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

In the Matter of the Accusation and Petition to Revoke Probation Against:	)	
PABLO GARZA CORTINA, M.D.	)	Case No. D1-2006-176267
Physician's and Surgeon's Certificate No. G47561	)	OAH No. 2013080739
Respondent	)	

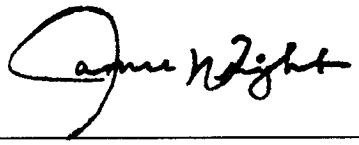
DECISION

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 June 18, 2015.

IT IS SO ORDERED: May 19, 2015.

MEDICAL BOARD OF CALIFORNIA



Jamie Wright, J.D., Chair
Panel A

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

In the Matter of the Accusation and Petition to Revoke Probation Against: PABLO GARZA CORTINA, M.D. Ukiah, California 95482 Physician and Surgeon's Certificate No. G 47561 Respondent.	Case No. D1-2006-176267 OAH No. 2013080739

PROPOSED DECISION

This matter was heard before Dian M. Vorters, Administrative Law Judge, Office of Administrative Hearings, State of California, on June 18 and 19, 2014, in Sacramento, California.

Jannsen Tan, Deputy Attorney General, represented the Executive Director (Complainant) of the Medical Board of California (Board).

Scott Harris, Attorney at Law,[1] represented Pablo G. Cortina, M.D. (respondent), who was present.

Evidence was presented and the record remained open for written closing briefs. On request by respondent, the briefing schedule was amended on October 15, 2014, without opposition.[2] The record closed on February 2, 2015, and the matter was submitted for decision.

[1] Scott J. Harris, Attorney at Law, 8383 Wilshire Boulevard, Suite 830, Beverly Hills, California 90211.

[2] Complainant's Closing Brief was marked as Exhibit 27, Respondent's Closing Brief was marked as Exhibit Q, and Complainant's Reply Brief was marked as Exhibit 28.

FACTUAL FINDINGS

1. On June 14, 1982, the Board issued Physician's and Surgeon's Certificate Number G 47561 (license) to respondent. Respondent's certificate was current at all times relevant to the charges set forth in the Accusation, and will expire on August 31, 2015, unless renewed or revoked.

Prior Discipline

2. On February 4, 1998, the Board filed an Accusation against respondent's license. Complainant alleged that respondent's treatment of two surgical patients fell below the standard of care and constituted repeated negligent acts. The parties reached a Stipulated Settlement and effective August 24, 1998, the Board placed respondent's license on two years' probation with terms and conditions including an education course, ethics course, and practice monitoring.

3. On July 15, 1999, the Board filed an Accusation and Petition to Revoke Probation. Complainant alleged that respondent had been convicted in federal court of filing a false tax return. Respondent pled guilty to the felony charge on June 2, 1998. Effective December 17, 1999, the Board placed respondent's license on probation for seven years with terms and conditions including a clinical training program, restitution/fines, and a psychiatric evaluation. On August 19, 2004, respondent filed a Petition to Terminate Probation. Effective February 28, 2005, the Board granted respondent's Petition to terminate probation early.

4. On February 10, 2009, the Board filed an Accusation against respondent's license. Complainant alleged unprofessional conduct by respondent in the gynecological care he provided three patients. Respondent's conduct was found to demonstrate gross negligence, repeated negligent acts, and failure to maintain adequate/accurate records in that he failed to conduct thorough evaluations of complaints, offer alternatives other than surgery, provide informed consent for surgery, or maintain adequate medical records. Effective June 9, 2010, the Board placed respondent's license on probation for seven years with terms and conditions to include a medical record keeping course, clinical training program, and practice monitoring.

5. On August 8, 2013, the Board filed this Accusation and Petition to Revoke respondent's current grant of probation. Complainant alleged that respondent operated an unaccredited surgical facility in violation of law and community standards of care. Respondent's conduct is alleged to demonstrate gross negligence, repeated negligent acts, and unprofessional conduct, as is set forth below. (Bus. & Prof. Code, §§ 2227, 2234, subds. (b) & (c); Health & Saf. Code, § 1248.)

Respondent's Education and Experience

6. Respondent obtained his undergraduate degree from the Pan American University in Texas in 1976. He completed his internship at Baylor Affiliated Hospitals in Houston, Texas, and his residency in Obstetrics and Gynecology (OB/Gyn) at Stanford in 1984. Respondent became board certified in OB/Gyn in 1986. Due to his Board probation in 2010, he is not currently board certified.

Respondent practiced medicine in the U.S. Air Force from 1984 through 1988. He functioned as Chief of OB/Gyn and Chief of Surgical Services. Since leaving the military at the rank of Major, he has practiced primarily in Northern California as an OB/Gyn physician. Since 2003, respondent has been self-employed, practicing OB/Gyn and cosmetic surgery in Ukiah, California.

April 2011 Complaint and Investigation

7. On April 21, 2011, the Board received a complaint against respondent's practice. The substance of the complaint was that respondent was performing cosmetic procedures in his office without adequate protocols and emergency equipment in place, respondent's surgical suite was not certified, there was no backup battery or portable emergency equipment, his medical assistant was not properly trained or certified in surgical procedures, respondent was administering Propofol which compromises the patient's respiratory function, and he had placed several patients at risk of infection and one patient had died.

8. On December 6, 2011, Board investigator Roberto Moya visited respondent's medical office in Ukiah. He spoke to respondent and a nurse assistant. Respondent told Mr. Moya that he performed two to three cosmetic procedures a month and his office was not accredited. Respondent received hands-on training from an experienced plastic surgeon. He had no other formal training. Respondent told Mr. Moya that his registered nurse (RN) Scott Wallace administered the anesthesia under respondent's supervision. Mr. Moya reported that he observed dangerous drugs stored in an unsecured manner. The dangerous drugs he was referring to are not identified in this record.

9. Mr. Moya inspected the operating room, which he described as a "standard exam room." There was no defibrillator or electric generator on site. Mr. Moya asked for a copy of respondent's transfer agreement with a local hospital, but there was none in place. Upon request, respondent provided a copy of his office policies and procedures. His "Policy and Procedure: Ambulatory Surgery Anesthesia" stated, in relevant part:

> I. ...Anesthesia services are only performed by a licensed Anesthesiologist or a licensed RN under direct supervision of the surgeon and have been credentialed by the organization in accordance to the standard.

II. Anesthesia administered in this facility will be under; Local or topical anesthesia, minimal sedation, moderate sedation or regional. The patient will be under constant monitoring with a pulse ox probe, a CR monitor, and have available up to 100% oxygen if needed. A reliable suction source to maintain airway will be available.

III. A qualified Physician will examine the patient immediately prior to anesthesia to evaluate the risks ... Pre-operative evaluation, post-operative evaluation, and discharge is conducted by the healthcare worker administering the anesthesia and documented in the clinical record.

10. Mr. Moya told respondent that he needed to "comply with the standards and the codes." He mentioned Institute for Medical Quality (IMQ) accreditation, Health and Safety Code section 1248, and Assembly Bill 595 to respondent. He instructed respondent that he needed to be certified as a practitioner with a solo office. At hearing, Mr. Moya stated that he assumed accreditation was required, "for the type of procedures he was doing there." He also assumed respondent was using deep sedation. Mr. Moya admitted that he only reviewed one patient file and did not know what levels of anesthesia respondent was administering.

11. On December 8, 2011, respondent sent a letter to Mr. Moya stating that he would stop performing cosmetic surgery in his office and would consult with IMQ on accreditation. Effective December 17, 2011, respondent became re-certified in ACLS. He mailed proof to Mr. Moya. Respondent also sent to Mr. Moya a copy of his "Transfer Agreement" with Ukiah Valley Medical Center for clinical patients requiring emergency and non-emergency hospitalization. The Transfer Agreement was dated December 15, 2011. On January 12, 2012, respondent purchased a defibrillator and sent a copy of the receipt to Mr. Moya.

12. On August 2, 2012, Mr. Moya returned to respondent's Ukiah office. The operating room still did not have a back-up generator. Mr. Moya spoke to respondent and Mr. Wallace. Respondent had resumed conducting cosmetic surgery in his unaccredited office. Respondent explained that due to financial pressures he needed to continue conducting surgery.

Mr. Moya asked respondent about patient LO who underwent a neck lift on December 21, 2011, at respondent's office. Respondent stated he sent the patient home with pain medication. She died the following morning at 3:06 a.m. The cause of death was "acute polypharmacy." The forensic pathologist, found: "There are elevated levels of total

morphine, total hydrocodone, total hydromorphone, and propofol glucuronide[3] in the urine. The sum of these opioids kills through apnea and fatal hypoxia. This is aggravated by the simultaneous use of ethanol, whose presence is also documented."

13. On August 21, 2012, respondent purchased a 3500 watt generator. On September 16, 2012, respondent completed an eight-hour course in the administration of conscious sedation. He submitted copies of his generator receipt and certificate of course completion to Mr. Moya. Respondent also sent Mr. Moya a copy of Scott Wallace's curriculum vitae, letters of reference, and documents related to Mr. Wallace's medical training.

14. On September 24, 2012, Mr. Moya interviewed Mr. Wallace at the Board's District Office. Mr. Wallace has worked for respondent since 2004. Mr. Wallace was a paramedic in the 1980s, became an RN in 1990, and a certified flight nurse in 1991. He holds numerous certifications as a certified critical nurse and is trained in the administration of analgesics, airway management, advance trauma, and advanced cardiovascular life support (ACLS). His job during cosmetic procedures was to provide procedural sedation and monitor the patient at all times.

15. On October 26, 2012, Mr. Moya interviewed respondent at the Board's District Office. Respondent brought with him his curriculum vitae and a letter dated October 10, 2012, from Norcal Specialty Surgery Center in Santa Rosa, stating that "[Respondent] is currently credentialed and has active privileges allowing him to perform cosmetic procedures" at the center.

16. Respondent took steps toward obtaining accreditation but found the fee of $23,000 prohibitive. In October 2012, respondent began performing cosmetic procedures at the Santa Rosa ambulatory center where an anesthesiologist was provided. Respondent stated that some of the tools he used were not at the ambulatory center. Other criticisms were that the procedure took much longer, general anesthesia was being used which caused nausea in some patients and presented a risk of bleeding and tearing sutures, and the location was one and one-half hours away from Ukiah. Due to poorer outcomes at the ambulatory center respondent resumed performing surgeries at his office. He limited his procedures to eye lifts, breast work, and liposuction. He shied away from face lifts and adbominoplasty which are more radical procedures.

Respondent's Testimony

17. Respondent has lived and practiced in Ukiah for 24 years. His OB/Gyn practice is supplemented by cosmetic surgery. He performs 20 deliveries a month but is not

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[3] According to the January 24, 2012 Toxicology Report requested by the Coroner, Propofol Glucuronide is the main urinary metabolite of propofol, a hypnotic agent used for the induction and maintenance of general anesthesia.

always paid. Normal OB/Gyn surgical procedures include diagnostic and surgical laparoscopies, lysis of adhesions, hysterectomies, bladder suspensions, tape suspensions, and vaginal surgeries for prolapse. Respondent was initially motivated to begin offering cosmetic surgery due to a perceived need for affordable procedures and to supplement his income. Many patients over the years had approached him for referrals to a plastic surgeon. Some found the cost to be prohibitive. Due to the Board discipline, major insurance providers dropped him leaving only Medi-Cal, private pay, and smaller plans.

18. Respondent began performing cosmetic surgery in 2004. He contacted Bernard Kouri, M.D., in Beverly Hills, and asked him to explain some procedures. Respondent began accumulating patients. Dr. Kouri would fly up to Ukiah and they worked together on approximately100 patients. This included at least 30 abdominoplasties, five face lifts, five neck lifts, and approximately 40 liposuctions. Respondent has also attended several conferences at which he worked on cadavers. He also studies the American Journal of Cosmetic Surgery and the Journal of Plastic And Reconstructive Surgery. In December 2011, 90 percent of his practice was OB/Gyn and 10 percent was cosmetic surgery. He performed three to four cosmetic surgery procedures a month.

19. Respondent was on probation in 2004 and he informed Board monitors he was performing cosmetic procedures in his medical office. No Board representative informed him that his clinic needed to be accredited. Respondent participated in the PACE program at the University of California, San Diego. He was required to tell them about his scope of practice which included cosmetic surgery in his office. Dr. Charles Nager was respondent's PACE monitor. Dr. Nager's specialty was OB/Gyn but he did not perform cosmetic surgery and did not feel qualified to review cosmetic surgery, so PACE assigned an additional monitor. Both monitors reviewed respondent's charts and submitted quarterly reports to the Board. Respondent was not aware of any negative reports. Respondent uses electronic medical records for all of his notes. His notes are extensively evaluated by his PACE monitor who told him he was doing great.

20. In 2011, his most common cosmetic procedures were breast augmentation and reduction, abdominoplasty, liposuction, neck lifts, fact lifts, brachioplasty (arm lift), and medial thigh lift. Respondent uses Tumescent solution, a numbing agent, as well as Morphine, Fentanyl "to provide opiate analgesia," Versed "to facilitate sedation and amnesia," and Propofol "to provide procedural sedation." He submitted a document used in his office that lists the medications, dosages, and contraindications, and instructs:

> When dosing procedural medications, the [RN] should report any changes in hemodynamic status, oxygenation issues, or cardiac arrhythmias to [respondent]. A baseline for each of these areas will be established prior to the start of the procedure. [Respondent] will be notified for a change in blood pressure or heart rate of more than 15%, oxygen saturation changes below 92%, and respiratory rates of fewer than 8 per minute.

21. Respondent received resuscitation training during his general medical training in the surgical ICU at Stanford and in the cardiac care and intensive care units at Baylor in Houston. He also took a course in conscious sedation and routinely attends ACLS meetings at the local hospital. To reduce the risk, he selects patients who do not have a history of cardiac or lung problems, or severe metabolic disorders like hypertension or diabetes.

22. Respondent's intent during surgical procedures in his office is for patients to have pain relief and be able to communicate ("conscious sedation"). Mr. Wallace and respondent's medical assistant Rose are present during procedures. During procedures they communicate about the patient's status and titrate the amount of anesthesia depending on how the patient is feeling and how conscious the patient is. They have never had to intubate or perform cardiac resuscitation on a surgical patient in the office.

23. Respondent stated that Mr. Moya came to the office and asked if respondent was using "deep sedation." After Mr. Moya left, respondent sent Mr. Moya a letter on December 8, 2011, stating he would stop performing procedures and would contact IMQ. Respondent timely contacted IMQ and spoke to Dr. Mark Mandell-Brown in Cincinnati, Ohio. IMQ sent respondent a handbook that spoke of anesthesia and anxiolysis being on a continuum.

24. Respondent's research satisfied him that accreditation was unnecessary since he was using "minimal sedation/anxiolytic" for procedures. In order to improve safety, respondent purchased a defibrillator, generator, and headset to lighten the operating field in case of power loss. Respondent stated that his operating room has windows up high that allow in natural light at all times.

Patient LO

25. On December 21, 2011, respondent operated on LO. LO was 61 years of age. LO was unhappy about her sagging neck. LO completed a patient questionnaire in which she disclosed she was taking Zoloft and multivitamins, was a social drinker, did not use recreational drugs, and had stopped smoking. It is noted that LO's toxicology was positive for Lorazepam (Anxiety), Clonazepam, Hydrocodone, Dicyclomine (Bentyl), Sertraline (Zoloft), THC (marijuana metabolite), Caffeine, Nicotine, and Ethanol. Zoloft is an anti-depressant which according to respondent would have no impact on sedation medications. LO signed an informed consent form acknowledging she was "aware of the risks which include but are not limited to infection, hemorrhage, scars, anesthesia reaction."

Respondent performed "a short SMAS lift" and a "neck lift" with minimal sedation. The anesthetic load for LO was Propofol, Versed, and Morphine. There were no complications during the procedure, no need to adjust her neck for breathing, no snoring sounds. Respondent stated that they would periodically ask LO "are you doing okay, in any pain?" and LO was able to verbalize that she was doing okay.

26. LO reached an Aldrete score of five during the surgery.[4] Respondent denied any intent to bring LO to this score or induce moderate or deep sedation. He stated that LO had been "comfortable" during the procedure but at the end, "she was sleeping" and not answering his questions any longer. She was hooked up to a cardiac monitor and an oxygen saturation monitor so they knew she had good cardiovascular function and was breathing well. Her "EKG looked good" and her coloring was "a little pale." They kept her on monitors, kept fluids running through IV, and "just watched her." LO achieved an Aldrete score of 10 prior to discharge.

27. Respondent learned of LO's passing the next day. He later learned the results of her toxicology report. He noted that LO had not disclosed she was taking the drugs found in her system. Respondent had prescribed an antibiotic, Phenergan (anti-nausea), and Percocet (generic oxycodone). He did not prescribe the drugs found in LO's system, including the Hydrocodone and Lorazapam. He testified that had he known about these drugs, he would have delayed the procedure because, "those other meds can cause her to drift more."

28. Respondent stated that his patients commonly reach Aldrete Scores of eight or nine, but never as low as five. "A handful" of patients had to be assisted in breathing, mostly by means of "jaw tilt" or he had to "bag" one or two by placing an oxygen mask over their face. The intervention was "quick and minimal." Respondent explained that these patients were "a little apneic," and "not breathing as well as I would like." He would instruct Mr. Wallace to "give them a couple of puffs" meaning oxygen. Respondent clarified that these patients did not have be "rescued."

29. Respondent is 60 years of age. He lives with his girlfriend and their one and one-half year old daughter. He considers Ukiah to be his home. If the Board tells him he is in violation and must cease performing cosmetic surgery until he becomes accredited or that he must work out of an accredited facility, he will do it. He feels he performs good work in the community and if he did not, everyone in this small town would know it. He plans to continue performing cosmetic surgery though he would stop for a time if needed. He does not believe he is practicing in violation of Health and Safety Code section 1248. He reiterated that he does not use general anesthesia or deep sedation, he only uses minimal sedation/anxiolysis, and the Board has known about his activities for years.

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[4] The Aldrete score is commonly used to determine when a patient can safely be discharged from a post-anesthesia care unit. The Aldrete scoring system assigns a "0" (no impairment), "1" (moderate impairment), or "2" (seriously impaired) to each of five categories: Activity, Respiration, Circulation, Consciousness, and Color. A total score of 9 or 10 is required for discharge.

Character Evidence

30. Mark Luoto, M.D. testified on respondent's behalf. Dr. Luoto is board certified in emergency medicine and was the previous Medical Director of Ukiah Valley Medical Center. He has been a colleague of respondent's for 25 years. They interact on gynecologic patients at the hospital. When a problem with an early pregnancy is presented, Dr. Luoto is glad when respondent is on call. Respondent is always willing and available to assist. He believes the quality of respondent's medical practice is "excellent." Respondent is well respected amongst area surgeons.

31. Respondent submitted several professional letters in support of his practice.[5] Respondent has worked with each of these physicians and anesthesiologists. Also, three nurses who are also patients of respondent's wrote letters of support as follows:

a. Kathleen Persky, M.D. is a breast cancer surgeon who has observed respondent's work and referred a family member to him for breast augmentation. She described respondent's work-up and preoperative and postoperative care as "meticulous" and "impeccable." In her opinion he has "excellent surgical skills and aesthetic results." She continues to refer patients to him without reservation, describing his surgical judgment and ability as "exemplary."

b. Charles E. Evans, M.D. is an emergency medicine physician who has worked with respondent for over 20 years. He wrote a letter to the Board dated June 10, 2014, in which he described respondent's prompt professional response to emergency calls for surgical assistance with OB/Gyn patients, several with ruptured ectopic pregnancies. Dr. Evans noted that respondent is bilingual and frequently accepts referrals with little or minimal reimbursement from uninsured patients.

c. Ronald Guth, M.D., is an anesthesiologist with 30 years of practice. He wrote two letters in September and November 2013. Dr. Guth worked with respondent on an emergency C-section delivery in September 2013. This was a difficult delivery with a morbidly obese 36-week gestation patient who had ingested methamphetamine a few hours prior. Due to complications in placing an IV line the surgery began with local anesthesia until the line was placed. Dr. Guth stated that throughout the "very stressful" procedure, respondent remained calm. He praised respondent's ability to deliver a baby under such extreme circumstances. Dr. Goth has worked with respondent on over a thousand cases and stated it would be a "tremendous loss to Ukiah" if he were not practicing there.

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[5] These letters were admitted as administrative hearsay pursuant to Government Code section 11513, subdivision (d), which states in pertinent part, "Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. ..."

d. Marvin G. Trotter, M.D. is Chief Medical Officer at Pacific Redwood Medical Group, Inc. In his letter dated October 8, 2012, he noted that respondent had worked at the Ukiah Valley Medical Center (UVMC) for over 20 years delivering over 5,000 babies. Respondent serves the Spanish-speaking population and E/R without fail and largely without compensation. Dr. Trotter stated, "Nobody on the staff is considered his superior in C-section or GYN surgery." Respondent also regularly sees difficult patients with chronic pain or mental issues who otherwise cannot find care.

e. David DeBooy, M.D. is an anesthetist who has been operating with respondent for over 20 years. In his letter dated October 7, 2013, he described respondent as an "excellent surgeon," easy to work with, well-like by colleagues and staff, a hard worker, and always available for his patients.

f. Karen E. Crabtree, M.D. is a board certified OB/Gyn physician who has practiced with respondent for 20 years. He described respondent as an "excellent surgeon" who has assisted Dr. Cortina on several occasions. Respondent is consistent and reliable in his willingness to take extra calls or assist with colleagues are unavailable. The nurses on Labor and Delivery at UVMC have come to rely on respondent in a crisis. She stated, "There is always a sense of security knowing [respondent] is available."

g. Valerie Jackson wrote a letter dated May 1, 2014. She is a nurse as well as one of respondent's OB/Gyn and cosmetic surgery patients. She has worked with respondent in the operating room and underwent breast augmentation surgery approximately five years ago. She expressed confidence in his surgical skills and good judgment in the OR and in labor and delivery where she has observed him work. Her breast surgery took place in his office with Dr. DeBooy as the anesthesiologist and another nurse assisting. She was awake but sedated and monitored during the procedure. She stated that the community is lucky to have respondent practicing in Mendocino County.

h. Sara Brown is a nurse, OB/Gyn patient, and plastic surgery patient of respondent's. She wrote a letter dated May 20, 2014, in which she expressed satisfaction with the care she received from him. She has always felt safe in his care and his skills far exceeded her expectation. She would highly recommend him to family and friends for plastic surgery.

i. Nancy Bray is a nurse who has worked with respondent for over 20 years. She is also a patient. She described him as professional and collaborative with his colleagues and nursing staff. He has a calm nature in a crisis, is respected by the nursing staff at UVMC, and often called on by his other physicians to consult on difficult and challenging patients.

Complainant's Expert – James A. Willis, M.D.

32. Two experts provided their opinions in this case. Complainant called James W. Willis, M.D., as an expert witness. Respondent called Jeffrey Kuhn, M.D as his expert witness.

33. Dr. Willis is Board Certified by the American Board of Anesthesiology. He received his Applied Baccalaureate (A.B.) degree and Master of Arts (M.A.) degrees from the University of California, Berkeley, and Doctor of Medicine (M.D.) degree from George Washington University in 1977. Dr. Willis completed his internship in 1977 and his residency in Anesthesiology in 1985, at the University of California, Davis Medical Center (UCDMC). Dr. Willis' clinical experience includes practice as an E/R and Family Practice physician (1978-1983), clinical instructor at UCDMC (1985-1989), consulting anesthesiologist at Auburn Pain and Rehabilitation (1988-1991), and anesthesiologist at Auburn Faith Community Hospital (1986-2006). Dr. Willis has taught ACLS for the American Heart Association. He is certified in pain management and currently practices as a pain management consultant in Auburn. Dr. Willis prepared a report of his opinions and testified at hearing.

34. Dr. Willis last provided anesthesia services in 2006, and agreed that there has been an evolution in the use of Propofol and the use of nurses in administering this drug. As a consultant he has nurses under his direction in accredited facilities. Since 2008, Dr. Willis has volunteered with Institute for Medical Quality (IMQ) as an outpatient accreditation surveyor. Accreditation is a certification by a recognized agency such as the IMQ that has a set of criteria or standards (IMQ Standards). The standards are applied when looking at an office for accreditation. The office does not need to meet all standards but some are "drop dead" standards of particular importance that a facility must meet on the day of the survey. For example, an office must have emergency equipment and medications available on site. (IMQ Standard 6.3.3.) IMQ has a consultative unit that goes out to give the licensees guidance.

35. Dr. Willis attends annual IMQ training seminars on ambulatory surgery center standards and accreditation. He was accompanied by an experienced surveyor on his first two or three surveys. His duties are to review the application for accreditation, visit the site, verify all standards are met, and write report to the Board of the IMQ Outpatient Accreditation Division, with findings and a recommendation on whether accreditation should occur, for how long, and any outstanding issues. He has performed 15 to 20 surveys of medical offices ranging from smaller single physician sites, to plastic surgery settings, and hospital ambulatory and outpatient facilities.

36. IMQ reviews whether the facility has the appropriate administrative standards, bylaws, peer review systems, how they maintain medical records, whether those records are appropriate and complete, consent issues, continuity of care, how meds are managed in facility (kept secured), environmental safety (inspections by fire agencies), equipment periodic maintenance, surgery protocols (personnel, monitoring, equipment), and anesthesia.

37. According to Dr. Willis, if surgeries are being appropriately performed in an outpatient surgical setting with only local anesthesia or with peripheral nerve blocks, Health and Safety Code section 1248 (Section 1248) does not apply; for example, if removing a mole from a patient's hand or certain dental procedures. However, when drugs are being administered using an IV (IV Sedation), Section 1248 may apply to preclude the procedure in a non-accredited setting. Dr. Will stated that there is "a little bit of wiggle room," depending on community standards. (Health & Saf. Code, § 1248; Legal Conclusions 4 & 5.)

38. Dr. Willis noted that respondent regularly performed IV Sedation in his office administering Propofol, Versed, Fentanyl, and Morphine. He explained the uses of these medications, all of which have the potential of rendering a patient incapable of maintaining airway.

a. Propofol is an anesthetic agent that can also be used to provide continuous sedation through an IV drip. Propofol is commonly used when setting bones in ER and as a short-term sedative in ICUs. Propofol is never used outside a hospital setting with one exception, and that is if a patient needed to be crash intubated in the field. In Dr. Willis's opinion, the standard of care is that IV administered Propofol should be given in an accredited setting.

b. Morphine administered through IV should be given in an accredited setting. Morphine tablets do not require accreditation but are generally not given for sedation. In Dr. Willis' opinion, the standard of care is that IV administered Morphine should be given in an accredited setting.

c. Versed is a benzodiazepine. It is used to provide anxiolytic (to relieve a person's anxiety). In large doses (and in some normal doses), it can produce fairly deep sedation and loss of protective reflexes. Versed can be given by IV most of the time and can be given orally. In Dr. Willis's opinion, it is highly unusual to find Versed being administered outside of a hospital, hospital outpatient facility, or an accredited surgery setting.

d. Fentanyl is an opioid and 100 times more potent than morphine. It can be used as an anesthetic. It can produce apnea meaning person can stop breathing, putting the patient's life at risk. It should be administered in an accredited setting.

39. Dr. Willis defined the community standard of practice as what most physicians and facilities are going to expect in terms of how a patient is being treated. In Dr. Willis's opinion, the standard for IV administration of Propofol, Versed, and Fentanyl, is that they will be administered for light to moderate and deep sedation, and must be given in an accredited facility. Dr. Willis believes respondent was putting patients' lives at risk with all of these drugs because patient responses are not always predictable. For example, if person has a full stomach, they can regurgitate with loss of protective reflexes causing death. If a patient has taken other drugs before coming to the facility, i.e., narcotics, benzodiazepines, or

street drugs, the response can be unpredictable. The facility must be prepared to deal with those situations. In Dr. Willis's opinion, respondent was operating outside the community standard of practice in his sedation practices.

40. Dr. Willis did not believe respondent's office would have been granted an accreditation based on a lack of emergency equipment, defibrillator, and backup generator. (IMQ Standard 7.1.2.) Even with natural lighting, energy is needed to power the monitors. The physician needs to see the cardiac rhythm and oxygen saturation level. It is a matter of safety. Dr. Willis opined that respondent's lack of the necessary equipment to safely perform cosmetic procedures amounted to an extreme departure from the standard of care.

41. *Treatment of Patient LO.* Dr. Willis noted that LO's cosmetic surgery took place approximately two weeks after Mr. Moya visited respondent and cautioned that he was not in compliance with accreditation standards. According to LO's Anesthesia Record, respondent used an IV to administer titrated doses of Zofran 4 mg, Versed 2.5 mg, Morphine 7 mg, and Propofol 240 mg to achieve IV sedation. According to Dr. Willis, in the "average patient" these doses are appropriate and consistent with minimal or moderate sedation. But it depends on the person's tolerance. Given her Aldrete score, these doses resulted in deep sedation because of other "meds on board" that respondent did not know about.

Respondent's Post Anesthesia Care Notes indicate that LO's Aldrete score was a five upon arrival in recovery: Activity was "0," Respiration was "2," Circulation was "2," Level of Consciousness was "0," and Oxygen Saturation was "1." According to Dr. Willis a total score of "five" means the patient was deeply sedated and substantially compromised upon arrival in the recovery room. LO was a 10 upon discharge 45 minutes later. According to Dr. Willis, the other drugs in her system (Lorazepam, Clonazepam, Hydrocodone, marijuana, and alcohol) were depressants and affected how LO responded to the anesthetic.

In his report Dr. Willis stated that LO's death was due to an "accidental overdose of multiple medications and cannot be directly attributed to the surgical or anesthetic care provided by [respondent] during the facelift procedure." However, in Dr. Willis's opinion, respondent's treatment of LO did not meet the community standard of care for IV sedation in an outpatient setting.

In Dr. Willis's opinion, because respondent was "warned" prior to operating on LO it was an extreme departure for him to continue to perform surgery with IV sedation at his unaccredited office. Had respondent not been warned, his lack of knowledge would have amounted to a simple departure from the standard of care.

42. *Use of a Certified Flight Nurse.* Mr. Wallace was a certified flight nurse. Though he possessed adequate training and skills to function in a supervised capacity, Mr. Wallace was not a nurse anesthetists or anesthesiologist. In Dr. Willis' opinion, in an accredited setting, an RN can give IV sedation under doctors' orders, as long as it is "conscious sedation" meaning the patient can communicate meaningfully at all times. An RN may not give IV deep sedation (meaning the patient is unconscious) even if the clinic is

accredited. In Dr. Willis' opinion, respondent's use of an RN to administer anesthesia represents a simple departure.

43. Dr. Willis was asked about the Board's restatement of Section 1248 that appears on its website (www.mbc.ca.gov/consumers/outpatient). The restatement states:

> If the surgery only requires local anesthesia or a peripheral nerve block (complying with the community standard of practice), or if the setting administers anxiolytics (anti-anxiety medications) or analgesics ("pain killers") in doses that do not place the patient at risk for loss of life-preserving protective reflexes, then the surgery does not have to be performed in an accredited, licensed or certified setting.

Dr. Willis conceded that the law and restatement do not speak to route of administration. But, he reiterated that "IV is a worrisome mode of administration." Dr. Willis conceded that "dose" is important to the question of whether accreditation is necessary. He stated it was important to "start low and go slow." Finally, Dr. Willis agreed that the inquiry is on the intent of the doctor, the community standard, and the doses being administered.

Respondent's Expert – Jeffrey P. Kuhn, M.D.

44. Jeffrey P. Kuhn, M.D. received his Doctor of Medicine degree from the University of Chicago School Of Medicine in 1985. He completed a residency in Internal Medicine at Stanford University Medical Center in 1988, a fellowship in Pulmonary Medicine at Cedars-Sinai Medical Center in 1991, and his residency in Anesthesiology at the University of California, Los Angeles in 1994. Dr. Kuhn is board certified in Internal Medicine and Anesthesiology. He became licensed to practice medicine in California in 1986. Dr. Kuhn is a staff anesthesiologist at Sutter Medical Center and Santa Rosa Memorial Hospital. He is a member of the American and California Societies of Anesthesiology (ASA, CSA). Dr. Kuhn prepared a report of his opinions and testified at hearing.

45. According to Dr. Kuhn, if the physician is intending anxiolysis, the office does not need to be accredited. And, use of anxiolytics does not trigger an event where you need to be accredited. If moderate sedation is intended, the physician should set up for deep sedation. If deep sedation is intended, the office should be certified. Dr. Kuhn agreed that deep sedation in an unaccredited setting is against the standard of care.

46. *Route of Administration.* Dr. Kuhn did not agree with Dr. Willis' opinion that it is against the standard of practice to administer sedation via IV in an unaccredited setting. He stated that the route of administration does not dictate the patient response. The trigger is whether there will be a "loss of protective reflexes." Routes of administration can be IV, oral, or gas. Dr. Kuhn explained that protective reflexes maintain you being alive, such as

the ability to breathe. Dr. Kuhn stated that 95 percent of untoward events are "airway events." The patient stops breathing usually because the tongue falls back and enters the airway. If the tongue falls back into the throat, a protective reflex allows you to wake up and move your tongue out of the way and breathe. Sedation suppresses these reflexes to move the tongue, swallow, or cough. The practitioner's first step is to support the airway and attempts should be noted in the anesthesia record.

47. Comparing the different routes of administration, Dr. Kuhn stated that an IV bolus is the quickest way to get a drug into the blood stream. Pills have a slower onset and intramuscular shots have the next slowest onset. Anesthesiologists try not to give oral medication before surgery because the stomach should be empty. There is a trend to give oral medications one to two hours before a procedure. However, the route of administration has "nothing to do with a patient's loss of protective reflexes."

48. *Drugs Used to Achieve Sedation.* Dr. Kuhn reviewed the Anesthesia Record and assessed the drugs and dosages administered to LO. During the surgery, LO received Propofol (240 mg), Morphine (7 mg), and Versed (2.5 mg.) In his opinion, the medications administered to LO would put her somewhere between anxiolysis (minimal sedation) and moderate sedation. He stated that Propofol is one of the more predictable drugs used. The other two are more unpredictable.

49. According to Dr. Kuhn, in a "narcotic naïve patient," seven mg of Morphine is a low dose. If he gave 10 mg of Morphine to a 120 pound female, he would expect to see "some somnolence." Versed is an anxiolytic providing minimal sedation. Dr. Kuhn calculated the dose of Propofol needed to achieve different levels of sedation in LO. Per Dr. Kuhn, if respondent had wanted to achieve deep sedation in LO, he would have needed to use 25 times the amount of Propofol administered.

50. Dr. Kuhn stated that the sedative given to this 120 pound, 60 year old female would not normally cause an Aldrete Score of 5. He would expect this person to be "walking and talking" at the end of the procedure. LO's result was "very unusual." Also, according to Dr. Kuhn, a patient's Aldrete score can change throughout a procedure meaning LO was not necessarily at the same level of sedation throughout. Dr. Kuhn noted the other drugs in LO's toxicology report. If she took these drugs on the morning of her surgery, they would have affected her throughout the day, well beyond the short-term anesthetics given by respondent. He surmised that LO slipped into unintended deep sedation based on the other medications she was taking.

Regardless, Dr. Kuhn saw no indication in LO's record that an airway event occurred or that LO lost her protective reflexes in spite of an Aldrete score of 5. He noted that her "respiration" and "circulation" remained normal (Aldrete scores of 2). He acknowledged that her "activity" and "responsiveness" levels were impaired with Aldrete scores of 0, however, he stated that the ability to move your extremities is not a "life preserving reflex." Dr. Kuhn also note that LO's respiratory rate was 12 throughout so no airway support was

needed. And, her oxygen rate was 98 percent so there was no desaturation which would result from apnea or problems with airway support.

51. In Dr. Kuhn's expert opinion, respondent did not violate the community standard of practice when he administered medication through an IV at the levels noted in LO's chart. These doses would be expected to achieve "mild sedation" in the patient and did not require accreditation. Also, respondent's administration of Versed, Morphine, and Propofol at the levels noted did not depart from the standard of care. Based on the record, respondent was aiming for mild sedation/anxiolysis which would not require accreditation because it would not put a patient at risk of loss of "protective reflexes."

52. *Use of a Certified Flight Nurse.* According to Dr. Kuhn, RN's may administer sedation under supervision of a physician. In California, the physician must be in the room or at least in the same facility. This is often seen in gastroenterology suites, ambulances, and flight medicine. The American Society of Anesthesiology has delineated guidelines on administration of anesthesia by non-anesthesiologists. In his review of this and several other guidelines, he found none that state that Propofol must be given by a nurse anesthetist or anesthesiologist. These guidelines refer to "skill sets," such as airway management, understanding physiology of drugs, and rescue from cardiovascular collapse. Hence, a non-anesthesiologist can administer Propofol as long as someone with rescue skills is in the room.

53. Dr. Kuhn noted that Mr. Wallace was qualified as an advanced practice nurse. Mr. Wallace had training in advanced airway (repositioning head, inserting tracheal tube) and resuscitation or rescue techniques. Mr. Wallace "absolutely" had training to administer general anesthesia on his own in a helicopter and give Fentanyl, Propofol, or a neuromuscular blockade (a med that causes paralysis – block between nerve impulses and contraction – and interrupts transmission from nerve to muscle). Dr. Kuhn stated that a blockade is a much more dangerous drug than anything respondent employed.

54. In Dr. Kuhn's opinion, Mr. W was "well within his scope of practice" to administer the three drugs in LO's case. Further, he was within his scope of practice to administer these drugs in a non-accredited setting because there was never any loss of protective reflexes. Finally, respondent was not negligent in allowing Mr. Wallace to administer the listed meds to LO. Respondent was acting well within his scope of practice.

Credibility of Expert Opinions

55. It is well settled that the standard of care for physicians is the reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.) Importantly, a medical professional is held to the standard of care in his or her own "school" or specialty. Specialists are held to that standard of learning and skill normally possessed by such specialists in the same or similar locality under the same or similar circumstances.

(*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Proof of this standard is ordinarily provided by another physician. (*Brown, supra*, 11 Cal.3d at p. 643.)

56. Two physicians were called as experts in this case and offered divergent opinions on the applicable standard of care and whether respondent acted within accepted standards in administering IV sedation in a non-accredited medical office. Differences between the experts' opinions go to the weight of the evidence. (*In re Marriage of Duncan* (2001) 90 Cal.App.4th 617, 632.) Dr. Willis is a board certified in anesthesiology. He currently works as a pain management consultant and an IMQ evaluator. He last provided anesthesia services in 2006. Dr. Kuhn is a board certified anesthesiologist who performs anesthesia for a large medical group.

57. Dr. Willis opined that respondent was acting outside the scope of his practice in administering IV sedation at his unaccredited medical office. He stated that the community standard for IV sedation is that it must be done in an accredited setting. Further, had respondent not been warned prior to proceeding with surgeries requiring sedation, this would have been a simple departure. However, since Mr. Moya had visited respondent's office two weeks prior, Dr. Willis considered this to be an extreme departure. (Factual Finding 41.) Dr. Willis stated that respondent's office would not have been granted accreditation since respondent lacked equipment considered essential under the IMQ Ambulatory Standards. In his opinion, the lack of life saving equipment amounted to an extreme departure. (Factual Finding 40.) Finally, respondent's use of an RN to achieve the level of sedation seen in LO was an simple departure. (Factual Finding 42.)

58. Dr. Kuhn opined that respondent's cosmetic surgery practice employing a trained RN to deliver minimal IV sedation using Propofol, Versed, and Morphine was within the standard of care. He stated that the route of administration was irrelevant to the inquiry. Further, Mr. Wallace was qualified to administered anesthesia and perform rescue. His review of LO's chart indicated low levels of sedative typically used to achieve axiolysis or minimal sedation. Dr. Kuhn found no departures from the standard of care.

59. Both Drs. Kuhn and Willis were qualified to provide expert opinions in this matter. The opinions of Dr. Willis were helpful in understanding accreditation criteria and the risks associated with any level of anesthesia. The opinions of Dr. Kuhn were helpful in understanding the modes, drugs, and dosages needed to achieve sedation. It is noted that Dr. Willis has not practiced as an anesthesiologist since 2006. Trained in IMQ accreditation and having acted as an IMQ surveyor since 2008, his opinions were clearly influenced by his preference for accreditation. Dr. Kuhn is a practicing anesthesiologist.

Dr. Kuhn's looked at Section 1248 objectively without factoring in the possibility of reaching unintended levels sedation, even with low doses of anesthesia, due to other factors. Dr. Willis looked at Section 1248 from a community standards view point and considered the unintended consequences associated with even low doses of anesthesia.

The issue in this case is not whether respondent's office would have passed accreditation. The issue is whether he administered anesthesia in his unaccredited office in violation community standards and/or in doses that place patients at risk for loss of protective reflexes. Even with Dr. Willis's bias in favor of accreditation, his testimony was more persuasive.[6] However, in determining the level of negligence demonstrated by respondent, other factors weight against Dr. Willis's opinions.

Discussion

60. The Board has charged respondent with 1) gross negligence in willfully and knowingly violating the provisions of Health and Safety Code section 1248, 2) repeated negligent acts in failing to utilize the services of nurse anesthetist or anesthesiologist and performing cosmetic surgery under sedation in an unaccredited office, and 3) general unprofessional conduct. (Bus. & Prof. Code, § 2234, subds. (b), (c).)

61. *Gross Negligence.* Complainant alleged that respondent was grossly negligent in administering anesthesia in an unaccredited outpatient surgical setting.

62. Respondent administered anesthesia in his medical office to achieve minimal sedation during cosmetic surgery procedures. In Dr. Willis's opinion, if sedation is achieved by means of IV, or certain drugs such Propofol (in any dose), accreditation is required. In Dr. Kuhn's opinion, the route of administration and type of drug used to achieve sedation are not relevant. Dr. Kuhn focused on dosage and the intended level of sedation. Dr. Kuhn stated that if the surgeon is intending anxiolytics, accreditation is not needed. However, he cautioned that if moderate sedation is intended, set up for deep sedation, and if deep sedation is intended, the facility should be accredited because it is a "slippery slope" to general anesthesia.

63. Section 1248 looks to probability of risk for loss of life-preserving protective reflexes and the community standard. Both experts agreed that the doses of sedatives respondent gave LO were consistent with minimal to moderate sedation. Both experts also agreed that LO slipped into deep sedation during the surgery which was likely due to other depressive drugs that LO had not disclosed. It is uncontested that LO's accidental death, "cannot be directly attributed to the surgical or anesthetic care provided by respondent." (Dr. Willis's Report, p. 4.) However, in assessing "risk" associated with anesthesia, respondent's own admission that a handful of patients had to be assisted in breathing is informative.

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[6] In determining the credibility of a witness, the court can consider any matter that has any tendency in reason to prove or disprove the truthfulness of the testimony at the hearing. Considerations include but are not limited to the witness's demeanor, his character for honesty or veracity, the existence or nonexistence of a bias, interest, or other motive, a statement previously made by him that is consistent or inconsistent with any part of his testimony. (Evid. Code, §780, subds. (a)-(k).)

64. Section 1248 does not speak to the mode of administration or type of sedatives used. It speaks to risk. In addition to the presence of drugs the physician may not know about, Tumescent solution contains epinephrine and lidocaine, which can cause severe cardiac arrhythmia and death. Dr. Willis opined that respondent needed to be accredited because of the risk associated with the *cumulative impact* of all drugs on board. Dr. Willis's opinion is reasonable and supported by the evidence. According to Dr. Willis, respondent's lack of accreditation was an extreme departure from the standard of care. However, at hearing he clarified that his opinion depended on whether respondent had been "warned." And, lack of knowledge would constitute a simple departure. As such, it is important to look at the warning or notice that respondent received.

65. Respondent was credible in his testimony that he believed he was operating within the law. Respondent had not heard of Section 1248 prior to speaking to investigator Moya. And, he found it hard to read. In fact, Dr. Willis stated in his report and at hearing that, "The vast majority of California physicians are still unaware of this legislation or its regulatory implementation in the Health and Safety Code." Further, at hearing, Mr. Moya conceded that he was "not an expert" on the law and basically told respondent to "follow the guidelines."

It is noted that Mr. Moya assumed respondent was using "deep sedation" when he communicated his concerns to respondent. In fact, respondent's dosages were consistent with minimal or "conscious sedation." After the meeting, respondent timely contacted IMQ, spoke to Dr. Mendall-Brown, and read journals and other reference materials. Prior to operating on LO, he came to the conclusion that he did not need to seek accreditation because he was not using "deep sedation." Respondent's conclusion was more reasonable in light of the fact that his PACE practice monitors were aware that he was performing cosmetic surgery and did not identify his lack of accreditation as an issue. Still, respondent then took positive steps to improve safety at his office. He reviewed his policies on sedation. He stopped doing face-lifts and abdominoplasties. He purchased safety equipment.

66. For the reasons stated above, respondent's administration of anesthesia in an unaccredited outpatient surgery center amounted to a simple departure.

67. *Repeated Negligent Acts.* Complainant alleges that respondent's use of an RN to administer sedatives coupled with the lack of safety equipment and protocols amounted to repeated negligent acts.

68. It is uncontested that Mr. Wallace, is a skilled RN, who is trained and qualified to resuscitate a patient who has reached a deeper level of sedation than intended. In Dr. Kuhn's opinion, Mr. Wallace's credentials permit him to regularly administer Propofol and other sedatives via IV in an unaccredited office. In Dr. Willis's opinion, an RN may administer drugs to achieve minimum to moderate sedation in an accredited office. However, those situations are unusual and limited to specific circumstances such as in the ICU or ER during bone setting, with a physician in attendance who is trained in sedation and rescue.

69. Respondent points to a Statement on the Safe Use of Propofol, published by the ASA Committee on Ambulatory Surgical Care (Oct. 21, 2009), which provides that "involvement of an anesthesiologist in the care of every patient undergoing anesthesia is optimal. However, when this is not possible, non-anesthesia personnel who administer Propofol should be qualified to rescue patients whose level of sedation becomes deeper than initially intended..."

This Statement does not say that RNs should be regularly used in a surgical practice nor does it discuss accreditation. Dr. Kuhn testified that he has given Morphine, Propofol, and Versed in an unaccredited outpatient setting. However, Dr. Kuhn is a licensed anesthesiologist. Respondent offered no evidence to contradict Dr. Willis's opinion that reliance on an RN to induce sedation in an unaccredited setting is a simple departure from the standard of care.

70. Certain safety equipment is required for accreditation. But even without accreditation such equipment is necessary to ensure the safety of surgical patients. As of December 2011, respondent's office lacked essential safety equipment. Respondent stated that if the power went out, there would be natural light from the windows. His backup plan included closing the procedure and calling 911. According to Dr. Willis, if the power went out on the monitors, respondent would be unable to see the EKG (cardiac rhythm) or oxygen saturation. Also, with some procedures such as abdominoplasty, there can be significant blood loss and exposure to air that safety equipment would ensure against.

71. Prior to speaking to Mr. Moya, respondent lacked knowledge of accreditation standards. After speaking to Mr. Moya in December 2011, respondent purchased a defibrillator, light headset, and backup generator, secured a transfer agreement, and stopped performing more complex procedures. However, he continued to utilize his RN, albeit trained in rescue, for surgical sedation.

72. For the reasons stated above, respondent engaged in repeated negligent acts when he performed surgical procedures without safety equipment and used an RN (non-anesthesia personnel) to administer IV sedation at his medical office.

73. *Unprofessional Conduct.* Complainant alleges that respondent engaged in unprofessional conduct when he performed surgery under anesthesia in his unaccredited surgical office. Relative to outpatient settings, the law states: "It shall constitute unprofessional conduct for a physician and surgeon to *willfully and knowingly* violate this chapter." (Health & Saf. Code, §§ 1248.65, 1248, 1248.1; *Italics* added.)

74. For the reasons stated above, respondent believed he was operating within the law. When confronted with alleged violations, he took steps to mitigate issues and consulted with IMQ authorities. Like many physicians, respondent was ignorant of the Health and Safety provisions for outpatient surgery centers. His efforts to educate himself and institute safe practices are noted. Respondent credibly believed that the law did not enjoin minimal

sedation at his unaccredited office. There is insufficient evidence that respondent willfully and knowingly violated the law dealing with accreditation. As such, there is insufficient evidence respondent engaged in general unprofessional conduct.

75. When all of the evidence is considered, complainant established that respondent engaged in repeated negligent acts when he performed surgery without proper safety equipment and used an RN for anesthesia in an unaccredited office. He demonstrated simple negligence when he administered anesthesia in an unaccredited office which placed patients at risk and was outside of the community standard of practice. Respondent offered substantial and impressive letters of support from members of the medical community in which he practices. He demonstrated a desire and willingness to comply with the Board's recommendations. As such, there is not a risk to the public such that respondent should not be allowed to continue his OB/Gyn practice, with appropriate restrictions.

LEGAL CONCLUSIONS

1. To discipline respondent's medical license, complainant must prove cause for disciplinary action by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 855-856.)

2. Pursuant to Business and Professions Code section 2234, subdivision (b), the Board may discipline a licensee's medical license for "Gross negligence." Gross negligence is defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941; *Franz v. Board of Medical Quality Assurance* (1982) 31 Cal.3d 124, 138; *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196.)

3. Pursuant to Business and Professions Code section 2234, subdivision (c), the Board may discipline a licensee's medical license for "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. Negligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm. A physician/surgeon is required to exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by other prudent physician's under similar circumstances. (*Flowers v. Torrance Memorial Hospital Medical* Center (1994) 8 Cal.4th 992, 998.)

4. No association, corporation, firm, partnership, or person shall operate, manage, conduct, or maintain an outpatient setting in this state, unless the setting is one of the following ... (g) An outpatient setting accredited by an accreditation agency approved by the division pursuant to this chapter. (Health & Saf. Code, § 1248.1, subd. (g).)

5. "'Outpatient setting' means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section

1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes." (Health & Saf. Code, § 1248, subd. (b)(1).)

6. Every outpatient setting which is accredited shall be inspected by the accreditation agency and may also be inspected by the Medical Board of California. The Medical Board of California shall ensure that accreditation agencies inspect outpatient settings. (Health & Saf. Code, § 1248.35, subd. (a).)

7. It shall constitute unprofessional conduct for a physician and surgeon to willfully and knowingly violate this chapter. (Health & Saf. Code, § 1248.65.)

Cause for Discipline

8. Cause for disciplinary action exists under Business and Professions Code sections 2227 and 2234, subdivision (c), by reason of the matters set forth in Factual Findings 67 through 72. Complainant established by clear and convincing evidence that respondent committed repeated negligent acts in the operation of his surgical practice.

9. Cause for disciplinary action does not exist under Business and Professions Code sections 2227 and 2234, subd. (b), by reason of the matters set forth in Findings 61 through 66. Complainant did not establish by clear and convincing evidence that respondent committed gross negligence in the operation of an unaccredited surgical office in violation of Health and Safety Code section 1248.

10. Cause for disciplinary action does not exist under Business and Professions Code sections 2227 and 2234, by reason of the matters set forth in Findings 73 and 74. Complainant did not establish by clear and convincing evidence that respondent engaged in unprofessional conduct in knowingly violating Health and Safety Code section 1248.

11. Cause to revoke respondent's current grant of probation does not exist, by reason of the matters set forth in Factual Finding 19 and Legal Conclusions 9 and 10. Complainant did not establish that respondent violated any of the probationary terms ordered by the Board Case No. 12-2006-176267, or willfully failed to obey all laws.

12. Mr. Moya testified that respondent was cooperative during the interview. Respondent took action to implement safety changes. He contacted IMQ and attempted to comply with those standards. The evidence supports a finding that respondent acted in good faith. Respondent demonstrated his willingness to work with the Board to achieve full compliance with accepted standards of medical practice. The letters submitted from numerous physicians, anesthesiologists, nurses, and patients attest to respondent's OB/Gyn knowledge and practice, surgical skills, pre/post-operative care, work ethic, and good reputation in the community. (Factual Finding 31.)

13. The matters set forth in the Factual Findings and Legal Conclusions as a whole were considered in making the following Order. Respondent is currently on Board probation for a period of seven years effective June 9, 2010, and ending June 8, 2017. It would not be contrary to the public interest to allow respondent to continue to practice under the current Order of probation, while adding terms and conditions under an additional two (2) years of probation, to protect the public.

ORDER

Physician's and Surgeon's Certificate No. G 47561 issued to respondent Pablo Garza Cortina, M.D, is revoked pursuant to Legal Conclusion 8; however, revocation is stayed and respondent is placed on probation for an additional (2) two years, consecutive to his current (7) seven year term of probation which became effective June 9, 2010. All of the original terms and conditions of respondent's probation in Case No. 12-2006-176267 shall remain in full force and effect, and the following terms and conditions in paragraph number 1 below are added:

1. **Accredited Surgical Practice Involving use of Anesthesia**

a. Respondent shall not perform any surgical procedure involving the administration of anesthesia in a non-accredited outpatient setting.

b. Respondent shall not utilize non-anesthesia personnel in the administration of anesthetics for purposes of inducing sedation in a non-accredited surgical setting.

Terms and conditions imposed pursuant to the Board's Decision and Order in Case No. 12-2006-176267, made May 10, 2009, which became effective June 9, 2010, that remain in full force and effect:

2. **Medical Record Keeping Course**

Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation.

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

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

3. **Clinical Training Program**

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine (Program).

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

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

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. The Program's determination whether or not Respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after Respondent's initial enrollment unless the Board or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

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

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

4. **Monitoring – Practice**

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

The Board or its designee shall provide the approved monitor with copies of the Decision, and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

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

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

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, Respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall

cease the practice of medicine within three calendar days after being so notified by the Board or designee.

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

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

5. **Notification**

Prior to engaging in the practice of medicine Respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

6. **Supervision of Physician Assistants**

During probation, Respondent is prohibited from supervising physician assistants.

7. **Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court-ordered criminal probation, payments, and other orders.

8. **Quarterly Declarations**

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

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. **Probation Unit Compliance**

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee.

Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

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

10. **Interview with the Board or its Designee**

Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

11. **Residing or Practicing Out-of-State**

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Probation Monitoring Costs.

Respondent's certificate shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However, Respondent's certificate shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the

medical licensing authority of that state, in which case the two-year period shall begin on the date probation is completed or terminated in that state.

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12. **Failure to Practice Medicine - California Resident**

In the event Respondent resides in the State of California and for any reason Respondent stops practicing medicine in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's certificate shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

13. **Completion of Probation**

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

14. **Violation of Probation**

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

15. **License Surrender**

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

16. **Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: March 20, 2015

DIAN M. VORTERS
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation and Petition to Revoke Probation Against: **PABLO GARZA CORTINA, M.D.** **1101 South Dora Street** **Ukiah, CA 95482** Physician's and Surgeon's Certificate No. G 47561 Respondent.	Case No. D1-2006-176267 **ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation and Petition to Revoke Probation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about June 14, 1982, the Medical Board of California issued Physician's and Surgeon's Certificate Number G 47561 to Pablo Garza Cortina, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2015, unless renewed.

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PRIOR DISCIPLINARY ACTION

3. On August 24, 1998, Respondent's Physician's and Surgeon's Certificate was revoked, but the revocation was stayed, and Respondent was placed on probation for two (2) years probation with terms and conditions. On December 17, 1999, Respondent's Physician's and Surgeon's Certificate was revoked, but the revocation was stayed, and Respondent was placed on probation for seven (7) years probation with terms and conditions. On June 9, 2010, in the case entitled "In the Matter of the Accusation and Petition to Revoke Probation Against: Pablo Garza Cortina, M.D.," Case No. 12-2006-176267, Respondent's Physician's and Surgeon's Certificate was revoked, but the revocation was stayed, and Respondent was placed on probation for seven (7) years on terms and conditions that included, the requirements that Respondent complete the PACE Clinical Training Program, a Medical Record Keeping Course, and his practice be monitored by a practice monitor during the period of probation.

JURISDICTION

4. This Accusation and Petition to Revoke Probation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

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

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct.[1] In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

[1] Unprofessional conduct has been defined as conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

(continued...)

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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

7. Health and Safety Code section 1248, subdivision (b)(1) provides:

"'Outpatient setting' means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes."

8. Health and Safety Code section 1248.1 provides:

"No association, corporation, firm, partnership, or person shall operate, manage, conduct, or maintain an outpatient setting in this state, unless the setting is one of the following:

(a) An ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

(b) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined by Section 450 or 1601 of Tile 25 of the United States Code, and located on land recognized as the tribal land by the federal government.

(c) Any clinic directly conducted, maintained, or operated by the United States or by any of its departments, officers, or agencies.

(d) Any primary care clinic licensed under subdivision (a) and any surgical clinic licensed under subdivision (b) of Section 1204.

(e) Any health facility licensed as a general acute care hospital under Chapter 2 (commencing with Section 1250).

(f) Any outpatient setting to the extent it is used by a dentist or a physician and surgeon in compliance with Article 2.7 (commencing with Section 1646) or Article 2.8 (commencing with Section 1647) of Chapter 4 of Division 2 of the Business and Professions Code.

(g) Any outpatient setting accredited by an accrediting agency approved by the division[2] pursuant to this Chapter.

(h) Any setting, including, but not limited to, a mobile van, in which equipment is used to treat patients admitted to a facility described in subdivision (a), (d), or (e),and in which the procedures performed are staffed by medical staff of, or other healthcare practitioners with clinical privileges at, the facility and are subject to the peer review process, but which setting is not a part of the facility described in subdivision (a), (d), or (e).

Nothing in this section shall relieve an association, corporation, firm, partnership, or persons from complying with all other provisions of law that are otherwise applicable."

9. Health and Safety Code section 1248.65 provides:

"It is unprofessional conduct for a physician and surgeon to willfully and knowingly violate this chapter."

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

10. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in the practice of medicine in that, Respondent willfully and knowingly violated provisions under Health and Safety Code section 1248 et seq., by performing cosmetic surgery that require induction of anesthesia that has the probability of placing a patient at risk for loss of the patient's life preserving protective reflexes, in a surgical facility that Respondent knew was not an accredited surgery facility. The circumstances are as follows:

A. On or about April 21, 2011, the Board received an anonymous complaint indicating Respondent was performing cosmetic and other surgical procedures that require induction of

[2] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code, §§2000, et. seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

anesthesia in an unaccredited surgical facility in his office. In the course of ensuing investigation, the Board's investigator visited Respondent's surgical facility on or about December 6, 2011. Several deficiencies were found during the visit. These included the lack of a defibrillator and source of back-up electrical power as well unsecured controlled substances and dangerous drugs.

B. Respondent and his office staff were interviewed during the visit. Respondent admitted he performed cosmetic surgery procedures such as breast implants and tummy tucks in his surgical facility. Respondent and his staff appeared unaware of the provisions of Health and Safety Code section 1248 et seq. and were unaware of the requirements necessary to qualify as an "outpatient setting" surgical facility under Health and Safety Code section 1248 et seq. The Board's investigator explained the requirements necessary for Respondent to operate his surgical facility as an "outpatient setting." In particular, the Board investigator informed Respondent that his surgery facility had to be accredited by an agency approved by the Board before he could perform any surgery that requires induction of anesthesia that has the probability of placing a patient at risk of loss of the patient's life-preserving protective reflexes.

C. Following the office visit, Respondent wrote a letter to the Board's investigator on or about December 8, 2011. The letter states in part: "As a result of your findings, I will stop performing cosmetic surgery in my office setting. I intend to consult IMQ, but until then I will cease my office procedures as above all, I want to be safe."

D. On or about December 21, 2011, Respondent performed a neck and partial face lift cosmetic procedures on a female patient, then 61 years old at his surgery facility. Despite the promise in his letter, Respondent failed to apply for and obtain accreditation for his surgical facility before performing the neck and partial face lift cosmetic procedures.[3] The procedures commenced at about 9:50 a.m. (on December 21, 2011), and were performed under IV sedation with Versed 2.5 mg,[4] Morphine 7 mg[5] and Propofol 240 mg[6] as the anesthetic agents. The

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[3] At physician's interview on or about October 26, 2012, Respondent stated that despite the promise in his letter, he could not stop performing cosmetic surgery because he needed money.

[4] Versed, a brand name for Midazolam, is a Schedule IV controlled substance under Heath and Safety Code section 11057(d)(21) and a dangerous drug under Business and (continued...)

anesthesia was administered and monitored by a registered nurse who is not a nurse anesthetist. Post surgery, the patient was taken to the recovery room. Her Aldrete Score[7] was 5 at admission to the recovery room, and she was not moving and was not responsive to verbal stimulation. However, the patient was fully awake, functional and ready for discharge within 45 minutes of arriving in the recovery room. The patient was discharged home at about noon on December 21, 2011.

E. At about 1:30 a.m. on or about December 22, 2011, the patient's husband found the patient unresponsive in bed and called 911. The paramedics arrived and performed CPR, however, the patient could not resuscitate and she was pronounced dead. An autopsy was performed. The autopsy report indicated that the patient's death was accidental. The cause of death was acute poly-pharmacy. The toxicology report indicated that the patient had substances other than the sedatives utilized during the cosmetic procedures, in her blood and urine specimens.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

11. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in the practice of medicine as follows:

A. Paragraph 10, above, is hereby incorporated herein by reference and realleged as if fully set forth herein.

Professions Code section 4022. It is indicated for use as a preoperative sedative.

[5] Morphine is a Schedule II Controlled Substance under Health and Safety Code section 11055(b)(1)(L) and a Dangerous Drug under Business and Professions Code section 4022. It is indicated for management of patient not responsive to non-narcotic analgesics.

[6] Propofol, a brand name for Diprivan, is a sedative-hypnotic used in the induction and maintenance of anesthesia or sedation.

[7] Aldrete Score is a measurement of recovery after anesthesia that includes gauging consciousness, activity respiration and blood pressure.

B. On or about December 21, 2011, Respondent failed to utilize the services of a nurse anesthetic or an anesthesiologist to administer and monitor the anesthetic agents (Versed, Morphine and Propofol) he utilized in performing the cosmetic surgery on the 61-year-old female patient.

THIRD CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

12. Respondent has further subjected his license to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breached the rules or ethical code of the medical profession or which was unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 10 and 11, above, which are incorporated herein by reference and realleged as if fully set forth herein.

CAUSE TO REVOKE PROBATION
(Failure to Obey All Laws)

13. At all times after the effective date of Respondent's probation in Case No. 12-2006-176267, Condition No. 6 provided:

"Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court-ordered criminal probation, payments, and other orders."

14. Respondent probation is subject to revocation in that Respondent willfully and knowingly violated provisions under Health and Safety Code section 1248 et seq., by performing cosmetic surgery that require induction of anesthesia that has the probability of placing a patient at risk for loss of the patient's life preserving protective reflexes, in a surgical facility that Respondent knew was not an accredited surgery facility, as more particularly alleged in paragraph 10 through paragraph 12, which are incorporated herein by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 47561, issued to Respondent Pablo Garza Cortina, M.D.;

2. Revoking the probation previously granted Respondent Pablo Garza Cortina in Case No. 12-2006-176267;

3. Revoking, suspending or denying approval of Respondent Pablo Garza Cortina, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

4. Ordering Respondent Pablo Garza Cortina, M.D., to pay the costs of probation monitoring, if placed on probation; and,

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

DATED: August 8, 2013

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

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