1 XAVIER BECERRA Attorney General of California 2 ANTOINETTE B. CINCOTTA Supervising Deputy Attorney General 3 ALAN MACINA Deputy Attorney General 4 State Bar No. 233540 600 West Broadway, Suite 1800 5 San Diego, CA 92101 P.O. Box 85266 6 San Diego, CA 92186-5266 Telephone: (619) 738-9083 7 Facsimile: (619) 645-2061 Attorneys for Complainant 8 9 BEFORE THE DENTAL BOARD OF CALIFORNIA 10 DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA 11 DBC 2018 -18 12 In the Matter of the Accusation Against: Case No. 13 RYAN P. WATKINS ACCUSATION 3039 Jefferson Street, Suite A 14 Carlsbad, CA 92008 15 Dental License No. 52130 General Anesthesia Permit No. 1328 16 Fictitious Name Permit No. 9242 17 Respondent. 18 19 Complainant alleges: 20 **PARTIES** 21 1. Karen M. Fischer (Complainant) brings this Accusation solely in her official capacity 22 as the Executive Officer of the Dental Board of California (Board), Department of Consumer 23 Affairs. 24 2. On or about January 8, 2004, the Board issued Dental License Number 52130 to Ryan 25 P. Watkins (Respondent). The Dental License was in full force and effect at all times relevant to 26 the charges brought herein and will expire on March 31, 2019, unless renewed. 27 3. On or about May 16, 2005, the Dental Board of California issued General Anesthesia 28 Permit Number 1328 to Ryan P. Watkins (Respondent). The General Anesthesia Permit was in

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and electrolytes in those who have low blood volume or low blood pressure.

COST RECOVERY

14. Code section 125.3 provides that the Board may request the administrative law judge to direct a licentiate 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 licentiate 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.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Excessive Administration or Treatment)

- 15. Respondent is subject to disciplinary action under Code section 1680, subdivision (p), in that Respondent clearly excessively administered drugs or treatment. The circumstances are as follows:
- 16. Patient MK ["MK"] had utilized Respondent's dental services approximately three times before he was to have dental surgery on or about October 21, 2016 at Respondent's Carlsbad, California office. By the time he did the pre-surgery evaluation at Respondent's office on or about September 22, 2016, Respondent knew that then 54 year-old MK was a triathlete and considered him to be in excellent health. MK said that he had a very low resting heart rate.
- MK experienced dental phobia and had a history of fainting. In turn, MK sought Respondent's care because Respondent offered surgical dental care while MK would be anesthetized. Respondent did not investigate or document the frequency of MK's fainting. But due to MK's fainting and phobia, Respondent designated MK's pre-surgery fitness as ASA-2¹,

¹ The ASA physical status classification system is a system for assessing the fitness of patients before surgery. In 1963 the American Society of Anesthesiologists (ASA) adopted the five-category physical status classification system; a sixth category was later added. These are:

^{1.} Healthy person;

^{2.} Mild systemic disease;

^{3.} Severe systemic disease;

Severe systemic disease that is a constant threat to life;

A moribund person who is not expected to survive without the operation;

A declared brain-dead person whose organs are being removed for donor purposes.

indicated his physical status put him at a mild risk (that is, at a risk mildly more than that of an otherwise healthy person) when undergoing surgery.

- 18. At 8:35 am on the day of the surgery, October 21, 2016, MK arrived at Respondent's office. Respondent placed vital sign monitors that reported MK's heart rate to be 88 bpm and his blood pressure as 135/88. Respondent found MK's vital signs appropriate for administering general anesthesia. Respondent administered intravenous anesthesia to MK that included Propofol IV, Midazolam, Fentanyl, Glycopyrrolate, and Dexamethasone.
- 19. At 8:45 am, another dentist began surgery on MK while Respondent attended to MK while under anesthesia. At 8:48 am, and over the ensuing minutes, MK's vital signs declined. His blood pressure dropped to as low as 60/30, and his heart rate fell to 48 bpm.
- 20. At 8:58 am, Respondent gave MK an intravenous 25-mg dose of undiluted ephedrine along with 250 ml of lactated Ringer's fluid. By 9:01 am, MK's blood pressure had increased to 205/155 and his heart rate had risen to 147 bpm, which Respondent reported as "rapid narrow complex tachycardia (SVT)" (supraventricular tachycardia). Respondent then performed a vagal or Valsalva maneuver by closing the anesthesia breathing circuit and pressing the breathing bag, but Respondent's heart rate continued to rise.
- 21. At 9:06 am, Respondent administered 6 mg of intravenous adenosine. MK's heart then stopped and Respondent initiated CPR. The other dentist delivered ventilations. They applied an automated external defibrillator (AED) to shock Respondent's heart and continued chest compressions. At 9:08 am, staff summoned emergency medical services (EMS).
- 22. At 9:15 am, EMS arrived and took MK to the hospital. MK was initially unresponsive during transport but by his arrival at the hospital was able to respond non-verbally by opening his eyes in response to voice. Staff checked MK's vital signs twice during the trip and the final figures reflected normal values.
- 23. Hospital staff did not find evidence of cardiac ischemia (restriction in blood supply to the heart), but MK's ribs were fractured from the chest compressions. Subsequent evaluations revealed that MK's heart was of a normal size and function and had an excellent exercise capacity. His resting bradycardia (very slow heart rate) did not represent any abnormality. A

doctor concluded that the administration of ephedrine likely caused MK's tachycardia (increased heart rate above 100 bpm) that would have subsided and that the use of adenosine was unnecessary and caused MK's heart to stop (asystole). His discharge, two days after admission, listed his admission to be for cardiac arrest and his discharge diagnosis of "poisoning by other drug primarily affecting the autonomic nervous system, accidental (unintentional), initial encounter."

24. About six months later, in March 2017, neurologic reports found that MK continued to experience disequilibrium, lightheadedness, anxiety, and forgetfulness. A neuropsychologist concluded in November 2017 that MK continued to suffer from a "mild neurocognitive disorder" caused by cardiac arrest with "adjustment disorder with mixed anxiety and depressed mood," consistent with others who had experienced out-of-hospital cardiac arrest.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Violation of Law related to Dangerous Drugs)

25. Respondent is subject to disciplinary action under section Code section 1680, subdivision (m), in that Respondent violated provision(s) of law regulating the administration of dangerous drugs or controlled substances, as is described in paragraphs 21 through 29 above, which are incorporated by reference and re-alleged as if fully set forth here.

PRAYER

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

- 1. Revoking or suspending Dental License Number 52130 issued to Ryan P. Watkins;
- 2. Revoking or suspending General Anesthesia Permit Number 1328 issued to Ryan P. Watkins;
- 3. Revoking or suspending Fictitious Name Permit Number 9242 issued to Ryan P. Watkins;
- 4. Ordering Ryan P. Watkins to pay the Dental Board of California the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and

1	5. Taking such other and further	er action as deemed necessary and proper.
2	DATED:	KAREN M. FISCHER
4		Executive Officer
5		Dental Board of California Department of Consumer Affairs State of California
6		Complainant
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