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

In the Matter of the Accusation Against: Robert Dean Tonks, M.D. Physician's & Surgeon's Certificate No A 46158 Respondent.	Case No. 800-2017-039010

DECISION

The attached Stipulated Settlement and Disciplinary Order for Public Reprimand 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 24, 2022.

IT IS SO ORDERED January 25, 2022.

MEDICAL BOARD OF CALIFORNIA

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

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

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

In the Matter of the Accusation Against: **ROBERT DEAN TONKS, M.D.** **8010 Frost St., Ste. 604** **San Diego, CA 92123** **Physician's and Surgeon's Certificate No. A 46158** Respondent.	Case No. 800-2017-039010 OAH No. 2021020095 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER FOR PUBLIC REPRIMAND**

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 Keith C. Shaw, Deputy Attorney General.

2. Respondent Robert Dean Tonks, M.D. (Respondent) is represented in this proceeding by attorney Robert W. Frank, Esq., whose address is: 110 West A Street, Ste. 1200, San Diego, CA 92101.

3. On or about June 5, 1989, the Board issued Physician's and Surgeon's Certificate No. A 46158 to Respondent Robert Dean Tonks, M.D. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-039010, and will expire on October 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-039010 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 November 23, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-039010 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-039010. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order for Public Reprimand.

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. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-039010, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent gives up his right to contest that, at a hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in the Accusation.

11. Respondent agrees that if a subsequent accusation is filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2017-039010 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

12. 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

13. 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 for Public Reprimand shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Robert Dean Tonks, M.D., Physician's and Surgeon's Certificate No. A 46158, shall be and hereby is publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This public reprimand is issued in connection with allegations that Respondent committed repeatedly negligent acts in his care and treatment of patients A and B, and continually used offensive language in the operating room, as set forth in Accusation No. 800-2017-039010.

B. EDUCATION COURSE

Within 60 calendar days of the effective date of this Decision, 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. 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 participate in and successfully complete the classroom component of the course(s) not later than nine (9) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course(s) within one (1) year of enrollment.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course(s), or

not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

C. MEDICAL RECORD KEEPING COURSE

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the 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.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order for Public Reprimand 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 for Public Reprimand voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 12/1/21

ROBERT DEAN TONKS, M.D.
Respondent

I have read and fully discussed with Respondent Robert Dean Tonks, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order for Public Reprimand. I approve its form and content.

DATED: 12-2-21

ROBERT W. FRANK
Attorney for Respondent

ENDORSEMENT

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

DATED: 12/2/21

Respectfully submitted,

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

KEITH C. SHAW
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-039010

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

In the Matter of the Accusation Against: **ROBERT DEAN TONKS, M.D.** 8010 Frost St., Ste. 604 San Diego, CA 92123-4204 **Physician's and Surgeon's Certificate No. A 46158** Respondent.	Case No. 800-2017-039010 **A C C U S A T I O N**

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 June 5, 1989, the Medical Board issued Physician's and Surgeon's Certificate No. A 46158 to Robert Dean Tonks, 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 October 31, 2022, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, 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 authorizes the Board to discipline a licensee and obtain probation costs.

5. Section 2228 of the Code authorizes the Board to discipline a licensee by placing them on probation.

6. Section 2234 of the Code, states in 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.

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

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

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

8. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a

licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence as more particularly alleged hereinafter:

10. Respondent is an orthopedic surgeon and was on the medical staff at Sharp Memorial Hospital (Sharp) from approximately April 1990 through May 2018. Respondent was a member of Sharp's Orthopedic Trauma On-Call Panel. Sharp began addressing multiple behavioral issues with Respondent shortly after his employment began,[1] and continuing until his separation with Sharp, which included yelling at and using offensive language toward other physicians and medical staff in front of patients. Since at least August 2000, Sharp's Medical Executive Committee (MEC) and multiple Chiefs of Staff have spoken with and counseled Respondent numerous times regarding his behavioral issues.

11. Since approximately June 2016, Respondent incurred three (3) Behavioral Variance Reports (BVR's) for reasons that included yelling at and using obscenities toward other Sharp medical staff. On or about April 5, 2017, Sharp's MEC addressed Respondent's behavioral issues, which included using "foul" language toward Sharp medical staff. Sharp's MEC noted that Respondent does not take responsibility for his actions and does not fully comprehend the impact of his conduct on staff, peers, and patients. Sharp's MEC determined that Respondent would be required to attend UCSD's PACE program,[2] which he subsequently refused.

12. On or about November 7, 2017, Respondent's Trauma On-Call Panel privileges were summarily restricted by Sharp for numerous reasons, including 1) his behavior toward nursing

[1] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[2] The University of California at San Diego's Physician Assessment and Clinical Education (PACE) program is the largest assessment and remediation program for healthcare professionals in the country.

and other health care staff, and his inappropriate and disrespectful communications with Sharp staff and nurses in front of patients; and 2) Respondent's inability or unwillingness to address these concerns raised at multiple meetings with Sharp medical staff leadership.

13. In an interview on or about January 23, 2019, Respondent admitted that he used offensive language in the Sharp operating room multiple times. Respondent acknowledged that he was warned by Sharp's MEC numerous times to cease that behavior, but the behavior continued. Respondent indicated that he elected to resign his privileges at Sharp rather than proceed with Sharp's judicial review process, which he believed was "ridiculous" and a "waste of time."

14. Respondent committed gross negligence, which included, but was not limited to, the following: Respondent continually used offensive language toward Sharp medical staff.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

15. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in unprofessional conduct and committed repeated negligent acts based on the following circumstances.

16. The allegations of Paragraphs 9 through 14, above, are incorporated herein by reference as if fully set forth.

17. On or about the morning of December 15, 2018, Patient A, a then 78-year-old female, sustained a fracture to her right elbow and a left wrist injury following a fall. Patient A, who suffered from dementia, was immediately taken to the Scripps Memorial Hospital emergency room. She was quickly examined in the ER, where it was determined following x-rays that she would likely require surgery pending an orthopedic consultation by Respondent. She was placed on an NPO [3] status. Even though Respondent was on duty the entire day, he did not examine Patient A, explain her injuries, or discuss a treatment plan with her family.

[3] NPO, which means "nothing by mouth," is fasting that is generally prescribed in preparation for an operation.

18. The next morning at approximately 7:30 a.m., Respondent appeared in Patient A's doorway and stated that Patient A had a fractured right elbow requiring surgery, but failed to examine or speak directly with her. Patient A's husband, a retired physician, explained to Respondent that he was concerned that Patient A also had a fractured left wrist. Respondent indicated that he would obtain an x-ray of her left wrist after he performed surgery of the right elbow. Patient A's husband also expressed concern to Respondent that Patient A, who was diabetic, was needlessly placed on an NPO for many hours the previous day even though her surgery was not scheduled until the next morning.[4]

19. Patient A was taken into surgery that morning for her right elbow fracture, which was performed by Respondent. Respondent discovered during surgery following a review of x-rays that Patient A also sustained a fracture to her left wrist requiring surgical intervention. Respondent called Patient A's husband from the operating room and asked for verbal permission to proceed with surgery of Patient A's left wrist, which he agreed. Had Respondent examined Patient A on the day she was admitted to the hospital, he would have been aware earlier of her left wrist injury and ordered appropriate x-rays, corrected the unnecessary NPO for that day, explained the treatment plan to Patient A's husband, and obtained a more appropriate informed consent for surgery of the left wrist.

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

(a) Respondent failed to properly examine Patient A until the morning of her surgery; and

(b) Respondent failed to obtain appropriate informed consent for surgery of Patient A's left wrist.

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[4] Respondent indicated that he had informed the ER physician that Patient A should be taken off NPO since the surgery would not be performed until the next morning, but "somehow, they didn't get that memo." Instead, Patient A was on NPO from the afternoon of December 15, 2018, all the way through her surgery the next morning.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

21. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in unprofessional conduct and committed repeated negligent acts based on the following circumstances.

22. The allegations of Paragraphs 9 through 20, above, are incorporated herein by reference as if fully set forth.

23. On or about August 7, 2016, Patient B, a then 47-year-old male physician visiting from Arizona, rolled his pickup truck down a 100-foot embankment and was airlifted to Sharp Memorial Hospital with major injuries. Patient B was found to have acute fractures of his left radius and ulnar,[5] an acute fracture of the L2 transverse process,[6] a 15% acute fracture of T12 vertebrae,[7] and a left forehead laceration. Respondent was the orthopedic surgeon on call at Sharp and attended to Patient B. Respondent noted that Patient B had closed markedly displaced and comminuted radius and ulnar shaft fractures and would require surgery. Respondent also noted that Patient B was unable to move his left hand.

24. Respondent performed a left forearm open reduction and internal fixation[8] with a left supraclavicular anesthetic block on the day of Patient B's admission. Respondent inserted a six-hole radius plate with six (6) screws at the fracture site. Four (4) out of the six (6) screws implanted by Respondent were excessively long by 4-6 millimeters and should have been replaced with shorter screws before the surgery was completed. Respondent noted that the surgery was performed appropriately with no complications. Respondent recorded his preoperative orthopedic examination, diagnosis, and plan after performing surgery on Patient B.

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[5] A fracture of the radius and ulnar is a break of the bones in the forearm.

[6] The L2 vertebra is the second lumbar spinal vertebra in the human body. A transverse process fracture is an injury that affects a vertebrae of the spine.

[7] The T12 vertebra is the twelfth thoracic vertebra in the spine of the human body.

[8] An open reduction and internal fixation (ORIF) puts pieces of a fractured bone into place using surgery. Screws, plates, sutures, or rods are used to hold the fractured bone together.

In the days following surgery, Patient B experienced left arm pain and a persistent inability to extend his wrist or thumb.

25. Once Patient B returned home to Arizona, he followed up with a hand specialist and it was determined that the posterior interosseous nerve [9] was injured in his left forearm. During an exploration of Patient B's left forearm on about October 6, 2016, it was discovered that the posterior interosseous nerve injury was caused by one of the excessively long radius bone plate screws inserted by Respondent during surgery. Specifically, one of the middle screws went through the middle portion of the posterior interosseous nerve with "near full disruption of the nerve."

26. In an interview on or about June 22, 2020, Respondent admitted that he was aware that a screw appeared to be too long in fluoroscopy, "but I didn't think it would be a big problem because – usually it isn't a big problem, but in this case, it was a big problem." Respondent indicated that Patient B had a crushed arm injury and had an aesthetic block during surgery, making it difficult to assess whether there was damage to the posterior interosseous nerve. Respondent stated that he did not believe there was a complete nerve injury that would require exploration, so he wanted to watch it during the patient's recovery at Sharp.

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

(a) Respondent failed to record Patient B's preoperative orthopedic examination, evaluation, diagnosis and treatment plan prior to surgery; and

(b) Respondent inserted excessively long radius plate screws and failed to replace them with screws of appropriate length during surgery.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

28. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate

[9] The posterior interosseous nerve (or PIN) is a motor nerve in the forearm.

records regarding his care and treatment of Patients A and B, as more particularly alleged in paragraphs 17 through 27, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 46158, issued to Robert Dean Tonks, M.D.;

2. Revoking, suspending or denying approval of Robert Dean Tonks, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Robert Dean Tonks, 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: NOV 23 2020

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

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