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

In the Matter of the Accusation Against: CHRISTOPHER DOTSON, M.D. 10150 National Blvd. Los Angeles, CA 90034 Physician's and Surgeon's Certificate No. C19255, Respondent.	Case No. 06-95-50838 FIRST AMENDED **ACCUSATION**

The Complainant alleges:

PARTIES

1. Ron Joseph ("Complainant") brings this amended accusation solely in his official capacity as the Executive Director of the Medical Board of California (hereinafter the "Board"). This amended accusation supersedes and replaces nunc pro tunc the accusation previously filed in this action on October 8, 1997.

2. On or about December 16, 1957, Physician's and Surgeon's Certificate No. C19255 was issued by the Board to

Christopher Dotson (hereinafter "respondent"). At all times relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on June 30, 1999.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the Business and Professions Code (hereinafter "Code"):

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

B. Section 2234 of the Code provides that unprofessional conduct includes, but is not limited to, the following:

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

(b) Gross negligence.

(c) Repeated negligent acts.

(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.

C. Section 16.01 of the Budget Act of the State of California provides, in pertinent part, that:

(a) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any service performed by a physician while that physician's license is under suspension or revocation due to disciplinary action of the Medical Board of California.

(b) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any surgical services or other invasive procedure performed on any Medi-Cal beneficiary by a physician if that physician has been placed on probation due to a disciplinary action of the Medical Board of California related to the performance of that specific service or procedure on any patient, except in any case where the board makes a determination during its disciplinary process that there exist compelling circumstances that warrant continued Medi-Cal reimbursement during the probationary period.

D. Section 125.3 of the Code provides in pertinent part that in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to

pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

IN RE: R.J.I.

4. Complainant makes the following factual allegations regarding patient R.J.I.:

A. R.J.I. was, is, and at all times relevant herein, a female adult individual residing in the State of California.[1]

B. R.J.I., a 36-week pregnant female was admitted to Centinela Hospital on February 2, 1992 with a history of vaginal bleeding; blood had been running down her leg for approximately 1/2 to two hours prior to admission.

C. In the early morning hours of February 3, 1992, R.J.I. underwent a cesarean section. R.J.I. was experiencing disseminated intravascular coagulopathy (a condition associated with the inability of the body's mechanism to stop bleeding resulting in profuse generalized bleeding) while undergoing a cesarean section.

D. A male infant was delivered, and at approximately 2:05 in the morning, R.J.I. was closed and taken to recovery where she continued to bleed from the uterus.

E. During the two hours in recovery, blood replacement was not adequate to cover her continued blood loss. R.J.I. was returned to the operating room for a

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1. For privacy reasons, the initials of the patient will be used until revealed during the discovery process.

hysterectomy, but by then, her clotting factors were washed out and she began to bleed from all sites. Cardiac arrest ensued and the patient died at approximately 6:00 a.m.

F. The cause of death was from exanguanating hemorrhage (severe bleeding).

CAUSES FOR DISCIPLINE

I

(Gross Negligence)

5. Respondent Christopher Dotson, M.D., is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he was grossly negligent in the care and treatment of patient R.J.I. The circumstances are as follows:.

E. Respondent failed to take an adequate patient history. R.J.I. should have been classified as a high-risk patient due to her history of seven pregnancies. Her history would have alerted respondent to the risk of severe bleeding, which would have lead respondent to order a large amount of blood and clotting factor replacement prior to surgery.

B. The patient's blood count indicated the need for at least four units of packed red blood cells, however, respondent mistakenly ordered only two units, which was clearly insufficient.

C. Respondent failed to have the appropriate equipment present during the cesarean section so as to continuously monitor the patient's vital signs and blood volume. Respondent failed to provide continued evaluation of

the amount of blood loss during the procedure.

D. Respondent should have stayed in the operating room with R.J.I. after the cesarean section, kept the abdomen open, and called for a hematologist. Instead, he closed the abdomen, and sent the patient to the recovery room.

E. The patient was not transfused soon enough and there was an inadequate attempt to stop the bleeding.

II

(REPEATED NEGLIGENT ACTS)

6. Respondent Christopher Dotson, M.D., is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he committed repeated acts of negligence in his care and treatment of patient R.J.I. The circumstances are as follows:

A. The facts and circumstances as described in paragraphs 4 and 5 above are incorporated by reference as though fully set forth herein.

III

(INCOMPETENCE)

7. Respondent Christopher Dotson, M.D., is subject to disciplinary action under section 2234, subdivision (d) of the Code in that he was incompetent in his care and treatment of patient R.J.I. The circumstances are as follows:

A. The facts and circumstances as described in paragraphs 4 and 5 above are incorporated by reference as though fully set forth herein.

8. Complainant makes the following factual allegations regarding patient E.P.:

A. E.P. was, is, and at all times relevant herein, a female adult individual residing in the State of California.[2]

B. On or about December 29, 1993, patient E.P. presented at the Dotson Medical Group ("Group") for confirmation of pregnancy and pre-natal care. The patient was in fact pregnant at the time of this appointment, with a gestational age of approximately eight (8) weeks. The patient was 37 years old and weighed 210 pounds, with a history of seven prior pregnancies: five live deliveries (two vaginally, the rest by caesarean section), and two therapeutic abortions.

C. The patient continued to receive pre-natal care from the Group for the next several months, with visits on or about January 14, 1994; January 21, 1994; February 25, 1994; March 30, 1994; and May 5, 1994. During these appointments, the patient saw a variety of health care practitioners, including respondent, the owner of the group, and Dr. Flanigan. Although at one point the patient complained of a vaginal discharge and was accordingly prescribed medication, the treatment rendered during these appointments was more or less routine, including ultrasound and amniocentesis. However, shortly after the May 5 appointment, the patient

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2. For privacy reasons, the initials of the patient will be used until revealed during the discovery process.

began experiencing abdominal pain, with subsequent nausea and vomiting.

D. On or about May 15, 1994, E.P. went to the Emergency Room of Centinela Hospital, with complaints of abdominal pain and vomiting. She was diagnosed with hypertension and told to follow up with her regular physician.

E. On or about May 16, 1994, E.P. went to the Group, complaining of abdominal pain, nausea, and vomiting. She had also lost a half pound since her prior visit on May 5. She was given Compazine and told to return in two weeks. On or about May 21, 1994, she returned to the Group, and was seen by Dr. Flanigan. Her condition had not improved, and in fact the symptoms had actually worsened: she was vomiting a greenish-brown liquid, was not eating much, was unable to have a bowel movement, and had lost approximately 14 pounds in five days, although her abdominal girth had actually increased in that time. Dr. Flanigan's diagnosis was urinary tract infection and dehydration, and he prescribed Macrobid and instructed her to return in two weeks.

F. On or about May 25, 1994, E.P. made one more visit to the Group during which she was seen by respondent. She was unable to urinate or have a bowel movement, and she had lost more weight. Respondent prescribed valium for her "anxiety". At none of these visits was her urine evaluated for protein or sugar.

G. On or about May 30, 1994, E.P. went to Centinela Hospital 1994, still suffering from pain, nausea, vomiting,

inability to void, weight loss, and general weakness. Shortly after admission, the fetus, now approximately 30 weeks gestation, was delivered stillborn. After several tests and a gastro-intestinal consultation, she was diagnosed with a small bowel obstruction and acute renal failure. E.P. underwent a laparotomy to repair the bowel adhesions, as well as some dialysis until she regained her kidney functions. She was discharged from the hospital approximately one month later, July 1, 1994.

IV

(Gross Negligence)

9. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he has committed acts of gross negligence in his care and treatment of E.P. The circumstances are as follows:

A. The facts and circumstances as described in paragraph 8 above are incorporated by reference as though fully set forth herein.

B. Respondent failed to make the diagnosis of bowel obstruction despite the patient exhibiting several signs, including but not limited to abdominal pain, distension, persistent green vomiting, significant weight loss, and finally inability to void. Had respondent made the diagnosis in a timely fashion, the patient most likely would not have delivered a stillborn.

C. Respondent failed to obtain a gastro-intestinal or general surgical consultation;

D. Respondent failed to follow the American College of Obstetricians and Gynecologists guidelines for prenatal care and obtain urine samples at each visit with respondent to detect protein and glucose.

V

(Incompetence)

10. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code in that he has committed acts of incompetence in his care and treatment of a patient. The circumstances are as follows:

A. The facts and circumstances as described in paragraphs 8 and 9 above are incorporated by reference as though fully set forth herein.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C19255, heretofore issued to respondent Christopher Dotson;

2. Revoking, suspending or denying approval of respondent's authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering respondent to pay the Division the

reasonable costs of the investigation and enforcement of this case and, if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as the Division deems necessary and proper.

DATED: December 7, 1998.

Douglas Lane, Deputy Director

Ron Joseph for
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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