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

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| In the Matter of the Accusation Against:<br><br>Yifan Yang, M.D.<br><br>Physician's & Surgeon's Certificate No. A 109921<br><br>Respondent. | Case No. 800-2022-087489 |

## 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 July 31, 2024.

IT IS SO ORDERED: July 1, 2024.

MEDICAL BOARD OF CALIFORNIA

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

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

## In the Matter of the Accusation Against:

## YIFAN YANG, M.D., Respondent

## Agency Case No. 800-2022-087489

## OAH No. 2023100715

## PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by videoconference on May 6 through 8, 2024.

Karolyn M. Westfall, Deputy Attorney General, represented complainant, Reji Varghese, Executive Director of the Medical Board of California (board), Department of Consumer Affairs, State of California.

David Rosenberg, Attorney at Law, Rosenberg, Shpall & Zeigen, A.P.L.C., represented respondent Yifan Yang, M.D., who was present throughout the hearing.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on May 8, 2024.

## PROTECTIVE SEALING ORDER

The name of the patient in this matter is subject to a protective sealing order. No court reporter or transcription service shall transcribe the actual name of the patient but shall instead refer to the patient as Patient A, as set forth in a Confidential Names List admitted into evidence as Exhibit 20 and placed under seal. To protect privacy and confidential personal and medical information from inappropriate disclosure, a written Protective Order Sealing Confidential Records was issued. The order lists the exhibits ordered sealed and governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the order, provided that such documents are protected from release to the public.

## FACTUAL FINDINGS

### Jurisdictional Matters

1. On November 4, 2009, the board issued Physician's and Surgeon's Certificate Number A 109921 to respondent. Said certificate has been renewed with an expiration date of November 30, 2025. Respondent's certificate has a history of prior discipline as follows: On December 10, 2020, the board filed an accusation against respondent, and on February 17, 2022, a decision pursuant to a stipulated settlement became effective, which issued a public reprimand against respondent for his negligent care and treatment of two patients. The Disciplinary Order provides as follows:

IT IS HEREBY ORDERED that Respondent Yifan Yang, M.D.'s Physician's and Surgeon's Certificate No. A 109921 shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2018-040084, is as follows:

As more fully described in Accusation No. 800-2018-040084, during an abdominal surgery in 2015 you neglected to have a high index of suspicion for a possible ureter injury after being unable to identify the ureter during surgery. In addition, during holiday call coverage in 2016 you incorrectly assumed you were covering two hospitals, and agreed to perform surgeries at two different hospitals, which resulted in a patient's critical surgery being delayed at one hospital.

2. On September 12, 2023, the board filed accusation number 800-2022-087489 seeking revocation or suspension of respondent's certificate based upon three causes of discipline, all related to respondent's care and treatment of Patient A, namely: (1) gross negligence, (2) repeated negligent acts, and (3) failure to maintain adequate and accurate records, with the disciplinary consideration of the February 12, 2022, prior discipline listed above. The accusation further requested costs of investigation and enforcement.

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

## Summary of Medical Records Regarding Patient A's Medical Treatment

4. On October 18, 2018, Patient A first saw respondent in his office on a referral from Patient A's physician, Stephania Hasan, M.D., for the treatment of hemorrhoids. Respondent's medical records show that on that date, Patient A was a 64-year-old woman with symptoms related to her hemorrhoids for over two years, including anal pain, bleeding, itching, and bulge. Respondent noted that Patient A was "already on a high fiber diet and try [*sic*] OTC [over the counter] medications." Respondent also noted that Patient A had a surgical history of having a hysterectomy in 1991, and a surgery on her left foot in 2013. No other mention of surgical history was provided in respondent's medical records for that October 18, 2018, visit. Respondent noted in his physical examination findings on the October 18, 2018, visit that an anorectal exam for Patient A showed "anoderm demonstrated no abnormalities." On the rectal digital examination, respondent noted, "normal tone, no masses." On the rectal proctoscopic examination, respondent noted, "office anoscopy showed grade 3 internal and external hemorrhoids." Under his diagnosis in the October 18, 2018, medical records for Patient A, respondent wrote as follows:

> [Patient A] is a 64 year old woman that has grade 3 internal and external hemorrhoids that is causing her significant amount of symptoms. She would like to have these hemorrhoids removed. I explained to her the risk of surgery: bleeding, infection, pain, and small chance of incontinence. She understood the risk and agree [*sic*] to proceed with surgery. I also stressed the importance of high fiber diet with lots of water and good bathroom hygiene. She will

attempt to start these changes as soon as possible. I will get insurance authorization and schedule her for exam under anesthesia and hemorrhoidectomy.

5. On November 12, 2018, respondent performed a hemorrhoidectomy surgery on Patient A. In respondent's operative report he noted that he performed an anorectal examination under anesthesia, and a two column internal and external hemorrhoidectomy. Respondent noted that the hemorrhoidectomy was successfully performed, and Patient A tolerated the surgery well.

6. On November 26, 2018, Patient A was seen by respondent for a follow-up from surgery and to check her incision. In respondent's medical records for that visit, he wrote that Patient A "[c]omplains of some incisional pain. Feel like hemorrhoids are back. Some drainage." On the physical examination during that visit for rectal examination, respondent wrote, "Incision is clean with granulation tissue." Respondent further summarized this visit as follows: "Doing well post-op. Reassured patient about normal wound healing. Follow-up again in 2 weeks."

7. On December 10, 2018, Patient A was seen by respondent for a second follow-up from surgery. In respondent's medical records for that visit, he wrote that Patient A is "Doing well. Still some discharge. Pain much better." On the physical examination during that visit for rectal examination, respondent wrote, "Incision is clean with granulation tissue." Respondent further summarized this visit as follows: "Doing well post-op. Reassured patient about normal wound healing. Follow-up again in 4 weeks."

8. On January 7, 2019, Patient A again saw respondent for a follow-up visit. In his medical records for this visit, respondent wrote:

> [Patient A] is a 64 year old woman status post hemorrhoidectomy on 11/12/18 for grade 2[1] hemorrhoids. She complains of persistent anal pain and difficulty with defecation and mucus discharge. Some constipation. On bowel care.

During that visit respondent conducted a physical examination that included a rectal examination. Respondent wrote in the medical records that the anorectal examination inspection revealed, "anoderm demonstrated no abnormalities." For the rectal digital examination using his finger, respondent wrote that the digital examination revealed, "abnormal tone (Anal stenosis), no masses." Under the section of his medical records regarding his diagnosis, respondent wrote that Patient A has acquired anal stenosis, and further wrote:

> [Patient A] is a 64 year old woman that has a [*sic*] anal stenosis after hemorrhoidectomy that is causing her significant amount of symptoms. She would like to have these hemorrhoids removed. I explained to her the risk of surgery: bleeding, infection, pain, and small chance of incontinence. She understood the risk and agree [*sic*] to proceed with surgery. I also stressed the importance of high fiber diet with lots of water and good bathroom hygiene. She will attempt to start these changes as soon as possible.

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[1] Respondent testified at hearing that this note is incorrect and should state that Patient A had grade 3 hemorrhoids before hemorrhoidectomy.

> I will get insurance authorization and schedule her for exam under anesthesia, possible lateral internal anal sphinterotomy [*sic*].

Under the section of the medical records for the January 7, 2019, visit for "Plan" respondent wrote as follows:

> Risks and benefits of anorectal surgery explained. Discussed the risks and benefits of the procedure, including but not limited to: bleeding, infection, incontinence, chronic pain, recurrence were discussed. The patient understands and consents for the intended procedure.

9. On January 28, 2019, respondent performed an anorectal exam with anesthesia, and lateral anal internal sphincterotomy on Patient A as set forth in the operative note medical records. In the postoperative report respondent wrote under "indications for procedure" as follows:

> The patient is a 64 y.o. female that underwent 3 column hemorrhoidectomy several months ago who has persistent anal pain. Examination clinic demonstrated significant anal stenosis from scarring. She was brought to the operative suite for exam under anesthesia and anal sphincterotomy.

Under the section titled "intraoperative findings" respondent wrote:

> Significant anal stenosis from scarring only able to accommodate 1 fingerbreadth.

Under the section titled "description of procedure" respondent, in part, wrote:

> The patient was brought to the operative suite..... Rectal rectal [*sic*] exam demonstrated significant anal stenosis due to scarring only able to accommodate 1 fingerbreadths [*sic*]. There is [*sic*] no hard masses in the anal canal. Examination was [*sic*] anal speculum did not demonstrate any significant hemorrhoids. No other pathology were [*sic*] noted. The anal sphincter was then placed on tension. A 11 blade was placed in the intersphincteric groove and tearing medially. Some of the scar tissue was also divided with this maneuver. The anal opening was dilated to 3 fingerbreadths..... The patient tolerated procedure well.

10. On February 11, 2019, Patient A had a follow-up visit with respondent after the sphincterotomy surgery. Respondent's medical notes from that February 11, 2019, office visit state that Patient A's "[a]nal pain significantly improved after surgery. 1 episode of fecal soiling on pad per day. No large volume incontince [*sic*]." Respondent performed a physical examination of Patient A on that date, including a rectal examination and noted, "[a]nal incisions healed. Good anal tone and DRE [digital rectal examination]." Respondent summarized the visit as follows: "Monitor fecal incontinence for now. High fiber diet with Kugal [*sic*] exercises. Follow-up again in 4 weeks."

11. Patient A's next visit to respondent was on February 28, 2019. Respondent wrote in the medical records for this visit as follows:

> [Patient A] presents today with worsening anal incontinence over the last few weeks. She had no sensation in the area. She had one episode of incontinence at night in bed. She

has been on a high fiber diet and doing Kugal [*sic*] exercises. No anal pain or bleeding.

Respondent further noted in the medical records for the February 28, 2019, visit that his rectal examination of Patient A disclosed, "No internal or external anal pathology. No voluntary anal tone on DRE today. There was some delayed sphincter contraction." Respondent diagnosed Patient A with anal sphincter incontinence. Respondent summarized this visit in the medical records as follows:

> Worsening anal incontinence with no voluntary anal sphincter control on DRE today. Will refer to UCSD for anal incontinence and possible sacral nerve stimulator. Follow-up after consultation.
>
> s/p Grade 3 hemorrhoidectomy in 11/2018.
>
> s/p/ anal scar release for post-op anal stenosis in 1/2019.

Under the section titled "Plan" for this visit, respondent wrote: "REFER TO UCSD colorectal surgery: Anal incontinence, eval for sacral nerve stimulator. Follow up after consultation with UCSD."

12. Patient A had no further treatment and care from respondent.

## Expert Testimony Regarding the Care and Treatment of Patient A

### TESTIMONY OF BARD C. COSMAN, M.D.

13. Dr. Bard Cosman has been a licensed physician in California since 1995. He obtained his undergraduate degree in History of Science from Harvard University in 1983. He obtained his Doctor of Medicine degree, as well as a master's degree in

public health, in 1987 from Columbia University. Thereafter, Dr. Cosman completed a general surgery residency program in 1994 from Stanford University. From 1989 to 1991, Dr. Cosman worked as a post-doctorate fellow in a science laboratory at Stanford University, Department of Surgery. Dr. Cosman thereafter completed a residency in colon and rectal surgery in 1995 at the University of Minnesota Hospitals.

Since 1995 Dr. Cosman has worked as a Staff Physician at the VA San Diego Healthcare System, as well as an Attending Staff Physician at the University of California San Diego (UCSD) Medical Center. From 2000 to 2014 Dr. Cosman served as the Chief of General Surgery at the VA San Diego Healthcare System. At the UCSD School of Medicine from 1995 to 2001, he served as an Assistant Professor, from 2001 to 2007, he served as Associate Professor, and from 2007 to the present, he serves as a Professor of Clinical Surgery. In his current position, Dr. Cosman teaches both medical students and general surgery residents. He is a member of various committees at both UCSD Medical Center and the VA San Diego Healthcare System, including surgical peer review and chair of the cancer committee. Dr. Cosman is currently board certified in general surgery, colon and rectal surgery, and spinal cord injury medicine. Dr. Cosman has worked as an expert reviewer for the board for approximately 100 cases, all involving surgery. Dr. Cosman currently works about 60 hours per week seeing a variety of surgical patients. His practice consists of about 70 percent colon and rectal surgery patients and 30 percent general surgery patients. He sees patients in both inpatient and outpatient settings. The following factual findings are based on Dr. Cosman's expert testimony and supporting documents received in evidence, including his expert report.

14. Dr. Cosman testified that he understands his role as an expert reviewer for the board is to review medical records and other information, to provide his expert

opinion on whether a physician has deviated from the standard of care, which he understands to mean what a similarly trained physician would reasonably do under similar circumstances. Dr. Cosman explained that there are variations in the degree of departure from the standard of care with an extreme departure from the standard of care being gross negligence and a lower departure from the standard of care being simple negligence. Dr. Cosman used these standards when providing his opinions in this matter.

15. In his practice, Dr. Cosman has treated over 2,000 patients for hemorrhoids. He explained that there are both surgical and non-surgical treatment options for hemorrhoids, and the surgical treatment is a hemorrhoidectomy. Dr. Cosman has performed approximately 400 hemorrhoidectomies, which he described as a common procedure. Dr. Cosman stated that an uncommon condition called anal stenosis can develop from a prior hemorrhoidectomy. Anal stenosis is a narrowing of the anal opening due to either excessive muscle tension, called functional anal stenosis, or due to scarring. He explained that a patient may also have a combination of both functional anal stenosis and scar anal stenosis. Dr. Cosman also explained that the term anal stricture is sometimes used interchangeably with scar anal stenosis. Dr. Cosman explained that the standard of care for the treatment for both types of anal stenosis involves a step approach, meaning less invasive treatment options are used first prior to surgery. He further explained that anal stenosis is generally characterized by its severity as either mild, moderate or severe.

If a patient presents with functional anal stenosis due to excessive muscle tension, then the standard of care requires following an established protocol of dietary modification, topical sphincter relaxers, and if those fail then surgery. Dr. Cosman stressed that surgery is only indicated when the second line of treatment has failed.

Surgical treatment for functional anal stenosis is a sphincterotomy, which involves surgically dividing the lower half of the internal anal sphincter to relieve muscle spasm related anal stenosis. The standard of care also requires that sufficient time after a hemorrhoidectomy is given to allow post-operative healing so that if anal stenosis does develop, it has sufficient time to "declare itself" as either functional anal stenosis, scar anal stenosis, or a combination of the two, as a chronic condition prior to any follow-up surgical treatment.

If a patient presents with scar anal stenosis, then the standard of care requires a first line of treatment of dietary modification, then mechanical dilation of the sphincter, and if those fail, then surgery. Notably, the standard of care for the surgical treatment of scar anal stenosis is a different kind of surgery than what is required for functional anal stenosis. Namely, for scar anal stenosis the appropriate surgery is anoplasty, which is to move normal tissue into the area where scar tissue is present.

16. Dr. Cosman reviewed medical records from respondent's care and treatment of Patient A, as well as a transcript of the board's interview of respondent conducted on June 7, 2023, the transcript of the deposition of respondent, and other documents. After his review of all materials provided to him by the board, Dr. Cosman summarized his opinions regarding respondent's care of Patient A in his expert report, which was received in evidence.

17. With regard to respondent's treatment of Patient A related to the November 12, 2018, hemorrhoidectomy, Dr. Cosman testified that he is not critical of respondent's decision to perform a hemorrhoidectomy on Patient A on that date and stated that the surgery was "an appropriate thing to do" on Patient A with her presentation. Dr. Cosman wrote in his report and testified that respondent's hemorrhoidectomy surgery on Patient A did not deviate from the standard of care.

However, in his report and his testimony Dr. Cosman was critical of respondent's efforts to obtain a pre-operative history of Patient A, as well as the time it took him to perform the surgery, nine minutes, which Dr. Cosman noted in his expert report to be indicative of a "slapdash approach to surgical practice." With regard to Patient A's pre-operative history taken by respondent, Dr. Cosman noted that respondent failed to recognize that Patient A "was a re-operative patient and had a chronic pelvic floor problem." Dr. Cosman testified that Patient A's medical records from her gynecologist for a visit on July 7, 2017, show that Patient A underwent a hysterectomy in 1990 resulting in a complication of a fistula formation between the vagina, rectum and bladder. Patient A then underwent a surgery in 1991 to repair the fistula, which Dr. Cosman explained is an abnormal connection between two hollow organs or a hollow organ and the outside world. Dr. Cosman noted that this history shows that Patient A likely had degraded pelvic floor function prior to the hemorrhoidectomy, which is an issue not recognized or noted by respondent. Dr. Cosman noted that this information was readily available on Patient A's electronic medical record to which respondent had access.

18. With regard to respondent's January 28, 2019, sphincterotomy surgery on Patient A, Dr. Cosman opined that respondent deviated from the standard of care in two respects.

19. First, Dr. Cosman opined that respondent deviated from the standard of care to an extreme degree with regard to the plan and timing of performing a surgery to address Patient A's anal stenosis. During Patient A's January 7, 2019, visit to respondent for post-operative evaluation after the hemorrhoid surgery, respondent noted that Patient A complained of persistent anal pain, constipation, difficulty with defecation, and mucus discharge. On this visit after his rectal examination of Patient A,

respondent noted that the anoderm (or outside of the anus) demonstrated no abnormalities, but on digital examination noted an abnormal tone with no masses with a diagnosis of anal stenosis. Dr. Cosman stated that if the anal stenosis is based only on abnormal tone, then this would be functional anal stenosis only. Respondent made no mention of any scar tissue in this medical record from this examination. Dr. Cosman stated that in this record respondent diagnosed "acquired anal stenosis" but failed to classify to what degree the anal stenosis was, namely mild, moderate or severe. Respondent also failed to note any specific location of the anal stenosis. On the January 7, 2019, visit, which was only 56 days after the hemorrhoidectomy, respondent recommended a lateral, internal anal sphincterotomy. Respondent did not note or attempt any less invasive treatment options such as the use of topical muscle relaxation medications in the case of functional anal stenosis, or mechanical dilation in the case of scar anal stenosis. Dr. Cosman opined that respondent's recommendation of surgery only 56 days after the hemorrhoidectomy without sufficient time for the anal stenosis condition to be chronic and without the use of any other less invasive treatment options was an extreme departure from the standard of care and constitutes gross negligence. He explained that only 56 days after the hemorrhoidectomy is "not even close" to the end of the post-operative healing period such that Patient A's condition was chronic.

20. Second, with regard to the sphincterotomy surgery performed by respondent on January 28, 2019, on Patient A, Dr. Cosman opined that respondent committed a simple deviation from the standard of care because he had illogical rationale on the type of surgery to perform and failed to properly document the specifics of the procedure, including failure to document how much muscle was divided and on what side the muscle was divided. Dr. Cosman testified and noted in his report that he is critical of respondent's choice of surgery in this case because

medical records from respondent show that in the operative note he examined Patient A and found the stenosis was due to scarring, and he failed to note whether the stenosis was mild, moderate or severe or the location of the scarring. However, in his January 7, 2019, office visit medical records he failed to note any scarring present and instead only noted abnormal muscle tone indicating functional anal stenosis. These findings are inconsistent. Dr. Cosman stated, "if the scar tissue is the problem, then why is he cutting the muscle?" Dr. Cosman also stated that a sphincterotomy surgery creates irreversible change in the muscle. Dr. Cosman stated that fecal incontinence is a possible side effect of a sphincterotomy for patients who have a number of risk factors, which Patient A had. Specifically, Patient A was overweight and had prior pelvic floor disfunction with a prior surgery to fix fistulas. Dr. Cosman noted that he saw nothing in respondent's medical records for Patient A indicating that he had any knowledge of Patient A's prior fistula repair surgery despite that information being readily available in Patient A's electronic medical records.

Dr. Cosman explained that if Patient A's anal stenosis was caused by scarring, as respondent noted in his operative note on January 28, 2019, then this was an entirely different diagnosis than that of Patient A's last office visit on January 7, 2019, when he noted only abnormal muscle tone indicating functional anal stenosis. As such, because the operative note for the January 28, 2019, sphincterotomy surgery showed that the entire procedure lasted only seven minutes, Dr. Cosman opined that this raises serious questions to him because this is a new diagnosis made exclusively during the exam under anesthesia with no medical records indicating the location of the scar or its severity, any decisions on the appropriate method of treatment of this new diagnosis of scar anal stenosis such as dilation, and then performance of a sphincterotomy instead of an anoplasty, which would be more appropriate for a scar anal stenosis diagnosis. While a sphincterotomy procedure itself can easily be done in seven

minutes, each of the above steps of new diagnosis, identification of the scars and decisions on proper treatment would typically take more time. Dr. Cosman again stressed that if Patient A's diagnosis was actually scar anal stenosis, then the standard of care demands that respondent abort any surgery that day, and perform less invasive treatments such as dilation in a reasonable step-up approach prior to performing any surgery, which in this case would be the surgery of anoplasty rather than sphincterotomy. Dr. Cosman again stressed that a sphincterotomy surgery would be appropriate to use for functional anal stenosis and not scar anal stenosis.

Dr. Cosman noted that the sphincterotomy surgery for Patient A happened 77 days after the hemorrhoidectomy. He stated that for some patients, who are low risk and have an extreme version of the problem of anal stenosis, the 77-day time period may be appropriate. However, that is too short of a time period for a patient with higher risk and not an extreme version of anal stenosis. Dr. Cosman stressed that respondent failed to document the severity of Patient A's anal stenosis in the records, and he failed to document that he had any knowledge of her prior fistula repair or pelvic floor issues.

Dr. Cosman opined that respondent's sphincterotomy surgery itself was fairly standard in respondent's technique of the performance of the surgery, it was a simple departure from the standard of care because the surgery was "misapplied" in this case. However, the timing of his performance of any surgery without using a step approach was an extreme departure from the standard of care. Dr. Cosman acknowledged that there is some literature supporting a sphincterotomy surgery for post-hemorrhoidectomy stenosis, but that literature is "non-recent and plagued with the aforementioned terminological ambiguity" relating the terms stenosis and stricture being used interchangeably, when they are in fact different.

21. Dr. Cosman reviewed respondent's expert report in this matter and disagrees with his conclusion that early surgical intervention for the treatment of anal stenosis is appropriate. Specifically, Dr. Cosman testified that the standard of care, as well as the overwhelming literature on the topic, supports that a step-up approach with less invasive treatment prior to surgery is appropriate.

22. On cross-examination Dr. Cosman agreed that it was appropriate for respondent to rely on Patient A's representation of her prior medical and surgical history without reference to other electronic medical records because she is a nurse, but only for the first hemorrhoidectomy surgery. However, Dr. Cosman stressed that for the second anal stenosis surgery it would not be appropriate for respondent to fail to review those other electronic medical records showing that Patient A had a prior fistula repair surgery in 1991 after a hysterectomy in 1990.

23. On cross-examination, Dr. Cosman also stated that it is possible for a patient to have both functional anal stenosis and scar anal stenosis at the same time but is rarely seen. Dr. Cosman also noted that respondent characterized Patient A's anal stenosis as "significant" in Patient A's medical records, however Dr. Cosman stated that significant only means that clinical intervention is needed but does not equate to severe anal stenosis. Respondent simply provided no grading of the anal stenosis for Patient A in the medical records.

## TESTIMONY OF GLENN THOMAS AULT, M.D.

24. Dr. Glenn Ault has been a licensed physician in California since 1995. Dr. Ault received his undergraduate degree in 1987 from Muhlenberg College and his Doctor of Medicine degree in 1993 from Hahnemann University School of Medicine. He also received a Master of Science in Education from the University of Southern

California in 2001. Dr. Ault completed his general surgery residency in 2002 at the University of Southern California (USC) Medical Center. From 2002 to 2003 he was a colorectal surgery research fellow at the Keck School of Medicine of USC. Dr. Ault also completed a residency in colorectal surgery in 2004 at USC Medical Center.

Since completing his residency in 2004, Dr. Ault has been on the faculty of Keck School of Medicine at USC. From 2004 to 2011, Dr. Ault was an Assistant Professor at the Department of Surgery, Division of Colorectal Surgery, USC Medical Center. From 2006 to the present, Dr. Ault has worked as the Residency Program Director of the Department of Surgery, Division of Colorectal Surgery, USC Medical Center. From 2009 to 2015, he was the Associate Dean, Clinical Administration of Keck School of Medicine, USC, and from 2011 to 2018 he was an Associate Professor, Clinical Education, at the Department of Surgery, Division of Colorectal Surgery, USC Medical Center. From 2015 to the present, Dr. Ault has worked as the Senior Associate Dean, Clinical Administration of Keck School of Medicine, USC. From 2018 to the present, Dr. Ault has been a professor of the colorectal residency program, as well as the associate residency program director of the surgery residency program at Keck School of Medicine of USC. Currently, about 65 percent of Dr. Ault's day involves direct patient care in a clinical setting, either inpatient or outpatient. Dr. Ault always has a "learner," such as a medical student, resident or other form of student, with him during all of his clinical work. Dr. Ault is currently board certified in both general surgery and colon and rectal surgery. The following factual findings are based on Dr. Ault's expert testimony and supporting documents received in evidence, including his expert declaration regarding this matter.

25. Dr. Ault testified that he was retained by respondent to review this matter and provide his opinion on whether respondent deviated from the standard of

care in his treatment of Patient A. Dr. Ault testified that he understands the phrase standard of care to mean what a similarly trained physician would reasonably do under similar circumstances. Dr. Ault provided no testimony or information in his declaration about his understanding of the meaning of gross negligence versus simple negligence. Notably, Dr. Ault testified and wrote in his declaration that a general surgeon performing a sphincterotomy surgery would be subject to a different standard of care than would a colorectal surgeon performing the same surgery. Dr. Ault's testimony and declaration regarding that point is deeply concerning given that the standard of care requires a medical professional to possess and exercise that level of knowledge and skill ordinarily possessed by members in good standing in the same or similar circumstances (*Landeros v. Flood* (1976) 17 Cal.3d 399, 408), and both types of physicians would be considered to be acting in the same or similar circumstances because they are performing the exact same surgery. Accordingly, this point calls into question Dr. Ault's understanding of the standards to be applied in this matter under applicable statutes and regulations.

26. Dr. Ault reviewed respondent's medical records for Patient A from his practice, as well as hospital records related to Patient A, respondent's deposition, the interview of respondent by the board, and Dr. Cosman's expert report. Based on his review of that information, Dr. Ault testified and wrote in his declaration that respondent did not deviate from the standard of care in his treatment of Patient A in any way.

27. With regard to respondent's performance of the hemorrhoidectomy on Patient A in November 2018, Dr. Ault opined that respondent was within the applicable standard of care in his decision to perform that surgery, as well as his actual performance of it. Both Dr. Ault and Dr. Cosman agree on this point.

28. With regard to the issue raised by Dr. Cosman that Patient A was a higher risk patient because of her fistula repair surgery in 1991 after a hysterectomy in 1990, Dr. Ault testified and wrote in his declaration that he disagrees with Dr. Cosman on this point because Patient A's fistulas resulting from her hysterectomy were "high rectovaginal fistulas which are not located near the sphincter complex." Dr. Ault stated that there was no indication that the surgical fistula repair had an anal approach rather than an approach through the abdomen. Furthermore, Patient A is a nurse and never communicated to respondent any problems like ongoing pelvic floor dysfunction to him indicating that it was not a contributing factor to her chief complaint of hemorrhoids.

29. Dr. Ault also testified and opined that respondent's planning and timing of the January 28, 2019, sphincterotomy to treat Patient A's anal stenosis was within the standard of care. Specifically, Dr. Ault testified and wrote in his declaration that respondent performed the sphincterotomy 77 days after the hemorrhoidectomy, which was within the standard of care because "once a degree or level of anal stenosis is documented," it is the judgement call of the physician on how to proceed with treatment. Dr. Ault admitted that Patient A's anal stenosis was not considered to be chronic at this time because it was not present for at least six months. Dr. Ault disagreed with Dr. Cosman's opinion that the correct approach to treat the anal stenosis in this case was to temporize, meaning to wait for a period of time before surgery. His declaration also cited to a scientific article for the proposition that "early surgical intervention" is appropriate to treat anal stenosis and, as a result, respondent did not violate the standard of care. However, on cross-examination regarding that scientific article, Dr. Ault admitted that the article did not, in fact, support the proposition that anal stenosis should be treated early with surgery prior to using non-surgical treatment options, and, in fact, the patients referenced in that article were

treated with a step approach using non-surgical treatment options first. Dr. Ault wrote in his declaration that the decision on whether or not to temporize "is one based on the circumstances of that individual patient and the surgeon's comfort and experience." On cross-examination Dr. Ault testified that he was not aware at the time he wrote his declaration that respondent had only ever performed a sphincterotomy for the treatment of anal stenosis on four occasions during his entire career prior to performing that surgery on Patient A. Dr. Ault admitted that respondent had never performed an anoplasty and was not familiar with that surgical procedure.

On cross-examination when questioned about his position that whether to use early surgical treatment is solely a decision for the physician based on his or her judgment, Dr. Ault eventually admitted that the decision should be made by both the patient and physician together. Dr. Ault finally admitted that ultimately it is the patient's decision on how to proceed with treatment after a full discussion of the risks and benefits of the treatments. Dr. Ault testified that there was patient consent given for the sphincterotomy in the medical records, but he admitted that there was no documentation of any discussion of the option of waiting more time before surgery or non-surgical treatments such as dilation. Dr. Ault admitted that he was relying simply on a signed consent form from Patient A to establish that those discussions took place.

30. Dr. Ault also testified that the type of surgery performed by respondent, namely sphincterotomy, on Patient A to treat her anal stenosis was appropriate and within the standard of care. Specifically, Dr. Ault testified and wrote in his declaration that a lateral internal sphincterotomy is one of the operations advocated for the treatment of anal stenosis. However, on cross-examination Dr. Ault admitted that if the cause of the anal stenosis was scarring on the anoderm, as opposed to muscle tone for

functional anal stenosis, then sphincterotomy is not the appropriate surgery to perform and that anoplasty is the appropriate surgery to perform. Dr. Ault also testified that the anal stenosis can be caused by both scarring and muscle tone. On cross-examination Dr. Ault admitted that respondent's medical records, including the operative report, and deposition testimony contradicted each other because respondent noted in the operative report that there was no scarring in the anoderm area, but in respondent's deposition he testified that there was significant scaring in the anoderm area. Dr. Ault admitted that if respondent's testimony in his deposition is true, then the operative report for Patient A is inaccurate. Dr. Ault also admitted on cross-examination that if this were the case, then respondent's record keeping for Patient A would fall below the standard of care.

Regardless of the inconsistency in the medical records and deposition testimony of respondent regarding whether the cause of the anal stenosis was from scarring, muscle tone, or a combination of both, Dr. Ault opined that respondent determined after conducting an anal examination under anesthesia that the cause of the anal stenosis was muscle tone "based on the procedure he performed," namely the sphincterotomy. Dr. Ault stated that he believes it is within the standard of care to not put information in the operative report on whether the cause of the anal stenosis was scaring or muscle tone.

With regard to the degree of anal stenosis Patient A had prior to the sphincterotomy, Dr. Ault stated that respondent wrote in the medical records that the degree was "significant" and that he was only able to put one finger breadth into the anal opening, which Dr. Ault stated indicates that the anal stenosis was severe, and that Patient A had difficulty with defecation. Accordingly, these findings supported respondent's decision to perform a sphincterotomy.

## Testimony of Respondent

31. Respondent obtained his Doctor of Medicine degree in 2008 from Harvard Medical School. He completed an internship in surgery in 2009, completed his residency in trauma surgery in 2012, and completed his residency in general surgery in 2014, all at the University of California, Davis Medical Center (UC Davis). From 2013 to 2014 respondent worked as the chief resident in general surgery at UC Davis. Since July 2014 respondent has worked in private practice as a full partner at Coast Surgical Group and has hospital privileges and affiliation at Sharp Chula Vista Medical Center, Sharp Coronado Hospital, and Scripps Mercy Hospital, where he has worked as a staff surgeon. Since May 2016, respondent has had hospital privileges and affiliation with Paradise Valley Hospital where he works as a staff surgeon. Since 2021, respondent has served as the co-chief of surgery at Scripps Mercy Hospital. Since 2022, he has served as a physician advisor at Scripps Mercy Hospital. Since January 2024, he has served on the medical executive committee of Paradise Valley Hospital.

32. Respondent works as a general surgeon with a broad practice treating "everything from rectal disease to the removal of masses, repair of hernia, removal of gallbladder, removal of breast cancer, removal of pancreas for pancreatic cancer" for adult patients over the age of 18. Respondent performs about 40 to 60 surgeries per month. Respondent testified that in his career he has performed over 1,000 hemorrhoidectomy surgeries, and has performed about 150 anal sphincterotomy surgeries, but only five of those sphincterotomy surgeries have been for the treatment of anal stenosis, including Patient A. Respondent has never performed an anoplasty surgery to treat anal stenosis and is not familiar with the surgical techniques to perform an anoplasty. Respondent testified that about 30 percent of his general surgery practice involves colon and rectal treatment.

33. With regard to his treatment of Patient A, respondent first saw Patient A in October 2018 for her complaints related to her hemorrhoids. On that first visit, he performed a rectal examination and determined she suffered from grade 3 internal and external hemorrhoids, for which he recommended a hemorrhoidectomy surgery as treatment. Respondent informed Patient A of the risks associated with the surgery and obtained her signed written consent. Prior to the hemorrhoidectomy, respondent was not aware of Patient A ever having any prior anal surgeries. On her first visit to respondent, respondent provided a medical and surgical history form for Patient A to complete, which asked her if she had undergone any prior anal surgeries, and Patient A did not indicate that she had done so. Respondent reviewed the records of the referring physician, and nothing in those records indicated any previous surgeries to repair a fistula. Respondent admitted that he did not review any gynecology records in Patient A's electronic medical records, and he stated it is not his normal practice to do so.

Respondent performed the hemorrhoidectomy surgery on Patient A on November 12, 2018, with no complications or problems. He utilized a LigaSure device to perform the surgery, which he described as a clamp-like device that shoots electricity and coagulates the vessels while also cutting tissue at the same time. Respondent explained that the use of a LigaSure device significantly reduces the time necessary to perform the surgery, and most surgeries are performed in under ten minutes using this device.

34. After the hemorrhoidectomy surgery on Patient A, she came to respondent's office for follow-up visits. On her third post-operative follow-up visit on January 7, 2019, Patient A was complaining of more anal pain, constipation despite using a stool softener respondent had already prescribed, and difficulty defecating.

Respondent testified that this was six weeks after the hemorrhoidectomy, and he had expected that Patient A would be more recovered by that point because in his experience, by that time about 98 to 99 percent of patients are healed. He performed a rectal exam, which showed that she had "abnormal tone," which respondent said meant that her anus was really tight, and she had anal stenosis. Respondent stated that this "abnormal tone" did not mean that the anal stenosis was caused only by muscle tone but could also be caused by scar tissue. Respondent testified that at that time Patient A was already taking stool softener medication he had prescribed, as well as taking opioid pain medication of Norco, which can cause constipation, and had already been on a high fiber diet. Respondent testified that he had prescribed Norco to Patient A, and he admitted that his medical records failed to document that fact. On direct examination, when asked if he discussed treatment options with Patient A other than surgery, respondent stated, "I believe I did." However, in the transcript of the deposition of respondent taken on September 28, 2021, he was asked if he ever provided Patient A with any alternative to the anal sphincterotomy to treat the anal stenosis, and respondent answered, "No," because Patient A was already on a stool softener and fiber supplements. Respondent advised Patient A that she needed a rectal examination under anesthesia and possibly a sphincterotomy surgery, and the procedure was scheduled after obtaining patient consent.

35. On January 28, 2019, respondent performed the anal examination under anesthesia for Patient A and determined she suffered from "significant" anal stenosis, which is what he wrote in is operative report for that day. Respondent testified that he wrote "significant" to mean "severe," which was his "way of saying that." On cross-examination respondent admitted that it is important to note in medical records if the anal stenosis is mild, moderate, or severe, and he did not do that. He also admitted that it is important to note in medical records if the cause of the anal stenosis is

scarring, muscle tone, or both. Respondent also wrote in his operative report that he was only able to put one fingerbreadth, or one to one and a half centimeters, into the anal opening. Typically, the anal opening should be able to have four to five centimeters opening, but "scar tissue does not stretch so the opening gets very small." Respondent testified that he determined during that examination that Patient A's anal stenosis was caused by scarring. Respondent also testified that during his deposition on September 28, 2021, he believed that the anal stenosis was caused by scarring as reflected in his deposition testimony. However, as of the date of the hearing, he testified that he believed the anal stenosis was caused by a combination of muscle tone and scarring, but he could not provide information as to why his opinion changed.

Respondent testified that about 30 seconds after completing this anal examination under anesthesia, respondent made the determination to perform a sphincterotomy surgery to treat the condition. In response to the question of whether after determining that her anal stenosis was caused by scarring if he thought to abort the surgery, respondent stated, "No, she was already under anesthesia – that did not make sense." Respondent testified that if he did not perform the surgery, Patient A would have been unhappy to wake up with the same symptoms, and he believed that conservative therapy would not have helped her. Respondent believed that waiting months prior to performing surgery would simply result in the patient having pain for months. Respondent testified that the sphincterotomy surgery was successful in that it achieved improvement in Patient A's anal stenosis and after the surgery he could open the anus about three fingerbreadths.

36. After the sphincterotomy surgery on Patient A and during her follow-up visits to respondent, Patient A experienced fecal incontinence that worsened and a

lack of sensation resulting in respondent referring her to UCSD for a possible sacral nerve stimulator to help with the incontinence. Respondent testified that he had discussed with Patient A the risk of fecal incontinence as a result of the sphincterotomy, and he had never seen this degree of anal incontinence in a patient previously.

37. Since his treatment of Patient A, respondent has enrolled in a medical record keeping course, although no proof of completion was received in evidence. He has also enrolled in a medical ethics course, but he has not yet completed that course. Respondent is also currently up to date on all his required continuing medical education (CME) courses and provided certificates of completion of those CME.

38. Respondent testified that with hindsight, he would have waited six months between the hemorrhoidectomy and the sphincterotomy surgeries for Patient A to see if more conservative treatment options, such as dilation, would be successful. However, he believes that his decision-making in this case was logical and rational, and his actions overall were within the standard of care.

## Testimony of Hugo H. Barrera, M.D.

39. Dr. Hugo Barrera obtained his Doctor of Medicine degree in 1992 from the University of Maryland, School of Medicine. He completed his internship in surgery and his general surgery residency in 1997 at UCSD Medical Center. He is board certified in surgery. After completing his general surgery residency, Dr. Barrera joined Coast Surgical Group in private practice, which is also respondent's practice group. Dr Barrera is currently the President of Coast Surgical Group. Dr. Barrera has known respondent since respondent joined his practice group. Dr. Barrera has worked with respondent for the past ten years and has performed surgeries with him. Dr. Barrera

testified that he has performed about 100 surgeries with respondent over the past ten years, including Whipple procedures for patients with pancreatic cancer, which is a complex surgery requiring a high degree of skill. Dr. Barrera testified that after observing respondent perform these 100 surgeries, he has never seen respondent perform below the standard of care.

40. Dr. Barrera stated that respondent has a stellar professional reputation, and his colleagues enjoy working with him. He testified that respondent is liked and respected by his patients, and he has a good bedside manner. Dr. Barrera testified that respondent is honest and has integrity. Dr. Barrera would not hesitate to allow respondent to perform surgery on him or his family, and he has no reservations regarding respondent's skill as a physician.

41. On cross-examination Dr. Barrera admitted that he has not read the allegations in this matter. Dr. Barrera is not aware of how many internal anal sphincterotomy operations respondent has performed, but he stated that respondent does do a lot of colon and rectal surgeries for the practice. Dr. Barrera is aware that respondent has a prior disciplinary matter with the board, but "does not know the details of that." Dr. Barrera stated that he believes, "these complaints are generated by disgruntled patients." Dr. Barrera has never discussed this matter with respondent.

42. Dr. Barrera provided a declaration that mirrored his testimony at hearing, which was received in evidence.

## Respondent's Documentary Evidence

43. In addition to the above referenced documents, including respondent's enrollment in the medical record keeping course and the ethics course, as well as CME certificates, and the expert declaration of Dr. Ault, respondent provided various other

documents received into evidence. These documents include his curriculum vitae, and various scientific articles related to anal stenosis and treatment.

## Cost of Investigation and Enforcement

44. Business and Professions Code section 125.3 authorizes complainant to seek recovery of the reasonable costs of its investigation and enforcement in disciplinary matters. Complainant submitted a certification of costs for work performed by the Office of the Attorney General. Attached to that certification is a form entitled, "Matter Time Activity By Professional Type." The attachment contains a general description of the tasks performed, the time spent on the tasks, and the hourly rate charged for the work of each employee. The certification of costs submitted in this matter established that the Department of Justice billed $19,435 for 88.75 hours expended on the case for the cost of enforcement.

Complainant submitted a Declaration of Investigative Activity for work performed by investigators for the Department of Consumer Affairs allocated to the board for this matter. Attached to that declaration is a form entitled "Investigator Log," which contains a description of the tasks performed, the date the tasks were performed, and the time spent on the tasks. The declaration also includes the hourly rate of the investigators working on this matter. The declaration of investigative activity in this matter established that the Department of Consumer Affairs billed $1,627.25 for 15.25 hours expended on the case for the cost of investigation. Additionally, another Certification of Costs of Investigation and Enforcement in this matter was submitted by complainant related to expert review and was signed and attested to by an Associate Government Program Analysis for the board. This certification provided that the board's expert, Bard Cosman, M.D., spent a total of 15 hours reviewing and evaluating this matter and writing his report at a billing rate of

$200 per hour, totaling expert costs of $3,000 spent on this matter. Accordingly, the total costs of investigation in this matter are $4,627.25.

45. All three of the certifications and the declaration satisfied the requirements of California Code of Regulations, title 1, section 1042, subdivision (b), and the certifications and declaration support a finding that costs in the amount of $24,062.25 are reasonable in both the nature and extent of the work performed. Accordingly, the reasonable cost of enforcement and investigation of this matter is $24,062.25.

## LEGAL CONCLUSIONS

1. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (Evid. Code, § 115; 500.) The standard of proof required is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The obligation to establish charges by clear and convincing evidence is a heavy burden. It requires a finding of high probability; it is evidence so clear as to leave no substantial doubt, or sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

### Applicable Statutes

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

those deficiencies." (Bus. & Prof. Code, § 2229, subd. (c).) However, "[w]here rehabilitation and protection are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

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

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

5. It is also unprofessional conduct for a physician and surgeon to fail to maintain adequate and accurate records relating to the provision of services to his or her patients. (Bus. & Prof. Code, § 2266.)

## The Standard of Care, Gross Negligence, and Simple Negligence

6. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

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

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

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

10. A physician's failure to complete or maintain patient records can constitute gross or simple negligence, depending on the circumstances. (*Kearl v. Board of Medical Quality Assurance, supra,* at pp. 1054.)

## Disciplinary Guidelines

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

disciplinary guidelines shall identify the departures and the facts supporting the departure.

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

## Evaluation

13. Respondent provided care to Patient A in November 2018 including a hemorrhoidectomy. Respondent, and both experts in this matter, agree that respondent met the standard of care for this hemorrhoidectomy. However, with regard to the second January 28, 2019, sphincterotomy surgery, each of the two experts disagree on whether respondent met the standard of care for this procedure and his medical record documentation related to that procedure. An evaluation and comparison of both expert opinions is necessary to determine whether discipline is appropriate.

14. Dr. Cosman credibly testified regarding his understanding of the definition and meaning of the phrases "standard of care," "gross negligence," and "simple negligence." While Dr. Ault provided his understanding of the meaning of the phrase "standard of care," which was correct, he thereafter testified that he believed that the standard of care of a general surgeon was different than the standard of care

of a colon and rectal surgeon performing the exact same surgery, which called into question his understanding of the legal standards in this matter. It is disturbing to contemplate that a patient located in the same city having the very same operation would expect to have a lower standard of care simply because he or she had a general surgeon performing the surgery as opposed to a colon and rectal surgeon. Accordingly, Dr. Ault's conclusions regarding whether respondent met the "standard of care" in this case are not as persuasive as the opinion rendered by Dr. Cosman.

15. Dr. Cosman credibly testified that the standard of care for the treatment of post-hemorrhoidectomy anal stenosis requires a step-up approach of providing less invasive treatment options, such as dilation in the case of scar anal stenosis, and topical muscle relaxant medications for functional anal stenosis, prior to using surgery as a treatment method. Dr. Cosman also credibly testified that the standard of care requires that anal stenosis should be chronic, meaning at least six months old, prior to the use of surgery to treat the anal stenosis caused after hemorrhoidectomy. He opined that the patient needs time to heal and time to show that the anal stenosis is chronic and will not resolve with more conservative treatments. Dr. Cosman opined that respondent simply failed to allow sufficient time prior to the second surgery and failed to provide any less invasive treatment options to Patient A other than sphincterotomy. Also, respondent's medical records failed to show that he ever provided other treatment options to Patient A other than surgery, and respondent admitted so in his deposition.

Furthermore, Dr. Cosman opined that respondent failed to properly document whether the anal stenosis was mild, moderate, or severe, and failed to document whether it was caused by scarring or muscle tone or both, all of which is critical information when making a decision on the proper treatment options. Dr. Cosman

noted that respondent documented after the rectal exam under anesthesia on the sphincterotomy surgery note that Patient A had scarring, which was presumably the cause of the anal stenosis. Notably, respondent testified in his deposition that the anal stenosis was caused by scarring. If so, then according to Dr. Cosman, the appropriate surgery to rectify that problem is anoplasty and not sphincterotomy, which respondent performed. Notably, Dr. Ault generally agreed with Dr. Cosman on this point even though he opined that a sphincterotomy can be used to treat both types of anal stenosis. Dr. Cosman also testified that respondent's medical record keeping for Patient A was insufficient and below the standard of care in many respects as noted above. Dr. Cosman's testimony was credible and persuasive.

16. Dr. Ault opined that respondent did not fall below the standard of care in any respect in this matter. However, on cross-examination Dr. Ault admitted that respondent's recordkeeping was lacking with regard to whether the anal stenosis in this matter was caused by scarring, muscle tone or both. Dr. Ault also opined that respondent's choice to perform the sphincterotomy on Patient A after the rectal exam under anesthesia was respondent's decision based on his level of experience. However, Dr. Ault failed to take into account that respondent had only ever performed a sphincterotomy surgery to treat anal stenosis on four prior occasions, and he had never performed an anoplasty, demonstrating that respondent did not have a high level of experience in this area. Furthermore, Dr. Ault admitted on cross-examination that if the anal stenosis was caused by scarring that anoplasty would be the appropriate surgery to use. Dr. Ault also ultimately admitted that it is the patient's decision on which treatment should be done only after discussion of treatment options were provided. However, evidence demonstrates that respondent failed to document any such discussion of non-surgical treatment options with Patient A, such as dilation or muscle relaxant topical medications, and respondent stated during his

deposition that he did not give Patient A any such options. With regard to the timing of the sphincterotomy, Dr. Ault opined that 77 days after the hemorrhoidectomy was within the standard of care because "early intervention is appropriate" and cited to a scientific article for the proposition that early surgery is appropriate. However, on cross-examination Dr. Ault admitted that scientific article does not stand for the proposition that early surgery is appropriate and instead the patients at issue in that article were given a step-up approach with less invasive treatments first. 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.) Given Dr. Ault's questionable understanding of the applicable legal standards in this matter, as well as the above referenced flaws in his opinions, Dr. Cosman's testimony and opinions are found more credible than those of Dr. Ault.

## Cause Exists to Discipline Respondent's License

17. Cause exists under Business and Professions Code section 2234, subdivision (b), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in gross negligence with respect to his care and treatment of Patient A for prematurely performing a sphincterotomy surgery on Patient A without first doing less invasive non-operative treatments in a step-up approach.

18. Cause exists under Business and Professions Code section 2234, subdivision (c), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in repeated acts of negligence with respect to Patient A for performing a sphincterotomy surgery on Patient A prematurely, without first doing less invasive non-surgical treatments or waiting sufficient time after the

hemorrhoidectomy, and without proper rationale with regard to whether another surgery such as anoplasty would be more appropriate given his failure to properly determine if the cause of the anal stenosis was scarring or muscle tone or a combination of both. Furthermore, respondent's medical record keeping fell below the standard of care.

19. Cause exists under Business and Professions Code section 2266 to impose discipline. Complainant established by clear and convincing evidence that respondent maintained inadequate or inaccurate medical records with respect to Patient A by failing to properly document whether the cause of Patient A's anal stenosis was scarring or muscle tone or a combination of both, failing to document the degree of anal stenosis, and failing to document any discussion with Patient A regarding less invasive non-operative treatment options for the anal stenosis.

## Application of Disciplinary Guidelines

20. Because cause for discipline exists, a determination of the degree of discipline necessary must be made with application of the Disciplinary Guidelines. Respondent has had a history of prior discipline as recently as 2022. He has been working in private practice as a general surgeon for over ten years and has a good reputation in the community as a physician. Dr. Barrera provided testimony regarding respondent's stellar reputation as a surgeon, integrity, honesty, and professionalism. Additionally, respondent has taken the step of enrolling in a medical record keeping course and an ethics course, although no evidence was provided that he has completed these courses.

21. The allegations in this accusation involve only one patient, and the incidents occurred in 2019, about five years ago, and there have been no further

incidents involving patient care since that time. The Disciplinary Guidelines provide that in a situation where there are repeated negligent acts involving only one patient, a public reprimand may be appropriate. However, respondent does have prior discipline imposed against his license, that discipline is recent, and respondent exhibited a lack of knowledge regarding a step-up approach to treatment for Patient A with non-surgical options, a lack of knowledge regarding the use of anoplasty versus sphincterotomy surgery and engaged in sparse and insufficient medical record keeping. These factors raise public protection concerns. Respondent has provided sufficient mitigating evidence to warrant a reduction from the recommended probationary period of five years as set forth in the Disciplinary Guidelines to a probationary period of three years. In consideration of the record as a whole, public protection dictates that a probationary period with terms and conditions is appropriate under the circumstances.

22. The public will be protected by placing respondent's certificate on probation for three years, with requirements that he complete certain educational and medical record keeping courses, and ethics courses; he complete a clinical competence assessment program; be subject to a practice monitoring requirement; and be prohibited from having a solo practice. The probation requirements imposed are designed to remediate respondent's deficiencies and ensure that he practices in a safe and professional manner.

## Costs of Investigation and Enforcement

23. Business and Professions Code section 125.3, subdivision (a), authorizes an administrative law judge to direct a licensee who has violated the applicable licensing act to pay a sum not to exceed the reasonable costs of investigation and prosecution. The reasonable costs in this mater are $24,062.25.

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

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

26. After consideration of the *Zuckerman* factors in this case, a reduction of the costs of enforcement are not appropriate. Accordingly, an appropriate cost amount of $24,062.25 is deemed reasonable and respondent shall pay that amount to the board, which may be paid pursuant to a payment plan approved by the board.

## ORDER

IT IS HEREBY ORDERED that respondent Yifan Yang, M.D.'s Physician's and Surgeon's Certificate, No. A 109921 is revoked. However, the revocation is stayed, and

respondent is placed on probation for three 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 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 no 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 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 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.

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 3 and no more than 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.

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.

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 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. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting 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 not resume practice until an appropriate practice setting is established.

If, during the course of the probation, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this Decision, respondent shall notify the board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, 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 practice until an appropriate practice setting is established.

7. NOTIFICATION. Within seven (7) 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.

8. SUPERVISION OF PHYSICAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. 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.

10. 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.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit. Respondent shall comply with the board's probation unit and all terms and conditions of this decision.

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 Business and Professions Code section 2021(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.

12. INTERVIEW WITH THE BOARD, OR ITS DESIGNEE. Respondent shall be available in person 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.

13. 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 in California 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 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 (2) years.

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

Periods of non-practice for 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; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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, 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.

15. LICENSE SURRENDER. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of his license. The board reserves the right to evaluate respondent's request and to exercise its discretion 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. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., 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.

18. COST RECOVERY. Respondent shall pay to the board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $24,062.25. Respondent shall be permitted to pay these costs in a payment plan approved by the board, with payments to be completed no later than 120 calendar days prior to the end of the probation term.

DATE: June 10, 2024

*Debra D. Nye-Perkins*

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