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

In the Matter of the First Amended Accusation Against: James Peng Guan Ooi, M.D. Physician's and Surgeon's Certificate No. C 39127 Respondent.	Case No.: 800-2018-045566

DECISION

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

This Decision shall become effective at 5:00 p.m. on June 27, 2022.

IT IS SO ORDERED: May 26, 2022.

MEDICAL BOARD OF CALIFORNIA

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

BEFORE THE
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DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the First Amended Accusation Against:

JAMES PENG GUAN OOI, M.D., Respondent

Agency No. 800-2018-045566

OAH No. 2021080314

PROPOSED DECISION

Tiffany L. King, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on February 14 through 17, 2022, via videoconference, from Sacramento, California.

Ryan J. McEwan, Deputy Attorney General, represented William Prasifka (complainant), Executive Officer of the Medical Board of California (Board).

D. Marc Lyde, Attorney at Law, represented James Ooi, M.D. (respondent).

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on February 17, 2022.

FACTUAL FINDINGS

Jurisdictional Matters

1. On March 17, 1980, the Board issued Physician's and Surgeon's Certificate No. C39127 (license) to respondent. The license is in full force and effect and will expire on August 31, 2023, unless renewed.

2. On June 10, 2021, complainant, in his official capacity, made and served an Accusation seeking to discipline respondent's license alleging he committed gross negligence and repeated acts of negligence, and failed to maintain adequate and accurate records. The allegations arise from the care and treatment of Patient A[1] over the course of six visits between 2015 and 2017. Specifically, complainant alleges respondent failed to conduct an appropriate follow-up evaluation of Patient A after his chest x-ray results were inconclusive, failed to properly supervise the family nurse practitioner who was also treating Patient A, and failed to maintain adequate and accurate records regarding the same. Respondent timely filed a Notice of Defense.

Respondent's Background & Practice

3. Respondent was born in Penang, Malaysia. In 1970, he emigrated to Canada. He graduated with a Bachelor of Science in biochemistry from the University of Toronto in 1972, and earned his medical doctorate from the same school in 1977. Respondent then completed a combined internship and surgical residency at Montreal General Hospital from 1977 to 1978. He next worked at a few rural clinics in Ontario

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[1] To maintain his privacy, the confidential patient is referred to as Patient A.

before moving to San Diego, California, where he worked in private practice for 17 years. Respondent was board-certified in family medicine from 1995 to 2000; he has not renewed his certification.

4. In 1997, respondent moved to Corning and opened a solo practice clinic; shortly thereafter, he opened a second clinic in Chico. He continues to work at both clinics. At the Corning clinic, respondent serves a rural population and is the only primary care physician in the area. Approximately 40 percent of his patients are privately insured while the remaining 60 percent have Medi-Cal or Medicare coverage. As required by Medicare, there is one full-time family nurse practitioner (FNP) employed by the clinic. At the Chico clinic, roughly 90 percent of the patients are privately insured. Finally, in addition to offering primary care, respondent specializes in weight loss.

5. For more than twenty years, respondent has proctored several FNP students, employing them at his Corning clinic. As part of this process, respondent developed and adopted Standardized Procedures for the FNPs in his employ. Under these procedures, the FNP's responsibilities include providing treatment and care to patients without the direct observation, supervision, or approval of a physician such as: obtaining a health history and performance of a physical examination; ordering diagnostic testing; diagnosing patient conditions and formulating a treatment plan; dispensing and furnishing medications; and, completing medical records in a timely fashion. The procedures also directed FNPs to refer patients and present cases to respondent as appropriate, including any patient condition that: exceeds the intent of the Standardized Procedures or the expertise of the FNP; fails to respond to the management plan in a timely manner; is deemed to have uncommon, unstable or

multi-system problems beyond the scope of the FNP's practice; has unexplained findings; or, requests or desires a physician consultation.

6. In the summer of 2015, respondent hired FNP Adam Strishak to work in the Corning clinic. Upon his hire, they both reviewed and signed the Standardized Procedures. This was FNP Strishak's first job as an FNP. He primarily saw patients on respondent's weight loss program and some elderly patients. FNP Strishak continued to work at the Corning clinic until November 2018. His FNP license expired on March 31, 2020, and was not renewed.

Patient A

TREATMENT AT RESPONDENT'S CLINIC

7. Patient A was a male in his seventies who established care with respondent's Corning clinic in the early 2010s. He was treated primarily for hypertension for which he took Lisinopril. He was later diagnosed with type 2 diabetes, requiring his hemoglobin A1c (HbA1c) level to be tested regularly. Patient A generally visited the clinic only when he needed a refill on his medications, and was frequently reluctant to have his HbA1c tested. On his visits, he would be seen by FNP Strishak, respondent, or both.

8. On July 14, 2016, Patient A was seen by FNP Strishak after falling from a ladder. At this visit, he weighed 167 pounds and had a body mass index (BMI) of 26.95. Patient A reported a sharp pain on his left side when he coughed. FNP Strishak ordered a chest x-ray to rule out a rib fracture. He also ordered a blood test for HbA1c and a chemistry panel.

9. On July 15, 2016, the radiologist interpreted the chest x-ray as follows:

> LUNGS: The lungs are well expanded without consolidation. There is some minimal patchy density at the right midlung field, not definitely identified on lateral view. Finding could represent pulmonary vascularity although underlying mass/consolidation cannot be excluded. No comparisons are available to assess change/debility of this finding.

The radiologist then made the following impression:

> Indeterminant ovoid hazy density in the right midlung field medially. Recommend clinical correlation and follow-up. Finding could represent an underlying mass versus evolving infiltrate versus other.

Shortly thereafter, respondent reviewed the x-ray results and handwrote the word "scan" on the document to indicate he wanted to order a computerized tomography (CT) scan for Patient A.

10. On July 27, 2016, Patient A returned to the clinic to review the x-ray results. Both respondent and FNP Strishak were present, the latter acting as a scribe only. At this visit, Patient A weighed 166 pounds and had a BMI of 26.79. He reported his rib pain symptoms had lessened. Respondent then read the x-ray results to Patient A, noting the finding of the ovoid hazy density which he explained "could be something [or] ... could be nothing." Respondent did not mention the mass could be cancerous as he did not want to "scare" the patient unnecessarily. Patient A agreed to return in three months for a repeat chest x-ray to compare to the original x-ray. FNP Strishak documented the following into the electronic health record (EHR):

> Patient is here for labs and x-ray results. Patient states that his rib pain on his left side is going away. Patients last HbA1c was 6.0, will repeat the HbA1c in 3 months. No pleural effusion and no rib fracture on x-ray, he does have an accidental finding of ovoid hazy density in right midlung medially, he does not smoke, will repeat the chest x-ray in 3 months.

11. On October 11, 2016, Patient A returned to the clinic to see FNP Strishak for a flu shot. Respondent was not present at this visit. FNP Strishak noted Patient A's weight was 165 pounds (loss of one pound) and his BMI was 26.63. Patient A told FNP Strishak he did not want a repeat x-ray because he no longer had pain in his ribs from the fall. He also refused the recommendation to do a repeat HbA1c test. After the visit ended, FNP Strishak told the medical assistant that respondent needed to see Patient A as soon as possible. He later informed respondent that Patient A had refused the repeat chest x-ray. Respondent did not contact Patient A concerning his refusal of the repeat x-ray. Instead, he directed FNP Strishak to document the refusal in the medical chart, which FNP Strishak did. Thereafter, neither respondent nor FNP Strishak took any further steps to investigate the lung shadow on the x-ray.

12. On April 17, 2017, Patient A returned to the clinic for a follow-up visit with FNP Strishak regarding his hypertension. In the medical chart, FNP Strishak noted Patient A has lost two pounds and his blood pressure is normal.

13. On November 1, 2017, Patient A had a follow-up visit with FNP Strishak regarding his hypertension and diabetes. In the medical chart, FNP Strishak noted Patient A has lost six pounds since his last visit. This was Patient A's final visit with respondent's clinic.

SUBSEQUENT MEDICAL TREATMENT

14. On April 23, 2018, Patient A underwent x-ray imaging at another medical clinic. The x-ray findings state: "Lungs demonstrate 5.4 cm right perihilar mass. Heart is unremarkable. No acute osseous abnormality." The impression states: "Right perihilar mass, likely neoplasm. Recommend CT to evaluate definitively."

15. On April 24, 2018, Patient A underwent a CT scan, which showed a right lower lobe mass in the lung. A biopsy confirmed squamous cell cancer in the right lower lung. A subsequent positron emission tomography (PET) scan showed metabolic active lymph nodes. On May 18, 2018, Patient A underwent a right bilobectomy, right complete pneumonectomy, and lymph node dissection. The postoperative diagnosis was Stage IIB non-small cell lung cancer.

16. Following these procedures, Patient A continued to receive cancer treatment, including chemotherapy. Ultimately, on August 30, 2019, Patient A died. According to his death certificate, the immediate cause was non-small cell lung cancer. Other contributing conditions included bone metastases, lung metastases, and chronic obstructive pulmonary disease.

Board Investigation

17. On June 21, 2018, the Board received a telephone complaint from Patient A's daughter, M.H.,[2] alleging that respondent did not inform Patient A of the mass in his right lung as shown on the July 2016 x-ray or further evaluate his recurrent cough.

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[2] To protect her privacy, the daughter is identified by her initials only.

The Board opened an investigation, obtained copies of Patient A's medical records, and conducted interviews including with M.H., FNP Strishak, and respondent.

18. On April 2, 2019, respondent submitted a written response to the consumer complaint, asserting that Patient A never reported having a cough as alleged by his daughter. Respondent recounted the July 27, 2016 visit with Patient A as follows:

> I think I may have recommended a CT scan when the first chest [x-ray] showed the vague shadow, but it was not documented by the FNP in his notes though we saw the patient together, as we remembered it. The 3 months (*sic*) follow up of the chest may have been a compromise when the CT scan was suggested to the patient and he had refused. But again this was not documented by the FNP in the notes.

Respondent further contends, during that same visit, he had warned Patient A the lesion could be serious. Patient A agreed to the follow-up chest x-ray, but changed his mind and refused it at the October 11, 2016 visit. Respondent described Patient A as a challenging patient, one who was "always playing down his symptoms, and tests, even the blood test was always considered a big bother by him." Respondent continued:

> [Patient A] is the kind of person who does not want much done to him. He would be contented if we would simply refill his medication without making him come in for follow up blood test. I have experienced many such patients and have refused to refill their medications may time [*sic*] unless

> they come in to be seen.... [Patient A] generally would call for refills without being seen.

19. On May 5, 2020, FNP Strishak was interviewed by the Board investigator by telephone. FNP Strishak stated he did not see Patient A very often, mostly for diabetes screenings. FNP Strishak remembers respondent noted the abnormality on the x-ray, and on July 27, 2016, respondent and FNP Strishak met with Patient A together. FNP Strishak recalled the discussion at that appointment as follows:

> As far as I can remember, [respondent] said to [Patient A] this could be a shadow, it may not be what you think it is. You have the option to come back in to see the imagery. The patient didn't seem very alarmed. He didn't want his A1c checked very often. I didn't see him very often, [respondent] saw him. I think the patient was finally told to come back.

Later during the same interview, FNP Strishak reiterated:

> I recall [respondent] stated to him exactly what was in the imagery that there may be something there. He said it may be a shadow, may be nothing or may be something. At any rate, come back and repeat the imagery.....I don't know if [Patient A] was very concerned.....[Respondent] read off in front of [Patient A] the results [of the x-ray].

FNP Strishak could not recall whether he or respondent asked Patient A about symptoms such as a persistent cough or chest discomfort on his right side. FNP

Strishak believes respondent read the x-ray results to Patient A and said that the shadow could be a tumor or mass.

When FNP Strishak saw a patient, he would write a chart note and then had respondent review his note. When a patient refused to follow his instructions, FNP Strishak would chart the same and then notify respondent. Respondent always told him to "document, document, document" but FNP Strishak preferred to discuss each patient with respondent before charting a visit.

20. On March 10, 2021, respondent was interviewed by the Board investigator by videoconference. Respondent remembers reviewing the x-ray results. He handwrote the word "scan" on the paper, indicating he would recommend ordering a CT scan to further investigate the abnormal finding. When he met with the patient on July 27, 2016, he went over the x-ray results and recommended a CT scan which the patient refused. Ultimately, they "compromised" and agreed to a repeat x-ray after three months. When asked what possibilities they discussed regarding the abnormal finding, respondent answered:

> Now, I don't like to tell patients – uh – you know, that – uh – it is a cancer or malignancy right away because if it turns out not to be, then the patient is going to be very mad at me. But I always tell them that it is significant. That it may be something significant. That it has be followed up with a more specific x-ray or a specific procedure.

Concerning the July 27, 2016 visit with Patient A, respondent explained:

> Now, if on [*sic*] July 2016, I had said to him, this is a cancerous lesion, I may have been wrong. And to try and

> scare a patient this way, he may go the other way and accuse me of, you know, wanting to do a – a bunch of unnecessary stuff.

21. Respondent conceded FNP Strishak's documentation of the July 27, 2016 visit was lacking. There is no notation regarding respondent's recommendation of a CT scan, Patient A's refusal of the same, or the "compromise" to repeat the x-ray in three months to see if there were any changes. Had those facts been documented, respondent contended it "would be more proof that the patient delayed his own diagnosis" and "we would not be here." Respondent did not believe a pulmonary exam or referral to a specialist was warranted at that time because the purpose of the visit was to review the x-ray results only.

22. When Patient A subsequently refused to get a repeat x-ray, respondent noted he directed FNP Strishak to document the refusal. He did not believe any further action was necessary, explaining he had already advised Patient A that the abnormal finding may be "significant" and he could not force the patient to have a repeat x-ray. When asked about the six-pound weight loss noted during the November 1, 2017 visit, respondent explained Patient A had been actively trying to lose weight to manage his diabetes. He did not believe there was any correlation between the weight loss and the mass on the x-ray. Ultimately, respondent placed the blame for the delayed diagnosis "squarely on the patient" when he refused the repeat x-ray on October 11, 2016.

FNP Strishak's Testimony

23. FNP Strishak testified at hearing. He previously discussed the case with respondent before respondent's Board interview and again a few days before the hearing in this matter.

24. At hearing, FNP Strishak did not recall very much about the July 27, 2016 visit with Patient A as it was almost six years ago. He remembered respondent recommended getting a second x-ray, but could not specifically recall if respondent recommended a CT scan first. Patient A was quiet at the appointment. FNP Strishak does not recall the patient "outright disagreeing" with respondent, but at some point, he stated he felt fine. No pulmonary examination was performed, and FNP Strishak could not recall if respondent asked the patient about respiratory symptoms. Had Patient A reported any such symptoms, FNP Strishak would have documented them.

Respondent's Testimony

CARE AND TREATMENT OF PATIENT A

25. When confronted with an unexpected mass on imaging, respondent explained his custom and practice is to ask the patient if they have a previous x-ray to compare with the present one. He would then offer a CT scan or a follow-up chest x-ray in three months, if the patient declined the CT scan. Respondent would expect to see a change in the imaging in that time if the mass is malignant. If there is no change after three months, then the mass is most likely benign. Respondent explained that while the CT scan is the "gold standard" of imaging, sometimes an x-ray is the only option due to the availability of insurance coverage.

26. Respondent remembered Patient A and his character very well, describing him as someone who "dictated his own care" and was "noncompliant with anything he thinks is superfluous or unnecessary." Patient A used the clinic primarily to refill his medications and was reluctant to come in for an in-person visit every six months as is respondent's protocol for refilling medications. Although Patient A

qualified for a free annual physical under Medi-care, he never took advantage of it; instead, he opted to travel to Mexico for physical examinations.

27. When respondent learned Patient A had refused the repeat scan, he was not surprised because it consistent with the patient's past refusals to follow medical advice, such as testing his HbA1c or getting a CT scan. It was not necessary to "badger" the patient about repeating the x-ray because such tactics would not change the patient's mind. Had Patient A later presented to the clinic with symptoms possibly associated with cancer – such as shortness of breath, difficulty breathing, or coughing – respondent may have revisited his recommendation for a CT scan or repeat x-ray. However, Patient A presented with no such symptoms and stated he was in good health.

MEDICAL RECORD-KEEPING

28. Respondent explained he has worked in hospitals and clinics larger than his current practice and there is a difference in the level of documentation. At large hospitals and clinics, charting usually consists of a long and thorough dictated note because other physicians will be reading and relying on it. By contrast, charting at a private or solo practice is generally done for the benefit of the treating physician alone. At his two locations, respondent is concise and precise in his charting and has developed his own style that lets him recognize what had occurred previously.

29. Respondent did not review or sign off on FNP Strishak's charting immediately after Patient A's visits. If he had reviewed them, he likely would have supplemented the notes with additional details. Respondent had previously counseled FNP Strishak concerning the sparsity in his charting, noting it was an area where improvement was needed. Nonetheless, he maintained FNP Strishak's charting after

the July 27, 2016, and October 11, 2016 visits was sufficient because respondent knew he himself had counseled Patient A on the x-ray findings and importance of doing follow-up imaging.

30. At hearing, respondent also admitted he did not immediately sign some of his charts for Patient A's visits in 2014 and 2015; rather, he signed them years after the fact. For example, chart notes were entered for visits on November 7, 2014 and November 17, 2014, but respondent did not electronically sign the notes until 2018. A chart note entered for a visit on April 1, 2015 was not electronically signed by respondent until March 2017. And, a chart note entered for a visit on April 29, 2014 was not electronically signed by respondent until May 25, 2020.

31. Respondent explained he has had three different electronic health record (EHR) programs since 2014. When he first began using EHRs, he did not sign off on many of the charts. His current program, Office Ally, auto-populates all of the unsigned charts every time he opens a document for that patient, mixing old charts with present ones. As a result, respondent is "now doing a little at a time to finish up all the singing and to get rid of the automatic population of documents." The EHR lists whatever date he electronically signed the chart. Now, respondent has the FNP type in what he says immediately, like dictation, and also write "seen with Dr. Ooi" at the top of the page in the EHR note.

FINANCIAL IMPACT

32. After the Accusation was filed, respondent was contacted by insurance providers, Health Net and Anthem Blue Cross, informing him that each company was conducting its own investigation into the allegations regarding Patient A. Respondent

believes if his license is disciplined and placed on probation, it is likely these insurance carriers will cancel his contract.

Should respondent lose the ability to bill private insurance companies, it would have a devastating impact on his Chico office, as 90 percent of his patients have private insurance. In Corning, 40 percent of his current patients could no longer see him as a primary care provider.

33. Respondent firmly believes his clinical management of Patient A's case was within the standard of care, though the documentation could have been better. He requested an evidentiary hearing to seek dismissal of the Accusation because of the potential financial impact to his practice and black mark on his license, when he believes he did nothing wrong.

Expert Witnesses

BOARD EXPERT - RAMAN VERMA, M.D.

34. Dr. Verma practices internal medicine at his own medical office in Visalia, and serves as a medical consultant for a bariatrics surgical group in Fresno. He completed his undergraduate education in pre-medicine at S.D. College, Barnala in 1981, and in modern medical science at the University of Delhi, Maulana Azad Medical College in 1987. He then completed his medical degree and three-year internal medicine residency at the Institute of Medical Education and Research, Chandigarh, India in 1992. After immigrating to the United States in 1994, Dr. Verma completed a one-year internship and two-year pediatrics residency at the Medical College of Ohio, Toledo. Dr. Verma became licensed to practice in California in 1999. He is board-certified in internal medicine and obesity medicine. Prior to owning his own practice,

Dr. Verma worked as the medical director for several correctional facilities and a medical center in Ohio, and practiced at a family clinic in California.

35. Complainant retained Dr. Verma to review respondent's care and treatment of Patient A. Dr. Verma reviewed documents including: the consumer complaint; respondent's medical records for Patient A; Patient A's medical records from subsequent providers; Patient A's death certificate and obituary; respondent's statements and interview transcript with the Board; and respondent's standardized procedures for FNP Strishak. He prepared a written report of his findings, dated March 30, 2021. On January 12, 2022, Dr. Verma prepared a supplemental report after reviewing additional materials including the Board's investigation report and the written report of respondent's expert, Richard Andolsen, M.D. Dr. Verma testified at hearing consistent with his reports.

36. Dr. Verma defined the standard of care as the level of skill and knowledge ordinarily possessed and exercised by a reasonably careful and prudent physician in diagnosing and treatment of similar cases in similar circumstances. Negligence is a simple departure from the standard of care. Gross negligence is an extreme departure or the want of even scant care.

Follow-Up on Lung Shadow and Documentation

37. When presented with a lung shadow on an x-ray, Dr. Verma explained the standard of care requires a primary care physician to order a CT scan to investigate the cause of the abnormality, and also to explain to the patient the severity of the consequences of not evaluating the finding further. In the instant case, a CT scan was particularly appropriate because Patient A was elderly and "continued to have cough

and weight loss."[3] Instead, after noting the shadow in the right lung, respondent recommended a repeat x-ray in three months, which the patient ultimately refused. At no time was a pulmonary examination performed or the patient asked about any respiratory symptoms. Nor was there any documentation that Patient A refused the repeat chest x-ray, or that he was advised of the risks of not further investigating the lung shadow. Dr. Verma opined that respondent's failure to be "more diligent" by not ordering a CT scan, not performing a pulmonary exam or inquiring as to respiratory symptoms, and not explaining "to the patient clearly the risks of missing a cancer if they do not follow up with additional studies" constituted an extreme departure from the standard of care.

38. Following his initial report, complainant asked Dr. Verma to assume respondent's statements to Board investigators (i.e., that he had recommended a CT scan which Patient A refused) as true, and whether that would change his opinion in any way. In a supplemental report, dated January 12, 2022, Dr. Verma noted his opinion that respondent had committed an extreme departure from the standard of care did not change even if respondent's statements at his Board interview were truthful. Dr. Verma explained, there was no documentation of whether respondent explained all the possibilities the lung shadow could be, as well as no documentation of respondent recommending the CT scan, Patient A refusing it, or a compromise of a repeat x-ray reached. Dr. Verma continued:

> Quite often in our profession patient refused the medical advice and the care but it also depends on how the doctor

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[3] On cross-examination, Dr. Verma admitted there was no documentation in the medical record that Patient A had experienced a cough.

> or the provider presents the symptoms to them. If the doctor downplays the symptoms or a finding the patients tends to do the same .....[T]he burden is on the doctor to explain that it can be a potentially very serious problem and emphasized (*sic*) to the patient about the consequences of not following up.
>
> [¶] ... [¶]
>
> [T]he deviation of care in this matter is due to not documenting anything what they have claimed that they told the patient. According to [respondent's] letter dated 4/2/2019, he is not certain and he wrote he may have recommended a CT scan. But it was not documented by his nurse practitioner. He also mentioned that the repeat chest x-ray may have been a compromise but again it was not documented. So without documentation it is now who said what which nobody can determine without documentation.

Failure to Supervise FNP

39. Dr. Verma pointed out the Standardized Procedures for FNPs requires an FNP to consult with respondent as necessary and respondent is to review 10-percent of the FNP's charts. Here, FNP Strishak ordered the initial chest x-ray which was reviewed by respondent. However, based on the lack of documentation, neither respondent nor FNP Strishak ensured there was a follow-up x-ray or CT scan. Dr. Verma opined this was a simple departure from the standard of care as both FNP

Strishak and respondent failed to follow up on the abnormal x-ray finding, and in turn, respondent failed to properly supervise FNP Strishak.

RESPONDENT EXPERT - RICHARD ANDOLSEN, M.D.

40. Dr. Andolsen earned a bachelor's degree in philosophy from the University of Dayton in 1968, and a bachelor's degree in chemistry from California State University, Sonoma in 1971. He completed his medical degree from the University of California School of Medicine in San Francisco in 1975. Dr. Andolsen has been board-certified in family medicine since 1978, and has run his own private practice in Healdsburg for 42 years. He treats patients of all ages, from infants to seniors. Dr. Andolsen is also on the clinical faculty at the University of California, San Francisco, instructing and training nurse practitioners. He has reviewed over 100 medical legal cases, including over a dozen Board matters.

41. Respondent retained Dr. Andolsen to conduct a review of documents and provide an opinion as to whether respondent's care and treatment of Patient A was within the medical standard of care for a family practice doctor. Dr. Andolsen reviewed multiple documents provided by respondent, including the Accusation, consumer complaint, Patient A's medical records, the Board's investigation report, respondent's statements and the transcript of respondent's interview with the Board. On December 7, 2021, Dr. Andolsen issued a Report, finding respondent did not depart from the standard of care at any time during his treatment of Patient A following the abnormal results from the chest x-ray. Dr. Andolsen testified at hearing consistent with his report.

42. At the outset, Dr. Andolsen disagreed with Dr. Verma that the issue at the heart of this matter is the failure to follow up on a chest x-ray abnormality; rather, the

issue is "how does a physician deal with a patient who refuses to follow medical advise (*sic*) when there may be serious consequences of that refusal." In the latter instance, Dr. Andolsen explained the standard of care requires a physician to "respectfully and collaboratively" deal with the patient's refusal, explain the consequences in understandable terms, and respect the patient's decision.

43. Dr. Andolsen found the handwritten "scan" on the x-ray results denotes respondent's intent to recommend Patient A get a CT scan. Based on the chart notes, Board interviews, and respondent's written statements, Dr. Andolsen concluded respondent reviewed the abnormal x-ray results with Patient A, recommended a CT scan which the patient declined, and reached a "compromise" to have a repeat chest x-ray. Patient A ultimately refused to submit to a repeat x-ray. Dr. Andolsen noted, "[d]ealing with a difficult patient requires the ability to compromise and, form a collaborative decision ... It is humbling for a physician to realize that he cannot change a patient's mind and acknowledge he has the right to make a bad decision." Noting Patient A's history as a difficult patient, Dr. Andolsen deduced he was a man who valued his autonomy and independence, saw "himself as tough and a fighter," and had difficulty accepting that something may be wrong.

44. Dr. Andolsen opined respondent provided appropriate clinical follow up on the chest x-ray, and properly dealt with a noncompliant patient. He disagreed with Dr. Verma's suggestion that respondent or FNP Strishak should have "taken [Patient A] to task" each time he refused to undergo further imaging, arguing it is unrealistic to go over every possible outcome and doing so only scares the patient.

45. Dr. Andolsen also disagreed with Dr. Verma's opinion that respondent's documentation deviated from the standard of care, explaining there is a different standard of care for solo practices than hospitals. Medical records at a hospital or

multi-person practice serve two purposes: a record of ongoing care; and, a means of communicating to other providers. However, a solo practitioner knows his patient and background, and therefore, is not required to document as much detail.

RESPONDENT EXPERT - RICHARD JOHNSON, M.D.

46. Dr. Johnson completed his Bachelor of Science in physics in 1973 at the University of Washington, before earning his Medical Degree from Washington University School of Medicine, St. Louis, Missouri in 1977. Dr. Johnson thereafter completed a three-year residency in family medicine at the University of California, Los Angeles (UCLA) Medical Center. In 1978, he became licensed to practice medicine in California. He is board-certified in family practice. In 1980, he joined the family medicine faculty at UCLA, serving as a director for clinical services and the residency program for 20 years. He has been a family physician in an office-based practice for more than 40 years. Currently, Dr. Johnson practices family medicine with the Pacific Palisades Medical Group and simultaneously provides clinical direction to rotating UCLA medical students and residents. He has held administrative and committee positions, presented and led workshops at medical conferences, and published in peer-reviewed journals in the area of family medicine.

47. Respondent retained Dr. Johnson to conduct a review of documents and provide an opinion as to whether respondent's care and treatment of Patient A was within the medical standard of care for a family practice doctor. Dr. Johnson reviewed multiple documents provided by respondent, including the Accusation, consumer complaint, Patient A's medical records, the Board's investigation report, respondent's statements and the transcript of respondent's interview with the Board. On January 8, 2022, Dr. Johnson issued a Report, finding respondent did not depart from the standard of care at any time during his treatment of Patient A and that his medical

documentation was sufficient. Dr. Johnson testified at hearing consistent with his report.

48. Dr. Johnson defined the standard of care as "the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians of the same specialty would carry out under the same or similar circumstances." However, he explained that the standard of care is a spectrum and that two physicians can approach the same problem differently and both can still be appropriate. Hence, "the standard of care allows for the range of clinical practices and judgments that would represent a spectrum of care that could be observed within a large group of reasonable, prudent and careful physicians for any given similar patient encounter." Dr. Johnson defined simple negligence as occurring "if in a given episode of care, a physician's care and treatment substantially deviates from the care that could be observed within a large group of reasonable, prudent and careful physicians managing a similar episode of care." In comparison, "[g]ross negligence is care below that standard of care that is characterized as the lack of even scant care."

49. When presented with a newly found chest x-ray abnormality, Dr. Johnson explained the standard of care requires a physician to do one of the following: compare it to an older x-ray to evaluate the temporal course of the abnormality, retrospectively; repeat the x-ray to evaluate the temporal course of the abnormality, prospectively; obtain a CT scan to evaluate the abnormality more directly; or refer the patient to a pulmonologist or chest surgeon.

50. When respondent met with Patient A on July 27, 2016, he did not yet know the etiology of the abnormality, which could be something benign to something more concerning, such as cancer. Dr. Johnson noted, in such a situation, the standard of care requires the physician to inform the patient of the significance of the need for

follow-up. This does not mean the physician must describe "every possibility imaginable and the consequences of noncompliance with the physician's advice." Nor, he continued, does it require "defensive medical record discourse including all the potential diagnostic possibilities and consequences thereof." Here, Dr. Johnson opined, Patient A's agreement to do a repeat x-ray in three months demonstrates that he was aware of the significance of the abnormal finding.

Dr. Johnson opined respondent's care and treatment following the abnormal x-ray was within the standard of care. Once respondent identified the abnormality and made his recommendation to the patient, and patient refused it, the standard of care has been met. If at any point Patient A exhibited pulmonary symptoms which correlated with a possible malignancy, such as a persistent cough or shortness of breath, then a different approach would be required. However, there was no evidence in the record or other documents reviewed that Patient A reported any such symptoms, and respondent was under no obligation to inquire about them. For these same reasons, Dr. Johnson also found nothing in the records, testimony or the Board investigation that demonstrated respondent's supervision of FNP Strishak was inadequate.

51. Finally, Dr. Johnson noted there is no definitive standard of care for medical record-keeping, and "there is a large variety of ways to record it." In a small or solo practice, there is less need for the next provider to understand what occurred during a visit because the patient will likely be seeing the same doctor. In this case, Dr. Johnson opined the documentation of Patient A's treatment and care met the standard of care, noting that a reasonable reviewer would conclude, based on the medical record, that respondent had discussed with Patient A getting a CT scan and the need to follow up on the abnormality.

Character Evidence

SUPPORT LETTERS

52. Respondent submitted a dozen character letters from colleagues and long-time patients alike. The letters generally describe respondent as a competent, caring, and honest physician. However, there is no indication in any of the letters that the authors are aware of the allegations against respondent in the instant matter. Thus, they are afforded only minimal weight.

STATEMENTS AGAINST INTEREST - TEXT MESSAGES WITH FNP STRISHAK

53. On cross-examination, respondent admitted communicating with FNP Strishak extensively by text message regarding the care and treatment respondent provided to Patient A: on March 10, 2021, shortly before respondent's Board interview; on June 17, 2021, one week after respondent was served with the Accusation; and weeks prior to this hearing on December 19, 2021 and January 31, 2022. Over the course of these communications, respondent repeatedly implored FNP Strishak to recall that respondent had recommended a CT scan before the repeat x-ray. However, FNP Strishak consistently stated that he did not recall either way, and that "[i]f it's in the chart, that's what occurred." Respondent also insisted to FNP Strishak he did not downplay the seriousness of the x-ray findings, but he "did not always frighten the patient either ... wrong thing to frighten patient." Respondent expressed frustration to FNP Strishak at the Board's allegations:

> How can we predict the vague shadow could be a cancer? We are not magician [*sic*]. They are trying to make a case that we did not impress upon him that that vague shadow

can be a cancer. If we had done that, he would not have refused repeat chest x-ray.

54. Respondent also blamed the current disciplinary action brought against his license squarely on FNP Strishak's poor note-taking: "But your documentation is usually short. I have always tried to get you to doc more"; "I wish you had documented more, especially when I had told you"; "You did not document my discussion down ... what I said to him. That is the problem now." Finally, respondent expressed concern to FNP Strishak about his potential testimony at hearing, noting it could not be inconsistent with his own:

> [January 31, 2022]
>
> FNP Strishak: I don't remember much. I told them you saw the patient and I was writing what you said. And, at that time, you read everything off the x-ray to the patient including possibility of tumor, and you told him return and repeat x-ray. Then later, I saw him and he only wanted a refill of his medication and that is all he wanted, that's all.
>
> Respondent: I thought I told him that he could have a scan, a CT scan first. He refused. I remembered he went in first. I wrote scan on chest x-ray to indicate to talk with him about a scan. Always to remind me to talk to him about a scan. You remember that I always write some notes on the x-ray or lab when there is something wrong.
>
> You did not document my discussion down or what I said to him. That is the problem now. We have to say the same

thing in our testimony. If we contradict each other, then we are hung because we did not document it down. What you just said is fine. I remember telling him that he can have a scan to better define the lesion. When he refused is when I offered him a repeat chest x-ray in three months. The fact that we read report to him, and the fact that you wrote down word for word what was said on report is important to show that he is aware that it might be a mass tumor. In your testimony, you said that I read the report and used the word tumor. . . .

Our only chance from the documentation is that you document the exact words of the report and that you document he refused the repeat chest x-ray. But if you had documented that you again told him that the lesion may be a tumor, or even mention the word cancer, we would be in a better position.

FNP Strishak. I don't remember that.

Matters in Aggravation

55. Effective October 12, 1990, in a prior disciplinary action (Board Case No. D-3567), respondent's license was revoked, the revocation stayed, and the license placed on probation for five years. The underlying Accusation alleged respondent committed gross negligence, repeated negligent acts, and incompetence based on abortions he performed on two patients which resulted in the patients' hemorrhaging.

Respondent successfully completed probation. He was not subject to further disciplinary action until the instant Accusation.

Analysis

56. It is well settled that the standard of care for physicians is the reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.) Importantly, a medical professional is held to the standard of care in his or her own "school" or specialty. Specialists are held to that standard of learning and skill normally possessed by such specialists in the same or similar locality under the same or similar circumstances. (*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Proof of this standard is ordinarily provided by another physician. (*Brown v. Colm, supra*, 11 Cal.3d at p. 643.)

57. Drs. Verma, Andolsen, and Johnson are all highly qualified members of the medical community, but their opinions in this matter are at odds on every issue. In resolving the conflicts in their testimony, Dr. Verma's opinions must be weighed against those of Drs. Andolsen and Johnson and the evidence presented at hearing. Differences between experts' opinions go to the weight of the evidence. (*In re Marriage of Duncan* (2001) 90 Cal.App.4th 617, 632.) In doing so, consideration must be given to the qualifications and persuasiveness of each witness, the reasons for each opinion, and the factual basis of their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

58. The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) In addition, a fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

FOLLOW-UP ON LUNG SHADOW

59. Complainant alleges respondent made an extreme departure from the standard of care when he: (1) did not recommend a CT scan to further investigate the abnormal x-ray; (2) did not adequately discuss the serious possibilities presented by the mass, including cancer; and (3) did not explain the risks of not investigating it further after Patient A declined the repeat x-ray.

60. The opinions of Drs. Andolsen and Johnson that respondent acted within the standard of care were based on the belief that respondent had, in fact, recommended the CT scan at the July 27, 2016 visit, which Patient A then refused. However, the evidence does not bear this out. First, there is nothing in the record that documents Patient A was ever advised to obtain a CT scan. Second, FNP Strishak consistently maintained he could not recall whether or not respondent recommended

a CT scan: at his Board interview, in pre-hearing text communications with respondent, and in his hearing testimony. Rather, FNP Strishak stated, "[i]f it's in the chart, that's what occurred." Third, early on, respondent's recollection of the July 27, 2016 visit was equivocal at best. He repeatedly stated he "may have" recommended a CT scan, but blamed FNP Strishak for not documenting it. Later, he insisted that he must have recommended it because he wrote "scan" on the x-ray report. However, intending to recommend a course of action does not prove that respondent actually recommended it to the patient. For these reasons, it was established by clear and convincing evidence that respondent did not recommend Patient A have a CT scan at the July 27, 2016 visit.

61. Further, Dr. Johnson opined that a CT scan was not necessary and a repeat x-ray was sufficient to follow-up on the lung shadow unless and until the patient exhibited pulmonary symptoms which correlate with a possible malignancy, such as a persistent cough or shortness of breath. Because there were no such symptoms listed in the medical chart, and FNP Strishak and respondent stated Patient A did not complain of any, Dr. Johnson assumed Patient A was asymptomatic and respondent was not required to pursue any additional symptomology. In fact, Patient A was never asked if he had experienced any pulmonary symptoms nor told to report them if he did, nor was a pulmonary exam performed to rule symptoms out. Moreover, given Patient A's propensity to avoid medical treatment or testing, it is unlikely he would have volunteered that he had any respiratory symptoms; thus, it was incumbent upon respondent or FNP Strishak to look for and evaluate any subjective or objective symptoms consistent with the impressions found on the x-ray.

62. Finally, it is undisputed that respondent did nothing following Patient A's refusal to submit to a repeat x-ray at the October 11, 2016 visit. Dr. Verma's opinion that this failure was a departure from the standard of care was more persuasive than

the opinions of Drs. Andolsen and Johnson that it was not. Drs. Andolsen and Johnson appear to excuse respondent's decision not to counsel Patient A again regarding the potential serious risk of not further investigating the lung shadow on the fact that Patient A was a "difficult" patient. However, being a difficult patient cannot preclude a physician from giving appropriate medical care or treatment. In any event, the record shows that Patient A did not refuse the repeat x-ray because he was being "difficult." Rather, Patient A refused the repeat x-ray because his ribs no longer hurt after the fall. This suggests that he believed the repeat x-ray was to address his rib pain and that he did not know or understand it was to investigate the undefined mass in his lung. Thus, respondent should have met with Patient A to revisit the need for further investigation and risks of not doing so to ensure the patient's refusal was an informed one.

63. When all of the evidence is considered as a whole, Dr. Verma's opinion and testimony is credited over that of Drs. Andolsen and Johnson. Respondent's failures to follow-up constitute an extreme departure from the standard of care and repeat negligent acts.

SUPERVISION OF FNP STRISHAK

64. Given the above, respondent's supervision of FNP Strishak in the care and treatment of Patient A constituted simple negligence, or a departure from the standard of care.[4] A large part of respondent's defense is blaming FNP Strishak for not fully documenting what occurred at the July 27, 2016 visit. However, respondent admitted he did not review FNP Strishak's chart notes following the visit despite

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[4] In his expert report, Dr. Johnson incorrectly defines simple negligence as a substantial departure from the standard of care.

having previously counseled him multiple times for inadequate charting. Additionally, the Standard Procedures for FNPs dictate that an FNP should consult with respondent when a patient "fails to respond to the management plan in a timely manner" or the matter is "beyond the scope of the FNP's practice." After Patient A refused the planned repeat x-ray on October 11, 2016, FNP Strishak requested office staff to inform respondent he must contact Patient A immediately. Respondent failed to do so; instead, directing FNP Strishak to simply document the patient's refusal. Thus, respondent failed to follow his own adopted Standardized Procedures.

MEDICAL RECORD-KEEPING

65. Respondent admitted that FNP Strishak's documentation was lacking, and that he did not frequently review the FNP's medical charts after visits. In his own words, if he had made such a review, "we would not be here." At the same time, despite the lack of detail, respondent and his experts argue that his medical record-keeping meets the standard of care for a solo practitioner because respondent would know his patient's history. However, this argument is belied by the fact that respondent did not remember the specifics of his treatment and care of Patient A, including not recalling whether or not he recommended a CT scan to Patient A on July 27, 2016.

66. Respondent also admitted he did not immediately sign several of Patient A's medical charts within a reasonable time; rather, he signed many of them four or five years after the fact. Respondent's excuses about switching EHR programs multiple times and that the process is time-consuming are unavailing. For all of these reasons, respondent's medical record-keeping of the treatment and care of Patient A fell below the standard of care.

APPROPRIATE PENALTY

Ultimately, respondent's treatment and care of Patient A constitutes gross negligence, or an extreme departure from the standard of care, and repeated negligent acts. Moreover, his substandard medical record-keeping constitutes unprofessional conduct. Respondent failed to accept responsibility for his own inactions, instead placing the blame on FNP Strishak and Patient A himself. For these reasons, placing respondent's license on probation with the terms and conditions set forth in the below Order is appropriate to protect the public's health, safety, and welfare.

Costs

67. Pursuant to Business and Professions Code section 125.3, respondent may be ordered to reimburse the Board for the reasonable costs of investigation and enforcement of this matter. California Code of Regulations, title 1, section 1042, subdivision (b)(2), requires that when seeking reimbursement of costs charged to the Board by a service provider, complainant must submit cost certifications that either "describe the general tasks performed, the time spent on each task and the hourly rate or other compensation for the service" or include "copies of the time and billing records submitted by the service provider."

68. Complainant submitted a Certification of Prosecution Costs and Declaration of Ryan J. McEwan, seeking an order requiring respondent to reimburse the Board for its enforcement costs in this matter in the amount of $17,543.75. Attached to the declaration are computer printouts entitled "Cost of Suit Summary" and "Matter Time Activity by Professional Type," detailing the work performed by the

Attorney General's Office. The activities, time for each activity, and hourly rates were undisputed, and are reasonable in light of the nature and complexity of this case.

LEGAL CONCLUSIONS

1. The Medical Practices Act (Bus. & Prof. Code, § 2000, et seq.)[5] provides that "protection of the public shall be the highest priority for the Board in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

2. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This is a heavy burden and requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt, and must be sufficiently strong that it commands the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84 [citations omitted].)

3. The Board is authorized to discipline a license where the licensee has violated the Medical Practices Act. (§ 2227.) Said discipline may include revocation, suspension, placement on probation with terms and conditions the Board or an ALJ may deem proper, or issuance of a letter of reprimand. (*Ibid.*)

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[5] Unless otherwise noted, all statutory references are to the Business and Professions Code.

4. Section 2234 requires the Board to "take action against any licensee who is charged with unprofessional conduct." "Unprofessional conduct" includes, but is not limited to gross negligence and repeated negligent acts. (§ 2234, subds. (b) & (c).) "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." (§ 2234, subd. (c).) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. Unprofessional conduct also includes "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients." (§ 2266.)

Causes for Discipline

5. Cause exists to discipline respondent's license pursuant to section 2234, subdivision (b), by reason of the matters set forth in the Factual Findings as a whole. Clear and convincing evidence established that respondent engaged in gross negligence in his care and treatment of Patient A by failing to discuss and send Patient A for a CT scan on July 27, 2016 and failing to follow-up with Patient A when he refused a second x-ray on October 11, 2016.

6. Cause exists to discipline respondent's license pursuant to section 2234, subdivision (c), by reason of the matters set forth in the Factual Findings as a whole. Clear and convincing evidence established that respondent engaged in repeatedly negligent acts in his care and treatment of Patient A, and supervision of FNP Strishak.

7. Cause exists to discipline respondent's license pursuant to section 2266, by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent failed to maintain adequate and accurate records for the care and treatment of Patient A.

Level of Discipline

8. Considering the Factual Findings and Legal Conclusions as a whole, respondent's actions, or inaction, constitute cause for discipline. Placing respondent's license on probation subject to the terms and conditions set forth below is appropriate to protect the public health, welfare and safety.

Costs

9. Pursuant to section 125.3, a licensee found to have violated a licensing act may be ordered to pay the reasonable costs of investigation and prosecution of a case. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth factors to be considered in determining the reasonableness of the costs sought pursuant to statutory provisions like section 125.3. These factors include whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate in light of the alleged misconduct.

10. Complainant seeks to recover a total of $17,543.75 for the Board's prosecution costs in this matter. As set forth in Factual Finding 68, these costs are reasonable. The *Zuckerman* factors have been considered. Respondent should be ordered to pay a total amount of $17,543.75 for the Board's costs in this matter.

ORDER

Physician's and Surgeon's Certificate No C39127 issued to respondent James Ooi is REVOKED. However, the revocation is STAYED, and respondent is placed on probation for five years upon 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 40 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 65 hours of CME of which 40 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping

course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the 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 California Code of Regulations, title 16, 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 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 year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the 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 would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

4. **Notification.** Within seven days of the effective date of this Decision, respondent shall provide a true copy of this Decision and 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.

5. **Supervision of Physician Assistants and Advanced Practice Nurses.** During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

6. **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.

7. **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.

8. **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 circumstances shall a post office box serve as an address of record, except as allowed by section 2021(b).

Place of Practice. Respondent shall not engage in the practice of medicine in respondent's or a 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 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.

9. **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.

10. **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 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 Board'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 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.

11. **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.

12. **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.

13. **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 or her 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.

14. **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.

15. **Prosecution Costs.** Respondent shall pay to the Board its reasonable prosecution costs pursuant to section 125.3 in an amount not to exceed $17,543.75. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

If respondent has not complied with this condition during the probationary term, and respondent has presented sufficient documentation of his good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of respondent's probation period up to one year without further hearing in order to comply with this condition. During the one-year extension, all original conditions of probation will apply.

DATE: March 30 2022

TIFFANY L. KING
Administrative Law Judge
Office of Administrative Hearings

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
RYAN J. MCEWAN
Deputy Attorney General
State Bar No. 285595
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7548
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **JAMES PENG GUAN OOI, M.D.** **320 Solano St., Ste. A** **Corning, CA 96021** **Physician's and Surgeon's Certificate No. C 39127,** Respondent.	Case No. 800-2018-045566 OAH No. 2021080314 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First 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 March 17, 1980, the Board issued Physician's and Surgeon's Certificate No. C 39127 to James Peng Guan Ooi, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2023, unless renewed.

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JURISDICTION

3. This First Amended Accusation 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"..."

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."

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of Patient A.[1] The circumstances are as follows:

9. Respondent is a physician and surgeon who at all times relevant to this action worked at his rural health clinic in Corning, California, and his other clinic in Chico, California. During the relevant time, Respondent employed Family Nurse Practitioner (FNP) A.S. Respondent and FNP A.S. entered an agreement concerning "Standardized Procedures for Nurse Practitioners," in which Respondent agreed to serve as FNP A.S.'s supervising physician.

10. Patient A, born in September 1942, first established care with Respondent at his rural health clinic in or around 2014. Patient A first presented with hypertension and eventually with type 2 diabetes. Patient A was often seen by FNP A.S. According to the medical records provided by Respondent, Patient A was seen at Respondent's rural health clinic six times from November 12, 2015 through November 1, 2017.[2] Each visit summary is signed by FNP A.S. None of the visit summaries are signed by Respondent or document that Respondent saw Patient A.

[1] The patient's name is omitted to protect privacy. It has been provided in discovery.

[2] FNP A.S. also documented several medication refills that do not appear to correspond with office visits.

11. On or about July 14, 2016, FNP A.S. saw Patient A who had fallen from a ladder and reported left-sided sharp pain when he coughed. FNP A.S. ordered a chest x-ray to rule out a rib fracture. In addition, FNP A.S. ordered a blood test for hemoglobin A1c, and a chemistry panel.

12. The x-ray study included the following findings related to the lungs: "The lungs are well expanded without consolidation. There is some minimal patchy density at the right midlung field, not definitely identified on lateral view. Finding could represent pulmonary vascularity although underlying mass/consolidation cannot be excluded. No comparisons are available to assess change/debility of this finding." The x-ray impression states: "Indeterminant ovoid hazy density in the right midlung field medially. Recommend clinical correlation and follow-up. Finding could represent an underlying mass versus evolving infiltrate versus other."

13. On or about July 27, 2016, Respondent and FNP A.S. saw Patient A for a follow-up visit.[3] The history of present illness states: "Patient is here for labs and x-ray results. Patient states that his rib pain on his left side is going away. Patients last HbA1c was 6.0, will repeat the HbA1c in 3 months. No pleural effusion and no rib fracture on x-ray, he does have an accidental finding of ovoid hazy density in right midlung medially, he does not smoke, will repeat the chest x-ray in 3 months." The documented plan was to repeat the HbA1c and x-ray in 3 months. The patient weighed 166 lbs.

14. On or about October 11, 2016, Patient A returned to the clinic for a flu shot. The visit summary, signed by FNP A.S., states: "Patient lost 1 lb. Patient has been feeling well. He does not want to repeat the x-ray of his chest, he does not have any more pain in his ribs from the fall, patient refuses a repeat HbA1c, patients last HbA1c was 6.0% about three months ago."[4]

15. On or about April 17, 2017, Patient A returned to the clinic for a hypertension follow-up. The visit summary, signed by FNP A.S., states that Patient A lost 2 lbs. and that his blood pressure had been normal.

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[3] At a March 10, 2021 interview with Board Investigators (the "Board Interview"), Respondent stated that FNP A.S. served only as a scribe during this particular office visit.

[4] At the Board Interview, Respondent did not recall whether or not he saw Patient A at this particular visit.

16. On or about November 1, 2017, Patient A returned to the clinic for a hypertension and diabetes follow-up. The visit summary, signed by FNP A.S., states that Patient A lost 6 lbs.

17. On or about April 23, 2018, Patient A underwent x-ray imaging at another medical clinic in or around Corning, California. The x-ray findings state: "Lungs demonstrate 5.4 cm right perihilar mass. Heart is unremarkable. No acute osseous abnormality." The impression states, "Right perihilar mass, likely neoplasm. Recommend CT to evaluate definitively." Shortly thereafter, Patient A flew to Portland, Oregon, to obtain further medical treatment.

18. On or about April 24, 2018, Patient A underwent a CT scan, which showed a right lower lobe mass in the lung. Shortly thereafter, a biopsy confirmed squamous cell cancer in the right lower lung. A subsequent PET scan showed metabolic active lymph nodes. On or about May 18, 2018, at Providence St. Vincent Medical Center in Portland, Oregon, Patient A underwent a right bi-lobectomy, right complete pneumonectomy, and lymph node dissection. The post-operative diagnosis was Stage IIB non-small cell lung cancer (or greater).

19. Following the above procedures, Patient A continued to receive cancer treatment from oncologists in both California and Oregon, which included chemotherapy. Ultimately, on or about August 30, 2019, Patient A died. According to the death certificate, the immediate cause was non-small cell lung cancer, and other contributing conditions included bone metastases, lung metastases, and chronic obstructive pulmonary disease.

20. Respondent committed gross negligence in the care and treatment of Patient A by failing to provide an appropriate follow-up evaluation of the July 14, 2016 chest x-ray results.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

21. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patient A, as more particularly alleged in paragraphs 8 through 20 above, which are hereby incorporated by reference and realleged as if fully set forth herein. Additional circumstances are as follows:

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22. Respondent committed repeated negligent acts, including but not limited to:

A. Failing to conduct an appropriate follow-up evaluation of Patient A's July 14, 2016 chest x-ray results;

B. As a supervising physician, failing to properly supervise FNP A.S.; and

C. Failing to maintain adequate and accurate medical records for Patient A.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

23. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records relating to the care and treatment of Patient A, as more particularly alleged in paragraphs 8 through 22, above, which are hereby incorporated by reference and realleged as if fully set forth herein. Additional circumstances are as follows:

24. During the Board Interview, Respondent stated that, contrary to the medical records for the July 27, 2016 visit, he advised Patient A of the significance of the x-ray results and the need for further imaging, and that he advised Patient A that he needed to get a CT scan. Respondent further stated that Patient A refused the CT scan, so they compromised by agreeing to repeat the x-ray imaging in 3 months. Respondent acknowledged that the medical records did not reflect any of these points, and he stated that he did not review the visit notes.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

25. Respondent's license is subject to disciplinary action under sections 2227 and 2234 of the Code in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 8 through 24, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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DISCIPLINARY CONSIDERATIONS

26. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about October 12, 1990, in a prior disciplinary action titled *In the Matter of the Accusation Against James Peng Guan Ooi, M.D.*, before the Medical Board of California, in Case No. D-3567, Respondent's license was revoked; however, the revocation was stayed and Respondent's license was placed on probation for a period of five (5) years with certain terms and conditions.[5] The underlying Accusation alleged that Respondent committed gross negligence, repeated negligent acts, and demonstrated incompetence in his treatment of two patients. As part of the Stipulation for Settlement and Decision, Respondent admitted that he violated section 2234, subdivisions (b) and (d), of the Code. That Decision is now final and is incorporated by reference 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. C 39127, issued to Respondent James Peng Guan Ooi, M.D.;

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

3. Ordering Respondent James Peng Guan Ooi, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: JAN 19 2022

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

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[5] On or about December 7, 1992, Respondent filed a petition for termination of probation. On or about June 3, 1993, the Board, in a unanimous vote, denied the petition.