BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

GEORGE A. DAVIDSON, M.D.

Holder of License No. **13477**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-04-0270A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 10, 2005. George A. Davidson, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 13477 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-0270A after receiving notification of a medical malpractice settlement involving Respondent's care and treatment of a 33 year-old female patient ("RS") in 1998. RS was gravida 3, para 2, at 39 weeks of estimated gestational age. RS weighed in excess of three-hundred pounds. RS's first child was delivered by normal vaginal delivery and her second child was delivered by cesarean section ("C-section"). RS and her obstetrician ("Obstetrician") had agreed upon RS attempting a vaginal delivery rather than a repeat C-section.

4. RS was seen in the office by Obstetrician who found her to have elevated blood pressure. As a result, Obstetrician decided to induce labor. Obstetrician was not on call and asked Respondent to cover for him. Respondent agreed and saw RS at 9:00 a.m. in the hospital and then returned to his office to see patients. RS was given prostaglandin and Pitocin per Obstetrician's orders. At 3:15 p.m. the nurses noted they were unable to obtain satisfactory fetal tracings and called Respondent asking him to place internal monitors. Respondent declined to do so and said he would be in at 5:00 p.m. after finishing with patients at the office.

5. At 3:55 the nurse-midwife diagnosed uterine rupture. Respondent was notified and he asked one of the nurses to call one of his partners who was closer to the hospital. The partner arrived and began delivery of the infant. Respondent arrived shortly after. The infant was delivered at 4:20 p.m. with Apgars of zero and a pH of 6.5. The infant died approximately two days later.

6. Respondent testified that Obstetrician sent RS to the hospital for labor induction with prostaglandin gel and the orders were that she have three doses of the gel followed the next day by Pitocin. Respondent testified that after he saw RS in the morning he advised the nurses to wait about four hours after the prostaglandin to start the Pitocin and the Pitocin was not started until approximately 3:00 p.m. Respondent noted that when he arrived at the hospital RS was ambulating because she was not contracting and had just been given the third dose of prostaglandin.

7. Respondent testified the nurse called him sometime after 3:00. RS had been started on one milliunit of Pitocin at 3:15 and at 3:30 she was not contracting adequately and the Pitocin was increased to 2 milliunits. Respondent stated the nurse called him sometime after that and advised that because of RS's obesity she could not adequately monitor the contractions or the fetal heart tones. Respondent recalled the

1 conversation as the nurse indicating she was able to record the fetal heart tracing and it
2 seemed reactive. At the time Respondent was seeing patients in the office. Respondent
3 testified he advised the nurse not to increase the Pitocin any further and as soon as he
4 was able to finish seeing patients he would come down to the hospital and attempt to
5 rupture her membranes and try to put in internal monitoring.

6 8. Respondent testified the next time her heard from the hospital is when the
7 midwife had examined RS and diagnosed the rupture. Respondent left his office at that
8 time. Respondent noted that incidentally, RS received one dose of analgesia at
9 approximately 3:45 and approximately ten minutes later, her uterus ruptured.

10 9. Respondent was asked if the basis for proceeding with the induction on RS
11 who had a previous C-section was based on his verbal information from Obstetrician that
12 RS had a transverse incision. Respondent testified he did not remember exactly what
13 happened in 1998, but he knew he had a conversation with Obstetrician where he
14 indicated he had done the previous C-section and had discussions with RS about vaginal
15 birth after cesarean section ("VBAC"). Respondent then felt comfortable that it would
16 have been a transverse incision.

17 10. Respondent was asked if he was comfortable (at the time of RS's delivery)
18 with inducing a patient in a VBAC situation. Respondent testified he felt pretty
19 comfortable and the literature at that time was saying that the risks in a patient having a
20 VBAC, especially one who had a vaginal delivery, was not much more than in a patient
21 who had not had a C-section and induction with Pitocin was not a contraindication.
22 Respondent noted he had patients that he had previously induced with Pitocin, but he did
23 not routinely use prostaglandin to induce patients with VBACs.

24 11. Respondent was asked what the nurses requested of him in the first call.
25 Respondent testified he was going purely on memory, but his recollection was that they

said "this patient is really heavy, and I am having trouble monitoring contractions and the fetal heart tones." Respondent noted that the record is static, however, the conversation as he recalled it was that he asked the nurse whether she could pick up the heartbeat at all and she said in the time she gets the fetal heart tracing, it looked good, like the baby was okay, but she just could not keep it on the monitor. Respondent testified the nurse said she had to stand at the bedside and hold the monitor onto the abdomen because the baby was so active that it was hard to keep it on the monitor.

12. Respondent was asked if this concerned him. Respondent testified it did, but he did not think he had a very serious situation on hand and, if he did, he would have gone right in. Respondent noted at RS's last examination prior to the rupture she was just getting into active labor and was three or four centimeters and should be monitored adequately. Respondent testified he did not get a sense of urgency from the nurse that he needed to be there immediately. Respondent was asked whether it concerned him that he had a high risk patient who is obese and a VBAC and the nurses were telling him they had been able to detect heart tones prior to that time and then were not getting it without having to hold the monitor. Respondent testified he did not think there was ever a time the nurse was getting a good tracing and he believed from the time the Pitocin had been started and RS had been in bed with the monitor on the nurse could not get long periods of the fetal heart trace. Respondent noted the change in the tracing occurred just when the rupture occurred and the midwife examined RS.

13. Respondent testified he and Obstetrician were the backup to the midwives and if they had patients in labor it was a reciprocal relationship – if they needed membranes ruptured or internal catheters put in or internal electrodes applied, the midwives could do it for them. Respondent noted there was no reason the midwife could

not have placed the internal monitor when the nurse called him, but he could not recall if there was a midwife on the unit at the time of that phone call.

14. Respondent was asked what he would change looking back. Respondent testified that since 1998 obstetricians have learned a lot – that VBACs are not as benign as thought and whereas the American College of Gynecology ("ACOG") opinion in 1988 said hospitals should be able to do a C-section within 30 minutes, he thinks that has changed because of the number of uterine ruptures that have occurred and the litigation that resulted. Respondent testified that looking back, he would not have tried to induce a three-hundred plus pound patient with Pitocin who had had a VBAC. Respondent also noted he did not induce her with prostaglandin, he "inherited" that. Respondent stated he felt he could handle the situation by going to the hospital after he finished seeing his patients and applying the internal monitors at that time.

15. Respondent was asked if he did VBACs now. Respondent said he did some and is now in a practice where he can be at the hospital and most of the time is at the hospital when he has patients in labor. Respondent also noted the hospital had anesthesiologists available 24 hours a day to do C-sections immediately. Respondent testified he did not induce VBACs at this time and in 1998 encouraged patients to have VBACs. Respondent noted most third-party payers at the time almost mandated it – that patients be allowed a trial of labor and he actively encouraged patients at that time. Respondent testified that in his current practice if a patient requests it, he would probably oblige, but he does not encourage it. Respondent also noted that in 1998 he had several patients who had VBACs and he had never had a problem and that may have given him a false sense of security that if RS was started on Pitocin in the afternoon, by the time she actually got into a good active pattern, he would be finished in the office and be able to go back to the hospital and manage her.

1 16. Respondent testified that seven years had passed since RS's delivery and
2 there is now a whole different perspective on VBACs and how they should be managed.
3 In fact, ACOG changed their recommendation in 1999, but at the time, he felt he was
4 doing the right thing.

5 17. The standard of care required Respondent to timely manage labor and
6 delivery in a high risk pregnancy.

7 18. Respondent fell below the standard of care because he did not timely
8 manage labor and delivery in high risk patient resulting in the death of an infant.

9 19. An aggravating factor is two previous advisory letters issued to
10 Respondent.

11 **CONCLUSIONS OF LAW**

12 1. The Arizona Medical Board possesses jurisdiction over the subject matter
13 hereof and over Respondent.

14 2. The Board has received substantial evidence supporting the Findings of
15 Fact described above and said findings constitute unprofessional conduct or other
16 grounds for the Board to take disciplinary action.

17 3. The conduct and circumstances described above constitutes unprofessional
18 conduct pursuant to A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is
19 gross negligence, repeated negligence or negligence resulting in harm to or the death of
20 a patient.")

21 **ORDER**

22 Based upon the foregoing Findings of Fact and Conclusions of Law,

23 IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for
24 failure to manage labor and delivery in a timely manner resulting in the death of an infant.

25

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 12 day of August, 2005.

THE ARIZONA MEDICAL BOARD

By [signature]
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 12th day of August, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 12th day of August, 2005, to:

George A. Davidson, M.D.
Address of Record

[signature]