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

In the Matter of the First Amended Accusation Against:	)	
Robert Alan Yoho, M.D.	)	**Case No. 17-2013-235101**
Physician's and Surgeon's Certificate No. C 41114	)	
Respondent	)	

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 November 3, 2017.

IT IS SO ORDERED: October 5, 2017.

MEDICAL BOARD OF CALIFORNIA

Michelle Anne Bholat, M.D., Chair
Panel B

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

In the Matter of the First Amended Accusation Against: **ROBERT ALAN YOHO, M.D.** **301 South Fair Oaks Avenue, #202** **Pasadena, CA 91107** **Physician's and Surgeon's Certificate No. C41114,** Respondent.	Case No. 17-2013-235101 OAH No. 2016030693 **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. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Tan N. Tran, Deputy Attorney General.

2. Respondent Robert Alan Yoho, M.D. (Respondent) is represented in this proceeding by attorney Albert J. Garcia, Esq., whose address is: 2000 Powell Street, Suite 1290, Emeryville, California 94608.

3. On or about September 19, 1983, the Board issued Physician's and Surgeon's Certificate No. C41114 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 17-2013-235101, and will expire on October 31, 2018, unless renewed.

JURISDICTION

4. First Amended Accusation No. 17-2013-235101 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on October 11, 2016. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 17-2013-235101 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 First Amended Accusation No. 17-2013-235101. Respondent has also carefully read, fully discussed with 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 First Amended 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.

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CULPABILITY

9. Solely for the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie case for the charges in First Amended Accusation No. 17-2013-235101, and that Respondent hereby gives up his right to contest those charges.

10. Respondent further agrees that his Physician 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.

11. Respondent further agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in First Amended Accusation No. 17-2013-235101 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.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

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 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.

14. 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.

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

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C41114 issued to Respondent Robert Alan Yoho, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. ACTUAL SUSPENSION. As part of probation, Respondent is suspended from the practice of medicine for 30 days beginning the sixteenth (16th) day after the effective date of this decision.

2. 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.

3. MEDICAL RECORD KEEPING COURSE-Condition Satisfied. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment

and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program 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.

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 three (3) and no more

than five (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. The 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 the Respondent did not successfully complete the clinical competence assessment program, the 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(s), 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 equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, 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. ANESTHETIST/ANESTHESIOLOGIST. After the effective date of this Decision, Respondent shall have a Certified Registered Nurse Anesthetist or Anesthesiologist present for medical procedures on all moderately sedated patients. Respondent shall document the name(s) of said Anesthetist/Anesthesiologist(s) in the patient(s)' medical record, and shall make said records available for inspection by the Board or its designee.

7. PROCTOR REQUIREMENT. 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 proctor, 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 proctor 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 proctor 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 proctor. Respondent shall pay all proctoring costs.

The Board or its designee shall provide the approved proctor with copies of the Decision(s) and Accusation(s), and a proposed proctoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed proctoring plan, the proctor shall submit a signed statement that the proctor has read the Decision(s) and Accusation(s), fully understands the role

of a proctor, and agrees or disagrees with the proposed proctoring plan. If the proctor disagrees with the proposed proctoring plan, the proctor shall submit a revised proctoring plan with the signed statement for approval by the Board or its designee.

Respondent shall be proctored by the approved proctor for the first 25 elective cosmetic surgeries Respondent performs after the effective date of this Decision. Respondent shall make all records available for immediate inspection and copying on the premises by the proctor at all times during business hours and shall retain the records for the entire term of probation.

Respondent shall cease performing surgeries until a proctor is approved to provide proctoring responsibility.

The proctor 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 performing surgeries safely. It shall be the sole responsibility of Respondent to ensure that the proctor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the proctor 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 proctor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement proctor within 15 calendar days of the resignation or unavailability of the proctor, Respondent shall receive a notification from the Board or its designee to cease performing surgeries within three (3) calendar days after being so notified Respondent shall cease performing surgeries until a replacement proctor is approved and assumes proctoring responsibility.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended 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.

9. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

10. 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.

11. 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.

12. 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.

13. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

14. 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 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; and General Probation Requirements.

15. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

16. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

18. 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Albert J. Garcia, 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: 8/12/17

ROBERT ALAN YOHO, M.D.
Respondent

I have read and fully discussed with Respondent Robert Alan Yoho, 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: 8-15-17

ALBERT J. GARCIA, ESQ.
Attorney for Respondent

Exhibit A

First Amended Accusation No. 17-2013-235101

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct 11 2016
BY D. Richards ANALYST

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

In the Matter of the First Amended Accusation Against: **Robert Yoho, M.D.** **301 South Fair Oaks Avenue, #202** **Pasadena, CA 91105** **Physician's and Surgeon's Certificate No. C41114,** Respondent.	Case No. 17-2013-235101 OAH No. 2016030693 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended 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 September 19, 1983, the Medical Board issued Physician's and Surgeon's Certificate Number C41114 to Robert Yoho, 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, 2016, unless renewed.

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JURISDICTION

3. This First Amended 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 unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, be placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the board deems proper.

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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

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."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of patients K.P., M.B., O.J., and M.A.[1] The circumstances are as follows:

Patient K.P.

9. Patient K.P. (or "patient") first presented to Respondent on or about January 7, 2013,[2] for elective cosmetic surgery (liposuction of the upper and lower abdomen, waist, hips, and lower back). The patient also inquired about a breast lift and reduction. No height was listed for the patient, but records indicate that the patient was 250 pounds on January 7, 2013, and 249 pounds on March 8, 2013.[3] The patient was evaluated for her first surgery, which occurred on or about March 11, 2013. Records prior to this first surgery listed, among other things, that medical conditions were "n/a" (non-applicable). Many boxes on the patient health questionnaire were left unchecked and there was essentially no useful information written at any location on the form other than last menstrual period and next anticipated date. The history and physical consisted of nothing more than horizontal lines in Normal/WNL (Within Normal Limits) boxes. No impression was listed, nor is any comment made of the patient's elevated blood pressure. No plan is found in the records.

10. The patient underwent her first elective surgery on or about March 11, 2013. The anesthesia record does not reflect the patient's height or weight. There is no output recorded and it is not possible to discern whether the person monitoring the patient was also part of the surgical team and therefore sterilely involved with surgery and doing "double-duty," or whether he/she was fully devoted to monitoring the patient.[4] No preoperative note is found, no recovery record is found. There is no discharge note or notation of the patient having achieved an appropriate post-

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[1] The patients are identified by initial to protect their privacy.

[2] There did not appear to be a medical consultation on this date.

[3] Records note that Respondent indicated that the patient "needs to lose 20 lbs. and return."

[4] Respondent performed as both the anesthesiologist and the surgeon in this case.

operative status, which would include: voiding, lack of orthostasis,[5] ability to take fluids, ability to ambulate, completion of an Aldrete scale,[6] or other similar criteria. The patient returned after the first surgery for follow-up visits, but it was not possible from the records to tell how the first operation affected the patient's desired outcome.

11. The patient underwent her second surgery on or about September 4, 2013.[7] Records show a blood pressure of 156/96 and a weight of 247.2 lbs., thus reflecting essentially no weight loss approximately nine months since the patient's initial visit on January 7, 2013, when a 20 lb. weight loss was advised. The brief entries in the preoperative evaluation are marginally legible and can be "decoded" to infer that the physical exam was unremarkable. Nothing in the record suggests that the patient had congestive heart failure (CHF).[8]

12. The anesthesia record does not reflect the patient's height or weight, nor the time in the operating room. There is no output recorded and it is not possible to discern whether the person monitoring the patient was also part of the surgical team and therefore sterilely involved with surgery and doing "double duty," or whether that person was fully devoted to monitoring the patient.[9]

13. As in the first surgery, no preoperative note is found, no recovery record is found or completed, and there is no place on the anesthesia form to note transport to the recovery area. There is no discharge note or notation of the patient having achieved an appropriate post-operative status, which would include: voiding, lack of orthostasis, ability to take fluids, ability to ambulate, completion of an Aldrete scale, or other similar criteria. Furthermore, there is no

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[5] A form of low blood pressure, known colloquially as a head rush or dizzy spell.

[6] Used to measure the recovery of a patient after general anesthesia.

[7] There is no record of any preparation for surgery between August 8, 2013 and August 29, 2013 (the date originally scheduled for the second surgery). There is no history and physical information other than horizontal lines through a form in the WNL column, no progress note, and no indication why surgery was canceled or what it was scheduled for in the first place.

[8] While the record does not show CHF, Respondent stated that he thought that the patient had CHF, and that the patient died of it as a primary cause after surgery.

[9] As in the first surgery, Respondent was both the anesthesiologist and the surgeon.

indication of personnel with demonstrated skills to administer propofol,[10] manage complications, or endotracheally intubate[11] the patient.[12]

14. On September 4, 2013, patient K.P. died. On September 6, 2013, an autopsy was performed. Perforations/punctures of the pleura, as well as rib fractures and hemorrhaging were found. The pathologist noted a Body Mass Index (BMI) of 39 with a heart weighing 550 grams (slight cardiomegaly).[13] The autopsy report also states that the manner of death was likely due to "trauma" caused by the surgical procedure, and also that the patient died as a result of "cardiac dysfunction and arrhythmia due to hypertensive cardiomyopathy."[14] An anesthesiology consultation also emphasized toxic levels of lidocaine[15] in the femoral vein, and that seizures or unconsciousness and cardiac depression would likely be present.

Patient M.B.

15. Patient M.B. (or "patient") first presented to Respondent on or about April 24, 2013, for breast augmentation. The patient questionnaire reflects that the patient was in excellent health. The physical exam form is dated April 24, 2013 mostly consists of horizontal lines in the form for Normal/WNL. The preoperative evaluation is difficult to read, but seems to reflect a normal exam. Preoperative laboratory data on April 25, 2013 are unremarkable and show a hematocrit[16] of 41.7.

16. Notes from a staff member indicate that the patient was notified at 3pm on April 30, 2013, that she was scheduled for breast augmentation surgery on May 1, 2013, the next day at 10 am. There is no space in the anesthesia record for immediate preop vital signs, height, weight,

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[10] A short-acting hypnotic agent used in general anesthesia.

[11] Endotracheal intubation is a medical procedure in which a tube is placed into the windpipe (trachea) through the mouth or nose, to assist with respiration.

[12] Although the patient died shortly after the second surgery, the operative note contained statements like, "The patient tolerated the procedure well…" and "liposuction was carried out in the usual fashion."

[13] Abnormal enlargement of the heart.

[14] Disease of the heart muscle.

[15] A local anesthetic often used for minor surgery.

[16] Volume percentage of red blood cells in the blood. It is usually 45% for men and 40% for women.

ASA status and no indications for the beginning and ending of the procedure. There is no indication of what the operation is, or the position of the patient.

17. The patient underwent breast augmentation surgery on May 1, 2013. The patient awakened after the short surgery, but soon experienced respiratory distress. Paramedics arrived shortly thereafter, and the patient was transported to Huntington Hospital where resuscitation efforts failed, and she was pronounced dead shortly upon arrival.

18. There is no output recorded and it is not possible to discern whether the person monitoring the patient was also part of the surgical team and therefore sterilely involved with surgery and doing "double duty," or whether that person was fully devoted to monitoring the patient.[17]

19. No preoperative note is found, no recovery record is found or completed, and there is no place on the anesthesia form to note transport to the recovery area. There is no discharge note or notation of the patient having achieved an appropriate post-operative status, which would include: voiding, lack of orthostasis, ability to take fluids, ability to ambulate, completion of an Aldrete scale, or other similar criteria. Furthermore, there is no personnel that has the demonstrated skills to administer propofol and manage complications or endotracheally intubate the patient.

20. The duration of the operation is listed as 25 minutes.[18] The operative note appears to be a template and no volume or actual implant used is recorded. The inflation volume of the implant sizer is not mentioned either. The operative note concludes by stating the patient did well during surgery and no abnormalities were noted procedurally. There was no recording of the patient awakening, no record of transport to recovery, and other related absences of post-procedure complications and attendant documentation.

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[17] As in the case of patient K.P., Respondent was both the anesthesiologist and the surgeon for patient M.B.

[18] This is little time to accomplish anatomic pocket dissection, check for hemostasis, preserve antisepsis and preserve tissues, Halstead's four basic principles of surgery.

Patient O.J.

21. The patient first presented to Respondent on or about June 5, 2013, to inquire about information on elective cosmetic surgery (e.g. adiposity of the upper and lower abdomen, flanks, upper back, inner and outer thighs, a tummy tuck tuneup, and fat transfer to the buttocks). The initial consultation form is unsigned and is essentially a checklist of desires used to price information, but not a medical history and physical form. The record for this patient also consists of a two-page patient health questionnaire, which had an overwhelming majority of boxes which were left unchecked, and which provided essentially no useful information written in at any location on the form, other than last menstrual period and next anticipated date.

22. A physical examination form, dated June 5, 2013, was signed by a physician assistant and the form consists of nothing more than diagonal lines/check marks in Normal/WNL boxes, other than the breast section, which contains a long horizontal line. No impression was listed, no comment was made of the elevated diastolic blood pressure, no proposed operative plan by the surgeon was found, no consultation note or history and physical by the operating surgeon, no attestation, and many of the entries contained illegible handwriting.

23. The patient underwent surgery on June 19, 2013, and the operative note used to document this surgery was a template, with many sentences in the dictation seeming remarkably similar to another surgical case.[19] Postoperatively, the patient was in respiratory distress (i.e. found to be in fluid imbalance with hypotension) and was transported to a nearby emergency department.[20]

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[19] For example, the final sentence states, "The patient tolerated the procedure well and was taken to the recovery room in good condition." This identical sentence stating that the patient was in good condition was also found in the operative note of patient K.P.

[20] The recovery record on this patient, while under respondent's care, does not extend beyond 12:50 p.m., and there is no indication of monitoring thereafter. The blood pressure and heart rate are essentially the same, horizontal for two consecutive hours, which is almost inconceivable in someone who is in respiratory distress with dysphagia. There is also a gap of more than two or three hours in the written recovery or observation record of this patient, who was in fluid imbalance with hypotension and respirator distress. After the patient was transported to the hospital, respondent made numerous visits to the hospital and provided medical care to this patient, despite not having medical privileges at the hospital.

Patient M.A.

24. The patient first presented to Respondent on or about May 12, 2014, expressing interest in having elective cosmetic surgery. In November 2014, the patient was prepared for abdominoplasty surgery. The history and physical over Respondent's signature consists of nothing more than horizontal lines in Normal/WNL boxes. No impression was listed, nor was any plan found in the chart. There is no surgeon's note, attestation form, or history and physical examination of any substance, clarity or content by either Respondent or Dr. W.[21]

25. On or about December 4, 2014, the patient underwent her first surgery (abdominoplasty/tummy tuck). Post surgery, there is no brief op note, post-anesthesia unit (PACU) note or other records to reflect contemporaneously the condition of the patient. Also, there is no record of intravenous fluids administered by the anesthesia caregiver and there are what appears to be two different signatures on the two pages of the anesthesia record. There is no record of any physician making any mention of the intravenous fluids administration in the operating room or recovery period. There was no mention of the patient's total I/O's from surgery, or after the IV fluids. No record of voiding was mentioned. The record does not reflect that Respondent or Dr. W. were aware of the patient's fluid status from the 3-hour abdominoplasty procedure.

26. In July 2015, the patient underwent a second elective surgery (breast augmentation and liposuction) with Respondent listed as the surgeon and Dr. W. as the assistant. After this second procedure, the patient experienced complications (pain and bleeding in her left breast), and she was transferred to the Emergency Room (ER) in Visalia. The patient's diagnosis after being admitted to the ER was left breast post-operative hematoma, acute hemorrhagic shock/instability, and acute blood loss anemia. In August 2015, the patient was treated by another physician (Dr. L.) for corrective surgery of her left breast.[22]

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[21] The true identity of "Dr. W." is not disclosed to protect his identity. Dr. W's identity will be disclosed upon a proper discovery request. There is no indication that the patient was aware that Dr. W., as opposed to Respondent, would perform the surgery. Apparently, Respondent had communicated with Dr. W or he [Respondent] was in attendance at the procedure.

[22] Dr. L's notes indicated that Respondent confirmed that the patient's left breast implant (continued...)

27. The following acts or omissions committed by Respondent in his care and treatment of patients K.P., M.B., O.J., and M.A. constitute an extreme departure from the standard of care:

Patient K.P.

a. Failing to properly evaluate/screen a high-risk patient[23] for an elective surgery(ies), and to document same;

b. Failing to properly address the patient's complicated medical conditions and/or to consult with or refer the patient to the appropriate specialists;

c. Failing to properly follow-up on a preoperative plan that significantly impacts a patient's risk for surgery and surgical outcome, specifically a plan for the patient to lose 20 lbs. prior to surgery;

d. Performing elective cosmetic surgery on a patient with congestive heart failure (CHF);[24]

e. Failing to dedicate a solely-focused nurse anesthetist or anesthesiologist to a patient's anesthesia;

f. Failing to use endotracheal intubation on the patient;

g. Failing to properly perform a surgical procedure, as shown by the rib fracture and multiple pleural punctures during liposuction; and

h. Failing to ensure that staff were performing appropriate procedures during surgery, and to provide an adequate backup surgeon(s) to relieve Respondent when necessary.

Patient M.B.

i. Failing to dedicate a solely-focused nurse anesthetist or anesthesiologist to a patient's anesthesia;

(...continued)
was ruptured, but this is not reflected in Respondent's notes.

[23] Records indicate that the patient had morbid obesity, or near morbid obesity, and exhibited signs of hypertension and anemia, which are all contradictions to an elective surgery.

[24] Although there are no indications that the patient had CHF, Respondent testified in a deposition that he thought that the patient had CHF *preoperatively*. If this statement by Respondent reflects his true thought processes before the surgery, choosing to perform an elective cosmetic surgery on a patient who Respondent thought had CHF would be an extreme departure from the standard of care.

j. Failing to use endotracheal intubation on the patient;

k. Rushing to place an elective patient on the surgery schedule;[25] and

l. Failing to perform appropriate screening and evaluation of the patient's medical condition prior to surgery.[26]

Patient O.J.

m. Failing to properly evaluate/screen this patient for an elective surgery(ies), and to document same;

n. Using a template for reporting a surgical procedure (i.e. not updating individually the actual procedure performed, but instead using a "cookie cutter" operative note, which contained similar/same statements as in other cases).

Patient M.A.

o. Failing to perform emergent surgical care to address postoperative hemorrhaging of the patient's left breast;[27]

p. Failing to properly diagnose acute hemorrhagic shock while in the operating or recovery room;

q. Failing to properly follow up on the patient's hospital course;

r. Failing to properly record IV fluids in a tummy tuck procedure;

s. Failing to safeguard by monitoring I/O's in a patient who undergoes a major operation associated with blood loss, higher morbidity and mortality.

28. Respondent's acts and/or omissions as set forth in paragraphs 9 through 27, inclusive, above, whether proven individually, jointly, or in any combination thereof, constitute gross

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[25] A surgery slot became available on April 30, 2013 at 3pm, and the patient was placed on that schedule on May 1, 2013, the next day, at 10am.

[26] There is no indication that the patient was properly screened/prepared for surgery. Respondent did not seem to have knowledge, or overlooked the patient's narcotic use and medical condition such as migraine headaches and asthma, conditions which should have changed the preoperative preparation of this patient for surgery. There is also no indication that Respondent consulted with the patient's personal physician prior to the surgery.

[27] Respondent's recommendation was "Not [to] operate on [the] left breast emergently…a technically difficult procedure…"

negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care of patients K.P., M.B., O.J. , and M.A.

30. The facts and allegations in the First Cause for Discipline, above, are incorporated by reference as if set forth in full herein.

31. Respondent also committed repeated negligent acts as follows:

a. Failing to properly maintain accurate and adequate medical records in his care of patients K.P , M.B., O.J., and M.A.;

b. Failing to decrease the lidocaine dose to avoid toxicity with respect to patient K.B.;

c. Failing to address a mildly elevated diastolic blood pressure and failing to document an evaluation, history and physical exam, interim progress notes recording the patient's condition, and indications for surgery and appropriate consultation, before performing the procedure on patient O.J.;

d. Failing to adequately administer intravenous fluids and to monitor the patient's intake and output levels to avoid complications with respect to patient O.J.;

e. Failing to use an indwelling catheter for patient O.J., a hypotensive patient who was under respiratory distress;

f. Using heated IV crystalloid bags as a warming device, causing burns to patient O.J.;

g. Administering medical care to patient O.J. in a hospital setting without having medical privileges at the hospital.

h. Failing to properly evaluate patient M.A. for surgery and to adequately document same in the medical records.

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THIRD CAUSE FOR DISCIPLINE

(Inadequate Records)

32. By reason of the facts and allegations set forth in the First and Second Causes for Discipline, above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of patients K.P. , M.B., O.J., and M.A.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

33. By reason of the facts and allegations set forth in the First and Second Causes for Discipline, above, Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code, in that Respondent showed incompetence in his care and treatment of patients K.P., M.B., O.J., and M.A.

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 C41114, issued to Robert Yoho, M.D.;

2. Revoking, suspending or denying approval of Robert Yoho, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Robert Yoho, 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: October 11, 2016

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