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

In the Matter of the Accusation Against Arthur M. Park, M.D. Physician's and Surgeons License No. A44597 Respondent.	Case No. 800-2016-026837

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 June 26, 2020.

IT IS SO ORDERED: May 28, 2020.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
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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: **ARTHUR M. PARK, M.D.** **2502 Tiverton Drive** **Bakersfield, CA 93311** **Physician's and Surgeon's Certificate No. A 44597,** Respondent.	Case No. 800-2016-026837 OAH No. 2019110063 **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. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). Kimberly Kirchmeyer, the former Executive Director of the Board, brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. Respondent Arthur M. Park, M.D. (Respondent) is represented in this proceeding by attorneys Brian L. Hoffman, Esq. and Jeffrey M. Oberto, Esq., whose address is: Wood, Smith,

Henning & Berman LLP, 10960 Wilshire Blvd., 18th Floor, Los Angeles, CA 90024, (310) 481-7649.

3. On or about March 21, 1988, the Board issued Physician's and Surgeon's Certificate No. 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 in Accusation No. 800-2016-026837, and will expire on February 28, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-026837 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 August 14, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2016-026837 is attached as Exhibit "A" and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-026837. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his 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 him; the right to present evidence and to testify on his 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.

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2016-026837, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2016-026837 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent and the State of California.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

13. 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 his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his 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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14. 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.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 44597 issued to Respondent ARTHUR M. PARK, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. PROHIBITED PRACTICE – HOSPITAL-BASED PRACTICE. During probation, Respondent is prohibited from engaging in hospital-based practice of medicine at a "health facility" as defined in Health and Safety Code section 1250, et seq. After the effective date of this Decision, all of Respondent's current patients shall be notified, in writing, that the Respondent is prohibited from engaging in hospital-based practice of medicine. Any new patients must be provided a written notification at the time of their initial appointment. The written notification shall be initialed by the patient. Respondent shall maintain a copy of the written notification, initialed by the patient, in the patient's medical record.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

2. PROHIBITED PRACTICE – OBSTETRICS. During probation, Respondent is prohibited from engaging in the practice of obstetrics. For the purpose of this Order, "obstetrics" includes care and management, including surgical management, of labor and delivery during

childbirth. This prohibition on Respondent's practice of obstetrics does not include engaging in routine, office-based prenatal care and practice of gynecology, such as performance of annual well-woman exams, pap-smears, or other office-based gynecological practice, subject to the limitation of Condition 3. Respondent may engage prenatal care, subject to the following limitations: 1) Respondent shall not render prenatal care to any high-risk patient; 2) Respondent shall not render prenatal care to patients during their initial prenatal appointment, and after 36th week of pregnancy; 3) Every patient to whom Respondent renders prenatal care shall have a designated obstetrician who will be responsible for the patient's care during labor and delivery; and 4) the designated obstetrician shall review and sign off on all prenatal care rendered by Respondent.

After the effective date of this Decision, all patients being treated by the respondent shall be notified that the respondent is prohibited from engaging in the practice of obstetrics, as defined herein. Any new patients must be provided this notification at the time of their initial appointment. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

3. PROHIBITED PRACTICE – SURGICAL PRACTICE AS OPERATING SURGEON. During probation, Respondent is prohibited from acting as the Operating Surgeon in any out-patient surgery setting. "Operating Surgeon" is defined as the surgical attending of record, or the principal surgeon, or primary surgeon, who is responsible for the planning, orchestrating and performing of any surgical procedure, including any cosmetic or gynecological out-patient procedure. This prohibition on Respondent's surgical practice does not include serving as an assistant surgeon in an out-patient surgery setting.

After the effective date of this Decision, all of Respondent's current patients shall be

notified, in writing, that the Respondent is prohibited from serving as the Operating Surgeon, but is not prohibited from serving as an Assistant Surgeon. Any new patients must be provided a written notification at the time of their initial appointment. The written notification shall be initialed by the patient. Respondent shall maintain a copy of the written notification, initialed by the patient, in the patient's medical record.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

4. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, 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 practice until an appropriate practice setting is established.

5. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 20 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

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

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

Respondent shall submit a certification of successful completion to the Board or its

designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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

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

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which

includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

8. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Before completion of probation, Respondent shall successfully complete a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than three (3) months before completion of probation, or before pursuing penalty relief.

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 three (3) and no more than five (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 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.

9. 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.

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10. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

11. 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.

12. 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.

13. 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.

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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.

14. 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.

15. 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 Boards'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.

16. 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.

17. 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.

18. 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.

19. 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Jeffrey M. Oberto, 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: 4-1-2020

ARTHUR M. PARK, M.D.
Respondent

I have read and fully discussed with Respondent Arthur M. Park, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 4/1/2020

JEFFREY M. OBERTO, ESQ.
Attorney for Respondent

[Endorsements continued on next page].

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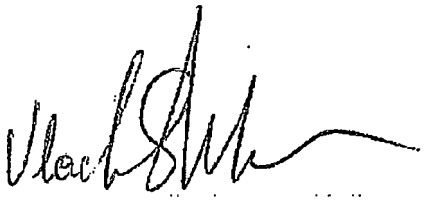
ENDORSEMENT

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

DATED: April 2, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General



VLADIMIR SHALKEVICH
Deputy Attorney General
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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 14, 2019
BY [signature] ANALYST

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

In the Matter of the Accusation Against: ARTHUR M. PARK, M.D. 2502 Tiverton Drive Bakersfield, California 93311 Physician's and Surgeon's Certificate No. A 44597, Respondent.	Case No. 800-2016-026837 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On March 21, 1988, the Board issued Physician's and Surgeon's Certificate Number A 44597 to Arthur M. Park, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2020, 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 (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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated 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."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code for gross negligence in the care and treatment of Patient 1.[1] The circumstances are as follows:

8. Respondent was the on-call Obstetrician / Gynecologist at the Adventist Health Joaquin Community Hospital (hospital) on September 6, 2016. Patient 1 was 23 years old at the time. She already had two children and was about to have her third. At approximately 38.5 to 41.1 weeks gestation, Patient 1 came to the hospital, at approximately 3:00 a.m. on September 6, 2016, reporting that she had a spontaneous rupture of membranes approximately 54 hours previously. She was leaking amniotic fluid and was having mild intermitted labor contractions. Patient 1 had a history of limited prenatal care during this pregnancy. She was admitted to Respondent's care in the hospital's labor and delivery department.

9. Patient 1's initial triage assessment by the labor and delivery nurse revealed that she was progressing appropriately. Respondent was notified by phone of the patient's status and he gave admission orders, which included prenatal lab assessment and group B strep antibiotic prophylaxis. The nursing staff reassessed the patient's cervical exam within an hour of admission and found that her labor was steadily progressing, and her baby showed no signs of distress. Contractions were reported to be moderate in intensity. Approximately one hour later, the patient received an epidural for labor analgesia and a Foley catheter was inserted. The patient's vital signs remained stable and within a normal range; her labor continued to steadily progress, and her baby had no complications.

10. Respondent first examined Patient 1 at approximately 8:06 a.m. He recorded her history and physical examination on a handwritten form. Respondent recorded a history of no prenatal care, two normal spontaneous vaginal deliveries and a history of spontaneous rupture of membranes. The physical exam showed a fundal height of 37 cm, estimated fetal weight of 7.5

[1] The patient is referred to as Patient 1 to protect her privacy. The true identity of the patient is known to the Respondent or will be made known to him in response to a Request for Discovery.

pounds, fetal heart rate 140 beats per minute and uterine contractions five minutes apart. Respondent's history and physical examination were inadequate, as he left many portions of the form blank. The patient's history and physical examination, as recorded by Respondent, lacked appropriate detail and documentation concerning the patient's present clinical situation, such as duration of ruptured membranes, the color of amniotic fluid, onset of contractions, intensity of contractions, presence of fetal movement, or his assessment of gestational age. The document also lacked an assessment and documentation of the patient's past obstetric history. Respondent did not inquire about and/or did not record information about past complications such as postpartum hemorrhage or retained placenta, a record of any prenatal care, or maternal drug or alcohol use. The assessment document prepared by Respondent also lacked a record of a complete physical exam and omitted vital signs, a detailed assessment of abdominal findings such as uterine tenderness, baseline fetal heart tones, fetal heart rate variability, periodic decelerations, frequency, duration and intensity of uterine contractions. Respondent's history and physical form also lacked detailed information concerning clinical pelvimetry and cervical examination. Respondent did not consider and/or made no note of the fact that admitting laboratory studies were available for review and showed that the patient was anemic with a hemoglobin of 8.4 gm/dL. Respondent's handwritten history and physical form also lacked proper assessment and a detailed plan of the patient's management and did not address prolonged rupture of membranes, unknown group B strep carrier status and maternal anemia. Respondent then left the hospital.

11. At approximately 11:00 a.m., the patient was noted to have a category II fetal heart rate tracing. The nursing staff appropriately performed uterine resuscitative measures, and the problem resolved. The nursing staff notified Respondent by telephone, but he made no record of this event and did not come to the hospital to monitor the patient's fetal heart rate more closely.

12. At noon, the patient was fully dilated, with 100% effacement and at zero station. Respondent was notified that Patient 1 was ready to deliver her baby by a telephone call to his home. Respondent arrived at the patient's bedside at 12:21 p.m., and helped deliver a healthy baby girl by normal spontaneous vaginal delivery at 12:28 p.m. On Respondent's orders, Pitocin infusion was started after the delivery. The placenta remained in Patient 1's uterus.

13. Respondent then extracted the placenta. He dictated a procedure note, which described the removal of the placenta as follows:

> "The patient's umbilical cord was noted to be coming loose from the placenta after a gentle pull; therefore, no further pulling is done at this time. Before this, cord blood was obtained. The patient's fundus is massaged, but the patient is complaining of tenderness, and then there is moving in her tummy from the umbilicus to the right side of her abdomen freely without any further bleeding. After gentle massaging, there is noted to be bleeding from what was thought to be placental attachment. The ring forceps were used to grasp the lower part of the placenta with no avail. After approximately 10 minutes, the patient was informed that I would do manual removal. After this was attempted, the placenta is not reachable at this time and the procedure is promptly discontinued. Further massaging of the fundus is performed. After several attempts to grasp the placenta with ring forceps which the patient was not tolerating very well because the patient appeared agitated, this was discontinued. After further bleeding, the patient was informed sometime later that an additional attempt at manual extraction would be attempted. The second attempt was successful. The lower part of the placenta was grasped and pulled, resulting in delivery of a complete placenta which did not appear to have any abnormalities. The fundus is firm with minimal bleeding thereafter with a total blood loss of approximately 150 ml."

The labor and delivery nurse recorded that the placenta was delivered by manual extraction at 12:36 p.m.

14. Thus, Respondent, within several minutes after the delivery of the baby, attempted to deliver the placenta without observing or documenting the usual signs of placental separation. Respondent's initial attempts at placental delivery were by increased cord traction and uterine massage. Respondent incorrectly managed this patient as if she had a retained placenta, with attempts at manual and instrument removal of placenta. Respondent removed the placenta less than 30 minutes after the delivery of the baby when there was no indication of, or a recorded reason for, the need for the placenta to be rapidly extracted.

15. Respondent did not wait for 30 minutes prior to attempting to extract the placenta, nor did he stop the Pitocin infusion or give the patient medication to relax the myometrium and cervix to facilitate placental delivery. During an attempt to manually remove the placenta, Respondent noted that the cervix was contracted, an indication to consider stopping the Pitocin infusion or giving medication to relax the patient's myometrium and cervix, yet Respondent did not consider doing so, or record any such consideration. The nursing staff documented that during the placental extraction, the patient was screaming in pain and moving around in bed, and in his note

Respondent described her as "agitated," and did not consider or record consideration summoning the anesthesiologist to add medication to the patient's epidural infusion prior to attempting to extract the placenta. Respondent proceeded to attempt an instrument delivery of the placenta, despite the patient having a contracted cervix, without adequate pain control, and without ultrasound guidance. Respondent did not perform and did not document a thorough post extraction examination of the patient's uterus, cervix, vaginal or perineum tissue for injuries.

16. Within approximately a half hour after Respondent removed the placenta, the patient's vital signs began to deteriorate, and she began to show signs of shock. At approximately 12:50 p.m., she had a pulse of 100 and blood pressure of 65/34, with pulse oximetry of 98%. Respondent was notified of the low blood pressure and was asked to come to the patient's bedside by the nursing staff. Respondent did not observe frank vaginal bleeding and made no orders at that time. His uterine examination revealed the uterus to be firm and in the midline with minimal lochia rubra. At approximately 12:55 p.m., the nurse recorded that she had difficulty assessing the patient's blood pressure and was unable to record a reading. After the blood pressure cuff was readjusted, the patient's blood pressure was noted to be 68/33 with a pulse rate of 90 and pulse oximetry of 98%. At 1:06 p.m., Respondent was notified by telephone of the decreased blood pressure, the patient's pallor and her decreased level of consciousness. Respondent made no orders at that time. At 1:07 p.m, Respondent was at the nurse's station and was again informed of the patient's low blood pressure by the nursing staff who asked him to come to the patient's room to reevaluate her. At 1:09 p.m., Respondent reevaluated the patient with fundal massage with the fundus noted to be firm and at the umbilicus and noted scant vaginal bleeding. Respondent made no orders at this time. At 1:14 p.m., the patient's blood pressure remained low, and the patient was noted to be pale; Respondent who was at the nurse's station was asked to come back once again and reevaluate the patient. Within one minute, Respondent was at the bedside reevaluating the patient, whose pulse was 93, blood pressure was 50/26, and pulse oximetry was 100%. She was conscious but pale and denied difficulty with breathing; fundal exam was recorded as firm with scant vaginal bleeding. Seeing no blood, Respondent did not order ultrasound imaging of the patient's abdomen, did not order any blood transfusions or any other life-saving resuscitative

measures. He ordered that a one-liter LR bolus be administered. At a later interview with the Board's investigators, he explained that he did not believe that the patient was hemorrhaging at all, and based on the procedure that he did, he had no reason to believe that he perforated the patient's uterus in any manner.

17. At 1:23 P.M., the patient's pulse rate was 88, blood pressure was 73/37, pulse oximetry was 98%, her temperature was 97.6. Repeat evaluation at 1:30 p.m. revealed her pulse at 100, blood pressure 74/39, and pulse oximetry 97% with the fundal exam unchanged. The patient's medical record notes that the charge nurse was at the patient's bedside at 1:29 p.m. The labor and delivery nurse noted at 1:30 p.m., "M.D. out of the room, per M.D. bleeding is fine."

18. Respondent failed to take appropriate notice of clinical signs suggestive of ongoing hemorrhage when he was or should have been, aware of the patient's tachycardia, hypotension, and changes in the patient's level of consciousness. The standard of care dictates that hemodynamic instability in any postpartum patient, with or without observed vaginal bleeding, should have prompted Respondent to consider uterine rupture and/or intra-abdominal bleeding. Respondent did not perform a proper historical assessment, physical exam or laboratory studies to aid in the diagnosis of this patient's hypovolemic hemorrhagic shock. Respondent failed to recognize that he had inadvertently perforated the uterus at the time of instrument delivery of the placenta. In the immediate postpartum Respondent did not recognize that the patient was in shock with deterioration of maternal vital signs out of proportion to the vaginal bleeding that he observed. Respondent failed to rule out intraperitoneal or retroperitoneal bleeding. Respondent did not perform and/or document a thorough physical examination of the patient that would have aided in differentiating the type of shock the patient was suffering. Despite his lack of a diagnosis, Respondent did not initiate immediate life-saving resuscitative measures or emergent laboratory studies and did not perform any further diagnostic assessment such as an ultrasound evaluation.

19. At 1:44 p.m., a rapid response team was called by the nursing staff, and immediately responded to the patient's bedside. Respondent, who at the time was downstairs talking to his partner, trying to figure out what might be happening to Patient 1, was notified by telephone by

the ICU nurse who suggested that an intensivist should be called to assist in the care of this patient. The intensivist arrived at Patient 1's bedside at 1:53 p.m. and immediately ordered aggressive resuscitation.

20. The intensivist spoke to Respondent, who informed him that there was no excessive bleeding at the time of the delivery, and Respondent could not explain the source of the patient's severe anemia. The intensivist's note, which was written at 2:43 p.m., indicated that the "patient could be suffering from amniotic fluid embolism since as per the report, the patient did not lose much blood during vaginal delivery, no amniotic fluid was seen and there was a problem with placenta removal." At 3:12 p.m., Respondent wrote a progress note, which describes that the patient had been transferred to the ICU and care had been accepted by the intensivist. He reported that the patient's condition had deteriorated and her presumptive diagnosis was amniotic fluid embolism. The notation does not include any further history, physical examination, laboratory studies, assessment or suggested management plan.

21. After Patient 1 was transferred to the intensive care unit, despite aggressive attempts to resuscitate her, she suffered two cardiac arrests and was eventually pronounced dead at 7:50 p.m. The patient's autopsy revealed extensive laceration of the lower uterine segment and cervix and concluded that she died of postpartum hemorrhage due to traumatic laceration of uterus and cervix during forceps application and manual extraction during labor and removal of the placenta, though trauma caused during childbirth and delivery could not be excluded.

22. Each of the following, taken together or separately, constitutes an extreme departure from the standard of care by Respondent:

(a) Respondent did not wait the appropriate 30 minutes before attempting removal of the patient's placenta.

(b) Respondent did not stop the Pitocin infusion or give the patient medication to relax the myometrium and cervix to facilitate placental delivery despite noting that the patient's cervix was contracted.

(c) Respondent inappropriately proceeded to attempt an instrument delivery of the placenta without ultrasound guidance.

(d) Respondent inappropriately proceeded to attempt to deliver the placenta without appropriate pain management.

(e) Respondent did not perform and/or document a thorough post extraction examination of the issue uterine, cervix, vagina or perineum for lacerations or bleeding.

(f) In the immediate postpartum, Respondent did not recognize that the patient was in shock with deterioration of maternal vital signs well out of proportion to the observed vaginal bleeding.

(g) Respondent did not perform and/or document an appropriate assessment, physical exam or laboratory studies to aid in the diagnosis of the shock symptoms apparent in Patient 1.

(h) Respondent made an incorrect presumptive diagnosis of amniotic fluid embolism, a rare condition, without ruling out more common causes of shock.

(i) Respondent did not initiate immediate life-saving resuscitative measures despite the patient's symptoms consistent with post-partum hemorrhage.

(j) Respondent improperly delayed calling the hospital's rapid response team.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

23. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts in the case and treatment of Patient 1. The circumstances are as follows:

24. The allegations of paragraphs 8 through 22 are incorporated herein by reference. In addition to the allegations in paragraph 22 (a) through (j), the respondent further departed from the standard of care as follows:

(k) Respondent inadequately documented the patient's history and physical examination and the patient's progress through labor.

(l) Respondent incorrectly diagnosed a retained placenta.

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THIRD CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

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

26. Allegations of paragraphs 8 through 22 and paragraph 24 are incorporated herein by reference.

DISCIPLINARY CONSIDERATIONS

27. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about October 18, 2000, in a prior disciplinary action entitled 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. That decision was based on Respondent's admission that in delivering obstetrical care to two patients in 1996 and 1997 he committed repeated negligent acts in violation of Business and Professions Code section 2234, subdivision, (c). 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 his authority to supervise physician assistants and advance practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

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

DATED: August 14, 2019

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

Complainant

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