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

In the Matter of the Fourth Amended Accusation Against: Obaida Batal, M.D. Physician's and Surgeon's License No. A 140060 Respondent	Case No. 800-2017-039494

DECISION

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

This Decision shall become effective at 5:00 p.m. on July 2, 2021.

IT IS SO ORDERED: June 4, 2021.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
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ALEXANDRA M. ALVAREZ
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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 Fourth Amended Accusation Against: **OBAIDA BATAL, M.D.** **17525 Ventura Blvd., Ste. 203** **Encino, CA 91316-3843** **Physician's and Surgeon's Certificate No. A 140060,** Respondent.	Case No. 800-2017-039494 OAH No. 2019060180 **STIPULATED SETTLEMENT AND DISCIPLINARY 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 Christine A. Rhee, Deputy Attorney General.

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

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

JURISDICTION

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

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

ADVISEMENT AND WAIVERS

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

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Fourth Amended Accusation; 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.

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

CULPABILITY

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

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

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

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. 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 Settlement 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.

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ADDITIONAL PROVISIONS

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

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

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

DISCIPLINARY ORDER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

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

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

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

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

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

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

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

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15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

17. FUTURE ADMISSIONS CLAUSE. 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 action agency in the State of California, all of the charges and allegations contained in Fourth Amended Accusation No. 800-2017-039494 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 license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Derek F. O'Reilly-Jones, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

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DATED: 02/14/2021

OBAIDA BATAL, M.D.
Respondent

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

DATED: 02/15/2021

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

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

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

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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DATED: _____ _____
OBAIDA BATAL, M.D.
Respondent

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

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

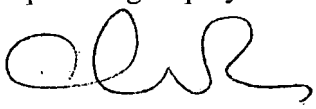
ENDORSEMENT

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

DATED: February 16, 2021

Respectfully submitted,

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



CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Fourth Amended Accusation No. 800-2017-039494

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ALEXANDRA M. ALVAREZ
Supervising 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 Fourth Amended Accusation Against: **OBAIDA BATAL, M.D.** **15200 Magnolia Blvd** **Unit 302** **Sherman Oaks, CA 91403-1180** **Physician's and Surgeon's Certificate No. A 140060,** Respondent.	Case No. 800-2017-039494 **FOURTH AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

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

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

JURISDICTION

3. This Fourth Amended Accusation, which supercedes the Third Amended Accusation filed on August 4, 2020, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

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

> (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.
>
> (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.
>
> ...

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

> 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.
>
> ...
>
> (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.
>
> ...

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

...

6. 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."

FIRST CAUSE FOR DISCIPLINE

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

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

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

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

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

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

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SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

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

Patient A

13. On or about November 22, 2017, at approximately 0817, Patient A, a sixty-eight-year old woman, presented to the emergency department (ED) at Hoag complaining of black stool and lower abdominal pain with increased weakness. J.S., M.D., examined Patient A in the ED and diagnosed her with hypokalemia[2] and a gastrointestinal bleed. J.S. recommended that Patient A be admitted to Hoag.

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

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

[2] Hypokalemia is a low potassium level in the blood.

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

[4] Hyponatremia is a low sodium level in the blood.

15. On or about November 22, 2017, K.P.Y. also examined Patient A at Hoag and recommended an urgent upper endoscopy,[5] empiric intravenous PPI[6] treatment, and a review of a computed tomography (CT) scan of Patient A's abdomen. K.P.Y.'s differential diagnoses were peptic ulcer disease, gastroenteritis, and colitis.

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

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

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

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

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

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

[7] Protonix, brand name for Pantoprazole, is a PPI.

[8] Gastritis is inflammation of the lining of the stomach.

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

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

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

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

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

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

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

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

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

27. On or about November 28, 2017, at approximately 1208, Y.T. noted that Patient A had experienced a vasovagal near syncope[17] when walking to the bathroom. Patient A reported

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

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

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

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

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

[16] Jejunojejunostomy is a surgical technique used in an anastomosis between two portions of the jejunum.

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

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

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

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

30. On or about November 30, 2017, at approximately 0816, hospitalist E.K., M.D., who had taken over for Y.T., saw Patient A and observed that Patient A was diaphoretic[18] and tachycardic.[19] E.K. ordered one (1) unit of blood stat and notified K.P.Y. and Respondent of Patient A's condition.

31. On or about November 30, 2017, a Rapid Response Team note documented that Patient A was minimally responsive to painful stimuli, had irregular breathing, and was tachycardic and hypotensive.[20] The note documented that Patient A had been intubated and that a Code RBC[21] was called at approximately 0942. Patient A was transferred to the Critical Care Unit and taken to the operating room at approximately 1025.

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

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

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

[20] Hypotension is low blood pressure.

[21] Patient A was given blood transfusions.

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

34. On or about November 30, 2017, at approximately 1423, Respondent drafted an immediate post-operative note. According to the note, the surgery took place from 1000 to 1425. Respondent performed an intraoperative endoscopy, exploratory laparotomy, control of duodenal bleeding, ligation of the gastroduodenal artery, oversewing of the duodenal stump with jejunal patch, cholecystectomy,[22] and duodenal biopsies. His findings included a duodenal stump blowout[23] and severe duodenal inflammation due to chronic peptic ulcers. Respondent electronically signed the note on or about December 3, 2017, at 1944.

35. On or about November 30, 2017, at 1800, Respondent documented a progress note stating that Patient A had been transferred from the operating room to the Intensive Care Unit (ICU), and that he had informed Patient A's husband of the critical situation and his findings. Respondent was later called back to the ICU because Patient A's JP drain[24] was filling quickly. Respondent performed a bedside laparotomy, opening up Patient A's surgical incision in the ICU. He found no evidence of surgical bleeding, but observed diffuse oozing. M.F. attempted to resuscitate Patient A with multiple rounds of cardiopulmonary resuscitation (CPR) and other lifesaving measures. Patient A was pronounced dead at 1653.

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

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

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[22] A cholecystectomy is the surgical removal of the gallbladder.

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

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

repeated esophagogastroduodenoscopies (EGDs)[25] and attempts at balloon dilation of the pylorus;

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

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

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

Patient B

37. On or about October 3, 2017, Respondent saw Patient B, then a fifty-two-year old male, for abdominal bloating and pain that he had been experiencing for the past three months. Patient B's symptoms included constipation, nausea, dizziness, fatigue, and significant weight loss. He had previously gone to the emergency room multiple times where labs and scans were done, with no conclusive diagnosis. Respondent ordered diet modifications, an EGD, and a colonoscopy[26] with possible biopsies.

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

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

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[25] An EGD is a diagnostic procedure to examine the esophagus, stomach, and duodenum.
[26] A colonoscopy is an endoscopic examination of the large intestine.

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

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

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

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

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

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

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[27] Ascites are the abnormal buildup of fluid in the abdomen.
[28] Ansarca is a severe form of edema with widespread subcutaneous tissue swelling.

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

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

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

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

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

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

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

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

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

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Patient C

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

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

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

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

[29] Vicryl is a type of suture.

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

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

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

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

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

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

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

Patient D

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

61. On or about November 10, 2018, Patient D returned to the hospital with complaints of abdominal pain, nausea, and vomiting. The original surgeon, T.N., M.D., saw Patient D on or about that day and recommended a HIDA scan[31] to rule out a leak.

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

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

62. T.N., M.D., was going on vacation and asked Respondent to cover Patient D's treatment and care. On or about November 11, 2018, Respondent saw Patient D. Respondent noted that the HIDA scan and a CT scan showed a post-operative bile leak, although an ERCP[32] did not show the source of the leak. Respondent ordered a MRCP.[33] His documented plan was for a laparoscopic, possibly open, drainage of the biloma, possible common bile duct exploration, and possible "hepatojejunostomy."[34]

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

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

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

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

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

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

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

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

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

Patient E

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

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

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

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

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

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[36] Hypercalcemia is a condition in which there is too much calcium in the blood.
[37] Bradycardia is a slow heart rate.
[38] Respondent likely meant hyperparathyroidism, or overactive parathyroid glands which create an excess of hormone.
[39] An adenoma is a benign tumor formed from glandular structures in epithelial tissue.

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

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

74. On or about October 19, 2018, Respondent examined Patient E. Respondent noted that pathology showed that the right parathyroid adenoma had been excised. He noted, however, that Patient E's calcium and PTH[40] levels remained high. Respondent referred to the 1.9 cm area from the neck CT and wrote that it was likely seroma or fluid that had collected from the surgical procedure. Respondent's plan was for a surgical exploration of the left parathyroids with possible parathyroidectomy. Respondent failed to document whether he discussed the risks, benefits, and alternatives to surgery with Patient E.

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

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

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

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

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

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

Patient F

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

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

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

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

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

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

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

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

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

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

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

88. On or about December 15, 2018, an x-ray of Patient F's abdomen showed possible post-operative ileus[41] and early complete or partial small bowel obstruction.

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

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

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

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

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

93. On or about December 27, 2018, Patient F returned to the hospital. Patient F complained of foul-smelling discharge from his surgical wound site. A CT scan of Patient F's abdomen showed a prominent right parastomal herniation of the small bowel and colon through a colostomy with contiguous induration[42] of the mesentery. Patient F was admitted to the hospital.

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

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

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[42] Induration is an increase in the fibrous elements in tissue commonly associated with inflammation.

[43] Respondent likely meant "plastered."

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

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

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

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

Patient G

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

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

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

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[44] Cholecystitis is inflammation of the gallbladder.

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

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

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

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

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

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

2. Revoking, suspending or denying approval of Respondent Obaida Batal, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Obaida Batal, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: FEB 0 9 2021

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