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**SACRAMENTO
DBC ENFORCEMENT**

8 **BEFORE THE**
9 **DENTAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. **DBC 2015 -68**

13 **MICHAEL JOHN DOUCET**
14 **410 San Pablo Avenue**
15 **Albany, CA 94706**

A C C U S A T I O N

16 **Dental License No. DDS 35099**
17 **General Anesthesia Permit No. 798**
18 **Fictitious Name Permit No. 9052**

Respondent.

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, Department of Consumer Affairs.

23 2. On or about October 16, 1986, the Dental Board of California issued Dental License
24 Number DDS 35099 to Michael John Doucet (Respondent). The Dental License was in full force
25 and effect at all times relevant to the charges brought herein and will expire on September 30,
26 2017, unless renewed.

27 3. On or about June 24, 1987, the Dental Board of California issued General Anesthesia
28 Permit Number 798 to Michael John Doucet (Respondent). The General Anesthesia Permit was
in full force and effect at all times relevant to the charges brought herein and will expire on
September 30, 2017, unless renewed.

1 **FACTUAL SUMMARY**

2 9. On or about March 13, 2015, Respondent attempted to perform dental procedures on
3 patient C.S., a six-year-old child.¹ Respondent administered anesthesia to patient C.S. Patient
4 C.S. then stopped breathing and went into cardiac arrest. Patient C.S. suffered hypoxia and,
5 subsequently, died. Respondent's response and actions during this emergency incident were
6 inadequate and constituted incompetence, gross negligence and repeated acts of negligence.

7 Respondent's inadequate response and actions included, but were not limited to:

- 8 a. Respondent failed to utilize EKG monitoring during the incident.
- 9 b. Respondent failed to establish a supraglottic airway for patient C.S.
- 10 c. Respondent proceeded directly to an attempted intubation of patient C.S. rather than
11 attempt to preoxygenate patient C.S. with a non-invasive technique.
- 12 d. Respondent improperly proceeded to attempting to intubate patient C.S. without first
13 administering succinylcholine.
- 14 e. Instead of establishing a supraglottic airway, Respondent established, but failed to
15 utilize, an invasive emergency airway by cricothyrotomy needle.
- 16 f. Respondent failed to utilize advanced cardiac life support protocols including, but not
17 limited to, monitoring of pulse and EKG patterns and BLS chest compressions.
- 18 g. Respondent failed to apply and utilize an AED device to attempt to revive patient C.S.
- 19 h. Respondent and his staff failed to utilize an effective team approach to the emergency
20 situation and failed to have an established protocol in place for this type of situation.

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22 **FIRST CAUSE FOR DISCIPLINE**

23 (Negligence/Incompetence)

24 10. Respondent is subject to disciplinary action under section 1670 of the Code in that he
25 acted with incompetence, gross negligence and repeated acts of negligence, as set forth above in
26 paragraph 9 and its subparts.

27 _____
28 ¹ Patient C.S.'s name is withheld to protect the patient's privacy.

