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

## In the Matter of the Accusation Against:

## BRIAN GLENN QUIROGA BEITEL, M.D., Respondent

## Physician's and Surgeon's Certificate No. A 65151

## Case No. 800-2018-050015

## OAH No. 2021040407

### DECISION AFTER NON-ADOPTION

Abraham M. Levy, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by video/telephone conference on October 26 and 27, 2021.

Karolyn M. Westfall, Deputy Attorney General (DAG), represented Complainant, William J. Prasifka, Executive Director of the Medical Board of California (Board).

Michael D. Gonzalez, Attorney at Law, Law Offices of Michael D. Gonzalez, represented Respondent, Brian Glenn Quiroga Beitel, M.D. (Respondent), who was present.

The matter was submitted on October 27, 2021. A proposed decision was issued on November 24, 2021. On February 17, 2022, Panel A of the Board issued an Order of Non-Adoption of Proposed Decision. Oral argument on the matter was heard by Panel A on May 18, 2022, with ALJ Marcie Larson presiding. DAG Karolyn M. Westfall appeared by phone on behalf of the Complainant. Respondent was present and was

represented by Michael D. Gonzalez, Attorney at Law. Panel A, having read and considered the entire record, including the transcript and the exhibits, and having considered the written and oral argument, hereby enters this Decision After Non-Adoption.

## SUMMARY

Complainant asserts that Respondent's license should be disciplined because he committed gross negligence in his care and treatment of Patient A, a pregnant patient who was under Respondent's care at a hospital on February 1 and 5, 2016, when she presented with high blood pressure and Respondent was the on-call physician. Complainant proved by clear and convincing evidence that Respondent failed to appropriately manage and treat Patient A's hypertension on these dates. A period of probation with terms and conditions will ensure public protection.

## PROTECTIVE ORDER

A protective order has been issued on Complainant's motion without objection sealing Exhibits 7 to 12 and 14, and the confidential name list, without objection. On the undersigned's motion Exhibits A to C have also been sealed and included in the protective order. A reviewing court, parties to this matter, and a government agency decision maker or designee under Government Code section 11517 may review materials subject to the protective order provided that this material is protected from disclosure to the public.

## FACTUAL FINDINGS

### Jurisdiction

1. On March 12, 2021, Complainant filed the accusation in this matter. The accusation alleges that Respondent committed gross negligence in his treatment

of Patient A when he failed to appropriately treat her hypertension during pregnancy on February 1 and 5, 2016.

## License History

2. On May 15, 1998, the Board issued Physician's and Surgeon's Certificate No. A 65151 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges in this matter and will expire on May 31, 2022. Respondent has no history of discipline.

## Summary of Patient A's Pregnancy and Medical Condition in February 2016

3. The facts of Patient A's condition and Respondent's treatment and care of her on February 1, February 5, and February 17, 2016, are found in medical records and the deposition transcripts of Respondent and Stephen Hordynski, M.D., Patient A's primary obstetrician-gynecologist (OBGYN), in addition to Patient A's August 28, 2020, Board interview, and a summary of his treatment that Respondent provided to the Board. These materials have been received as evidence. They document the following:

### PATIENT A'S FEBRUARY 1, 2016, HOSPITAL ADMISSION

4. On Monday, February 1, 2016, at 7:01 p.m., Patient A, who was then 32 years old, went to the Labor and Delivery department at Redlands Community Hospital (Labor and Delivery), with complaints of elevated blood pressure (bp) and blurred vision. At the time of her visit to the hospital she was 27 weeks pregnant.

5. At the hospital Patient A stated she was "very concerned due to delivery at 29 weeks with first baby due to preeclampsia via [C-section]." Preeclampsia is a condition in pregnancy characterized by high blood pressure, sometimes with fluid retention and proteinuria (protein in the urine). Patient A was diagnosed with preeclampsia in her previous pregnancy and the baby was delivered preterm by C-section.

6. Before she went to Labor and Delivery, over the weekend at her home,

Patient A had recorded elevated bp readings and called Dr. Hordynski. To control her blood pressure, Dr. Hordynski prescribed Aldomet 500 mg to be taken three times daily. Aldomet is an antihypertensive medication used to treat high blood pressure. At the hospital Patient A denied headaches and epigastric pain, but she had mild edema in her ankles and feet.

7. Respondent was the on-call OB/GYN at the hospital and was responsible for Patient A's care at the hospital. Through Beaver Medical Group, he provided emergency room coverage for patients who presented to the emergency room at the hospital. Respondent and Dr. Hordynski were members of Beaver Medical Group. They knew each other and Respondent described him as a friend in his deposition.

At 7:01 p.m. Patient A was admitted to the hospital to monitor her bp and she was directed to a labor room for evaluation. At 7:05 p.m. a protein urine test strip was taken. Protein was not detected in the urine.

8. Patient A's admission profile was recorded as follows: Her chief complaint was high blood pressure. She was identified as having chronic hypertension and her obesity was identified as a risk factor. She was also noted to have had preeclampsia and a previous pregnancy.

9. Patient A's bp was monitored serially and readings were recorded between 7:01 p.m. and 9:31 p.m. These readings are documented as follows: 159/98, 169/92, 106/85,[1] 171/91, 170/93 170/96, 162/79, 168/95, 164/87, and 157/76.[2]

10. At 8:28 p.m. a nurse talked to Respondent at the nurses' station. Patient A's bp was just recorded at 8:21 p.m. as 170/93. Respondent ordered that Patient A be given one pill of 100 mg of Labetalol, a medication to treat high blood pressure. The

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[1] This reading taken at 7:46 p.m. was anomalous and not considered accurate.

[2] Blood pressure is measured in millimeters of mercury (mmHG) which measures how much force blood exerts on the arteries' walls. The first number measures the pressure when the heart beats and the second number measures the pressure when the heart rests.

nurse obtained the medication and gave it to Respondent.

11. At 8:36 p.m. Respondent examined Patient A. He noted her initial bp was 159/98, and her bp when he examined her was 170/93. He also noted her history of preeclampsia and then chronic hypertension. She reported her vision was blurry when she tried to focus on objects in the distance, but without scotoma, or black dots in the visual field, small flashing lights or wavy lines. In his deposition, Respondent denied that blurry vision can be one of the risk factors of preeclampsia, but he said "visual changes" can be.

Patient A further denied she had headaches. He reviewed fetal heart tracings[3] which he found were reassuring. Respondent noted in his deposition that the baby was appropriately oxygenated.

12. Respondent's plan was for Patient A to follow up with Dr. Hordynski at her scheduled appointment with him on February 5, 2016, for medication management. Respondent also ordered a comprehensive metabolic panel. This panel checks the platelet count, liver enzymes, and creatinine levels to assess kidney functioning. As recorded in Patient A's chart, Respondent reviewed the lab results at the nurses' station at 9:45 p.m. The results were essentially normal, including the test results for liver and kidney functioning. Fetal Heart Tracings were appropriate.

13. After reviewing the test results at 9:45 p.m., Respondent discharged Patient A. Patient A's bp was recorded just before he discharged her as 157/76 at 9:31p.m. He prescribed 100 mg Labetalol to be taken daily. As he said at his deposition, Respondent discharged her even though he recognized that she did not have a "normal" bp. He also said at his deposition that he did not want "[Patient A] discharged with blood pressures systolically in the range of 160."

14. Patient A was informed of the lab results and given a prescription for Labetalol. Patient A signed discharge instructions at 9:51 p.m.

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[3] These tracings are referred to as "FTHS CAT1."

15. Upon her discharge, Patient A was told what she should do in the event of preterm labor despite her presenting concerns that she might have had preeclampsia and her history. Patient A was advised only to take the Labetalol and to follow-up with Dr. Hordynski at her next scheduled appointment with him on February 5, 2016. She was also advised to call her physician if she had any questions, concerns, or a change in her status.

16. Respondent did not believe that Patient A had developed preeclampsia on February 1, 2016. In his various statements, he explained he did not think she had preeclampsia, at that time, based on the lack of proteinuria, liver enzymes, elevated serum creatinine, anemia, and low platelet counts. He reiterated this in his hearing testimony.

17. At the hospital, Respondent did not have access to Beaver Medical Group's electronic records for Patient A. He was thus not able to see Patient A's bp readings before she went to the hospital on February 1, 2016. Respondent does not think he talked to Dr. Hordynski about Patient A on February 1, 2016. At any rate, there is no documentation he consulted with Dr. Hordynski on February 1 or 5, 2016.

**FEBRUARY 5, 2016 VISIT**

18. On Friday February 5, 2016, Dr. Hordynski instructed Patient A to report to Labor and Delivery for further monitoring after her blood pressure was measured to be 178/100 without proteinuria.

19. At 12:47 p.m., Patient A arrived at Labor and Delivery as instructed, and was seen by Respondent, who was again the on-call OB/GYN. Patient A had been taking Aldomet 500 mg three times daily and the Labetalol Respondent prescribed 100 mg once daily. She denied headaches, visual changes, or abdominal pain. Shortly after arrival, her blood pressure was measured to be 173/87, and dipstick urinalysis revealed no protein. Patient A's bp readings as recorded on the fetal monitoring strips were as follows: 173/87 at about 1:00 p.m. and 162/84 at 1:56 p.m.

20. Respondent again ordered a comprehensive blood panel. These results were normal. As documented in a note he dictated at 2:18 p.m., Respondent assessed that Patient A had gestational hypertension and no evidence of preeclampsia. At his deposition, Respondent defined gestational hypertension as follows: elevated blood pressures that occur during pregnancy in a patient who does not have hypertension prior to pregnancy, but there is no evidence of preeclampsia. It is based solely on the patient's blood pressure values. Respondent discharged Patient A with a prescription for Labetalol 100 mg twice daily and instructed her to follow-up with Dr. Hordynski for a blood pressure check the following week.

21. At the time of her discharge, as he wrote at 2:18 p.m., Respondent noted Patient A's bp was 178/100, but there was no proteinuria and Patient A denied headaches, visual changes, and abdominal pain. He reviewed the fetal monitoring strips and found them appropriate for her estimated gestational age. Respondent noted the test results were normal for kidney and liver functioning. He further noted Patient A's heart rhythm was regular without "gallop" and the lungs were clear. She did not exhibit clonus, a neurological condition that occurs when nerve cells are damaged. The Fetal Heart Tracings were appropriate.

Respondent stated that since Patient A displayed no evidence of preeclampsia superimposed on chronic hypertension and her hypertension was not in a range that would put her at risk for heart failure or stroke, he discharged her home. He increased Labetalol to two times daily.

22. In discharge instructions given to Patient A, which she signed at 2:15 p.m., she was advised to follow-up with Dr. Hordynski on Monday. She was given general pre-term labor advisements but no specific advisement to monitor her bp levels.

### FEBRUARY 17, 2016 VISIT

23. On February 17, 2016, Dr. Hordynski instructed Patient A to report to Labor and Delivery for further monitoring after her blood pressure was measured to be

180/124, and the result of a 24-hour urine protein test was 350 mg. A 24-hour urine test is different than a dipstick test and more sensitive. Above 300 mg is consistent with preeclampsia. Dr. Hordynski diagnosed Patient A with chronic hypertension and superimposed preeclampsia. He contacted Respondent about Patient A to alert him that Patient A was coming to the hospital. Dr. Hordynski gave Respondent the information about the blood pressure reading and the positive proteinuria result.

24. At 11:45 a.m., Patient A arrived at Labor and Delivery as instructed and Respondent, the on-call OB/GYN saw her. Upon arrival, Patient A was in no distress. But she very quickly decompensated.

25. At 12:04 p.m. Patient A's bp was measured at 203/115. At 12:07 p.m., Respondent recorded her bp at 210/119. At 12:13 p.m., Patient A complained of difficulty breathing, was extremely agitated, and had a cough with frothy clear sputum tinged with blood. Respondent noted Patient A's lungs sounded diffusely wet. Respondent then ordered an emergent cesarean section and Dr. Hordynski was called in to assist.

26. At 12:49 p.m., a baby girl was delivered. Minutes later Patient A went into cardiac arrest. Eventually she was resuscitated and transferred to the intensive care unit, where she was diagnosed with an anoxic brain injury with a poor prognosis.

## Testimony of Complainant's Expert, Jane van Dis, M.D.

27. Complainant called Jane van Dis, M.D., as an expert. In addition to her testimony, Dr. van Dis prepared a report she submitted to the Board's complaint unit, which was received as evidence.

28. Dr. van Dis is board-certified in Obstetrics and Gynecology. She obtained her M.D. from the University of South Dakota in 2003 and completed an internship at the University of Hawaii in 2004 and a residency at University of California Los Angeles in 2007. She is a Fellow of the American College of Obstetricians and Gynecologists (ACOG), and a Member and Board Member of the Society of OB Hospitalists. She is

Medical Director of OB Hospitalist Group where she is actively engaged in the practice of clinical hospital care and treatment of pregnant patients. Dr. van Dis has held numerous professional and academic leadership positions. Dr. van Dis is presently an assistant professor of medicine at the University of Rochester in New York. She is licensed to practice medicine in California.

29. Dr. van Dis reviewed the materials which were admitted as evidence in this matter and prepared a report. Her testimony is consistent with what she wrote in her report.

30. Dr. van Dis is familiar with the definition of standard of care and extreme departure from the standard of care.

31. Dr. van Dis identified the applicable standard of care as follows: For a pregnant patient with less than 34 weeks gestation with severe preeclampsia the standard of care requires that the patient be admitted with bp readings repeated every 15 minutes; the initiation of antihypertensive medications; fetal heart rate and contraction monitoring; and ultrasound monitoring for fetal growth and amniotic fluid. The patient should be considered for magnesium sulfate. In her opinion Respondent departed from this standard of care in his care and treatment of Patient A on February 1 and 5, 2016. She further found that the departure was extreme.

32. In reaching her conclusion Dr. van Dis stated the determination whether a patient has severe preeclampsia is made using an algorithm found in the ACOG Practice Bulletin on Preeclampsia which was in effect in 2016: One of the following factors must be present for this diagnosis: a systolic bp reading of 160 or a diastolic reading of 110 four hours apart while patient is on bed rest, or proteinuria at certain levels, or cerebral or visual symptoms, among other factors relevant to this case. ACOG developed the bulletin in 2013 and this algorithm as part of the organization's "Safe Mother Initiative" because severe hypertension is one of the leading causes of maternal death. Severe hypertension is common in pregnant patients.

33. Dr. van Dis stressed that the diagnosis of severe preeclampsia can be met by any one of the laboratory data points or the elevated bp readings alone. She said a physician in California is expected to know this. With such elevated bp readings as the ones presented here, the concern for the mother is that she may suffer a stroke which could injure her ocular system, kidneys, and/or cardiovascular system. The concern for the fetal body is that high bp can cause the placenta to sheer away and rupture causing injury to the fetus from lack of oxygen.

34. Dr. van Dis believes that Patient A met one of the factors for Patient A to have been diagnosed with severe preeclampsia both on February 1 and February 5, 2016: Patient A had repeated systolic bp readings of over 160 on both occasions. Patient A met this criterion for severe preeclampsia even though the four-hour timeline was not met because the case criteria for severe bp elevation can be met without waiting until four hours have passed. She said that Respondent should not have been reassured regarding Patient A's wellbeing and the fetal wellbeing given these repeated bp levels above 160 even with the lab results.

35. Dr. van Dis explained that the elevated bp readings need to be persistent to trigger this diagnosis: two elevations in the severe range four hours apart with patient on bed rest. Clinically, the physician can recognize severe preeclampsia without this four-hour time frame with repeated readings of over 160 systolic (or 110 diastolic) 15 minutes apart. In such situations, Dr. van Dis said, the clinician would not want to wait to treat the patient in four hours.

36. As additional factors that informed her opinion, Dr. van Dis stated that Patient A had two significant risk factors for developing severe preeclampsia: Patient A previously had preeclampsia resulting in a C-section, and she was obese.

37. Dr. van Dis concluded that Respondent failed to act on Patient A's behalf in that: He failed to diagnose her with severe preeclampsia; he did not initiate anti-hypertensive therapy; he only gave her one Labetalol pill while she was in the hospital. In her view this did not bring Patient A's bp down to a "safe" level, as she wrote in her report, because her systolic bp was only 3 mmHg below the 160 range.

Respondent further did not admit Patient A for observation and serial bp measurements and laboratory draws; he failed to administer antenatal corticosteroids to protect the fetus from the consequences and sequalae of preterm delivery which, given her history of preeclampsia at 29 weeks, was a profound and imminent threat; he did not order an ultrasound to check on the wellbeing of the fetus.

38. Dr. van Dis criticized Respondent for discharging Patient A even though he recognized that he never saw a "normal" bp reading for Patient A before discharge as he said in his deposition. She said his statement was a dangerous lapse of judgment for Patient A given her high risk. Dr. van Dis further criticized Respondent for stating in his deposition that blurry vision was not a risk factor for severe hypertension when it could have been, and it warranted further investigation and treatment with anti-hypertensive medications.

## Testimony of Respondent's Expert Craig V. Towers, M.D.

39. Respondent called Craig V. Towers, M.D., as an expert. Dr. Towers is a professor and Vice-Chair of the Department of Obstetrics and Gynecology at the University of Tennessee Medical Center. He has been at the University of Tennessee Medical Center since 2010. He obtained his medical degree from the University of Kansas School of Medicine in 1981 and completed a residency in Obstetrics and Gynecology in 1985 from the University of Kansas School of Medicine and a fellowship in Maternal-Fetal Medicine at the University of California Irvine (UCI) Long Beach Memorial Women's Hospital in 1987. From 1985 to 1999 he held various academic appointments at UCI. He is Obstetrical Director at the East Tennessee Regional Perinatal Program. Dr. Towers is board certified in Obstetrics and Gynecology and Maternal-Fetal Medicine and is a member and fellow of numerous professional organizations in the field of Obstetrics and Gynecology and Maternal-Fetal Medicine. Dr. Towers is licensed to practice medicine in California in addition to Tennessee and other states. Dr. Towers testified he retired from his clinic a few months ago. Until he retired, he actively practiced obstetrics and gynecological medicine.

40. Dr. Towers is the co-author of 107 peer reviewed articles in the field Obstetrics and Gynecology and Maternal-Fetal health and is the co-author or author of non-peer reviewed articles in the field. He has served as a reviewer of peer reviewed publications in the field.

41. Dr. Towers reviewed the materials of record in this matter and prepared a report, which has been admitted as evidence. His review included records from Beaver Medical Group, which as noted above, Respondent was not able to review when he treated Patient A on February 1 and 5, 2016. Dr. Towers is familiar with the definition of standard of care and what constitutes departures from a standard of care. His testimony is consistent for the most part with what he wrote in his report.

Based on his review of the record Dr. Towers found that Respondent did not depart from the standard of care for these reasons:

42. Dr. Towers does not agree with Dr. van Dis on a fundamental point: in his view, the ACOG algorithm does not constitute the standard of care and the diagnosis of severe preeclampsia cannot be made based on a bp reading alone because preeclampsia is a dynamic and progressive condition. He cited ACOG's November 2013 Task Force report entitled "Hypertension in Pregnancy" as follows: "One of the major challenges in the care of women with hypertension is deciphering whether chronic hypertension has worsened or whether preeclampsia has developed."

43. Dr. Towers stressed that the determination whether a patient has severe preeclampsia requires a review of information obtained about the patient including proteinuria lab results and whether a patient's symptomology indicates central nervous system involvement. In his opinion on February 1 and 5, 2016, Respondent acted appropriately within the standard of care and exercised sound clinical judgment based on the information Respondent obtained about Patient A's condition on these dates.

44. When Patient A went to Labor and Delivery on February 1, 2016, she had hypertension, which was related to her chronic hypertension that was being

treated with Aldomet. In his clinical view, there was no evidence that Patient A had superimposed preeclampsia. Respondent appropriately acted when he ordered tests, in his assessment of Patient A, and when he discharged her based on the information he obtained. Patient A tested negative for proteinuria, all of her laboratory values were within normal limits, including tests of her liver and kidney functioning, and she had no evidence of systemic findings.

45. Dr. Towers stated that Patient A's blurry vision only occurred with distances without accompanying scotoma which he found significant because her vision improved. If there had been central nervous system involvement, her vision would not have improved. In addition, after Patient A was discharged, she never reported visual disturbances. If the blurry vision in this case was related to preeclampsia, it should have progressed and become more severe over time.

Dr. Towers said Patient A responded to the Labetalol, because her bp after one oral dose was lowered to 157/76. He noted in patients with chronic hypertension, the recommended goal for bp maintenance are systolic blood pressure values between 120 and 160 mmHg and diastolic blood pressure values between 80 and 105 mmHg.

46. Dr. Towers reached the same conclusion regarding Respondent's treatment and care of Patient A on February 5, 2016. In his clinical judgment Patient A did not have superimposed preeclampsia at that time. She had no proteinuria, all her laboratory work was within normal limits, and she had no evidence of systemic findings.

47. In his report, Dr. Towers wrote that at her February 5, 2016, visit, Patient A had one reported bp reading which was 173/87 at 12:18 p.m. Dr. Towers was not aware when he wrote his report that Patient A's bp was recorded through the fetal heart monitor and documented in the strips. Dr. Towers conjectured there were other bp readings from these strips because these readings "had to have been obtained" because there was fetal heart monitoring but, clearly, he did know these bp results when he wrote his report.

48. Dr. Towers speculated in his report that Patient A's bp must have stabilized because in his clinical judgment it was "highly unlikely that the nurses would have agreed to a patient being discharged if only one blood pressure reading was obtained with a value of 173/87." Here, Dr. Towers seemed to say that the Labor and Delivery nurses, and not Respondent, were to decide to discharge Patient A based on their reading of Patient A's bp as recorded in her chart. Because Patient A's bp readings from the fetal monitoring strips are in Patient A's records, it appears that Dr. Towers did not have command of Patient A's record when he wrote his report.

49. When confronted with the bp results from the strips at the hearing, Dr. Towers stood by his opinion. He said Patient A's bp went down "significantly" from 178 to 162 according to the fetal monitoring strips and in the context of the lab results and lack of concerning symptomology Respondent appropriately assessed that Patient A was stable and in a non-compromised state and was able to follow-up in the office. He said that the diastolic reading of 82 was normal. Dr. Towers stated further that there was nothing on February 5, 2016, to suggest that Patient A was in a "hypertensive crisis" and he said Patient A did not have preeclampsia. He noted that Patient A had a regular heart rhythm and her lungs were clear and she did not display indications of clonus. Dr. Towers commented that a doctor does not want to administer antihypertensive medications to the extent that a patient's blood pressure would drop too low. Such a situation could have harmed the fetus.

50. Fundamentally, Dr. Towers concluded that given this information, the bp readings above 160 did not indicate that Patient A had preeclampsia, and there was nothing "ominous or unsafe" in discharging her home. Dr. Towers repeated that the ACOG algorithm is a guide and is not the standard of care.

Even with two systolic readings over 160, on February 5, 2016, Dr. Towers said that Respondent did not need to admit Patient A because she was taking her blood pressure readings at home. The instruction for her to take the bp medications and follow up with Dr. Hordynski on Monday complied with the standard of care. However, no evidence was provided that Patient A was instructed to take her bp readings at

home.

51. Dr. Towers stressed that he would not argue with a doctor who admitted her for observation. The decision to admit her for a period of observation was a judgment call and Respondent acted appropriately when he decided to not admit her for observation, in his opinion.

52. Dr. Towers commented further that it was not appropriate to admit Patient A or to administer magnesium and steroids in the absence of a diagnosis of preeclampsia. Such treatments are administered when a decision has been made to deliver the baby and such a decision would not have been appropriate in Dr. Towers's judgment. He said an ultrasound was not needed because there was no indication of an abruption.

53. Dr. Towers testified that preeclampsia did not cause Patient A's cardiac arrest on February 17, 2016. He attributed her cardiac disease to cardiac disease that developed before February 17, 2016, and he said there was no way to predict when a person with chronic hypertension will experience cardiac arrest or arrythmia. He said that Respondent acted promptly and appropriately in treating Patient A on February 17, 2016.

54. In response to a question on cross examination Dr. Towers agreed that a reasonably prudent doctor should have a high index of suspicion for the development of preeclampsia for a patient with chronic hypertension, who has had prior preeclampsia and was obese.

## Respondent's Testimony

55. Respondent's testimony is summarized as follows:

Respondent completed his residency in Obstetrics and Gynecology in 2000 at Loma Linda University. He began working at Beaver Medical Group in 2000 and has been there since that time. He is board certified in Obstetrics and Gynecology and has maintained certification. He has had privileges at Redlands since 2000. In 2016 he

began working in labor and delivery at Redlands. He served from 2006 to 2008 as chairman of department of Obstetrics and Gynecology at Beaver.

56. Respondent defined emergency care in Labor and Delivery as follows: The purpose is to evaluate the patient to determine if the patient requires immediate treatment or if the patient needs to follow-up with her primary care doctor in a day or two. Respondent followed this guidance in his treatment of Patient A.

57. Respondent said that there is an interplay between chronic hypertension and preeclampsia. Respondent wanted to determine if Patient A had preeclampsia versus acute exacerbation of hypertension. To do this he ordered a complete hemogram blood panel. This panel includes a platelets count. He noted that low platelets can be an indication of preeclampsia. Also, the panel records the liver enzymes and creatinine to check kidney functioning. Patients with chronic hypertension face a greater risk of developing preeclampsia, and he understood that Patient A's elevated bp placed her at risk of developing this condition.

If labs are not consistent with preeclampsia, then Respondent said he reasonably could call her condition an exacerbation of acute hypertension. Acute hypertension requires different treatment than preeclampsia. Preeclampsia, as he put it, is cured by delivery. He did not want to deliver Patient A's baby at 27 weeks and wanted to rule out preeclampsia by ordering and reviewing the lab tests and conducting a physical exam.

58. Regarding his care and treatment of Patient A on February 1, 2016, Respondent stressed that the results of the complete panel were all normal including the test results for her platelet count and liver and kidney functioning. He also did not attribute Patient A's blurry vision to central nervous system involvement, and Patient A did not have headaches. Based on the lab results and the physical exam, Respondent assessed that Patient A was having an acute exacerbation of her chronic condition without compromise to the baby or Patient A's system. He did not consider Patient A's condition emergent, and she could wait a day or two to see her primary OB/GYN. He noted that Patient A was checking her bp at home and if needed, she could return to

the hospital.

59. Regarding Respondent's treatment of Patient A on February 5, 2016, Respondent conducted the same inquiry he conducted on February 1, 2016. He noted first that she did not exhibit central nervous system involvement: no headaches, visual changes, or clonus. In addition, Patient A's heart rhythm indicated there was no strain or "gallop" suggesting her heart was under strain, and her lungs were clear. The lab results he ordered were all normal including the platelet counts tests for kidney and liver functioning and uric acid. Respondent explained that coagulation panel results, or ProTime results, which measure the blood clotting proteins, were normal. In the case of severe preeclampsia, these proteins are consumed and the ProTime levels increase.

60. These results led him to conclude that Respondent had acute exacerbation of a chronic pre-existing hypertension. In his chart note he incorrectly assessed that she had gestational hypertension; he should have written "chronic" instead of "gestational." Respondent noted that there was no evidence of deterioration since February 1, 2016, and no intervention was needed requiring preterm delivery. He did not order any more antihypertensive medications because he believed Patient A's bp was not acutely compromising her or the baby. Further, he did not want to hypoperfuse Patient A and jeopardize the baby's health with a blood pressure that was reduced too low.

61. Respondent addressed Patient A's high blood pressure readings during her February 5, 2016, visit in the context of his decision to discharge her. He recognized the readings were high with the last recorded reading at 1:56 p.m. at 162/84 and despite this reading, he discharged her shortly after this reading without administering anti-hypertensive medications. Respondent repeated Dr. Towers's comment that nurses would not let a patient be discharged with high blood pressure. He said they will notify the doctor when there is a high bp reading. Regardless, Respondent reiterated that Patient A's bp was stable, and she was in a non-compromised state in light of the lab results and lack of physical findings, so he

concluded she was able to follow up in the office.

62. Respondent recognized that Patient A had notable risk factors for severe preeclampsia because she previously had preeclampsia with a C-section, and was obese, and patients like Patient A with chronic hypertension face a greater risk of developing preeclampsia. In addition, Respondent agreed that Patient A's acute cardiac event on February 17, 2016, was the type of event that could occur due to severe preeclampsia.

63. As a result of what happened to Patient A, Respondent said he has thought a lot about his treatment and care of Patient A. In his Board interview he said whenever he thinks about what happened to Patient A, it eats him up. In hindsight Respondent believes his care of her was appropriate, but given the circumstances, a longer observation period would have been helpful. He said he is now more vigilant and errs on the side of caution and keeps patients for longer periods of observation.

64. Since his care and treatment of Patient A, Respondent has completed training modules in hypertensive disorders in pregnancy preeclampsia and hypertension in pregnancy. He said he will revisit the modules he did.

## Parties' Arguments

65. Complainant, in closing, argued that Respondent committed gross negligence in his care and treatment of Patient A based on Dr. van Dis's testimony consistent with the ACOG factors for diagnosing severe preeclampsia. Patient A met the definition of severe preeclampsia due to her persistently elevated bp levels on February 1 and 5, 2016. Due to these bp readings, and because of her history of preeclampsia and her obesity, Respondent should not have discharged Patient A on February 1 and 5, 2016, until he was satisfied with her wellness. He should have observed her longer and possibly administered steroids on these dates.

In terms of the degree of discipline to impose, Complainant seeks the imposition of five years' probation with an education course in the area of

preeclampsia. Complainant asserted this degree of discipline is warranted because Respondent did not present mitigation evidence or evidence of rehabilitation. Complainant does not believe a practice monitor is needed as a matter of public protection. Additionally, Complainant does not believe public protection requires the imposition of a solo practice prohibition.

66. In addition to Respondent's closing arguments, Respondent submitted a trial brief which has been reviewed and considered. Respondent argued that Complainant did not meet his burden to establish that Respondent committed gross negligence. In the alternative, Respondent argued that Respondent committed only simple negligence in his care and treatment of Patient A and at most a public reprimand should be issued. Respondent asserted that the record shows that he acted appropriately, and he thoroughly assessed Patient A. Based on his assessment, Patient A did not have proteinuria, or central nervous symptomology to indicate she had severe preeclampsia. Respondent had Patient A on a fetal monitor, which also monitored Patient A's bp, and he ordered bloodwork, the results of which were normal and did not indicate preeclampsia. Respondent further acted appropriately by not prescribing anti-hypertensive medications that could have lowered her blood pressure too much and compromised fetal health.

Respondent stated that per Dr. Towers's testimony, preeclampsia did not cause the type of heart problem Patient A had which resulted in her cardiac arrest.

In response to Complainant's assertion that Respondent offered no rehabilitation evidence, Respondent stated he has taken education modules and classes to update his knowledge in the area of hypertension during pregnancy.

## Evaluation of Expert Testimony and Evidence

67. The decision in this matter requires resolving the conflict in the testimony of the experts. In this regard, consideration has been given to their qualifications and credibility, including their biases that could color their opinions and review of the evidence, the reasons for their opinions, and the factual bases of their opinions.

California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

After giving due consideration to these factors, Dr. van Dis's opinion that Respondent departed from the standard of care when he failed to appropriately manage and treat Patient A's hypertension on February 1 and 5, 2016, is found more persuasive than Dr. Towers's opinions to the contrary for these reasons:

68. The criteria to diagnose severe preeclampsia is found in the ACOG Practice Bulletin on Preeclampsia which was in effect in 2016 when Respondent treated Patient A. To meet the diagnostic criteria for severe preeclampsia per the Bulletin, there must be systolic bp readings of over 160 four hours apart. Dr. van Dis testified clearly and unequivocally that this definition was the standard of care for diagnosing severe preeclampsia in 2016. Dr. Towers's testimony that the ACOG definition found in the Bulletin is only a guideline is not found persuasive. ACOG developed the diagnostic criteria for severe preeclampsia to ensure maternal health because hypertension during pregnancy is the leading cause of maternal death. If these criteria were just guidelines, as a matter of ensuring the health of pregnant women with persistently high bp readings, the criteria would have little value.

Per Dr. van Dis, Patient A met the definition of severe preeclampsia notwithstanding that the readings were not four hours apart because the readings were persistent, and Respondent committed an extreme departure when he failed to make this diagnosis and render appropriate care.

69. Regarding Patient A's hypertension when Respondent treated her on February 1 and 5, 2016, Patient A's systolic bp remained abnormally high on both dates. Certainly, by February 5, 2016, Respondent knew that Patient A's bp was persistently high and she had risk factors that threatened her wellbeing. Considering these readings, Respondent should not have been assured of Patient A's wellbeing to discharge her, even with the lab results he obtained, and the absence of symptomology to suggest central nervous system involvement.

70. Here, it is pointed out that Patient A herself understood that her health and wellbeing were at risk when she went to Labor and Delivery on February 1, 2016. She was alarmed by her high bp readings based on readings she took over the weekend before February 1, 2016, given her history of preeclampsia with a prior C-section. Dr. Hordynski was also sufficiently concerned that he sent Patient A to Labor and Delivery based on Patient A's systolic bp readings. On February 1, 2016, her systolic bp levels were recorded at Labor and Delivery between 7:01 p.m. and 9:31 p.m. at or near 160. Patient A's last systolic reading was 157 at 9:31 p.m. and the difference of 3 mmHG was negligible, a fact which Respondent did not dispute in his deposition. In fact, Respondent agreed in his deposition that Patient A's bp levels were not normal and he did not want "[Patient A] discharged with blood pressures systolically in the range of 160." Nonetheless, Respondent discharged Patient A after only a few hours on February 1, 2016. He discharged her for her to see Dr. Hordynski at her scheduled appointment on February 5, 2016. Notably, in the discharge instructions to Patient A, Respondent did not advise Patient A to monitor her bp readings despite her presenting concerns about her bp levels.

71. On February 5, 2016, when Patient A saw Dr. Hordynski, he became concerned about Patient A's bp readings and again sent Patient A to Labor and Delivery. Two readings were recorded at Labor and Delivery on this date: 173/87 at about 1:00 p.m. and 162/84 at 1:56 p.m. This later reading was obtained through the fetal monitor. Despite these readings, by 2:15 p.m. Respondent discharged Patient A for her to see Dr. Hordynski the next day. He did not communicate with Dr. Hordynski, he did not administer antihypertensive medications, and he did not order a period of observation. His discharge instructions further did not advise Patient A to take her bp readings. Respondent candidly admitted he should have admitted Patient A for a longer observation period.

72. Dr. Towers's opinion that Respondent acted appropriately is not found persuasive and his opinion is discounted for several reasons. First, in his review of the record and Respondent's conduct, Dr. Towers strained to defend Respondent's decision to discharge Patient A on February 5, 2016. He said Respondent appropriately

discharged Patient A without a meaningful observation period because a nurse would not have "agreed" to discharge Patient A with a single high blood pressure reading. Dr. Towers is wrong. Patient A's bp reading of 162/84 at 2:15 p.m. was a high blood pressure reading and she was discharged anyway. When confronted with this reading, Dr. Towers said the bp reading was not so high that discharge was not appropriate in Respondent's clinical judgment, but he would not argue with a doctor who ordered Patient A to be observed. Here, Dr. Towers's testimony conflicts with his earlier testimony where he found it appropriate for Respondent to have discharged Patient A on February 1, 2016 once her systolic bp went below the 160 threshold. This was after it is noted Patient A was observed with serial bp readings.

73. Dr. Towers's testimony must also be discounted because he stressed that Patient A's hypertension was chronic to justify Respondent's assessment, and treatment and care of Patient A. But Respondent did not have access to Beaver Medical Group's records that would have allowed him to identify Patient A's bp readings before February 1, 2016, for him to assess Patient A's chronic hypertension. Respondent did not know Patient A's bp readings before February 1, 2016. Respondent only knew that Patient A was taking blood pressure medicine. And Respondent did not contact Dr. Hordynski or anyone at Beaver Medical Group to obtain these readings. Thus, Respondent could not have known what Patient A's bp baseline was to assess whether her bp readings on February 1 and 5, 2016, were normative.

74. Dr. Towers, in addition, did not address in a material way the significance of Patient A's history of preeclampsia with a C-section and her obesity as risk factors that Dr. van Dis found important. This is an oversight suggesting he did not consider her history to be important, or he did not consider it as a factor.

75. With these conclusions regarding Respondent's care of Patient A on February 1 and 5, 2016, no conclusion is made that Respondent's care and treatment of Patient A on February 1 and 5, 2016, caused Patient A's unfortunate outcome on February 17, 2016.

But, Patient A's persistently high bp readings on February 1 and 5, 2016, placed her at increased risk of serious and adverse health consequences. Respondent recognized the risk Patient A faced. He stated that Patient A's acute cardiac arrest on February 17, 2016, was the type of event that could occur due to severe preeclampsia. To mitigate against this risk, Patient A needed to be closely monitored in the hospital as Dr. van Dis opined. This did not happen on February 1 or February 5, 2016.

## LEGAL CONCLUSIONS

### Purpose of Physician 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.)

### Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the first amended accusation are true.

The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

## Applicable Statutes Regarding Causes to Impose Discipline

3. Section[4] 2227, subdivision (a), states:

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 the discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

4. Section 2234 provides 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,

[4] References are to the Business and Professions Code unless otherwise stated.

but is not limited to, the following:

[¶] . . . [¶]

(b) Gross negligence.

## Decisional Authority Regarding Standard of Care

5. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.)

## Case Law Regarding Gross Negligence

6. 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.)

7. 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.

## Cause Exists Under the First Cause for Discipline to Impose Discipline Against Respondent's License for Gross Negligence

8. Complainant proved by clear and convincing evidence that Respondent committed gross negligence in violation of Section 2234, subdivision (b), in his

treatment and care of Patient A based on the findings in this decision. Dr. van Dis persuasively testified that Respondent failed to appropriately manage and treat Patient A's hypertension in pregnancy on February 1 and 5, 2016, when he failed to diagnose her with severe preeclampsia and when he failed to admit her for longer periods of observation where she could be monitored with serial bp readings and administered anti-hypertensive medications.

## The Board's Disciplinary Guidelines

9. With cause for discipline found, the determination now must be made regarding the degree of discipline and the terms and conditions to impose. In this regard, the Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016) states:

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

10. For the causes of discipline that have been found the Board's Disciplinary Guidelines provide that revocation is the maximum discipline and the minimum recommended term and conditions are as follows:

> For gross negligence under Business and Professions Code section 2234, subdivisions (b), revocation, stayed, and five years' probation, with conditions including an education course, prescribing practices course, medical

record keeping course, professionalism program (ethics course), clinical competence assessment program, monitoring, solo practice prohibition, and prohibited practices.

## Disciplinary Considerations and Disposition Regarding the Degree of Discipline

11. As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual, the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Fahmy*, *supra*, 38 Cal.App.4th at p. 817.) 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." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.)

12. The determination whether Respondent's license should be revoked or suspended includes an evaluation of the nature and severity of the conduct and rehabilitation and mitigation factors as set forth under California Code of Regulations, title 16, section 1360.1, which provides as follows:

> When considering the suspension or revocation of a license, certificate or permit on the ground that a person holding a license, certificate or permit under the Medical Practice Act has been convicted of a crime, the division, in evaluating the rehabilitation of such person and his or her eligibility for a license, certificate or permit shall consider the following criteria:
>
> (a) The nature and severity of the act(s) or offense(s).
>
> (b) The total criminal record.
>
> (c) The time that has elapsed since commission of the

act(s) or offense(s).

(d) Whether the licensee, certificate or permit holder has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against such person.

(e) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(f) Evidence, if any, of rehabilitation submitted by the licensee, certificate or permit holder.

13. After considering the Board's guidelines, and the factors under California Code of Regulations, title 16, section 1360.1, the evidence of rehabilitation, and mitigation, and the evidence of record as a whole, it is determined that a four-year period of probation with terms and conditions will ensure public protection. This conclusion is reached for these reasons:

The nature of Respondent's misconduct was serious and exposed Patient A to harm. Respondent failed to appropriately manage Patient A's hypertension during her pregnancy on February 1 and February 5, 2016. He did not diagnose her with severe preeclampsia, and he did not admit her for longer periods of observation on February 1 and 5, 2016, to be assured of her wellbeing. With this stated, Patient A's tragic outcome is not a factor in this analysis except to assess the risk of adverse health consequences Patient A faced due to her severe hypertension.

As factors in Respondent's favor the conduct at issue is not recent and Respondent does not have a history of discipline. As evidence of his rehabilitation, Respondent took affirmative steps to educate himself in the area of hypertension during pregnancy and he intends to take further courses in this area. He also recognized that he should have observed Patient A for a longer time period on February 5, 2016. As a matter of mitigating evidence, Respondent was attentive to Patient A on February 1 and 5, 2016. He ordered labs and carefully reviewed the

results before discharging her on both occasions. He also had the baby monitored. Respondent appears to be a conscientious and caring doctor.

As a result of the factors in his favor, departures from recommendations in the guidelines are warranted. A four-year period of probation in addition to a clinical competency assessment program will provide appropriate public protection and serve to rehabilitate Respondent. The clinical competence assessment program is necessary for public protection to ensure that Respondent is current on identifying significant patient risk factors in his practice.

Careful consideration has been given to Respondent's request for a public reprimand. But departure from the guidelines to that extent is not warranted. While Respondent presented evidence of rehabilitation, the evidence is not overwhelming, and the nature of the conduct is such that a period of probation is needed to ensure public protection.

## ORDER

Certificate No. G 65151 issued to Respondent Brian Glenn Quiroga Beitel, M.D., is revoked. However, revocation is stayed, and Respondent is placed on probation for four (4) years on the following terms and conditions:

**1. 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 no later than six (6) 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(s), Accusation(s), 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 3 and no more than 5 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 will submit a report to the Board or its designee which unequivocally states whether the 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 (3) calendar days after being so notified. The 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 the Respondent did not successfully complete the clinical competence assessment program, the 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.]

**2. Notification**

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

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

**3. Supervision of Physician Assistants and Advanced Practice Nurses**

During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

**4. Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

**5. Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

**6. General Probation Requirements**

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

**7. 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.

**8. Non-practice While on Probation**

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

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

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

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

Periods of non-practice for a Respondent residing outside of California, will relieve Respondent of the responsibility to comply with the probationary terms and

conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

**9. Completion of Probation**

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

**10. Violation of Probation**

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

**11. License Surrender**

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the

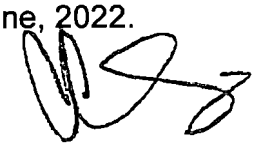
application shall be treated as a petition for reinstatement of a revoked certificate.

**12. Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

The Decision shall become effective at 5:00 p.m. on July 22, 2022.

IT IS SO ORDERED this 22nd day of June, 2022.



Laurie Rose Lubiano, J.D.
Chair, Panel A
Medical Board of California

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KAROLYN M. WESTFALL
Deputy Attorney General
State Bar No. 234540
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9465
Facsimile: (619) 645-2061

*Attorneys for Complainant*

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

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| In the Matter of the Accusation Against:<br><br>**BRIAN GLENN QUIROGA BEITEL, M.D.**<br>**1615 Marjorie Crest**<br>**Redlands, CA 92373**<br><br>**Physician's and Surgeon's Certificate**<br>**No. A 65151,**<br><br>Respondent. | Case No. 800-2018-050015<br><br>**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 May 15, 1998, the Medical Board issued Physician's and Surgeon's Certificate No. A 65151 to Brian Glenn Quiroga Beitel, 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, 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

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

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

## FIRST CAUSE FOR DISCIPLINE

**(Gross Negligence)**

6. Respondent has subjected his Physician's and Surgeon's Certificate No. A 65151 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patient A,[1] as more particularly alleged hereinafter:

7. On or about February 1, 2016, at approximately 7:01 p.m., Patient A presented to Labor and Delivery at Redlands Community Hospital (Labor and Delivery), with complaints of blurred vision and elevated blood pressure. Patient A was thirty-two years old and 27 weeks pregnant at that time, with a past medical history that included chronic hypertension, obesity, and preeclampsia in her first pregnancy that led to a premature birth via cesarean section at 29 weeks.

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[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.

The patient had been taking Aldomet[2] 500mg three times daily as prescribed by her obstetrician gynecologist (OBGYN). She denied headaches and epigastric pain, but was experiencing mild edema in her ankles and feet.

8. Between approximately 7:01 p.m. and 8:16 p.m., Patient A's blood pressure was measured to be 159/98, 169/92, 106/85, 171/91, and 170/93. A dipstick urinalysis revealed no protein. Patient A was then seen by Respondent, the on-call OBGYN, who ordered labs and Labetolol[3] 100mg.

9. Between approximately 8:31 p.m. and 9:31 p.m., Patient A's blood pressure was measured to be 170/96, 162/79, 168/95, 164/87, and 157/76.

10. Throughout her visit on or about February 1, 2016, Respondent did not diagnose Patient A with preeclampsia at any time, did not order or administer magnesium therapy, did not order or administer antenatal corticosteroids, did not admit the patient for further observation, did not order serial blood pressure measurement or serial lab draws, and did not order or perform an ultrasound.

11. At approximately 9:45 p.m., Respondent ordered Patient A to be discharged with a prescription for Labetolol 100mg once daily, and to follow-up with her OBGYN in four days.

12. On or about February 5, 2016, Patient A's OBGYN instructed her to report to Labor and Delivery for further monitoring after her blood pressure was measured to be 178/100 without proteinuria.

13. At approximately 12:47 p.m., Patient A arrived at Labor and Delivery as instructed, and was seen by Respondent, the on-call OBGYN. Patient A had been taking Aldomet 500mg three times daily and Labetolol 100mg once daily. She denied headaches, visual changes, or

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[2] Aldomet (brand name for Methyldopa) is an antihypertensive medication used to treat high blood pressure, and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Labetolol is a beta blocker medication used to treat high blood pressure, and a dangerous drug pursuant to Business and Professions Code section 4022.

abdominal pain. Shortly after arrival, her blood pressure was measured to be 173/87,[4] and a dipstick urinalysis revealed no protein.

14. Throughout her visit on or about February 5, 2016, Respondent did not diagnose Patient A with preeclampsia or severe preeclampsia at any time, did not order aggressive anti-hypertensive therapy, did not order or administer magnesium therapy, did not order or administer antenatal corticosteroids, did not admit the patient for further observation, did not order serial blood pressure measurement or serial lab draws, and did not order or perform an ultrasound.

15. At approximately 2:18 p.m., Respondent determined Patient A was experiencing gestational hypertension and had no evidence of preeclampsia. Respondent ordered Patient A to be discharged at that time with a prescription for Labetolol 100mg twice daily, and to follow-up with her OBGYN the following week.

16. On or about February 17, 2016, Patient A's OBGYN instructed her to report to Labor and Delivery for further monitoring after her blood pressure was measured to be 176/112, and 24 hour urine protein results of 350mg.

17. At approximately 11:45 a.m., Patient A arrived at Labor and Delivery as instructed and was seen by Respondent, the on-call OBGYN. Upon arrival, Patient A was in no distress.

18. At approximately 12:04 p.m., Patient A's blood pressure was measured to be 201/115. Within ten minutes, she complained of difficulty breathing, was extremely agitated, and had a cough productive of frothy clear sputum tinged with blood. Respondent noted Patient A's lungs sounded diffusely wet. Respondent then ordered an emergent cesarean section and Patient A's OBGYN was called in to assist.

19. At approximately 12:49 p.m., a baby girl was delivered, but minutes later Patient A went into cardiac arrest. The patient was eventually resuscitated and transferred to the intensive care unit, where she was diagnosed with an anoxic brain injury with a poor prognosis.

20. Respondent committed gross negligence in his care and treatment of Patient A by failing to appropriately manage and treat hypertension in pregnancy.

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[4] The patient's chart indicates this was the only blood pressure taken and/or documented on that visit.

## 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 65151, issued to Respondent, Brian Glenn Quiroga Beitel, M.D.;

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

3. Ordering Respondent, Brian Glenn Quiroga Beitel, 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 12 2021

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

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