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

In the Matter of the Accusation )
Against: )
 )
 )
JAMES T. LIN, M.D. ) Case No. 05-2011-212776
 )
 )
Physician's and Surgeon's ) OAH No. 2013070069
Certificate No. A-86869 )
 )
 )
Respondent )

DECISION

The attached Proposed Decision 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 July 23, 2014.

IT IS SO ORDERED June 23, 2014.

MEDICAL BOARD OF CALIFORNIA

By: Barbara Yaroslavsky, Chair
Panel A
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

JAMES T. LIN, M.D.,
Physician’s and Surgeon’s
Certificate Number A 86869,

Case No. 05-2011-212776

OAH Case No. 2013070069

Respondent.

PROPOSED DECISION

This matter came before Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, in Los Angeles, California, on April 8 and 9, 2014.

John E. Rittmayer, Deputy Attorney General, represented complainant Linda K. Whitney, Executive Director of the Medical Board of California (Board).

Laura C. McLennan, Attorney at Law, represented James T. Lin, M.D. (Respondent).

Complainant seeks to discipline Respondent’s medical license on grounds of alleged gross negligence, repeated negligent acts, and failure to maintain adequate records in connection with the care and treatment provided to two patients. Respondent denies most of the allegations and asserts that cause for discipline does not exist.

Oral and documentary evidence, and evidence by written stipulation, was received at the hearing. The record was left open for the parties to submit written closing argument. Initial closing arguments were received on April 28, 2014, which documents have been marked for identification only as Exhibits 9 (Complainant’s Closing Argument) and S (Respondent’s Closing Argument). Reply closing arguments were received on May 12, 2014, and have been marked as Exhibits 10 and T. The matter was submitted for decision on May 12, 2014.

FACTUAL FINDINGS

Parties and Jurisdiction

1. Complainant filed the Accusation on May 30, 2013, in her official capacity.
2. a. On April 23, 2004, the Board issued Physician’s and Surgeon’s Certificate Number A 86869 to Respondent. The certificate has been in effect since then and was due to expire on April 30, 2014, unless renewed. Respondent holds certificates from the American Board of Anesthesiology in anesthesia and in the pain management subspecialty.

b. On September 30, 2011, Respondent was publicly reprimanded for failing to perform opioid risk scales and/or order urine screens or tests in the care of a patient, failing to refer the patient to a psychologist or other mental health care practitioner, and failing to maintain a complete opiate contract in the patient’s chart, in violation of Business and Professions Code\(^1\) sections 2234, subdivision (c), and 2266.

3. Respondent graduated from the University of Chicago Medical School in Chicago, Illinois, in 2000. In 2004, he completed a four-year residency in anesthesiology at Rush Medical University (Rush), also in Chicago, and in 2005 he completed a one-year pain fellowship at the University of California, Los Angeles (UCLA).

4. a. In his training at Rush, Respondent was taught to use propofol to treat migraine headaches. Propofol is a short-acting anesthetic typically used to induce longer-acting anesthesia or to maintain sedation during surgical procedures. The technique employed by the physician in charge of the rotations, Timothy R. Lubenow, M.D. (Lubenow), involved infusions of 20 cubic centimeters (cc), or 200 milligram (mg), either at the patient’s bedside, in the intensive care unit, in the cardiac care unit, or in other specialized units in the medical center. Standard anesthesia monitoring was employed, namely, cardiac, via electrocardiogram (EKG), blood pressure, pulse, and blood oxygen saturation via pulse oxymetry. Respondent observed the technique used in 30 to 45 cases while in his residency.

b. In a letter dated July 24, 2013, Dr. Lubenow confirmed that Respondent had been trained, while rotating through the Rush Pain Center, to use propofol infusions for the treatment of chronic headaches. Dr. Lubenow wrote that the use of propofol infusions for headaches that have been non-responsive to other measures is well-recognized as a medically necessary treatment. Kenneth J. Truman, M.D., Residency Program Director at Rush, wrote a letter dated December 7, 2011, in which he stated that “[t]his letter serves to verify that during his residency years [Respondent] was involved in the care of patients receiving Propofol infusion for intractable migraines.” (Exh. D.)

5. Approximately 90 percent of Respondent’s practice is devoted to pain management. Most of his patients present chronic or difficult-to-treat conditions. He spends approximately 10 percent of his time providing anesthesia services in surgeries. Respondent participates in research studies for new drugs and therapies. He sees patients in his clinic and in hospitals or surgery centers. In October 2005, Respondent joined the staff of the Los Robles Hospital and Medical Center (Los Robles), where he performs procedures, such as epidural injections, and where he consults at the request of other physicians.

\(^1\) Unless otherwise noted, all further statutory references are to the Business and Professions Code.
Patient G.L.²

6. G.L., a 30-year-old woman at the time, presented to the Los Robles emergency room on August 6, 2008, complaining of having headaches for three weeks and persistent nausea and vomiting. She had been unable to retain food. She was approximately seven weeks pregnant. Her pain was so severe that she discussed the possibility of terminating her pregnancy with her obstetrician/gynecologist, Robert Grossman, M.D. (Grossman). Following a gastroenterology consultation on August 8, 2008, Shahram Daneshgar, M.D., concluded that G.L.'s symptomatology, which included dizziness, nausea and vomiting, was related to the headaches, and recommended continuation of intravenous fluids and a pain management consultation.

7. Respondent conducted the pain management consultation on August 11, 2008. Respondent reviewed the patient's chart, obtained a pertinent history, and conducted a physical examination focused on the presenting problem. The patient was in distress, suffering from headaches and nausea. She was contemplating termination of her pregnancy to obtain relief. In Respondent's recollection, she was at "the end of her rope" and wanted to get better. Respondent concluded that therapies that are typically used to control persistent migraine headaches, such as Imitrex and opioid analgesics, had been tried without success.

8. a. Respondent wrote the following history of present illness for the patient's chief complaint of acute migraine headaches: "[G.L.] is a 30-year-old female with [sic] history of acute persistent migraine headaches for the last 3 weeks. She is approximately 7 weeks pregnant. . . . She states that she has been having chronic continuous migraine headaches, an average of 7 to 8 out of 10, has tried numerous medications, has seen a neurologist, and also is currently seen by Dr. Robert Grossman. States she has tried Imitrex in the past, Dilaudid which causes increased nausea and vomiting, no benefit with Norco, Demerol, or Percocet. She states she does get some benefit from IV morphine which does not cause any nausea or vomiting and also states that the Zofran that she has been getting for persistent nausea has been starting to have decreased efficacy. States that headaches are mainly bilateral frontal areas, left side worse than right, mild neck pain, and has positive photophobia. She states that in her last pregnancy, approximately a year and a half ago, she did have a spontaneous abortion at approximately 11 weeks when she had spontaneous vaginal bleeding." (Exh. 4, at p. 46.)

b. The patient was taking six medications at the time Respondent saw her: Ancef, Senekot, Norco p.r.n., or as needed, Dilaudid p.r.n., Midrid and Darvocet.

c. A review of systems did not reveal any problems, except for the migraine headaches. The physical examination was normal. Her blood pressure was 110/68 and her pulse was 90. G.L.'s heart had a regular rate and rhythm and her lungs were clear to auscultation with no wheezing. The neck was supple and she had no pain with flexion or extension. There was no pain on palpation of bilateral frontotemporal areas.

² Initials have been used to protect patient confidentiality. The same initials were used in the Accusation, and the actual patient names have been disclosed to Respondent.
d. Respondent wrote the following assessment and plan: “[G.L.] is a 30-year-old female with history of acute migraine headaches secondary to her pregnancy. We will have her start intermittent doses of propofol to help break the cycle of her migraine headaches. If that does not work, we will have her started on MS-IR 30 mg q.4-6h [intravenous morphine].” (Exh. 4, at p. 47.)

9. At the hearing, Respondent explained that the patient had tried the available traditional treatments for migraine headaches without success and that propofol may have brought some relief. In his opinion, propofol had minimal side effects and, as a Class B medication, would be safer for the fetus than opioids.

10. Respondent explained the risks and benefits of using propofol to G.L., and obtained the patient’s informed consent to proceed. Respondent told the patient that propofol had been used to treat migraines, that it could be safely performed at her bedside, and that he would use a smaller dosage, in bolus form, rather than the infusions he had been trained to perform. He explained potential risks, such as increased high blood pressure in larger dosages. Respondent discussed alternatives, particularly if the intervention did not work. Respondent explained that propofol would be safer for her pregnancy than opioids. As was his custom when performing non-invasive procedures, Respondent did not have the patient sign an informed consent document or write in the chart that he verbally obtained the patient’s consent.

11. Respondent administered the propofol on August 11, 2008, starting at 3:30 p.m. Before proceeding, he inquired about the patient’s past drink and food intake, and learned that she had ingested clear fluids early in the morning. He concluded that this was sufficiently remote to meet the requirement that patients undergoing anesthesia not have anything by mouth close to the administration, typically referred to as “NPO,” after the Latin phrase “nil per os” or “nothing per mouth.”

12. Respondent administered the propofol in the patient’s room. He had the assistance of a nurse, and cardiac (EKG), blood pressure, pulse and blood oxygen monitoring. A crash cart was available outside the room in the event that it was needed in an emergency. He provided oxygen to the patient and tilted her head for airway optimization.

13. Respondent administered three boluses, 2 cc each, at ten minute intervals. The patient tolerated the administration well. She was slightly sedated, and was able to answer questions. Her vital signs remained normal during the process. Her pulse oxymetry readings never fell below 95 percent. She experienced no untoward side effects.

14. In addition to his consultation report, Respondent wrote two progress notes for the encounters with the patient on August 11, 2008. In the first, he stated: “Patient ... severe migraine headache. Will try to break the headache cycle with propofol. . . . MS IR 30 mg if propofol does not help. . . . consult.” The second note documents the times of propofol administration, 3:30, 3:40 and 3:50 p.m., the dosages, 2 cc each time, the blood pressure, 110/70 each time, and the pulse, 80, 85 and 85.
15. The patient was discharged on August 12, 2008. In the Discharge Summary, Dr. Grossman noted the following diagnoses: seven week intrauterine pregnancy; persistent migraine with poor response to analgesics; hyperemesis gravidarum, or severe vomiting during pregnancy, clinically improved; and hypokalemia, or low potassium levels. The plan was for G.L. to increase her caloric and vitamin intake and to follow up with any consultant as recommended. She received prescriptions for Ambien and Norco.

Patient T.K.


17. The patient had a history of neck pain, and had been involved in several accidents, most recently one week before her admission. Respondent reviewed the patient’s chart, obtained pertinent history, and conducted a physical examination focused on the presenting pain complaints.

18. a. Respondent wrote the following history of present illness for the patient’s chief complaint of acute neck pain: “[T.K.] is a 39-year-old female with [sic] history of chronic neck pain since 01/2010. She rear-ended a stopped vehicle going at high speed and immediately had neck pain with thoracic pain. At that point, had an MRI that showed a C4-C5 disk herniation and was treated with physical therapy and acupuncture which gradually helped her neck pain. She did also have head concussions in the past secondary to horse accident when she fell off the horse and hit her head. The longest time period of having chronic head pain was for approximately 6 months from one of these falls. Last week, she was hit from the side while driving her car. This exacerbated her chronic neck pain with radiation to both the arms. She states the pain is severe, 9/10 to 10/10, with radiation of severe pain going to the bilateral upper extremities. She got an MRI of the cervical spine and thoracic spine today. Again, Dilaudid helped with the pain control.” (Exh. 3, at p. 50.)

b. The patient was taking five medications: Seroquel, Xanax, Lexapro, Ritalin, and Inderal.

c. A physical examination and review of systems did not reveal any problems, except for musculoskeletal. She had trigger points along her cervical spine. She had pain with neck flexion. External rotation to the right and to the left also produced pain.

d. Respondent noted that MRI results of the cervical and thoracic spine were pending. He concluded: “[H]er neck pain is secondary to cervical degenerative disk disease with mainly C4-C5 disk herniation with mild compression, also with cervical brachial syndrome with trigger points in her neck and also trapezius bilaterally. It was discussed that we could proceed with a cervical epidural injection at C4-C5. The risks, benefits, and alternatives of the procedure were discussed. Continue with Dilaudid for severe breakthrough pain. She also is getting Soma for muscle spasms and Lyrica for neuropathic pain.” (Exh. 3, at p. 51.)
19. The patient signed a consent form, and Respondent performed an epidural injection at the C4-C5 level on April 5, 2010.

20. The patient continued to have pain, characterized as intermittent, and on April 6, 2010, Respondent administered trigger point injections in her left shoulder and upper back.

21. Respondent visited the patient in the early morning of April 7, 2010, before going to his clinic. The shoulder and neck pain had improved, but T.K. complained of migraine pain starting the night before. Respondent decreased the Duragesic, a fentanyl patch for pain, as she was expected to go home, and continued to prescribe Vicodin for pain as needed. He recommended additional trigger point injections on an outpatient basis.

22. Later in the morning of April 7, 2010, Respondent received a call from T.K.’s attending hospitalist, Pedram Bagheri, M.D. (Bagheri), requesting assistance as the patient had not been able to go home due to severe migraine headaches. Respondent authorized additional Dilaudid for the pain. He went to see the patient at Los Robles during his lunch break.

23. When he met T.K., she complained of severe migraine headaches. She appeared distraught, stressed, and had not responded to the treatment for the pain. Respondent concluded that since she had failed more traditional pain management interventions she might receive relief from propofol. He explained the risks and benefits of using propofol, as well as the limited alternatives, and obtained the patient’s informed consent to proceed. As was his custom when not performing invasive procedures, Respondent did not have the patient sign an informed consent document or write in the chart that he verbally obtained the patient’s consent.

24. Respondent administered the propofol around noon on April 7, 2010. Before proceeding, he inquired about the patient’s past intake, and was satisfied that she had not eaten anything for the past six hours. He concluded that this was sufficiently remote to meet NPO criteria, particularly since the patient had not been eating very much during her hospital stay.

25. Respondent administered the propofol in the patient’s room. Since he was administering a very small dosage and the patient was in general good health, Respondent did not deem necessary to use an EKG monitor. He had the assistance of a nurse, and blood pressure, pulse, and blood oxygen monitoring. A crash cart was available outside the room in the event that it was needed in an emergency. Oxygen was started for the patient and Respondent tilted her head for airway optimization.

26. Respondent administered three boluses, 2 cc each, at ten minute intervals. He believed that the patient would tolerate the small amount, since an anesthesiologist had administered 200 mg as part of the epidural injection procedure on April 5, 2010. The patient in fact tolerated the administration well. She was slightly sedated, and was able to answer questions. Her vital signs remained normal during the process, and she experienced no untoward side effects.
27. Because he had to rush back to the clinic to see his scheduled patients, Respondent did not write a progress note regarding the administration of propofol. His plan was to write the note upon his return to see the patient later in the day. However, Respondent failed to write the progress note, which failure constitutes a deviation from the standard of care.

28. Respondent returned the next day, April 8, 2010, and T.K. reported that she was doing better. On examination, Respondent found additional trigger points, and administered trigger point injections on the patient's left shoulder area.

29. The patient was discharged on April 8, 2010. In the Discharge Summary, Dr. Bagheri noted the following discharge diagnoses: cervical radiculopathy, status post motor vehicle accident; history of chronic cervical and thoracic pain; depression and anxiety; tension headache; and eating disorder. In Dr. Bagheri's opinion, the patient had improved during her stay and would continue with her medications at home, including narcotic pain medications prescribed by Respondent.

Expert Testimony and the Use of Propofol to Treat Migraine Headaches.

30. Complainant called Michael McBeth, M.D. (McBeth), as an expert witness. Dr. McBeth received his medical degree in 1990 from the University of Colorado School of Medicine, and completed an anesthesia internship in 1997 at the Naval Medical Center in San Diego, California, and a pain fellowship in 2000 at the University of California, San Diego. He holds certificates from the American Board of Anesthesiology in anesthesiology and in pain management (subspecialty). Dr. McBeth specializes in pain management and is the clinical director at Kaiser Permanente Naval Hospital in San Diego, California.

31. Respondent's expert witness was Marc D. Wolfsohn, M.D. (Wolfsohn), also an American Board of Anesthesiology dual-certified physician. Dr. Wolfsohn obtained his medical degree from the University of Southern California School of Medicine, in 1976, and completed his anesthesiology residence at UCLA, in 1980. He has been practicing pain management medicine on a full-time basis since 1991, and has been the medical director of the Spanish Hills Surgery Center since 2005.

32. Dr. McBeth opined that Respondent deviated from the standard of care in his treatment of both patients because propofol is not an accepted treatment for migraine headaches in California. Dr. Wolfsohn disagreed. He noted that there is more than one "right" way to treat a patient, and that what a physician utilizes is largely based on his training and experience. Propofol is a drug commonly used in hospitals and Dr. Wolfsohn cited the growing scientific literature in support of its use to treat migraine headaches. In his opinion, the standard of care for pain management is nationwide, if not global, which is evident by the shared knowledge and research in pain management and by the efforts to create widely applicable protocols in the subspecialty. Dr. McBeth, on the other hand, opined that the standard of care is focused on California practice and would require greater nationwide acceptance and study before a methodology is deemed part of a nationwide standard of care.
33. a. The first published article discussed at the hearing was *Intravenous Propofol: Unique Effectiveness in Treating Intractable Migraines*, published in 2000 in the peer-reviewed journal Headache, by John Claude Krusz, Ph.D., M.D. (Krusz), Virginia Scott, and Jeanne Belanger, R.N. Dr. Krusz and his colleagues treated 77 patients in a pain clinic in Dallas, Texas. Patients experienced an average reduction in headache intensity of 95 percent after an average of 20 to 30 minutes of intravenous propofol and lidocaine treatment. Patients received 20 to 30 mg of propofol administered as bolus dosages at fixed time intervals of three to five minutes.

b. In an article entitled *Propofol: A New Treatment Strategy for Refractory Migraine Headache*, published in 2002 in the peer-reviewed *Pain Medicine Journal*, Jacqueline Drummond-Lewis and Corey Scher, M.D., reported on their treatment of two patients in a hospital in New Orleans, Louisiana. The physicians administered higher dosages than Dr. Krusz had used and achieved good results.

c. In 2005, Dr. Krusz and his colleagues updated their study results during a presentation at the European Federation of Neurologic Societies. The total number of patients treated exceeded 1,700 and the treatments included therapies for the treatment of intractable or refractory migraines in addition to propofol.

d. In a 2007 letter to the editor of the peer-reviewed journal Anesthesia, Joshua Aaron, M.D., reported on the case of a patient in an Arizona hospital who received propofol injections of 20 mg every five minutes for 30 minutes, a total of 120 mg, to treat her migraine headache. The patient had been receiving treatment in the hospital for five days without success, but five hours after the propofol treatment commenced she was discharged without pain.

e. Dr. Wolfsohn cited eight additional, more recent articles, written in 2012 or later, which continue to report on the rising use of propofol to treat migraine headaches throughout the United States and the world. Significantly, the technique has been tried with pediatric patients. In an article entitled *Low-Dose Propofol for the Abortive Treatment of Pediatric Migraine in the Emergency Department*, published in the December 2012 issue of the peer-reviewed *Pediatric Emergency Care*, David C. Sheridan, M.D., David M. Spiro, M.D., M.P.H., Thuan Nguyen, M.D., Ph.D., Thomas K. Koch, M.D., and Garth D. Meckler, M.D., M.S.H.S. studied the cases of 48 patients treated in an Oregon pediatric emergency department during the period of January 2010 to July 2011, thirteen of whom were given propofol injections. The authors designed the study and had obtained the cooperation of treating physicians who were free to use their clinical judgment to use or not to use propofol. The authors found that patients who received subanesthetic doses of propofol achieved significantly greater reduction in pain scores (80 percent versus 61 percent) and shorter hospital stays than a control group who did not receive propofol. The authors concluded that propofol seems to be effective for the abortive treatment of pediatric migraine headache.
34. Dr. Wolfsohn’s opinion, which is supported by the medical literature and, indirectly, by the practices at a respected institution in Chicago, is persuasive and establishes that the use propofol is an appropriate intervention to treat migraine headaches. The fact that the technique is not required by the standard of care in California does not mean that its proper use by properly-trained physicians constitutes a deviation from the standard. As Dr. Wolfsohn pointed out, most of the medications used to treat migraine headaches were intended for other uses, and such “off label” use has become part of the standard of care.

35. As Dr. Wolfsohn’s testimony establishes, both patients were good candidates for the use of propofol because more traditional treatments had failed. Respondent was trained in the procedure, used a very conservative dosage, and the patients did well.  

36. Dr. McBeth opined that Respondent failed to obtain the patients’ informed consent because he did not document that he had discussed the risks and benefits with the patients. On cross-examination, Dr. McBeth conceded that verbal consent is sufficient and that the standard does not require documentation of the discussion, opinions that Dr. Wolfsohn shares. Dr. Wolfsohn reviewed prehearing statements of Respondent to the Board regarding his discussions with the patients, and concluded that Respondent had obtained their informed consent. As set forth in factual findings numbers 10 and 23, Respondent obtained the patient’s informed consent to use propofol to treat the migraine headaches. Accordingly, Respondent did not deviate from the standard of care.

37. Dr. McBeth also opined that Respondent deviated from the standard of care because he failed to properly assess both patients to determine that they had not eaten or drank anything by mouth for six to eight hours prior to the procedure. He concluded Respondent had failed to make the proper assessment because Respondent had not documented his actions or conclusions in this regard. However, as Respondent credibly testified, he made the necessary assessment and satisfied himself that the patients had not had anything to eat or drink for at least six hours before the administration of propofol. Dr. Wolfsohn accepted Respondent’s statements of what he had done and opined that Respondent had performed the necessary assessment and that his actions were within the standard of care. In Dr. Wolfsohn’s view, while additional detail in the patient’s chart would have been good, Respondent’s charting, except for one instance involving documentation of administration to T.K. on April 7, 2010, comported with the standard of care. Dr. McBeth’s opinion is based on an incorrect factual assumption and is insufficient to establish a deviation from the standard of care.

38. a. In Dr. McBeth’s opinion, because propofol is an anesthetic and there is always a risk that patients may stop breathing, it must be administered in a controlled environment, with appropriate monitoring and appropriate equipment to resuscitate a patient. He would expect monitoring of the heart (EKG), blood pressure, heart rate, and blood

3 Complainant’s argument that Respondent was trained to use higher-dosage infusions and that, therefore, he was not following his training is without merit. Respondent was trained to treat migraine headaches with propofol in certain circumstances, and the fact that he chose a smaller dosage than typically used in his training is within his professional discretion.
oxygenation. Thus, Dr. McBeth took issue with Respondent administering the propofol at the patients’ bedside and not utilizing EKG monitoring during the propofol administration to T.K.

b. Unlike Dr. McBeth, Dr. Wolfsohn took into account the nature and amount of the drug, and the monitoring that was actually warranted given the drug being administered. Thus, propofol is a drug familiar to anesthesiologists and routinely used in hospitals outside the operating room. The quantity used was very small, and the patient was only partially sedated. Respondent’s administration was akin to bedside administration of certain medications, such as intravenous narcotics. Given the foregoing, and keeping in mind that Respondent, as a board-certified anesthesiologist, is also a monitor, both patients received adequate monitoring. EKG monitoring is not always required, and Dr. Wolfsohn agreed with Respondent’s assessment that T.K., an otherwise healthy patient, did not require such monitoring. Moreover, Respondent took adequate precautions by providing supplemental oxygen and by having a crash cart nearby. Dr. Wolfsohn’s opinions are more persuasive, and, accordingly, Respondent did not deviate from the standard of care by administering the propofol at the patients’ bedside or by not employing EKG monitoring for T.K.

39. Dr. McBeth concluded that Respondent’s overall care of the patients constituted an extreme departure from the standard of care, and, as noted above, opined that specific aspects of the treatment independently constituted extreme departures from the standard of care. Dr. Wolfsohn, on the other hand, opined that both patients presented intractable migraine headaches, had failed typical multi-factorial treatments, and Respondent appropriately employed an acceptable technique. With the exception of Respondent’s failure to document the propofol administration to T.K., his care of both patients was entirely within the standard of care. Dr. Wolfsohn’s more persuasive and better-supported testimony is credited, as were his opinions with respect to specific aspects of the care and treatment provided, as discussed above.

In sum, the patients had tried conservative as well as more aggressive traditional treatments for their headaches without success. Propofol has been used in such circumstances and Respondent had been trained in its use. He obtained the patient’s informed consent for the use of propofol. He ensured that the patients had not consumed food or liquids and took appropriate precautions to minimize risks to the patients. He used small dosages at proper intervals. He had a crash cart available in the event of emergencies. He conducted appropriate monitoring of the patient’s vital signs during the procedure.

Additional Evidence Offered in Mitigation or Rehabilitation

40. On April 16 and 17, 2012, Respondent completed the 17-hour University of California, San Diego, Physician Assessment and Clinical Education Program (PACE) Medical Record Keeping Course.

41. At the time he utilized propofol to treat G.L. and T.K., Los Robles did not prohibit use of the drug to treat migraine headaches and did not have any protocols in place regarding the treatment. Respondent has now been informed that if he wishes to continue to employ propofol to treat migraine headaches, he will have to develop protocols for its use.
Other Allegations and Arguments

42. Except as set forth in this Decision, all other allegations in the accusation and all other arguments by the parties, lack merit or constitute surplusage.

LEGAL CONCLUSIONS

1. Complainant bears the burden of proving, by clear and convincing evidence to a reasonable certainty, that cause exists to discipline Respondent’s physician’s and surgeon’s certificate. (Ettinger v. Board of Medical Quality Assurance (1985) 135 Cal.App.3d 853, 856; James v. Board of Dental Examiners (1985) 172 Cal.App.3d 1096, 1104.) This means that the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal —so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (In re Marriage of Weaver (1990) 224 Cal.App.3d 478.)

2. Cause exists to discipline Respondent’s license pursuant to section 2266, in that he failed to maintain adequate medical records regarding his administration of propofol to T.K. on April 7, 2010, by reason of factual finding numbers finding numbers 26 and 27.

3. Cause does not exist to discipline Respondent’s license pursuant to section 2234, subdivision (b), in that he did not engage in gross negligence in his care and treatment of G.L. or T.K., by reason of factual finding numbers finding numbers 4 through 39. Only one deviation from the standard was established, and not even Dr. McBeth opined that Respondent’s failure to chart the administration of propofol to T.K. on April 7, 2010, constituted an extreme deviation from the standard of care.

Section 2234, subdivision (c), provides that the Board may take disciplinary action for repeated negligent acts, and states: “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.” In this case, Respondent’s failure to chart the administration of propofol to T.K. on April 7, 2010, constitutes a single departure from the standard and is insufficient grounds for discipline pursuant to this provision. Therefore, cause does not exist to discipline Respondent’s certificate pursuant to section 2234, subdivision (c), in that it was not established by clear and convincing evidence that he engaged in repeated negligent acts, by reason of factual finding numbers 26 and 27.

4. All evidence offered in mitigation and rehabilitation, as well as that presented in aggravation, has been considered. Respondent received a public reprimand on September 30, 2011, for failing to maintain adequate records. The established violation involves Respondent’s failure to maintain adequate records in a single instance, which predated the prior discipline. Respondent completed the PACE Record Keeping Course to address his record keeping shortcomings. There is no evidence of additional documentation problems following completion of the course and it is unnecessary to order repetition of the course or a similar one.
The Board’s Manual of Model Disciplinary Orders and Disciplinary Guidelines (2011) group the recommended discipline for violations of 2266, with that for violation of sections 2234 and 2234, subdivisions (b), (c), or (d). The minimum discipline for violations of these sections is revocation stayed for five years and the maximum is revocation. However, in an indication that lesser violations of a single statutory provision warrant less than a five-year-stayed probation, the Guidelines note that a public reprimand is appropriate in certain cases of repeated negligent acts under section 2234, subdivision (c).

While the conduct that establishes cause for discipline is relatively minor, it is Respondent’s second disciplinary action, and some discipline is warranted. Keeping in mind that the purpose of licensing statutes and administrative proceedings enforcing licensing requirements is not penal but public protection (Hughes v. Board of Architectural Examiners (1998) 17 Cal.4th 763, 784-786; Bryce v. Board of Medical Quality Assurance (1986) 184 Cal.App.3d 1471, 1476), public reprimand or reproval constitutes measured discipline appropriate for the violation established.

There are two options for effectuating the public reprimand or reproval, pursuant to section 495 or pursuant to section 2227, subdivision (a)(4). While section 2227, subdivision (a)(4), is specifically applicable to Board licentiates, the plain language of the statute does not indicate that it is the exclusive method of publicly reproving a physician. Section 495 is applicable, “notwithstanding any other provision of law,” to all entities authorized to issue a license or certificate pursuant to the Business and Professions Code, which includes the Board. Moreover, section 495 is not as limited as section 2227, subdivision (a)(4), in the terms of the conditions that may be imposed on a licensee, and it may be efficiently imposed in the same decision that contains the material factual findings and legal conclusions. Public reproval will be imposed pursuant to section 495.

By reason of the foregoing, the order that follows is necessary and sufficient for the protection of the public.

ORDER

Physician’s and Surgeon’s Certificate No. A 86869 issued to Respondent James T. Lin, M.D. is hereby publicly reproved pursuant to section 495.

DATED: [Signature]

[Signature]

SAMUEL D. REYES
Administrative Law Judge
Office of Administrative Hearings