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

In the Matter of the Accusation Against:	)	
David Huang Kwa Su, M.D.	)	Case No. 800-2017-029757
Physician's and Surgeon's Certificate No. G 59360	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and 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 September 13, 2018.

IT IS SO ORDERED September 6, 2018.

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
E. A. JONES III
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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: DAVID HUANG KWA SU, M.D. 4626 El Rito Drive Orange, California 92867 Physician's and Surgeon's Certificate No. G 59360, Respondent.	Case Nos. 800-2017-029757; 800-2015-014356 **STIPULATED SURRENDER OF LICENSE AND 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. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She 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 Claudia Ramirez, Deputy Attorney General.

2. David Huang Kwa Su, M.D. ("Respondent") is represented in this proceeding by attorney Raymond J. McMahon, whose address is 5440 Trabuco Road, Irvine, California, 92620.

3. On or about December 22, 1986, the Board issued Physician's and Surgeon's Certificate No. G 59360 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-029757 and will expire on March 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-029757 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, 2018. A copy of Accusation No. 800-2017-029757 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-029757. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. 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.

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

CULPABILITY

8. In the case entitled, *In the Matter of the Accusation Against David Huang Kwa Su, M.D.*, Medical Board of California Case No. 800-2015-014356, Respondent was placed on seven years' probation, effective May 18, 2018. Pursuant to the terms and conditions of the probationary order, Respondent has elected to surrender his license.

9. Further, Respondent understands that the charges and allegations in Accusation No.

800-2017-029757, 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 prima facie case for the charges in Accusation No. 800-2017-029757 and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

11. Respondent agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. G 59360, all of the charges and allegations contained in Accusation Nos. 800-2017-029757 and 800-2015-014356 shall be deemed true, correct and fully admitted by Respondent for purposes of that reinstatement proceeding or any other licensing proceeding involving Respondent in the State of California.

12. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

13. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, 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 Surrender 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.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including Portable Document Format (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 Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 59360, issued to Respondent David Huang Kwa Su, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation Nos. 800-2017-029757 and 800-2015-014356 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation Nos. 800-2017-029757 and 800-2015-014356 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully

discussed it with my attorney, Raymond J. McMahon, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8/25/2018

DAVID HUANG KWA SU, M.D.
Respondent

I have read and fully discussed with Respondent David Huang Kwa Su, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: August 27, 2018

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 8/27/18

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

CLAUDIA RAMIREZ
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-029757

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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: David Huang Kwa Su, M.D. 4626 El Rito Drive Orange, California 92867 Physician's and Surgeon's Certificate No. G 59360, Respondent.	Case No. 800-2017-029757 **A C C U S A T I O N**

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, Department of Consumer Affairs ("Board").

2. On or about December 22, 1986, the Board issued Physician's and Surgeon's Certificate Number G 59360 to David Huang Kwa Su, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states:

"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-Patients 1 and 2)

7. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of Patients 1 and 2.[1] The circumstances are as follows:

Patient 1

8. On or about October 7, 2016, Respondent began providing prenatal care to Patient 1, a then thirty-year-old female who was approximately thirty-three to thirty-four weeks pregnant. He annotated each visit with "U/S" next to the date of each visit, which indicates he did an in-office ultrasound. Respondent did not note several fundamental anatomic features such as fetal presentation, heart rate, amniotic fluid volume, placental location, biometric measurements, or calculated fetal weight estimate as specified by the American Institute of Ultrasound in Medicine.

9. On or about November 26, 2016, at approximately 10:59 a.m., Patient 1 was admitted to the hospital's Labor and Delivery unit for delivery of her baby. She had spontaneous rupture of membranes with lightly-stained (meconium-stained) amniotic fluid. She was not in active labor.

10. At approximately 3:00 p.m., Patient 1's cervix was dilated 1 cm, 50 percent effaced, with the fetal vertex at -3 station. Oxytocin augmentation was initiated.

11. By approximately 6:00 p.m., Patient 1's cervix was dilated 4 cm, completely effaced,

[1] The names of patients are not used in order to protect their right to privacy.

and the fetal vertex had descended to 0 station.

12. At approximately 7:13 p.m., Respondent was called for delivery. He arrived at Patient 1's bedside by 7:48 p.m.

13. By approximately 8:00 p.m., Patient 1's cervix was dilated 8 cm. At approximately 8:36 p.m., Respondent returned to, or remained at, Patient 1's bedside.

14. At approximately 8:39 p.m., Respondent applied the Kiwi vacuum. He applied it before the cervix was completely dilated, the bladder had been emptied, and support personnel were in the delivery room.

15. On or about November 27, 2016, at approximately 12:24 a.m., Patient 1 reached complete cervical dilation. After nearly 2 hours of pushing by Patient 1, Respondent performed a vacuum-assisted vaginal delivery. At approximately 2:14 a.m., at +1 station, Respondent applied the Kiwi vacuum cup with Respondent pulling 5 times over the ensuing 60 seconds of application time. At approximately 2:16 a.m., Respondent delivered the baby. Patient 1 had a first degree vaginal laceration which Respondent repaired.

16. The following day, on or about November 28, 2016, Patient 1 was discharged from the hospital. Respondent did not write a progress note on November 28, 2016 (postpartum day number one), which reflects that he either did not see Patient 1 again or that he failed to document that he evaluated her.

17. Two to three weeks following Patient 1's hospitalization, on or about December 14, 2016, Respondent dictated a late and incomplete History and Physical for Patient 1's hospital admission of November 26, 2016. He also dictated a Discharge Summary.

18. Respondent committed grossly negligent acts with respect to the care and treatment of Patient 1 as follows:

19. Respondent committed an extreme departure from the standard of care when, on or about November 26, 2016, at approximately 8:30 p.m., he initially applied the vacuum in the setting of an incompletely dilated cervix. It is a requisite that the cervix must be completely dilated before vacuum application in all but the most extreme emergency situations. The medical records, including electronic fetal monitor ("EFM") strips, do not reflect that such an

extraordinary emergency existed at the time to justify an emergent vacuum application. Respondent did not document or consider requisite pre-application steps in preparing for the vacuum-assisted delivery such as assessment of the maternal pelvis relative to fetal size, fetal station, fetal position and presentation, adequate analgesia, dilation, and an empty bladder.

Patient 2

20. On or about August 9, 2016, Respondent began providing prenatal care to Patient 2, a then twenty-four-year-old female who was approximately thirty-one to thirty-two weeks pregnant. He annotated each subsequent visit with "U/S" next to the date, which indicates he did an in-office ultrasound at each of her visits.

21. On or about October 12, 2016, Patient 2 was admitted to the hospital after spontaneous rupture of the membranes at approximately 8:00 a.m. The fluid was clear. No meconium-staining was noted.

22. At approximately 1:00 p.m., Patient 1 was transferred to the hospital's Labor and Delivery unit for delivery of her baby.

23. By approximately 1 hour later, Patient 2's cervix was completely dilated, with the fetal vertex at +2 station. At approximately 2:00 p.m., Respondent applied a vacuum. The vacuum popped off. At approximately 2:01 p.m., the charge nurse requested clarification of the indication for use of the vacuum. Respondent's documentation is absent regarding the indication and pre-application assessment for a vacuum-assisted vaginal delivery.

24. Per Respondent's subsequently-dictated Operative Report for Cesarean section, he described that after applying the vacuum and "a couple of pulls," he noted that the cervix was 8 cm dilated. Furthermore, with his pulling, the fetal heart rate decelerated. As a result, Respondent took the vacuum off and planned for an emergent Cesarean section. However, the fetal heart rate recovered. At approximately 2:43 p.m., the Cesarean section was done less emergently, under spinal-epidural analgesia.

25. The Delivery Summary indicated that Respondent performed an emergent Cesarean section for the listed indication of "Nonreassuring fetal status." According to Respondent, he had difficulty in delivering the fetal vertex (head), after making the Cesarean uterine incision. As a

result, he utilized the vacuum.

26. The Delivery Summary indicates that the vacuum popped off (from the head) three times, and the vacuum was applied for a total of 1 minute and 30 seconds. It is unclear whether the three pop offs occurred during the attempt at vaginal delivery (at approximately 2:00 p.m.), or at Cesarean section (at approximately 2:43 p.m.), or during a combination of both. The infant was delivered at approximately 2:55 p.m. Patient 2's postoperative course was uncomplicated.

27. Three days after the Cesarean-section, on or about October 15, 2016, Patient 2 was discharged from the hospital. Respondent did not write a progress note on October 13, 14, or 15, 2016, which reflects that he either did not see Patient 2 again or that he failed to document that he evaluated her.

28. On or about November 9, 2016, Respondent dictated a Discharge Summary.

29. Respondent committed grossly negligent acts with respect to the care and treatment of Patient 2 as follows:

30. Respondent committed an extreme departure from the standard of care when, on or about October 12, 2016, at approximately 2:00 p.m., he initially applied the vacuum without an indication and pre-application assessment. The standard of care requires, except in the utmost of emergencies, full patient counseling and consent to include at least the indications, risks, and options for operative vaginal delivery (forceps or vacuum). Pre-delivery assessment must include assessment of the maternal pelvis relative to fetal size, fetal station (descent in the birth canal), fetal position and presentation, adequate analgesia, complete cervical dilation, and an empty bladder.

31. According to Respondent, he pulled a couple of times before removing the vacuum as the cervix was 8 cm. This would suggest that either (1) he knowingly disregarded the requirement for complete cervical dilation before applying the vacuum, or (2) he failed to accurately assess the cervical dilation, as required by the standard of care, before applying the vacuum. The descriptions, in the nursing notes, of the EFM patterns, throughout Patient 2's labor, did not indicate a concern for an imminent threat to fetal well-being, per the nursing assessment, as a justification for Respondent's omitting many of the requisite pre-application assessments and

patient counseling/consent in preparing for a vacuum-assisted vaginal delivery attempt. Furthermore, Respondent did not document any such urgent concerns in the medical record. The EFM tracings did not demonstrate an indication for operative vaginal delivery on a fetal basis.

32. Respondent's acts and/or omissions as set forth in paragraphs 8 through 31, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to Code section 2234, subdivision (b). Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts-Patients 1, 2, 3, and 4)

33. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in repeated negligent acts in the care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

Patient 1

34. Respondent committed repeated negligent acts with respect to the care and treatment of Patient 1 as follows:

35. The facts and allegations in paragraphs 8 through 19, above, are incorporated by reference and re-alleged as if fully set forth herein.

36. Respondent's sparse documentation of Patient 1's prenatal care ultrasounds in her medical record is a departure from the standard of care.

37. Respondent's lacking documentation regarding the vacuum applications on November 26, 2016, at approximately 8:39 p.m., and November 27, 2016, at approximately 2:14 a.m., is a departure from the standard of care. The total application time, suction time, and traction times should be recorded and documented as soon as possible after delivery. An operative vaginal delivery should be documented by a detailed procedure note, which should include, but is not limited to, the fetal station, cervical dilation, the instrument used, the amount of rotation if any, duration of applications, and number of applications. Respondent failed to document the indication for the instrumented mid-pelvic delivery at +1 station on November 27, 2016. That is considered a mid-pelvic delivery, which should be reserved for very unusual circumstances, as the risks to both fetus and mother increase markedly with such higher stations

of application. Respondent did not identify the indication for the instrumented delivery in Patient 1's medical record.

38. Respondent's late and incomplete History and Physical for Patient 1's admission of November 26, 2016, is a departure from the standard of care.

39. Respondent's lack of documentation of his inpatient postpartum care and/or evaluation (if he rendered any) of Patient 1 is a departure from the standard of care.

Patient 2

40. Respondent committed repeated negligent acts with respect to the care and treatment of Patient 2 as follows:

41. The facts and allegations in paragraphs 20 through 31, above, are incorporated by reference and re-alleged as if fully set forth herein.

42. Respondent's lacking documentation regarding the vacuum applications at vacuum-assisted vaginal delivery and Cesarean delivery is a departure from the standard of care.

43. Respondent's performing Patient 2's Cesarean section without a valid medical/obstetric indication is a departure from the standard of care. The single prolonged fetal heart rate deceleration did not, in the overall context of Patient 2's obstetric circumstances, qualify as a valid indication for Cesarean section, particularly after the heart rate had recovered. The Operative Note does indicate that the patient wanted an elective Cesarean section to avoid a vaginal laceration and difficulties at vaginal delivery. According to Respondent, the patient kept changing her mind on whether or not she wanted a Cesarean section. There is no record of a patient-focused discussion of reassurance with the patient, or a specific discussion of risk and benefits of surgery. The EFM do not suggest a legitimate concern for fetal well-being that would excuse bypassing such a fundamental discussion before undertaking such a major surgical procedure, nor would it comprise an indication for same.

44. Respondent's inaccurate and/or incomplete description of the Cesarean section and pertinent procedural details is a departure from the standard of care. His Operative Report lacks salient information, including but not limited to, the application of the vacuum, with difficulty in delivering the fetal head. Instead, the Operative Report simply reads, "The baby delivered

without any complications."

45. Respondent's failure to daily evaluate Patient 2 during her inpatient postoperative course for the three days following her surgery, or failure to document such evaluation, is a departure from the standard of care.

Patient 3

46. On or about November 22, 2016, Respondent began providing prenatal care to Patient 3, a then twenty-four-year-old female who was approximately thirty-two weeks pregnant. Patient 3's prenatal course and laboratory values were normal. Respondent used the ACOG Antepartum Record template to document the prenatal care that he provided to her. His documentation on the form was sparse, the form had missing information in several areas, and his handwriting was borderline illegible. He did not document performing in-office ultrasounds or the standard American Institute of Ultrasound in Medicine parameters.

47. On or about January 12, 2017, at approximately 12:41 a.m., Patient 3 was admitted to the hospital's Labor and Delivery unit for delivery of her baby. At approximately 8:42 a.m., Respondent used a vacuum to assist him with the delivery. The baby was born at approximately 8:48 a.m. Patient 3 suffered a third-degree vaginal laceration during the delivery, which Respondent repaired. However, Respondent did not document the occurrence of the laceration, the details of the repair, or technique of the repair. Respondent also did not inform Patient 3 of the vaginal laceration. Patient 3 would not have known to take deliberate steps to avoid constipation to allow for optimal healing.

48. Respondent's handwritten delivery note, dated January 12, 2017, at approximately 9:00 a.m., is borderline legible. Respondent did not address the episiotomy, laceration, repair, or recto-vaginal defect. He noted a vacuum-assisted vaginal delivery, but did not document the details of the vacuum-assisted vaginal delivery, including, but not limited to, the indication, counseling, consent, pre-delivery assessment, station, fetal position, total application time, suction time, and traction time. Respondent noted there were no complications and that the estimated blood loss was 200 ml. He noted Patient 3 gave birth to a female infant, whereas the nursing documentation in at least two places shows Patient 3 gave birth to a male infant.

49. The next day, on or about January 13, 2017, at approximately 6:10 p.m., Patient 3 was discharged from the hospital. Respondent did not write a progress note on January 13, 2017 (postpartum day number one), which reflects that he either did not see Patient 3 again or that he failed to document that he evaluated her. Respondent signed, but did not complete, an Obstetrical Discharge Summary. He also did not date or time it.

50. On or about January 17, 2017, Respondent saw Patient 3 for postpartum care. On or about January 21, 2017, Respondent saw Patient 3 again. She complained of feces in her vagina. Patient 3 had a rectovaginal fistula.[2] On or about January 26, 2017, Respondent evaluated the rectovaginal fistula. He subsequently scheduled her for an episiotomy repair, but Patient 3 did not show up to the hospital or respond to Respondent's telephone calls.

51. Respondent committed repeated negligent acts with respect to the care and treatment of Patient 3 as follows:

52. Respondent's inadequate documentation of Patient 3's prenatal care in her medical record is a departure from the standard of care.

53. Respondent's lack of documentation regarding the details of his vacuum-assisted vaginal delivery of Patient 3 is a departure from the standard of care.

54. Respondent's lack of documentation of his in-patient postpartum care and/or evaluation (if he rendered any) of Patient 3 is a departure from the standard of care.

55. Respondent's failure to properly document the occurrence and repair of Patient 3's third degree rectal sphincter injury is a departure from the standard of care.

56. Respondent's repair technique of Patient 3's third degree rectal sphincter injury is a departure from the standard of care. The rectovaginal fistula occurred after Respondent repaired the vaginal laceration. She had no underlying medical conditions that could otherwise explain the occurrence of the rectovaginal fistula.

57. Respondent's estimate of Patient 3's obstetric blood loss is a departure from the standard of care. Estimating blood loss is important in anticipating and preparing for postpartum

[2] A rectovaginal fistula is an abnormal connection between the lower portion of the large intestine (the rectum) and the vagina. Bowel contents can leak through the fistula, allowing gas or stool to pass through the vagina.

hemorrhage, which is a leading cause of maternal morbidity. The average blood loss at vaginal delivery is approximately 500 ml (500 cc). In addition, Patient 3's hematocrit dropped from 34.4 percent on admission to 22.9 percent the morning after delivery, which is a significant drop. Her hemoglobin dropped correspondingly by 4 Gm/dL. The significant drop is consistent with and/or highly suggestive of significant volume of interval blood loss. Respondent did not document further significant ongoing excessive bleeding after delivery, which also suggests that the blood loss at or around delivery was greater than Respondent's estimate.

Patient 4

58. On or about March 31, 2017, Respondent began providing prenatal care to Patient 4, a then thirty-nine-year-old female who was approximately thirty-two weeks pregnant. Respondent used the ACOG Antepartum Record template to document the prenatal care that he provided to Patient 4. His documentation on the form was sparse, the form had missing information in several areas, and his handwriting was borderline legible. Patient 4 appeared to have an uncomplicated obstetric (prenatal-outpatient) course.

59. On or about May 26, 2017, at approximately 1:30 a.m., Patient 4 was admitted to the hospital's Labor and Delivery unit for delivery of her baby.

60. Later that day, at approximately 8:00 p.m., Patient 4's cervix was completely dilated (10 cm, 100% effaced, with the fetal head now at -1 station). Respondent was notified. He was documented as being at the bedside at 8:50 p.m.

61. At approximately 9:09 p.m., Respondent delivered the baby.

62. Respondent's handwritten delivery note was timed and dated May 26, 2017, at approximately 9:20 p.m. It was scant and cursory, lacking some critical information. The note begins with, "Vacuum assisted vaginal delivery," yet provides none of the important salient features and details that are required for the documentation of an operative vaginal delivery. Furthermore, the delivery note fails to contain some basic elements including, but not limited to, the baby's birthweight.

63. On or about May 27, 2017, Patient 4 was discharged from the hospital. Respondent did not write a progress note on May 27, 2017 (postpartum day number one), which reflects that

he either did not see Patient 4 again or that he failed to document that he evaluated her.

64. Respondent committed repeated negligent acts with respect to the care and treatment of Patient 4 as follows:

65. Respondent's sparse documentation of Patient 4's prenatal care in her medical record is a departure from the standard of care as follows:

a. Except for listing the last menstrual period and due date, Respondent failed to complete the Menstrual History and Expected Date of Delivery ("EDD") sections of the ACOG Antepartum Record template. The areas for listing ultrasound findings, pregnancy test results, and the menstrual history were left completely blank.

b. The Inpatient Pre-Anesthesia evaluation indicates that this was the patient's fifth pregnancy with four prior Dilations and Curettages. However, Respondent's prenatal records indicate that this was her first pregnancy, and makes no mention of four prior gynecologic surgical procedures. Also, the Admission Assessment, authored by nursing personnel, indicates that this is the patient's fifth pregnancy.

c. Respondent left blank the very top space (reflecting its utmost importance) on the ACOG Antepartum Record Prenatal Flowsheet. That space is provided for the physician to list the patient's allergies to medications. Patient 4's Labor and Delivery records and Anesthesia records indicate that the patient was allergic to Penicillin. This oversight, regarding a hypersensitivity reaction ("allergy") to a drug, by Respondent, or in his documentation, could lead to severe morbidities or even mortality if not picked up by other medical personnel.

d. Respondent's documentation is overall barely legible.

66. Respondent's inadequate documentation of the operative vaginal delivery of Patient 4 is a departure from the standard of care. Specifically, he wrote, "Vacuum-assisted vaginal delivery," but failed to address any important specific details required by the standard of care.

67. Respondent's lack of documentation of his inpatient postpartum care and/or evaluation (if he rendered any) of Patient 4 is a departure from the standard of care.

68. Respondent's acts and/or omissions as set forth in paragraphs 34 through 67, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute

repeated negligent acts pursuant to Code section 2234, subdivision (c). Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Recordkeeping-Patients 1, 2, 3, and 4)

69. Respondent is subject to disciplinary action under Code section 2266 in that he maintained inadequate and inaccurate medical records for Patients 1, 2, 3, and 4. The circumstances are as follows:

70. The facts and allegations in paragraphs 8 through 67, above, are incorporated by reference and re-alleged as if fully set forth herein.

71. Respondent's acts and/or omissions as set forth in paragraphs 8 through 67, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute inadequate and inaccurate recordkeeping pursuant to Code section 2266. Therefore, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Patients 1, 2, 3, and 4)

72. Respondent is subject to disciplinary action under Code section 2234 in that he engaged in unprofessional conduct with respect to the care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

73. The facts and allegations in paragraphs 8 through 71, above, are incorporated by reference and re-alleged as if fully set forth herein.

74. Respondent's acts and/or omissions as set forth in paragraphs 8 through 71, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct pursuant to Code section 2234. Therefore, cause for discipline exists.

DISCIPLINARY CONSIDERATIONS

75. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that, on or about May 18, 2018, in a prior disciplinary action entitled *In the Matter of the Accusation Against David Huang Kwa Su, M.D.* before the Medical Board of California, in Case Number 800-2015-014356, Respondent's license was revoked, the revocation

was stayed, and Respondent was placed on seven years' probation with various terms and conditions. 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 G 59360, issued to Respondent David Huang Kwa Su, M.D.;

2. Revoking, suspending or denying approval of Respondent David Huang Kwa Su, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent David Huang Kwa Su, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: August 14, 2018

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

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