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

In the Matter of the Accusation Against: John Timothy Waring, M.D. Physician's and Surgeon's Certificate No. A 109920 Respondent.	MBC File # 800-2019-061707

ORDER CORRECTING NUNC PRO TUNC CLERICAL ERROR IN "SIGNATURE BLOCK" PORTION OF DECISION

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the "signature block" portion of the Decision in the above-entitled matter and that such clerical error should be corrected so that the Board member's name conforms to the Board's issued Decision.

IT IS HEREBY ORDERED that the signature block contained on the Decision Order Page in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as *Richard E. Thorp, M.D., Chair, Panel B.*

January 31, 2022

William Prasifka
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against: John Timothy Waring, M.D. Physician's & Surgeon's Certificate No A 109920 Respondent.	Case No. 800-2019-061707

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 February 25, 2022

IT IS SO ORDERED January 27, 2022

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson

Kristina Lawson, J.D.
Panel B

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
State Bar No. 237826
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7549
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **JOHN TIMOTHY WARING, M.D.** 5530 Birdcage St., Ste 145 Citrus Heights, CA 95610-7621 Physician's and Surgeon's Certificate No. A 109920 Respondent.	Case No. 800-2019-061707 OAH No. 2021060546 **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 Rob Bonta, Attorney General of the State of California, by Jannsen Tan, Deputy Attorney General.

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2. Respondent John Timothy Waring, M.D. ("Respondent") is represented in this proceeding by attorney M. Bradley Wishek, Esq., whose address is:

Rothschild, Wishek & Sands LLP
765 University Avenue
Sacramento, CA 95825

3. On or about November 4, 2009, the Board issued Physician's and Surgeon's Certificate No. A 109920 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-061707, and will expire on July 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-061707 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 February 25, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-061707 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. 800-2019-061707. 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.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2019-061707, 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 for the charges in the Accusation, 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 terms and conditions as set forth in the Disciplinary Order below.

CONTINGENCY

12. 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.

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.

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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

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 109920 issued to Respondent John Timothy Waring, M.D. shall be and is hereby publically reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2019-061707, is as follows:

"On or about June through August 2019, while treating four patients, you committed a series of repeated negligent acts as more fully described in the Accusation No. 800-2019-061707."

B. CLINICAL COMPETENCE ASSESSMENT PROGRAM

Within ninety (90) days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than nine (9) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence

assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

C. **FAILURE TO COMPLY**

If Respondent fails to enroll in, participate in, or successfully complete the clinical competence assessment program as described in condition B within the designated time period, 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 the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed and comply with the cease practice order. If the Respondent does not successfully complete the clinical competence assessment program and the Board has issued a cease practice order, the Respondent shall not resume the practice of medicine until a final decision has been rendered on an Accusation. Failure to comply with a cease practice order issued by the Board under this term and condition shall be considered unprofessional conduct.

Any violation of condition B as described above by Respondent, including but not limited to, a failure to successfully complete the competence assessment program and/or follow the program recommendations, shall constitute general unprofessional conduct. Respondent understands and agrees that a violation of condition B shall be grounds for the filing of further immediate disciplinary action against Respondent's license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, M. Bradley Wishek, Esq. 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: 12/17/21

JOHN TIMOTHY WARING, M.D.
Respondent

I have read and fully discussed with Respondent John Timothy Waring, 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: 12-17-21

M. BRADLEY WISHEK, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 12-17-21

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

For JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

John Gotelli

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XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
State Bar No. 237826
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7549
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation Against: **John Timothy Waring, M.D.** **5530 Birdcage St., Ste. 145** **Citrus Heights, CA 95610-7621** **Physician's and Surgeon's Certificate No. A 109920,** Respondent.	Case No. 800-2019-061707 **ACCUSATION**

PARTIES

1. William Prasifka (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 November 4, 2009, the Medical Board issued Physician's and Surgeon's Certificate Number A 109920 to John Timothy Waring, 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, 2021, unless renewed.

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 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 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..

FACTUAL ALLEGATIONS

FIRST CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

7. Respondent is a physician and surgeon, board certified in anesthesiology, who at all times relevant to the charges brought herein worked in Mercy General Hospital (Mercy) in Sacramento, California.

8. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patients 9383[1], 7481, 2148, and 3355, as more particularly alleged hereinafter.

Patient 9383

9. On or about July 3, 2019, Patient 9383 was at the time, a 75-year-old woman who underwent a 12-hour general anesthetic for lumbar scoliosis reconstruction surgery. Her past

[1] Patient names have been redacted to protect patient confidentiality.

medical history was pertinent for a BMI = 24, hypertension, scoliosis, and hyponatremia (Na+ = 124).

10. On or about July 3, 2019, Patient 9383 underwent surgery. The total anesthesia time was 0745-2204 hours. Respondent did not begin the anesthetic, but was the relief anesthesiologist at the 9-hour mark at 1715 hours. The first anesthesiologist (Dr. P) placed a 20 gauge IV in the left hand and a 20 gauge arterial line in the right radial artery preoperatively, but no central venous pressure catheter (CVP) line was inserted. Dr. P induced general anesthesia, and Patient 9383 was turned prone. Anesthesia included sevoflurane and nitrous oxide, as well as propofol and sufentanil infusions. Three IV infusions were run through the 20 gauge left hand IV. These infusions, started at 0800 hours, were propofol, sufentanil, and phenylephrine. In addition, cell saver blood transfusions were administered through this same IV.

11. At around 1715 hours, Respondent took over the anesthetic, Dr. P told Respondent the blood pressure had been consistently low, requiring the vasopressor infusions, and that he was about to add a dopamine infusion. Respondent was concerned with four infusions being delivered through a small gauge peripheral IV, so he started a new 2nd IV, an 18-gauge IV in the right hand, at 1745 hours.

12. Respondent began a dopamine infusion at 2 – 3 micrograms/kg/min through the new 2nd IV. The hypotension remained resistant to the dopamine and phenylephrine. At around 1830 hours Respondent added a vasopressin IV infusion through the new 2nd IV to support the blood pressure. Over the next hours, Respondent noted that the arterial line tracing from the right radial artery was dampened, and that the right hand became dusky and swollen. Ultimately, Respondent wound up using the noninvasive blood pressure cuff to monitor the blood pressure.

13. At 1825 hours the chart reads "noted RUE ? infiltrated PIV," meaning right upper extremity ? infiltrated peripheral IV. It appeared that the dopamine and the vasopressin pressor infusions had extravasated into the soft tissues. Respondent called for help, and a third anesthesiologist came to his assistance. At or around 1846 hours the third anesthesiologist started a 3rd IV in the right antecubital fossa. After the surgery ended and Patient 9383 was turned

supine, Respondent inserted a central venous pressure (CVP) line, and Patient 9383 was transferred to the ICU. The estimated blood loss for the case was 1500 – 1800 ml.

14. Postoperatively, Patient 9383 was intubated overnight and extubated the next day. Vascular surgery was consulted regarding the dusky right hand. On the first post-op day, July 4, 2019, Patient 9383 was returned to the operating room and vascular surgeons performed a thrombectomy on the arterial supply to the right hand. The vascular surgery diagnosis was "IV infiltration with infiltration of vasopressor agents." The right hand had returned to normal function on discharge on or about July 11, 2019.

15. Respondent committed repeated negligent acts in that he failed to correctly place a peripheral IV. Respondent infused the powerful pressors dopamine and vasopressin into an incorrectly placed peripheral IV that was not inside the peripheral vein.

Patient 7481

16. On or about June 20, 2019, Patient 7481 was at the time, a 79-year-old male with severe aortic insufficiency (AI), dilated cardiomyopathy, pulmonary hypertension, congestive heart failure, a pacemaker, diabetes, cirrhosis, and asthma/COPD, for an aortic valve replacement (AVR), possible coronary artery bypass, and possible aortic root replacement surgery. His preoperative workup was also positive for a cardiac catheterization showing an ejection fraction of 30%, and an echo showing dilated left and right ventricles and moderate mitral regurgitation and tricuspid regurgitation. Patient 7481 was also prescribed and took Ativan 2 mg the night before his operation.

17. Respondent was the anesthesiologist. The anesthesia start time was 0643 hours. Patient 7481 was awake enough to move himself over from the gurney to the operating room table when he arrived in the operating room at 0643. His nasal oxygen cannula was removed and replaced by the oxygen mask from the anesthesia machine. Routine monitors were placed. IV sedation of fentanyl 25 micrograms and midazolam 1 mg was administered, and Respondent began attempts at a right radial arterial line.

18. At around 0715 hours, the pulse oximeter stopped working. Oxygen saturation of 100% was recorded on the anesthesia record until 0715 hours. Respondent asked the circulating

nurse to attempt to reposition the non-functioning pulse oximeter. Respondent requested the scrub tech to give a chin lift to improve the airway. Respondent realized there was no pulse in the radial artery, and he requested an ultrasound so he could locate the artery. He also began to assess the right brachial artery location for an arterial line.

19. The surgeon then entered the room and began to assist by helping Respondent place a brachial arterial line. Patient 7481 had a pacemaker, so the EKG still read electrical activity of paced beats. While the surgeon was attempting the arterial line, Respondent turned his attention to the Patient 7481's airway, and realized he was not breathing. He felt for a carotid pulse and could not detect a pulse. He administered naloxone (Narcan) and flumazenil reversal with no improvement. Patient 7481 developed ventricular fibrillation. A code was called and CPR was begun at 0739 hours. Patient 7481's blood pressure and respiratory rate was not recorded on the anesthesia record from 0643 until 0739 hours , when CPR was initiated.

20. Patient 7481 was shocked, with no improvement. Respondent intubated the Patient 7481's trachea. Patient 7481 was placed on emergency cardiopulmonary bypass, and his chest was opened. The surgery proceeded, and Patient 7481 was eventually taken to the ICU for an anesthesia stop time of 1343 hours. Postoperatively Patient 7481 had a hypoxic brain injury, and was declared dead on June 26, 2019.

21. Respondent committed repeated negligent acts in that he failed to vigilantly monitor Patient 7481's airway, breathing and circulation.

Patient 2148

22. On or about August 8, 2019, Patient 2148 was a 25-year-old female with a history of morbid obesity, obstructive sleep apnea, Graves disease, and asthma, who presented for a total thyroidectomy.

23. Respondent was the anesthesiologist. The anesthesia time was 0733 – 1059 hours. Respondent induced anesthesia with propofol, and paralyzed the patient with doses of 10 mg rocuronium/200 mg succinylcholine/40 mg rocuronium at approximately 0745 hours. He intubated the trachea using a Glidescope. The endotracheal tube was a NIM (neuro integrity monitor) tube. There was no neuromonitoring tech—the monitoring was done by the surgeon.

Maintenance anesthesia was sevoflurane 2 – 2.5% and fentanyl 350 micrograms. The initial paralysis would have worn off within about 45 minutes.

24. At around 0900 hours, Respondent administered another dose of rocuronium 30 mg because he was worried the patient could buck or move. The mid-surgery dose of the paralytic rendered the NIM monitor ineffective. Respondent failed to inform the surgeon that he administered rocuronium mid-surgery. The surgeon noted that when he stimulated the right recurrent laryngeal nerve, the NIM monitor did not work. For this reason, the surgeon decided to terminate the remainder of the surgery, and did not remove the left lobe of the thyroid.

25. At around 1030 hours, Respondent gave sugammadex 200 micrograms to reverse the paralysis prior to awakening the patient. Patient 2148 was discharged to home the same day.

26. In a subsequent case that day involving Patient 3355's parotidectomy, the surgeon learned that Respondent also administered rocuronium mid-surgery to prevent bucking which resulted in the NIM monitor being ineffective.

27. Respondent committed repeated negligent acts in that he administered rocuronium mid-surgery to "prevent bucking", blocking the efficacy of the neuromuscular monitoring. Respondent also failed to inform the surgeon that he administered a neuromuscular blocking drug while a neuromonitoring device was in place.

Patient 3355

28. On or about August 8, 2019, Patient 3355 was at the time, a 46-year-old female who presented for a left parotidectomy. Her past history was positive for a seizure disorder, with the last seizure occurring over one year in the past.

29. Respondent was the anesthesiologist. The anesthesia time was 1131 hours – 1500 hours. The anesthetic was propofol, sevoflurane, nitrous oxide, and 350 micrograms of fentanyl. Respondent administered rocuronium 50 mg at 1145 hours to intubate the trachea and once again in mid-case at 1250 hours. Respondent failed to inform the surgeon that he administered rocuronium mid-surgery.

30. The surgeon subsequently became aware that Respondent had administered rocuronium that re-paralyzed the patient and rendered neuro-stimulation monitoring ineffective. The surgeon asked that Respondent reverse the paralysis.

31. At around 1300 hours, Respondent administered sugammadex to reverse the paralysis. The surgeon asked if Respondent had re-paralyzed Patient 2148 with rocuronium mid-surgery during the total thyroidectomy, making the neuromonitoring ineffective. Respondent confirmed that had happened in both cases.

32. Patient 3355 was discharged on August 9, 2019 with left facial weakness, and was expected to make a full recovery.

33. Respondent committed repeated negligent acts in that he administered rocuronium mid-surgery blocking the efficacy of the neuromuscular monitoring. Respondent also failed to inform the surgeon that he administered a neuromuscular blocking drug while a neuromonitoring device was in place.

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 109920, issued to John Timothy Waring, M.D.;

2. Revoking, suspending or denying approval of John Timothy Waring, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering John Timothy Waring, 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: FEB 25 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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