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

In the Matter of the Accusation Against: David Wepin Lin, M.D. Physician's & Surgeon's Certificate No. A 54643 Respondent.	Case No. 800-2021-074549

DECISION

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

This Decision shall become effective at 5:00 p.m. on June 27, 2025.

IT IS SO ORDERED: May 28, 2025.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

Michelle A. Bholat, M.D., Chair
Panel A

ROB BONTA
Attorney General of California
MICHAEL C. BRUMMEL
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DAVID WEPIN LIN, M.D.** **7420 Greenhaven Dr., #130** **Sacramento, CA 95831** **Physician's and Surgeon's Certificate No. A 54643** Respondent.	Case No. 800-2021-074549 OAH No. 2024030313 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Megan R. O'Carroll, Deputy Attorney General.

2. Respondent David Wepin Lin, M.D. (Respondent) is represented in this proceeding by attorney Nicole D. Hendrickson, whose address is: 701 North Brand Blvd., Suite 600 Glendale, CA 91203.

3. On or about September 6, 1995, the Board issued Physician's and Surgeon's Certificate No. A 54643 to David Wepin Lin, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-074549, and will expire on December 31, 2024, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-074549 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 4, 2024. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-074549 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2021-074549. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2021-074549, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges and allegations in Accusation No. 800-2021-074549, a true and correct copy of which is attached hereto as Exhibit A, that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 54643 to disciplinary action, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

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

CONTINGENCY

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

14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this above-entitled matter.

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

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED THAT the Physician's and Surgeon's Certificate No. A 54643, issued to Respondent David Wepin Lin, M.D. shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2021-074549 is as follows:

"You were negligent in your care and treatment of a single patient, as more fully described in Accusation No. 800-2021-074549."

A. PRESCRIBING PRACTICES COURSE

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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A prescribing practices 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. Any violation of this condition or failure to complete the program and program recommendations shall be considered unprofessional conduct and grounds for further disciplinary action.

B. INVESTIGATION/ENFORCEMENT COST RECOVERY

Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $30,000.00 (thirty thousand dollars). Costs shall be payable to the Medical Board of California. Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to fully reimburse the Board the total amount of costs within twelve (12) months of the effective date of this Decision, unless the Board or its designee agrees in writing to an extension of that time, shall constitute general unprofessional conduct and may serve as the grounds for further disciplinary action.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

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ACCEPTANCE

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

DATED: 8/7/2024

DAVID WEPIN LIN, M.D.
Respondent

I have read and fully discussed with Respondent David Wepin Lin, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8/7/2024

NICOLE D. HENDRICKSON
Attorney for Respondent

ENDORSEMENT

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

DATED: 8/7/2024

Respectfully submitted,

ROB BONTA
Attorney General of California
MICHAEL C. BRUMMEL
Supervising Deputy Attorney General

MEGAN R. O'CARROLL
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2021-074549

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

In the Matter of the Accusation Against: **David Wepin Lin, M.D.** **7420 Greenhaven Dr., #130** **Sacramento, CA 95831** **Physician's and Surgeon's Certificate No. A 54643,** Respondent.	Case No. 800-2021-074549 **ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 6, 1995, the Medical Board issued Physician's and Surgeon's Certificate No. A 54643 to David Wepin Lin, 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 December 31, 2024, unless renewed.

STATUTORY PROVISIONS

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

4. 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, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (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.
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> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

8. Acetaminophen and oxycodone (Percocet®), is a combination of two medicines used to treat moderate to severe pain. Oxycodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of oxycodone. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist

preparations. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers and alcohol.

9. Benzodiazepines are a class of agents that work on the central nervous system, acting on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain. Valium, diazepam, alprazolam, lorazepam (Ativan®), and temazepam are all examples of benzodiazepines. All benzodiazepines are Schedule IV controlled substances and have the potential for abuse, addiction, and diversion.

10. Hydrocodone APAP (Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen, which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to Schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Food and Drug Administration (FDA). The FDA black box warning provides that "Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

11. Oxycodone (Oxycontin®) is a white odorless crystalline powder derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055,

subdivision (b)(1) of the Health and Safety Code, a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. When properly prescribed and indicated, oxycodone is used for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatment options are inadequate. Respiratory depression is the chief hazard from all opioid agonist preparations. The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. The DEA has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.)

12. Fentanyl –Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(c).

FACTUAL ALLEGATIONS

13. Respondent treated Patient[1] as his Primary Care Physician (PCP), since approximately 2000. Patient suffered from degenerative disc disease, migraine headaches, anxiety, and depression. Throughout his treatment with Respondent, Patient further raised complaints of injuries to his right shoulder and left knee. Initially, Patient used conservative therapies such as physical therapy and anti-inflammatory medications to manage his conditions, but in approximately early 2015, Patient reported having severe back pain that prevented him from walking despite taking 2400 mg of ibuprofen per day. This led Patient to take "leftover" hydrocodone-acetaminophen (Norco) tablets from a previous hernia surgery. Respondent began

[1] The name of the patient is redacted to protect their privacy.

prescribing Patient Norco, and referred him to a Physical Medicine and Rehabilitation (PMR), specialist.

14. On or about July 20, 2015, Patient saw the PMR doctor for chronic lower back pain, which was aggravated by golfing. Patient reported his pain ranged from 3 out of 10 to 7 out of 10. The PMR doctor noted Patient's current medication included Norco and noted that Patient used alcohol, but no recreational drugs. The PMR doctor noted that Patient had an MRI on June 14, 2015, which showed signs of degenerative disc disease, with bulging discs, but no significant disc herniation, and no significant central canal or foraminal stenosis. The PMR doctor recommended nonsteroidal anti-inflammatory drugs (NSAIDs), and a lumbar epidural injection.

15. On or about May 23, 2016, Patient saw Respondent for elbow pain and frequent migraines. Patient reported that he had stopped taking his anti-depressant because he believed it was not effective and caused bothersome side-effects. He requested prescriptions of Imitrex for his migraine headaches, and Norco for back pain. Patient stated that he takes the Norco rarely, but that when he does take it, he requires two tablets. Patient reported drinking approximately two cans of beer per week. Respondent prescribed hydrocodone, 5 milligrams, one-to-two tablets every six hours as needed.

16. On or about July 8, 2016, Patient followed up for continued elbow pain despite two steroid injections. Respondent refilled the Norco prescription, and noted Patient had a pain contract on file. At an appointment with Respondent, on or about February 27, 2017, Patient reported increased migraine headaches. Patient further noted that he required Norco four-to-five times per week for migraines and back pain associated with travel.

17. On or about April 19, 2017, Patient was seen by Respondent's associate physician, for acute anxiety following a workplace dispute. Patient reported having used lorazepam once in the Emergency Room, and requested a regular prescription for lorazepam. Respondent's associate physician agreed to provide Patient with a one-week prescription for lorazepam, 0.5 milligrams every eight hours, until he could follow up with Respondent. Respondent's associate also referred Patient to a psychiatrist, and recommended Patient begin treatment with a selective

serotonin reuptake inhibitor (SSRI). Patient declined to begin taking an SSRI until speaking with Respondent.

18. On or about May 1, 2019, Patient saw Respondent for follow up for anxiety. Patient reported having acute workplace anxiety and past trauma. Respondent prescribed Patient an SSRI, and continued the lorazepam prescription. Respondent did not document any discussion of the risks of combining opioid and benzodiazepine medications for Patient.

19. In approximately June of 2017, Respondent began increasing Patient's Norco dosage. Patient had an appointment with Respondent on or about June 19, 2017. At this appointment, Respondent continued the lorazepam at the current dose and increased the Norco from 5 mg to 10 mg tablets, 1-2 tablets by mouth every 8 hours as needed.

20. At an appointment with Respondent, on or about August 3, 2017, Patient reported that he was having increased back pain. Respondent ordered an MRI, and a new migraine headache medication and a muscle relaxant. Respondent prescribed Patient Percocet (acetaminophen with oxycodone), in addition to continuing the Norco. Respondent did not, however, make any reference to the new Percocet prescription in the medical record of August 3, 2017, and did not explain how Patient should take the new medication, whether he should take it with the Norco, or document what the reason was for the new prescription. CURES[2] records and pharmacy documents show that Patient filled a prescription from Respondent for 120 tablets of 10 milligram Percocet on August 3, 2017. This was only four days after Patient filled a prescription for 120 tablets of hydrocodone 10 milligram tablets. These prescriptions, taken together, increased Patient's daily morphine equivalent intake from approximately 40 MME[3] to 100 MME.

21. Patient underwent an MRI of the lower spine on or about August 4, 2017. The PMR doctor reviewed Patient's MRI and found it to be largely unremarkable. He noted that it showed

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[2] Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a database of Schedule II, III, IV and V controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

[3] MME is an abbreviation for the Morphine Milligram Equivalents used to evaluate the levels of opioids prescribed to a patient. The CDC recommends avoiding or carefully justifying any dosage greater than 90 MME/day.

mild degenerative disc disease with disc bulges and some narrowing of a portion of the L-5 nerve sleeve, but no frank nerve root involvement. The PMR doctor noted that although Patient reported 10 out of 10 pain, he was able to walk and did not appear to be in distress. The PMR doctor recommended physical therapy and NSAIDs and to consider facet blocks or radiofrequency ablation. He recommended oral steroids.

22. On or about August 21, 2017, Patient called Respondent's office to request a refill of the hydrocodone 10 milligrams, stating that he found the Percocet to be too strong. Respondent refilled the hydrocodone to be filled on August 30, 2017. However, a few days later, on or about September 5, 2017, Patient again called the office saying he preferred the Percocet and asked for that to be refilled. Respondent's associate noted the contradiction in Patient's statements and declined to refill the Percocet, instead referring Patient to make an appointment with Respondent.

23. Patient had an appointment with Respondent on or about September 12, 2017. During this appointment, Patient acknowledged he was filling and taking both the hydrocodone and the oxycodone (Norco and Percocet). Respondent refilled the oxycodone. Patient continued to take the lorazepam. Patient reported that he did not take the steroids recommended by the PMR doctor because they upset his stomach. Patient's pulse at this appointment was noted to be 120. At many appointments from this point onward, Patient's pulse was recorded as being elevated. Respondent did not, however, address this elevated heartrate or order an EKG to diagnose and treat the condition.

24. On or about October 16, 2017, Patient had an appointment with Respondent after having been in the Emergency Room for a headache. Patient stated that he had undergone a lumbar puncture and that it caused him a migraine. Patient stated that he would like to discontinue SSRI because he feels better. Despite this, Respondent refilled the lorazepam. Patient's pulse at this appointment was 116. Respondent ordered Patient off work for a month due to his migraine and degenerative disc back pain.

25. On or about October 20, 2017, Respondent's office received a message from Walgreens Pharmacy inquiring why Patient was seeking to fill a prescription for 180 tablets of Percocet despite having already filled a prescription for 180 tablets the week before. Respondent

authorized the early refill. This October early refill of Percocet meant Patient was taking 15 tablets of Percocet per day, which put him in excess of 4,000 milligrams of acetaminophen per day, which is not a safe dose that can result in liver damage or death. When asked about this during his interview with Board investigators, Respondent acknowledged that it was an unsafe dose, but stated that he felt the increased medication was necessary for Patient due to Patient having had a serious headache recently and a variety of other health conditions.

26. During approximately early November 2017, Respondent added Oxycontin to Patient's medication regimen, so that by December of 2017, Patient was taking 180 milligrams of Oxycontin and 60 milligrams of oxycodone, which put his daily morphine milligram equivalent at approximately 210. Respondent did not, however, document a medical basis warranting this sharp increase. At appointments in November and December 2017, Patient's pulse rate was noted to be 90 and 136, respectively, but Respondent did not address or treat this.

27. When Respondent initially added Oxycontin to Patient's medication regimen, Patient reported that he could not tolerate the Oxycontin because it caused him to have brain fog and affected his mental abilities. Instead, Patient requested additional Percocet, which Respondent prescribed. Despite prescribing Percocet, Respondent did not stop the Oxycontin, and instead doubled the dose of Oxycontin in approximately mid-December, 2017, from 20 milligrams twice daily to 40 milligrams twice daily. In mid-January 2018, Respondent authorized an early refill of both Oxycontin and Percocet for Patient. During an appointment on or about January 22, 2018, Respondent noted that Patient had self-escalated his dose of Percocet to 9 tablets per day on occasion, yet despite this, Respondent documented that Patient showed no signs of abuse of his medication. Patient also reported that he was taking excess lorazepam, up to three per day, to deal with work stress. Patient's pulse at this visit was 116. Respondent increased the lorazepam dose and increased Patient's Oxycontin to 60 milligrams twice daily.

28. On or about February 2018, Patient had an appointment with Respondent in which he reported he felt his current medication regimen was working well for him. Patient noted that he was continuing to work with a counselor and anticipated an increase in anxiety as they planned to address past traumatic incidents in therapy. Patient's pulse was 113. Respondent increased

Patient's SSRI medication. Between February and March of 2018, Respondent recommended Patient reduce his opioid medications by one pill per day, but Patient called back to report the reduction caused intolerable pain, and Respondent advised Patient to return to the previous higher dose.

29. In March of 2018, Patient's family contacted Respondent to report that they were concerned he was suicidal. The family members reported that, although Patient was seeing a therapist, he was getting worse. They explained to Respondent that Patient spoke to his pastor about his possible suicide, and also that he owned a firearm. Respondent referred Patient to mental health programs and altered his medications.

30. In April of 2018, Patient went to the Emergency Room complaining of severe back pain. Patient had an MRI performed in April of 2018, which showed no new disc protrusions or significant spinal canal stenosis for the thoracic spine, and mild degenerative changes and spinal canal stenosis of the cervical spine. During the spring of 2018, Patient made several requests for early refills of the oxycodone and Oxycontin medications. Respondent denied some of these requests and granted others. The pharmacy Patient used called seeking clarification because Respondent wrote several of the prescriptions for 20 days, however, Respondent indicated that he had intended the medication to be refilled at 30-day intervals. In August of 2018, Patient again requested an early refill of opioid medications citing increased pain. Respondent provided the early refill. When asked by Board investigators why Respondent agreed to this early refill of opioids, Respondent stated that after having denied several early refill requests, he gave in and agreed to a last early refill before he referred Patient to a Pain Management specialist for all further opioid medications.

31. At an appointment on June 5, 2018, Respondent documented that Patient had attended a mindfulness program at Sierra Tucson Residential Treatment Center in Arizona. Respondent documented that Patient stated that he did not find the program to be beneficial and he had experienced a flare-up of back pain. Patient further reported experiencing suicidal thoughts. Patient's pulse was 91.

32. A few days later, Patient called Respondent's office stating that the providers at Sierra Tucson had recommended he increase his Oxycontin to a maximum of 12 tablets per day. Respondent documented that he noted this in Patient's file. Respondent did not express concern or surprise at this and did not attempt to contact Patient's providers from Sierra Tucson to confirm whether this was accurate.

33. At appointments in early July 2018, Patient's pulse was 114 and 138. Patient reported that his anxiety was getting worse, and that he required additional lorazepam. At an appointment on or about July 20, 2018, Patient's pulse was 131. Patient reported that he was having increased thoughts of suicide and had drafted a suicide note. Patient had filled a prescription for 180 tablets of oxycodone on or about July 9, 2018, yet Respondent refilled Patient's oxycodone early, for 180 tablets on July 20, 2018, only 11 days later. The pharmacy contacted Respondent's office asking for justification for this excess medication.

34. At an appointment on or about August 6, 2018, Patient's pulse was 145. Patient reported continuing suicidal ideation and stated he was waiting to be seen by psychiatry. In August of 2018, Respondent referred Patient to a Pain Management specialist. Respondent sent a message to the Pain Management specialist stating that he believed Patient required greater doses of opioids than he felt he could provide, and recommended that the Pain Management specialists consider increasing the opioid dosage. Patient saw the Pain Management practitioner for the first time on or about August 24, 2018.

35. At Patient's pain management appointment on or about August 24, 2018, the practitioner indicated she would continue Patient's Percocet and Oxycontin medications as previously prescribed by Respondent, and they would consider adding a longer acting pain medication in the future. The pain management provider referred Patient for sacroiliac joint injections. She noted Patient consumed alcohol. She noted Patient's medications to include opioids, an SSRI, migraine medication, and a muscle relaxant. She did not document Patient's use of benzodiazepines.

36. On or about August 27, 2018, after Patient's appointment with the Pain Management specialist, Patient called Respondent to complain that the Pain Management specialist was giving

him less opioid medication than Respondent had prescribed previously. Patient explained that he had been taking 9 tablets of oxycodone per day, and that the Pain Management specialist reduced it to 6 tablets per day. Patient complained that the Pain Management office was treating him like a criminal. Patient's pulse was 142. Patient reported that the police had been sent to his house for a welfare check because his therapist was concerned about him. Respondent agreed to provide Patient with additional pain medication until he could follow up with Pain Management. Respondent documented that, in his opinion, Patient required greater analgesics, even at the risk of dependence, and that he did not believe Patient was at high risk for abusing pain medication. Respondent called the Pain Management provider's office and asked them to consider additional pain management intervention, even if it meant high-dose opioids.

37. After August of 2018, the Pain Management program prescribed all Patient's opioid medications, and Respondent did not provide any further opioid prescriptions, although he did continue to prescribe benzodiazepines to Patient. In September of 2018, the Pain Management specialists added fentanyl patches to Patient's pain medication regimen. The Pain Management specialists also began increasing the Oxycontin dose. Patient's daily morphine equivalent from September 2018 through June 2019 ranged from 395 MME to 379 MME.

38. On or about October 22, 2018, Respondent saw Patient for an ear infection. Patient's pulse was 124 and his blood pressure was 169/117. Respondent did not comment on the elevated pulse rate. On or about October 29, 2018, Respondent saw Patient again for a follow up from an Emergency Room visit. The Emergency physicians had diagnosed Patient with paroxysmal superventricular tachycardia (PSVT), a type of abnormal heart rhythm associated with elevated pulse rate of greater than 120. Patient told Respondent that he believed he was having side effects from his anti-depressant medications. Patient reported stopping taking the antidepressants. Respondent noted that Patient's liver enzymes were high, which could be due to fatty liver or liver toxicity from lorazepam. Respondent referred Patient to cardiology.

39. Beginning in December of 2018, Respondent's notes for Patient indicate that they discussed weaning Patient off pain medications. Respondent occasionally noted directions to reduce the number of pills per day of pain medication prescribed for Patient. However, there is

no indication that Respondent communicated this to the Pain Management providers, or that the Pain Management providers reduced Patient's prescriptions in accordance with Respondent's directions to Respondent. During some of the occasions that Respondent directed Patient to reduce pain medications, the Pain Management providers actually increased the amount of opioid medication Patient was receiving.

40. After reducing Patient's SSRI, Patient had increased depression and anxiety in November of 2018, and Respondent increased the SSRI again at the end of November, beginning of December 2018. In mid-December 2018, Patient reported the increased SSRIs to be helpful, however, on or about December 18, 2018, Respondent's office received a message from another of Patient's providers indicating that they were concerned about Patient's elevated heartrate and the possibility of serotonin syndrome due to the SSRI dose.

41. On or about December 20, 2018, Patient saw Respondent to rule out serotonin syndrome. Patient's blood pressure was normal, but his pulse was 138. Respondent noted that he would reduce the SSRI, but that the benefits of Effexor and Imitrex remained higher than the risks, and for Patient to keep taking them. On or about December 21, 2018, Patient's family called Respondent to say that they were worried about his depression and suicidality. Respondent sent in an urgent psychiatry referral for Patient.

42. Throughout December 2018 and January of 2019, Patient continued to experience suicidal ideation. During January of 2019, Respondent attempted to replace Patient's SSRI with Remeron, as an atypical antidepressant. In January of 2019, Respondent received a message from Patient's psychologist stating that Patient had experienced a mental breakdown in his office. Respondent documented that he would double Patient's lorazepam prescription. However, CURES records and pharmacy documents show that Respondent actually quadrupled the lorazepam dose he prescribed to Patient.

43. On or about April 2019, Patient's wife contacted Respondent to express her concerns again about Patient's suicidal ideations. Respondent attempted to call Patient and his wife with no response. During April of 2019, Patient seemed to decompensate and report greater depression and suicidal ideation. Patient reported marital troubles as well as workplace problems.

44. On or about May 10, 2019, Respondent received a message that Patient was going through a medically supervised detox from opioids for 15 days. Respondent did not communicate this to Patient's Pain Management Provider. On or about May 20, 2019, Patient contacted Respondent's office to report that he had completed a detox and requested 100 milligrams of quetiapine.[4] Respondent faxed a prescription for Patient.

45. On or about May 22, 2019, Patient was treated for an emergency condition in a Physical Therapist office. Respondent saw Patient the following day, and Patient reported he was detoxing from opioids and was having a panic attack, which led to the emergency. Respondent authorized an early refill of lorazepam, despite Patient's recent detox. Respondent documented that the risk of increasing the lorazepam dose was outweighed by the benefits of preventing uncontrolled anxiety and suicide.

46. Patient committed suicide on or about June 9, 2019, by applying multiple fentanyl patches to his body.

47. A retrospective review of Patient's daily morphine equivalent shows that between May 9, 2017 and August 25, 2017, he received 54 MME and 150 tablets of 0.5 mg lorazepam. From August 27, 2017 to January 8, 2018, he received 204 MME and 130 tablets of 0.5 mg lorazepam. From January 23, 2018 to June 25, 2018, he received 241 MME and 240 tablets of 0.5 mg lorazepam. From June 25, 2018 to September 13, 2018, he received 480 MME and 240 tablets of 0.5 mg lorazepam. After September 8, 2018, Respondent no longer prescribed any opioids to Patient. Respondent did, however, dramatically increase the lorazepam dose, while other providers were increasing the daily morphine equivalent. For example, from September 17, 2018 to January 18, 2019, Patient received 395 MME from other providers and Respondent prescribed 330 tablets of 0.5 mg lorazepam and 90 tablets of 2 mg lorazepam, while another provider also prescribed 20 tablets of 1 mg lorazepam. Similarly, from January 29, 2019 to June 3, 2019, Patient received 379 MME from other providers, while Respondent prescribed 450

[4] Quetiapine is an atypical anti-psychotic drug that is sometimes used off-label to treat anxiety and depression that is resistant to other medications.

tablets of 2 mg lorazepam. The rapid increases of opioids and the addition of increasing amounts of benzodiazepine doses increased Patient's risk of overdose death.

FIRST CAUSE FOR DISCIPLINE

(Gross negligence)

48. Respondent has subjected his Physician's and Surgeon's Certificate No. A 54643 to disciplinary action under section 2227, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patient. The circumstances are as follows:

49. Paragraphs 13 through 47 above, are incorporated by reference as if fully set forth here.

50. Respondent's acts and omissions, including, but not limited to, the following:

A. Prescribing a combination of opioids and benzodiazepines to Patient[5] despite the medical evidence that co-administration of these drug classes creates a synergistic effect resulting in increased risk for negative health outcomes, including overdose and death;

B. Prescribing excessive amounts of opioid medications to Patient;

C. Prescribing benzodiazepines to Patient for long-term use in the treatment of anxiety;

D. Providing dramatically escalating doses of morphine milligram equivalents (MME) to Patient, despite his demonstrated medication abuse behaviors, requests for early refills, and suicidal ideation;

E. Prescribing chronic, high-dose opioids to Patient for treatment of musculoskeletal pain; and

F. Failing to perform or order an EKG for Patient despite Patient frequently presenting for appointments with an elevated heart rate.

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SECOND CAUSE FOR DISCIPLINE

[5] Initially Respondent prescribed both the opioids and benzodiazepines, and later Respondent prescribed the benzodiazepines with the knowledge that Patient was concurrently prescribed opioids from the Pain Management program.

(Repeated Negligent Acts)

51. Respondent has subjected his Physician's and Surgeon's Certificate No. A 54643 to disciplinary action under section 2227, as defined by section 2234, subdivision (c), of the Code, in that he was repeatedly negligent in his care and treatment of Patient, as more particularly alleged in paragraphs 13 through 47 above, which are incorporated by reference as if fully set forth here. Additional circumstances are as follows:

A. Prescribing a combination of opioids and benzodiazepines to Patient[6] despite the medical evidence that co-administration of these drug classes creates a synergistic effect resulting in increased risk for negative health outcomes, including overdose and death;

B. Prescribing excessive amounts of opioid medications to Patient;

C. Prescribing benzodiazepines to Patient for long-term use in the treatment of anxiety;

D. Providing dramatically escalating doses of morphine milligram equivalents (MME) to Patient, despite his demonstrated medication abuse behaviors, requests for early refills, and suicidal ideation;

E. Prescribing chronic, high-dose opioids to Patient for treatment of musculoskeletal pain; and

F. Failing to perform or order an EKG for Patient despite Patient frequently presenting for appointments with an elevated heart rate.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing)

52. Respondent has subjected his Physician's and Surgeon's Certificate No. A 54643 to disciplinary action under section 2227, as defined by section 725, of the Code, in that he prescribed excessive amounts of controlled substances to Patient as described in Paragraphs 13 through 47, above, which are incorporated by reference as if fully set forth herein.

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PRAYER

[6] Initially Respondent prescribed both the opioids and benzodiazepines, and later Respondent prescribed the benzodiazepines with the knowledge that Patient was concurrently prescribed opioids from the Pain Management program.

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 54643, issued to Respondent David Wepin Lin, M.D.;

2. Revoking, suspending, or denying approval of Respondent David Wepin Lin, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent David Wepin Lin, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent David Wepin Lin, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: JAN 04 2024

Jenna Jones For
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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