

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

In the Matter of the Accusation )  
Against: )  
)  
)  
ROBERT CLYDE HOSTETTER, M.D. )  
)  
Physician's and Surgeon's )  
Certificate No. G 33650 )  
)  
Respondent )  
\_\_\_\_\_ )

Case No. 800-2013-000238

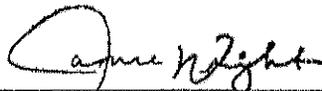
DECISION

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 October 28, 2016.

IT IS SO ORDERED: September 28, 2016.

MEDICAL BOARD OF CALIFORNIA



\_\_\_\_\_  
Jamie Wright, JD, Chair  
Panel A

1 KAMALA D. HARRIS  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 GREG W. CHAMBERS  
Deputy Attorney General  
4 State Bar No. 237509  
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5 San Francisco, CA 94102-7004  
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*Attorneys for Complainant*

7  
8 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

10 In the Matter of the Accusation Against:

Case No. 800-2013-000238

11 **ROBERT CLYDE HOSTETTER, M.D.**

OAH No. 2016031069

12 **Clinica de Salud del Valle de Salinas**  
13 **122 E. San Antonio Drive**  
14 **King City, CA 93930-2518**

**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

15 **Physician's and Surgeon's Certificate No.**  
**G33650**

16 Respondent.

17  
18 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-  
19 entitled proceedings that the following matters are true:

20 PARTIES

21 1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical  
22 Board of California. She brought this action solely in her official capacity and is represented in  
23 this matter by Kamala D. Harris, Attorney General of the State of California, by Greg W.  
24 Chambers, Deputy Attorney General.

25 2. Respondent Robert Clyde Hostetter, M.D. ("Respondent") is represented in this  
26 proceeding by attorney Robert W. Hodges, Esq., whose address is: 1211 Newell Ave.  
27 P. O. Box 5288, Walnut Creek, CA 94596  
28





1 for its prior approval educational program(s) or course(s) which shall not be less than forty (40)  
2 hours per year, for each year of probation. The educational program(s) or course(s) shall be  
3 aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified.  
4 The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition  
5 to the Continuing Medical Education ("CME") requirements for renewal of licensure. Following  
6 the completion of each course, the Board or its designee may administer an examination to test  
7 Respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-  
8 five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

9       2.    MEDICAL RECORD KEEPING COURSE. Within sixty (60) calendar days of the  
10 effective date of this Decision, Respondent shall enroll in a course in medical record keeping  
11 equivalent to the Medical Record Keeping Course offered by the Physician Assessment and  
12 Clinical Education Program, University of California, San Diego School of Medicine  
13 ("Program"), approved in advance by the Board or its designee. Respondent shall provide the  
14 program with any information and documents that the Program may deem pertinent. Respondent  
15 shall participate in and successfully complete the classroom component of the course not later  
16 than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete  
17 any other component of the course within one (1) year of enrollment. The medical record  
18 keeping course shall be at Respondent's expense and shall be in addition to the CME  
19 requirements for renewal of licensure.

20       A medical record keeping course taken after the acts that gave rise to the charges in the  
21 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board  
22 or its designee, be accepted towards the fulfillment of this condition if the course would have  
23 been approved by the Board or its designee had the course been taken after the effective date of  
24 this Decision.

25       Respondent shall submit a certification of successful completion to the Board or its  
26 designee not later than fifteen (15) calendar days after successfully completing the course, or not  
27 later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

28       3.    CLINICAL TRAINING PROGRAM. Within sixty (60) calendar days of the

1 effective date of this Decision, Respondent shall enroll in a clinical training or educational  
2 program equivalent to the Physician Assessment and Clinical Education Program ("PACE")  
3 offered at the University of California - San Diego School of Medicine ("Program"). Respondent  
4 shall successfully complete the Program not later than six (6) months after Respondent's initial  
5 enrollment unless the Board or its designee agrees in writing to an extension of that time.

6 The Program shall consist of a Comprehensive Assessment program comprised of a two-  
7 day assessment of Respondent's physical and mental health; basic clinical and communication  
8 skills common to all clinicians; and medical knowledge, skill and judgment pertaining to  
9 Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum,  
10 a forty (40) hour program of clinical education in the area of practice in which Respondent was  
11 alleged to be deficient and which takes into account data obtained from the assessment,  
12 Decision(s), Accusation(s), and any other information that the Board or its designee deems  
13 relevant. Respondent shall pay all expenses associated with the clinical training program.

14 Based on Respondent's performance and test results in the assessment and clinical  
15 education, the Program will advise the Board or its designee of its recommendation(s) for the  
16 scope and length of any additional educational or clinical training, treatment for any medical  
17 condition, treatment for any psychological condition, or anything else affecting Respondent's  
18 practice of medicine. Respondent shall comply with Program recommendations.

19 At the completion of any additional educational or clinical training, Respondent shall  
20 submit to and pass an examination. Determination as to whether Respondent successfully  
21 completed the examination or successfully completed the program is solely within the program's  
22 jurisdiction.

23 Respondent shall not practice medicine until Respondent has successfully completed the  
24 Program and has been so notified by the Board or its designee in writing, except that Respondent  
25 may practice in a clinical training program approved by the Board or its designee. Respondent's  
26 practice of medicine shall be restricted only to that which is required by the approved training  
27 program.

28 Within sixty (60) days after Respondent has successfully completed the clinical training

1 program, Respondent shall participate in a professional enhancement program equivalent to the  
2 one offered by the Physician Assessment and Clinical Education Program at the University of  
3 California, San Diego School of Medicine, which shall include quarterly chart review, semi-  
4 annual practice assessment, and semi-annual review of professional growth and education.  
5 Respondent shall participate in the professional enhancement program at Respondent's expense  
6 during the term of probation, or until the Board or its designee determines that further  
7 participation is no longer necessary.

8 4. MONITORING - PRACTICE. Within thirty (30) calendar days of the effective date  
9 of this Decision, Respondent shall submit to the Board or its designee for prior approval as a  
10 practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons  
11 whose licenses are valid and in good standing, and who are preferably American Board of  
12 Medical Specialties ("ABMS") certified. A monitor shall have no prior or current business or  
13 personal relationship with Respondent, or other relationship that could reasonably be expected to  
14 compromise the ability of the monitor to render fair and unbiased reports to the Board, including  
15 but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree  
16 to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

17 The Board or its designee shall provide the approved monitor with copies of the Decision(s)  
18 and Accusation(s), and a proposed monitoring plan. Within fifteen (15) calendar days of receipt  
19 of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a  
20 signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands  
21 the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor  
22 disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan  
23 with the signed statement for approval by the Board or its designee.

24 Within sixty (60) calendar days of the effective date of this Decision, and continuing  
25 throughout probation, Respondent's practice shall be monitored by the approved monitor.  
26 Respondent shall make all records available for immediate inspection and copying on the  
27 premises by the monitor at all times during business hours and shall retain the records for the  
28 entire term of probation.

1           If Respondent fails to obtain approval of a monitor within sixty (60) calendar days of the  
2 effective date of this Decision, Respondent shall receive a notification from the Board or its  
3 designee to cease the practice of medicine within three (3) calendar days after being so notified.  
4 Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring  
5 responsibility.

6           The monitor(s) shall submit a quarterly written report to the Board or its designee which  
7 includes an evaluation of Respondent's performance, indicating whether Respondent's practices  
8 are within the standards of practice of medicine, and whether Respondent is practicing medicine  
9 safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure  
10 that the monitor submits the quarterly written reports to the Board or its designee within ten (10)  
11 calendar days after the end of the preceding quarter.

12           If the monitor resigns or is no longer available, Respondent shall, within five (5) calendar  
13 days of such resignation or unavailability, submit to the Board or its designee, for prior approval,  
14 the name and qualifications of a replacement monitor who will be assuming that responsibility  
15 within fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor  
16 within sixty (60) calendar days of the resignation or unavailability of the monitor, Respondent  
17 shall receive a notification from the Board or its designee to cease the practice of medicine within  
18 three (3) calendar days after being so notified Respondent shall cease the practice of medicine  
19 until a replacement monitor is approved and assumes monitoring responsibility.

20           In lieu of a monitor, Respondent may participate in a professional enhancement program  
21 equivalent to the one offered by the Physician Assessment and Clinical Education Program at the  
22 University of California, San Diego School of Medicine, that includes, at minimum, quarterly  
23 chart review, semi-annual practice assessment, and semi-annual review of professional growth  
24 and education. Respondent shall participate in the professional enhancement program at  
25 Respondent's expense during the term of probation.

26           5.   SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the  
27 solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice  
28 where: 1) Respondent merely shares office space with another physician but is not affiliated for

1 purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that  
2 location.

3 If Respondent fails to establish a practice with another physician or secure employment in  
4 an appropriate practice setting within sixty (60) calendar days of the effective date of this  
5 Decision, Respondent shall receive a notification from the Board or its designee to cease the  
6 practice of medicine within three (3) calendar days after being so notified. The Respondent shall  
7 not resume practice until an appropriate practice setting is established.

8 If, during the course of the probation, the Respondent's practice setting changes and the  
9 Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent  
10 shall notify the Board or its designee within five (5) calendar days of the practice setting change.  
11 If Respondent fails to establish a practice with another physician or secure employment in an  
12 appropriate practice setting within sixty (60) calendar days of the practice setting change,  
13 Respondent shall receive a notification from the Board or its designee to cease the practice of  
14 medicine within three (3) calendar days after being so notified. The Respondent shall not resume  
15 practice until an appropriate practice setting is established.

16 6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the  
17 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the  
18 Chief Executive Officer at every hospital where privileges or membership are extended to  
19 Respondent, at any other facility where Respondent engages in the practice of medicine,  
20 including all physician and locum tenens registries or other similar agencies, and to the Chief  
21 Executive Officer at every insurance carrier which extends malpractice insurance coverage to  
22 Respondent. Respondent shall submit proof of compliance to the Board or its designee within  
23 fifteen (15) calendar days.

24 This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

25 7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is  
26 prohibited from supervising physician assistants.

27 8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules  
28 governing the practice of medicine in California and remain in full compliance with any court

1 ordered criminal probation, payments, and other orders.

2 9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations  
3 under penalty of perjury on forms provided by the Board, stating whether there has been  
4 compliance with all the conditions of probation.

5 Respondent shall submit quarterly declarations not later than ten (10) calendar days after  
6 the end of the preceding quarter.

7 10. GENERAL PROBATION REQUIREMENTS.

8 Compliance with Probation Unit

9 Respondent shall comply with the Board's probation unit and all terms and conditions of  
10 this Decision.

11 Address Changes

12 Respondent shall, at all times, keep the Board informed of Respondent's business and  
13 residence addresses, email address (if available), and telephone number. Changes of such  
14 addresses shall be immediately communicated in writing to the Board or its designee. Under no  
15 circumstances shall a post office box serve as an address of record, except as allowed by Business  
16 and Professions Code section 2021(b).

17 Place of Practice

18 Respondent shall not engage in the practice of medicine in Respondent's or patient's place  
19 of residence, unless the patient resides in a skilled nursing facility or other similar licensed  
20 facility.

21 License Renewal

22 Respondent shall maintain a current and renewed California physician's and surgeon's  
23 license.

24 Travel or Residence Outside California

25 Respondent shall immediately inform the Board or its designee, in writing, of travel to any  
26 areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty  
27 (30) calendar days.

28 In the event Respondent should leave the State of California to reside or to practice

1 Respondent shall notify the Board or its designee in writing thirty (30) calendar days prior to the  
2 dates of departure and return.

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

6 12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or  
7 its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting  
8 more than 30 calendar days and within fifteen (15) calendar days of Respondent's return to  
9 practice. Non-practice is defined as any period of time Respondent is not practicing medicine in  
10 California as defined in Business and Professions Code sections 2051 and 2052 for at least forty  
11 (40) hours in a calendar month in direct patient care, clinical activity or teaching, or other activity  
12 as approved by the Board. All time spent in an intensive training program which has been  
13 approved by the Board or its designee shall not be considered non-practice. Practicing medicine  
14 in another state of the United States or Federal jurisdiction while on probation with the medical  
15 licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-  
16 ordered suspension of practice shall not be considered as a period of non-practice.

17 In the event Respondent's period of non-practice while on probation exceeds eighteen (18)  
18 calendar months, Respondent shall successfully complete a clinical training program that meets  
19 the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary  
20 Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

21 Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

23 Periods of non-practice will relieve Respondent of the responsibility to comply with the  
24 probationary terms and conditions with the exception of this condition and the following terms  
25 and conditions of probation: Obey All Laws; and General Probation Requirements.

26 13. COMPLETION OF PROBATION. Respondent shall comply with all financial  
27 obligations (e.g., restitution, probation costs) not later than one-hundred twenty (120) calendar  
28 days prior to the completion of probation. Upon successful completion of probation,

1 Respondent's certificate shall be fully restored.

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

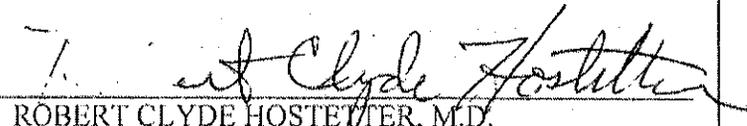
9 15. LICENSE SURRENDER. Following the effective date of this Decision, if  
10 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy  
11 the terms and conditions of probation, Respondent may request to surrender his or her license.  
12 The Board reserves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

19 16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated  
20 with probation monitoring each and every year of probation, as designated by the Board, which  
21 may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of  
22 California and delivered to the Board or its designee no later than January 31 of each calendar  
23 year.

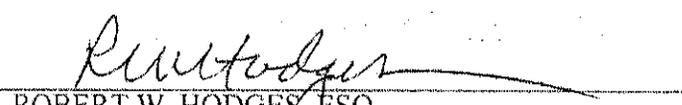
#### 24 ACCEPTANCE

25 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully  
26 discussed it with my attorney, Robert W. Hodges, Esq. I understand the stipulation and the effect  
27 it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement  
28

1 and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the  
2 Decision and Order of the Medical Board of California.

3  
4 DATED: 8/15/16   
5 ROBERT CLYDE HOSTETTER, M.D.  
6 Respondent

7 I have read and fully discussed with Respondent Robert Clyde Hostetter, M.D. the terms  
8 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary  
9 Order. I approve its form and content.

10 DATED: 8/15/16   
11 ROBERT W. HODGES, ESQ.  
12 Attorney for Respondent

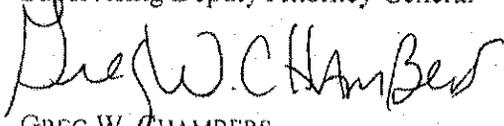
13 ENDORSEMENT

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

16 Dated: 8/15/2016

17 Respectfully submitted,

18 KAMALA D. HARRIS  
19 Attorney General of California  
20 JANE ZACK SIMON  
21 Supervising Deputy Attorney General

  
22 GREG W. CHAMBERS  
23 Deputy Attorney General  
24 Attorneys for Complainant

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27  
28

**Exhibit A**

**Accusation No. 800-2013-000238**

1 KAMALA D. HARRIS  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 VIVIEN H. HARA  
Deputy Attorney General  
4 State Bar No. 84589  
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E-mail: vivien.hara@doj.ca.gov  
7 *Attorneys for Complainant*

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO August 4, 2015  
BY: JYELMAK ANALYST

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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 CLYDE HOSTETTER, M.D.**  
Clinica de Salud del Valle de Salinas  
122 E. San Antonio Drive  
King City, CA 93930-2518  
Physician and Surgeon's Certificate  
No. G 33650,  
Respondent.

Case No. 800-2013-000238

**ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).
2. On or about March 7, 1977, the Medical Board issued Physician's and Surgeon's Certificate Number G 33650 to Robert Clyde Hostetter, M.D. (Respondent). The Physician and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2017, unless renewed.

///  
///

## JURISDICTION

1  
2       3.     This Accusation is brought before the Board, under the authority of the following  
3 laws. All section references are to the Business and Professions Code unless otherwise indicated.

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

8       5.     Section 2234 of the Code, states:

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

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

13               "(b) Gross negligence.

14               "(c) Repeated negligent acts. To be repeated, there must be two or more  
15 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.

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

18               "(2) When the standard of care requires a change in the diagnosis, act, or  
19 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  
20 licensee's conduct departs from the applicable standard of care, each departure  
constitutes a separate and distinct breach of the standard of care.

21               "(d) Incompetence.

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

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

26               "(g) The practice of medicine from this state into another state or country  
27 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  
28 become operative upon the implementation of the proposed registration program  
described in Section 2052.5.



1 38 (indicating a significant inflammatory process), but the urinalysis showed no signs of infection  
2 (indicating no urinary tract infection).

3 10. P-1 received intravenous (IV) fluids and was reexamined by Respondent at 8:47 p.m.  
4 (85 minutes after P-1's arrival), and Respondent noted that P-1 had a few bowel sounds and took  
5 a popsicle. In a third examination at 9:02 p.m., 15 minutes after the second examination and 100  
6 minutes after P-1's arrival, Respondent noted that the child's abdomen was non-tender to  
7 palpation and that he considered the patient non-surgical. Respondent's final clinical impression  
8 on April 20, 2011 was that P-1's illness was due to dehydration and fever. P-1 was discharged  
9 home with directions to push fluids, take Tylenol for pain and fever, and return the next morning  
10 for re-check. P-1 did not return the next day for follow-up examination. There is no indication in  
11 the record that an interpreter was provided for the mother or that the mother understood the  
12 instructions given.

13 11. P-1 returned to the MMH ER on April 28, 2011 at approximately 11:40 p.m. and was  
14 seen by another ER physician. Chief complaint at the time was a mild localized abdominal pain.  
15 Vital signs taken revealed a modestly elevated pulse of 125. Laboratory studies including a CBC  
16 and chemistry panel indicated a persistently elevated white blood count of 15.2, a falling  
17 hematocrit from 37 to 33.7 and falling sodium level at 129, as well as mildly low potassium.  
18 Apparently P-1 had had abdominal pain intermittently for the past week. P-1 was noted as  
19 asymptomatic on discharge at 12:48 a.m. with a non-tender abdomen and tolerating a popsicle.  
20 Instructions were given to return to the ER the next morning for follow-up, but the child did not  
21 return at that time.

22 12. On April 30, 2011 at approximately 1:25 p.m., P-1 returned to the MMH ER and  
23 was again seen by Respondent. The child's records indicate fever, abdominal pain, and vomiting  
24 over one day. P-1's abdomen was distended with tenderness but no guarding, rebound, or  
25 abnormal bowel sounds. She was lethargic and somnolent. Initial vitals signs indicated a normal  
26 temperature but elevated pulse rate of 143 bpm. IV fluid bolus was administered and maintained.  
27 Respondent ordered 1 mg. IV morphine initially and again at or about 4:00 p.m.  
28

1           13. Abdominal x-rays were ordered, and results indicated air-fluid levels with possible  
2 free air, which indicates a life-threatening perforation of an abdominal organ. Respondent did not  
3 document these results in the chart, so it is unclear if or when he became aware of these findings.  
4 Surgical consult was called at 2:35 p.m., and the surgeon called requested a CT scan with rectal  
5 contrast to better define the problem before operating. At about this time, Respondent was  
6 informed of a critical CRP level of 34. The CT scan requested by the surgeon and allowed by  
7 Respondent commenced at about 3:15 p.m. At about 4:10 p.m., Respondent was informed that  
8 the CT results showed free fluid and possible free air in the abdomen, indicating life-threatening  
9 leakage of bowel contents into the abdominal cavity. The surgeon was contacted again at 4:15  
10 p.m. and informed of the results.

11           14. The surgeon arrived to examine P-1 and recommend surgery at 5:00 p.m. New vital  
12 signs taken at 5:20 p.m. indicated a fever of 102.6° F, a rising pulse rate of 150 bpm, and a falling  
13 oxygen saturation reading of 95%. The surgeon ordered IV antibiotics and was prepared to  
14 commence surgery shortly after 5:20 p.m., but another operation was about to begin or had just  
15 begun in the operating room (OR), and so P-1 was taken to the operating room (OR) at 7:10 p.m.,  
16 and the operation commenced at 7:29 p.m., six (6) hours after P-1 had presented to the ER with  
17 clinical evidence of a surgical abdomen. Respondent indicated in his subject interview with the  
18 Board's investigator and medical consultant on September 22, 2014 that as soon as the surgeon  
19 appeared at the ER, he allowed him to take over the care of the patient.

20           15. The surgeon, commencing with a preoperative diagnosis of abdominal peritonitis,  
21 performed an exploratory laparotomy, lysis of adhesions, repair of enterotomy x 4, mobilization  
22 of splenic flexure, partial colectomy, drainage of multiple intra-abdominal abscesses; peritoneal  
23 lavage, and transverse colectomy. P-1 became persistently hypertensive, tachycardic, and  
24 hypodermic, and at or about midnight on April 30, 2011, she had no pulse and was on the  
25 maximum of dopamine pressers and IV fluids. The decision was made to discontinue  
26 resuscitative measures, and P-1 expired at or about 12:15 a.m. on May 1, 2011 of overwhelming  
27 sepsis. Postoperative diagnosis was peritonitis, bowel perforation, and sepsis.

28

1           16. Respondent's Physician and Surgeon's Certificate is subject to discipline pursuant to  
2 sections 2234(b) and/or (c) and/or (d) of the Code by reason of the following acts or omissions:

3           I. P-1's First Visit to MMH ER April 20, 2011

4           A. Respondent failed to recognize multiple problems revealed in the laboratory studies  
5 ordered that indicated a seriously ill child with a high likelihood of sepsis. The high white blood  
6 cell count with left shift suggested a bacterial illness. The CO2 level of 19 indicated acidosis.  
7 CRP level 38 times the normal range indicated a serious abdominal inflammatory process. The  
8 KUB x-ray, which Respondent found to be non-diagnostic, suggested a process in the patient's  
9 left upper quadrant. The combination of elevated white count, elevated CRP, elevated  
10 temperature and abdominal pain in a pediatric patient indicated a serious abdominal infection  
11 requiring further evaluation and treatment.

12           B. Respondent's diagnosis of dehydration and fever causing the child's symptoms is  
13 unsupported by symptoms such as vomiting and diarrhea, and laboratory studies indicated a  
14 normal serum blood-urea-nitrogen (BUN), creatinine, and urine specific gravity, which taken  
15 together, rule out significant dehydration.

16           C. Respondent wrote clinical impressions that were in opposition to the available  
17 findings.

18           D. Respondent's medical evaluation was inappropriately limited. Respondent  
19 considered but decided against ultrasound or CT scan for the patient without clear reasons. A  
20 child with abdominal pain, fever, elevated white count, and elevated CRP was very much a  
21 candidate for abdominal CT scan or further diagnostic testing to rule out life-threatening illness.

22           E. Respondent's observation period for P-1 was inadequate. Respondent failed to allow  
23 enough time to adequately assess P-1's condition and risk of serious decline. P-1 was assessed in  
24 the ER for a total of 113 minutes. This length of time is inadequate to fully rule out a developing  
25 surgical abdomen.

26           F. Respondent's discharge plan was inadequate. Respondent failed to provide  
27 appropriate medical follow-up commensurate with the risk as appreciated at the time of  
28 discharge. Although Respondent appropriately requested that P-1 be brought back the next day

1 for reexamination, he did not make a definite appointment or make it clear to P-1's non-English-  
2 speaking and indigent parents of the urgency of the situation. He did not consider a longer  
3 observation period for the child or even hospitalization for the safety of the patient in these  
4 circumstances.

5 G. Respondent failed to document the abdominal x-ray results. Respondent indicated  
6 that he read the KUB x-ray as undiagnostic, but the next day, the radiologist read the film as "left  
7 upper quadrant loops of small bowel suggesting inflammatory process (enteritis)." Because  
8 Respondent did not document his KUB findings in P-1's chart, it is uncertain that he saw the x-  
9 ray to interpret it correctly, and if he did view the x-ray, his impression was incorrect.

10 H. Respondent failed to appreciate the seriousness of the x-ray findings in conjunction  
11 with other laboratory tests and the patient's examination.

12 II. P-1's Third Visit to MMH ER April 30, 2011

13 A. Respondent failed to expedite care for a seriously ill child. P-1 presented to MMH  
14 ER again at 1:25 p.m., and Respondent immediately recognized that P-1 was seriously ill.  
15 Nevertheless, Respondent delayed calling the surgeon pending results of a CBC, even though  
16 crucial elevations and abnormalities had been found on the previous two ER visits. Respondent  
17 then acceded to the surgeon's request for a CT scan with contrast before examination for surgery,  
18 further delaying the time until the surgeon came into the hospital and examined the patient until  
19 5:00 p.m. An acute surgical abdomen should be evaluated by a surgeon as early as possible, and  
20 Respondent, as advocate for the patient, should have insisted that the surgeon examine the patient  
21 immediately without waiting for further studies and their results.

22 B. Respondent abdicated care of the patient in the ER to the surgeon. Respondent as ER  
23 physician was responsible for a patient until that patient is discharged home or admitted to the  
24 hospital. When the surgeon came into the ER to examine the patient, Respondent took no further  
25 responsibility for the patient and allowed the surgeon to delay surgery for a further two (2) hours  
26 citing unavailability of the OR, in which another operation had just commenced. P-1's illness  
27 required emergency care, and Respondent should have taken steps to relocate or preempt the  
28

1 operation commencing in the OR or to make alternative arrangements so that the child could have  
2 had surgery as soon as possible.

3 **SECOND CAUSE FOR DISCIPLINE**

4 **(Negligence - Patient P-2)**

5 17. On or about November 16, 2011 at approximately 7:15 p.m., patient P-2, a 10 year-  
6 old boy, was brought into MMH ER with a complaint of left earache documented as of three (3)  
7 days' duration by Respondent and one (1) day's duration by the nurse. Vital signs were basically  
8 normal with a temperature of 99.6° F. No obvious facial findings were documented. Pain scale  
9 was listed as 7/10. The ear examination was benign, and Respondent suggested Motrin and  
10 Sudafed. Subsequently, five (5) days after his visit to MMH ER, P-2 was diagnosed in another  
11 ER with periorbital cellulitis and sinusitis.

12 18. Respondent is subject to disciplinary action under section 2234(e) in that he was  
13 negligent in his treatment of P-2. Respondent performed an inadequate physical examination of  
14 the child. Respondent documented that he did only an external ear examination on a child  
15 complaining of earache, and no otoscopic ear examination was documented. The external ear  
16 examination was marked as normal by Respondent, but there was no description of the tympanic  
17 membrane or ear canal.

18 **THIRD CAUSE FOR DISCIPLINE**

19 **(Negligence/Incompetence - Patient P-3)**

20 19. On or about July 17, 2011 at 11:23 a.m., patient P-3, a 33 year-old female, presented  
21 to MMH ER with complaints of headache with fever, and Respondent attended her. ER records  
22 indicated that she was seen the day before by another ER physician with headache but no fever.  
23 Past medical history included occasional migraine with no mention of neurological consult or CT  
24 scan. Vital signs included a temperature of 101° F and a pulse of 140 bpm. Pain scale was 9/10.  
25 No abdominal examination was noted. P-3 was treated with Demerol and Phenergan 100/25 IM  
26 at 11:45 a.m., and pain was noted as 8/10 at 12:40 p.m. without vomiting. Dilaudid 1 mg was  
27 given at 1:00 p.m., and at 1:30 p.m., pain was noted to be 5/10. Respondent diagnosed P-3's  
28

1 fever as a viral fever but offered no advice concerning taking antipyretics for fever reduction. P-3  
2 was discharged at 1:35 p.m. with a fever of 103° F and a pulse of 130 bpm.

3 20. The next day, at 1:45 p.m., P-3 returned to MMH ER with abdominal pain. This was  
4 the fourth ER visit in two (2) days. Subumbilical pain of a severe nature was noted along with  
5 fever, nausea, and vomiting. Past medical history included hysterectomy and bilateral tubal  
6 ligation, facts not included in Respondent's history for this patient, but noted by the previous and  
7 subsequent ER physicians. P-3 was afebrile at this time with a pulse of 113 bpm, but with a  
8 significantly lower blood pressure. Pain was noted at 10/10. Laboratory studies indicated  
9 infection, and a CT scan showed a complex mass in the right lower quadrant. Subsequent  
10 preoperative history indicated that P-3 had reported a three (3) day history of lower abdominal  
11 pain associated with episodes of vomiting and fever. Surgery revealed a right tubo-ovarian  
12 abscess.

13 21. Respondent is subject to disciplinary action under sections 2234(c) and/or (d) of the  
14 Code in that he was negligent or incompetent in his treatment of patient P-3 by reason of the  
15 following acts or omissions:

16 A. Respondent's final diagnosis does not follow from P-3's history, physical, and  
17 workup. Respondent concluded that P-3's migraine and tachycardia were triggered by a viral  
18 fever. P-3 reported no symptoms consistent with a viral infection such as nasal congestion,  
19 cough, or nausea/vomiting with diarrhea. P-3 had also presented the previous day with a  
20 headache but no fever, but it is unclear whether Respondent knew this. Respondent did not treat  
21 P-3's fever with antipyretics and did not check for signs of an infectious process elsewhere. It is  
22 not clear from Respondent's records, however, whether P-3 complained to him concerning  
23 abdominal pain and nausea/vomiting.

24 B. Respondent inappropriately discharged P-3 with abnormal vital signs. Before  
25 discharge from the ER, all significant vital sign abnormalities should be documented either as  
26 resolved (*e.g.*, by treatment) or through an explanation as to why the abnormality is not  
27 significant or otherwise pertinent. P-3 was discharged with a significant fever of 103° F and a  
28 high heart rate of 130 bpm. There is no appropriate explanation as to why it was safe to discharge

1 the patient with this significant tachycardia and remarkable fever. Treatment with IV fluids and  
2 antipyretics was indicated and may have been diagnostic in that lack of resolution would have  
3 prompted a search for other causes.

#### 4 FOURTH CAUSE FOR DISCIPLINE

##### 5 (Gross Negligence/Negligence/Incompetence - Patient P-4)

6 22. On or about August 9, 2011 at approximately 3:55 a.m., patient P-4, a 35 year-old,  
7 non-English speaking, unemployed male, presented to Respondent at MMH ER complaining of  
8 three (3) days of abdominal pain, nausea, and vomiting with anorexia. P-4 had no documented  
9 prior similar episodes but had a history of heavy alcohol consumption. Vital signs included a  
10 temperature of 98° F and pulse rate of 86 bpm. Physical examination indicated normal bowel  
11 sounds and mild periumbilical tenderness, and distention. Rebound or guarding was not  
12 addressed. Nurse's notes indicate that the last alcohol consumed was one (1) day prior to  
13 admission, and abdominal pain had persisted for three (3) days. 4/10 pain level was noted.

14 23. At approximately 4:06 a.m., P-4's treatment began with 2 liters wide-open normal  
15 intravenous (IV) saline, a gastrointestinal (GI) cocktail, 5 mg. morphine IV and 4 mg. Zofran IV.  
16 Laboratory results revealed a mildly elevated WBC count of 13.2 with a left shift. Blood glucose  
17 was markedly elevated at 260 mg/dl (Normal fasting 70-100 mg/dl; normal non-fasting 125  
18 mg/dl or less; at >200 mg/dl, diabetes is presumed) without evidence of acidosis. Lipase level  
19 was below normal, and liver function tests were elevated. No alcohol was detected in the blood  
20 sample.

21 24. At approximately 6:15 a.m., P-4 was noted to be resting comfortably with a pain  
22 rating of 1/10. Vital signs included a temperature of 99.1° F and heart rate of 93 bpm. P-4's  
23 temperature and heart rate had risen despite fluid IV and pain medication. Respondent approved  
24 P-4 to be discharged home at 6:30 a.m. with oral instructions given through an interpreter to  
25 return if worse.

26 25. P-4 was returned by ambulance to MMH ER at 10:40 a.m. again complaining of  
27 abdominal pain, this time at a level of 10/10. Physical examination noted abdominal tenderness  
28 and distention without rebound or guarding. P-4's temperature was now 100.4° F and pulse rate

1 was 95 bpm. Laboratory findings noted the opiates administered at the previous visit but also  
2 barbiturates of unclear source. WBC count was markedly low at 6.4 and blood glucose level was  
3 now 421 mg/dl. Further, P-4 reported experiencing increased thirst and urination for the last three  
4 (3) days. A CT scan revealed a possible appendicitis with free fluid and inflammatory mass in  
5 the right lower quadrant. P-4 was taken to surgery at 5:00 p.m., where appendicitis was  
6 confirmed. P-4 was also admitted with a diagnosis of diabetes mellitus and treated with insulin  
7 drip to control blood sugar.

8 26. Respondent is subject to disciplinary action under sections 2234(b) and/or (c) and/or  
9 (d) of the Code by reason of the following acts or omissions:

10 A. Respondent failed to obtain an appropriate history and laboratory studies to rule out  
11 life-threatening illness. Respondent had not elicited information concerning recurrent abdominal  
12 pains under similar circumstances without a surgical cause, and yet he presumed that P-4's  
13 alcohol use was the overriding factor in his abdominal pain. Respondent failed to order a  
14 urinalysis, a valuable test in the workup of abdominal pain.

15 B. Respondent's final diagnosis did not follow from the history, physical, and workup of  
16 P-4. P-4 had WBC count and liver function abnormalities and had a history of heavy alcohol  
17 consumption, so Respondent's diagnosis of alcoholic gastritis was a reasonable differential  
18 diagnosis, but Respondent did not consider and rule out possible causes of the pain such as  
19 appendicitis and gallbladder disease, which would require surgical intervention. Respondent  
20 ignored P-4's high WBC count, which could have been an indication for appendicitis.

21 C. The observation period for P-4 was inadequate. Respondent did not allow enough  
22 time to adequately assess the patient's condition and the risk of serious decline. Respondent did  
23 not wait until the narcotic pain medication wore off to reexamine the patient over time for a  
24 possible surgical abdomen. The duration of morphine analgesia is four (4) to five (5) hours, and  
25 it was appropriate to relieve pain during the workup, but repeat examination reporting that the  
26 patient was comfortable during the duration of analgesia is inadequate to fully appreciate the  
27 course of the illness.

28

1 D. Respondent failed to record a history for P-4's high blood glucose level and perform  
2 tests to determine the nature and severity of the abnormal finding. The blood glucose level of 260  
3 mg/dl is suggestive of diabetes, and this was not previously diagnosed and required further  
4 history and laboratory studies. Ketones were not tested for in either blood or urine, although  
5 serum CO2 level was normal.

6 E. Respondent's discharge plan was inappropriate. P-4 was given instructions in  
7 Spanish at discharge, and Respondent did not record these instructions, but indicated that he  
8 would have instructed the patient to return if worse. No information was given concerning the  
9 elevated blood glucose. Respondent failed to identify and ensure appropriate follow-up for a  
10 remarkably elevated blood glucose level.

#### 11 FIFTH CAUSE FOR DISCIPLINE

#### 12 (Gross Negligence/Negligence/Incompetence – Patient P-5)

13 27. On or about December 10, 2012 at approximately 10:39 a.m., a colleague brought  
14 patient P-5, a 37 year-old reportedly alcoholic male, to MMH ER with mental changes and fever,  
15 and Respondent attended him. P-5 had reportedly been ill for up to four (4) days and had a  
16 history of drinking heavily. P-5 was unable to give history for his present illness. Social history  
17 consisted of heavy alcohol use and "12/d." Vital signs were: temperature 100.3° F, pulse rate 118  
18 bpm, respiratory rate 22, blood pressure (BP) 159/97 mmHg, and pulse oximetry 100% at room  
19 temperature. Physical examination revealed dry mucosa, lethargic appearance, poor dentition,  
20 lung rhonchi, and heart murmur 2/6 systolic. "Suspect ascites" was written, and jaundice was  
21 noted under the skin. P-5 was described as "obtunded."

22 28. Laboratory abnormalities included the following: WBC count 23.3 (high);  
23 hemoglobin and hematocrit (H&H) 9.4 g/dl/32% (low); Prothrombin Time/International  
24 Normalized Ratio (PT/INR) 21.2/2.03 (high); Sodium 130 (low); anion gap 21 (high). Blood  
25 Urea Nitrogen (BUN)/creatinine was 42/1.7 mg/dL (high). Lipase level was 226 (high). Total  
26 bilirubin was 5.6 (high). Alanine Aminotransferase (ALT) 112 (high); Aspartate  
27 Aminotransferase (AST) 53 (high); and CRP 13.7 (high).

1           29. Urine toxicology screen was negative for alcohol. Ammonia level was ordered, and  
2 two (2) days later, it was found to be normal. No rectal examination for gross blood is recorded  
3 and any consideration of a nasal-gastric (NG) tube to assess for upper gastrointestinal (UGI)  
4 bleed is not mentioned. No blood cultures were ordered during Respondent's initial evaluation.  
5 No consideration of lumbar puncture to assess for meningitis due to altered mental status and  
6 fever is documented.

7           30. Electrocardiogram (ECG) revealed sinus tachycardia, bifasicular block, and ST  
8 elevations with no prior ECG obtained for comparison. Chest x-ray revealed right upper lobe  
9 infiltrate. Troponin level was measured at .433 (elevated; levels .06 to 1.5 signify acute  
10 myocardial infarction (MI).)

11           31. Respondent clearly recognized P-5 as gravely ill and appropriately ordered diagnostic  
12 testing as well as medical care. Respondent apparently called in a consultant physician for  
13 hospital admission and further treatment, but that physician was not available right away. P-5  
14 was acutely ill with fever, mental status changes, jaundice, abnormal vital signs; he was septic  
15 with rising fever, tachycardia, severe acidosis, high WBC count, and lung infection. After the  
16 consultant physician was called, and while P-5 remained in the ER, Respondent rendered no  
17 further care to this patient from the time the consultant was called to the time the consultant  
18 appeared to examine and admit the patient to the hospital.

19           32. Respondent is subject to disciplinary action under section 2234(b) and/or (c) and/or  
20 (d) by reason of the following acts or omissions:

21           A. Respondent failed to expedite the care for P-5, who was clearly ill with life-  
22 threatening conditions. P-5 was recognized immediately as acutely ill with fever, mental status  
23 changes, jaundice, and abnormal vital signs. The admitting consultant was not called until after  
24 laboratory tests, x-ray and ECG were performed. At this point, P-5 was clearly septic with rising  
25 fever, tachycardia, severe acidosis, and clear lung infection. Respondent ordered appropriate  
26 fluids and initial laboratory tests, x-rays, and ECG, but failed to render appropriate treatment to  
27 this acutely ill patient until the consultant physician arrived to take over care and admit the patient  
28 to the hospital.

1 (1) Respondent failed to do a rectal examination to rule out rectal bleeding as cause for the  
2 patient's significant anemia and by considering blood transfusion; he failed to perform repeat  
3 hematocrits.

4 (2) Respondent failed to deal with the mental status changes with fever by lumbar puncture  
5 or administration of antibiotics and corticosteroids immediately after blood cultures were drawn,  
6 treating presumptively for meningitis.

7 (3) Respondent failed to deal with the mental status change in a reported alcoholic through  
8 a CT scan to rule out intracranial hemorrhage.

9 (4) Respondent failed to deal with the abnormal ECG with ST elevations, bifasicular block,  
10 and significantly elevated troponin, which must be treated as acute MI without an old ECG  
11 identifying the abnormalities as old.

12 (5) P-5 was known to be a heavy drinker, and Respondent failed to deal with the fact that  
13 the mental status changes and a zero alcohol level could be caused by alcohol withdrawal and rule  
14 this out or treat it if confirmed.

15 B. P-5 arrived at MMH ER acutely ill and Respondent called for consultation, but the  
16 consultant could not arrive promptly to manage and admit the patient or to maintain a sustained  
17 presence in the ER. As the emergency physician, Respondent was responsible for P-5's medical  
18 care until he was stabilized or admitted to the hospital under the care of the consultant physician.  
19 Respondent had an independent responsibility to manage the patient's care while P-5 was in the  
20 ER, and he abdicated his responsibility for a progressively critically ill patient.

#### 21 SIXTH CAUSE FOR DISCIPLINE

#### 22 (Gross Negligence/Negligence/Incompetence - Patient P-6)

23 33. Patient P-6, a 16 year old female, presented to MMH ER and Respondent at  
24 approximately 1:08 a.m. on April 11, 2012 with nausea, vomiting (x7), and 9/10 epigastric and  
25 right flank abdominal pain of six (6) hours duration. P-6 had a history of kidney stones from the  
26 year before. She had tried a non-steroidal anti-inflammatory drug (NSAID) for the pain, but it  
27 caused her to vomit again. She had urgency of stool and urine, and her last menstrual period  
28 (LMP) was in March 2012 (day unclear). Vital signs were normal. Physical examination

1 revealed a soft but tender abdomen, specifically in the epigastric and right flank area with  
2 costovertebral angle tenderness (CVAT) listed as questionable; a positive CVAT could indicate  
3 retrocecal appendicitis. There was a mildly elevated WBC count of 13.9 with a left shift of 92  
4 (indicating possible bacterial infection), a normal H&H, lipase level, and chemistry panel. A  
5 pregnancy test was ordered, but no result was recorded. IV fluids were given along with 5 mg. of  
6 morphine and Zofran 4 mg. IV at 1:40 a.m. Respondent did a repeat examination on P-6 one hour  
7 and 45 minutes later at 3:25 a.m., and the tenderness had migrated to the subumbilical position,  
8 and P-6 reported the pain as 2/10. Abdomen was still considered soft, and P-6 was discharged to  
9 family as improved with instructions to return if worse. Tylenol/Advil was recommended for  
10 pain.

11 34. P-6 returned to the ER 12 hours later at 4:00 p.m. with continued low abdominal pain  
12 and vomiting (x7 more). She now had a fever of 102.5° F with a pulse rate of 150 bpm. Pain was  
13 now localized in the right lower quadrant; abdomen was still soft; bowel sounds were decreased.  
14 There was a positive psoas sign (indicating acute appendicitis). P-6's WBC count was elevated at  
15 26.3. The pregnancy test ordered at the first ER visit was negative. An abdominal ultrasound at  
16 4:30 p.m. failed to adequately visualize the right lower quadrant, so a CT scan with rectal contrast  
17 was done at 6:30 p.m. An inflammatory mass was found in the right lower quadrant, and IV  
18 antibiotics were administered. A surgeon was consulted at 7:00 p.m. for a clinical impression of  
19 appendicitis.

20 35. Respondent is subject to disciplinary action under sections 2234(b) and/or (c) and/or  
21 (d) of the Code by reason of the following acts or omissions:

22 A. Respondent's medical evaluation was inappropriately limited. Nausea, vomiting, and  
23 abdominal pain in a fertile young female could indicate ectopic pregnancy, which is a life-  
24 threatening illness. A pregnancy test was ordered at P-6's first visit, but the results were not  
25 obtained or documented before discharge. Respondent had failed to rule out a life-threatening  
26 illness before discharging the patient.

27 B. Respondent did not provide for an adequate observation period for P-6. Respondent  
28 administered 5 mg. morphine at 1:40 a.m. but reexamined the patient less than two (2) hours later

1 before the analgesia wore off; he reexamined the patient with the effects of the morphine possibly  
2 hiding a surgical abdomen. A definitive diagnosis required time for analgesia effects to wear off  
3 and serial abdominal examinations. Respondent did not understand the onset, peak and duration  
4 of the narcotic medication given to P-6 and acted precipitously in his reexamination and  
5 discharge of this patient.

6 **SEVENTH CAUSE FOR DISCIPLINE**

7 **(Negligence/Incompetence - Patient P-7)**

8 36. On or about June 6, 2012, Patient P-7, a 47 year-old female, was transported to MMH  
9 ER at 4:15 p.m. by emergency medical technicians (EMT's) for a brief syncopal episode. P-7 had  
10 been sitting in a chair and had lost consciousness, falling to the floor, but she recovered  
11 consciousness right away. P-7 had a medical history of menorrhagia and current bleeding (10-15  
12 pads per day in nurse's notes). EMT's noted tachycardia. Respondent's history of the patient  
13 only notes prodromal lightheadedness, two to three seconds loss of consciousness, and the fall.  
14 He did not mention the current bleeding, and although he indicated a head injury in the record,  
15 nothing is mentioned concerning examination, diagnosis or treatment. He did note that P-7's  
16 gynecologist had recommended a hysterectomy. Respondent's review of systems was checked  
17 normal, which was inaccurate because menstrual history was included, and P-7 was presently  
18 experiencing a very heavy menstrual period, consistent with past episodes of menorrhagia. Vital  
19 signs were low blood pressure at 120/48 mmHg and elevated heart rate at 94 bpm, rising from 96  
20 to 106 from supine to standing on orthostatic measurement. No positives were noted on physical  
21 examination except for "pale conjunctiva" and "pale palms." No pelvic or rectal examination is  
22 documented. Respondent ordered normal saline IV at 150 ml. per hour. Laboratory studies were  
23 returned with H&H of 6.4 g/dl (extremely low) and 18.9% (very low) and benign chem panel.

24 37. Respondent called in the on-call family practice physician at 5:18 p.m., and the  
25 consultant was at bedside at 6:10 p.m., and P-7 was admitted with improved vital signs. The  
26 consultant immediately ordered the transfusion of three (3) units of blood. P-7's hemorrhaging  
27 continued after admission, and so the following day, she underwent the previously recommended  
28 hysterectomy.



1 Respondent. An x-ray of the right ribs revealed a single sixth rib fracture without pneumothorax.  
2 Another x-ray was positive for left fifth metacarpal fracture.

3 40. Laboratory studies revealed an elevated WBC count of 14.8 with a segmented count  
4 of 91. H&H was normal. Troponin was negative for cardiac injury. Chemistry panel was  
5 normal. Liver function tests (LFT) were mildly elevated with AST of 73 and ALT of 80. ECG  
6 revealed abnormalities, including anterior lateral ST-T wave depressions consistent with ischemia  
7 with no old ECG consulted for comparison. Respondent ordered a urinalysis, but Respondent did  
8 not document or address the results in the patient chart. The test was positive for blood and  
9 nitrates.

10 41. At 4:40 a.m., P-8 received 10 mg of IV morphine and 10 mg. of IV Zofran. At 6:00  
11 a.m., P-8 was re-medicated with IV morphine 10 mg., and 37 minutes later, Respondent  
12 documented a repeat examination of P-8 and described the patient as "drowsy with meds."  
13 Tetanus-Diphtheria-Pertussis (TDaP) vaccine was ordered, and P-8 was cleared for discharge, but  
14 due to a delay in obtaining the TDaP vaccine, the discharge order was not given until 8:30 a.m.  
15 P-8 was discharged at 8:48 a.m. with a pulse rate of 82 bpm; respiratory rate of 16; BP of 119/75;  
16 and pulse oximetry of 96%. She was discharged with instructions to see an orthopedist for her  
17 hand, and she was given a prescription for pain medication and a work release note for  
18 approximately three (3) weeks.

19 42. P-8 returned the following day; she was brought in by paramedics with fever and  
20 chest pain, apparently without severe shortness of breath. P-8 had not yet filled her pain  
21 prescription. A follow-up x-ray showed bibasilar atelectasis. A CT scan showed a 10%  
22 pneumothorax with mild right pulmonary effusion. An incidental upper lobe pulmonary  
23 arteriovenous malformation was noted. Treatment for urinary tract infection (UTI) detected by  
24 the urinalysis ordered the day before but not addressed, was provided. It was unclear whether P-  
25 8's fever was caused by the atelectasis or the UTI.

26 43. Respondent is subject to disciplinary action under sections 2234(b) and/or (c) and/or  
27 (d) by reason of the following acts or omissions:

28

1           A.    Respondent failed to admit P-8 to the hospital for observation. P-8 had been in a  
2 motor vehicle accident with a high risk of intra-thoracic and intra-abdominal injury. Her car had  
3 rolled over three times, and she had at least two (2) known fractures, blood in the urine, elevated  
4 LFT's, and evidence of cardiac ischemia on the ECG. P-8 had a significant mechanism of injury,  
5 evidence of extensive damage, and other unresolved medical problems that should have been  
6 addressed through hospital observation to determine the extent of the injuries involved.

7           B.    Respondent's medical evaluation of P-8 was inappropriately limited. P-8 was  
8 involved in a serious rollover automobile accident and had known fractures, elevated LFT's, and  
9 evidence of cardiac ischemia on ECG. Respondent should have done further investigation of  
10 these abnormalities with CT scans and other diagnostic mechanisms. Respondent also failed to  
11 document significant abnormalities or did not address those which were documented.  
12 Respondent failed to adequately examine P-8 and document findings pertinent to the patient's  
13 presentation after a potentially fatal automobile accident.

14           C.    Respondent failed to address ECG abnormalities consistent with ischemia. P-8's  
15 ECG showed signs of ischemia in the setting of an accident that could have caused cardiac injury.  
16 Respondent had no previous ECG of P-8 to compare, so it must be assumed that the ischemic  
17 changes are new. P-8 should have been admitted for this finding alone. A low initial troponin  
18 does not rule out cardiac injury.

19           D.    Respondent's observation period for P-8 was inadequate. In his examination and  
20 treatment of P-8, Respondent failed to allow enough time to adequately assess the patient's  
21 condition and the risk of serious decline. P-8 had been in an accident with a severe mechanism of  
22 injury, multiple fractures, and evidence of internal injury in three (3) different systems, and  
23 Respondent ordered two large doses of intravenous morphine close together and then  
24 precipitously discharged the patient without further reexamination or treatment. Respondent also  
25 did not appreciate the onset, peak, and duration of narcotic medications given when he reassessed  
26 the patient's pain level.

27    ///

28    ///

1 E. Respondent failed to perform and record an adequate back examination and order  
2 additional testing as indicated. Thoracic spine x-rays were ordered, but Respondent failed to  
3 perform or to document a back examination for back tenderness, and this finding was only noted  
4 on P-8's second visit to MMH ER.

5 F. Respondent failed to document or act upon significant abnormal findings. P-8's  
6 urinalysis was ordered but Respondent did not document the results in the patient record. He did  
7 not document evidence of blunt kidney trauma and/or infection. He did not document the  
8 significance of an abnormal ECG. Respondent either failed to review the abnormalities and so  
9 did not act upon them or he reviewed them, failed to document them, and then failed to appreciate  
10 the significance of the abnormalities.

11 G. Although he had evidence that P-8 had a UTI, Respondent failed to address the  
12 illness, which, left untreated, could have progressed to a serious illness such as pyelonephritis or  
13 sepsis. He failed to adequately examine and document findings pertinent to the patient's  
14 presentation.

#### 15 NINTH CAUSE FOR DISCIPLINE

#### 16 (Negligence/Incompetence - Patient P-9)

17 44. On or about September 10, 2012 at approximately 5:00 p. m., patient P-9, a 64 year-  
18 old male, was brought into MMH ER by ambulance on a backboard with cervical spine  
19 precautions taken after he fell eight (8) feet off of a ladder onto a concrete surface. P-9  
20 complained of pain in the chest, right elbow, and back. Medical history was significant for a  
21 mechanical heart valve requiring anti-coagulation with Warfarin. Vital signs included a normal  
22 temperature, pulse rate 57 bpm, respiratory rate 22, and pulse oximetry 96% on room air. Pain  
23 level was listed as 10/10. Tenderness was noted on the right chest and right elbow. A right  
24 laceration was noted one finger. The right elbow had limited range-of-motion (ROM).  
25 Respondent noted a palpable fracture on the right chest and ecchymosis. Breath sounds were  
26 marked as questionable/decreased. Blood work was ordered. CBC and chemistry were  
27 unremarkable, and PT/INR indicated anti-coagulation. Respondent noted no fractures on  
28

1 examining a series of rib x-rays ordered on P-9; CT scan of the head was negative for bleeding.  
2 Lumbosacral (LS) spine x-rays were also read by Respondent as negative.

3 45. Respondent ordered an intramuscular (IM) injection of 10 mg. of morphine given at  
4 approximately 5:15 p.m., and he ordered a second dose of 10 mg. morphine given at  
5 approximately 5:36 p.m. Respondent's last note was entered at 7:09 p.m. indicating that P-9 was  
6 improved and that a posterior splint was applied. At 7:20 p.m., P-9 could not walk due to pain in  
7 his tailbone. At 8:40 p.m., P-9 was discharged home with a supply of Norco and vital signs  
8 before discharge included normal temperature, pulse rate 66 bpm, respiratory rate 18, BP 112/73,  
9 and pulse oximetry down to 94%.

10 46. The following morning, the radiologist noted in the x-rays a 30% pneumothorax and a  
11 sixth-rib fracture and informed Respondent. Respondent called P-9 back to MMH and he was  
12 admitted and treated with a chest tube.

13 47. Respondent is subject to disciplinary action under sections 2234(c) and/or (d) of the  
14 Code by reason of the following acts or omissions:

15 A. Respondent failed to detect a large pneumothorax apparent on x-rays ordered and  
16 read by Respondent on P-9's initial ER visit. Traumatic rib fractures present a known risk of life-  
17 threatening pneumothorax. P-9 had experienced a significant mechanism of injury with an eight  
18 (8) foot fall onto concrete, clinical evidence of rib fracture, and falling pulse oximetry readings.

19 B. Respondent ordered and had administered two large doses of IM morphine  
20 approximately 21 minutes apart. The onset of IM narcotic medication is between 10-30 minutes,  
21 with analgesia peaking between 30-60 minutes and of 4-5 hours duration. The administration of  
22 two doses of IM morphine 10 mg. so close together before the first dose had a chance to take  
23 effect is virtually the same as giving one dose of 20 mg. morphine, an excessive amount.  
24 Respondent documented no reason for P-9 needing the back-to-back administration and noted no  
25 results for either injection. Furthermore, despite an aggressive initial approach to pain  
26 management, no additional pain medications were given to P-9 two (2) hours later when P-9 was  
27 unable to walk due to tailbone pain. Respondent did not appreciate the onset, peak, and duration  
28 of the narcotic medications given to P-9.



1 E. As to Patient P-6, Respondent failed to document the results of P-6's pregnancy test  
2 before discharge.

3 F. As to Patient P-7, Respondent failed to document the primary cause of P-7's syncope  
4 and anemia and did not address that cause. He failed to document an examination or any  
5 necessary treatment for P-7's head injury.

6 G. As to Patient P-8, Respondent failed to document significant abnormalities in this  
7 serious auto accident victim and did not document the treatment for those that were noted.  
8 Although thoracic spine x-rays were ordered, Respondent failed to document any back  
9 examination. Respondent failed to document evidence of blunt kidney trauma or infection, the  
10 significance of the abnormal ECG, or any action taken or ruled out as to P-8's UTI.

11 H. As to Patient P-9, Respondent failed to detect and document a large pneumothorax  
12 and sixth rib fracture evident on x-rays which he had ordered and allegedly read as normal.

13 52. Therefore, Respondent is subject to disciplinary action pursuant to section 2266 and  
14 2234 of the Code.

15 **PRAYER**

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

18 1. Revoking or suspending Physician's and Surgeon's Certificate Number G33650,  
19 issued to Robert Clyde Hostetter, M.D.;

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

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- 1           3.    Ordering Robert Clyde Hostetter, M.D., if placed on probation, to pay the Board the  
2 costs of probation monitoring; and  
3           4.    Taking such other and further action as deemed necessary and proper.

4  
5 DATED: August 4, 2015



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

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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 Clyde Hostetter, M.D.  
5828 Park Circle  
Shawnee, KS 66216-4905**

**Physician's and Surgeon's  
Certificate No. G 33650**

**Case No. 800-2013-000238**

**AGREEMENT FOR  
SURRENDER OF LICENSE**

Respondent.

**TO ALL PARTIES:**

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

1. Complainant, Kimberly Kirchmeyer, is the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. Robert Clyde Hostetter, M.D., ("Respondent") has carefully read and fully understands the effect of this Agreement.

3. Respondent understands that by signing this Agreement he is enabling the Board to issue this order accepting the surrender of license without further process. Respondent understands and agrees that Board staff and counsel for complainant may communicate directly with the Board regarding this Agreement, without notice to or participation by Respondent. The Board will not be disqualified from further action in this matter by virtue of its consideration of this Agreement.

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1           4.       Respondent acknowledges there is current disciplinary action against his  
2 license, that on August 4, 2015, an Accusation was filed against him and on October 28,  
3 2016, a Decision was rendered wherein his license was revoked, with the revocation  
4 stayed, and placed on five years' probation with various standard terms and conditions.

5           5.       The current disciplinary action provides in pertinent part, "Following the  
6 effective date of this Decision, if Respondent ceases practicing due to retirement or health  
7 reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent  
8 may request to surrender his or her license." (Condition #15).

9           6.       Upon acceptance of the Agreement by the Board, Respondent understands  
10 he will no longer be permitted to practice as a physician and surgeon in California, and  
11 also agrees to surrender his wallet certificate, wall license and D.E.A. Certificate(s).

12           7.       Respondent fully understands and agrees that if Respondent ever files an  
13 application for relicensure or reinstatement in the State of California, the Board shall treat  
14 it as a Petition for Reinstatement of a revoked license in effect at the time the Petition is  
15 filed. In addition, any Medical Board Investigation Report(s), including all referenced  
16 documents and other exhibits, upon which the Board is predicated, and any such  
17 Investigation Report(s), attachments, and other exhibits, that may be generated subsequent  
18 to the filing of this Agreement for Surrender of License, shall be admissible as direct  
19 evidence, and any time-based defenses, such as laches or any applicable statute of  
20 limitations, shall be waived when the Board determines whether to grant or deny the  
21 Petition.  
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ACCEPTANCE

I, Robert Clyde Hostetter, M.D., have carefully read the above Agreement and enter into it freely and voluntarily, with the optional advice of counsel, and with full knowledge of its force and effect, do hereby surrender Physician's and Surgeon's Certificate No. G 33650, to the Medical Board of California for its acceptance. By signing this Agreement for Surrender of License, I recognize that upon its formal acceptance by the Board, I will lose all rights and privileges to practice as a Physician and Surgeon in the State of California and that I have delivered to the Board my wallet certificate and wall license.

Robert Clyde Hostetter      8/12/17  
Robert Clyde Hostetter, M.D.      Date

R. W. Hodges      8/14/17  
Attorney or Witness      Date

Kimberly Kirchmeyer      8/30/17  
Kimberly Kirchmeyer      Date  
Executive Director  
Medical Board of California

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