

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

In the Matter of the Fourth Amended
Accusation Against:

Obaida Batal, M.D.

Physician's and Surgeon's
License No. A 140060

Respondent

Case No. 800-2017-039494

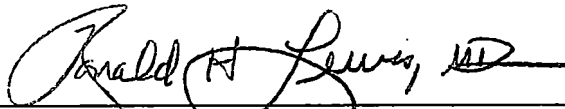
DECISION

The attached Stipulated Settlement and Disciplinary 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 July 2, 2021.

IT IS SO ORDERED: June 4, 2021.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

1 XAVIER BECERRA
Attorney General of California
2 ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
3 CHRISTINE A. RHEE
Deputy Attorney General
4 State Bar No. 295656
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8 *Attorneys for Complainant*

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

13 In the Matter of the Fourth Amended
14 Accusation Against:

15 **OBAIDA BATAL, M.D.**
17525 Ventura Blvd., Ste. 203
16 Encino, CA 91316-3843

17 **Physician's and Surgeon's Certificate**
18 **No. A 140060,**

19 Respondent.

Case No. 800-2017-039494

OAH No. 2019060180

20 **STIPULATED SETTLEMENT AND**
21 **DISCIPLINARY ORDER**

22 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
23 entitled proceedings that the following matters are true:

24 **PARTIES**

25 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
26 California (Board). He brought this action solely in his official capacity and is represented in this
27 matter by Xavier Becerra, Attorney General of the State of California, by Christine A. Rhee,
28 Deputy Attorney General.

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1 2. Respondent Obaida Batal, M.D. (Respondent) is represented in this proceeding by
2 attorney Derek F. O'Reilly-Jones, Esq., whose address is: 355 South Grand Ave., Ste. 1750
3 Los Angeles, CA 90071-1562.

4 3. On or about January 5, 2016, the Board issued Physician's and Surgeon's Certificate
5 No. A 140060 to Obaida Batal, M.D. (Respondent). Physician's and Surgeon's Certificate No.
6 A 140060 was in full force and effect at all times relevant to the charges brought in Fourth
7 Amended Accusation No. 800-2017-039494, and will expire on January 31, 2022, unless
8 renewed.

9 **JURISDICTION**

10 4. Fourth Amended Accusation No. 800-2017-039494 was filed before the Board, and is
11 currently pending against Respondent. The Fourth Amended Accusation and all other statutorily
12 required documents were properly served on Respondent on February 9, 2021. Respondent
13 timely filed his Notice of Defense.

14 5. A true and correct copy of Fourth Amended Accusation No. 800-2017-039494 is
15 attached as Exhibit A and incorporated herein by reference.

16 **ADVISEMENT AND WAIVERS**

17 6. Respondent has carefully read, fully discussed with counsel, and understands the
18 charges and allegations in Fourth Amended Accusation No. 800-2017-039494. Respondent has
19 also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated
20 Settlement and Disciplinary Order.

21 7. Respondent is fully aware of his legal rights in this matter, including the right to a
22 hearing on the charges and allegations in the Fourth Amended Accusation; the right to confront
23 and cross-examine the witnesses against him; the right to present evidence and to testify on his
24 own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the
25 production of documents; the right to reconsideration and court review of an adverse decision;
26 and all other rights accorded by the California Administrative Procedure Act and other applicable
27 laws.

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1 8. Having had the benefit of counsel, Respondent voluntarily, knowingly, and
2 intelligently waives and gives up each and every right set forth above.

3 **CULPABILITY**

4 9. Respondent does not contest that, at an administrative hearing, Complainant could
5 establish a prima facie case with respect to the charges and allegations contained in Fourth
6 Amended Accusation No. 800-2017-039494 and that he has thereby subjected his license to
7 disciplinary action.

8 10. Respondent agrees that if he ever petitions for early termination or modification of
9 probation, or if an accusation and/or petition to revoke probation is filed against him before the
10 Board, all of the charges and allegations contained in Fourth Amended Accusation No. 800-2017-
11 039494 shall be deemed true, correct and fully admitted by Respondent for purposes of any such
12 proceeding or any other licensing proceeding involving Respondent in the State of California.

13 11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to
14 discipline and he agrees to be bound by the Board's probationary terms as set forth in the
15 Disciplinary Order below.

16 **CONTINGENCY**

17 12. This stipulation shall be subject to approval by the Medical Board of California.
18 Respondent understands and agrees that counsel for Complainant and the staff of the Medical
19 Board of California may communicate directly with the Board regarding this stipulation and
20 settlement, without notice to or participation by Respondent or his counsel. By signing the
21 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek
22 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
23 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
24 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
25 action between the parties, and the Board shall not be disqualified from further action by having
26 considered this matter.

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1 **ADDITIONAL PROVISIONS**

2 13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to
3 be an integrated writing representing the complete, final, and exclusive embodiment of the
4 agreements of the parties in the above-listed matter.

5 14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order,
6 including copies of the signatures of the parties, may be used in lieu of original documents and
7 signatures and, further, that such copies shall have the same force and effect as originals.

8 15. In consideration of the foregoing admissions and stipulations, the parties agree that
9 the Board may, without further notice or opportunity to be heard by the Respondent, issue and
10 enter the following Disciplinary Order:

11 **DISCIPLINARY ORDER**

12 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 140060
13 issued to Respondent Obaida Batal, M.D., is revoked. However, the revocation is stayed and
14 Respondent is placed on probation for five (5) years from the effective date of this decision on the
15 following terms and conditions:

16 1. **EDUCATION COURSE.** Within 60 calendar days of the effective date of this
17 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
18 for its prior approval educational program(s) or course(s) which shall not be less than 25 hours
19 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
20 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
21 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
22 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
23 completion of each course, the Board or its designee may administer an examination to test
24 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 50
25 hours of CME of which 25 hours were in satisfaction of this condition.

26 2. **MEDICAL RECORD KEEPING COURSE.** Within 60 calendar days of the effective
27 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
28 advance by the Board or its designee. Respondent shall provide the approved course provider

1 with any information and documents that the approved course provider may deem pertinent.
2 Respondent shall participate in and successfully complete the classroom component of the course
3 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
4 complete any other component of the course within one (1) year of enrollment. The medical
5 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
6 Medical Education (CME) requirements for renewal of licensure.

7 A medical record keeping course taken after the acts that gave rise to the charges in the
8 Fourth Amended Accusation, but prior to the effective date of the Decision may, in the sole
9 discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the
10 course would have been approved by the Board or its designee had the course been taken after the
11 effective date of this Decision.

12 Respondent shall submit a certification of successful completion to the Board or its
13 designee not later than 15 calendar days after successfully completing the course, or not later than
14 15 calendar days after the effective date of the Decision, whichever is later.

15 3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of
16 the effective date of this Decision, Respondent shall enroll in a professionalism program, that
17 meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1.
18 Respondent shall participate in and successfully complete that program. Respondent shall
19 provide any information and documents that the program may deem pertinent. Respondent shall
20 successfully complete the classroom component of the program not later than six (6) months after
21 Respondent's initial enrollment, and the longitudinal component of the program not later than the
22 time specified by the program, but no later than one (1) year after attending the classroom
23 component. The professionalism program shall be at Respondent's expense and shall be in
24 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

25 A professionalism program taken after the acts that gave rise to the charges in the Fourth
26 Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of
27 the Board or its designee, be accepted towards the fulfillment of this condition if the program

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1 would have been approved by the Board or its designee had the program been taken after the
2 effective date of this Decision.

3 Respondent shall submit a certification of successful completion to the Board or its
4 designee not later than 15 calendar days after successfully completing the program or not later
5 than 15 calendar days after the effective date of the Decision, whichever is later.

6 4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days
7 of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment
8 program approved in advance by the Board or its designee. Respondent shall successfully
9 complete the program not later than six (6) months after Respondent's initial enrollment unless
10 the Board or its designee agrees in writing to an extension of that time.

11 The program shall consist of a comprehensive assessment of Respondent's physical and
12 mental health and the six general domains of clinical competence as defined by the Accreditation
13 Council on Graduate Medical Education and American Board of Medical Specialties pertaining to
14 Respondent's current or intended area of practice. The program shall take into account data
15 obtained from the pre-assessment, self-report forms and interview, and the Decision(s),
16 Accusation(s), and any other information that the Board or its designee deems relevant. The
17 program shall require Respondent's on-site participation for a minimum of three (3) and no more
18 than five (5) days as determined by the program for the assessment and clinical education
19 evaluation. Respondent shall pay all expenses associated with the clinical competence
20 assessment program.

21 At the end of the evaluation, the program will submit a report to the Board or its designee
22 which unequivocally states whether the Respondent has demonstrated the ability to practice
23 safely and independently. Based on Respondent's performance on the clinical competence
24 assessment, the program will advise the Board or its designee of its recommendation(s) for the
25 scope and length of any additional educational or clinical training, evaluation or treatment for any
26 medical condition or psychological condition, or anything else affecting Respondent's practice of
27 medicine. Respondent shall comply with the program's recommendations.

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1 Determination as to whether Respondent successfully completed the clinical competence
2 assessment program is solely within the program's jurisdiction.

3 If Respondent fails to enroll, participate in, or successfully complete the clinical
4 competence assessment program within the designated time period, Respondent shall receive a
5 notification from the Board or its designee to cease the practice of medicine within three (3)
6 calendar days after being so notified. Respondent shall not resume the practice of medicine until
7 enrollment or participation in the outstanding portions of the clinical competence assessment
8 program have been completed. If Respondent did not successfully complete the clinical
9 competence assessment program, Respondent shall not resume the practice of medicine until a
10 final decision has been rendered on the accusation and/or a petition to revoke probation. The
11 cessation of practice shall not apply to the reduction of the probationary time period.

12 5. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this
13 Decision, Respondent shall submit to the Board or its designee for prior approval as a practice
14 monitor, the name and qualifications of one or more licensed physicians and surgeons whose
15 licenses are valid and in good standing, and who are preferably American Board of Medical
16 Specialties (ABMS) certified. A monitor shall have no prior or current business or personal
17 relationship with Respondent, or other relationship that could reasonably be expected to
18 compromise the ability of the monitor to render fair and unbiased reports to the Board, including
19 but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree
20 to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

21 The Board or its designee shall provide the approved monitor with copies of the Decision(s)
22 and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the
23 Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed
24 statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role
25 of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees
26 with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the
27 signed statement for approval by the Board or its designee.

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1 Within 60 calendar days of the effective date of this Decision, and continuing throughout
2 probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall
3 make all records available for immediate inspection and copying on the premises by the monitor
4 at all times during business hours and shall retain the records for the entire term of probation.

5 If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective
6 date of this Decision, Respondent shall receive a notification from the Board or its designee to
7 cease the practice of medicine within three (3) calendar days after being so notified. Respondent
8 shall cease the practice of medicine until a monitor is approved to provide monitoring
9 responsibility.

10 The monitor(s) shall submit a quarterly written report to the Board or its designee which
11 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
12 are within the standards of practice of medicine, and whether Respondent is practicing medicine
13 safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the
14 quarterly written reports to the Board or its designee within 10 calendar days after the end of the
15 preceding quarter.

16 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
17 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
18 name and qualifications of a replacement monitor who will be assuming that responsibility within
19 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
20 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
21 notification from the Board or its designee to cease the practice of medicine within three (3)
22 calendar days after being so notified. Respondent shall cease the practice of medicine until a
23 replacement monitor is approved and assumes monitoring responsibility.

24 In lieu of a monitor, Respondent may participate in a professional enhancement program
25 approved in advance by the Board or its designee that includes, at minimum, quarterly chart
26 review, semi-annual practice assessment, and semi-annual review of professional growth and
27 education. Respondent shall participate in the professional enhancement program at Respondent's
28 expense during the term of probation.

1 6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
2 Respondent shall provide a true copy of this Decision and Fourth Amended Accusation to the
3 Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership
4 are extended to Respondent, at any other facility where Respondent engages in the practice of
5 medicine, including all physician and locum tenens registries or other similar agencies, and to the
6 Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage
7 to Respondent. Respondent shall submit proof of compliance to the Board or its designee within
8 15 calendar days.

9 This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

10 7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
11 NURSES. During probation, Respondent is permitted to supervise a maximum of two mid-level
12 practitioners consisting of physician assistants and/or advanced practice nurses.

13 8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules
14 governing the practice of medicine in California and remain in full compliance with any court
15 ordered criminal probation, payments, and other orders.

16 9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
17 under penalty of perjury on forms provided by the Board, stating whether there has been
18 compliance with all the conditions of probation.

19 Respondent shall submit quarterly declarations not later than 10 calendar days after the end
20 of the preceding quarter.

21 10. GENERAL PROBATION REQUIREMENTS.

22 Compliance with Probation Unit

23 Respondent shall comply with the Board's probation unit.

24 Address Changes

25 Respondent shall, at all times, keep the Board informed of Respondent's business and
26 residence addresses, email address (if available), and telephone number. Changes of such
27 addresses shall be immediately communicated in writing to the Board or its designee. Under no

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1 circumstances shall a post office box serve as an address of record, except as allowed by Business
2 and Professions Code section 2021, subdivision (b).

3 Place of Practice

4 Respondent shall not engage in the practice of medicine in Respondent's or patient's place
5 of residence, unless the patient resides in a skilled nursing facility or other similar licensed
6 facility.

7 License Renewal

8 Respondent shall maintain a current and renewed California physician's and surgeon's
9 license.

10 Travel or Residence Outside California

11 Respondent shall immediately inform the Board or its designee, in writing, of travel to any
12 areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty
13 (30) calendar days.

14 In the event Respondent should leave the State of California to reside or to practice,
15 Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of
16 departure and return.

17 11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
18 available in person upon request for interviews either at Respondent's place of business or at the
19 probation unit office, with or without prior notice throughout the term of probation.

20 12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
21 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
22 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
23 defined as any period of time Respondent is not practicing medicine as defined in Business and
24 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
25 patient care, clinical activity or teaching, or other activity as approved by the Board. If
26 Respondent resides in California and is considered to be in non-practice, Respondent shall
27 comply with all terms and conditions of probation. All time spent in an intensive training
28 program which has been approved by the Board or its designee shall not be considered non-

1 practice and does not relieve Respondent from complying with all the terms and conditions of
2 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
3 on probation with the medical licensing authority of that state or jurisdiction shall not be
4 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
5 period of non-practice.

6 In the event Respondent's period of non-practice while on probation exceeds 18 calendar
7 months, Respondent shall successfully complete the Federation of State Medical Boards's Special
8 Purpose Examination, or, at the Board's discretion, a clinical competence assessment program
9 that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model
10 Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

11 Respondent's period of non-practice while on probation shall not exceed two (2) years.

12 Periods of non-practice will not apply to the reduction of the probationary term.

13 Periods of non-practice for a Respondent residing outside of California will relieve
14 Respondent of the responsibility to comply with the probationary terms and conditions with the
15 exception of this condition and the following terms and conditions of probation: Obey All Laws;
16 General Probation Requirements; and Quarterly Declarations.

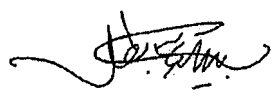
17 13. COMPLETION OF PROBATION. Respondent shall comply with all financial
18 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
19 completion of probation. Upon successful completion of probation, Respondent's certificate shall
20 be fully restored.

21 14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
22 of probation is a violation of probation. If Respondent violates probation in any respect, the
23 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
24 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke
25 Probation, or an Interim Suspension Order is filed against Respondent during probation, the
26 Board shall have continuing jurisdiction until the matter is final, and the period of probation shall
27 be extended until the matter is final.

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DATED: 02/14/2021



OBATDA BATAL, M.D.
Respondent

I have read and fully discussed with Respondent Obaida Batal, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 02/15/2021



DEREK F. O'REILLY-JONES, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: _____

Respectfully submitted,
XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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DATED: _____
OBAIDA BATAL, M.D.
Respondent


I have read and fully discussed with Respondent Obaida Batal, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____
DEREK F. O'REILLY-JONES, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: February 16, 2021

Respectfully submitted,
XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Fourth Amended Accusation No. 800-2017-039494

1 XAVIER BECERRA
Attorney General of California
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3 CHRISTINE A. RHEE
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8 *Attorneys for Complainant*

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

12
13 In the Matter of the Fourth Amended
14 Accusation Against:

Case No. 800-2017-039494

FOURTH AMENDED ACCUSATION

15 **OBAIDA BATAL, M.D.**
15200 Magnolia Blvd
16 **Unit 302**
Sherman Oaks, CA 91403-1180

17 **Physician's and Surgeon's Certificate**
18 **No. A 140060,**

Respondent.

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20
21 Complainant alleges:

22 **PARTIES**

23 1. William Prasifka (Complainant) brings this Fourth Amended Accusation solely in his
24 official capacity as the Executive Director of the Medical Board of California, Department of
25 Consumer Affairs (Board).

26 2. On or about January 5, 2016, the Medical Board issued Physician's and Surgeon's
27 Certificate No. A 140060 to Obaida Batal, M.D. (Respondent). Physician's and Surgeon's

28 ///

1 Certificate No. A 140060 was in full force and effect at all times relevant to the charges brought
2 herein and will expire on January 31, 2022, unless renewed.

3 **JURISDICTION**

4 3. This Fourth Amended Accusation, which supercedes the Third Amended Accusation
5 filed on August 4, 2020, is brought before the Board, under the authority of the following laws.

6 All section references are to the Business and Professions Code (Code) unless otherwise
7 indicated.

8 4. Section 2227 of the Code states, in pertinent part:

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

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

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

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

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

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

24 ...

25 5. Section 2234 of the Code, states, in pertinent part:

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
28 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.

...

(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.

...

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

...

4 6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain
5 adequate and accurate records relating to the provision of services to their patients constitutes
6 unprofessional conduct."

7 **FIRST CAUSE FOR DISCIPLINE**

8 **(Act of Dishonesty Substantially Related to the Qualifications, Functions, or Duties of a
Physician and Surgeon)**

9 7. Respondent has subjected his Physician's and Surgeon's Certificate No. A 140060 to
10 disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (e), of
11 the Code, in that he committed a dishonest act which is substantially related to the qualifications,
12 functions, or duties of a physician and surgeon, as more particularly alleged hereinafter:

13 8. On or about July 16, 2017, Respondent signed and submitted an initial application to
14 Hoag Memorial Hospital Presbyterian (Hoag) requesting staff privileges. Respondent certified
15 that the information he provided in the application was true and correct.

16 9. In the application, Respondent listed a gap in his employment history, stating that he
17 took an "advance GI/Minimally Invasive Surgery Course" at Fresno Heart and Surgical Hospital
18 from August 1, 2016 through December 15, 2016.

19 10. In the application, Respondent was asked whether he had ever surrendered,
20 voluntarily withdrawn, or been requested or compelled to relinquish his status as a student in
21 good standing in any internship, residency, fellowship, preceptorship, or other clinical education
22 program. Respondent wrote that he had not.

23 11. On or about September 18, 2018, Respondent told Board investigators that he had
24 started a fellowship at Fresno Heart and Surgical Hospital in advanced laparoscopy, minimally
25 invasive surgery, and bariatrics in 2016, but that he was asked to leave. Respondent admitted that
26 he answered no on his application for privileges at Hoag when asked whether he had ever been
27 asked to leave a fellowship or clinical education program.

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SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

12. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 140060 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in the care and treatment of Patients A, B, C, D, E, F, and G,¹ as more particularly alleged hereinafter:

Patient A

13. On or about November 22, 2017, at approximately 0817, Patient A, a sixty-eight-year old woman, presented to the emergency department (ED) at Hoag complaining of black stool and lower abdominal pain with increased weakness. J.S., M.D., examined Patient A in the ED and diagnosed her with hypokalemia² and a gastrointestinal bleed. J.S. recommended that Patient A be admitted to Hoag.

14. After being admitted to the hospital at approximately 0959, a hospitalist, Y.T., M.D., examined Patient A. Patient A reported that she had had abdominal pain for three (3) weeks, with nausea and loose stool. She had previously been treated by K.P.Y., M.D., a gastroenterologist, who prescribed her two (2) different antibiotics. Patient A reported that the pain had improved but was still present. She had also fainted two (2) days prior when at the gym, and that the day before, she had maroon-colored stool. Y.T. performed a physical examination and reviewed Patient A's labs. Y.T.'s assessment included gastrointestinal hemorrhage, likely lower gastrointestinal bleeding, anemia,³ abdominal pain, hypokalemia, hyponatremia,⁴ and severe protein-calorie malnutrition. Y.T.'s plan included giving Patient A potassium, IV fluids, and nutritional support.

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¹ To protect the privacy of the patients, the patients' names have not been included in this pleading. Respondent is aware of their identities.

² Hypokalemia is a low potassium level in the blood.

³ Anemia is a lack of red blood cells or dysfunctional red blood cells in the body.

⁴ Hyponatremia is a low sodium level in the blood.

1 15. On or about November 22, 2017, K.P.Y. also examined Patient A at Hoag and
2 recommended an urgent upper endoscopy,⁵ empiric intravenous PPI⁶ treatment, and a review of a
3 computed tomography (CT) scan of Patient A's abdomen. K.P.Y.'s differential diagnoses were
4 peptic ulcer disease, gastroenteritis, and colitis.

5 16. On or about November 22, 2017, at approximately 1710, Y.T. reviewed the CT of
6 Patient A's abdomen, noting that she had a severely distended stomach suspecting outlet
7 obstruction. Y.T. prescribed and ordered Protonix.⁷

8 17. On or about November 23, 2017, at approximately 0903, K.P.Y. performed an EGD
9 on Patient A. His relevant findings included severe gastritis⁸ in the antrum and body of the
10 stomach, an ulcer in the pylorus, and an ulcer on the greater curvature of the stomach body.
11 K.P.Y. documented that the scope could not pass beyond the pylorus during the EGD. K.P.Y.'s
12 recommendations included a review of the biopsy results, that Patient A continue taking Protonix,
13 and that a surgical consultation for an antrectomy⁹ and pyloroplasty¹⁰ take place.

14 18. On or about November 23, 2017, at approximately 1333, Y.T. documented an
15 assessment and plan for Patient A, noting that Respondent would be consulted for surgery. Y.T.
16 determined that Patient A was medically stable for surgery.

17 19. On or about November 23, 2017, at approximately 1903, Respondent saw Patient A
18 for a surgical consultation. He documented an examination of Patient A's head, ears, eyes, nose,
19 throat, lungs, heart, and abdomen. Respondent's note fails to document any recommendation,
20 plan, or discussion of a recommendation and plan with Patient A.

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24 ⁵ Upper endoscopy, also known as esophagogastroduodenoscopy (EGD), is a procedure
where a thin scope with a light and camera is used to look at the upper digestive tract.

25 ⁶ PPI stands for proton-pump inhibitor. PPIs are a group of drugs that reduce stomach
action production.

26 ⁷ Protonix, brand name for Pantoprazole, is a PPI.

27 ⁸ Gastritis is inflammation of the lining of the stomach.

28 ⁹ An antrectomy is the surgical removal of the antrum, or the lower third, of the stomach.

¹⁰ Pyloroplasty is a surgical procedure to widen the opening between the antrum and
duodenum.

1 20. On or about November 24, 2017, at approximately 0610, Patient A signed an
2 informed consent for Respondent to perform an exploratory laparotomy,¹¹ possible gastrectomy,¹²
3 possible vagotomy,¹³ and possible gastroenterostomy.¹⁴

4 21. On or about November 24, 2017, between 0900 to 1300, Respondent performed an
5 exploratory laparotomy, subtotal gastrectomy with Roux-en-Y, gastrojejunostomy,¹⁵
6 jejunajejunostomy,¹⁶ and relief of gastric obstruction. Respondent started drafting the operative
7 report on or about November 25, 2017, at 2114, and signed off on the report on or about
8 December 3, 2017 at 1851.

9 22. On or about November 24, 2017, at approximately 1718, Y.T. saw Patient A
10 following surgery. Patient A had a sore throat and moderate abdominal pain but was generally
11 doing well.

12 23. On or about November 24, 2017, at approximately 2120, J.S., M.D., saw Patient A
13 and noted that she was doing well.

14 24. On or about November 25, 2017, at approximately 1114, Y.T. noted that Patient A
15 was doing well and was having mild abdominal pain and no vomiting.

16 25. On or about November 26, 2017, at approximately 0954, Y.T. again noted that Patient
17 A was doing well, with moderate abdominal pain, no fever, and no chest pain.

18 26. On or about November 27, 2017, at approximately 1120, Y.T. noted that Patient A
19 was complaining of abdominal pain.

20 27. On or about November 28, 2017, at approximately 1208, Y.T. noted that Patient A
21 had experienced a vasovagal near syncope¹⁷ when walking to the bathroom. Patient A reported

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23 ¹¹ An exploratory laparotomy is a surgical operation in which the abdomen is opened and
the organs are examined for injury or disease.

24 ¹² A gastrectomy is a partial or total removal of the stomach.

25 ¹³ Vagotomy is a surgical procedure to remove part of the vagus nerve.

26 ¹⁴ A gastroenterostomy is the surgical creation of a connection between the stomach and
the jejunum.

27 ¹⁵ Gastrojejunostomy is the surgical creation of a connection between the stomach and the
jejunum.

28 ¹⁶ Jejunajejunostomy is a surgical technique used in an anastomosis between two portions
of the jejunum.

¹⁷ A syncope is a temporary loss of consciousness. A vasovagal syncope is a sudden drop
in heart rate and blood pressure often in reaction to a stressful trigger.

1 feeling more abdominal pain. Y.T. documented that he would check an electrocardiogram
2 (EKG), orthostatic blood pressure, and transthoracic echocardiogram (TTE) to determine the
3 etiology of the near syncope.

4 28. On or about November 29, 2017, at approximately 0839, Y.T. noted that Patient A
5 had had three (3) dark red bowel movements since the day prior. He saw that Patient A's
6 hemoglobin levels had dropped from 8.6 to 6.0. Y.T. documented that he spoke to Respondent
7 who suspected the bleeding came from the remaining segment of duodenum. Y.T. also
8 documented that he spoke to K.P.Y. Y.T. found that Patient A's EKG and TTE were within
9 normal limits.

10 29. On or about November 29, 2017, at approximately 1322, K.P.Y. saw Patient A and
11 documented a single episode of gastrointestinal bleeding and new anemia in the past 24 hours.

12 30. On or about November 30, 2017, at approximately 0816, hospitalist E.K., M.D., who
13 had taken over for Y.T., saw Patient A and observed that Patient A was diaphoretic¹⁸ and
14 tachycardic.¹⁹ E.K. ordered one (1) unit of blood stat and notified K.P.Y. and Respondent of
15 Patient A's condition.

16 31. On or about November 30, 2017, a Rapid Response Team note documented that
17 Patient A was minimally responsive to painful stimuli, had irregular breathing, and was
18 tachycardic and hypotensive.²⁰ The note documented that Patient A had been intubated and that a
19 Code RBC²¹ was called at approximately 0942. Patient A was transferred to the Critical Care
20 Unit and taken to the operating room at approximately 1025.

21 32. On or about November 30, 2017, at approximately 1029, a progress note from M.F.,
22 M.D., documented that Patient A had been transferred to Critical Care for management of
23 massive acute blood loss with shock. Patient A was unresponsive and was intubated. Respondent
24 was notified and Patient A was taken to the operating room.

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26 ¹⁸ Diaphoresis is sweating, especially to an unusual degree as a symptom of disease or
27 side effect of a drug.

28 ¹⁹ Tachycardia is a heart rate that exceeds the normal resting rate.

²⁰ Hypotension is low blood pressure.

²¹ Patient A was given blood transfusions.

1 33. From the time Respondent drafted his operative note on November 25, 2017 through
2 November 29, 2017, Respondent failed to document any follow up care of Patient A. In his
3 interview with Board investigators, Respondent stated that he saw Patient A every day following
4 the procedure, but failed to document his follow up care in the medical record because he was
5 still unfamiliar with the electronic medical record system.

6 34. On or about November 30, 2017, at approximately 1423, Respondent drafted an
7 immediate post-operative note. According to the note, the surgery took place from 1000 to 1425.
8 Respondent performed an intraoperative endoscopy, exploratory laparotomy, control of duodenal
9 bleeding, ligation of the gastroduodenal artery, oversewing of the duodenal stump with jejunal
10 patch, cholecystectomy,²² and duodenal biopsies. His findings included a duodenal stump
11 blowout²³ and severe duodenal inflammation due to chronic peptic ulcers. Respondent
12 electronically signed the note on or about December 3, 2017, at 1944.

13 35. On or about November 30, 2017, at 1800, Respondent documented a progress note
14 stating that Patient A had been transferred from the operating room to the Intensive Care Unit
15 (ICU), and that he had informed Patient A's husband of the critical situation and his findings.
16 Respondent was later called back to the ICU because Patient A's JP drain²⁴ was filling quickly.
17 Respondent performed a bedside laparotomy, opening up Patient A's surgical incision in the ICU.
18 He found no evidence of surgical bleeding, but observed diffuse oozing. M.F. attempted to
19 resuscitate Patient A with multiple rounds of cardiopulmonary resuscitation (CPR) and other
20 lifesaving measures. Patient A was pronounced dead at 1653.

21 36. Respondent committed repeated acts of negligence in his care and treatment of
22 Patient A which includes, but is not limited to, the following:

23 a. Respondent proceeded with surgery on November 24, 2017 rather than
24 opting for conservative management of Patient A's medical issues, including a

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26 ²² A cholecystectomy is the surgical removal of the gallbladder.

27 ²³ Duodenal stump blowout, also referred to a post-gastrectomy duodenal leak, is a known
28 complication of gastric surgery.

²⁴ A JP drain, or a Jackson-Pratt drain, is a closed suction medical device commonly used
as a post-operative drain for collecting bodily fluids from surgical sites.

1 repeated esophagogastroduodenoscopies (EGDs)²⁵ and attempts at balloon dilation of
2 the pylorus;

3 b. Respondent performed an antrectomy rather than a pyloroplasty or
4 gastrojejunostomy;

5 c. Respondent failed to document his post-operative care and treatment of
6 Patient A from November 25, 2017 through November 29, 2017; and

7 d. Respondent failed to order a radiographic work up at the first sign of
8 recurrent bleeding on November 29, 2017.

9 Patient B

10 37. On or about October 3, 2017, Respondent saw Patient B, then a fifty-two-year old
11 male, for abdominal bloating and pain that he had been experiencing for the past three months.
12 Patient B's symptoms included constipation, nausea, dizziness, fatigue, and significant weight
13 loss. He had previously gone to the emergency room multiple times where labs and scans were
14 done, with no conclusive diagnosis. Respondent ordered diet modifications, an EGD, and a
15 colonoscopy²⁶ with possible biopsies.

16 38. On or about October 11, 2017, Respondent performed the endoscopies on Patient B
17 and found a 2.5 cm duodenal polyp, which was partially biopsied. Respondent's records did not
18 include the endoscopy reports.

19 39. On or about October 24, 2017, Patient B saw Respondent for a follow up visit to
20 review the EGD and colonoscopy results. Patient B's symptoms remained the same, and he
21 reported vomiting most foods. Respondent noted that he talked to Patient B about the duodenal
22 polyp, and the possibility of that mass being a co-factor in Patient B's symptoms. The pathology
23 report revealed hyperplasia, not malignancy. Respondent's plan was for an upper gastrointestinal
24 (GI) small bowel follow through with fluoroscopy to study the functional effect of the duodenal
25 mass.

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28 ²⁵ An EGD is a diagnostic procedure to examine the esophagus, stomach, and duodenum.

²⁶ A colonoscopy is an endoscopic examination of the large intestine.

1 40. On or about November 10, 2017, Patient B underwent a fluoroscopy-guided double
2 contrast upper GI and small bowel follow through. The report ruled out obstruction, but noted
3 limited distensibility of the antrum and duodenal bulb, suggestive of antritis and duodenitis, and
4 duodenal mucosal thickening.

5 41. On or about November 14, 2017, Patient B saw Respondent for a follow up.
6 Respondent noted the upper GI results from the procedure on November 10, 2017, and planned to
7 remove the polyp via a double channel endoscopy with resection of duodenal mass. The risks and
8 benefits of the procedure were explained to Patient B.

9 42. On or about December 4, 2017, Respondent surgically removed the duodenal mass
10 using a hot snare. Following the excision, Patient B's abdomen was x-rayed to check for any
11 perforations. Patient B was discharged on or about the same day.

12 43. On or about December 5, 2017, Patient B went to the emergency room complaining
13 of abdominal pain following the procedure. According to the hospital records, Respondent sent
14 Patient B to the emergency room for a CT scan to rule out a possible perforation. A CT scan and
15 other lab tests were done and the results were relayed to Respondent. The CT scan showed mild
16 to moderate ascites,²⁷ small right pleural effusion, and anasarca.²⁸ Patient B was told to follow up
17 with Respondent and his primary care provider and was discharged on or about the same day.
18 Respondent's records fail to document any post-operative communication with Patient B or any
19 review of the CT scan or labs.

20 44. On or about December 9, 2017, Patient B returned to the emergency room and was
21 admitted to the hospital for his abdominal pain.

22 45. On or about December 10, 2017, Patient B was examined by a gastroenterologist at
23 the hospital. The gastroenterologist noted that Patient B experienced pain after the duodenal
24 polyp had been removed, and he had no appetite. A CT scan showed the presence of large
25 amounts of ascites. On or about the same day, a gastrografin procedure confirmed that there was

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²⁷ Ascites are the abnormal buildup of fluid in the abdomen.

²⁸ Anasarca is a severe form of edema with widespread subcutaneous tissue swelling.

1 a leak in the first portion of the duodenum which extended to the area of the liver. The hospital
2 records indicate these results were communicated to Respondent.

3 46. On or about the same day, Respondent performed an exploratory laparotomy on
4 Patient B to close the duodenal hole, wash out the peritoneal cavity, and place drains. In his
5 operative report, Respondent noted that the perforation was two by two centimeters. Respondent
6 failed to document in his operative report that he also performed a liver biopsy during the
7 procedure.

8 47. On or about December 12, 2017, another physician at the hospital noted that Patient B
9 was experiencing moderate post-operative pain. The physician documented that he conferred
10 with Respondent, and the plan was to wait for the liver biopsy results.

11 48. The records from the hospital and from Respondent show that on or about December
12 15, 2017, Respondent examined Patient B. This was Respondent's first note following the
13 procedure on December 10, 2017. Respondent wrote that the right drain was producing a
14 greenish fluid resembling bile. Respondent ordered a CT scan and a nasogastric (NG) tube, and
15 consulted with other surgeons. Respondent also spoke to Patient B's family about the possibility
16 of additional surgery.

17 49. On or about December 16, 2017, another surgeon at the hospital reviewed Patient B's
18 care. This surgeon recommended that Patient B be transferred to a higher level of care to be
19 treated by a hepatobiliary surgeon.

20 50. Respondent committed repeated acts of negligence in his care and treatment of Patient
21 B which includes, but is not limited to, the following:

22 a. Respondent failed to comply with the standard of care in the evaluation and
23 immediate management of Patient B's duodenal lesion;

24 b. Respondent contributed to the five-day delay in Patient B's post-treatment
25 care following the initial procedure on December 5, 2017; and

26 c. Respondent failed to either treat Patient B or document any post-operative
27 care between December 12, 2017 and December 14, 2017.

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1 Patient C

2 51. On or about November 14, 2017, Respondent first saw Patient C, then a fifty-one-year
3 old woman, for chronic abdominal pain. Patient C had a hysterectomy in 2015 and had been
4 experiencing pain since the procedure. She had no nausea, constipation, diarrhea, or vomiting.
5 Respondent told Board investigators that he reviewed a prior CT scan that showed no evidence of
6 a hernia. Patient C told Respondent that she had a normal colonoscopy in 2016 and a normal
7 EGD.

8 52. During this initial visit, Respondent examined Patient C and documented that he
9 suspected that the pain was from adhesions that had formed after the hysterectomy or abdominal
10 wall neuropathy. His plan was to perform a diagnostic laparoscopy, possible lysis of adhesions,
11 and all other indicated procedures based upon any laparoscopic findings.

12 53. On or about November 20, 2017, Respondent performed the diagnostic laparoscopy.
13 In his operative report, Respondent documented that he inspected all visible organs and could not
14 find an obvious cause for Patient C's abdominal pain. He also noted that the jejunum appeared to
15 be mildly hyperemic with fatty callus infiltrate on the wall. Respondent later told Board
16 investigators that the bowel appeared to be thickened, although he failed to document this
17 observation in his operative note, and intra-operative images taken during the procedure show a
18 normal bowel. Respondent decided to take a full-thickness bowel wall biopsy to test for
19 inflammatory bowel syndrome or Crohn's disease, despite no visual evidence of Crohn's.
20 Respondent used a harmonic scalpel to biopsy the bowel. Respondent initially closed the biopsy
21 with Vicryl,²⁹ but noticed a kink. He then took down the sutures and created a low bowel
22 anastomosis, using a stapler. In his interview with Board investigators, Respondent said that he
23 had asked for a 60 mm stapler, but that he used a 45 mm stapler for the anastomosis. In his
24 operative report, Respondent failed to document the steps taken when creating the anastomosis
25 and using the stapler.

26 54. Following the procedure, Patient C was discharged from the hospital on or about the
27 same day.

28 ²⁹ Vicryl is a type of suture.

1 55. On or about November 21, 2017, the pathology results from the biopsy were reported.
2 There was no evidence of dysplasia or malignancy.

3 56. In his interview with Board investigators, Respondent said that he described his
4 operative findings to Patient C following the procedure on November 20, 2017. Respondent
5 failed to document this conversation with Patient C, either in his own records or in the hospital's
6 records.

7 57. On or about November 22, 2017, Patient C went to the emergency room for vomiting
8 and increasing abdominal pain. A CT scan revealed that Patient C had a possible bowel
9 obstruction at the anastomosis, post-operative pneumoperitoneum,³⁰ and fluid in the pelvis. On or
10 about the same day, Respondent performed a revision surgery to create a new anastomosis, using
11 a 60 mm stapler.

12 58. On or about November 24, 2017, Respondent drafted a discharge summary, noting
13 that Patient C had left the hospital. Respondent failed to create any post-operative progress notes
14 tracking Patient C's recovery prior to her discharge.

15 59. Respondent committed repeated acts of negligence in his care and treatment of Patient
16 C which includes, but is not limited to, the following:

17 a. Respondent performed a full thickness bowel biopsy for the purposes of
18 diagnosing irritable bowel disease or Crohn's rather than using less invasive methods;
19 and

20 b. Respondent failed to properly document Patient C's post-operative care.

21 Patient D

22 60. On or about November 2, 2018, Patient D, then a thirty-eight-year old woman,
23 underwent a laparoscopic cholecystectomy which was performed by T.N., M.D.

24 61. On or about November 10, 2018, Patient D returned to the hospital with
25 complaints of abdominal pain, nausea, and vomiting. The original surgeon, T.N., M.D., saw
26 Patient D on or about that day and recommended a HIDA scan³¹ to rule out a leak.

27 ³⁰ Pneumoperitoneum is the abnormal presence of air or other gas in the peritoneal cavity.

28 ³¹ A HIDA (hepatobiliary) scan is an imaging test used to view the liver, gallbladder, bile ducts, and the small intestine.

1 62. T.N., M.D., was going on vacation and asked Respondent to cover Patient D's
2 treatment and care. On or about November 11, 2018, Respondent saw Patient D.
3 Respondent noted that the HIDA scan and a CT scan showed a post-operative bile leak,
4 although an ERCP³² did not show the source of the leak. Respondent ordered a MRCP.³³
5 His documented plan was for a laparoscopic, possibly open, drainage of the biloma, possible
6 common bile duct exploration, and possible "hepatojejunostomy."³⁴

7 63. On or about November 12, 2018, Respondent proceeded with a diagnostic
8 laparoscopy to further investigate the leak. Respondent accessed the peritoneal cavity at the
9 prior incision sites from the laparoscopic cholecystectomy. According to his operative note,
10 Respondent identified the bile leak from the ductal structure at the liver hilum. Respondent
11 did a cholangiogram which confirmed that the leak was from the common bile duct.
12 Respondent then requested a hepatobiliary surgeon for an intraoperative consult. In a
13 subsequent interview with Board investigators, Respondent admitted that he did not have
14 much experience with biliary reconstructions and revision surgery after bile duct injuries.

15 64. Respondent was told that a hepatobiliary surgeon would not be available for one
16 to two hours. Instead of closing Patient D up so that the repair could be scheduled at a later
17 date, Respondent opted to wait in the operating room until the surgeon became available.

18 65. While waiting, Respondent decided to start on the repair. He created a
19 laparotomy incision, converting the procedure from laparoscopic to open. He started the
20 repair by doing a jejunajejunostomy.

21 66. S.C., M.D., came in for the intraoperative consult. S.C., M.D., took down the
22 Respondent's anastomosis and completed the choledochojejunostomy.³⁵

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25 ³² ERCP, or endoscopic retrograde cholangio-pancreatography, is an imaging test to
examine the pancreatic and bile ducts.

26 ³³ MRCP, or magnetic resonance cholangiopancreatography, is an imaging test to
visualize the biliary and pancreatic ducts.

27 ³⁴ A hepaticojejunostomy is the surgical creation of an anastomosis between the hepatic
duct and the jejunum.

28 ³⁵ A choledochojejunostomy is the surgical creation of an anastomosis between the
common bile duct and the jejunum.

1 67. Respondent committed negligence in his care and treatment of Patient D for
2 proceeding with the bile leak repair in the absence of a life-threatening clinical emergency,
3 and without proper experience.

4 Patient E

5 68. On or about October 15, 2018, Patient E, a thirty-eight-year-old male, was
6 admitted to the hospital for hypercalcemia.³⁶ Patient E also complained of right flank pain
7 and was diagnosed with bradycardia.³⁷ A CT scan of Patient E's abdomen and pelvis showed
8 a two mm calcification in the distal right ureter. Consults with endocrinology, urology, and
9 cardiology were obtained.

10 69. On or about October 16, 2018, Respondent provided the requested general
11 surgery consult for Patient E. Respondent's documented assessment was
12 "hyperparathyroidectomy."³⁸ His plan was for an ultrasound of the neck, focusing on the
13 parathyroid gland, and a nuclear medicine scan.

14 70. On or about October 17, 2018, Patient E underwent parathyroid planar imaging
15 and an ultrasound of the head and neck. The nuclear medicine study showed "evidence of
16 persistent abnormal uptake suggesting parathyroid adenoma"³⁹ associated with the inferior
17 pole." The impression from the ultrasound was a 9 mm posterior thyroid versus parathyroid
18 lesion.

19 71. Later that day, on or about October 17, 2018, Patient E signed a consent form for
20 a parathyroidectomy. Respondent signed the consent form on or about October 18, 2018.
21 Respondent failed to document any progress note detailing his rationale to proceed to surgery
22 or his discussions with Patient E about the risks, benefits, and alternatives to surgery.

23 72. On or about October 18, 2018, Respondent performed the parathyroidectomy of
24 Patient E's right inferior parathyroid gland. Three specimens were collected and sent to

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26 ³⁶ Hypercalcemia is a condition in which there is too much calcium in the blood.

27 ³⁷ Bradycardia is a slow heart rate.

28 ³⁸ Respondent likely meant hyperparathyroidism, or overactive parathyroid glands which
create an excess of hormone.

³⁹ An adenoma is a benign tumor formed from glandular structures in epithelial tissue.

1 pathology. The pathology report for these specimens confirmed that a 5 mm parathyroid
2 gland and thymus tissue had been removed.

3 73. On or about October 19, 2018, a CT scan of Patient E's neck showed a
4 hypodense area measuring 1.9 cm in size, posterior to the right thyroid gland. The
5 radiologist interpreting the scan could not exclude a right parathyroid adenoma.

6 74. On or about October 19, 2018, Respondent examined Patient E. Respondent
7 noted that pathology showed that the right parathyroid adenoma had been excised. He noted,
8 however, that Patient E's calcium and PTH⁴⁰ levels remained high. Respondent referred to
9 the 1.9 cm area from the neck CT and wrote that it was likely seroma or fluid that had
10 collected from the surgical procedure. Respondent's plan was for a surgical exploration of
11 the left parathyroids with possible parathyroidectomy. Respondent failed to document
12 whether he discussed the risks, benefits, and alternatives to surgery with Patient E.

13 75. On or about October 20, 2018, Respondent performed a parathyroidectomy of the
14 posterior right thyroid lobe. Respondent noted that the left parathyroid glands appeared to be
15 normal-sized. The pathology report for the specimen collected during this procedure
16 confirmed the presence of a large parathyroid adenoma.

17 76. Respondent committed negligence in his care and treatment of Patient E which
18 includes, but is not limited to, the following:

19 a. Respondent failed to recognize that he failed to find the adenoma during
20 the first surgical procedure;

21 b. Respondent failed to document informed consent and the diagnosis and
22 rationale for surgery for the procedure that occurred on October 18, 2018; and

23 c. Respondent failed to document informed consent and the diagnosis and
24 rationale for the procedure that occurred on October 20, 2018.

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28 ⁴⁰ PTH stands for parathyroid hormone. It is released by the parathyroid gland.

1 Patient F

2 77. On or about August 2, 2018, Patient F, a sixty-four-year-old male, saw
3 Respondent in the hospital for a surgical consult. Approximately 10 years prior, Patient F
4 had undergone a laparoscopic umbilical hernia repair which had been revised by the same
5 treatment provider at a later date. One week prior to August 2, 2018, Patient F went to the
6 hospital for periumbilical cellulitis and abdominal wall abscesses. Respondent reviewed a
7 CT scan from August 1, 2018 showing possible hernia, fistula formation, infection abscess
8 formation, or some combination. Respondent's plan was for surgical abdominal wall
9 exploration, drainage of abscess, possible laparotomy, hernia repair, removal of mesh, and
10 possible bowel resections.

11 78. On or about August 2, 2018, Respondent incised, drained, and debrided Patient
12 F's abdominal wall abscess. Respondent documented that Patient F was to follow up for
13 possible removal of mesh and repair.

14 79. On or about August 17, 2018, Patient F went to Respondent's office for a post-
15 operative follow up visit. Respondent removed Patient F's sutures and JP drain.

16 80. On or about October 10, 2018, a CT scan of Patient F's abdomen and pelvis was
17 taken.

18 81. On or about November 19, 2018, Patient F returned to the office and saw
19 Respondent. Patient F was still having abdominal wall drainage from the lower midline
20 wound. Respondent noted that previous cultures of the incision site were sterile. He
21 performed a bedside incision and drainage and debrided the subcutaneous tissues to the level
22 of the fascial wound.

23 82. On or about December 3, 2018, Patient F returned to the office and saw
24 Respondent. Patient F had increased purulent drainage of the abdominal wound.
25 Respondent's plan was for an abdominal wall exploration, with possible excision of
26 subcutaneous tissues.

27 83. On or about December 11, 2018, Patient F went to the emergency department of
28 a hospital at Respondent's direction. Patient F was admitted on the same day.

1 84. On or about December 12, 2018, Respondent documented a history and physical
2 of Patient F at the hospital. His assessment included an abdominal wall chronic infection,
3 enterocutaneous fistula with possible abscesses, and infected mesh. His surgical plan was for
4 possible removal of mesh, possible repair of a fistula, and component separation.

5 85. On or about December 13, 2018, Respondent performed the following on Patient
6 F: abdominal wall exploration, incision and drainage, abdominal wall abscess, resection of
7 interocutaneous fistula, debridement of fascia, small bowel resection with anastomosis,
8 removal of mesh, bilateral myofascial flap, and ventral hernia repair. Respondent resected 40
9 cm of small bowel.

10 86. On or about December 13, 2018, December 14, 2018, and December 15, 2018,
11 T.T., D.O., monitored Patient F's post-operative recovery. T.T., D.O., noted that Patient F
12 had some belching but no flatus. The plan was to continue supportive care.

13 87. On or about December 15, 2018, Respondent performed his first post-operative
14 examination of Patient F. Patient F reported bloating with new onset nausea. Respondent
15 ordered an NG tube.

16 88. On or about December 15, 2018, an x-ray of Patient F's abdomen showed
17 possible post-operative ileus⁴¹ and early complete or partial small bowel obstruction.

18 89. On or about December 16, 2018, another x-ray of Patient F's abdomen showed
19 persistent small bowel dilation, progressive within the left abdomen, compatible with post-
20 operative ileus versus partial small bowel obstruction.

21 90. On or about December 17, 2018, Respondent examined Patient F. Patient F
22 reported having a bowel movement and passing gas. Respondent documented that he
23 removed the NG tube.

24 91. On or about December 17, 2018 and December 18, 2018, M.F., M.D., and S.C.,
25 N.P., examined Patient F. Their documented plan was continued care with the NG tube.

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28 ⁴¹ Ileus is a lack of movement somewhere in the intestines. An ileus can lead to an
intestinal obstruction.

1 92. On or about December 18, 2018, Respondent examined Patient F. Respondent
2 noted that Patient F was passing gas and had a bowel movement, signifying resolved ileus.
3 Respondent ordered a liquid diet. Patient F was discharged from the hospital on or about the
4 same day.

5 93. On or about December 27, 2018, Patient F returned to the hospital. Patient F
6 complained of foul-smelling discharge from his surgical wound site. A CT scan of Patient
7 F's abdomen showed a prominent right parastomal herniation of the small bowel and colon
8 through a colostomy with contiguous induration⁴² of the mesentery. Patient F was admitted
9 to the hospital.

10 94. On or about December 27, 2018, Respondent examined Patient F at the hospital.
11 He documented that Patient F complained of abdominal localized right-sided distention along
12 the abdominal incision. Respondent reviewed the latest CT scan of Patient F's abdomen
13 taken that day. His assessment was an abdominal wall infection and abscess, rule out lateral
14 abdominal wall hernia and/or enterocutaneous fistula. His plan included a pre-operative
15 workup for an abdominal wall exploration, washout, drainage, possible hernia repair with
16 mesh, and possible bowel resection.

17 95. On or about December 28, 2018, Respondent operated on Patient F. According
18 to Respondent's operative report, Respondent removed the staples from the surgical wound,
19 separated the wound edges, and saw that the small bowel was opened into the skin. He noted
20 that the small bowel was "plasted"⁴³ into the subcutaneous tissues. He proceeded to lyse
21 adhesions and requested a consultation from another surgeon, T.L., M.D. Respondent
22 documented that T.L., M.D., took over as lead for the procedure. T.L., M.D., continued
23 lysing adhesions of the small bowel off the subcutaneous tissues of the abdominal wall.
24 They found the area where the bowel appeared to be herniating from, causing the obstruction,
25 and reduced it from the rectus muscle defect. T.L., M.D., also performed an ostomy.

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27 ⁴² Induration is an increase in the fibrous elements in tissue commonly associated with
28 inflammation.

⁴³ Respondent likely meant "plastered."

1 96. T.L., M.D., also wrote an operative report for the procedure on December 28,
2 2018. T.L., M.D., documented that multiple loops of the small bowel were plastered to the
3 abdominal wall. T.L., M.D., dissected the small bowel loops from the abdominal wall. He
4 examined the length of the small bowel and saw portions that were torn and severed.
5 Because of the status of the small bowel and inflammation, T.L., M.D., recommended the
6 creation of a stoma rather than another small bowel anastomosis. Respondent preferred the
7 small bowel anastomosis. T.L., M.D., ultimately created the stoma and placed a gastrostomy
8 tube and JP drain.

9 97. Respondent committed negligence in his care and treatment of Patient F which
10 includes, but is not limited to, the following:

11 a. Respondent failed to adequately follow up and/or document and treat
12 Patient F's post-operative issues following the procedure on December 12, 2018; and

13 b. Respondent failed to adequately proceed with the December 27, 2018
14 procedure which resulted in multiple irreparable bowel injuries and significant loss of bowel
15 length.

16 Patient G

17 98. On or about July 16, 2018, Patient G, a seventy-eight-year-old woman, was
18 admitted to the hospital for right upper quadrant abdominal pain with nausea lasting several
19 days. Patient G had been transferred from another hospital, where she had been diagnosed
20 with acute cholecystitis.⁴⁴

21 99. On or about July 16, 2018, Respondent examined Patient G at the hospital. His
22 assessment for Patient G was gallstones with cholecystitis. His treatment plan was a
23 preoperative workup for a laparoscopic, possibly open, cholecystectomy.

24 100. On or about July 17, 2018, Respondent performed the cholecystectomy. Patient
25 G was discharged on or about July 19, 2018. Respondent failed to document any post-
26 operative follow up.

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28 ⁴⁴ Cholecystitis is inflammation of the gallbladder.

1 101. On or about July 23, 2018, Patient G returned to the hospital via the emergency
2 department. Patient G complained of abdominal pain and nausea. A CT scan of Patient G's
3 abdomen showed a suspect right renal cyst. Respondent was notified of Patient G's
4 condition.

5 102. On or about July 23, 2018, Respondent examined Patient G at the hospital.
6 Following the cholecystectomy, Patient G developed right upper quadrant pain, nausea, and
7 vomiting. Respondent had reviewed the latest CT scan and noted that the results of an
8 MRCP were pending. Respondent's plan was to order an ERCP for further workup.

9 103. On or about August 4, 2018, Respondent performed an exploratory laparotomy,
10 resection of a distal common bile duct, hepaticoduodenostomy, and cholangiogram on
11 Patient G.

12 104. Respondent committed repeated negligent acts for failing to document adequate
13 pre-operative documentation of any discussions with Patient G regarding the risks, benefits,
14 and alternatives to surgery and any post-operative inpatient follow up for Patient G's July 17,
15 2018 procedure.

16 **THIRD CAUSE FOR DISCIPLINE**
17 **(Failure to Maintain Adequate and Accurate Records)**

18 105. Respondent has further subjected his Physician's and Surgeon's Certificate No.
19 A 140060 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the
20 Code, in that he failed to maintain adequate and accurate records in his care and treatment of
21 Patients A, B, C, E, F, and G, as more particularly alleged in paragraphs 13 through 59 and 68
22 through 104, above, which are hereby incorporated by reference and re-alleged as if fully set forth
23 herein.

24 **PRAYER**


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

27 1. Revoking or suspending Physician's and Surgeon's Certificate No. A 140060, issued
28 to Respondent Obaida Batal, M.D.;

- 1 2. Revoking, suspending or denying approval of Respondent Obaida Batal, M.D.'s
- 2 authority to supervise physician assistants and advanced practice nurses;
- 3 3. Ordering Respondent Obaida Batal, M.D., if placed on probation, to pay the Board
- 4 the costs of probation monitoring; and
- 5 4. Taking such other and further action as deemed necessary and proper.

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DATED: **FEB 09 2021**


WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant