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

In the Matter of the Accusation Against: Paul Michael Protter, M.D. Physician's and Surgeon's Certificate No. G 55632 Respondent.	Case No. 800-2021-076332

DECISION

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

This Decision shall become effective at 5:00 p.m. on August 3, 2022.

IT IS SO ORDERED July 27, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka,
Executive Director

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
CAROLYNE EVANS
Deputy Attorney General
State Bar No. 289206
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3448
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: **PAUL MICHAEL PROTTER, M.D.** **2318 Heather Ct.** **Mountain View, CA 94043-2805** **Physician's and Surgeon's Certificate No. G 55632** Respondent.	Case No. 800-2021-076332 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. 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 Carolyne Evans, Deputy Attorney General.

2. PAUL MICHAEL PROTTER, M.D. (Respondent) is represented in this proceeding by attorney Tom Still, whose address is: Hinshaw, Marsh, Still & Hinshaw, LLP, 12901 Saratoga Ave, Saratoga, CA 95070.

3. On August 5, 1985, the Board issued Physician's and Surgeon's Certificate No. G 55632 to 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. 800-2021-076332 and will expire on May 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-076332 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 June 2, 2022. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2021-076332 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2021-076332. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2021-076332, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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 those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

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

CONTINGENCY

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

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

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 55632, issued to Respondent PAUL MICHAEL PROTTER, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline

against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2021-076332 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $6705.50 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2021-076332 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 7/18/2022

PAUL MICHAEL PROTTER, M.D.
Respondent

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

DATED: July 19, 2022

TOM STILL
Attorney for Respondent

ENDORSEMENT

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

DATED: July 22, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

CAROLYNE EVANS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2021-076332

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
CAROLYNE EVANS
Deputy Attorney General
State Bar No. 289206
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3448
Facsimile: (415) 703-5480
Attorneys for Complainant

BEFORE THE
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STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Paul Michael Protter, M.D.** **2318 Heather Ct** **Mountain View, CA 94043-2805** **Physician's and Surgeon's Certificate No. G55632,** Respondent.	Case No. 800-2021-076332 **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 August 5, 1985, the Board issued Physician's and Surgeon's Certificate Number G55632 to Paul Michael Protter, 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 May 31, 2023, 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 provides that a licensee who is found guilty under the Medical Practice Act may have his 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:

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

6. Unprofessional conduct is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.[1]

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[1] *Shea v. Board of Medical Quality Assurance* (1978) 81 Cal.App.3d 564, 575.

7. The American Medical Association (AMA) Principles of Medical Ethics define basic principles of ethical conduct by physicians, and constitute standards of conduct that define the essentials of honorable behavior by physicians. The AMA Principles of Medical Ethics require a physician to uphold the standards of professionalism, be honest in all professional interactions, and regard responsibility to the patient as paramount.

COST RECOVERY

8. 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.

RESPONDENT'S PRACTICE

9. Respondent is board certified in pediatrics. During the relevant time period alleged in this Accusation, Respondent was working as a physician at Palo Alto Foundation Medical Group.

FACTUAL ALLEGATIONS

10. On or about February 5, 2021, Respondent volunteered at a Coronavirus (COVID-19)[2] vaccination clinic as an onsite physician to monitor anaphylaxis reactions to the COVID-19 vaccine. As a physician volunteer, Respondent was required to complete specific training regarding the safe administration of the COVID-19 vaccine prior to working at the vaccination site. All volunteers, including Respondent were required to follow COVID-19 training and guidance developed by the Centers for Disease Control (CDC). The CDC provides specific information and training materials describing the storage, handling, preparation, and administration of vaccines. At the end of the training, volunteers were supposed to attest and confirm that they had reviewed the reference materials and training modules provided by the CDC.

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[2] Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus.

11. At his Board interview, Respondent stated that he did not complete the required COVID-19 training for volunteers because he "found it very elementary" and because he considered himself to be an expert at administering vaccines based on his prior experience. If Respondent had completed the requisite training, he would have learned that the remaining vaccine in the vials had to be discarded, and that there were specific temperature requirements for the vaccine, and specific instructions for the thawing, storage, and preparation of the vaccine.

12. The CDC states that with respect to *thawing* COVID-19 vaccines: the unpunctured vials may be stored in the refrigerator between 2 degrees Celsius and 8 degrees Celsius (36 degrees Fahrenheit and 46 degrees Fahrenheit) for up to one month (31 days). Unpunctured vials cannot be kept at room temperature (up to 25 degrees Celsius or 77 degrees Fahrenheit) for more than two hours (including thaw time). The amount of time needed to thaw a vaccine varies based on the temperature and number of vials.

13. The CDC states that with respect to *preparing* the COVID -19 vaccine, a provider must use a new vial every time. The CDC requires that COVID-19 vaccines be prepared "using a new vial of diluent every time. Discard the diluent vial and remaining diluent after mixing the vaccine." Additionally, the CDC specifically requires the following steps for the preparation of the Pfizer-BioNtech COVID-19 vaccine: "inject 1.8 mL 0.9 percent sodium chloride (normal saline, perseverative-free) diluent into the vaccine vial. Using the mixing syringe, remove 1.8 mL of air from the vaccine vial to equalize pressure in the vaccine vial."

14. The CDC states that with respect to vaccine *administration* that the provider must: "with the vaccine at room temperature, gently invert vial ten (10) times. Do not shake the vial. If the vial is shaken, contact the manufacturer. The vaccine is white to off-white in color and may contain opaque particles. Do not use if liquid is discolored." Further, the CDC requires that the provider "Discard diluent vial and any remaining diluent every time. Do not use bacteriostatic normal saline or other diluents to mix the vaccine."

15. On or about February 5, 2021, Respondent took discarded vaccine vials from the vaccination clinic and pooled vaccine materials from the bottom of the discarded vials. Respondent stated in his Board interview that he inverted the vial, inserted a needle, and

withdrew "whatever contents [he] could ... and then put that into a vial that had some discarded vaccine in it, basically collecting it in one of the vials." Respondent explained that he may have used his own insulin syringes to pool the unused Pfizer COVID-19 vaccines from the vials.

16. When Respondent took the discarded vaccine vials, he did not know the specific temperature of the vials and did not know how long each vial had been at room temperature. Respondent stated that the vaccines were administered before 6 pm on February 5, 2021 from the vaccines that were thawed and mixed after 12:00 p.m. Respondent acknowledged in his Board interview that the exact time that each vial was punctured was never recorded. Respondent did not keep track of how long the vaccines were left at room temperature and he could not have known this information since the vaccines he pooled came from various vials.

Respondent did not know precisely how much COVID-19 vaccine he was able to pool from each discarded vial.

17. Respondent did not obtain authorization to pool the leftover COVID-19 vaccine from the discarded vials, and no one at the COVID vaccine site gave Respondent official permission to do so.

18. On or about February 5, 2021, Respondent drove to family member's residences with the pooled COVID-19 vaccine leftovers from multiple discarded vials. Each vial had varying amounts of vaccine left over. It is not known whether these vials were shaken during the travel from the vaccine site to the family member's residences.

Respondent administered the vaccines (that he prepared in a nonstandard manner) to four family members. Respondent took another syringe (possibly his own unused diabetic syringe) to pull the discarded vaccines from the vials and mix them to obtain enough to constitute a dose for administration. Respondent did not have emergency equipment (except for an EPI pen) or personnel to assist him in an emergency, such as a family member suffering an adverse reaction to the then newly released COVID-19 vaccine. Respondent did not state whether or not he followed proper donning and offing of personal protective equipment and used the appropriate precautions when administering the vaccines to his family members.

19. Respondent did not have any scientific data or specific permission to support the safety or efficacy of pooling discarded COVID vaccine and administering it to other people offsite from the vaccine clinic.

20. Respondent explained at his Board interview that only Sutter patients were allowed to receive the vaccine at the Sutter-sponsored COVID-19 vaccination clinic. Eligible patients had to sign up for the clinic, get in line, and show up at a set appointment time. Respondent also stated that at the time of his actions, "every drop" of the COVID-19 vaccine was supposed to be administered to people over 75 years of age and healthcare workers.

21. Respondent did not document the vaccine dose or type of COVID-19 vaccine that he administered to the four individuals. Respondent did not register the four individuals with the CDC as required by the vaccine program provider and he did not provide them with a CDC COVID-19 vaccination record card.

CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts and/or Ethical Violations).

22. Respondent's overall conduct, acts and/or omissions as set forth in paragraphs 9 through 21 herein, constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or ethical violations, pursuant to Code sections 2234 subdivisions (b) and/or (c) and/or the AMA Principles of Medical Ethics and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct as follows:

a. Respondent did not follow the appropriate COVID-19 vaccination administration protocols that are related to the storage, handling, preparation, and administration of vaccines. Respondent refused to undertake the mandatory training that would have educated him about the safe administration of the vaccine. Respondent collected COVID-19 vaccine from multiple discarded vials and used his own method to draw the vaccine out of the vials (possibly with his own unused insulin syringes). Respondent did not know the temperature of the vaccine and he did not know exactly much vaccine he had collected from each discarded vial.

b. Respondent administered discarded COVID-19 vaccines to four family members who were not part of the COVID-19 distribution tier and did not meet the eligibility rules. Respondent used his position as a physician to obtain the discarded COVID-19 vaccine and allowed his family members to receive the vaccine before they were qualified to receive the COVID-19 vaccines.

c. Respondent did not have specific authorization to pool the COVID-19 vaccine. Respondent did not have any valid scientific data or specific permission to support the safety and efficacy of pooling discarded COVID-19 vaccines and administering it to people at their personal residences.

d. Respondent administered the COVID-19 leftovers to his family members at their personal residences without being adequately prepared to handle a situation where one of his family members could have suffered a serious adverse reaction to the COVID-19 vaccine.

e. Respondent failed to provide his family members with COVID-19 vaccination cards. Respondent did not register the individuals with the CDC as required by the vaccine program provider. Respondent did not document the vaccine dose or type of COVID-19 vaccine that he administered to the four individuals.

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 G55632, issued to Paul Michael Protter, M.D.;

2. Revoking, suspending or denying approval of Paul Michael Protter, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Paul Michael Protter, 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; and

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

DATED: JUN 0 2 2022

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

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