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

In the Matter of the Accusation Against David Dongwook Choi, M.D. Physician's and Surgeon's Certificate No. A36731 Respondent.	Case No. 800-2018-046369

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on OCT 07 2020.

IT IS SO ORDERED SEP 30 2020.

MEDICAL BOARD OF CALIFORNIA

By: William Prasifka
Executive Director

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: DAVID DONGWOOK CHOI, M.D. 1704 Old Baldy Way Upland, CA 91784 Physician's and Surgeon's Certificate No. A 36731, Respondent.	Case No. 800-2018-046369 OAH No. 2020050127 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. William Prasifka ("Complainant") is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. David Dongwook Choi, M.D. ("Respondent") is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

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3. On or about June 1, 1981, the Board issued Physician's and Surgeon's Certificate No. A 36731 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-046369 and will expire on October 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-046369 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 1, 2020. Respondent filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2018-046369 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 800-2018-046369. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2018-046369, agrees that cause exists for discipline and hereby surrenders his Physician's and Surgeon's Certificate No. A 36731 for the Board's formal acceptance.

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

CONTINGENCY

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

11. The parties understand and agree that Portable Document Format ("PDF") and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

12. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 36731, issued to Respondent David Dongwook Choi, M.D., is surrendered and accepted by the Board.

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

2. Respondent shall lose all rights and privileges as an obstetrician and gynecologist in California as of the effective date of the Board's Decision and Order.

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2018-046369 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2018-046369 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 9-15-2020 David Dongwook Choi

DAVID DONGWOOK CHOI, M.D.
Respondent

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ENDORSEMENT

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

DATED: 9-22-2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-046369

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
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In the Matter of the Accusation Against: DAVID DONGWOOK CHOI, M.D. 1704 Old Baldy Way Upland, California 91784 Physician's and Surgeon's Certificate No. A 36731, Respondent.	Case No. 800-2018-046369 **ACCUSATION**

PARTIES

1. Christine J. Lally ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about June 1, 1981, the Medical Board issued Physician's and Surgeon's Certificate Number A 36731 to David Dongwook Choi, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

5. Section 2227 of the Code states:

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

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

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

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

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

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

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

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7. Section 2266 of the Code, states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTUAL ALLEGATIONS

8. From 7:00 a.m. on May 25, 2014 to 7:00 a.m. on May 26, 2014, Respondent was the in-house obstetrician at Pomona Valley Hospital. As the in-house obstetrician, Respondent's duties included taking care of obstetrical patients from the emergency room who did not have their own obstetrician; teaching residents; and, assisting in the care of in-patients when requested by the patient's attending obstetrician.

9. On May 25, 2014 at 1451, Patient 1[1] presented to the Labor and Delivery Department at Pomona Valley Hospital in labor. She was 27 years old, gravida 2, para 0, at 40 2/7 weeks gestation. A vaginal examination performed by the labor and delivery nurse revealed dilatation of 2 cm, effacement of 90%, station at -2, and intact membranes.

10. Dr. S.C., the obstetrician on-call for Patient 1's prenatal care provider, was called by the labor and delivery nurse for admission orders. Dr. S.C. ordered that the patient be started on Pitocin per protocol and for the nursing staff to call Dr. S.C. with any Category II or Category III fetal heart rate patterns.

11. At 1921, the nurse assessed Category I fetal heart rate patterns. The external monitor showed a contraction frequency of 2-4 minutes, a contraction duration of 50-80 seconds, a baseline fetal heart rate of 150 with no baseline changes, moderate baseline variability, absent accelerations and no decelerations.

12. At 1953, Dr. S.C. was at Patient 1's bedside. Examination revealed dilatation of 5 cm, effacement of 100%, station at 1 and normal show. Dr. S.C. ruptured the patient's membranes and applied an internal electrode.

13. At 2000, the nurse assessed Category I fetal heart rate patterns. The fetal heart rate baseline was 150 with no baseline changes, moderate baseline variability, absent accelerations and no decelerations.

[1] For privacy purposes, the patient in this Accusation is referred to as Patient 1.

14. At 2330 and again at 2359, the nurse assessed Category II fetal heart rate patterns. The internal fetal monitor reflected a baseline fetal heart rate of 155, no baseline changes, moderate baseline variability, absent accelerations and early, episodic variable decelerations. Dr. S.C. was not notified of the Category II fetal heart rate pattern assessment.

15. At 0016, 0030 and 0045 on May 26, 2014, the nurse assessed Category II fetal heart rate patterns with absent accelerations and early episodic variable decelerations. Patient 1 was repositioned on her left side at 0048 and the Pitocin was discontinued at 0049.

16. At 0051, the nurse called Dr. S.C. when the fetal heart rate dropped into the 60's and was not recovering. Dr. S.C. instructed the nursing staff to have the in-house obstetrician, Respondent, immediately go to the bedside to assess the patient and intervene, if necessary, while Dr. S.C. was on her way to the hospital.

17. Respondent was at Patient 1's bedside at 0054. The nursing notes reflect that Patient 1 was placed in the right lateral position and then the left lateral position. The Neonatal Intensive Care Unit (NICU) team was called and at 0057, Respondent ordered that the patient be taken to the operative room. Patient 1 was in the operative room at 0100. In the operating room, Respondent instructed the patient to continue to push.

18. Dr. S.C. arrived at the operating room at 0106. The fetal heart rate was in the 170's and the fetal head was visible almost at the introitus. Respondent reported to Dr. S.C. that he assessed the patient, the fetal heart rate was normal and the head was low enough for a vacuum assisted vaginal delivery. Respondent then transferred care to Dr. S.C. and left the operating room.

19. During the 13 minutes that Respondent managed Patient 1's care, he did not apply a vacuum or commence a cesarean section.

20. Respondent did not document his involvement in Patient 1's care.

21. Upon her arrival at 0106, Dr. S.C. made two attempts at vacuum delivery. She used gentle traction for approximately 10 seconds at 0107 but was unsuccessful. She reduced the pressures on the vacuum and the fetal heart rate dropped to the 90's. At 0108, the heart rate quickly rose back to the 120-150's following scalp stimulation. The vacuum was reapplied at

0110 and three 10 second push/pulls were performed. There was good descent of the head during each cycle with the vacuum, but the baby could not be delivered. At 0111, Dr. S.C. ordered an emergent cesarean section. The patient was induced at 0114 and Dr. S.C. delivered the infant at 0118. The infant was limp, apneic and bradycardic with thick +4 meconium. He required bag ventilation, chemical resuscitation and chest compressions. The infant sustained hypoxic ischemic encephalopathy, meconium aspiration and brain damage.

STANDARD OF CARE

22. The standard of care requires that obstetricians promptly intervene to expedite delivery in the presence of prolonged fetal heart rate abnormalities.

23. The standard of care requires that obstetricians promptly and accurately interpret fetal heart rate monitoring information to determine if urgent delivery is warranted.

24. The standard of care requires that physicians, including in-house obstetricians, keep timely, accurate and legible medical records reflecting pertinent clinical information.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

25. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence in the care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 23, above, as though fully set forth herein. The circumstances are as follows:

26. At the time Respondent became involved in Patient 1's care as the in-house obstetrician, there was sufficient information to conclude that the fetus was in jeopardy requiring prompt delivery. Respondent failed to appreciate the severity of the fetal condition, including the prolonged fetal heart rate bradycardia and absent variability with no significant recovery.

27. At the time Respondent became involved in Patient 1's care as the in-house obstetrician, he failed to make any effort to expedite delivery, in spite of evidence of imminent fetal distress. Upon Dr. S.C.'s arrival, Respondent advised her that he believed that the delivery could be accomplished by vacuum extraction but failed to initiate that procedure immediately as the in-house obstetrician responding to Dr. S.C.'s request for in-house obstetrical assistance.

28. Respondent's acts and/or omissions as set forth in paragraphs 8 through 23 and 25 through 27, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 27, above, as though fully set forth herein. The circumstances are as follows:

30. At the time Respondent became involved in Patient 1's care as the in-house obstetrician, there was sufficient information to conclude that the fetus was in jeopardy requiring prompt delivery. Respondent failed to appreciate the severity of the fetal condition, including the prolonged fetal heart rate bradycardia and absent variability with no significant recovery.

31. At the time Respondent became involved in Patient 1's care as the in-house obstetrician, he failed to make any effort to expedite delivery, in spite of evidence of imminent fetal distress. Upon Dr. S.C.'s arrival, Respondent advised her that he believed that the delivery could be accomplished by vacuum extraction but failed to initiate that procedure immediately as the in-house obstetrician responding to Dr. S.C.'s request for in-house obstetrical assistance.

32. Respondent failed to document in the medical record his involvement in the care of Patient 1 while he was the in-house obstetrician responding to Dr. S.C.'s request for in-house obstetrical assistance.

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

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

34. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to his care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8, 17 through 20 and 24, above, as though fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 36731, issued to David Dongwook Choi, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

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

DATED: APR 0 1 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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