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

In the Matter of the Accusation Against:	)	
HUEY CHOU LIN, M.D.	)	**Case No. 800-2015-018501**
Physician's and Surgeon's Certificate No. A35361	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on February 1, 2018

IT IS SO ORDERED November 9, 2017 .

MEDICAL BOARD OF CALIFORNIA

By: _____
Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
REBECCA L. SMITH
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Attorneys for Complainant

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

In the Matter of the Accusation Against: HUEY CHOU LIN, M.D. 2621 South Bristol Street, Suite 207 Santa Ana, California 92704 Physician's and Surgeon's Certificate No. A 35361, Respondent.	Case No. 800-2015-018501 OAH No. 2017050994 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Huey Chou Lin, M.D. ("Respondent") is represented in this proceeding by attorney Raymond J. McMahon, whose address is 100 Spectrum Center Drive, Suite 520, Irvine, California 92618.

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3. On June 11, 1980, the Board issued Physician's and Surgeon's Certificate No. A 35361 to Respondent. That licence was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-018501 and will expire on August 31, 2019, unless renewed.

JURISDICTION

4. Accusation No. 800-2015-018501 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 3, 2017. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2015-018501 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-018501. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2014-007236, agrees that cause exists for discipline and hereby surrenders Physician's and Surgeon's Certificate No. A 35361 for the Board's formal acceptance.

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9. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

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

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

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

ORDER

IT IS HEREBY ORDERED THAT Physician's and Surgeon's Certificate No. A 35361, issued to Respondent Huey Chou Lin, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2015-018501 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2015-018501 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

HUEY CHOU LIN, M.D.
Respondent

I have read and fully discussed with Respondent Huey Chou Lin, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: _____

RAYMOND J. MCMAHON
Attorney for Respondent

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2015-018501 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 10-12-17

HUEY CHOU LIN, M.D.
Respondent

I have read and fully discussed with Respondent Huey Chou Lin, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: October 25, 2017

RAYMOND J. MCMAHON
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: October 25, 2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-018501

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Attorneys for Complainant

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

In the Matter of the Accusation Against: HUEY CHOU LIN, M.D. 2621 South Bristol Street, Suite 207 Santa Ana, California 92704 Physician's and Surgeon's Certificate No. A 35361, Respondent.	Case No. 800-2015-018501 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board ("Board").

2. On June 11, 1980, the Board issued Physician's and Surgeon's Certificate number A 35361 to Huey Chou Lin, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2017, unless renewed.

3. On April 20, 2017, an Order on Petition for Interim Suspension Order after Noticed Hearing was issued. Pursuant to that Order, Respondent's Physician's and Surgeon's Certificate number A 35361 is restricted pending a full administrative determination of Respondent's fitness to practice medicine, as follows:

a. Respondent is prohibited from engaging in the solo practice of medicine during the period the Interim Suspension Order is in effect.

b. Respondent is prohibited from performing any nephrectomies during the period the Interim Suspension Order is in effect.

c. During the period the Interim Suspension Order is in effect, Respondent shall have a urologist, or, if Respondent can establish to the reasonable satisfaction of the Board or its designee that a urologist is not available, a licensed surgeon qualified to perform the surgery or procedure, acting as his co-surgeon during any surgeries or procedures he performs at any hospitals or facilities where Respondent has privileges or engages in the practice of medicine.

d. During the period the Interim Suspension Order is in effect, Respondent shall have a urologist or urologists acting as his practice monitor(s) at all hospitals or facilities where Respondent has privileges or engages in the practice of medicine. Respondent's practice monitor(s) shall review all of Respondent's medical records and document a concurring second opinion in the medical record before Respondent performs any surgery or procedure. If Respondent can establish to the reasonable satisfaction of the Board or its designee that a urologist is not available to serve as a practice monitor, Respondent may have a licensed surgeon, qualified to perform the surgery or procedure Respondent proposes to perform, serve as his practice monitor.

e. Within five (5) days following the issuance of the Interim Suspension Order, Respondent shall provide a true copy of the Interim Suspension Order to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent and at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies. The notification requirement shall apply to any change(s) in hospitals or other facilities during the period that the Interim Suspension Order is in effect. Respondent shall submit proof of compliance with the notification requirement to the Board or its designee within fifteen (15) calendar days after the issuance of the Interim Suspension Order.

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f. Respondent shall be allowed to continue using his current monitors and assistant surgeons at Fountain Valley Regional Hospital and Medical Center.

g. For hospitals or facilities where Respondent has privileges or engages in the practice of medicine, other than Fountain Valley Regional Hospital and Medical Center, Respondent shall, within 10 calendar days from the issuance of the Interim Suspension Order, submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties ("ABMS") certified in urology.

h. If Respondent fails to obtain approval of a monitor within twenty-five (25) calendar days from the issuance of the Interim Suspension Order, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine at that hospital or facility within three (3) calendar days after being so notified. Respondent shall thereafter cease the practice of medicine at that hospital or facility until a monitor is approved to provide monitoring responsibility.

i. The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance indicating whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor(s) submit(s) the quarterly written reports to the Board or its designee within ten (10) calendar days after the end of the preceding quarter.

j. If a monitor resigns or is no longer available, Respondent shall, within five (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility. Respondent shall cease the practice of medicine at that hospital or facility until a replacement monitor is approved and assumes monitoring responsibility.

k. Failure to comply with the restrictions and conditions outlined above shall be a violation of the Interim Suspension Order and cause for immediate suspension.

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JURISDICTION

4. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

5. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

"..."

6. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

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"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

7. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

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

9. Section 820 of the Code states:

"Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licentiate and may be received as direct evidence in proceedings conducted pursuant to Section 822."

10. Section 822 of the Code states:

"If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

"(a) Revoking the licentiate's certificate or license.

"(b) Suspending the licentiate's right to practice.

"(c) Placing the licentiate on probation.

"(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

"The licensing section shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated."

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FIRST CAUSE FOR DISCIPLINE

(Mental Illness Affecting Competency)

11. Respondent is subject to disciplinary action under section 822 of the Code in that his ability to practice medicine safely is impaired due to mental illness affecting competency. The circumstances are as follows:

12. In December 2015, the Board received a Health Facility/Peer Review Reporting Form pursuant to Business and Professions Code section 805 report ("805 report") from Fountain Valley Regional Hospital and Medical Center ("hospital") dated December 2, 2015. According to the 805 report, Respondent was scheduled to perform left nephrectomy surgery[1] on October 31, 2015, but instead removed the patient's spleen, leaving the left kidney in place. On November 17, 2015, the hospital summarily suspended Respondent's privileges to perform nephrectomies for fourteen (14) days, pending further investigation by the hospital which included a review of the October 31, 2015 case and two additional 2015 cases where Respondent performed nephrectomies resulting in patient deaths. Following the hospital's Medical Executive Committee ("MEC") interview of Respondent and review of the three cases, Respondent's summary suspension remained in place with recommendations that Respondent undergo a neuropsychological evaluation and complete a medical record keeping course.

13. The Board initiated an investigation of Respondent based upon the receipt of the 805 report.

14. In February 2016, the Board received an updated 805 report from the hospital reporting that on February 4, 2016, Respondent's nephrectomy privileges were terminated.

15. In terminating Respondent's nephrectomy privileges, the hospital concluded that Respondent's surgical conduct on October 31, 2015 was egregious and included deviations from the standard of care that could not be satisfactorily explained or excused by Respondent. Specifically, Respondent's failure to properly identify surgical landmarks and his removal of the wrong organ were deemed to be extreme deviations from the standard of care. Furthermore, his

[1] Surgical removal of a kidney.

failures to recognize the spleen before it was removed and to realize that he had removed the spleen and his delay in notifying the patient of the removal of the spleen were below the standard of care.

16. On January 27, 2016, Respondent underwent a neuropsychological evaluation by Arnold D. Purisch, Ph.D., to determine whether Respondent had a neuropsychological impairment which might prevent him from practicing safely as a urologist and urological surgeon. Following the evaluation, Dr. Purisch prepared a report, dated March 14, 2016, wherein he concluded:

> "Thus, overall, the results of this evaluation are highly inconsistent. [Respondent] demonstrated an intact presentation during the interview but often appeared cognitively impaired during the test administration process. He demonstrated an unreliable pattern of performance on neuropsychological testing such that it is difficult to identify a core cognitive problem unaffected by language, anxiety and distraction due to competing priorities."
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> "Regardless of the factors resulting in such an unreliable presentation, it is concluded that [Respondent] is not functioning normally. He may or may not have bona fide neuropsychological problems when language, anxiety and competing priorities are controlled but their ability to disrupt his functioning during this evaluation is probably not an isolated circumstance. The potential for unreliable functioning in his medical and surgical practice is real and could certainly constitute reason for concern. I would recommend a period of close monitoring and observation by his peers before being granted independent privileges. Absent such a mechanism, I cannot in good conscience provide clearance to resume his normal practice, at least from a neuropsychological perspective."

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17. On July 25, 2016, the Board received an 805 report from CalOptima[2] reporting that Respondent's application was denied due to a surgical error that led to an 805 report and summary restriction of privileges at the hospital.

18. On August 29, 2016, the Board received a further updated 805 report from the hospital reporting that on July 28, 2016, Respondent's clinical privileges were summarily restricted for twenty-nine days pending further investigation. The summary restrictions required that he have (1) a urologist document a second opinion in the medical record before he performs any surgery or procedure, and (2) have a urologist as a co-surgeon during all of his surgeries and procedures. On August 18, 2016, the hospital continued the restriction of Respondent's privileges, with the exception of procedures for urinary retention and torsion, performed in the emergency department. Respondent was also mandated to use the electronic medical record immediately, not to write any notes on paper and he is required to dictate his consultations and operative reports.

19. On November 29, 2016, the Board issued an Order compelling a mental examination of Respondent. That mental examination was ordered to take place no later than December 30, 2016.

20. On December 29, 2016, Respondent underwent a mental examination by psychiatrist, John Hochman, M.D. Upon completion of his examination of Respondent, Dr. Hochman concluded that Respondent has a mental illness or condition that impacts his ability to engage in the practice of medicine. Dr. Hochman is of the opinion that Respondent is unable to practice medicine safely at this time and Respondent's impairment places the public at risk. Dr. Hochman is further of the opinion that Respondent's limitations are beyond being addressed by monitoring or oversight.

21. On March 3, 2017, the Board received an 805 report from Orange Coast Memorial Medical Center setting forth that "[o]n January 18, 2017, Orange Coast Memorial Medical Center's MEC summarily restricted [Respondent's] Medical Staff privileges at the Hospital as

[2] CalOptima is one of California's Medi-Cal health plans.

follows: For all surgical procedures, [Respondent] is required to have a second urologist present as a co-surgeon for the entire procedure. The MEC based the summary restriction on concerns arising form National Practitioner Data Bank reports filed by Fountain Valley Regional Hospital and CalOptima in 2016. On February 10, 2017, the MEC voted to continue the restriction on [Respondent's] Medical Staff privileges."

22. Respondent's ability to practice medicine safely is impaired due to a mental illness or condition that affects his competency.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence as to Patient S.M.)

23. Respondent is subject to disciplinary action under Code Section 2234, subdivision (b), in that he engaged in acts and omissions in the care and treatment of patient S.M., constituting gross negligence. Paragraphs 12 and 15 are incorporated herein by reference as if fully set forth herein. The circumstances are as follows:

24. Patient S.M. was a 65-year-old male patient with a past medical history significant for pulmonary aspergillosis, coronary artery disease, status-post coronary artery bypass graft, chronic obstructive pulmonary disease, congestive heart failure and end stage renal disease on hemodialysis. S.M. was also noted to have type 2 diabetes, hypertension, hyperlipidemia, recurrent pleural effusion, status post thoracentesis, urinary tract infection with septic shock, status post a long hospitalization the past year and a history of asthma.

25. On October 23, 2015, S.M. presented to the emergency room at Fountain Valley Regional Hospital and Medical Center ("the hospital") with complaints of fevers at home with left flank pain. A CT scan of the abdomen and pelvis showed a new left renal mass described as an isodense mass seen off of the inferior pole of the left native kidney, measuring 3.8 cm in size. S.M. was admitted to the hospital for pain management and a possible CT-guided biopsy of the renal mass by interventional radiology.

26. A renal biopsy was performed and pathology was renal cell carcinoma. A consultation was requested with Respondent.

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27. On October 28, 2015, Respondent consulted the patient noting that he was a "64-year-old male admitted to the hospital because of back pain, new renal mass and chronic kidney disease." Respondent noted that the patient had a past history of renal transplantation and open heart bypass. Respondent performed a physical examination. His impression was left renal cancer, right renal transplantation. He recommended a triple renal nuclear scan (nuclear medicine flow test).

28. On October 30, 2015, the nuclear medicine flow test showed decreased renal function bilaterally with no effective renal function after a diuretic was given. It was consistent with chronic renal failure of the native kidneys.

29. On October 31, 2015, Respondent performed an open left nephrectomy. Respondent's Operative Report was dictated on October 31, 2015 but failed to set forth the date of the surgery on the report. In addition, there was no assistant surgeon listed on the report. Respondent noted that the preoperative diagnosis was left renal cancer and the operation was an exploration and left radical nephrectomy. With respect to informed consent, Respondent noted that he explained the operation, procedure and possible complications to the patient who understood and agreed. Respondent did not list what complications were mentioned to the patient. With respect to the procedure, Respondent noted that he was not able to palpate the solid mass on the lower pole of the left kidney and that since the patient was on hemodialysis, kidney function was very poor and it was very difficult to do a partial nephrectomy to identify the mass. Therefore, Respondent decided to remove the entire kidney and in fact noted in his operative report that the whole kidney was removed.

30. Pathology subsequently reported that the collection from S.M.'s October 31, 2015 surgery was a normal spleen (not a kidney).

31. Respondent followed the patient postoperatively. Respondent set forth in his November 8, 2015 progress note: "Talked to patient about surgery. Removed spleen, not kidney. Make arrangements for another operation for kidney." On November 9, 2015, Respondent noted "had explanation about previous surgery, not kidney specimen but spleen, not really effective for

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his health. Spoke to patient and daughter. Plan to do kidney surgery tomorrow." Respondent's November 10, 2015 progress note documented that the family refused surgery.

32. S.M. chose not to undergo further surgery by Respondent and was discharged home on November 13, 2015 with a persistent and now larger mass in the left native kidney.

33. The standard of practice in California requires that before removing a kidney, the urologist appropriately assess the patient preoperatively, including review of imaging studies and discussing the treatment options with the patient, including the risks and benefits of alternative treatments.

34. The standard of practice in California requires that before removing a kidney, the urologist ascertain the upper and lower poles, including identifying the renal artery vein and ureter.

35. The standard of practice in California requires that physicians maintain adequate and accurate medical records reflecting the care and treatment rendered to the patient.

36. Respondent committed gross negligence when he removed S.M.'s spleen instead of the left kidney. Respondent failed to ascertain the upper and lower poles and he failed to identify the renal artery vein and ureter.

37. Respondent's acts and/or omissions set forth in paragraphs 12, 15 and 23 through 36 above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence as to Patient D.G.)

38. Respondent is subject to disciplinary action under Code Section 2234, subdivision (b), in that he engaged in acts and omissions in the care and treatment of patient D.G., constituting gross negligence. The circumstances are as follows:

39. Patient D.G. was a 59-year-old male admitted to the hospital on May 12, 2015 with an admitting diagnosis of hematuria, renal mass, possible renal cell carcinoma, hypertension, morbid obesity, probable liver cirrhosis and thrombocytopenia related to liver cirrhosis. It was noted that one week prior, D.G. started having hematuria and suprapubic pain. He presented to

the emergency room at Garden Grove Hospital where a catheter was placed and approximately 1,000 cc of urine was removed, most of it bloody. CT scan showed a right renal mass in the lower pole with possible thrombus of the vein and further revealed that the patient had a 1.4 cm stone in the right collecting system with mild right sided hydronephrosis. He also was noted to have enlargement of the right renal vein with tumor thrombus, splenomegaly as well as liver cirrhosis. He had been scheduled for surgery but it was noted to have been cancelled and he was transferred to Fountain Valley Hospital Medical Center ("the hospital") due to insurance reasons.

40. At the hospital, D.G. was seen in consultation by Respondent on May 12, 2015. Respondent noted that the patient was a 59-year-old white male known to him who developed abdominal pain, especially on the right side, for the past one to two months. He had been to the emergency room at another hospital and was found to have a large tumor, a mass in the right kidney measuring 13 x 10 cm. He was transferred to the hospital for treatment. With respect to a physical examination, Respondent documented that the abdomen was soft and flat; the liver and spleen were impalpable with some obesity and the prostate was slightly boggy. Respondent's impression was right renal mass, rule out carcinoma and gross hematuria. Respondent recommended an exploration and excision of the mass and possible radical nephrectomy.

41. On May 13, 2015, Respondent noted that he spoke with the patient about the procedure and possible complications.

42. On May 14, 2015, Respondent noted that he spoke with the patient again and that the surgery was highly risky with a liver problem and large tumor. He noted that the patient agreed to surgery. That same day, Respondent performed a right radical nephrectomy on D.G. The preoperative and postoperative diagnosis was a large right renal tumor, rule out carcinoma and gross hematuria. Respondent noted that the patient had a CT scan of the abdomen performed at the other hospital showing a 13 x 10 cm large mass in the right lower pole of the kidney. Respondent made no note about the renal vein, inferior vena cava or thrombosis. Respondent removed the right kidney. Blood loss was noted to be 1,500 cc and 4 units of blood was given. Following the procedure, while still on the operating table, the patient's condition worsened and his pressure dropped. D.G. was given 4 additional units of blood. The patient coded and CPR

was performed. The incision was opened and Respondent reported no active bleeding. The wound was packed and the plan was to transfer the patient to the intensive care unit and obtain a hematology consult. In the interim, while still in the operating room, the patient coded again and after 48 minutes of aggressive resuscitation, the code was called. The cause of death was noted to be probable shock related to massive perioperative hemorrhage in the setting of thrombocytopenia and possible coagulopathy.

43. Surgical pathology revealed renal cell carcinoma, clear cell type, firm and nuclear grade 3, tumor lower pole of 13 cm with capsule involved. The pathology report further set forth "renal vein tumor thrombus 2.5 cm in length at renal vein margin and resection. Ureter free."

44. The standard of practice in California requires that before performing a radical nephrectomy, the urologist assess the patient preoperatively, including a review the patient's imaging studies, diagnostic studies and order appropriate consultations.

45. Respondent committed gross negligence in failing to appropriately assess the patient, who had a complicated medical history with significant co-morbidities. Respondent failed to review the patient's preoperative CT scan. A review of the preoperative CT scan would have alerted Respondent to the enlarged renal vein and large vena cava and would have prompted him to repeat the CT scan with and without contrast and possibly have an MRI performed to more formally evaluate the renal vein or the inferior vena cava for tumor thrombus. Further, Respondent should have recognized the necessity for more preoperative staging work-up as well as an oncology consult given the patient's laboratory values.

46. Respondent's acts and/or omissions set forth in paragraphs 38 through 45 above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence. Therefore, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence as to Patient H.N.)

47. Respondent is subject to disciplinary action under Code Section 2234, subdivision (b), in that he engaged in acts and omissions in the care and treatment of patient H.N., constituting gross negligence. The circumstances are as follows:

48. Patient H.N. was a 64-year-old Vietnamese male found to have a large right renal mass by his primary care physician and was referred to the emergency department on March 31, 2015 for further evaluation. The patient was admitted to the medical surgical floor. CT scan of his abdomen and pelvis revealed a large cystic and solid right renal mass consistent with renal cell carcinoma. A urology consultation with Respondent was requested.

49. On March 31, 2015, H.N. was seen by Respondent at which time Respondent noted that H.N. was a "64-year-old white male who developed right abdomen pain and a swollen mass. He has had the mass for two to three months. He has had hematuria on and off. He denies loss of body weight. The right lower leg shows some edema. Past history notes no surgery, allergies none." Respondent performed a physical examination and noted that the abdomen was soft and there was a large mass on the right side with some tenderness. Respondent concluded "large right renal mass, possible cancer, will evaluate and will arrange for surgery." Respondent did not comment on the patient's elevated liver enzymes and elevated creatinine. Further he did not investigate whether the large renal mass was resectable.

50. On April 3, 2015, Respondent performed an exploration right radical nephrectomy on H.N. In his description of the operation, Respondent noted ascites and portal vein hypertension as well as the spermatic vein being very engorged. Respondent transected the ureter and a Pean clamp, a surgical tool used to control bleeding, was applied to the renal pedicle. Respondent noted "because of huge tumor and friable, some necrotic tumor tissue was removed. Oozing of the vein was carefully clamped and tied with silk. Surgical powder and anticoagulation was placed in the retro peritoneum. No oozing was identified. Postoperatively, Respondent transferred the patient to the medical-surgical floor. The following day, the patient had a lower blood pressure, tachycardia and poor urine output. Respondent then transferred the patient to the intensive care unit for observation where a code was called. The patient was unable to be resuscitated and subsequently expired.

51. Surgical pathology revealed clear cell renal cell carcinoma with a tumor size of 18.7 x 8 cm. It was noted that there was an extension through the capsule into the perinephric fat and the large renal vessel showed intravascular tumor emboli and extensive necrosis.

52. The standard of practice in California requires that before performing a radical nephrectomy in a patient with large renal cell carcinoma, the urologist assess the patient preoperatively, including a review of the patient's imaging studies and laboratory studies as well as ordering appropriate consultations.

53. The standard of practice in California requires that when performing a radical nephrectomy in a patient with large renal cell carcinoma, the urologist dissect the renal artery and renal vein separately and tie them off separately. If it is not possible to dissect and tie them off separately, staples are used to control hemostasis.

54. Respondent committed gross negligence by failing to appropriately evaluate H.N., preoperatively. H.N. had a large renal cell carcinoma and was another complicated case that required a thorough work-up. At a minimum, an MRI should have been performed to evaluate the renal vein and vena cava. Further, an evaluation of the patient's elevated enzymes should have been conducted and an oncology consult should have been ordered to determine whether the patient has metastatic disease.

55. Respondent also committed gross negligence by failing to dissect the renal artery and renal vein separately and tie them off separately.

56. Respondent's acts and/or omissions set forth in paragraphs 47 through 55 above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence. Therefore, cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence as to Patients S.M., D.G. and H.N.)

57. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he has engaged in acts and omissions in the care and treatment of patients S.M., D.G. and H.N., constituting repeated negligent acts. Paragraphs 12, 15 and 23 through 56 are incorporated herein by reference as if fully set forth herein. The circumstances are follows:

58. With respect to patient S.M., Respondent was negligent when he removed S.M.'s spleen instead of the left kidney. Respondent failed to ascertain the upper and lower poles and he failed to identify the renal artery vein and ureter.

59. With respect to patient D.G., Respondent was negligent when he failed to appropriately assess this complicated patient with significant co-morbidities. Respondent failed to review the patient's preoperative CT scan. A review of the preoperative CT scan would have alerted Respondent to the enlarged renal vein and large vena cava and would have prompted him to repeat the CT scan with and without contrast and possibly have an MRI performed to more formally evaluate the renal vein or the inferior vena cava for tumor thrombus. Further, Respondent should have recognized the necessity for more preoperative staging work-up as well as an oncology consult given the patient's laboratory values.

60. With respect to patient H.N., Respondent was negligent in failing to appropriately evaluate him preoperatively. H.N. had a large renal cell carcinoma and was another complicated case that required a thorough work-up. At a minimum, an MRI should have been performed to evaluate the renal vein and vena cava. Further, an evaluation of the patient's elevated enzymes should have been conducted and an oncology consult should have been ordered to determine whether the patient has metastatic disease.

61. Respondent also was negligent during H.N.'s surgery by failing to dissect the renal artery and renal vein separately and tie them off separately.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

62. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to his care and treatment of patients S.M., D.G. and H.N. Paragraphs 21 through 61 are incorporated herein by reference as if fully set forth herein. The circumstances are follows:

63. With respect to S.M., Respondent failed to maintain adequate and accurate medical records reflecting the care and treatment rendered. Respondent's preoperative consultation was extremely brief and failed to address the complexity of the patient's case. Respondent failed to mention any of the significant past medical history relevant to the nephrectomy and the various treatment options available. Further, Respondent failed to document any discussion with the patient or the patient's family regarding the treatment alternatives other than radical nephrectomy.

64. With respect to D.G., Respondent failed to maintain adequate and accurate medical records reflecting the care and treatment rendered. Respondent failed to document an appropriate preoperative assessment and his operative note was brief failing to adequately address the surgical findings. Respondent's documentation for D.G. was extremely poor and limited.

65. With respect to H.N., Respondent failed to maintain adequate and accurate medical records reflecting the care and treatment rendered, including the failure to appropriate assess the patient preoperatively.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 35361, issued to Huey Chou Lin, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants pursuant to section 3527 of the Code and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: May 3, 2017

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

Complainant

LA2017504400