericardial effusion around the right side of the heart, and mild to moderate ascites were noted." Dr. Hameed diagnosed Patient A with Stage 4 TTTS, and counseled Patient A extensively regarding the poor prognosis (in the absence of intervention), and various options for treatment.

32. On August 29, 2012, R. Chmait, M.D.[8], at Children's Hospital of Orange County (CHOC), performed laser ablation of placental anastomoses on Patient A that was complicated by incidental septostomy.

33. On September 14, 2012, Patient A (29 weeks 5 days) was admitted to Labor and Delivery at University of California Irvine (UCI) Medical Center for continuous fetal monitoring.

34. On September 18, 2012, Patient A (30 weeks 2 days) experienced preterm rupture of membranes and was found to be in active preterm labor with cervical dilation at 7 cm. Patient A was taken urgently to the operating room for repeat cesarean section with delivery of two female infants, Twin A and Twin B. On day two of life, Twin B died.

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[8] Dr. Chmait's first name was not included in this record.

Complainant's Expert Witness

35. Dr. Kingston served as complainant's expert witness. Among other things, she evaluated the care and treatment that respondent provided Patient A[9] identified in this case and the remaining allegations identified in the Accusation.

36. Based on her testimony and curriculum vitae, Dr. Kingston provided evidence of her relevant education, training and experience.

She obtained a bachelor of arts degree in chemistry from the University of Texas – Austin (1993) and a medical degree from Yale University School of Medicine (1998). She completed an internship and residency in obstetrics and gynecology at University of California San Diego in 2002.

Dr. Kingston has been licensed to practice medicine in California since 1999 and has no history of discipline.

She has been certified by the American Board of Obstetrics and Gynecology continuously since 2003.

Dr. Kingston is a clinical professor at University of California, San Diego School of Medicine in the Department of Reproductive Medicine, where she has worked (teaching medical students, interns and residents) continuously since she completed her residency.

Among other things, Dr. Kingston served as a member of the Patient Care Peer Review Committee as the Department of Gynecology representative (between

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[9] The letter is used to protect patient confidentiality.

November 2009 and June 2013). Representatives from each department evaluated a variety of different kinds of cases to determine if there had been a violation of the standard of care; if so, who was to blame and what degree of departure there was; essentially to identify issues that led to the departure, the staff member's involvement or potentially a systems issue.

For 10 years, Dr. Kingston has served as an expert witness in 50 board cases (a mix of obstetrics and gynecology), for the United States Attorney's Office and for private firms. In the majority of cases, she has testified on behalf of the defense but she has testified on behalf of plaintiffs; in the majority of cases, she has determined that there has been no deviation from the standard of care. She makes her determination based on the medical records and other documents before her and does not believe that she is biased.

For the past four years, Dr. Kingston has served as an oral board examiner for the American Board of Obstetrics and Gynecology; in this capacity, once a year, she and other board examiners examine candidates who are applying for board certification.

In addition, for the past three years, she has been on a women's health test item writing committee for the National Board of Medical Examiners; along with other members of the committee, she writes test items for the United States Medical Licensing Examination (USMLE); traditionally, physicians have to take the examinations to become licensed, independently-practicing physicians.

Since its inception, Dr. Kingston has been the co-director of the Endocrine, Reproduction and Metabolism Block; she will step down from this position fall 2020.

As part of her duties, she set the curriculum for the students and arranged speakers and faculty members for the course.

Dr. Kingston is involved in the daily clinical care of OBGYN patients; the mix is half obstetrics and half gynecology. She sees patients in the office; they may be her personal patients that she is treating independently or supervising resident physicians in providing care to their patients. Dr. Kingston works in the hospital for one week every six weeks; during this time, she covers labor and delivery for her medical group as well as any patients who may walk in. Dr. Kingston takes obstetrics night call once or twice per month. She operates on gynecology patients once or twice a week, depending on the week. When she operates on patients in the hospital or on call in labor and delivery, she is supervising and teaching resident physicians and medical students.

In addition to the foregoing, Dr. Kingston's curriculum vitae sets forth the relevant societies of which she is a member, her outside professional activities, other university, academic and teaching activities, and grants awarded to her.

37. Based on her experience, training and knowledge gained over her 20 years of practice, she understands the standard of care in the medical community, and, in particular, in 2012, with regard to the management of care and treatment of twin pregnancies.

Dr. Kingston established that there are varying degrees of departure from the standard of care. A simple departure from the standard of care is the failure to use that level of skill, knowledge and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances. An extreme

departure from the standard of care is the want of even scant care or an extreme departure from the standard of care.

38. Dr. Kingston described the documents she reviewed prior to rendering opinions and issuing her report in this case.

- Investigation report prepared by Chris Jensen, the board's investigator,
- Summary of care from respondent,
- Certified medical records from respondent,
- Certified medical records from CHOC,
- Certified medical records from Genetics Center,
- Certified medical records from Pacific Fertility Center,
- Certified medical records from University of California – Irvine,
- Certified medical records from St. Joseph Hospital,
- Transcript of board interview of respondent,
- Respondent's curriculum vitae,
- Deposition of K.B.,
- Deposition of M.B.,
- Deposition of Vicken Sahakian, M.D., and

- Deposition of Richard Cho, M.D.

Respondent's Education, Training and Experience

39. Respondent provided evidence of his education, training and experience.

He was born in Bogota, Columbia, and attended medical school in Columbia; consistent with the educational system in Columbia, when he finished high school, he attended medical school (1990 – 1996). After completing medical school in Columbia, as required, he completed one year of social service in a rural area, working as a general physician. Spanish is respondent's first language, and English is his second language.

Respondent immigrated to the United States in 1999; he participated in visiting fellow research at Cornell University Hospital. While participating in the fellowship, he obtained his license to practice medicine in the United States. After completing a preliminary position in OB/GYN at Flushing Hospital, respondent participated in and completed the formal residency program in OB/GYN (2001 – 2005). During this program, among other things, he had a four-month training with a perinatologist, performing ultrasounds on a weekly basis. Upon completion of his residency program, respondent moved to California; he had an offer from St. Joseph Hospital[10] to start practicing; and he began his private practice in OB/GYN.

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[10] St. Joseph Hospital is a community hospital in Orange County operated by the sisters of St. Joseph for the past 90 years. St. Joseph is a tertiary center, which means, among other things, that the "highest complexity of [*sic*] cases related to mom and baby" can be treated at this hospital.

In addition to California, respondent is licensed in the State of New York.

He has been certified by the American Board of Obstetrics and Gynecology continuously since 2007.

40. Respondent has maintained a private practice in Orange County since 2005. He is on staff at several hospitals, delivers most of the babies at St. Joseph Hospital, has an active role at St. Joseph Hospital and in the community.

- Since 2012 respondent has developed or helped develop a hospitalist program at St. Joseph Hospital. He explained that it is a national trend to have an OB/GYN physically available in any labor and delivery to provide immediate care of emergencies that could arise, which often occurs in obstetrics.

  For the past three years, the St. Joseph Hospital Program has merged with the UCI program; so, they work together.

- He is chair of the Department of Obstetrics and Gynecology at St. Joseph Hospital; there are 65 active members and 20 associate members. The chair serves a two-year term. He was initially elected in 2015 and, again in 2017; he was requested to continue as chair in order to continue achieving some of the benchmarks that had been achieved in the past few years.

Among other things, his duties as chair include a role on the peer review quality board committee (issues regarding questionable standard of care or questionable management comes through this department committee).

- For the past six years, he has served, in a management capacity, as part of the Peer Quality Review Board at St. Joseph Hospital. This board reviews "any write-up that could come through a system that we have that can be from any person at the hospital." The cases involve investigations and recommendations for correction; examples of cases are those involving standard of care or behavioral issues.

- Since 2017 he has been a member of the Women's and Children's Advisory Board Leadership Council, a council created when St. Joseph Hospital became a part of the Providence Healthcare System; there are 12 hospitals in the Southern California region, and there are representatives (obstetricians, nurses and pediatricians) who discuss a variety of issues, from standard of care to making regional decisions and to have best practices at all hospitals.

- Organized in 2019, he is the OB/GYN leader member of the OB Specialty Advisory Group for Providence

Southern California; this is an advisory group of different specialties (including family practice, OB/GYNs and others) that tries to provide better safety standards.

- Respondent and another physician represent St. Joseph Hospital with California Maternal Quality Care Collaborative, a prenatal organization, created in the last six years or so, to reduce NTSV postpartum Hemorrhage, improve the management of hypertensive disorders and improve diabetes.

- Respondent is organizing the midwifery program (presumably at St. Joseph Hospital) to create a midwifery environment on the same floor as labor and delivery so the patients can have the experience they wish with a safety net.

Respondent is on staff at Orange County Global Medical Center and at Garden Grove Hospital. At each hospital, he has helped develop the labor program and has implemented standards of care in order to provide safety for patients. At Garden Grove Hospital, in addition to developing, he supervises the labor program.

In 2016 the Orange County Health Department invited respondent to develop policies and procedures to implement TDAP, vaccines in pregnant women.

41. Respondent discussed his volunteer work in the community.

Respondent volunteers with the Care for the Poor Committee at St. Joseph Hospital; this involves a variety of activities that support Clinica de La Amistad, a clinic that provides medical care for people without insurance. Because of the conditions at the clinic and care provided for the patients through the clinic, he opened his office in Santa Ana, where he provides care and treatment for low income patients.

Once a year for at least the last eight years, respondent has volunteered in medical missions around the world.

In coordination with the Columbian consulate and other Latin American consulates, respondent has helped organize clinics for low-income patients in Los Angeles. He explained that they have a council that organizes some clinics for education; for example, he and others "do STD prevention and Pap smears with education."

For the past year, respondent has volunteered with Harvesters, a nonprofit organization with entrepreneurs and business owners in Orange County that brings groceries for people in need throughout Orange County.

Respondent does hands-on teaching of family practice residents at UCI.

42. Respondent maintains two offices, one in Orange and the other in Santa Ana, staffed by a full-time nurse practitioner in each office. The patient population in the office in Orange is "mainly commercial based in terms of the insurance profile." The patient population in Santa Ana is "close to a hundred percent is Medi-Cal, Cal-Optima base, low-income Hispanic population."

Normally respondent works five days a week, divides his time between the two offices, performs surgeries on Friday mornings and does not work on Wednesday

afternoon. About 65 percent of his practice has been obstetrics and 35 percent gynecology. He estimated that he has provided care for 6,500 women and 400 twin gestations. In addition, during the past 10 years, he has managed IVF patients, maybe one to three per month. He performs an ultrasound for his pregnant patients every office visit.

Respondent's Expert Witness

43. Dr. Serden served as respondent's expert witness. His education, training and experience was established by his testimony and curriculum vitae.

In 1975 Dr. Serden obtained a Bachelor of Science degree in biochemistry from St. Lawrence University, and, in 1979, his medical degree from New York Medical College. He completed his internship and three-year residency in OB/GYN at Cedars-Sinai Medical Center. In 1980, he obtained his physician's and surgeon's certificate and has no history of discipline. Since 1985 Dr. Serden has been board certified continuously by the American Board of OB/GYN.

Dr. Serden has been in private practice for the last 40 years; for the past six years, he has been part of Cedar Sinai Medical Group; there are approximately 300 physicians in the group and 15 OB/GYNs. He does 200 to 225 deliveries per year; in his office, he sees 30 to 35 patients a day (50 percent of the patients are obstetrics and the other 50 percent are gynecology).

Since 1983 he has been a clinical instructor with the Cedars Sinai residency program. Since 1991 he has been an associate clinical professor in the Department of Obstetrics and Gynecology at UCLA.

He has staff privileges at Cedars-Sinai Medical Center.

Dr. Serden is a member of numerous organizations related to his OB/GN medical practice, such as the Los Angeles County Medical Association, California Medical Association and the American Medical Association. In addition, since 2001, he has been chair of the Peer Review Committee, Department of Obstetrics and Gynecology, Cedars-Sinai Medical Center; since 1995, he has been a member of the Department of OB/GYN Performance Improvement Committee; and since 1999, he has been a member of the Cesarean Section Task Force; since 2002, he has been on the advisory board and executive committee of the Los Angeles OB/GYN Society; since 2000, he has been an advisor to the Women's Health Advisory Board at Cedars-Sinai Medical Center; and since 2001, he has been an advisor to OBGYN.net.

Finally, Dr. Serden made presentations and has published articles, none recently and none relevant to the issues in this case.

Dr. Serden had reviewed two or three cases on behalf of the board; prior to this case, he had not testified in an administrative hearing; he had testified as an expert in civil actions, maybe 50 times over the past 30 years, divided equally between plaintiffs and defendants. He had one to twin pregnancies per month in his practice.

44. In order to render his opinions in this case, Dr. Serden reviewed the Accusation and the board's investigation file.

45. Dr. Serden described his understanding of the "concept of standard of care and the difference between simple and gross negligence." In his report, he stated:

> The standard of care is defined by the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians of the same specialty would do under the same or similar circumstances. Given the

uniqueness of each physician-patient relationship, the complexity and vast variety of human disease states, as well as the variation in patient's perceptions of the severity of their symptoms and the relationship of these perceptions to the function and quality of their lives, it is obvious that no two physicians will necessarily treat a patient in the same fashion. Hence, the standard of care allows for the range of clinical practices and judgments that would represent the spectrum of care that could be observed within a large of [*sic*] group of reasonable prudent and careful physicians for any given similar patient encounter. The patient uses the information provided to make an informed decision as to whether to proceed with treatment. There is no obligation on the part of physicians to force patients to accept their advice.

Simple negligence occurs if in a given episode of care a physician's care and treatment substantially deviates from the care that could be observed within a large group of reasonable prudent and careful physicians managing a similar episode of care.

Repetitive acts of simple negligence occur if a physician deviates from the standard of care regarding the management of different problems at different times. Therefore, if a physician fails to comply with the standard of care for the same problem on two or more occasions, this

does not represent repetitive acts of simple negligence, just an act of simple negligence relating to the evaluation and management of that respective problem.

Gross negligence is care below that standard of care that is characterized as the lack of even scant care.

Evaluation of Expert Witnesses

46. In assessing the opinions of the experts, in order to determine which was more trustworthy and persuasive, the trier of fact considered a variety of factors, including, the education, training and experience of each, the bases for her/his opinion, the facts underlying the opinions, whether the witness understood the standard of care in the community, relied on the legal definition of standard of care, repeated negligent acts and gross negligence; in addition, whether the witness provided clear and reliable testimony and whether the witness was biased.

Both physicians had the necessary, education, training and experience to qualify as an expert witness in this case.

Dr. Kingston was thorough in her report and testimony when she rendered her opinions. She clearly described the information upon which she relied; she provided a clear understanding of the potential harm associated with twin pregnancy, how important it is to diagnose chorionicity properly and as early as possible well as the consequences of failure to do so. She clearly explained the importance of proper and adequate documentation of medical records. Dr. Kingston based her opinions on the actual facts in this case, the proper definition of standard of care, and she was not biased or evasive. Respondent identified inconsistencies in Dr. Kingston's testimony, none relevant to the determinations in this case.

During the hearing, Dr. Serden admitted that his report was prepared by an associate of respondent's attorney. He explained that he reviewed and made changes so that it would properly reflect his opinions. There are times in his written opinion and during his testimony that were inconsistent with the facts of the case. His definition of standard of care, simple negligence, repeated negligent acts and gross negligence are not consistent with the legal definitions of these terms. Regarding medical records, Dr. Serden stated "documentation has nothing to do with actual care," which was not relevant to the reason for maintaining patient chart notes.

Further, despite the absence of information in the medical records and therefore lack of information upon which to render an opinion, Dr. Serden opinioned that Patient A did not have the growth ultrasound in a timely manner, which was not respondent's fault. Based on this and other similar testimony, Dr. Serden was clearly biased and intended to support respondent's testimony rather than provide clarity regarding the standard of care.

For the foregoing reasons, Dr. Kingston's opinions were more persuasive than Dr. Serden's.

Respondent's Credibility and Reliability

47. Respondent's credibility was carefully evaluated. In doing so, the trier of fact considered a number of factors. The board seeks to discipline respondent's license; presumably he was nervous and concerned about the potential negative impact on his reputation, practice and income. Nevertheless, the trier of fact presumed that he was truthful when he testified and completed Patient A's chart. Some, but little consideration, was given to the fact that English is his second language because he has functioned using English for more than 10 years.

Also, the trier of fact considered that respondent provided a version of his care and treatment of Patient A on four different occasions: (1) at a deposition in the underlying civil matter, on April 29, 2016, (2) in his written explanation of care to the board, on April 29, 2016, (3) the board's subject interview on July 18, 2018, and (4) his testimony during this hearing, on October 8, 2019. There were inconsistencies between his prior statements and his testimony in the hearing. Prior to hearing (four years after his treatment of Patient A), respondent frequently stated he did not remember many facts. However, during the hearing (seven years after his treatment of Patient A), he was specific about what occurred, despite the inconsistency with his prior statements as well as the lack of information in Patient A's medical records. Noteworthy, however, was respondent's specificity about facts or what occurred, despite the limited documentation in the patient's medical records, calling into question the credibility of his testimony.

IDENTIFY AND APPROPRIATELY MONITOR TWIN PREGNANCY

48. Expert testimony established that the standard of care in providing prenatal care for twin gestation is to determine the level of risk for the pregnancy at the initiation of prenatal care. At this time, chorionicity is established by ultrasound. Due to the risk involved, as long as chorionicity is in doubt, the pregnancy should be regarded a monochorionic. In order to optimize outcome, monochorionic twin gestations should be managed by a perinatologist or maternal fetal physician or in close collaboration with one of these specialist.

An OB/GYN, practicing within the standard of care, recognizes that a patient who had gone through IVF would have had one or more first trimester ultrasounds and therefore exert an effort to obtain that information, if not received through the

usual requisition, call the clinic directly to obtain that information. That information from an IVF clinic is typically provided when requested.

The following facts were not in dispute: (1) all multiple pregnancies are riskier than singletons; (2) Patient A's pregnancy resulted from implantation of a single embryo; (3) at least two-thirds of single embryo twin pregnancies are monochorionic; (4) monochorionic pregnancies are significantly higher risk than dichorionic pregnancies, particularly for TTTS; (5) TTTS can, and often does, lead to the death of one or both fetuses; (6) the earlier TTTS detected, the better the outcome; (7) respondent saw no confirmatory sign of dichorionic pregnancy.

To assist with determination of chorionicity, in addition to the ultrasounds he performed, respondent had additional reliable sources of information available to him, including: (1) the three ultrasounds performed at the fertility center, (2) the ultrasounds performed at St. Joseph Hospital on May 1 and 5, 2012, and (3) the ultrasound performed at the Genetics Center; in addition, he had the option to contact any or all of the individuals who performed the ultrasounds.

There was no evidence in the record to support a finding that Patient A had two placentas or a dichorionic pregnancy; all indications were to the contrary.

Expert testimony established that, with the information that respondent had available to him prior to 14 weeks, respondent should have concluded that the pregnancy was monochorionic.

49. In this case, on her first prenatal visit in his office, respondent attempted to identify chorionicity but was unable to do so. He explained that when he is unable to determine chorionicity, he consults with a reliable source, such as Ms. Lenz, the sonographer who works in his office or the Genetics Center.

Respondent referred Patient A to the Genetics Center for the California prenatal screening program. Blood was drawn and the NT ultrasound was performed in a timely manner. Respondent relied on the diagnosis of dichorionic identified on the test request form from the Genetics Center that was submitted to the State of California requesting fetal risk assessment for prenatal screening. Respondent testified that "a certified sonographer" performs the NT studies at the Genetics Center.

The report from the Genetics Center identifies the sonographer, has a place for signature of the sonographer but does not include the sonographer's signature or chorionicity of Patient A's twins.

In support of respondent's position that the test request form from the Genetics Center was sufficient to make a diagnosis of chorionicity, respondent provided the Comprehensive Manual for Nuchal Translucency (NT) Practitioners (Manual), from the California Department of Public Health Genetic Disease Screening Program (Program) as well as the report and testimony of his expert witness. The trier of fact evaluated the test request form, the Manual, the report and testimony of respondent's expert witness as well as Dr. Kingston's testimony regarding the issue.

50. The trier of fact considered relevant sections of the Manual.

Section 1.3 Purpose of this Manual states:

> The purpose of this manual is to introduce NT Practitioners to the Prenatal Screening Program, to familiarize practitioners with the web interface for the Programs Screening Information System (SIS) and to provide them with training and support

necessary to participate in the PNS Program. The manual includes:

- Explanation of the role of NT data in the PNS Program and discussion of how to facilitate participation in the Program.
- Instructions on how to enter NT data directly into SIS or provide data to referring clinicians.
- Examples of results and interpretations.
- A description of the disclosure of first trimester risk interpretations and options for follow-up with ***Screen Positive*** patients.
- Communication of NT exam findings.
- Additional information on PNS Program participation. . .

Section 1.2 (of the Manual) NT Practitioner Prenatal Screening Program Participation states:

> NT Practitioners (NTPs) must be credentialed by the Nuchal Translucency Quality Review (NTQR) or the Fetal Medicine Foundation (FMF) and registered with GDSP to participate in the Program. Data submitted by unregistered practitioners will not be used for risk interpretation or gestational dating . . .

Section 2.1 (of the Manual) describes the methods of entering NT data into the Screening Information System. One of the methods is "recording NT data on the Test Request Form (NRF), which will be carried by the patient to the lab for her 1st or 2nd Trimester blood draw (Section 2.3) and submitted to the Program with the specimen. Another method is "sending NT data to the referring clinician, who will add data to a Test Request Form (TRF)."

Section 2.3 (of the Manual) describes who may enter data into the SIS and states, in part: "To access SIS, you must complete an e-Course training program, obtain a USER ID and password, and sign the NT Practitioner Oath of Confidentiality."

Among other things, Section 2.2.3 (of the Manual) states that, the individual who enters the data must indicate whether there are twins and "if the twins are monochorionic or dichorionic or if the chorionicity cannot be determined."

51. The Manual identified how data is obtained and who was authorized to input data into the form but does not mention the purpose of chorionicity.

52. According to the test request form, Ms. Vargas completed the form; the collector's initials are identified on the on this form but are not legible and were not identified during the hearing. The report from the Genetics Center identifies the sonographer, has a place for signature of the sonographer but does not include the sonographer's signature or chorionicity of Patient A's twins. Both the test request form and the report from the Genetics Center includes the sonographer's "NTQR NT ID".

Dr. Kingston had not reviewed the Manual but testified that chorionicity was not necessary to make a determination about the potential risks being tested for; instead, it was easier to leave the requirement on the form than reprint the form. Nevertheless, in the Manual, there is a specific requirement that the person who completed the form

identify chorionicity if it is determined. However, given the lack of findings regarding chorionicity on the report, there is sufficient reason to question why chorionicity is identified on the request form.

53. For the reasons stated previously, specifically because he appeared to be biased, Dr. Serden's opinion (regarding this issue of whether respondent could rely on chorionicity identified on the test request form) was unreliable and therefore disregarded.

54. The issue in this case is not whether respondent made a mistake in his diagnosis or whether the Genetics Center misdiagnosed the chorionicity; instead, the issue is whether respondent acted within the standard of care when he diagnosed chorionicity.

Respondent did not consider all relevant reliable information available to him. He acknowledged that he considered the ultrasound report from the radiologist, dated May 5, 2012, to be reliable but did not believe that the diagnosis identified in the radiologist's report to be definitive. Further, he made no further effort to obtain documents from the fertility center. He made no effort to contact the IVF physician who performed ultrasounds (at six, eight and 10 weeks); he made no effort to obtain a clarification from the radiologist who performed the ultrasound performed on May 5, 2012, or speak to the sonographer who performed the NT ultrasound. There is no evidence that he considered the signs that indicate or exclude diagnosis or the facts in this case (Finding 49) which were strongly indicative of a monochorionic pregnancy.

55. Considering the potential harm to the fetuses in the misdiagnose of chorionicity and the information available to him, respondent had an obligation to rely on more than the form from the Genetics Center to make the diagnosis. He did not.

56. It was established by clear and convincing evidence that this was a monochorionic pregnancy.

57. Expert testimony established that respondent's care and treatment of Patient A was below the standard of care because he failed to appropriately monitor a monochorionic twin pregnancy.

The standard of care for monochorionic twin gestation is that they should be monitored by growth ultrasound every two weeks, beginning at 16 weeks to assess for any signs of developing TTTS. If it appears to be developing, they need to be followed every week to see if there is progression of the syndrome.

An ultrasound occurred on July 5, 2012 when respondent was 19 weeks three days. The next growth ultrasound was ordered on August 16, 2012, six weeks later.

Considering the foregoing, respondent did not order the growth ultrasounds in a timely manner; as such, his monitoring of this monochorionic twin pregnancy was below the standard of care.

58. Expert testimony established that respondent committed gross negligence in his care and treatment of Patient A, which included failing to identify and appropriately monitor a monochorionic twin pregnancy, because the information was available, and the diagnosis was critically important to the appropriate care of Patient A.

RECORDKEEPING

59. Expert testimony established that documentation contained in a patient's medical chart is a record of the care that has been provided and what was conveyed at each visit to the patient. The record should reflect what is happening with the patient

so that another physician knows what is relevant, pertinent and important. There were deficiencies in respondent's record keeping that Dr. Kingston described as below the standard of care. In Dr. Kingston's opinion, "there were incomplete areas and areas that were hard to piece together. The information was not compiled in an organized way." In addition, as stated repeatedly, the chart notes do not include a reference to chorionicity or amnionicity; the chart notes do not include documentation of diagnosis, education and discussion of gestational diabetes. For ultrasounds performed in the office, there were notes in the chart that were difficult to interpret and lacked complete information.

60. Respondent described the manner in which he maintained medical records for his patients in 2012; he had hard copies of chart notes and reports in each patient's medical records; these documents were scanned into the computer; after the care was provided, the chart notes were scanned into the computer.

61. In the chart notes for Patient A, there was no diagnosis of amnionicity or chorionicity; for some of the ultrasounds performed by him, there were no ultrasound reports but there is data obtained from the ultrasound; sometimes, the data or ultrasound report was inaccurate; however, there is a copy of Dr. Cho's ultrasound report, dated May 5, 2012, from Dr. Cho, as well as the test request form from the Genetics Center that includes the diagnosis of dichorionic.

Also, respondent referred Patient A for prenatal screening; when the blood tests were returned to the office, respondent's nurse practitioner referred Patient A to Sweet Beginnings; he was aware of the Sweet Beginnings program, the healthcare professions in the program, and how the program operated; though not documented in the medical chart, respondent testified that he discussed the glucose log with

Patient A at every visit; according to respondent, had there been a problem in the program, he would have been notified by Sweet Beginnings.

The chart notes contained missing information and were difficult to follow. It was established by clear and convincing evidence that respondent failed to maintain adequate and accurate records; this constituted a simple departure from the standard of care.

Evidence of Mitigation and Rehabilitation

62. Respondent has been licensed by the board for more than 15 years. With the exception of this case, there is no evidence of prior discipline by the board. Two to three civil actions have been filed against respondent, including a civil action involving the facts of this case.

63. His curriculum vitae and his testimony regarding his activities in the community, the testimony of Dr. Maya and letters of support establish a clear picture of who respondent is and his role in the community.

The letters of support are from a variety of people including: (1) Erin McLeod, BSN, RNC-OB, Patient Safety Program, St. Joseph Hospital, (2) Sudeep Kukreja, M.D., Medical Director, CHOC NICU at St. Joseph Hospital, (3) Than Tran, M.D., OB Anesthesia Medical Director, CHOC, and (4) Kishan Patel and Salomon Maya, M.D., anesthesiologists with Allied Anesthesia Medical Group. Dr. Maya testified in this proceeding.

In summary, they described respondent as a physician with a busy practice; over the past 10 years or more, he has had a significant role in participating in hospital committees and other organizations that have improved care for women at St. Joseph

Hospital and in the Orange County community. By physicians, nurses and other health care practitioners, he is respected as one of the best, and one who communicates well and is knowledgeable and compassionate.

The majority of the patients in respondent's Orange County practice are low-income Spanish speakers. In addition, he has participated in missions around the world providing free medical care.

Other Facts Considered

64. The circumstances and facts underlying the charges in the Accusation occurred more than seven years prior to the hearing. A civil action was filed against him. His deposition was taken; and the board interviewed respondent. All occurred before he testified in this hearing. He had a significant amount of time to think about the facts and circumstances alleged in the Accusation. During the hearing, when asked based on the information he had at the time, would he change anything, respondent answered "no." There is no evidence that, since 2012 he carefully evaluated what occurred in his care and treatment of Patient A's twin pregnancies or that he had reviewed and considered the information that should be included in chart notes for his patients.

LEGAL CONCLUSIONS

Purpose of Discipline

1. The purpose of the Medical Practice Act (Chapter I, Division 2, of the Business and Professions Code) is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of

unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Relevant Statutes

2. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the board deems proper.

3. Section 2234 of the Code states in 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:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.

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

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

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

4. 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.

Relevant Case Law

5. 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.)

6. Courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care.

Violations

7. Pursuant to Business and Professions Code section 2234, subdivision (b), cause exists to discipline respondent's Certificate in that he committed gross negligence in his care and treatment of Patient A.

8. Pursuant to Business and Professions Code section 2234, subdivision (c), cause exists to discipline respondent's Certificate in that he engaged in repeated negligent acts in his care and treatment of Patient A.

9. Pursuant to Business and Professions Code section 2266, cause exists to discipline respondent's Certificate in that respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patient A.

Appropriate Measure of Discipline

10. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Conduct supporting the revocation or suspension of a medical license must

demonstrate unfitness to practice. The purpose of a disciplinary action is not to punish but to protect the public. In an administrative disciplinary proceeding, the inquiry must be limited to the effect of the doctor's actions upon the quality of his service to his patients. (*Watson v. Superior Court* (2009) 176 Cal.App.4th 1407, 1416.) Because the main purpose of license discipline is to protect the public, patient harm is not required before the board can impose discipline. It is far more desirable to impose discipline on a physician before there is patient harm than after harm has occurred. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772-773).

11. Rehabilitation requires a consideration of those offenses from which one has allegedly been rehabilitated. (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1048.) Rehabilitation is a state of mind, and the law looks with favor upon rewarding with the opportunity to serve one who has achieved reformation and regeneration. (*Id.*, at 1058.) The absence of a prior disciplinary record is a mitigating factor. (*Chefsky v. State Bar* (1984) 36 Cal.3d 116, 132, fn. 10.) Remorse and cooperation are mitigating factors. (*In re Demergian* (1989) 48 Cal.3d 284, 296.) While a candid admission of misconduct and full acknowledgment of wrongdoing may be a necessary step in the rehabilitation process, it is only a first step. A truer indication of rehabilitation is presented if an individual demonstrates by sustained conduct over an extended period of time that he is once again fit to practice. (*In re Trebilcock* (1981) 30 Cal.3d 312, 315-316.)

12. In making a determination about the appropriate level of discipline the highest priority is protection of the public from harm.

Respondent had been licensed by the board more than 14 years. At the time of the hearing, it had been more than seven years since the facts and circumstances underlying the Accusation. The testimony and letters in support of respondent were considered, particularly his service to women at St. Joseph Hospital, in Orange County,

his respect in the community and his volunteer work. This case involved violations of the Medical Practice Act.

Of greatest concern was respondent's failure to consider all the information available to him to make the determination of chorionicity and his failure to understand the necessity to document completely the patient's chart notes.

Respondent did not take responsibility for his mistakes. He said that, with the same information (regarding diagnosis of chorionicity), he would not change anything. He had no appreciation for the deficiencies in his chart notes.

Given the facts and the law, in order to adequately protect the public, the following order is made.

ORDER

Physician and Surgeon's Certificate No. A 91309 issued to Alan Akerman, M.D., is revoked. However, the revocation is stayed, and he is placed on probation for three years upon the following terms and conditions.

1. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a medical record keeping course, 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of

enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of his license.

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.

2. Clinical Competence Assessment Program

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

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision, the Accusation, and any other information that the board or its designee deems relevant. The program shall require

respondent's on-site participation for a minimum of three and no more than five days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

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

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

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

Respondent is prohibited from performing any care or treatment of twin pregnancies until after successful completion of Clinical Competence Assessment Program has been provided to the board.

3. 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 24 hours per year, for each year of probation. The educational program(s) or course(s) shall be on the diagnosis, care and treatment of multiple fetus pregnancies 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 his license. Following 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.

4. Monitoring Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the board, including but not limited to any form of bartering, shall be in

respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

The monitor(s) shall submit a quarterly written report to the board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of

respondent to ensure that the monitor submits the quarterly written reports to the board or its designee within 10 calendar days after the end of the preceding quarter.

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

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

5. Notification

Within seven days of the effective date of this Decision, respondent shall provide a true and correct copy of this Decision and this Accusation to the chief of staff or the chief executive officer at every hospital where privileges or membership are extended to him, 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 him. Respondent shall provide proof of compliance to the board or its designee within 15 calendar days of the effective date of this Decision.

6. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and shall 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 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

Respondent shall comply with the board's probation unit.

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

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.

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

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 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 years.

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

Periods of non-practice for 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, and Quarterly Declarations.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., payment of educational courses, 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, after giving notice and the opportunity to be heard, the board 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 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, within 15 calendar days, respondent shall deliver his wallet and wall certificate to the board or its designee, and respondent shall no longer practice medicine. Respondent shall 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 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: July 27, 2020

DocuSigned by:
Vallera Johnson
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VALLERA J. JOHNSON
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO January 31 2019
BY K. Vong ANALYST

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

In the Matter of the Accusation Against: **ALLAN AKERMAN, M.D.** **1310 W. STEWART DR., STE. 307** **ORANGE, CA 92868-3838** **Physician's and Surgeon's Certificate No. A91309,** Respondent.	Case No. 800-2017-030133 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about May 20, 2005, the Medical Board issued Physician's and Surgeon's Certificate No. A91309 to Allan Akerman, 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 May 31, 2019, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states, in pertinent part:

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

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

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

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

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

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

"..."

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:

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

"(b) Gross negligence.

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"(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.

"..."

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. A91309 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patient A,[1] as more particularly alleged hereinafter:

8. On or about March 8, 2012, Patient A, a then thirty-three-year-old female serving as a surrogate, underwent in vitro fertilization of a single embryo, performed by Dr. V.S. at Pacific Fertility Center. Patient A's obstetric history was notable for two prior vaginal births in 1996 and 2001, and a cesarean section delivery in 2010.

9. On or about March 20, 2012, Patient A's pregnancy was confirmed with an estimated due date of November 26, 2012.

[1] To protect the privacy of the patient involved, the patient's name has not been included in this pleading. Respondent is aware of the identity of the patient referred to herein.

10. On or about April 2, 2012, and April 16, 2012, Dr. V.S. performed obstetric ultrasounds on Patient A. On each of these ultrasounds, Dr. V.S. detected a twin pregnancy with two fetal heart rates and monochorionic[2] gestation. The chart notes by Dr. V.S. do not reflect the amnionicity[3] of the twins.

11. On or about May 5, 2012, Patient A presented to the emergency room at St. Joseph Hospital after experiencing vaginal bleeding. Both transabdominal and endovaginal pelvic ultrasounds were performed on Patient A, which revealed living intrauterine twin pregnancies with findings consistent with likely monochorionic monoamniotic twins.

12. On or about May 7, 2012, Patient A initiated prenatal care with Respondent, and presented with complaints of vaginal bleeding. At that initial visit, Respondent performed an obstetric ultrasound that revealed an intrauterine twin gestation with two fetal heart rates, and an estimated delivery date of November 29, 2012. Respondent was able to identify two amniotic sacs, but was unable to determine chorionicity at that time. The chart notes for this visit do not identify either amnionicity or chorionicity of the twins. Respondent ordered prenatal lab work and had Patient A complete a medical release of authorization form consenting to the release of her medical records from Pacific Fertility Center. Those records were never received by Respondent.

13. On or about May 17, 2012, Patient A's prenatal lab work revealed an increased risk for diabetes. Sometime between on or about May 17, 2012, and on or about August 16, 2012, Respondent diagnosed Patient A with gestational diabetes, and referred her to "sweet beginnings." Throughout that time period, the chart notes do not indicate whether the patient was counseled regarding this diagnosis, educated on diet, or instructed to monitor home glucose values.

14. On or about May 21, 2012, Patient A returned to Respondent's office for a follow-up evaluation and was seen by a nurse practitioner (N.P.). The N.P. performed an ultrasound noting

[2] Single placenta.

[3] The number of amnions (inner membranes) that surround fetuses in a multiple pregnancy. Pregnancies with one amnion (so that all fetuses share one amniotic sac) are described as monoamniotic; twin pregnancies with two amnions are described as diamniotic.

two fetal heart rates, and referred Patient A for first trimester screening as soon as possible. The chart notes for this visit do not identify either amnionicity or chorionicity of the twins.

15. On or about May 22, 2012, Patient A was seen at the Genetics Center for a nuchal translucency ultrasound and first trimester serum integrated screening. The genetic consultation report from the Genetics Center noted a gestation of 18 weeks and 6 days for Fetus A, and 13 weeks and 4 days for Fetus B, but was silent as to amnionicity or chorionicity of the twins. The first trimester screening form for the California Prenatal Screening Program completed by a technician at the Genetics Center noted the chorionicity to be dichorionic. The prenatal screening results from the nuchal translucency ultrasound and first trimester serum integrated screening issued by the California Department of Public Health noted the chorionicity to be dichorionic.

16. On or about May 24, 2012, Patient A was seen by Respondent for a follow-up evaluation with complaints of continued vaginal bleeding. Respondent performed an obstetric ultrasound and identified two fetal heart rates. The chart notes for this visit do not identify either amnionicity or chorionicity of the twins.

17. On or about June 18, 2012, Patient A was seen by Respondent for a follow-up evaluation. Respondent performed an obstetric ultrasound that identified two fetal heart rates. The chart notes for this visit do not identify either amnionicity or chorionicity of the twins. Respondent referred Patient A to return to his office in three weeks for a detailed growth ultrasound to rule out anomalies.

18. On or about July 5, 2012, Patient A returned to Respondent's office for the detailed growth ultrasound. The OB Report prepared by the sonographer revealed two female twins with normal anatomy and normal amniotic fluid. The report further revealed that the amniotic dividing membrane was visualized, but did not identify chorionicity of the twins. Respondent reviewed this report on July 18, 2012, but did not speak with the sonographer at any time about chorionicity.

19. On or about July 17, 2012, Patient A was seen by Respondent for a follow-up evaluation. Respondent performed an obstetric ultrasound that identified two fetal heart rates. The chart notes for this visit do not identify either amnionicity or chorionicity of the twins.

20. On or about August 16, 2012, Patient A was seen by Respondent for a follow-up evaluation. Respondent performed an obstetric ultrasound that identified two fetal heart rates. The chart notes for this visit do not identify either amnionicity or chorionicity of the twins. On that date, Patient A requested a letter for her employer indicating that she cannot work due to having irregular contractions. At the conclusion of this visit, Respondent referred Patient A for a detailed growth ultrasound in 4 weeks, recommended she continue "sweet beginnings," and scheduled her for a cesarean section delivery on November 11, 2012.

21. On or about August 25, 2012, Patient A had an informal 3D/4D ultrasound performed. The ultrasound technician noted one twin's heart rate was slow and irregular compared to the other twin, and recommended Patient A follow-up with her doctor.

22. On or about August 27, 2012, Patient A contacted Respondent's office regarding the concerns she received from the ultrasound technician. Patient A was told that Respondent was on vacation, and was referred for non-stress testing. On that same date, Patient A presented to St. Joseph Hospital and an ultrasound revealed "stuck twin B with oligohydramnios,[4] biophysical score 2/8, twin A with polyhydramnios,[5] biophysical score 8/8, twin A with ascites and pericardial fluid, poor ventricular contraction."

23. On or about August 28, 2012, Patient A was seen by Dr. A.H. at St. Joseph Hospital for a perinatology consultation. Dr. A.H. performed an ultrasound that revealed deepest vertical pocket for twin A of 13 cm, and twin B without any fluid. No bladder was visualized for twin B, and absent end-diastolic flow was noted on twin B as well. Twin B was stuck to the cellophane to the right side of the uterus. Twin A appeared normal with normal umbilical artery Doppler, but cardiomegaly was noted with depressed cardiac function, significant tricuspid regurgitation, 8 mm pericardial effusion around the right side of the heart, and mild to moderate ascites were noted. Dr. A.H. diagnosed Patient A with Stage 4 twin-to-twin transfusion syndrome,[6] and

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[4] Oligohydramnios is a medical condition in pregnancy characterized by a deficiency of amniotic fluid.

[5] Polyhydramnios is a medical condition describing an excess of amniotic fluid in the amniotic sac.

[6] Twin-twin transfusion syndrome (TTTS) is a rare, serious condition that can occur in

counseled Patient A extensively regarding the poor prognosis absent intervention, and various options for treatment.

24. On or about August 29, 2012, Dr. R.C. performed laser ablation of placental anastomoses on Patient A, that was complicated by incidental septostomy.

25. On or about September 14, 2012, Patient A was admitted to Labor and Delivery at the University of California Irvine Medical Center at 29 weeks 5 days' gestation for continuous fetal monitoring.

26. On or about September 18, 2012, Patient A experienced preterm rupture of membranes and was found to be in active preterm labor with cervical dilation at 7 cm. Patient A was then taken urgently to the operating room for repeat cesarean section with delivery of two female infants, twin A and twin B. Twin B died on day two of life.

27. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, failing to identify and appropriately monitor a monochorionic twin pregnancy.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

28. Respondent has further subjected his Physician's and Surgeon's Certificate No. A91309 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged hereinafter:

A. Paragraphs 7 through 27, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to appropriately document ultrasounds performed at each visit and their findings; and

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pregnancies when identical twins share a placenta. Abnormal blood vessel connections form in the placenta and allow blood to flow unevenly between the babies. One twin – called the donor – becomes dehydrated; and the other – called the recipient – develops high blood pressure and produces too much urine and over fills the amniotic sac.

C. Failing to appropriately document a gestational diabetes diagnosis, and patient counseling regarding this diagnosis.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

29. Respondent has further subjected his Physician's and Surgeon's Certificate No. A91309 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 A, as more particularly alleged in paragraphs 7 through 28, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A91309, issued to Respondent, Allan Akerman, M.D.;

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

3. Ordering Respondent, Allan Akerman, 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: January 31, 2019

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

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