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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 14, 2019
BY *[Signature]* ANALYST

8
9 **BEFORE THE**
10 **MEDICAL BOARD OF CALIFORNIA**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
12 **STATE OF CALIFORNIA**

13 In the Matter of the Accusation Against:

Case No. 800-2016-026837

14 ARTHUR M. PARK, M.D.

A C C U S A T I O N

15 2502 Tiverton Drive
16 Bakersfield, California 93311

17 Physician's and Surgeon's Certificate
No. A 44597,

18 Respondent.

19
20 Complainant alleges:

21 **PARTIES**

- 22 1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official
23 capacity as the Executive Director of the Medical Board of California (Board).
- 24 2. On March 21, 1988, the Board issued Physician's and Surgeon's Certificate Number
25 A 44597 to Arthur M. Park, M.D. (Respondent). That license was in full force and effect at all
26 times relevant to the charges brought herein and will expire on February 29, 2020, unless
27 renewed.
- 28

JURISDICTION

1
2 3. This Accusation is brought before the Board, under the authority of the following
3 laws. All section references are to the Business and Professions Code (Code) unless otherwise
4 indicated.

5 4. Section 2227 of the Code states:

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

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

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

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

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

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

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

25 5. Section 2234 of the Code, states:

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

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

3 “(b) Gross negligence.

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

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

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

14 “(d) Incompetence.

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

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

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

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

25 6. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain
26 adequate and accurate records relating to the provision of services to their patients constitutes
27 unprofessional conduct.”

28

1 **FIRST CAUSE FOR DISCIPLINE**

2 (Gross Negligence)

3 7. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section
4 2234, subdivision (b) of the Code for gross negligence in the care and treatment of Patient 1.¹

5 The circumstances are as follows:

6 8. Respondent was the on-call Obstetrician / Gynecologist at the Adventist Health
7 Joaquin Community Hospital (hospital) on September 6, 2016. Patient 1 was 23 years old at the
8 time. She already had two children and was about to have her third. At approximately 38.5 to
9 41.1 weeks gestation, Patient 1 came to the hospital, at approximately 3:00 a.m. on September 6,
10 2016, reporting that she had a spontaneous rupture of membranes approximately 54 hours
11 previously. She was leaking amniotic fluid and was having mild intermitted labor contractions.
12 Patient 1 had a history of limited prenatal care during this pregnancy. She was admitted to
13 Respondent's care in the hospital's labor and delivery department.

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

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

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

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

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

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

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

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

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

23 14. Thus, Respondent, within several minutes after the delivery of the baby, attempted to
24 deliver the placenta without observing or documenting the usual signs of placental separation.
25 Respondent's initial attempts at placental delivery were by increased cord traction and uterine
26 massage. Respondent incorrectly managed this patient as if she had a retained placenta, with
27 attempts at manual and instrument removal of placenta. Respondent removed the placenta less
28 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

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

7 16. Within approximately a half hour after Respondent removed the placenta, the
8 patient's vital signs began to deteriorate, and she began to show signs of shock. At approximately
9 12:50 p.m., she had a pulse of 100 and blood pressure of 65/34, with pulse oximetry of 98%.
10 Respondent was notified of the low blood pressure and was asked to come to the patient's bedside
11 by the nursing staff. Respondent did not observe frank vaginal bleeding and made no orders at
12 that time. His uterine examination revealed the uterus to be firm and in the midline with minimal
13 lochia rubra. At approximately 12:55 p.m., the nurse recorded that she had difficulty assessing
14 the patient's blood pressure and was unable to record a reading. After the blood pressure cuff was
15 readjusted, the patient's blood pressure was noted to be 68/33 with a pulse rate of 90 and pulse
16 oximetry of 98%. At 1:06 p.m., Respondent was notified by telephone of the decreased blood
17 pressure, the patient's pallor and her decreased level of consciousness. Respondent made no
18 orders at that time. At 1:07 p.m, Respondent was at the nurse's station and was again informed of
19 the patient's low blood pressure by the nursing staff who asked him to come to the patient's room
20 to reevaluate her. At 1:09 p.m., Respondent reevaluated the patient with fundal massage with the
21 fundus noted to be firm and at the umbilicus and noted scant vaginal bleeding. Respondent made
22 no orders at this time. At 1:14 p.m., the patient's blood pressure remained low, and the patient
23 was noted to be pale; Respondent who was at the nurse's station was asked to come back once
24 again and reevaluate the patient. Within one minute, Respondent was at the bedside reevaluating
25 the patient, whose pulse was 93, blood pressure was 50/26, and pulse oximetry was 100%. She
26 was conscious but pale and denied difficulty with breathing; fundal exam was recorded as firm
27 with scant vaginal bleeding. Seeing no blood, Respondent did not order ultrasound imaging of
28 the patient's abdomen, did not order any blood transfusions or any other life-saving resuscitative

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

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

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

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

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

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

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

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

- 22 (a) Respondent did not wait the appropriate 30 minutes before attempting removal of
23 the patient's placenta.
- 24 (b) Respondent did not stop the Pitocin infusion or give the patient medication to
25 relax the myometrium and cervix to facilitate placental delivery despite noting
26 that the patient's cervix was contracted.
- 27 (c) Respondent inappropriately proceeded to attempt an instrument delivery of the
28 placenta without ultrasound guidance.

- 1 (d) Respondent inappropriately proceeded to attempt to deliver the placenta without
2 appropriate pain management.
- 3 (e) Respondent did not perform and/or document a thorough post extraction
4 examination of the issue uterine, cervix, vagina or perineum for lacerations or
5 bleeding.
- 6 (f) In the immediate postpartum, Respondent did not recognize that the patient was
7 in shock with deterioration of maternal vital signs well out of proportion to the
8 observed vaginal bleeding.
- 9 (g) Respondent did not perform and/or document an appropriate assessment, physical
10 exam or laboratory studies to aid in the diagnosis of the shock symptoms apparent
11 in Patient 1.
- 12 (h) Respondent made an incorrect presumptive diagnosis of amniotic fluid embolism,
13 a rare condition, without ruling out more common causes of shock.
- 14 (i) Respondent did not initiate immediate life-saving resuscitative measures despite
15 the patient's symptoms consistent with post-partum hemorrhage.
- 16 (j) Respondent improperly delayed calling the hospital's rapid response team.

17 **SECOND CAUSE FOR DISCIPLINE**

18 **(Repeated Negligent Acts)**

19 23. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section
20 2234, subdivision (c), in that he committed repeated negligent acts in the case and treatment of
21 Patient 1. The circumstances are as follows:

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

- 25 (k) Respondent inadequately documented the patient's history and physical
26 examination and the patient's progress through labor.
- 27 (l) Respondent incorrectly diagnosed a retained placenta.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Inadequate Record Keeping)**

3 25. Respondent Arthur M. Park, M.D. is subject to disciplinary action under section
4 2266, in that failed to keep adequate or accurate medical records of his care and treatment of
5 Patient 1. The circumstances are as follows:

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

8 **DISCIPLINARY CONSIDERATIONS**

9 27. To determine the degree of discipline, if any, to be imposed on Respondent,
10 Complainant alleges that on or about October 18, 2000, in a prior disciplinary action entitled In
11 the Matter of the Accusation Against Arthur M. Park, M.D. before the Medical Board of
12 California, in Case Number 08-1997-76654, Respondent's license was revoked, but the revocation
13 was stayed, and Respondent's license was placed on probation for a period of three years, with
14 various terms and conditions. That decision was based on Respondent's admission that in
15 delivering obstetrical care to two patients in 1996 and 1997 he committed repeated negligent acts
16 in violation of Business and Professions Code section 2234, subdivision, (c). That decision is now
17 final and is incorporated by reference as if fully set forth herein.

18 **PRAYER**

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

- 21 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 44597,
22 issued to Arthur M. Park, M.D.;
- 23 2. Revoking, suspending or denying approval of his authority to supervise physician
24 assistants and advance practice nurses;
- 25 3. If placed on probation, ordering him to pay the Board the costs of probation
26 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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