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

In the Matter of the Accusation Against: Yifan Yang, M.D. Physician's and Surgeon's Certificate No. A 109921 Respondent.	Case No. 800-2018-040084

DECISION

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

This Decision shall become effective at 5:00 p.m. on February 17, 2022.

IT IS SO ORDERED January 18, 2022.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp MD

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

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KAROLYN M. WESTFALL
Deputy Attorney General
State Bar No. 234540
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9465
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **YIFAN YANG, M.D.** **786 3rd Ave., Suite B** **Chula Vista, CA 91910-5826** **Physician's and Surgeon's Certificate No. A 109921,** Respondent.	Case No. 800-2018-040084 OAH No. 2021020610 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Karolyn M. Westfall, Deputy Attorney General.

2. Respondent Yifan Yang, M.D. (Respondent) is represented in this proceeding by attorney Robert W. Frank, Esq., whose address is: Neil, Dymott, Frank, McFall & Trexler, McCabe & Hudson, APLC, 110 West A Street, Suite 1200, San Diego, CA 92101.

3. On or about November 4, 2009, the Board issued Physician's and Surgeon's Certificate No. A 109921 to Yifan Yang, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-040084, and will expire on November 30, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-040084 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 10, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-040084 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-040084. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

///

///

///

///

CULPABILITY

9. Respondent admits that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2018-040084, and agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. A 109921 to disciplinary action.

10. Respondent further agrees that if he ever petitions for modification or early termination of probation, or if an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2018-040084 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

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

CONTINGENCY

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

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that 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 the 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.

ACCEPTANCE

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

DATED: 11/15/2021

YIFAN YANG, M.D.
Respondent

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

DATED: 11-16-21

ROBERT W. FRANK, ESQ.
Attorney for Respondent

///

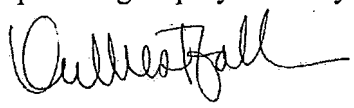
ENDORSEMENT

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

DATED: 11/16/21

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General



KAROLYN M. WESTFALL
Deputy Attorney General
Attorneys for Complainant

SD2020800300
83134097.docx

Exhibit A

Accusation No. 800-2018-040084

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KAROLYN M. WESTFALL
Deputy Attorney General
State Bar No. 234540
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9465
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **YIFAN YANG, M.D.** **786 3rd Ave., Suite B** **Chula Vista, CA 91910-5826** **Physician's and Surgeon's Certificate No. A 109921,** Respondent.	Case No. 800-2018-040084 **ACCUSATION**

PARTIES

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

2. On or about November 4, 2009, the Medical Board issued Physician's and Surgeon's Certificate No. A 109921 to Yifan Yang, 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 November 30, 2021, unless renewed.

///

JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

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

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

6. Respondent has subjected his Physician's and Surgeon's Certificate No. A 109921 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patient A,[1] as more particularly alleged hereinafter:

PATIENT A

7. On or about November 27, 2016, at approximately 8:20 p.m., Patient A was transported to the emergency room (ER) at Scripps Mercy Chula Vista Hospital (SMCV) by ambulance with complaints of acute onset abdominal pain, nausea, and vomiting. Patient A was a 55-year-old male patient with a history of peptic ulcer disease, multiple bowel obstructions, complicated hernia repair, hemicolectomy, and ventral hernia.

8. Upon admission to the ER, Patient A was evaluated by R.M., M.D. (Dr. R.M.), who noted the patient looked acutely ill and in severe distress, and had a fairly distended tender abdomen. Patient A's vitals revealed a normal temperature and blood pressure but an elevated heart rate. Initial lab work revealed no leukocytosis and normal creatine.

9. At approximately 10:00 p.m., a CT scan of Patient A's abdomen revealed a large multilobulated ventral abdominal wall hernia with herniation of multiple loops of the small bowel and a severe dilation of an isolated loop of the small bowel that was highly concerning for small bowel obstruction. In addition, multiple adjacent foci of free air were seen with large pneumoperitoneum, likely secondary to strangulated loop of small bowel with perforation. This result was communicated to Dr. R.M. at approximately 10:50 p.m. Dr. R.M. formed the opinion that emergency surgery would be necessary and directed naval resident, C.A., D.O. (Dr. C.A.) to contact the on-call surgeon for a surgery consultation.

10. On or about November 27, 2016, Respondent was assigned to be the on-call surgeon at SMCV for a twenty-four hour shift beginning at approximately 7:00 a.m. Respondent was not

[1] To protect the privacy of the patients involved, the patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

assigned to be the on-call surgeon at Sharp Coronado Hospital (SCH) on that same date. At approximately 9:30 p.m., Respondent received a call from SCH to perform an emergent surgery on a patient with a perforated colon. Respondent mistakenly believed he was on-call at SCH and arrived at the hospital shortly thereafter to perform the surgery.

11. Sometime between approximately 10:50 p.m. and 11:10 p.m., Dr. C.A. called Respondent's cell phone for a surgical consultation. During the brief discussion, Respondent understood, among other things, that Patient A had a perforated bowel and complex surgical history, but was stable at that time with normal labs, not intubated, not septic, and not on pressors. Respondent determined Patient A would need surgery, but believed it could wait for a few hours until he completed his surgery at SCH. Respondent asked Dr. C.A. to admit Patient A to the hospitalist service to be prepped for surgery, and informed him that he would be there as soon as he completed his surgery at SCH.[2] Respondent then contacted the OR scheduler at SMCV to inform her of the impending surgery, but did not call for a back-up surgeon to assist in Patient A's care at that time, or anytime thereafter.

12. At approximately 11:15 p.m., Respondent began the surgery at SCH.

13. At approximately 11:15 p.m., Patient A's lactic acid was noted to be markedly elevated at 5.3, and at approximately 11:45 p.m, he was determined to be in sepsis. Over the course of the next several hours until approximately 1:45 a.m., Patient A's condition continued to deteriorate as he became more tachycardic, tachypneic, and hypoxic. Throughout that time, staff members at SMCV called Respondent's cell phone multiple times to inform him of the patient's critical lab results and to inquire of his whereabouts.[3] Throughout that time, Respondent's cell phone sat on a table in the operating room at SCH and was never answered.

///

///

---

[2] Although Respondent claims he informed Dr. C.A. that he was about to begin a surgery at SCH, this information was not relayed to Dr. R.M. and it was not noted in Patient A's medical record.

[3] During his interview with an investigator for the Board on January 29, 2020, Respondent admitted that he does not have a pager or other mechanism for contact, and that his cell phone was the only way he could be reached while he was in surgery.

14. On or about November 28, 2016, at approximately 1:45 a.m., after completing his surgery at SCH, Respondent noted several missed calls on his cell phone. Respondent then called SMCV, learned of Patient A's worsening condition, and immediately headed over to SMCV.

15. At approximately 2:24 a.m. Respondent arrived at SMCV and personally evaluated Patient A. Respondent determined Patient A to be in severe sepsis and recommended he undergo urgent surgery to repair his bowel perforation.

16. Between approximately 3:40 a.m. and 6:15 a.m., Respondent performed a complex small bowel and hernia repair on Patient A. At the completion of the procedure, Patient A was transferred to the Intensive Care Unit (ICU) while still intubated and in septic shock.

17. While in the ICU, Patient A remained critically ill, and hemodynamically unstable with multiorgan failure, severe acidosis, leukopenia, and severe septic shock requiring multiple pressor support.

18. At approximately 3:30 p.m., Patient A was noted to have elevated bladder pressure and had become oliguric. Respondent became concerned Patient A had developed abdominal compartment syndrome, and performed a bedside reopening of the laparotomy to decompress the abdominal cavity. Patient A's bladder pressure initially dropped, but over the next several hours, Patient A's condition continued to worsen.

19. On or about November 29, 2016, at approximately 10:00 a.m., Patient A's family chose to deescalate his care and the patient died shortly thereafter.

20. Respondent committed gross negligence in his care and treatment of Patient A, by delaying his evaluation and proper surgical treatment in a critically ill patient with an acute abdomen with sepsis.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

21. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 109921 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A and B, as more particularly alleged hereinafter:

PATIENT B

22. On or about October 24, 2015, Patient B, a then 61-year-old female patient with a history of HIV, hepatitis, and recurrent diverticulitis, presented to the ER at Sharp Chula Vista Medical Center (SCVMC) with complaints of worsening abdominal pain despite recent treatment with IV and oral antibiotics. A CT scan revealed worsening sigmoid diverticulitis and the presence of an obvious abscess. Patient B was admitted to the hospital for conservative management with IV hydration and antibiotics.

23. On or about October 25, 2015, Patient B developed worsening leukocytosis and fever. Respondent evaluated Patient B, noted that her lab work indicated that she was failing medical therapy, and recommended surgery.

24. On or about October 25, 2015, Respondent performed a difficult four-hour laparoscopic sigmoid colectomy with end colostomy (Hartmann's procedure) on Patient B, using a GIA stapler multiple times throughout the procedure. During the procedure, Respondent found the patient to have an extremely diseased segment of sigmoid colon with associated abscess to the left abdominal wall, and associated small bowel inflammation and phlegmon in that area. Due to the severe inflammation, Respondent was unable to clearly identify the left side ureter. In an effort to identify the left ureter, Respondent injected methylene blue dye intraoperatively and did not see any dye extravasation. Respondent did not obtain an intraoperative second opinion from another surgeon or urologist, and did not convert to an open procedure in a further effort to identify the left ureter. Respondent then completed the procedure, and the patient was taken to recovery in stable condition.

25. Over the course of the next few days, Patient B was stable but her white blood count and creatine began to rise.

26. On or about October 29, 2015, Patient B developed a fever and complained of abdominal and bilateral flank pain. A CT scan revealed mild left-sided hydronephrosis and small areas of gas within the subcutaneous tissues in the bilateral flanks. Due to the concern of possible infection in a high-risk patient, Respondent performed a bilateral flank exploration on Patient B, and found no abscess or necrotizing tissue infection. Respondent did not obtain a urology

consultation or order a renal scan or MRI at that time or anytime thereafter in his care and treatment of Patient B.

27. Over the course of the next five days, Patient B improved postoperatively and was discharged from SCVMC on or about November 4, 2015.

28. On or about November 20, 2015, Patient B presented to Respondent for a post-operative follow-up visit. Patient B had no complaints, denied any fevers, and reported a functional colostomy. Due to insurance coverage issues, Patient B's subsequent care was transferred to UCSD.

29. On or about April 1, 2016, in preparation for a colostomy takedown procedure at UCSD, an abdominal CT scan of Patient B revealed moderate left hydronephrosis with moderate cortical thinning of the left kidney, and moderate severe left hydroureter that extended from the renal pelvis into the mid distal ureter.

30. On or about June 15, 2016, Patient B underwent a cystoscopy, left retrograde pyelogram and left diagnostic ureteroscopy at UCSD. During the procedure, a complete obstruction of the mid left ureter was found with a staple or stitch present within the obstruction.

31. On or about September 27, 2016, after continued atrophy and poor kidney function, Patient B underwent a simple left nephrectomy at UCSD.

32. Respondent committed repeated negligent acts in his care and treatment of Patients A and B, which included, but was not limited to, the following:

(A) Paragraphs 6 through 20, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(B) Failing to know his own call schedule on or about November 27, 2016, and erroneously providing surgical treatment to another patient at SCH, thereby delaying his evaluation and treatment of Patient A at SMCV;

(C) Failing to ensure SMCV staff could communicate with him about the status of Patient A over an approximate 3-hour period on or about November 27, 2016, while he was providing surgical treatment to another patient at SCH; and

///

(D) Failing to have a high enough index of suspicion for a left ureteral injury in Patient B, and failing to do enough intraoperatively and postoperatively after he failed to identify the left ureter during his surgery on the patient.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 109921, issued to Respondent, Yifan Yang, M.D.;

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

3. Ordering Respondent, Yifan Yang, 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: DEC 10 2020

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

SD2020800300
82442660.docx