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

In the Matter of the Accusation Against: Monique Ford Mabey, M.D. Physician's & Surgeon's Certificate No A41544 Respondent	Case No. 800-2018-048371

DECISION

The attached Stipulated Settlement and Disciplinary Order 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 March 10, 2021.

IT IS SO ORDERED February 8, 2021.

MEDICAL BOARD OF CALIFORNIA

By: Richard E. Thorp MD

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

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
DAVID CARR
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **MONIQUE FORD MABEY, M.D.** 485 Jersey St. San Francisco CA 94114-3632 Physician's and Surgeon's Certificate No. A 41544 Respondent.	Case No. 800-2018-048371 OAH No. 2020070036 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by David Carr, Deputy Attorney General.

2. Monique Ford Mabey, M.D., is represented in this proceeding by attorney Ann H. Larson, Esq., of Craddick, Candland & Conti, whose address is 2420 Camino Ramon, Suite 202, San Ramon, CA 94583-4202.

3. On March 6, 1985, the Board issued Physician's and Surgeon's Certificate No. A 41544 to Monique Ford Mabey, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-048371, and will expire on February 28, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-048371 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 16, 2019. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-048371 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

1. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-048371. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

2. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

3. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

4. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-048371, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

5. Respondent agrees that, at a hearing, Complainant could establish a prima facie case for the allegations of the Accusation. Respondent hereby gives up her right to contest those charges.

6. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

7. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

8. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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9. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

10. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 41544 issued to Respondent Monique Ford Mabey, M.D., shall be and hereby is Publicly Reprimanded pursuant to Business and Professions Code section 2227. This Public Reprimand is issued as a result of the following conduct by Respondent as set forth in Accusation No. 800-2018-048371:

> As the hospital's on-call anesthesiologist, your reliance on the representations of the certified nurse anesthetist rather than immediately personally attending the obstetrics patient to assess and treat a post-partum hemorrhage in 2013, and your failure to ensure timely and adequate blood replacement had been administered, were departures from the standard of care.

Respondent further agrees to the following conditions as requirements for the issuance of this reprimand:

EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, 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 30 hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 55 hours of CME of which 30 hours were in satisfaction of this condition.

Failure to comply with the Education Course requirement may constitute unprofessional conduct and may result in disciplinary action.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Ann H. Larson, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: Sept 9, 2020

MONIQUE FORD MABEY, M.D.
Respondent

I have read and fully discussed with Respondent Monique Ford Mabey, M.D., the terms and conditions and other matters contained in this Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9/11/20

ANN H. LARSON, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: Sept. 15, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

DAVID CARR
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-048371

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 16 2019
BY: ANALYST

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

In the Matter of the Accusation Against: **MONIQUE FORD MABEY, M.D.** 485 Jersey Street San Francisco, CA 94114 Physician's and Surgeon's Certificate No. A 41544, Respondent.	Case No. 800-2018-048371 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On March 6, 1985, the Board issued Physician's and Surgeon's Certificate Number A 41544 to Monique Ford Mabey, 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 February 28, 2021, unless renewed.

JURISDICTION

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

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2001.1 of the Code provides that the Board's highest priority shall be public protection.

6. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

7. 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.

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

"(d) Incompetence

". . . ."

8. Section 2266 of the Code states that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. The facts alleged herein occurred in California.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts and/or Gross Negligence)

10. Respondent is subject to disciplinary action in that her care and treatment of Patient P-1[1] includes departures from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c). The circumstances are as follows:

11. Thirty-one year-old Patient P-1 presented to the hospital at around noon on November 22, 2013, at full term and in the early stages of labor. As was standard practice in the Labor and Delivery Unit, P-1 was placed under the care of a nurse midwife. Epidural anesthesia for pain was given at approximately 1:40 pm, by a certified registered nurse anesthetist (CRNA) and a

[1] The patient is designated in this document as Patient P-1 to protect her family's privacy. Respondent knows the name of the patient and can confirm her identity through discovery.

student nurse anesthetist. Respondent was the on-call anesthesiologist for the obstetrics department and was responsible for supervising the anesthesia care provided by the CRNA to P-1.

12. After a protracted labor, augmented with Pitocin, P-1 was completely dilated and at 0 station by 7:48 p.m. Fetal heart rate was classed as category II due to repeated variable decelerations; when P-1 became fully dilated, the pattern of decelerations to 60 beats per minute became more frequent. At 9:36 p.m. there was a deep deceleration of the fetal heart rate with a slow return to baseline. The attending obstetrician was advised of the deceleration. By the time the obstetrician arrived at P-1's bedside the fetal heartrate tracing had recovered. The obstetrician printed out a consent form for a C-section and notified P-1's family that such surgery might be necessary. The presence of thin meconium was noted at 10:15 p.m.

13. After P-1 began pushing, the vertex descended to +1 station and remained there. Because of the arrest of descent and the number of obstetrical patients requiring attention, P-1's care was transferred to a second attending obstetrician. At 10:03 p.m., that obstetrician obtained a signature on the consent form for a C-section and at 11:17 p.m.--after two hours of pushing and failure of the vertex to descend any farther—the obstetrician ordered a C-section.

14. Respondent stated to Board investigators that she did not see the patient prior to the C-section surgery, but was notified of the pending surgery by the CRNA. Respondent added that she offered to attend the administration of the surgical anesthesia, but was assured by the CRNA that he did not need assistance. The CRNA administered a spinal anesthetic at about midnight and within minutes the obstetrician made the initial incision. A baby with Apgars of 7/9 was delivered ten minutes later.

15. The obstetrician observed an extension of the left lateral uterine incision, which was repaired. Surgery was completed at 12:50 a.m. The medical record indicates that P-1 had a post-operative quantitative blood loss of 1450 ml. Notes entered by the CRNA reflect that P-1 passed only a small amount of blood-tinged urine. Respondent had not yet seen P-1; neither of the two obstetricians caring for P-1 clinically addressed P-1's low urine output.

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16. Immediately after the surgery, an additional 700 ml of blood was expressed from P-1's uterus; her total quantitative blood loss now measured 2150 ml. Uterotonics to staunch blood loss were administered at ten minutes and again at twenty minutes post-operatively. Although P-1 was hypotensive and tachycardic and had very little urine output immediately post-op, critical care measures were not promptly initiated. Respondent was notified of the patient's continued blood loss but was not personally present at the bedside. At 1:20 a.m., an additional 980 ml of bright red blood was noted, making total blood loss now 3130 ml.

17. Approximately an hour after the surgery, the two obstetricians jointly performed a vaginal examination. By 2:06 a.m., they had placed a Bakri balloon in an attempt to stop the hemorrhaging. Three lap pads were used to pack the vagina but P-1 subsequently bled through the packing. Attempts to place a central line, to facilitate rapid blood transfusion, failed.

18. Although there is no formal order documented in the record for initiation of the Massive Transfusion Protocol (MTP) or to transfuse P-1, the CRNA wrote in the obstetric anesthesia record that the MTP was initiated at 2:11 a.m. and that Respondent was immediately notified; Respondent arrived at the patient's bedside at approximately 2:14 a.m. The only written order related to the MTP was conditional, containing parameters for the transfusion of two units of packed red blood cells (PRBCs) when the hemoglobin was less than 7 and the patient symptomatic. The MTP includes administration of fixed ratios of PRBCs, fresh plasma, platelets, and cryoprecipitate. There is no documentation that P-1 received fresh plasma, platelets, or cryoprecipitate and the attending obstetrician stated that the patient did not receive the plasma, the platelet, or the cryoprecipitate infusions. When asked later about decisions concerning blood and fluid replacement for P-1, one of the attending obstetrician stated that those decisions were in the hands of the anesthesia team. P-1's quantitative blood loss at 2:39 a.m. was 4455 ml. P-1 remained hypotensive and tachycardic.

19. P-1 was transfused with a total of 6 units of PRBCs along with 5 liters of crystalloids (a hydration solution) prior to 4:00 a.m. No transfusion flow sheet is included in the medical record. Although urine output was negligible, neither Respondent nor any other member of the medical team consulted with an intensivist or nephrologist about the lack of urine production.

Critical blood gas results and electrolyte imbalance demonstrated by progressively abnormal lab results were not noted nor clinically addressed. Respondent stated to Board investigators that she believes she would have given calcium to address the patient's increasing hypokalemia, but acknowledged that the medical records do not indicate that calcium was given. By 3:40 a.m. the quantitative blood loss had exceeded 4590 ml.; P-1's vital signs had not improved after the transfusions.

20. At approximately 4:00 a.m. Respondent ordered an airway be established by intubation. The CRNA initially attempted to intubate P-1 but the tube was misplaced; Respondent then successfully intubated the patient. A Code Blue (summons for emergency resuscitation medical team) was initiated soon thereafter when P-1 became bradycardic and developed cardiac arrhythmia. Two additional units of PRBC were administered during the emergency resuscitation, for a total of eight units. Despite the emergency measures taken, P-1 died at 5:05 a.m.

21. Respondent is subject to license discipline for unprofessional conduct in that her failure to adequately monitor the anesthesia care given to P-1 with sufficient frequency and to personally attend after being notified of the post-cesarean hemorrhage was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

22. The allegations of paragraphs 11 through 20 above are incorporated by reference as if set out in full. Respondent is subject to license discipline for unprofessional conduct in that her failure to ensure adequate replacement of the blood P-1 lost in her post-cesarean hemorrhage by timely transfusion of sufficient quantities of packed red blood cells and plasma was a departure from the standard of care. That departure constitutes gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate Medical Records)

23. The allegations of paragraphs 11 through 20 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that her failure to maintain adequate and accurate medical records of her care and treatment of P-1 constitutes unprofessional conduct by application of section 2266.

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. A 41544, issued to Monique Ford Mabey, M.D.;

2. Revoking, suspending or denying approval of Monique Ford Mabey, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Monique Ford Mabey, 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:

July 16, 2019

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