

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

In the Matter of the Accusation Against:

David Stanton Hodge, M.D.

Physician's and Surgeon's
Certificate No. G 39325

Respondent.

Case No. 800-2017-038350

DECISION

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

This Decision shall become effective at 5:00 p.m. on April 1, 2021.

IT IS SO ORDERED March 25, 2021.

MEDICAL BOARD OF CALIFORNIA



William Prastka
Executive Director

1 XAVIER BECERRA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 LYNETTE D. HECKER
Deputy Attorney General
4 State Bar No. 182198
California Department of Justice
5 2550 Mariposa Mall, Room 5090
Fresno, CA 93721
6 Telephone: (559) 705-2320
Facsimile: (559) 445-5106
7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:

13 **DAVID STANTON HODGE, M.D.**
14 **P. O. Box 27500**
Fresno, CA 93729-7500

15 **Physician's and Surgeon's Certificate No.**
16 **G 39325**

17 Respondent.

Case No. 800-2017-038350

OAH No. 2019080845

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

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

21 **PARTIES**

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

26 2. David Stanton Hodge, M.D. (Respondent) is represented in this proceeding by
27 attorney Michael F. Ball, whose address is 7647 North Fresno Street, Fresno, CA 93720-8912.

28 ///

1 approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive
2 Director and/or the Board may receive oral and written communications from its staff and/or the
3 Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the
4 Executive Director, the Board, any member thereof, and/or any other person from future
5 participation in this or any other matter affecting or involving respondent. In the event that the
6 Executive Director on behalf of the Board does not, in his discretion, approve and adopt this
7 Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it
8 shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied
9 upon or introduced in any disciplinary action by either party hereto. Respondent further agrees
10 that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason
11 by the Executive Director on behalf of the Board, Respondent will assert no claim that the
12 Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review,
13 discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or
14 of any matter or matters related hereto.

15 **ADDITIONAL PROVISIONS**

16 15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties
17 herein to be an integrated writing representing the complete, final and exclusive embodiment of
18 the agreements of the parties in the above-entitled matter.

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

22 17. In consideration of the foregoing admissions and stipulations, the parties agree the
23 Executive Director of the Board may, without further notice to or opportunity to be heard by
24 Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

25 **ORDER**

26 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 39325, issued
27 to Respondent, David Stanton Hodge, M.D., is surrendered and accepted by the Board.
28

1 I have read and fully discussed with Respondent David Stanton Hodge, M.D. the terms and
2 conditions and other matters contained in this Stipulated Surrender of License and Order. I
3 approve its form and content.

4 DATED: _____
5 MICHAEL F. BALL
6 *Attorney for Respondent*

7 **ENDORSEMENT**

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

10 DATED: _____ Respectfully submitted,
11 XAVIER BECERRA
12 Attorney General of California
13 STEVE DIEHL
14 Supervising Deputy Attorney General

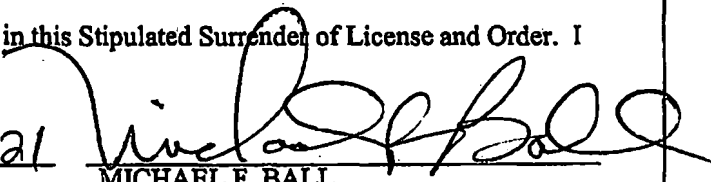
15 LYNETTE D. HECKER
16 Deputy Attorney General
17 *Attorneys for Complainant*

18 FR2019103371
19 95381185.docx

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

I have read and fully discussed with Respondent David Stanton Hodge, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED:

3/21/2021 
MICHAEL F. BALL
Attorney for Respondent

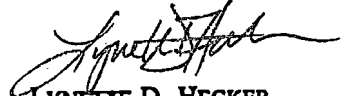
ENDORSEMENT

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

DATED: 3/22/2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General


LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

FR2019103371
95381185.docx

Exhibit A

Accusation No. 800-2017-038350

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
State Bar No. 235250
California Department of Justice
2550 Mariposa Mall, Room 5090
Fresno, CA 93721
Telephone: (559) 705-2313
Facsimile: (559) 445-5106
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO *August 5 2019*
BY *K. Voong* ANALYST

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

In the Matter of the Accusation Against:

DAVID STANTON HODGE, M.D.
P.O. Box 27500
Fresno, CA 93729-7500

Physician's and Surgeon's Certificate
No. G 39325,

Respondent.

Case No. 800-2017-038350
ACCUSATION

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).
2. On or about May 29, 1979, the Medical Board issued Physician's and Surgeon's Certificate No. G 39325 to David Stanton Hodge, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2021, unless renewed.

\\
\\

1 **JURISDICTION**

2 3. This Accusation is brought before the Board, under the authority of the following
3 laws. All section references are to the Business and Professions Code (Code) unless otherwise
4 indicated.

5 4. Section 2227 of the Code states:

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

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

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

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

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

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

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

27 **STATUTORY PROVISIONS**

28 5. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

9 (d) Incompetence.

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

13 (f) Any action or conduct which would have warranted the denial of a
14 certificate.

15 (g) The practice of medicine from this state into another state or country
16 without meeting the legal requirements of that state or country for the practice of
17 medicine. Section 2314 shall not apply to this subdivision. This subdivision shall
18 become operative upon the implementation of the proposed registration program
19 described in Section 2052.5.

20 (h) The repeated failure by a certificate holder, in the absence of good cause, to
21 attend and participate in an interview by the board. This subdivision shall only apply
22 to a certificate holder who is the subject of an investigation by the board.

23 6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain
24 adequate and accurate records relating to the provision of services to their patients constitutes
25 unprofessional conduct.

26 DEFINITIONS

27 7. Esophageal atresia is a congenital defect in which the esophagus fails to develop as a
28 continuous passage. Instead, both the lower (distal) and upper (proximal) esophagus end in blind
pouches. Treatment typically consists of a surgical repair to connect the two ends of the
esophagus.

8. Tracheoesophageal fistula (TEF) is a congenital defect related to esophageal atresia,
in which one or both ends of the esophagus connect to the trachea, rather than ending in a blind
pouch.

\\

\\

\\

1 **FACTUAL ALLEGATIONS**

2 9. On or about May 22, 2017, Patient A¹ was born with esophageal atresia. The patient
3 was delivered by urgent C-section, and Respondent performed immediate open gastrostomy
4 placement to allow the patient to feed and grow pending a later surgery to correct the atresia.

5 10. On or about June 30, 2017, Respondent attempted a repair of the patient's esophageal
6 atresia. However, the patient's upper esophageal pouch would not hold the sutures, and the repair
7 could not be accomplished. Respondent closed the upper and lower ends of the esophagus and
8 ended the attempted repair.

9 11. On or about July 17, 2017, an upper gastrointestinal contrast study (UGI) established
10 that the patient had developed a fistulous connection between the distal and proximal esophageal
11 pouches. On two occasions, Respondent consulted with another pediatric surgeon in Boston,
12 Massachusetts, regarding his treatment of Patient A, but did not document this consultation.
13 Based in part on this consultation, Respondent planned to continue to wait before attempting
14 another surgery. Respondent continued to follow the patient with periodic UGI studies. On or
15 about September 6, 2017, a UGI study established that the fistula had closed. This was confirmed
16 by another UGI study on or about October 16, 2017.

17 12. On or about October 18, 2017, Respondent attempted again to perform a repair of the
18 patient's esophageal atresia. Respondent did not have a preoperative conference with the
19 attending anesthesiologist prior to the surgery, and only spoke to the anesthesiologist for the first
20 time about the case on the morning of the surgery. Respondent did not arrange for assistance by a
21 second surgeon. No arterial line was placed prior to incision. During the surgery, Respondent
22 encountered dense adhesions from the lung to the chest wall, and adhesiolysis resulted in air
23 leaks. An hour into the operation, Respondent noted a tracheal injury, which he repaired.
24 Subsequently, a persistent air leak resulted in difficulties with ventilation. Respondent noted an
25 injury to the left mainstem bronchus, and attempted a repair. The anesthesiologist suggested that
26 Respondent obtain assistance from a second surgeon to perform this repair, but Respondent
27 ignored the anesthesiologist's suggestion. Difficulty with ventilation continued, and eventually

28 ¹ Patient names are redacted to protect privacy.

1 an oscillating ventilator was brought to the operating room. Despite these difficulties with
2 ventilation and air leakage, Respondent proceeded to attempt to connect the upper and lower
3 esophageal pouches. The patient became extremely unstable, and required epinephrine for
4 resuscitation. Respondent abandoned the attempted esophageal repair and closed the chest, but
5 the patient continued to deteriorate. Following additional interventions, the patient died.

6 **FIRST CAUSE FOR DISCIPLINE**

7 **(Gross Negligence)**

8 13. Respondent is subject to disciplinary action under section 2234, subdivision (b), of
9 the Code, in that he engaged in act(s) or omission(s) amounting to gross negligence. The
10 circumstances are set forth in paragraphs 9 through 12, which are incorporated here by reference
11 as if fully set forth. Additional circumstances are as follows:

12 14. The standard of care requires adequate preparation prior to performing surgery. A
13 repeat thoracotomy and mediastinal dissection in the chest of an infant, whose postoperative
14 course was complicated by a fistula formation, is a challenging surgery that requires preparation
15 and communication between the anesthesiologist and surgeon. Such preparation and
16 communication must occur sufficiently early so that problems can be anticipated and planned for.
17 Respondent's failure to conduct a preoperative conference with the anesthesiologist prior to the
18 October 18, 2017, surgery constitutes gross negligence. Respondent's failure to plan for surgical
19 assistance, and instead relying upon the scrub tech to provide assistance during surgery,
20 constitutes gross negligence.

21 15. The standard of care requires adequate communication between the surgeon and
22 anesthesiologist during surgery. If the patient become unstable for any reason, the operation must
23 cease until the anesthesiologist feels it is safe to proceed. Should additional monitoring become
24 necessary during the operation, the surgeon must cease operating and assist in achieving
25 necessary monitoring. During the October 18, 2017, surgery, the anesthesiologist repeatedly
26 requested that Respondent momentarily cease operating to wait for the patient's oxygen
27 saturation to return. Respondent ignored these requests. Despite hours of poor oxygenation and
28 persistent instability, Respondent attempted to repair the esophageal atresia. Respondent's failure


1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 39325, issued to David Stanton Hodge, M.D.;
2. Revoking, suspending or denying approval of David Stanton Hodge, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering David Stanton Hodge, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and
4. Taking such other and further action as deemed necessary and proper.

DATED: August 5, 2019


KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

FR2019103371
95322626.docx