

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

1 XAVIER BECERRA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 REBECCA L. SMITH
Deputy Attorney General
4 State Bar No. 179733
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7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 DAVID DONGWOOK CHOI, M.D.
1704 Old Baldy Way
14 Upland, CA 91784

15 Physician's and Surgeon's Certificate
No. A 36731,

16 Respondent.
17

Case No. 800-2018-046369

OAH No. 2020050127

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

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

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

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

5 **JURISDICTION**

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

11 **ADVISEMENT AND WAIVERS**

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

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

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

24 **CULPABILITY**

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

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

4 **CONTINGENCY**

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

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

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

19 **ORDER**

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

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

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

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

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

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

14 ACCEPTANCE

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

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20 DATED: 9-15-2020

David Dongwook Choi, M.D.
Respondent

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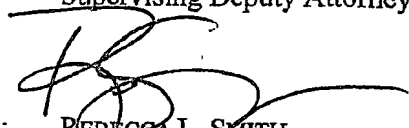
ENDORSEMENT

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

1 XAVIER BECERRA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 REBECCA L. SMITH
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4 State Bar No. 179733
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9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2018-046369

13 DAVID DONGWOOK CHOI, M.D.
14 1704 Old Baldy Way
Upland, California 91784
15 Physician's and Surgeon's Certificate
16 No. A 36731,

A C C U S A T I O N

17 Respondent.

18
19
20 **PARTIES**

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

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

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1 **JURISDICTION**

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

4 4. Section 2004 of the Code states:

5 "The board shall have the responsibility for the following:

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

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

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

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

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

15 "..."

16 5. Section 2227 of the Code states:

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

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

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

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

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

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

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

9 6. Section 2234 of the Code, states:

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

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

15 “(b) Gross negligence.

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

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

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

26 “...”

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1 7. Section 2266 of the Code, states:

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

4 **FACTUAL ALLEGATIONS**

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

10 9. On May 25, 2014 at 1451, Patient 1¹ presented to the Labor and Delivery Department
11 at Pomona Valley Hospital in labor. She was 27 years old, gravida 2, para 0, at 40 2/7 weeks
12 gestation. A vaginal examination performed by the labor and delivery nurse revealed dilatation of
13 2 cm, effacement of 90%, station at -2, and intact membranes.

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

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

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

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

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

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

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

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

12 17. Respondent was at Patient 1's bedside at 0054. The nursing notes reflect that Patient
13 1 was placed in the right lateral position and then the left lateral position. The Neonatal Intensive
14 Care Unit (NICU) team was called and at 0057, Respondent ordered that the patient be taken to
15 the operative room. Patient 1 was in the operative room at 0100. In the operating room,
16 Respondent instructed the patient to continue to push.

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

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

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

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

1 0110 and three 10 second push/pulls were performed. There was good descent of the head during
2 each cycle with the vacuum, but the baby could not be delivered. At 0111, Dr. S.C. ordered an
3 emergent cesarean section. The patient was induced at 0114 and Dr. S.C. delivered the infant at
4 0118. The infant was limp, apneic and bradycardic with thick +4 meconium. He required bag
5 ventilation, chemical resuscitation and chest compressions. The infant sustained hypoxic
6 ischemic encephalopathy, meconium aspiration and brain damage.

7 **STANDARD OF CARE**

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

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

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

14 **FIRST CAUSE FOR DISCIPLINE**

15 **(Gross Negligence)**

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

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

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

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

5 **SECOND CAUSE FOR DISCIPLINE**

6 **(Repeated Negligent Acts)**

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

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

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

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

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

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

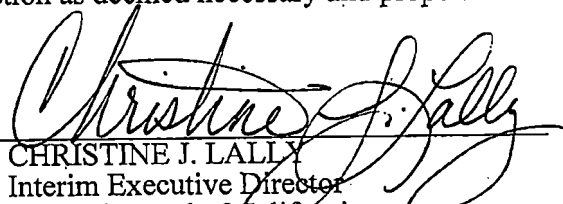
34. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to his care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8, 17 through 20 and 24, above, as though 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 01 2020


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

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