XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
State Bar No. 173955
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6538
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 800-2019-059394
Arthur M. Park, M.D. **2502 Tiverton Drive** **Bakersfield, CA 93311-9387** **Physician's and Surgeon's Certificate No. A 44597,** Respondent.	**A C C U S A T I O N**

PARTIES

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

2. On or about March 21, 1988, the Medical Board issued Physician's and Surgeon's Certificate Number A 44597 to Arthur M. Park, 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, 2022, 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:

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

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

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

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

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

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

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

5. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

(1) An initial negligent diagnosis followed by an act or omission medically

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

(d) Incompetence.

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

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

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

6. Section 2266 of the Code states:

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

FACTUAL ALLEGATIONS

7. Patient 1[1] was 23 years old and pregnant for the first time, when she presented for prenatal care to H. Y., D.O., on or about October 31, 2018. She was approximately 7.5 weeks gestation when her prenatal care began. During her first visit, Patient 1's blood pressure was normal, at 126/72 and she reported no present medical comorbidities, no prior history of significant medical problems, and no history of hospitalization or surgery. She did not use tobacco, alcohol, or street drugs. There were no reported significant clinical issues. Patient 1's pregnancy proceeded normally, with periodic prenatal visits. She had a normal fetal anatomic ultrasound in the early third trimester. She had an elevated 1 hour glucola (171) test with a normal 3 hr Glucose Tolerance Test (1/4 values elevated). She had a prenatal visit on April 3, 2019, at which time a normal blood pressure of 121/89 was recorded. She had no proteinuria on urine dipstick at that time.

8. On April 15, 2019, at approximately 2:30 p.m., Patient 1 presented to the Labor and Delivery Department at Mercy Southwest Hospital in Bakersfield, complaining of increased

[1] The patient is identified by number in this Accusation to protect her privacy.

swelling. She was 32+ weeks gestation and had high blood pressure of 146/93. Her urine protein/creatinine ratio was elevated at 0.83 (>.3 is abnormal). External fetal monitoring was generally reassuring.

9. Respondent was the obstetrician on call, and he assumed care of Patient 1. After he was notified of Patient 1's elevated blood pressures, at approximately, 4:45 p.m. on April 15, 2019, Respondent ordered labetalol[2] 200 mg PO TID, "with a call back in 1 hr. after administration." At 6:21 p.m. on April 15, 2019, the nursing staff documented that they informed Respondent of serial blood pressures since labetalol administration, and Respondent gave orders to admit Patient 1 for observation for 23 hours, regular diet, no IV needed at this time. Continue monitoring. Labetalol 200 mg TID.

10. While she was admitted for observation, Respondent did not directly assess or examine Patient 1, and did not document any such direct assessment or observation. During his interview with the Board's investigators, Respondent claimed to have directly seen the patient on three different occasions, telling the Board's investigators that he personally assessed Patient 1 "when she first checked in, and then I presented around 11:00 p.m., but she was asleep. So I had to get the nurse's report, and then I went and saw her again at 6:30 in the morning, but then she was still sleeping, so I had to rely on the nurse's report." When it was pointed out to Respondent that no chart notes document his observation visits with Patient 1, Respondent explained that he forgot to enter those chart notes.

11. There is no documentation that Respondent ever spoke directly with Patient 1, ever obtained a history, ever performed a physical exam, and ever formulated in writing a differential diagnosis. Respondent never discussed his diagnosis with Patient 1, did not formulate a plan of care, never counseled her concerning the risks of her diagnosis or recommended precautions and follow-up.

12. Patient 1's blood pressure, which was closely monitored by the nursing staff, fluctuated during her hospitalization, but remained generally elevated even after labetalol was

[2] Labetalol is a blood pressure lowering medication.

given to her. The following chart is a sampling of Patient 1's blood pressures following the administration of labetalol:

April 15, 2019	Blood Pressure
5:00 pm	163/93
6:45 pm	158/92
7:00 pm	159/93
7:15 pm	150/69
7:30 pm	168/81
7:45pm	150/85
April 16, 2019	
3:17 am	161/75
4:05 am	171/77
5:23 am	142/79
5:53 am	137/70
6:23 am	128/64
6:53 am	146/69

Patient 1's lowest blood pressure was recorded at 123/59 at midnight, and the highest recorded was 171/77 at 4:05 a.m. on April 16, 2019. At 6:47 a.m. on April 16, 2019, the nursing staff charted that Respondent was at the nursing station and that he gave a verbal order to discharge Patient 1 home. Patient 1 was discharged at 7:27 a.m., with instructions to follow-up with her outpatient provider, Dr. H. Y.. At that time Patient 1's blood pressure was 140/79.

13. Respondent did not consider and did not document considering administering a steroid to advance fetal lung maturity, or the use of magnesium sulfate for seizure prophylaxis. Respondent did not consult with a Maternal Fetal Medicine specialist for delivery planning. Respondent did not consider and did not document considering a transfer to a higher level of maternity care, or retaining Patient 1 in the hospital for continued observation. Respondent simply discharged Patient 1 with instructions to follow up with her outpatient provider.

14. Patient 1 followed up with Dr. H. Y. the next day, on April 17, 2019. Her blood pressure at that time was recorded as 133/98 and 145/100, with trace protein on urine dipstick. Dr. H. Y. noted "F/u from ER, preeclampsia, tr protein, started labetalol this am. Precautions for severe features given. Weekly NST @MSW." Dr. H. Y. scheduled a follow up visit for two weeks later.

15. At approximately 1:19 a.m. on the morning of April 19, 2019, Patient 1's fiancé awoke to find her suffering from a seizure. He called 911. Patient 1 was taken to the emergency

room at Mercy South West Hospital, in full cardiac arrest. Efforts to resuscitate her were not successful. A 4 lb 7 oz male infant was delivered by a perimortem cesarean section while Patient 1 was undergoing CPR in the hospital emergency room. The infant did not survive.

16. On autopsy, the cause of Patient 1's death was cardiopulmonary arrest, due to status epilepticus, due to eclampsia.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient 1. The circumstances are as follows:

18. Allegations of paragraphs 7 through 16 are incorporated herein by reference.

19. Each of the following constitutes gross negligence:

A) Respondent's failure to provide bedside assessment and evaluation of Patient 1 was an extreme departure from the applicable standard of care.

B) Respondent's failure to diagnose Patient 1 with preeclampsia with severe features and to provide Patient 1 and her fetus with appropriate treatment was an extreme departure from the applicable standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

20. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he was repeatedly negligent in his care and treatment of Patient 1. The circumstances are as follows:

21. Allegations of paragraphs 7 through 19 are incorporated herein by reference.

22. Each of the following constitutes a separate act of negligence:

A) Respondent's failure to provide bedside assessment and evaluation of Patient 1 was a departure from the standard of care.

B) Respondent's failure to diagnose Patient 1 with preeclampsia with severe features and to provide Patient 1 and her fetus with appropriate treatment when he presented to

the hospital at approximately 11:00 p.m. on April 15, 2019, was a departure from the standard of care.

C) Respondent's failure to take into consideration Patient 1's overnight blood pressure record and to diagnose Patient 1 with preeclampsia with severe features, and to provide Patient 1 and her fetus with appropriate treatment, after he presented to the hospital at approximately 6:30 a.m. on April 16, 2019, was a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Records)

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

24. Allegations of paragraphs 7 through 22 are incorporated herein by reference.

DISCIPLINARY CONSIDERATIONS

25. To determine the degree of discipline, if any, to be imposed on Respondent Arthur M. Park, M.D., Complainant alleges that on or about November 17, 2000, in a prior disciplinary action titled *In the Matter of the Accusation Against Arthur M. Park, M.D.* before the Medical Board of California, in Case Number 08-1997-76654, Respondent's license was revoked, but the revocation was stayed and Respondent's license was placed on probation for a period of three years with various terms and conditions, including a completion of the PACE Program, and practice monitoring. In resolving that matter, Respondent admitted committing repeated negligent acts in the care and treatment of two patients. That Decision is now final and is incorporated by reference as if fully set forth herein. Respondent completed his probation in November 2003.

26. To further determine the degree of discipline, if any, to be imposed on Respondent Arthur M. Park, M.D., Complainant alleges that on or about June 26, 2020, in a prior disciplinary action entitled *In the Matter of the Accusation against Arthur M. Park, M.D.*, before the Medical Board of California, case number 800-2016-026837, Respondent's license was revoked, but the revocation was stayed and the license was placed on probation for a period of five years with

various terms and conditions which include restrictions on Respondent's practice, including: a prohibition from engaging in the practice of obstetrics; engaging in hospital-based practice; engaging in surgical practice as the operating surgeon; engaging in solo practice of medicine; requiring him to complete education courses; completion of an ethics course; submitting to practice monitoring. Before completion of his probation Respondent is required to complete a Clinical Competence Assessment Program. Respondent made no admissions, but was charged with Gross Negligence, Repeated Negligent Acts and Inadequate and Inaccurate Record Keeping, in connection with his care and treatment of a single patient. That Decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 44597, issued to Arthur M. Park, M.D.;

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

3. Ordering Arthur M. Park, 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: MAR 10 2021

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

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