**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**DEPARTMENT OF HEALTH**
**HEALTH REGULATION AND LICENSING ADMINISTRATION**
**BOARD OF NURSING**

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| **IN RE:** | : |
| | : |
| **CATHERINE CHAPMAN** | : |
| | : |
| **License No. RN63235** | : |
| | : |
| **Respondent** | : |

## DECISION AND ORDER

### Jurisdiction

This matter comes before the District of Columbia Board of Nursing ("Board") pursuant to D.C. Official Code § 3-1201.01 *et seq.* (2021 Repl.), otherwise known as the Health Occupations Revision Act (HORA). Section 204(b)(1) of the HORA authorizes the Board to regulate the practice of advanced practice registered nursing (APRN). D.C. Official Code § 3-1202.04(b)(1). Pursuant to section 408(8), the Board is authorized to conduct hearings necessary to carry out its function. D.C. Official Code § 3-1204.08(8).

### Background

On or about May 17, 2019, a complaint was filed with the Board by V.B.,[1] who received abortion service at Capital Women's Services (CWS) on March 8, 2019, which was performed by Respondent. According to V.B.'s complaint, she returned to her home state of Louisiana after the procedure and continued to have pelvic pain and cramping. A few weeks after her return, V.B. sought medical care locally and was informed that she remained pregnant as of May 9,

[1] The complainant's identity is withheld for privacy reasons. Respondent was, however, aware of the identity.

2019. V.B. contacted CWS and returned there for the second procedure to terminate the pregnancy, performed by a CWS physician, on May 15, 2019.

On or about June 5, 2019, Washington Hospital Center (WHC) contacted the Department of Health (DC Health) with concerns regarding patients who presented to WHC for care due to abortion services received at Capital Women's Services (CWS) and the resulting complications. The information included a reference to a patient who herself called an ambulance at 2 AM to be taken to a hospital after she became certain CWS could not complete the abortion procedure. In the OR, the patient was found to have partially aborted fetal parts remaining in her abdomen and likely perforation of the vagina.

Based on this complaint, DC Health initiated an investigation into V.B.'s complaint as well as conduct a random review of Respondent's patient records. The investigation identified two additional patients who received subsequent care at WHC after the abortion procedure performed by Respondent at CWS. The patients are K.J. and B.W.[2]

On January 19, 2022, the Board issued a Notice of Intent to Take Disciplinary Action (NOI) against her APRN authorization, issued in the category of nurse practitioner. The notice charged the Respondent as follows:

**CHARGES RELATED TO V.B.**

**I** **You failed to conform to standards of acceptable conduct and prevailing practice within a health profession in violation of D.C. Code § 3-1205.14(a)(26), for which the Board may take disciplinary action under D.C. Code § 3-1205.14(c).**

**II** **You demonstrated a willful or careless disregard for the health, welfare, or safety of a patient in violation of D.C. Code § 3-1205.14(a)(28), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).**

[2] Patients' name and identity are withheld for privacy reason. Respondent was made aware of their identity during the investigation.

**III** **You failed to keep adequate medical and client records as determined by the Board in violation of D.C. Code § 3-1205.14(a)(27), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).**

**CHARGES RELATED TO K.J.**

**IV** **You failed to conform to standards of acceptable conduct and prevailing practice within a health profession in violation of D.C. Code § 3-1205.14(a)(26), for which the Board may take disciplinary action under D.C. Code § 3-1205.14(c).**

**V** **You demonstrated a willful or careless disregard for the health, welfare, or safety of a patient in violation of D.C. Code § 3-1205.14(a)(28), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).**

**VI** **You failed to keep adequate medical and client records as determined by the Board in violation of D.C. Code § 3-1205.14(a)(27), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).**

**CHARGES RELATED TO B.W.**

**VII** **You failed to conform to standards of acceptable conduct and prevailing practice within a health profession in violation of D.C. Code § 3-1205.14(a)(26), for which the Board may take disciplinary action under D.C. Code § 3-1205.14(c).**

**VIII** **You demonstrated a willful or careless disregard for the health, welfare, or safety of a patient in violation of D.C. Code § 3-1205.14(a)(28), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).**

**IX** **You failed to keep adequate medical and client records as determined by the Board in violation of D.C. Code § 3-1205.14(a)(27), for which the Board may take the proposed action under D.C. Code § 3-1205.14(c).**

The NOI was served on Respondent by certified mail. It was returned unclaimed to DC Health on February 14, 2022. Section 4105.5 of Title 17 of the District of Columbia Municipal Regulations (DCMR) provides that the service of process, if by certified mail, shall be deemed to have been made on the date the mail was returned. Section 4103 of Title 17 of the DCMR provides that the board may, without a hearing, take the action contemplated in the NOI if the

person who is the subject of the proposed action does not request a hearing within the time allotted.

## Findings of Fact

Based on the evidence in its record,[3] the Board enters the following findings of fact:

1. Respondent was initially licensed as a registered nurse in the District on October 10, 2015. She was granted the APRN authorization as a Nurse Practitioner (NP) on July 1, 1998. She held valid RN and NP licenses during all times relevant.
2. On or about March 8, 2019, Respondent attempted to perform an elective first-trimester abortion on V.B. at Capital Women's Services (CWS). On that day, V.B. presented a pregnancy with a gestational age of 6 weeks and 6 days.
3. Respondent began the procedure at 2:25 PM and concluded at 2:35 PM.
4. Respondent did not record intra-operative vital signs and did not examine V.B. or perform another sonogram after the procedure to determine whether any perforation had occurred and whether the Products of Conception (POC) had been fully removed.
5. While Respondent recorded the weight of the extracted issue as 23 grams, she failed to inspect and record the contents of POC, thus failing to identify the villi, sac/placenta, parts, and decidua.
6. There was no post-operative sonogram report in the patient's record but V.B. distinctly remembered that one was performed upon which the technician said in her hearing "Is that the gestational sac right there?" V.B. also recalled that suction was then used. However, there was no mention of these facts in the patient records.

[3] In addition to the professional expertise of its members, the Board also benefited from an evaluation and opinion of an external objective peer reviewer.

7. While the Abortion Procedure Record shows the procedure was concluded at 2:35 PM, the Recovery Room Record did not begin until 2:53 PM.
8. An Against Medical Advice Sign-Out Form was found in V.B. file; it was signed but not witnessed. V.B. denied that she had signed the form and stated that she did not leave CWS against medical advice but was discharged. She also had a friend accompanying her at the time, who agreed with V.B.'s recollection.
9. Respondent failed to ensure that a CWS staff contacted V.B. for follow-up and to ensure that she experienced no complications from the procedure.
10. On or about May 9, 2019, due to the persistent pelvic pain and cramping, V.B. received medical care in her state of residence and was informed that she was still pregnant.
11. On May 15, 2019, V.B. returned to CWS and underwent further procedures to terminate the pregnancy performed by another CWS provider.
12. On or about April 13, 2019, K.J., 13.5 week pregnant, presented for abortion at CWS. Respondent's role at CWS was to perform first-trimester abortions. At 13.5 weeks, K.J. is at the upper limit of the first trimester and in fact may be considered as early second trimester.
13. Although a sonogram was obtained prior to the procedure, Respondent failed to review it. At 11:43 AM K.J. was given 800 mcg of misoprostol, with Respondent's note indicating that the dosage should be repeated every three hours.
14. At 2:25 PM, Respondent administered 2 ml of ketamine 50mg/ml and began the procedure; however, Respondent failed to determine the depth of the instruments she was utilizing. K.J. moved during the procedure. Respondent administered an

additional 1 ml of ketamine at 2:30 PM. The patient continued to move during the procedure. Respondent discontinued at 2:50 PM and did not complete the procedure. After the curette was withdrawn, "tissue resembling bowel [was] noted in cervix." Respondent notified CWS physician and contacted EMS to take K.J. to WHC for emergency care.

15. At WHC, K.J. was found to have two tears in the wall of the uterus with 75 centimeters of the small bowel protruding through the larger opening and then through the cervix. She underwent urgent exploratory laparotomy in which the perforated uterus was repaired. WHC physicians removed 13.1 gram of POC and completed the abortion procedure. The physicians also performed repair and resection of the small bowel.
16. Respondent failed to note in the patient record whether she had used suction and failed to record the details of lacerations.
17. On or about June 3, 2019, B.W. presented a pregnancy with gestational age of 9 weeks and 2 days. Prior to the initiation of the procedure, Respondent noted a left lateral deviation of B.W.'s cervix. Nevertheless, Respondent attempted the procedure with ultrasound-guided manipulation at 2:10 PM, utilizing the 11 dilator.
18. Respondent failed to note B.W.'s intra operational vital signs or what she had informed the patient after the procedure was discontinued. Additionally, Respondent failed to obtain B.W.'s consent for the surgical procedure.
19. At 2:20 PM, Respondent discontinued the procedure noting that the retroverted uterus and lateral deviation made further attempts by herself likely futile.

20. Respondent noted that the patient would be referred to a CWS physician for further procedure. The Recovery Room record shows that while the patient was urged to stay for one hour, she was instructed "to follow-up with a 2-week visit." There was a physician signature verifying that the patient was "stable for discharge."
21. Respondent failed to inform B.W. that the procedure was terminated without completion. Respondent also failed to perform a sonogram after the termination to determine whether any damage had occurred. These failures left the patient vulnerable to grave danger.
22. Later that night, B.W. experienced abdominal pain and cramping and presented at WHC for emergency care. Further examination on June 4, 2019 revealed that B.W.'s uterus was perforated and a segment of the small bowel had protruded into the vagina. Repairs were made to the uterus and 36 cm of the small bowel was resected. Thereafter WHC completed the abortion procedure and confirmed the removal of a gestational sac, chorionic villi, 3 extremities, spine and thorax.

## **Analysis and Conclusions of Law**

The facts of this matter indicate that during the four months' period between March and June 2019, three of Respondent's abortion patients suffered significant complications and damage. The cases bear striking resemblance to each other in the matter of the outcomes, standard of practice, and the record maintenance practice. In all three cases, the procedure was not successfully completed, leaving the patients pregnant and with live fetus remaining in the uterus – in the case of V.B. the maimed but live fetus remained in the womb for two months. In all three cases, documentation was incomplete. Worse, there is some inconsistency in the

documentation sufficient to cause further concerns regarding potential efforts to conceal or misrepresent facts. Respondent's conduct and the deficiencies found in her skills as well as record practice indicate a lack of regard for patients' health and safety.

In addition to the overall assessment noted above, the Board believes it important to review each individual case to underscore the noted deficiencies.

In the case of V.B., the patient's pregnancy was quite early and should have been a relatively straightforward procedure, yet the patient was discharged to return home still pregnant. This outcome is a strong evidence of standard violation on the part of the practitioner. There are normal procedural steps to ascertain that the procedure was successful and that the patient is not discharged still pregnant. Such procedural steps include close observation and identification of the product of conception (POC) and a post-procedure sonogram. B.V.'s record contains no evidence of a post-procedure sonogram and there is no clear identification of the contents of the POC, except the overall weight. By themselves, these deficiencies already indicate Respondent's failure to conform to the standard of acceptable practice.

But the evidence in V.B.'s case causes an even greater level of concern. Despite there being no record of a post-procedure sonogram, V.B. gave a clear account of one being performed and the clinic personnel's observation that the gestational sac was still there. According to V.B.'s recollection, a further suction was performed, which she distinctly remembered to cause her some pain. The recovery room record supports V.B.'s recollection since her recovery room procedure did not start until 2:53 PM whereas Respondent had noted that the abortion procedure was concluded at 2:35 PM, suggesting that additional actions or procedures were taken during that time gap. These facts point to two troubling conclusions. First, Respondent tried but failed to complete the abortion and, despite having to perform a further procedure, failed at that point to

ascertain that the further procedure was successful. Secondly, the lack of any notes of the second sonogram and the further suction procedure indicates either a failure of documentation or, worse, an effort to conceal the unsuccessful efforts to complete the abortion.

At this point, it must be noted that there was an Against Medical Advice (AMA) form in V.B.'s record. However, V.B.'s denied that she had signed the form. Her account of her discharge and departure was clear and contains no indication that she was lying when she denied having signed the AMA. V.B. also had a witness who corroborates her assertion that she did not leave against medical advice. Accordingly, the evidence supports V.B.'s version of the story – which is that she did not leave against medical advice but rather was normally discharged. The presence of the false AMA therefore provides support for the conclusion that Respondent had attempted to conceal her unsuccessful procedure and place the responsibility for the unsuccessful abortion on the patient.

The picture that emerges from this case is one of a practitioner who, letting an abortion leave while still pregnant, failed to perform and complete a procedure according to the prevailing standard. The patient record is woefully incomplete and was likely falsified. Respondent's actions indicate a clear lack of regard for the patient's health and safety. Accordingly, the Board now concludes that Respondent is liable for disciplinary action due to the violations identified in Charges I through III.

In the case of K.J., it must be noted at the outset that Respondent's decision to perform the abortion is questionable because, at 13.5 weeks, K.J. was at the upper limit of the first trimester and could be considered as the early stage of the second trimester. A more cautious practitioner would be well supported to refer the patient to a more experienced professional. In fact, the actual outcome of this case, which is distressing in the extreme, points to the

advisability of the more cautious approach. Given the fact that K.J.'s pregnancy was possibly beyond the scope of her training and duty, Respondent should have performed an honest and thorough assessment of her own competency to take on such a procedure. The American Nurses Association (ANA) has long adopted nursing code of ethics (ANA Code), which is binding on the District's registered nurses in accordance with 17 DCMR § 5416.1. Provision 4.1 of the ANA Code states: "Registered nurses are accountable for nursing judgments made and actions taken in the course of their nursing practice, therefore, the registered nurse is responsible for assessing individual competence and is committed to the process of lifelong learning." Here, Respondent clearly failed to know and observe the limitation of her skills and competence.

Indeed, Respondent's judgments and actions throughout this case did fall below the standard of practice. To begin with, Respondent failed to review the sonogram prior to the start of the procedure. Additionally, Respondent failed to adequately sedate the patient. She administered 2 ml of 50mg/ml ketamine at 2:25 PM and began the procedure immediately after that. However, the patient moved when the procedure started and Respondent administered another milliliter of ketamine at 2:30 PM. Clearly, the first dosage was insufficient. The additional dosage also appeared to be insufficient since the patient had continued movements, which Respondent noted as "thrashing", leading to Respondent's decision to discontinue the procedure at 2:50 PM.

In addition to insufficient dosage, Respondent did not appear to be informed that ketamine sometimes produces involuntary movements in patients. The appropriate action in this case should have been the administration of sufficient dosage and a slight delay to allow the drug to take full effect and the patient fully sedated before starting the procedure. Additionally, when the patient moved, Respondent should have paused to assess whether the movements had caused

any damage to the uterus and whether it was safe to proceed. Closer care and attention should have been paid to the instrument depth to ensure that the patient would not be injured.

It is clear that Respondent failed to determine the depth of the instruments inserted into the vagina to ensure that the uterus wall was safe from perforation. Thus, the patient's involuntary movements during sedation likely caused the instruments to puncture the uterus. In fact, the uterus was punctured in two places with one puncture being quite large at approximately 3 centimeters through which about 3 feet of the small bowel protruded. That section of the small bowel had to be resected later at WHC. The extent of the damage points to Respondent's failure to carefully and closely observe the effects of the patient's involuntary movements and the depth of the instruments. Respondent's only reaction to the event was to increase the dosage and continue on with what she had been doing without examination and judgment. It is clearly possible that had Respondent been vigilant about the instrument depth and possible perforation, the damage may not have been so extensive.

Respondent also overmedicated K.J. with misoprostol. The appropriate dosage is 200-400 mcg every four hours. However, Respondent started with 800 mcg and ordered that the same dosage should be repeated every three hours. This prescription is grossly beyond the normal acceptable dosage.

K.J.'s patient record was also inadequately maintained. There is no notation of how deep the instruments were inserted or an examination or determination following the patient's involuntary movements to ascertain whether any damage had occurred. There is no notation whether suction was used in the procedure; however, WHC notes show that Respondent informed them that suction was used. While a sonogram was taken before the initiation of the procedure, Respondent did not sign to confirm that she had reviewed it, which led to the finding

of fact that she in fact failed to review the sonogram. There was a progress note in another handwriting without clear identification of the person who entered the note, which says "Pt wouldn't follow commands while under twilight medication. Pt continued to move during the procedure which resulted in NP Chapman perforating the uterus." This note clearly was not entered by Respondent. Worse, still, the person entering it placed the blame for the perforation on the patient who was under sedation for "not following commands."

Based on the analysis above, the Board now concludes that Respondent is liable for disciplinary action in accordance with Charges IV, V, and VI.

In the case of B.W., the evidence shows that Respondent initiated the abortion procedure with awareness of the left deviation of the cervix. Respondent used the 11 dilator, which is too large for a 9-week pregnancy. She attempted to perform an ultrasound-guided procedure. However, Respondent discontinued the procedure after 10 minutes. The patient was never informed of the unsuccessful procedure. The Recovery Room record shows that while the patient was urged to stay for one hour, she was instructed "to follow-up with a 2-week visit. There was a physician signature verifying that the patient was "stable for discharge." There was no evidence at all that the patient was made aware that she remained pregnant at that time. She was not closely examined and monitored after the discontinuance of the procedure despite the fact that she did suffer a significant blood loss. In light of what occurred, the patient should have been told that she had to return as soon as possible to complete the procedure. She should have been informed that she had lost a significant amount of blood and should be under close observation to ensure her safety. However, Respondent took none of these actions and let the patient return home. Respondent's negligent action resulted in the worsening of B.W.'s condition forcing her to seek emergency care at WHC, where it was discovered that she was still

pregnant, the uterine had been perforated, and a portion of the small bowel had protruded into the uterus.

Based on the analysis above, the Board now concludes that Respondent is liable for disciplinary action in accordance with Charges VII, VIII, and IX.

Based on these findings Respondent is now found to have violated D.C. Official Code §§ 3-1205.14(a)(26), (27), and (28) with regard to all three patients.

The Board's mandate is to protect the public. *Davidson v. District of Columbia Bd. of Medicine*, 562 A.2d 109, 112 (D.C.1989), *quoting* Report of the D.C. Council on Consumer and Regulatory Affairs on Bill 6–317, at 7 (November 26, 1985). It would be a violation of that mandate if the Board were to permit to continue in independent and advanced practice a nurse practitioner who has demonstrated ample evidence of her failure to conform to the standard of practice, of inadequate record maintenance, and of a lack of regard for patients' health and safety.

D.C. Official Code § 3-1205.14(c) provides, in pertinent part:

> Upon determination by the board that an applicant, licensee, or person permitted by this subchapter to practice in the District has committed any of the acts described in subsection (a) of this section, the board may:
>
> (1) Deny a license to any applicant;
>
> (2) Revoke or suspend the license of any licensee;
>
> (3) Revoke or suspend the privilege to practice in the District of any person permitted by this subchapter to practice in the District;
>
> (4) Reprimand any licensee or person permitted by this subchapter to practice in the District;
>
> (5) Impose a civil fine not to exceed $5,000 for each violation by any applicant, licensee, or person permitted by this subchapter to practice in the District;

(6) Require a course of remediation, approved by the board, which may include:

(A) Therapy or treatment;
(B) Retraining; and
(C) Reexamination, in the discretion of and in the manner prescribed by the board, after the completion of the course of remediation;

(7) Require a period of probation; or

(8) Issue a cease and desist order pursuant to § 3-1205.16.

Accordingly, the Board, by unanimous vote, issues the order below.

## ORDER

Based upon the aforementioned it is hereby

**ORDERED** that the nurse practitioner license, **RN63235**, of **CATHERINE CHAPMAN,** be and is hereby **REVOKED,**[4] effective as of the date of service.

Meedie L. Bardonille RN

May 25, 2022
Date

Meedie Bardonille, RN
Acting Chairperson
Board of Nursing

## Judicial and Administrative Review of Actions of Board

Pursuant to D.C. Official Code § 3-1205.20 (2016 Repl.):

> Any person aggrieved by a final decision of a board or the Mayor may appeal the decision to the **District of Columbia Court of Appeals** pursuant to D.C. Official Code § 2-510 (2012 Repl.).

[4] Pursuant to D.C. Official Code § 3-1201.01(12A), "revocation" means termination of the right to practice a health profession and loss of licensure for five (5) years or more.

Pursuant to D.C. Court of Appeals Rule 15(a):

> Review of orders and decision of an agency shall be obtained by filing with the clerk of this court a petition for review within thirty (30) days after the notice is given.

**This Order is the Final Order of the Board in this disciplinary matter and a public record and, as mandated by federal law, 42 USC § 11101 and 45 CFR § 60, "the National Practitioner Data Bank – Health Integrity and Protection Data Bank," this disciplinary action shall be reported to the U.S. Department of Health and Human Services.**

Copies to:

Catherine Chapman
[redacted]

Colin Cenci, Esquire
James Jordan, Esquire
Assistant Attorney General
Counsels for the Government
Civil Enforcement Section
Office of the Attorney General
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