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

In the Matter of the Accusation Against: Linda Jane Tang, M.D. Physician's & Surgeon's Certificate No. A 80493 Respondent.	Case No. 800-2017-036099

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 July 8, 2021.

IT IS SO ORDERED: June 8, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
State Bar No. 113083
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3884
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the Accusation Against: **LINDA JANE TANG, M.D.** **301 Main St., #25E** **San Francisco, CA 94105-5032** **Physician's and Surgeon's Certificate No. A 80493** Respondent.	Case No. 800-2017-036099 OAH No. 2020100266 **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. William Prasifka (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 Xavier Becerra, Attorney General of the State of California, by Mary Cain-Simon, Supervising Deputy Attorney General.

2. Respondent Linda Jane Tang, M.D. (Respondent) is represented in this proceeding by attorney Dominique Pollara, whose address is: 100 Howe Avenue, Suite 165N, Sacramento, CA 95825.

3. On September 13, 2002, the Board issued Physician's and Surgeon's Certificate No. A 80493 to Linda Jane Tang, 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. 800-2017-036099, and will expire on July 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-036099 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 October 1, 2019. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-036099 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. 800-2017-036099. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her 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 her; the right to present evidence and to testify on her 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.

CULPABILITY

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual

basis for the charges in the Accusation, and that Respondent hereby gives up her right to contest those charges.

10. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

11. 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 her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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.

12. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in Accusation No. 800-2017-036099 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

13. 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.

14. 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 Physician's and Surgeon's Certificate No. A 80493 issued to Respondent LINDA JANE TANG, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for thirty-five (35) months on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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 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 medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. PROOF OF SATISFACTORY COMPLETION OF INTERVENTIONAL RADIOLOGY PRIVILEGING PROCESS AT TWO HOSPITALS. Within 60 calendar days of the effective date of this Decision, Respondent shall provide to the Board or its designee proof, including but not limited to privileging reports, that Respondent has successfully completed the privileging process to practice in Interventional Radiology at two separate hospitals, unless the Board or its designee agrees in writing to an extension of that time.

Respondent shall pay all expenses associated with providing the proof that she has successfully completed the privileging process to practice interventional radiology at two hospitals.

Determination as to whether Respondent successfully completed the discipline specific privileging process is solely within the Board's jurisdiction. Respondent shall cooperate fully with the Board or its designee in reaching its determination, and shall ensure prompt access by the Board or its designee to all documents or information necessary to make its determination.

5. MONITORING - PRACTICE/BILLING. 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(s), 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(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), 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 for approval by the Board or its designee.

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.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective

date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent'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 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee 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.

6. SOLO PRACTICE PROHIBITION. Until Respondent has been notified by the Board or its designee that the Board or its designee have determined that she has successfully completed the privileging process to practice Interventional Radiology at two separate hospitals, as described in Paragraph 4, above, Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1)

Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

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

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

STANDARD CONDITIONS

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this 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.

8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. 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.

10. 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.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. 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).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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.

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.

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

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice for a Respondent residing outside of 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; General Probation Requirements; Quarterly Declarations.

14. 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.

15. 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.

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining 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. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. 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.

18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-036099 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Dominique Pollara. 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: 3/12/21

LINDA JANE TANG, M.D.
Respondent

I have read and fully discussed with Respondent Linda Jane Tang, 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: 3/15/21

DOMINIQUE POLLARA
Attorney for Respondent

ENDORSEMENT

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

DATED: March 15, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

Mary Cain-Simon

MARY CAIN-SIMON
Supervising Deputy Attorney General
Attorneys for Complainant

SF2019200850
Tang stipulation with revision.docx

Exhibit A

Accusation No. 800-2017-036099

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
State Bar No. 113083
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3884
Facsimile: (415) 703-5480
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct. 1 2019
BY A. Esperia ANALYST

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

In the Matter of the Accusation Against: **Linda Jane Tang, M.D.** **301 Main St., #25E** **San Francisco, CA 94105-5032** **Physician's and Surgeon's Certificate No. A 80493,** Respondent.	Case No. 800-2017-036099 **ACCUSATION**

PARTIES

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

2. On or about September 13, 2002, the Medical Board issued Physician's and Surgeon's Certificate Number A 80493 to Linda Jane Tang, 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 July 31, 2020, unless renewed.

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JURISDICTION

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 states:

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

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

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

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

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

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

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

STATUTORY PROVISIONS

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:

(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 by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

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

FACTS

7. At all times relevant to this matter, Respondent practiced medicine as a licensed physician specializing in Interventional Radiology. On around August 23, 2017, her employer initiated an investigation into her practice, based on issues of judgment and/or technical skill as identified in a number of cases in which she had provided medical care and services. Respondent resigned her employment before any investigation was commenced.

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PATIENT 1[1]

8. Patient 1 was a 67-year old woman with multiple comorbidities including hypertension, Type II diabetes, history of coccidioidomycosis, renal failure and bilateral pleural effusions. Patient 1 came under Respondent's care when Patient 1 was referred to Interventional Radiology for a CT- guided needle biopsy of a left upper lobe mass with associated mediastinal adenopathy.

9. On July 11, 2017, Respondent performed a CT- guided biopsy of the left upper lobe mass lesion, while Patient 1 was under conscious sedation in the interventional radiology suite. At around 1:39 p.m., the proposed skin entry site was marked by CT localization, and following sterile preparation and draping, a team time out was performed at 1:40 p.m. 1% lidocaine anesthetic was then injected beginning at 1:42 p.m., followed by insertion under CT guidance of a 17-gauge biopsy needle where two core biopsies of the mass were obtained without difficulty. Respondent made a third biopsy attempt, but was unsuccessful due to sudden onset of profuse patient coughing and more than expected bleeding. Two images of the procedure show wide trajectory excursions from the best intended path, with both penetrating deeply into lung parenchyma.

10. After the patient began to desaturate to the mid 80's, Respondent stopped the procedure. The patient was recovered with supplemental oxygen and a post-procedure chest X-ray revealed no pneumothorax. At 4:10 p.m., the patient was observed to be clinically stable without pain or respiratory distress and no medical issues related to the lung biopsy.

11. After the biopsy procedure, one of the CT technicians involved in the procedure filed a responsible reporting form with Hospital Quality Control. The concern expressed in the report was that there were several wide trajectories of the needles used during the procedure with a captured image Series 2, Image 32 showing a needle tip in close apposition to the aortic arch.

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[1] The patients are designated in this document as Patients 1-5 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Negligence and/or Gross Negligence)

12. Respondent is subject to disciplinary action under sections 2234 and 2234(a), (b), and (c) in that her care and treatment of Patient 1 included repeated negligent acts and/or gross negligence. The circumstances are as follows:

13. The allegations of paragraphs 8-11 above are incorporated herein as if set out in full.

14. The penetration of the lung tissue and wide deviations of the needles as shown in the CT images of the procedure comprise negligent acts and/or gross negligence.

PATIENT 2

15. Patient 2 was a 66- year old woman, and presented with multiple comorbidities including multiple sclerosis, tracheostomy, colostomy, stag horn calculus and neurogenic bladder. Patient 2 came under Respondent's care when she was referred to Interventional Radiology for an elective exchange of a preexisting left-sided nephrostomy tube on October 13, 2016. The procedure was performed under moderate sedation using fluoroscopic guidance and the post-procedure note indicates that an 8.2 French nephrostomy tube was exchanged successfully with no complication using the original nephrostomy tube track and into a previous mid renal pole calyceal entry site.

16. However, during the procedure on Patient 2, Respondent made the choice of placing the pigtail tip of the replacement nephrostomy tube within the mid pole calyx as opposed to electively placing the pigtail end more centrally within the renal pelvis.

17. In a non-emergent, uncomplicated patient clinical procedure of establishing a nephrostomy tube and final drainage position, the standard of care requires placement of the pigtail loop within the central renal pelvis. Even where a coexistent stag horn calculus is also present within the renal pelvis, it is best to place the pigtail end centrally within the renal pelvis, as best allowed by the presence of the renal calculus. Placement of the pigtail entirely within a single renal calyx predisposes the patient to potential complications of poor drainage, catheter induced bleeding and or pain.

18. Respondent has admitted that the ideal positioning of the nephrostomy tube would have indeed been centrally within the renal pelvis towards the infundibulum, despite the presence of the staghorn calculus, and that she should have considered that at the time of the procedure.

19. Patient 2 had undergone previous tube replacements for issues of poor drainage and debris blockage before the October 13, 2016 procedure by Respondent. After Respondent's decision and action electively leaving the pigtail in a suboptimal location, Patient 2 required an additional procedure at a later date to reposition the nephrostomy tube into the correct position within the renal pelvis.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Negligence and/or Gross Negligence)

20. Respondent is subject to disciplinary action under sections 2234 and 2234(a), (b), and (c) in that her care and treatment of a patient included negligence and/or gross negligence, and repeated negligent acts. The circumstances are as follows:

21. The allegations of paragraphs 8-11 and 15-19 above are incorporated herein as if set out in full.

22. Respondent's decisions and actions in electively leaving the pigtail in a suboptimal location comprise negligent acts that required Patient 2 to undergo an additional procedure at a later date to reposition the nephrostomy tube into the correct position within the renal pelvis.

PATIENT 3

23. Patient 3 was a 56-year old woman, with a past medical history including surgical and radiation treatment of a sarcoma of the leg, and had metastatic nodules discovered on a chest CT examination in May 2014. Patient 3 came under Respondent's care when she was referred to Interventional Radiology on January 22, 2016 for a CT guided biopsy of a right lung base nodule that the radiologist had described as being suspicious for a metastatic lesion, based on a recently performed follow-up surveillance CT of the chest.

24. Chart notes indicate that on January 22, 2016, Respondent initiated a procedure involving the CT localization of the right lung base, followed by a time out assessment of the

proposed procedure; and then a total of five biopsy specimens were obtained without patient complication.

25. The CT localization images acquired on the January 22, 2016 interventional study that was supervised and performed by Respondent show that there is a smooth-margined, approximately 10mm lung nodule at the right lung base posteriorly that, given the patient's history and that it was a new interval finding, necessitated biopsy as was intended by the ordering physician. Instead, Respondent decided to biopsy a 2.6cm partially calcified mass superior to the intended requested biopsy site.

26. When asked about her failure to biopsy the correct site, Respondent stated that on the morning of January 22, 2016, she had multiple earlier procedures as well as phone calls to deal with, and implied that these activities may have led to her becoming distracted in localizing the requested nodule. However, Respondent had taken the mandatory procedural time out that should have prevented her from committing this type of error.

27. The error in biopsy was not recognized until three months later when a follow-up chest CT then reported the suspicious nodule to have now increased in size to 1.9 cm. Irrespective of the time out procedure, it is mandatory that the interventional radiologist review all available relevant reports and prior imaging to ensure both that the correct tissue is targeted for the requested procedure, and that other pathologic factors or anatomy are recognized before the onset of the procedure. Respondent did not recognize the concern and need for biopsy of the smaller and more inferior nodule relative in position to the much larger adjacent lesion that was erroneously biopsied.

28. Respondent's failure to review prior imaging studies and reports resulted in Respondent failing to identify the true area of clinical concern for Patient 3. This failure resulted in a three-month delay for Patient 3 to obtain the correct diagnosis and to initiate proper treatment.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Negligence and/or Gross Negligence/Inadequate Medical Record-Keeping)

29. Respondent is subject to disciplinary action under sections 2234, 2234(a), (b), and (c) and 2266, in that her care and treatment of a patient comprised negligence and gross negligence, repeated negligent acts and inadequate medical record-keeping. The circumstances are as follows:

30. The allegations of paragraphs 8-11, 15-19, and 23-28, above are incorporated herein as if set out in full.

31. Respondent's actions in failing to review prior images and reports and then not performing the biopsy on the correct site comprise negligence and/or gross negligence.

32. Respondent's failure to note in the records that she did not take a biopsy on the correct site comprises inadequate medical record-keeping.

33. Respondent's actions in failing to perform the biopsy on the correct site and failure to keep adequate medical records caused a three-month delay before Patient 3 was able to obtain a correct diagnosis and proper treatment.

PATIENT 4

34. Patient 4 was a 64-year old man with a past medical history of end stage renal disease who was hemodialysis dependent. Patient 4 came under Respondent's care when Patient 4 was referred to Interventional Radiology for evaluation and possible interventional treatment of a dialysis fistula, having symptoms of arterial spasm and a burning sensation during active hemodialysis.

35. Respondent performed a fistulogram of both the arterial and venous limbs of the dialysis fistula with a total of seven fluoroscopically recorded run offs obtained. In her post-procedural note, Respondent stated there was "no significant stenosis seen," and listed the post-operative diagnosis to be unchanged from the preoperative diagnosis of "arterial spasm and burning sensation with dialysis."

36. Respondent's post-procedural note indicating arterial spasm is inconsistent with the final procedural dictation of September 12, 2016, which Respondent concluded with "unremarkable dialysis access, no hemodynamically significant stenosis identified."

37. Respondent failed to document and failed to initiate possible remedial treatment of an approximately 50% short segment narrowing of the venous limb of the shunt that is clearly seen on seven of the eight contrast injection series.

38. Respondent did not identify or report any abnormalities during her evaluation on September 12, 2016 of the hemodialysis shunt in Patient 4, who was referred for dialysis-related symptoms of pain and arterial spasm during episodes of active hemodialysis. Shunt blood flow images taken by Respondent do show a short segment stenosis in the venous limb of the shunt just distal to the arterial anastomosis that appears visually to be about a 50% reduction in vessel lumen. In a symptomatic dialysis graft patient with an otherwise anatomically normal fistulogram, consideration should be given to this single abnormality as either an active or potentially active problem to the patient.

39. Whether this issue reflected a new interval finding or a stable finding present on previous studies, Respondent did not undertake the simple procedure to angioplasty this solitary area of stenosis and potentially either resolve the patient's current symptoms or possibly prevent a subsequent procedure in time, should this focal stenosis further worsen. When asked to explain why she did not undertake the angioplasty, Respondent stated that she "didn't find anything so I didn't do any angioplasty."

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Negligence and/or Gross Negligence/Inadequate Medical Record-keeping)

40. Respondent is subject to disciplinary action under sections 2234 and 2234(a), (b), and (c) and 2266 in that her care and treatment of a patient included negligence and/or gross negligence, repeated negligent acts and inadequate medical record-keeping. The circumstances are as follows:

41. The allegations of paragraphs 8-11, 15-19, 23-28 and 34-39 above are incorporated herein as if set out in full.

42. Respondent's failures to document and to initiate possible remedial treatment of the approximately 50% short segment narrowing of the venous limb of the shunt comprise negligent acts and inadequate medical record-keeping.

43. Respondent's failure to appreciate the need for and to undertake an angioplasty for the solitary area of stenosis comprises negligence.

44. In a patient with dialysis-related shunt symptoms with a single solitary finding of focal stenosis with an otherwise anatomically normal fistulogram study, consideration should be made of performing an angioplasty on the isolated stenosis. Respondent's failure to discuss the presence of this focal stenosis in the medical records and to consider possible remedial options comprises negligence and inadequate medical record-keeping.

45. Respondent's failure to discuss the presence of this focal stenosis in the medical records and to consider possible remedial options comprises negligence.

PATIENT 5

46. Patient 5 was a 79-year old woman with a past medical history of end-stage renal disease. She had been on chronic peritoneal dialysis. Patient 5 came under Respondent's medical care when Patient 5 was referred to Interventional Radiology on August 15, 2017 for placement of a tunneled dialysis catheter for planned future hemodialysis. Due to a confirmed chronic occlusion of the right jugular vein, the procedure was performed through the left jugular venous system.

47. When asked about her treatment of Patient 5, Respondent described technical difficulties that she encountered during the placement of the left-sided tunneled catheter including initial difficulty in passing a guide wire from the left jugular vein to the level of the right atrium due to anatomical angulation of the left brachiocephalic vein with the superior vena cava. Following a cava gram to delineate the venous anatomy, successful passage of a guide wire to the right atrial level was achieved and a subsequent series of attempted or revised dialysis catheters were then tried.

48. The chart notes provide little detail of the procedural difficulties, but when asked to discuss the procedure, Respondent related that once she successfully passed a dialysis catheter to the right atrial level she was unable to aspirate blood back through the catheter. Respondent believed at the time the failure to aspirate was due to the catheter tenting or pressing against the right atrial wall and accordingly pulled the catheter back slightly to alleviate any potential flow-restrictive contact between the catheter tip and the right atrial wall. When asked about these events, Respondent explained that this maneuver resulted in a successful aspiration of blood back through the catheter confirming the desired intravascular location. Subsequent to this maneuver, several additional catheter exchanges/manipulations were performed to better optimize catheter length and final catheter tip position.

49. In the post-procedural note from August 15, 2017, Respondent documented the procedure, including that she performed the time out as well as final catheter size and final catheter placement location and of no apparent complications as a consequence to the procedure.

50. Films taken during the procedure, though, show the following:

(A) A catheter-delivered contrast injection performed at 17:16 demonstrates a normally patent superior vena cava and no suggestion of any complex anatomy in the region of the brachiocephalic superior vena caval junction;

(B) A single fluoroscopic image taken at 17:56 (Series 2, Image 1) shows a dialysis catheter to have been placed over the interval with the catheter tip clearly projecting outside the projected margins of the right heart silhouette;

(C) A second single fluoroscopic image taken at 18:02 shows the catheter to have been repositioned over the interval with the tip now clearly within the silhouette of the right heart border, but this image shows a large area of new radio opaque density obscuring the right hilar structures that was not present on the 17:56 image.

51. Based on Respondent's failure to aspirate the catheter as described in paragraph 49, above, and the abnormal catheter tip location on the 17:56 image with interval opacification of the perihilar lung in this same region on the 18:02 image, it is apparent that there was an unrecognized cardiac wall penetration that occurred at the time of the 17:56 image.

52. After the procedure, Patient 5 was discharged in reported stable condition. However, the following day, Respondent entered a chart note that Patient 5 had returned to the emergency room with a complaint of chest pain. A chest X-ray taken demonstrated a "new density in the right perihilar area" and a CT of the chest taken for further evaluation revealed a large right pleural hematoma.

53. The standard of care for the practice of interventional radiology requires guarding against the inadvertent penetration of a vascular wall by either a guide wire or the catheter. Because of these potential problems, specific procedures are in place to look for such potential issues. Here, Respondent did address the failure to aspirate back blood through the catheter and followed up with a fluoroscopic picture of the area; but Respondent did not do a contrast injection, and Respondent did not perform or cause to be performed an immediate CT scan.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Negligence and/or Gross Negligence/Inadequate Medical Record-Keeping)

54. Respondent is subject to disciplinary action under sections 2234, 2234(a), (b), and (c) and 2266 in that her care and treatment of a patient included negligence and/or gross negligence and repeated negligent acts, as well as inadequate record-keeping. The circumstances are as follows:

55. The allegations of paragraphs 8-11, 15-19, 23-28, 34-39, and 46-53 above are incorporated herein as if set out in full.

56. Respondent's actions in perforating Patient 5's cardiac wall and failure to undertake specific procedures to guard against and detect that occurrence comprises gross negligence and repeated negligent acts.

57. Respondent's actions in failing to document in the medical record that she had perforated Patient 5's wall comprises inadequate medical record-keeping.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 80493, issued to Linda Jane Tang, M.D.;

2. Revoking, suspending or denying approval of Linda Jane Tang, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Linda Jane Tang, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: October 1, 2019

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

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