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

In the Matter of the Accusation Against: Dat William Nguyen, M.D. Physician's & Surgeon's Certificate No. A 83262 Respondent.	Case No. 800-2022-092972

DECISION

The attached Proposed Decision 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 February 6, 2026.

IT IS SO ORDERED: January 5, 2026.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

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

In the Matter of the Accusation Against:

DAT WILLIAM NGUYEN, M.D., Respondent

Physician's and Surgeon's Certificate No. A 83262

Agency Case No. 800-2022-092972

OAH No. 2025040828

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by videoconference and telephone on November 12, 13, and 14, 2025.

Andres T. Carnahan, Deputy Attorney General, represented complainant, Reji Varghese, Executive Director of the Medical Board of California (board), Department of Consumer Affairs, State of California.

David Balfour, Attorney at a Law, Buchalter, P.C., represented respondent, Dat William Nguyen, M.D., who was present throughout the hearing.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on November 14, 2025.

SUMMARY

Complainant asserts that respondent's license should be disciplined because he committed gross negligence and repeated negligent acts in his care and treatment of Patient A..[1] Complainant proved by clear and convincing evidence that respondent committed gross negligence and repeated negligent acts when he failed to properly review Patient A's allergy and adverse reaction information in her electronic chart prior to his approval of the administration of a medication to which Patient A had an adverse reaction ultimately resulting in her death. Respondent provided substantial evidence of his rehabilitation and mitigation such that a public reprimand is appropriate in this case, and costs are awarded but reduced.

FACTUAL FINDINGS

Jurisdictional Matters

1. On May 23, 2003, the board issued Physician's and Surgeon's Certificate Number A 83262 to respondent (certificate or license). The license was in full force and effect at all times relevant to this case and will expire on August 31, 2026, unless renewed. Respondent's certificate has no prior history of discipline.

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[1] The name of the patient in this matter is confidential, and the patient will be referred to as Patient A. The name of the patient has been redacted from all exhibits for patient privacy.

2. On February 4, 2025, the board filed accusation number 800-2022-092972 seeking revocation or suspension of respondent's certificate based upon two causes for discipline, all related to respondent's care and treatment of Patient A, namely: (1) gross negligence, and (2) repeated negligent acts. The accusation further requested costs of investigation and enforcement.

3. Respondent timely filed a notice of defense, and this hearing followed.

The Undisputed Events of October 20, 2022, Regarding Patient A

4. On October 19, 2022, Patient A, a 72-year-old woman with schizophrenia and chronic obstructive pulmonary disease (COPD) on home oxygen presented to Alvarado Medical Center (Alvarado) Emergency Department by ambulance with shortness of breath. Respondent admitted Patient A to the hospital with COPD exacerbated by community acquired pneumonia.

5. On October 20, 2022, at approximately 3:45 p.m. while treating Patient A bedside for pneumonia, respondent saw an allergy "pop-up/alert/warning" on Patient A's electronic medical record chart[2] when he attempted to order Rocephin[3] to treat Patient A's pneumonia. The pop-up alert noted that Patient A had an allergy or adverse reaction to Rocephin but did not provide more specific information regarding

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[2] The electronic medical record system used by Alvarado and at issue in this matter is the EPIC electronic medical record system, referred to herein as "EPIC."

[3] Rocephin is the brand name for the generic drug ceftriaxone, which is a cephalosporin antibiotic used to treat many kinds of bacterial infections including pneumonia.

the nature of that adverse reaction. The specific allergy and adverse reaction information was contained within the allergy tab of the EPIC system in Patient A's medical record, but respondent did not "click" on the pop-up alert or otherwise "hover over" the alert such that the EPIC system would display more specific information about the allergy or adverse effect. Located within that allergy section of the EPIC system were listed Patient A's allergy to Rocephin, which was listed as "seizures, syncope[4], and anxiety." After seeing only the pop-up alert on EPIC (but without checking the allergy tab in EPIC), respondent discontinued the order for Rocephin, and switched the order to another antibiotic of Levaquin, which is an antibiotic for which Patient A had no listed allergies or adverse reactions.

Thereafter, respondent's Levaquin order for Patient A was discontinued in the EPIC system by a hospital pharmacist. The pharmacist then contacted respondent by text message on October 20, 2022, during a time when respondent was in his vehicle driving home from the hospital. During that text conversation, the pharmacist told respondent that the only allergy or adverse reactions she was aware of for Patient A were anxiety and syncope, and that the pharmacist recommended a switch back to Rocephin from the Levaquin order pursuant to hospital protocol, which requires that Levaquin be avoided, if possible, due to side effects. Based only on the information from the pharmacist, as respondent was in his vehicle and did not have access to EPIC at that time, respondent by text message authorized the pharmacist to change the order from Levaquin back to Rocephin at approximately 4:06 p.m.

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[4] Syncope is commonly known as fainting or "passing out" and is a loss of consciousness and muscle strength characterized by a fast onset, short duration, and spontaneous recovery.

6. After 4:06 p.m. Patient A's bedside nurse received respondent's order to administer Rocephin to Patient A. The bedside nurse saw in the EPIC medical records that Patient A was allergic to Rocephin. As a result, the bedside nurse called respondent on the telephone while respondent was still in his vehicle driving home. During that telephone call respondent told the bedside nurse that he was aware that Patient A had Rocephin listed as an allergen in her medical records. The bedside nurse asked respondent if it was safe to administer the Rocephin to Patient A. Respondent told the nurse he had just spoken to the pharmacist and the Rocephin was "ok to give." The bedside nurse documented that conversation in Patient A's medical chart.

7. At 4:21 p.m. the bedside nurse administered the prescribed Rocephin to Patient A by intravenous administration. Immediately thereafter, Patient A stated that she did not feel well and minutes later started to have a seizure. Patient A then stopped breathing and was noted to be pulseless. The bedside nurse immediately called a "code blue" at 4:30 p.m. Resuscitation and life saving measures continued until Patient A was declared dead at 4:58 p.m.

Complainant's Evidence

8. Complainant provided the testimony of two witnesses at hearing, namely its expert Lija Xie, M.D., and the board's investigator Michael Buckley. The following factual findings are based on their testimony and related documents received in evidence.

TESTIMONY OF LIJA XIE, M.D.

9. Dr. Lija Xie has been a licensed internal medicine physician in California since 2018, with no history of disciplinary actions. In 2015 she obtained both her M.D. degree from the University of California (UC) San Francisco, and her Master of Science

degree from UC Berkeley, where she also completed interdisciplinary studies focusing on sociology and women's health. Dr. Xie completed her internship and residency in internal medicine at Stanford Hospital and is board-certified in internal medicine. She is a Fellow of the American College of Physicians, has published medical literature, regularly teaches medical students, residents, and physician assistants. From 2018 to 2022 Dr. Xie served as a faculty member and clinical competency committee chair at Highland Hospital where she was responsible for training about 70 internal medicine residents per year. Dr. Xie currently works full-time as a hospitalist and Clinical Assistant Professor of Medicine in the Division of Hospital Medicine at Stanford Health Care Tri-Valley Hospital providing direct patient care of patients in the hospital and supervision of medical students and internal medicine and family medicine residents. Dr. Xie's responsibilities include providing care and treatment to hospitalized patients for a variety of conditions, as well as ensuring that the internal medicine and family medicine residents she trains are competent to graduate from residency.

10. Dr. Xie has served as an expert reviewer for the board for the past year and has reviewed a total of two cases for the board during that time. Dr. Xie was provided the 2023 Expert Reviewer Guidelines from the board, which she reviewed prior to conducting her review in this case. Dr. Xie was asked by the board to review this matter for an unbiased and objective determination of whether respondent's care and treatment of Patient A was within the standard of care.

11. Dr. Xie testified that the phrase standard of care means the level of patient care and skill that a reasonably careful or prudent provider would have carried out in the same or similar circumstances. In the context of this matter the particular standard of care requires physicians to obtain detailed allergy information from the patient and to review the documented allergy history within the electronic medical

record system, such as EPIC. Simply asking a patient about allergies is insufficient, particularly for patients with complex medical histories or cognitive impairment. Allergies and drug reactions are routinely recorded and carried forward in EPIC across encounters. Physicians should also heed alerts generated in electronic medical records when ordering medications, especially those contraindicated by documented allergies. In this case, the patient's allergy to Rocephin was prominently noted in the allergy section of EPIC, including specific reactions to Rocephin of syncope and seizures. In the pop-up notification regarding the allergies there is a note to "see comments" for details. These alerts and allergy information were readily accessible to the respondent; the information was visible on the sidebar and could be seen through mouse-hover or note review, constituting an expected part of standard care to verify before prescribing. Dr. Xie testified that gross negligence is an extreme departure from the standard of care or a "want of even scant care," as opposed to negligence, which is a simple departure from the standard of care. She stated that the difference between negligence and gross negligence is the degree of departure from the standard of care.

12. In this case Patient A had a documented allergy to Rocephin in the EPIC medical records, specifically syncope and seizures. Seizures are abnormal electrical activity in the brain and, although rare, can be a known toxic effect of cephalosporins such as Rocephin. The patient had no previous history of seizure disorder, which made this an allergic/toxic reaction. Dr. Xie explained that syncope is a loss of consciousness from lack of blood flow to the brain, usually caused by cardiac reasons. As a result of the administration of the Rocephin Patient A had a fatal adverse reaction, leading to cardiopulmonary arrest shortly after administration of the Rocephin. Dr. Xie noted that syncope and seizures are both adverse effects rather than classic allergic reactions like anaphylaxis. She stated the adverse effect is listed as an allergy in the electronic medical records. Dr. Xie also noted that cephalosporins, like Rocephin, and penicillin

are the most common antibiotics that produce adverse reactions. Respondent's failure to recognize and act upon the patient's allergy/adverse reaction history with Rocephin was a critical lapse in care that constituted an extreme departure from the standard of care, gross negligence, in Dr. Xie's opinion. She stressed that respondent had an independent responsibility to verify Patient A's allergy information in EPIC rather than to simply delegate this responsibility to the pharmacist or rely solely on the pharmacist's report over the phone without conducting his own chart review. Respondent's actions of ordering Rocephin despite Patient A's known severe allergic history as documented in her EPIC medical record, without reviewing the allergy details in EPIC or adequately documenting risk-benefit discussions with Patient A, constituted gross negligence. She also criticized respondent's form of communication with the pharmacist, specifically the use of unsecured text messages, for medication orders, noting that it was informal and risky for patient safety and likely violated privacy regulations and hospital policy.

13. Dr. Xie testified that in this case the standard or care would have required respondent to review Patient A's allergy/adverse reaction information in the allergy tab of EPIC after he saw the pop-up alert, which specifically stated that if Rocephin is administered the severity of the allergy/adverse reaction was "high" and the reaction was "Other (See comments), Anxiety." However, respondent admitted during his interview with the board (and at this hearing) that he never looked at the information under the allergy section of Patient A's medical records and only saw the pop-up alert. Dr. Xie stated that the standard of care requires a physician to perform a "risk benefit analysis" when providing any medication to a patient who has an allergy to that medication. In cases where the risk is seizure, which is a severe adverse effect, versus using another antibiotic with a small risk of adverse effects, then the risk of seizure far outweighs the use of another antibiotic, which was a safer alternative for Patient A.

14. Dr. Xie also noted that with regard to his decision to switch the antibiotic order from Levaquin back to Rocephin, during his interview with the board's investigator respondent appeared to place the responsibility for the order on the pharmacist, instead of himself. Specifically, she cited the following testimony from the interview transcript, which was received in evidence:

> Dr. Nguyen: Yeah. As – as I said, you know, I think I established I knew there was an allergy to Rocephin, and so I wasn't oblivious to the fact patient was allergic to Rocephin. When the nurse called me about the allergy, I said yes, but the pharmacist and the stewardship had contacted already and recommended that we switch to Rocephin. So I asked nurse if you have a question about that, please ask the pharmacist.
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> [¶] . . . [¶]
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> Dr. Nguyen: Because I was going based on the advice of the - - PharmD to switch from Levaquin to Rocephin. So when the nurse called me, (inaudible). I said, well, I didn't want it either, but the pharmacist is recommending we switch to Rocephin. So if you have a question, please contact the pharmacy and ask them yourself because it was based on their recommendation.

Dr. Xie again opined that while pharmacists are valuable team members, they do not replace the physician's responsibility to verify clinical information and make final decisions. Respondent's incomplete review of Patient A's medical records was

particularly egregious given the life-threatening nature of the documented allergy. Dr. Xie opined that respondent's order to change the antibiotic from Levaquin back to Rocephin without completing a review of Patient A's medical records regarding her adverse effect constituted gross negligence. Dr. Xie also opined that respondent's actions in authorizing the bedside nurse to administer the Rocephin despite her concerns regarding allergy/adverse reaction in Patient A's medical record and without respondent reviewing Patient A's allergy information in her medical record also constituted gross negligence.

15. Dr. Xie also testified that respondent did not document in Patient A's medical records his rationale for switching from Levaquin to Rocephin, did not document any of his risk/benefit analysis for administering the Rocephin or Levaquin. She noted that respondent did complete his history and physical examination notes (H&P) for Patient A in her medical chart only after Patient A died. That documentation did include information about Patient A's adverse reaction to Rocephin, but that information was not known to respondent at the time the medication was administered to Patient A.

16. Dr. Xie reviewed the report of respondent's expert, Dr. Daniel Bressler, and disagrees with his opinions. Specifically, Dr. Bressler criticized Dr. Xie's opinions that respondent failed to review the allergies tab in EPIC for Patient A and failed to have that information in his H&P prior to the administration of the Rocephin. Instead, Dr. Bressler wrote in his report that respondent did complete the H&P after Patient A died, and the H&P included the allergy information. Dr. Xie credibly testified that the purpose of an H&P is to obtain information to be used to carry out care of the patient. So, regardless of when it was written, respondent is required to know the information contained in the H&P at the time he provides patient care, and in this case he did not

know Patient A had a severe adverse reaction of seizure from the administration of Rocephin at the time that drug was given to her. She stated, "just because [respondent] had not written his H&P note yet does not mean he is not responsible for knowing the information in it."

Dr. Xie also criticized Dr. Bressler's opinion that Patient A told respondent she had no allergies. She noted that the history that a patient provides is extremely important, but it is not the only source of information a physician must consider, particularly because many times the patient is unable to give all information. This is particularly true with patients with complex medical histories or who are not cognitively intact. Dr. Xie stressed that respondent was required pursuant to the standard of care to review the patient's medical record regarding allergies and adverse reactions, and respondent did not do so in this case.

Dr. Xie also takes issue with Dr. Bressler's assertion in his report that, "[t]he requirement that a doctor practicing at the standard of care would be required to "click through" to a Comment Section in Epic is patently absurd." Dr. Xie stressed this opinion is simply wrong and "clicking through" on EPIC is required by the standard of care, particularly as it is easy to do so, all physicians are required to be trained on EPIC, and this information is crucial for patient care.

17. Dr. Xie is aware that some hospitals avoid prescribing Levaquin because they want to avoid the bacteria becoming resistant to antibiotics; she stated that this is called antibiotic stewardship and most hospitals have it. She is also aware that Alvarado recommended the use of Rocephin over Levaquin because of that antibiotic stewardship. Dr. Xie understands that the pharmacists recommendation in this case to change from Levaquin to Rocephin was based primarily on the antibiotic stewardship of Alvarado. However, she noted that this did not change her opinion on respondent's

responsibilities as required by the standard of care. She admitted that in her report she wrote that respondent "chose to follow the recommendation of the pharmacist, which many physicians would likely have done as well." However, she noted that a pharmacist does not have a license to practice medicine, only the physician does. The physician is the ultimate decision maker when it comes to clinical matters.

TESTIMONY OF MICHEAL BUCKLEY

18. Michael Buckley currently works as an investigator with the Department of Consumer Affairs Health Quality Investigation Unit (HQIU). Prior to this position Mr. Buckley worked for six years as a law enforcement officer with the San Diego Harbor Police. Mr. Buckley has received specialized investigative training for his current role handling civil, criminal, and administrative investigations for various California agencies, including the board. Over the course of his career at the Department of Consumer Affairs, he has conducted approximately 10 to 15 investigations on behalf of the board. Mr. Buckley was assigned to investigate this matter after a complaint was received through the central complaint unit of HQIU based on allegations received from the Department of Public Health that respondent had treated a patient in a hospital setting, and the patient had a documented allergy to a specific antibiotic but was prescribed and administered that very antibiotic, resulting in the patient's death.

19. Mr. Buckley testified that his custom and practice as an investigator, which was followed in this case, includes maintaining a record of his investigation by attaching all documents he receives throughout his investigation to his written report summarizing his findings. Mr. Buckley's report was received in evidence. That report includes as attachments various documents including uncertified medical records from the hospital provided with the original complaint to HQIU. Mr. Buckley subsequently procured certified medical records through properly authorized medical release forms.

He also obtained the patient's death certificate to confirm vital details and located the patient's next of kin to request medical release permissions. Further he also made requests to Alvarado Hospital, which provided certified records, as well as policy and peer review documents relating to the respondent's care of Patient A. Other documents summarized in his report include emails from the Department of Public Health initiating the case, summaries of the allegations, and correspondence with involved parties such as an attorney representing the bedside nurse involved in the incident. Mr. Buckley attempted to interview the bedside nurse but was ultimately unsuccessful. He also conducted an interview with the pharmacist, who was involved in the case, and the transcription of that interview was received in evidence. Mr. Buckley also interviewed respondent for this investigation, and a copy of the transcript of that interview was received in evidence.

20. Mr. Buckley also obtained a copy of the investigative report from the Board of Registered Nursing regarding their investigation of the bedside nurse involved in this matter. That investigative report was received in evidence. Mr. Buckley also obtained peer review materials and executive minutes from Alvarado Hospital following its takeover by UC San Diego (UCSD), which provided insight into hospital policies and hospital oversight committee discussions regarding the care and treatment of Patient A.

21. After Mr. Buckley obtained all of the above documents as part of his investigation, HQIU assigned an expert reviewer, specifically Dr. Xie, to review the information collected for a determination of whether respondent deviated from the standard of care for his care and treatment of Patient A.

22. Mr. Buckley testified that during his interview of respondent as part of his investigation, respondent did express remorse for the death of Patient A, and he did take accountability for Patient A's death.

Respondent's Evidence

23. Respondent provided the testimony of three witnesses at hearing, namely his expert David J. Bressler, M.D., character witness Robin Jennell Gomez, and respondent. The following factual findings are made from their testimony, and related documents received in evidence. Respondent also provided numerous documents, including character reference letters received into evidence pursuant to Government Code section 11514.

TESTIMONY OF DAVID J. BRESSLER, M.D.

24. Dr. Daniel J. Bressler is a board-certified internal medicine physician licensed in California since 1984. Dr. Bressler completed his undergraduate degree in biology at Stanford University in 1977. He earned his M.D. degree in 1981 from Harvard University School of Medicine. He completed his residency at Beth Israel Hospital in Boston in 1984. Dr. Bressler currently works at his own private solo practice, which he has done since 2005. Dr. Bressler also currently works as a medical staff physician at Mission Hills Post Acute Care Skilled Nursing Facility, a position he has held since 2005. In addition to those positions, he has worked as the Quality Assurance Advisor at Mission Hills Post Acute Care since 2020. Throughout his medical career Dr. Bressler has maintained a medical practice largely focused on outpatient internal medicine, including some inpatient care, particularly prior to the widespread establishment of hospitalists. For about 20 years beginning in 1987, Dr. Bressler worked as a private practice internal medicine physician with a group called Internal

Medicine Associates in San Diego. During that time his inpatient hospital work was at Scripps Mercy Hospital, and his outpatient practice was located across the street from that hospital. Over the course of his career, Dr. Bressler has also served in leadership roles and contributed to training residents, as well as participating in various hospital committees including biomedical ethics, physician wellbeing, pharmacy and therapeutics, quality assurance, and peer review.

25. Dr. Bressler's current private practice in internal medicine consists principally of outpatients with a median age of 65 years or older. While he does have some younger patients, the vast majority of his patients are elderly. Dr. Bressler does not currently work as a hospitalist. Dr. Bressler testified that the EPIC electronic medical record system is "relatively new" to him, and he was first introduced to EPIC about five or six years ago when it came to Scripps Mercy Hospital.

26. Dr. Bressler testified that he has also worked for the past 20 years as an expert reviewer for medical malpractice cases. For the last 10 years, he spends about 25 percent of his time working on medical malpractice cases as an expert reviewer, which equates to about 10 to 15 cases per year over the past 10 years. Dr. Bressler was retained in this matter to review this case and provide his expert opinion regarding whether respondent deviated from the standard of care. He testified that he is being paid $15,000 for doing so in this case. Dr. Bressler stated that the phrase standard of care means what a reasonable physician would do under the same or similar circumstances. Dr. Bressler reviewed various documents in this case including: the accusation, complaint submitted to the board, the board's investigative report with attachments including certified medical records and transcript of respondent's interview with the board, transcript of the pharmacist's interview with the board, the bedside nurse's interview with the Board of Registered Nursing investigator and the

investigator's report, and Dr. Xie's expert report. Dr. Bressler summarized his opinions in this matter in his report, which was received in evidence.

27. Dr. Bressler explained that he has extensive experience treating patients with pneumonia, particularly in older patients with comorbid conditions such as COPD, a population that typically requires more cautious and aggressive treatment. Dr. Bressler explained the general principles guiding antibiotic prescribing to patients with pneumonia. He explained the decision regarding which antibiotic to prescribe depends on whether the infection is community or hospital-acquired, patient comorbidities, and prior adverse reactions to antibiotics. The standard outpatient treatment involves a combination of antibiotics targeting typical and atypical bacteria, often a cephalosporin or broad-spectrum penicillin with doxycycline or azithromycin. Dr. Bressler emphasized the importance of antibiotic stewardship and to use a narrow-spectrum antibiotic when appropriate to minimize the creation of antibiotic resistance and possible adverse effects. He stated, "you don't want to use a bazooka to kill a mosquito," and you should reserve the more powerful broad-spectrum antibiotics for more serious infections. Dr. Bressler opined that a physician is required to do a risk/benefit assessment when prescribing an antibiotic. Dr. Bressler also stated that Levaquin is an antibiotic that has the Food and Drug Administration's (FDA) highest level of warning (a black box warning) because it has potential side effects of weakening tendons and blood vessels, and older patients are significantly at risk of spontaneous tearing or rupturing of tendons, or even their aorta. Levaquin is also a broad-spectrum antibiotic that raises the risk of antibiotic resistance or "superinfection." By comparison, cephalosporins, such as Rocephin, are considered one of the safest drugs to use, generally.

28. Regarding Patient A's treatment by respondent, Dr. Bressler agreed with respondent's diagnosis of pneumonia and his treatment choices of the use of an intravenous antibiotic and hospitalization, particularly given Patient A's age and underlying COPD. Dr. Bressler stated that respondent's diagnosis and treatment of Patient A with antibiotics was within the standard of care. Dr. Bressler opined that respondent's initial choice to use Levaquin as the antibiotic for Patient A after respondent saw the pop-up alert in EPIC that Patient A was allergic to Rocephin was appropriate and within the standard of care. Dr. Bressler stated that changing the order from Rocephin to Levaquin was appropriate if Patient A had "a true allergy." Dr. Bressler stated that respondent "weighed the risks here" and "out of an abundance of caution" ordered the Levaquin based on the pop-up showing an allergy to Rocephin. In response to question of what a reasonable physician should do if he or she saw the same pop-up alert that respondent saw, Dr. Bressler stated, "it is mixed . . . it becomes a red flag for the doctor, causing the doctor to second guess himself to say – maybe there is something else I should use." Dr. Bressler testified that his review of respondent's interview with the board showed him that respondent "had the impression that [Patient A] did not have allergies."

29. Dr. Bressler stated that after respondent ordered the Levaquin and left the hospital, respondent got a text message from the pharmacist wherein the pharmacist requested that respondent switch the antibiotic prescription back to Rocephin "because the pharmacist had researched the allergy and determined it was not a true allergy." Dr. Bressler stated that respondent's interpretation of the text messages from the pharmacist was reasonable, and it was reasonable for respondent "to assume that the pharmacist did a deeper dive on the allergy than he did." Dr. Bressler also opined that respondent was reasonable in believing that the pharmacist was telling him it was safe to prescribe Rocephin. Dr. Bressler testified, and wrote in his

report, that the standard of care in this situation did not require respondent to check Patient A's medical records again before he switched the antibiotic back to Rocephin because it was appropriate for him to rely exclusively on the input from the pharmacist, who is a professional colleague. Dr. Bressler stated that it is common, particularly in hospital practice, for pharmacists to make such recommendations and for physicians to rely on those recommendations. Accordingly, Dr. Bressler opined that respondent did not deviate at all from the standard of care when he switched the order for antibiotics back to Rocephin by relying exclusively on the pharmacist's recommendation.

30. Dr. Bressler also opined that the information that Patient A had the adverse reaction of seizures from Rocephin administration "was not readily available to respondent at the time of his encounter with the patient." Dr. Bressler argued that while respondent's H&P note, which was written after Patient A died, included the information that Patient A had an allergy to Rocephin causing seizures, that information was "auto-populated from EPIC" and respondent was not aware of that information. In response to the question of whether respondent was required to know the information contained in the H&P note prior to his treatment of Patient A, Dr. Bressler stated that the standard of care does not require that respondent know that information but instead for him to be reasonable. Dr. Bressler does not agree that respondent deviated from the standard of care in any way for his treatment and care of Patient A "because [respondent] has the right to rely on the pharmacist."

31. Dr. Bressler also testified that his review of information related to the bedside nurses communication with respondent about Patient A's allergy to Rocephin shows that the nurse never communicated to respondent that the medical records showed that Patient A had the adverse reaction of seizures from the drug. He opined

that respondent was reasonable for instructing the nurse to administer the Rocephin based on his understanding from the pharmacist that Patient A did not have a real allergy to the medication.

32. Dr. Bressler concluded after his review of all information provided to him that respondent's care and treatment of Patient A were within the standard of care in all respects despite the unfortunate patient outcome.

33. On cross-examination Dr. Bressler admitted that the pop-up alert respondent saw on the EPIC medical records for Patient A showed that the allergy was "high" for severity. Dr. Bressler testified that respondent "did not have easy access to the information" that Patient A had the adverse reaction to Rocephin of seizures. However, Dr. Bressler's testimony in this regard simply ignores the fact that respondent could easily get that information from simply hovering his mouse over the pop-up alert, or by clicking on the allergy information in Patient A's chart. On cross-examination Dr. Bressler admitted that it would have taken "a second or two" to simply click on that allergy section. Dr. Bressler stated that respondent's treatment and care of Patient A was not perfect or ideal, but it was reasonable and within the standard of care.

RESPONDENT'S TESTIMONY

34. Respondent is 55 years old and originally from Saigon, Vietnam. He immigrated to the United States in 1980 at the age of nine under difficult circumstances, smuggled by boat to Thailand before settling in Minnesota with a foster family. Despite arriving without English proficiency, he succeeded academically, graduating from high school and then earning a full scholarship to the University of Minnesota for his undergraduate degree. Initially pursuing aerospace engineering, he

shifted to biology and later committed to a combined medical school program at the University of Minnesota. He graduated with his undergraduate degree in 1993 and then went directly into medical school at the University of Minnesota. Respondent obtained his M.D. degree from the University of Minnesota in 2000. He explained that it took him seven years to obtain his M.D. degree in the joint program because he complete an initial two years of the program and then took some time off in order to do a program of reunification for his family. Specifically, his mother, father and brother came to the United States from Vietnam, but none of them spoke English. Eventually, his mother and father returned to Vietnam, but his brother remained in the United States. After obtaining his M.D. degree in 2000, respondent completed an internship in internal medicine at the University of Southern California in 2001 and thereafter began his residency in internal medicine at the University of Southern California until 2002. In 2002 he moved to New York and completed his residency in internal medicine at New York University hospital in 2004.

35. After completing his residency program in 2004, respondent worked in private practice as an internal medicine physician at Care View Medical Group in San Diego where he served an underserved population at both a hospital setting (at both Alvarado Hospital and Paradise Valley Hospital) and outpatient setting. Respondent worked for Care View Medical Group from 2004 to 2007. Thereafter, respondent opened his own private practice in 2007, as a hospitalist, a practice where he currently works. In 2007 when respondent started his practice, his patient population was primarily in the hospital at Alvarado and at Paradise Valley Hospital. In 2013 respondent brought five other physicians into his practice, which was then granted a contract with Alvarado to oversee its hospitalist program. At that time respondent was on-call every three days and was the Director of the Hospitalist practice at Alvarado overseeing the entire hospitalist program at Alvarado. On December 10, 2023, UCSD

took over ownership of Alvarado, and respondent's contract with Alvarado ended. He explained that UCSD required all of the hospitalist physicians working at the hospital to be salaried employees. Respondent "did not think that was for me" and he left Alvarado in December 2023. Since December 2023, respondent had continued his private practice, which has pivoted to more outpatient clinic work. Respondent stated that in 2019 he started another group called Golden Physician Medical Group, which consists of about 125 primary physicians with about 350 consulting physicians. Respondent is the chairman of Golden Physician Medical Group, which is an Independent Physician Association (IPA) or a pool of physicians who enroll their patients into the IPA. Golden Physician Medical Group manages the patients in the pool. Respondent explained that he currently only treats patients in the hospital at Paradise Valley Hospital. He further explained that Golden Physician Medical Group is owned by 18 primary physicians, including himself, and the other physicians are just participants in the IPA and are paid by the IPA.

36. In addition to his current private practice work, respondent recently joined Community Healthcare Solutions, a community resource for homeless patients that consists of a network of physicians who provide care to homeless people. This organization will "walk through downtown to check on homeless patients." When a homeless patient is found to need medical assistance, they are taken to an emergency room and the physicians from Community Healthcare Solutions manage their care in the hospital. The physicians will bill insurance for the care if the insurance is available, but if not, then the physicians provide the care without pay. Respondent currently limits the number of patients he sees through Community Healthcare Solutions to four or five.

Over the past year-and-a-half respondent has shifted his practice to the outpatient clinic. Since the COVID-19 pandemic, respondent "went to a dark place" and "lost his passion" for medicine. However, he is now slowly getting it back and now looks forward to going to work. Respondent stated that his passion is working with the homeless patients. As a result, he spends one day per week at his outpatient clinic and devotes the remainder of his time to homeless patients. Additionally, he also sees some patients at about four nursing homes, but he does not have a large volume of patients from that work. In addition to all of those areas of work, respondent also recently teamed up with a young man knowledgeable of technology to develop an app for your phone that uses artificial intelligence to diagnose skin cancer from a photo you take with your phone. Respondent stated that he is passionate about this entrepreneurial endeavor as well.

37. Regarding the care and treatment of Patient A, respondent testified that he recalls this case every day, and every time he places and order for Rocephin he remembers every detail of his care of Patient A. Respondent testified, "How Patient A died is something that I blame myself for a lot. Patient A's death was not how I wanted to lose my patient . . . I could have prevented that." In October 2022, respondent was seeing patients in the hospital every day, and he would be on-call every three days with his group admitting about five patients to the hospital per day. Respondent stated that Patient A was admitted to the hospital through the emergency department at around midnight on October 20, 2022, and respondent received a call regarding Patient A at about 4:00 or 5:00 a.m. on October 20, 2022.

Respondent first saw Patient A at about 10:30 a.m. on October 20, 2022, and was aware she had a diagnosis of end-stage COPD, a history of schizophrenia, and anxiety. Respondent interviewed Patient A to get her history and perform a physical

examination of her. Patient A was alert, not confused, and able to communicate well with respondent. Patient A was short of breath, had been smoking for many years and continued to smoke, her schizophrenia was currently controlled with no signs of being delusional, and she had previously been on hospice care for the past six months because of her diagnosis of end-stage COPD. Patient A continued to smoke despite her end-stage diagnosis of COPD and had attempted to stop smoking but could not. Respondent explained that Patient A wanted to remain on hospice care but was not allowed to do so for over a six-month time period. Respondent asked Patient A if she had any allergies to any medications, and she informed him that she did not. Patient A also discussed her anxiety, and she specifically asked for a prescription for Ativan for that because she stated that was the only medication that would calm her down. After respondent reviewed the results of Patient A's chest x-ray, he diagnosed her with pneumonia because of right lung infiltrate indicative of pneumonia. Respondent noted that the emergency physician had ordered an antibiotic of doxycycline to treat the pneumonia, but doxycycline is not a broad-spectrum antibiotic and not the best antibiotic for treatment of pneumonia.

As a result of the pneumonia diagnosis, respondent wanted to treat the pneumonia immediately with a broad-spectrum antibiotic and ordered the antibiotic at about 11:00 a.m. He first entered into the EPIC medical record his order for intravenous Rocephin with Zithromax, which are typically the two drugs used as the first line of treatment antibiotics for pneumonia, and when he did so the pop-up alert showing that Patient A had an allergy to Rocephin appeared on the screen. The pop-up stated under "reactions" the following "other (see comments) & anxiety." Respondent testified that "in [his] mind, he only saw anxiety as the only listed allergic response." As a result of seeing the pop-up alert, respondent immediately changed the order from Rocephin to Levaquin at about 11:00 a.m. Respondent admitted during his

testimony that he did not take the time to click on the allergy section in EPIC to see the comments regarding Patient A's allergy to Rocephin, and he did not hover his cursor over that pop-up for additional information. Respondent testified that he regrets that decision. After putting those orders into the EPIC system, respondent left the hospital.

After leaving the hospital and while he was in his car driving home, respondent received a text message from the pharmacist at about 1:00 p.m. Respondent stated that he understood her text to request that "we" switch the Levaquin order back to Rocephin because the pharmacist "felt the allergy listed for Rocephin was not a true allergy." Respondent stated that the pharmacist is a very vital part of the medical team, who specializes in medication, and he takes the pharmacist's opinion "just like I do another physician." Respondent admitted during his testimony that he did not ask the pharmacist for her input relating to her choice of the Rocephin medication for Patient A, which is something respondent regrets. Respondent stated, "I should have called her to ask her why she wanted to change the order [to Rocephin] to get her reasoning." Respondent stated that he has guilt for that, and in his mind, he assumed that the pharmacist "had researched the issue" to go through the analysis of why Rocephin was safe for Patient A. He simply trusted the pharmacist. Respondent recalled thinking that Patient A told him she had no allergies, the only allergy he recalled seeing in EPIC was anxiety, and the pharmacist told him Rocephin was safe and he trusted the pharmacist. Respondent admitted to not checking the EPIC system for the allergen information when he received the text from the pharmacist because he was in his car. He stated that in hindsight, he should have turned his car around to go back to the hospital to check the EPIC chart before agreeing to the changes. However, he had simply assumed the pharmacist had done so.

About three hours after the text from the pharmacist, respondent received a phone call from the bedside nurse regarding the prescription for Rocephin for Patient A. Respondent explained that it takes a few hours for the medications to be prepared and delivered to the area where the patient is located. The bedside nurse was concerned about Patient A's allergy to Rocephin as listed in her electronic medical records. According to respondent, the bedside nurse never mentioned the specific adverse reaction of seizures during her phone call with respondent. Respondent testified that he told the nurse that he had communicated with the pharmacist and that the allergy was anxiety. He told the nurse that if she had any questions to call the pharmacist. Respondent testified that he regrets not asking the nurse specifically what she was concerned about. Respondent also testified that he "just learned yesterday" that Patient A had told the bedside nurse that she did not want the Rocephin medication. Respondent stated, "I wish the nurse had told me that, if that was the case I would not have given that medication." Respondent said he does not know why the nurse did not tell him that. Respondent admitted that he failed Patient A because he "did not call either the pharmacist or the nurse to ask why or what they were worried about." Respondent testified that as the attending physician, he is responsible for the medication Patient A received, and "what happened is on me." While he does not blame anyone else, he is angry because there were so many opportunities to prevent this outcome.

About 30 minutes after receiving the phone call from the bedside nurse, respondent received a second phone call from the bedside nurse informing him that immediately after she administered the Rocephin to Patient A, Patient A started to deteriorate, had a seizure, and the nurse called the rapid response team for assessment, and very soon thereafter the nurse called a "code blue" because the patient went into cardio-pulmonary arrest. The nurse informed respondent that the

code team was working on Patient A while she was speaking to respondent. Respondent did not go back into the hospital but told the nurse to keep him informed. About 15 to 20 minutes later, the nurse called respondent to inform him that Patient A died.

38. After Patient A died, respondent spoke to the emergency department attending physician, who told him what happened and the actions he took to attempt to save Patient A. Respondent then took about 30 minutes to "collect his notes" before he reached out to his colleagues to ask them what he should do. His colleagues told him to simply complete his H&P note as he normally would. Respondent stated that he knew at that time that this event would change him as a physician and he would never be the same. Thereafter, respondent wrote the H&P for Patient A, which he signed at 5:19 p.m. on October 20, 2022. Respondent wrote and signed the discharge summary for Patient A on October 28, 2022, at 3:32 p.m. Respondent explained that the attending physician always completes the discharge summary on a patient even if the patient dies. He stated that the hospital provides the physician 14 days to complete the discharge summary, but he did this one within one week. Respondent stated that he spoke to legal counsel for the hospital prior to writing the discharge summary. Respondent stated that he knew the case would be reviewed and he did not want to seem defensive in the discharge summary. As a result he did not include information about how he changed the antibiotic order from Levaquin back to Rocephin.

39. Respondent stated that after Patient A's death, numerous California state regulatory agencies had to be notified, and each conducted an investigation, as well as the hospital administration. Respondent was interviewed by the Department of Public Health, as well as the medical executive committee (MEC) of Alvarado. Respondent

was emotional in the meeting with the MEC during his interview. Respondent stated that he was told by the MEC that he needed to take some time off, which he did. Respondent testified that he was not made aware at the time of his interview with the MEC that he was being summarily suspended. He was not aware of his suspension until this hearing. MEC session minutes received in evidence show that after their interview of respondent, the MEC summarily suspended him for a few days. After a few days, the MEC recommended a corrective action plan for respondent that included recommendations that respondent complete coursework, specifically a prescribing medication course, and a medical record keeping course from the UCSD Physician Assessment and Clinical Education (PACE) Program, both of which respondent successfully completed in January 2023. Respondent provided certificates of completion for each of those courses.

40. Respondent testified that in addition to those two courses he completed as recommended by the MEC, he sought additional coursework on his own accord related to this incident. Respondent testified that he completed the following courses, and he provided a certificate of completion for each: antibiotic review on October 8, 2025; medical error prevention on October 8, 2025; and palliative care and pain management at end of life on December 31, 2023.

41. Respondent testified that since Patient A's death, he has changed his practice to include more rigorous verification of consultants' recommendations and medication orders. He started questioning his consultants' recommendations more. He stated that this was the first time a consultant made a recommendation to him that was wrong, and he hates that in the back of his mind he has to question the advice that other professionals give to him. He has since learned that communication is critical and enhanced communication among medical team members is necessary to

prevent similar errors. Respondent stated that he is his own worse critic, and he will be vigilant to make sure such a mistake never happens again. Respondent loves being a doctor, and this event "took the joy out of being a doctor" for a time. He stated he knows what his father went through to give him the opportunity he has to be a doctor, and he will not waste that opportunity.

TESTIMONY OF ROBIN JENNELL GOMEZ

42. Robin Gomez is a registered nurse currently serving as the market Chief Executive Officer (CEO) for Scion Health, the owner of Kindred Hospital in San Diego, which is a long-term acute care facility with 70 beds specializing in extended patient stays of 30 days or more treating patients requiring long-term ventilator weaning and those with significant wounds, acting as an intermediary between community care, rehabilitation, home, or nursing home settings. In this role, she oversees all hospital operations including clinical care, quality metrics, fiscal management, and supply oversight. Despite not managing physicians directly, she maintains oversight over their activities. Ms. Gomez has held this position for 25 months and previously worked in acute care. Prior to her current position, Ms. Gomez was the CEO of Alvarado Hospital from October 2012 until March 2022. At Alvarado, she held comprehensive responsibility for hospital operations, quality improvement, and fiscal oversight. Before Alvarado, she worked at Loma Linda Murrietta as Vice President of Patient Care Services.

43. Ms. Gomez first met the respondent in 2004 while working at Paradise Valley Hospital, where she began as a nursing supervisor and eventually became the Chief Nursing Officer. Respondent was a hospitalist in internal medicine at Paradise Valley and was well regarded by the nursing staff for his respectful, straightforward communication and dedication to patient care. Ms. Gomez noted that the respondent

was liked by staff and patients alike and consistently showed clinical competence and professionalism during her time there through 2012.

44. When Ms. Gomez became CEO of Alvarado Hospital, she discovered that the respondent was already part of the hospital staff. Since both Alvarado and Paradise Valley were owned by the same parent company, Ms. Gomez initiated a contract with the respondent's physician organization to run Alvarado's hospitalist group, a relationship that lasted six to eight years. Throughout this period, she worked closely with the respondent around quality metrics, regularly meeting to review performance and identify areas for improvement. Ms. Gomez testified that she had no recollection of any professional issues or complaints involving respondent at Alvarado, and instead only had positive experiences with respondent. She described him as extremely structured, organized, and compassionate in his approach to patient care, highlighting his habit of engaging patients through meaningful conversation. She affirmed that nurses frequently brought concerns to respondent, who in turn communicated these issues to her, reflecting open and respectful collaboration. Ms. Gomez trusts respondent's care and noted that he treated her mother-in-law and even Ms. Gomez in the past for serious medical issues, and she would have no hesitation having him provide care to herself of her family members again. Ms. Gomez supports respondent's continued medical practice. She is aware of the allegations in the accusation in this matter but stated these had no impact on her positive opinion of his clinical abilities and character. She emphasized her confidence in respondent's medical competence and the respect he commands from staff and patients alike.

45. Ms. Gomez wrote a letter in support of respondent, which was received into evidence and generally mirrored her testimony at hearing.

RESPONDENT'S DOCUMENTARY EVIDENCE

46. In addition to the documents discussed above regarding coursework completed by respondent and letter from Ms. Gomez, respondent provided 14 additional character reference letters from various individuals, which were received in evidence. The letters were written by physician colleagues of various specialties, the founder and Chief Executive Officer of Community Healthcare Solutions, Director of Medical Staff at Alvarado, and the Director of Business Development at Community Care Center. Each of those letters praised respondent's professionalism, integrity, work ethic, patient care, and dedication to community.

Cost of Investigation and Enforcement

47. Business and Professions Code section 125.3 authorizes complainant to seek recovery of the reasonable costs of its investigation and enforcement in disciplinary matters. Complainant submitted a certification of costs for work performed by the Office of the Attorney General. Attached to that certification is a form entitled, "Matter Time Activity By Professional Type." The attachment contains a general description of the tasks performed, the time spent on the tasks, and the hourly rate charged for the work of each employee. The certification of costs submitted in this matter established that the Department of Justice billed $38,768.50 for 172.50 hours expended on the case for the cost of enforcement.

Complainant submitted a Declaration of Investigative Activity for work performed by the investigator for the Department of Consumer Affairs allocated to the board for this matter. Attached to that declaration is a form entitled "Investigator Log," which contains a description of the tasks performed, the date the tasks were performed, and the time spent on the tasks. The declaration also includes the hourly

rate of the investigator working on this matter. The declaration of investigative activity in this matter established that the Department of Consumer Affairs billed $13,247.75 for 77.50 hours expended on the case for the cost of investigation. Additionally, a Statement of Services in this matter was submitted by complainant related to expert review and was signed and attested to by Dr. Lija Xie, expert for the board. This certification provided that Dr. Xie spent a total of 10 hours reviewing and evaluating this matter and writing her report at a billing rate of $150 per hour, totaling expert costs of $1,500 spent on this matter. Accordingly, the total costs of investigation in this matter are $14,747.75.

48. All three of the certifications satisfied the requirements of California Code of Regulations, title 1, section 1042, subdivision (b), and the certifications support a finding that costs in the amount of $53,516.25 are reasonable in both the nature and extent of the work performed. Accordingly, the reasonable cost of enforcement and investigation of this matter is $53,516.25.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (Evid. Code, § 115; 500.) The standard of proof required is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The obligation to establish charges by clear and convincing evidence is a heavy burden. It requires a finding of high probability; it is evidence so clear as to leave no substantial doubt, or sufficiently strong evidence to command the

unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Applicable Statutory Authority

2. The primary purpose of disciplinary action is to protect the public. (Bus. & Prof. Code, § 2229, subd. (a).) The Medical Practice Act emphasizes that the board should "seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies." (Bus. & Prof. Code, § 2229, subd. (c).) However, "[w]here rehabilitation and protection are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

3. Business and Professions Code section 2227 provides that a licensee who is found to have violated the Medical Practices Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay costs of probation monitoring, be publicly reprimanded, or such other action taken in relation to the discipline as the board deems proper.

4. Under Business and Professions Code section 2234, the board shall take action against a licensee charged with unprofessional conduct. Grounds for unprofessional conduct include, but are not limited to, gross negligence (*Id.* at subd. (b)), and repeated negligent acts (*Id.* at subd. (c)).

The Standard of Care, Gross Negligence, and Simple Negligence

5. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar

circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

6. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-198; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

7. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.)

8. Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

Disciplinary Guidelines

9. California Code of Regulations, title 16, section 1361, provides that when reaching a decision on a disciplinary action, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). Under the Guidelines the board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the board and proposed

settlements submitted to the board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

10. Under the Disciplinary Guidelines, the minimum discipline for gross negligence and repeated negligence is a stayed revocation for five years. The Disciplinary Guidelines provide that in cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered. The maximum discipline is revocation. Among the conditions of probation, the guidelines recommend an education course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, a practice monitor, and solo practice prohibition.

Evaluation of Expert Testimony and Evidence

11. The decision in this matter requires resolving the conflict in the testimony of the experts. In this regard, consideration has been given to their qualifications and credibility, the factual bases of their opinions, the reasons for their opinions, and any biases that could color their opinions and review of the evidence. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

12. After giving due consideration to these factors, Dr. Xie's opinions regarding respondent's care and treatment of Patient A are found more persuasive than Dr. Bressler's opinions for the following reasons. While Drs. Xie and Bressler both have impressive credentials and experience, on balance, Dr. Xie is found to be more

qualified as an expert in the area of the use of electronic medical records and EPIC specifically. Dr. Xie has worked with EPIC extensively, by comparison Dr. Bressler only recently became familiar with the EPIC system over the past five or six years and his experience with EPIC is more limited. Dr. Xie credibly testified that respondent could have obtained Patient A's adverse reaction information from Rocephin of seizures simply by hovering his curser over the pop-up alert or by clicking on the allergen information within EPIC, a process that would have taken only seconds. By comparison Dr. Bressler repeatedly testified, without support, that respondent did not have easy access to that adverse reaction information, an assertion that is simply not supported by the evidence. Both Dr. Xie and Dr. Bressler articulated correctly the applicable legal standards related to standard of care, gross negligence, and simple negligence. Both experts agree that the standard of care required respondent to review the chart regarding identified allergies to prescribed antibiotics, and that a physician is generally allowed to rely upon the specialized expertise of a pharmacy consultant. However, Dr. Xie persuasively and credibly opined that despite generally being able to rely on the specialized expertise of a pharmacist, the standard of care requires a physician to be familiar with and to review the allergies or adverse reactions contained within the patient's medical chart prior to prescribing medication. In this case, respondent admitted that he simply never looked at the allergies tab in EPIC or hovered over the pop-up alert that specifically said to "see comments." As a result, he was not familiar with the allergies or adverse reactions to the medication for Patient A, which was an extreme departure from the standard of care. Respondent's failure to review that information in the patient's electronic medical record even after a text from the pharmacist and thereafter again after a phone call from the bedside nurse regarding her concern are further instances of respondent's negligence. Dr. Xie's testimony in this regard is more credible than the opinion of Dr. Bressler that respondent did not

have easy access to that allergy or adverse reaction information and could rely exclusively on the recommendation of the pharmacist without questioning. Dr. Xie's opinion is persuasive. Dr. Bressler's opinion is not accepted.

Cause Exists to Discipline Respondent's License

13. Cause exists under Business and Professions Code section 2234, subdivision (b), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in gross negligence with respect to his care and treatment of Patient A for prescribing Rocephin for Patient A even though Patient A had a long-standing documented life-threatening adverse reaction to the drug that included seizures and syncope, for instructing the pharmacist to change Patient A's prescription back to Rocephin without first carefully reviewing Patient A's medical records, and for instructing Patient A's bedside nurse to administer Rocephin despite her concerns without first carefully reviewing Patient A's medical records.

14. Cause exists under Business and Professions Code section 2234, subdivision (c), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in repeated acts of negligence with respect to Patient A for prescribing Rocephin for Patient A even though Patient A had a long-standing documented life-threatening adverse reaction to the drug that included seizures and syncope, for instructing the pharmacist to change Patient A's prescription back to Rocephin without first carefully reviewing Patient A's medical records, and for instructing Patient A's bedside nurse to administer Rocephin despite her concerns without first carefully reviewing Patient A's medical records.

Application of Disciplinary Guidelines

15. Because cause for discipline exists, a determination of the degree of discipline necessary must be made with application of the Disciplinary Guidelines. Respondent has no history of prior discipline. He has been working in private practice as an internal medicine physician for over 22 years and has a good reputation in the community as a physician. Ms. Gomez provided testimony regarding respondent's stellar reputation as a physician, integrity, honesty, and professionalism. Additionally, respondent has taken the step of successfully completing the UCSD PACE medical records and prescribing medication course, as well as completing other courses on his own for antibiotic review, medical error prevention, and palliative care and pain management at end of life. Respondent credibly testified that he has changed his practice since Patient A's death to be much more rigorous regarding his review of patient allergen or adverse reaction information and with regard to any professional colleague recommendation, and to question any such recommendation. Since the incident he has learned to engage in more communication with his colleagues regarding treatment recommendations. The allegations in this accusation involve only one patient, and the incidents occurred in 2022, about three years ago, and there have been no further incidents involving patient care since that time. The Disciplinary Guidelines provide that in a situation where there are repeated negligent acts involving only one patient, a public reprimand may be appropriate.

16. As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual, the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Rehabilitation is a state of mind, and the law looks with favor upon rewarding with the

opportunity to serve, one who has achieved reformation and regeneration. (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) Fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.) The evidentiary significance of misconduct is greatly diminished by the passage of time and by the absence of similar, more recent misconduct. (*Kwasnik v. State Bar* (1990) 50 Cal.3d 1061, 1070.)

17. After considering the board's guidelines, evidence of mitigation, and the evidence of record as a whole, it is determined that it is not contrary to the public interest to issue a public reprimand in this case. The determination is made for the following reasons: The nature and extent of respondent's conduct of failing to review the allergy or adverse reaction information in Patient A's medical record ultimately resulted in Patient A's death. Respondent took a passive approach to the requirement that he know Patient A's allergy information in her chart by relying on the pharmacist to review that information and make a determination, and respondent did so without questioning the pharmacist on her rationale. He again simply relied on the pharmacist's recommendation when the bedside nurse called him with concerns, and he directed the nurse to call the pharmacist if she had any questions instead of taking it upon himself to review Patient A's records. Respondent was required to know Patient A's allergy and adverse reaction information, which was readily available in EPIC if he had bothered to look, which he admitted he did not.

With this stated, there are mitigating factors in respondent's favor that warrant the imposition of less serious discipline even though his conduct resulted in gross negligence: There were multiple opportunities for the pharmacist and the nurse to convey the allergy and adverse effect information to respondent or the fact that Patient A did not want to take that medication, each of which would have

independently provided respondent with the required information, that he should have obtained on his own, that would have prevented the tragic outcome of this case. Regardless, respondent takes full responsibility for his actions and admits that it was ultimately his failure that resulted in the tragic outcome. He has taken steps to make sure that a similar event never happens again. Respondent credibly testified that Patient A's death changed him as a physician forever, and he will never again take a passive approach to medication orders or patient care and will carefully review all information prior to prescribing. All evidence in this case point to a conclusion that Patient A's death from respondent's negligent prescribing was an isolated incident that will not be repeated.

Costs of Investigation and Enforcement

18. Business and Professions Code section 125.3, subdivision (a), authorizes an administrative law judge to direct a licensee who has violated the applicable licensing act to pay a sum not to exceed the reasonable costs of investigation and prosecution. The reasonable costs in this matter are $53,516.25.

19. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45, the California Supreme Court set forth five factors to be considered in determining whether a particular licensee should be ordered to pay the reasonable costs of investigation and prosecution under statutes like Business and professions Code section 125.3. Those factors are: whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Ibid.*)

20. Applying the *Zuckerman* factors to this case leads to the following conclusions: respondent was not successful in getting the charges reduced or dismissed; respondent did assert a good faith belief in the merits of his position; respondent did raise a colorable challenge to the proposed discipline; respondent provided no evidence or argument to establish that he does not have the financial ability to pay costs; and the scope of the investigation was appropriate in light of the alleged misconduct.

21. After consideration of the *Zuckerman* factors in this case, a reduction of the costs of enforcement are appropriate, particularly in light of respondent's extensive rehabilitation evidence presented. Accordingly, an appropriate cost amount of $37,461.37 is deemed reasonable, and respondent shall pay that amount to the board, which may be paid pursuant to a payment plan approved by the board.

ORDER

Dat William Nguyen, M.D.'s Physician's and Surgeon's Certificate, No. A 83262 is hereby publicly reprimanded. This Decision shall serve as Dr. Nguyen's Public Reprimand, and it is conditioned upon Dr. Nguyen paying the costs associated with the prosecution of this matter in the amount of $37,461.37 within 90 days, or via a payment plan as arranged with the board.

DATE: December 11, 2025

Debra D. Nye-Perkins

DEBRA D. NYE-PERKINS
Administrative Law Judge
Office of Administrative Hearings