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

In the Matter of the Accusation and Petition to Revoke Probation Against: **WILLIAM KENNETH EBERT, M.D.** **2025 Soquel Avenue** **Santa Cruz, CA 95062** **Physician's and Surgeon's Certificate No. G 77739** Rspondent.	Case No. 800-2021-078335 **DEFAULT DECISION AND ORDER** [Gov. Code §11520]

FINDINGS OF FACT

1. On June 17, 2021, an employee of the Medical Board of California (Board), served by Certified and First Class Mail a copy of the Accusation and Petition to Revoke Probation (Accusation and Petition) No. 800-2021-078335, Statement to Respondent, Notice of Defense in blank, copies of the relevant sections of the California Administrative Procedure Act as required by sections 11503 and 11505 of the Government Code, and a request for discovery to William Kenneth Ebert, M.D. (Respondent) 's address of record with the Board, which was and is 2025

Soquel Avenue, Santa Cruz, CA 95062. (Exhibit Package, Exhibit 1[1]: Accusation and Petition to Revoke Probation package, Declaration of Service, U.S. Postal Service track and confirm results.)

2. There was no response to the Accusation and Petition. On July 7, 2021, an employee of the Attorney General's Office sent by certified mail, addressed to Respondent at his address of record, a courtesy Notice of Default, advising Respondent of the Accusation and Petition, and providing him with an opportunity to file a Notice of Defense and request relief from default. The certified mail was delivered to Respondent's address of record. On July 16, 2021, Deputy Attorney General Lynne K. Dombrowski received an email from Tascha.Haut informing her that the clinic which was Respondent's address of record had received the certified mail package; however, Respondent had not worked as a physician at the address of record since June 6, 2018, and the clinic did not have a forwarding address. (Exhibit Package, Exhibit 2: Courtesy Notice of Default, Declaration of Service, certified mail return receipt card, Declaration of Tascha Haut.)

Respondent has not responded to service of the Accusation and Petition or the Notice of Default. He has not filed a Notice of Defense. As a result, Respondent has waived his right to a hearing on the merits to contest the allegations contained in the Accusation and Petition.

FINDINGS OF FACT

I.

3. William Prasifka is the Executive Director of the Board. The charges and allegations in the Accusation were at all times brought and made solely in the official capacity of the Board's Executive Director.

II

4. On October 14, 1993, the Board issued Physician's and Surgeon's Certificate No. G 77739 to Respondent. On March 16, 2016, Accusation 03-2013-230884 was filed against Respondent. On March 3, 2017, a Decision became effective in which Respondent's license was

[1] The evidence in support of this Default Decision and Order is submitted herewith as the "Exhibit Package."

revoked, revocation stayed and the license was placed on three years probation with terms and conditions. The Physician's and Surgeon's Certificate expired on March 31, 2019, and has not been renewed. (Exhibit Package, Exhibit 3: Certificate of License.)

III

5. On June 17, 2021, Respondent was duly served with an Accusation and Petition, alleging causes for discipline against Respondent. A courtesy Notice of Default was thereafter served on Respondent. Respondent failed to file a Notice of Defense.

IV.

The allegations of the Accusation and Petition are true as follows:

Patient A

6. Patient A, a female born in July 1988, first saw Respondent on or about October 1, 2015. Patient A reported a car accident five years previously in which she suffered a severe whiplash injury and a chronic history of head and neck pain. Patient A reported an initial MRI study, physical therapy, and pain management with Norco. Patient A complained of a burning discomfort in the back of her neck and upper shoulders. She reported taking gabapentin 600 mg 3 times daily, nortriptyline 10 mg. at bedtime, and getting moderate relief with oxycodone 30 mg. every 4 hours (as needed). There is no documentation that Respondent made attempts to obtain Patient A's prior treatment records. Respondent prescribed #200 oxycodone Hcl 30 mg. without documenting an appropriate examination and a medical indication.

7. On or about November 3, 2015, Respondent's records for Patient A contain a signed pain management agreement but it is unclear whether the patient was seen on that date.

8. For more than two years, from November 3, 2015 through February 21, 2018, Respondent documented visits with Patient A occurring about every three months, for a total of nine office visits. Respondent continued to prescribe to Patient A, on an approximate monthly basis, #200 oxycodone Hcl 30 mg., which is a very high morphine equivalent dose (MED) of about 270.

9. According to the California Department of Justice's Prescription Drug Monitoring Program, Controlled Substance Utilization Review and Evaluation System (CURES) database,

Respondent prescribed to Patient A #200 oxycodone Hcl 30 mg. on an approximate monthly basis from October 2, 2015 through about May 30, 2018, with no prescription filled between January 14, 2017 and August 17, 2017.

10. Respondent's notes on a pain management flowsheet dated August 18, 2017 indicate that a urine drug screen was performed on July 11, 2017. There, however, is no corresponding note, order, or lab results for a urine drug screen in the patient's chart.

11. Respondent's last documented visit with Patient A that was in the records produced to the Board is dated February 21, 2018.

12. Lawrence Dardick, M.D., the Board's expert witness, reviewed the records regarding Patient A and made the following findings (Exhibit Package, Exhibit 4: Lawrence Dardick, M.D. Declaration):

a. Respondent's documentation of Patient A's medical history and physical examination failed to include an appropriate assessment of the patient's pain, including physical and psychological status and function, substance abuse history, history of prior pain treatment and assessment of any other underlying or coexisting conditions, and documentation of recognized medical indications for the use of controlled substances, especially the use of opiates for pain control. Respondent did not attempt to obtain the patient's previous medical records.

b. During the course of his treatment of Patient A, Respondent failed to document an appropriate treatment plan and objectives and periodic review of his treatments. More specifically, Respondent: did not further evaluate the patient's underlying conditions; did not document a review of the patient's progress, or lack of progress with the treatments; did not attempt to taper medications; did not seek pain management or addiction medicine consultations; and, did not order periodic blood tests to screen for end-organ damage.

c. Respondent failed to document a discussion with Patient A regarding the risks associated with his chronic prescribing of controlled substances, particularly with a very high MED.

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Patient B

13. Patient B, a male born in August 1988, first saw Respondent on or about October 15, 2016. Respondent noted that the patient was seen for lingering right radicular pain and moderate low back pain from an injury three months prior. Respondent also noted that prior records were requested, but there is no evidence in Respondent's records that Patient B's prior records were actually requested, received, or reviewed. Respondent prescribed #200 oxycodone Hcl 30 mg. without documenting an appropriate examination and a medical indication.

14. From October 15, 2016 through February 9, 2018, Respondent documented visits with Patient B occurring about every two months, for a total of seven office visits. Respondent continued to prescribe to Patient B, on an approximate monthly basis, #200 oxycodone Hcl 30 mg., which is a very high morphine equivalent dose (MED) of about 270.

15. On or about November 4, 2016, Respondent signed a pain management agreement that is in the patient's chart but it is unclear whether he saw the patient on that date.

16. On or about February 6, 2016, although Respondent noted that Patient B had decreased his oxycodone to 4-5 pills daily, Respondent did not decrease the amount of oxycodone prescribed and continued to issue a prescription for #200 oxycodone.

17. Respondent's last documented visit with Patient B that was in the records produced to the Board is dated February 9, 2018. Respondent documented that the patient had not tapered medication and that he might need a referral to physical therapy, acupuncture, or pain management. There is no evidence in the records that any referrals or consultations were made. There are also no records of lab tests, urine drug screens, or of any imaging studies for Patient B.

18. According to the CURES database, Respondent prescribed to Patient B #200 oxycodone Hcl 30 mg. on an approximate monthly basis from October 7, 2016 (before the first documented visit) through about March 14, 2018 and then prescribed #180 oxycodone Hcl 30 mg. in April and in May of 2018.

19. Expert witness Lawrence Dardick, M.D., made the following findings re Patient B in his report (Exhibit Package, Exhibit 4):

a. Respondent's documentation of the patient's medical history and physical examination failed to include an appropriate assessment of the patient's pain, including physical and psychological status and function, substance abuse history, history of prior pain treatment and assessment of any other underlying or coexisting conditions, and documentation of recognized medical indications for the use of controlled substances, esp. the use of opiates for pain control. Respondent did not attempt to obtain the patient's previous medical records.

b. During the course of his treatment of Patient B, Respondent failed to document an appropriate treatment plan and objectives and periodic review of his treatments. More specifically, Respondent: did not further evaluate the patient's underlying conditions; did not attempt to taper medications; did not seek pain management or addiction medicine consultations; and, did not order periodic blood tests to screen for end-organ damage.

c. Respondent failed to document a discussion with Patient B regarding the risks associated with his chronic prescribing of controlled substances, particularly with a very high MED.

d. Respondent continued to prescribe controlled substances at each visit without documenting appropriate periodic review and evaluation of the effectiveness of the treatment. There is no documented indication that Respondent seriously considered alternate treatment, tapering of medications, or obtaining a consultation regarding Patient B.

Patient C

20. Patient C, a male born in March 1986, first saw Respondent on or about October 15, 2015. Respondent noted that the patient reported that, two years prior, he had dropped some concrete and fractured his right foot. The patient continued to have pain and reported that he had tried pain relief with gabapentin and Norco but they did not work. It was noted that Patient C reported using oxycodone up to 6 per day but stated that he sometimes needed more. Respondent documented an order for a urine drug screen but, according to the records, the lab order expired without a collection/submission of the patient's urine and without any follow-up by Respondent. Respondent noted in the records that Patient C was to return in one month to review records and to sign a pain contract. There is no evidence that prior treatment records were ever obtained or

reviewed. According to the CURES database, Patient C filled a prescription from Respondent for #195 oxycodone Hcl on October 14, 2015, which was one day prior to the first documented visit. There is no documentation that Respondent performed an appropriate prior examination and had a medical indication for issuing the prescription.

21. From November 16, 2015 through February 9, 2018, Respondent documented visits with Patient C occurring about every two to four months. Respondent continued to prescribe to Patient C, on an approximate monthly basis, #200 oxycodone Hcl 30 mg., which is a very high morphine equivalent dose (MED) of about 270.

22. Although there is a reference in the records to a pain agreement being signed on December 17, 2015, there is no copy of such an agreement in the medical records for Patient C.

23. Respondent's last documented visit with Patient C in the records produced to the Board is dated February 9, 2018. Respondent noted in the chart that Patient C had not tapered medication and that he might need a referral to physical therapy, acupuncture, or pain management. There is no evidence in the records that Respondent decreased the quantity or dosing of his prescription for oxycodone and/or that any referrals or consultations were made by Respondent. There are also no records of lab tests, urine drug screes, or of any imaging studies for Patient C that were ordered by Respondent.

24. According to the CURES database, Respondent issued to Patient C monthly prescriptions for #200 oxycodone that were filled for a period of about two and a half years, from November 16, 2015 through May 25, 2018.

25. Expert witness Lawrence Dardick, M.D., made the following findings re Patient C in his report (Exhibit Package, Exhibit 4):

a. Respondent's documentation of Patient C's medical history and physical examination failed to include an appropriate assessment of the patient's pain, including physical and psychological status and function, substance abuse history, history of prior pain treatment and assessment of any other underlying or coexisting conditions, and documentation of recognized medical indications for the use of controlled substances, esp. the use of opiates for pain control. Respondent did not attempt to obtain the patient's previous medical records.

b. During the course of his treatment of Patient C, Respondent failed to document an appropriate treatment plan and objectives and periodic review of his treatments. More specifically, Respondent: did not further evaluate the patient's underlying conditions; did not attempt to taper medications; did not seek pain management or addiction medicine consultations; and, did not order periodic blood tests to screen for end-organ damage.

c. Respondent failed to document a discussion with Patient C regarding the risks associated with his chronic prescribing of controlled substances, particularly with a high MED. Although there is a pain management agreement in the records, it was not signed by the patient.

d. Respondent continued to prescribe controlled substances at each visit without documenting appropriate periodic review and evaluation of the effectiveness of the treatment. There is no documented indication that Respondent seriously considered alternate treatment, tapering of medications, or obtaining a consultation regarding this patient.

e. Respondent did not attempt to refer Patient C for pain management or addiction consultation when the patient presented with complex pain problems.

FIRST CAUSE TO REVOKE PROBATION

(Non-practice in excess of two years during probation)

26. At all times after March 3, 2017, the effective date of the Board's Decision, Probation Condition No. 13 "Non-Practice While On Probation" stated:

> "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 in California 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.** All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state of 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 a clinical training 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 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 probations: Obey All Laws; and General Probation Requirements." (Emphasis added.)

27. Respondent's period of non-practice in California exceeded two years as of May 25, 2020. The facts and circumstances regarding this violation of Probation Condition No. 13 are as follows:

a. Respondent reported to the Board's Probation Unit that his last day of practice was May 25, 2018, that he retired and would no longer practice medicine in California. (Exhibit Package, Exhibit 5: Quarterly Declaration dated October 1, 2018.)

b. On April 17, 2019, the Board's Probation Unit sent Respondent via electronic mail two letters that had been sent to him and to which he had not responded. The letters were dated March 05, 2019 and March 12, 2019. In both letters, Respondent was informed that his probation is in non-practice status, that his license had expired and had not been renewed, that payment was overdue on 2018 probation costs, and that he had not submitted two quarterly declarations, for October – December 2018 and for January – March 2019. No communications or response were received from Respondent. (Exhibit Package, Exhibit 6: Declaration of Christina Valencia, Medical Board of California.)

c. On April 15, 2020, the Board's Probation Unit sent a letter to Respondent at his address of record and advised him of the following probation violations: (1) failing to be in

contact with the Board's probation monitor and not responding to the Board's correspondence and communications; (2) letting his license expire without renewal; (3) failing to submit quarterly declarations after October 4, 2018; (4) not paying the outstanding probations costs for the year 2018 ($1874). The letter also advised Respondent that his period of non-practice would exceed two years on May 25, 2020, in violation of Probation Condition No. 13 and that the Board would seek further disciplinary action. Respondent was asked to contact the Board's probation monitor by April 25, 2020, which he never did. (Exhibit Package, Exhibit 6: Declaration of Christina Valencia, Medical Board of California.)

28. Respondent's period of non-practice while on probation exceeded two years on May 25, 2020 and Respondent continues to be in non-practice. Respondent, therefore, is in violation of the terms of Probation Condition No. 13 and cause exists for carrying out the disciplinary Decision and Order which provides for a revocation of the probation and the license for failure to fully comply with any term or condition of probation, after giving Respondent notice and the opportunity to be heard.

SECOND CAUSE TO REVOKE PROBATION

(Failure to Maintain a Current Address of Record and Failure to Respond to Board Communications)

29. At all times after March 3, 2017, the effective date of the Board's Decision, Probation Condition No. 11 "General Probation Requirements" stated, in pertinent part:

"Compliance with Probation Unit. Respondent shall comply with the Board's probation unit and all terms and conditions of the Decision."

"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(b)."

"License Renewal. Respondent shall maintain a current and renewed California Physician's and Surgeon's license."

30. The Board's Probation Unit has made numerous attempts to contact Respondent by sending correspondence to his address of record and his home address 3685 Bascom Avenue, Apartment 18, Campbell, California 95008 which he provided, and also by sending e-mail messages. Respondent has been out of contact with the Board for over two years.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent WILLIAM KENNETH EBERT, M.D. has subjected his Physician's and Surgeon's Certificate No. G 77739 to discipline.

ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. G 77739, heretofore issued to Respondent WILLIAM KENNETH EBERT, M.D., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on OCT 27 2021.

It is so ORDERED SEP 27 2021

WILLIAM PRASIFKA
EXECUTIVE DIRECTOR
FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **William Kenneth Ebert, M.D.** **2025 Soquel Avenue** **Santa Cruz, CA 95062** **Physician's and Surgeon's Certificate No. G 77739,** Respondent.	Case No. 800-2021-078335 **ACCUSATION AND PETITION TO REVOKE PROBATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation and Petition to Revoke Probation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 14, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number G 77739 to William Kenneth Ebert, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on March 31, 2019, and is in delinquent status because it has not been renewed.

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LICENSE RESTRICTION (PROBATION)/DISCIPLINARY CONSIDERATIONS

3. On February 2, 2017, in a prior disciplinary action before the Medical Board of California, titled *In the Matter of the Accusation Against William Kenneth Ebert, M.D.*, Case Number 03-2013-230884, Respondent's license was disciplined for allegations regarding three patients and issues of excessive prescribing of opioids and inadequate medical records. Respondent's license was revoked but the revocation was stayed and his license was placed on three years of probation with special terms and conditions. The Board's Decision and Order became effective on March 3, 2017, and currently remains in effect. A true and correct copy of the Decision and Order is attached as Exhibit A and is incorporated by reference, as if fully set forth.

4. On or about June 19, 2018, while Respondent's license probation was in effect but in tolled status because of non-practice, the Board received from Palo Alto Foundation Medical Group ("PAFMG") a Health Facility/Peer Review Reporting Form, as required by Section 805 of the California Business and Professions Code ("805 Report"). The 805 Report stated that, as of June 6, 2018, Respondent's "Shareholder Employment Agreement" was terminated for cause "due to his broad-based failure to follow the requirements in his Performance Improvement Plan ("PIP"), dated February 23, 2018." It was further reported that Respondent was notified that "he was not authorized to write any further prescriptions that, in any way, suggest he is affiliated with PAMF/PAFMG."

5. The 805 Report from PAFMG listed the following deficiencies and violations of the Performance Improvement Plan that were cause for termination of Respondent's employment:

a. No urine toxicology screens;

b. Improper documentation of Medication Safety Agreements;

c. Inadequate documentation of CURES;

d. Lack of thoroughness of evaluation, inappropriateness of care, lack of medical judgment and incompleteness of notes, incomplete documentation of conversation with the patient, and lack of documentation of compliance with laws, guidelines, and PIP requirements;

e. Lack of documentation of morphine-equivalent dose (MED) for every visit;

f. Lack of consistent pain referral with documentation;

g. Prescribing medications for patients with no work-up for their pain; and,

h. Buprenorphine found in his office, which constituted a violation of numerous policies of PAFMG and the Palo Alto Medical Foundation.

6. The Board opened and conducted an investigation into Respondent's conduct after receiving the 805 Report and obtained redacted patient records.

JURISDICTION

7. This Accusation and Petition to Revoke Probation 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.

8. Section 118 of the Code states, in pertinent part:

> "(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.
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> (c) As used in this section, "board" includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and "license" includes "certificate," "registration," and "permit."

9. Section 725 of the Code states:

> (a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.
>
> (b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.
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> (c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

10. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

11. 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.

12. Section 2228 of the Code, states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

13. 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.

14. Section 2242 of the Code states, in pertinent part:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care."

15. Section 2261 of the Code states:

Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

16. Section 2266 of the Code states that 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.

DESCRIPTION OF PERTINENT CONTROLLED SUBSTANCES

17. Oxycodone hydrochloride, known by the trade name OxyContin for its extended-release version, is a pure opioid agonist whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022.

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ACCUSATION

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient A[1]: Gross Negligence, Repeated Negligent Acts, Prescribing Without Appropriate Examination and Medical Indication, Excessive Prescribing)

18. Respondent William Kenneth Ebert, M.D. is subject to disciplinary action for unprofessional conduct under Business and Professions Code sections 2234, subdivision (b) and/or subdivision (c), and/ or section 2242 and/or section 725 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient A constitutes gross negligence and/or repeated negligent acts and/or prescribing without an appropriate prior examination and medical indication and/or excessive prescribing, as more fully described herein below.

19. Patient A, a female born in July 1988, first saw Respondent on or about October 1, 2015. Patient A reported a car accident five years previously in which she suffered a severe whiplash injury and a chronic history of head and neck pain. Patient A reported an initial MRI study, physical therapy, and pain management with Norco. Patient A complained of a burning discomfort in the back of her neck and upper shoulders. She reported taking gabapentin 600 mg 3 times daily, nortriptyline 10 mg. at bedtime, and getting moderate relief with oxycodone 30 mg. every 4 hours (as needed). There is no documentation that Respondent made attempts to obtain Patient A's prior treatment records. Respondent prescribed #200 oxycodone Hcl 30 mg. without documenting an appropriate examination and a medical indication.

20. On or about November 3, 2015, Respondent's records for Patient A contain a signed pain management agreement but it is unclear whether the patient was seen on that date.

21. For more than two years, from November 3, 2015 through February 21, 2018, Respondent documented visits with Patient A occurring about every three months, for a total of nine office visits. Respondent continued to prescribe to Patient A, on an approximate monthly

[1] To protect the patients' privacy rights, they will be identified by letters in this pleading. Respondent will be provided the patients' names through the discovery process.

basis, #200 oxycodone Hcl 30 mg., which is a very high morphine equivalent dose (MED) of about 270.

22. According to the California Department of Justice's Prescription Drug Monitoring Program, Controlled Substance Utilization Review and Evaluation System (CURES) database, Respondent prescribed to Patient A #200 oxycodone Hcl 30 mg. on an approximate monthly basis from October 2, 2015 through about May 30, 2018, with no prescription filled between January 14, 2017 and August 17, 2017.

23. Respondent's notes on a pain management flowsheet dated August 18, 2017 indicate that a urine drug screen was performed on July 11, 2017. There, however, is no corresponding note, order, or lab results for a urine drug screen in the patient's chart.

24. Respondent's last documented visit with Patient A that was in the records produced to the Board is dated February 21, 2018.

25. In summary, Respondent's overall conduct, through his acts and omissions, regarding Patient A, as set forth in Paragraphs 18 through 24 herein, constitutes unprofessional conduct under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication] and/or section 725 [excessive prescribing] and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient A as follows:

a. Respondent's documentation of Patient A's medical history and physical examination failed to include an appropriate assessment of the patient's pain, including physical and psychological status and function, substance abuse history, history of prior pain treatment and assessment of any other underlying or coexisting conditions, and documentation of recognized medical indications for the use of controlled substances, esp. the use of opiates for pain control. Respondent did not attempt to obtain the patient's previous medical records.

b. During the course of his treatment of Patient A, Respondent failed to document an appropriate treatment plan and objectives and periodic review of his treatments. More specifically, Respondent: did not further evaluate the patient's underlying conditions; did not

document a review of the patient's progress, or lack of progress with the treatments; did not attempt to taper medications; did not seek pain management or addiction medicine consultations; and, did not order periodic blood tests to screen for end-organ damage.

c. Respondent failed to document a discussion with Patient A regarding the risks associated with his chronic prescribing of controlled substances, particularly with a very high MED.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient B: Gross Negligence, Repeated Negligent Acts, Prescribing without Appropriate Examination and Medical Indication, Excessive Prescribing)

26. Respondent William Kenneth Ebert, M.D. is subject to disciplinary action for unprofessional conduct under Business and Professions Code sections 2234, subdivision (b) and/or subdivision (c), and/ or section 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient B constitutes gross negligence and/or repeated negligent acts and/or prescribing without an appropriate prior examination and medical indication and/or excessive prescribing, as more fully described herein below.

27. Patient B, a male born in August 1988, first saw Respondent on or about October 15, 2016. Respondent noted that the patient was seen for lingering right radicular pain and moderate low back pain from an injury three months prior. Respondent also noted that prior records were requested, but there is no evidence in Respondent's records that Patient B's prior records were actually requested, received, or reviewed. Respondent prescribed #200 oxycodone Hcl 30 mg. without documenting an appropriate examination and a medical indication.

28. From October 15, 2016 through February 9, 2018, Respondent documented visits with Patient B occurring about every two months, for a total of seven office visits. Respondent continued to prescribe to Patient B, on an approximate monthly basis, #200 oxycodone Hcl 30 mg., which is a very high morphine equivalent dose (MED) of about 270.

29. On or about November 4, 2016, Respondent signed a pain management agreement that is in the patient's chart but it is unclear whether he saw the patient on that date.

30. On or about February 6, 2016, although Respondent noted that Patient B had decreased his oxycodone to 4-5 pills daily, Respondent did not decrease the amount of oxycodone prescribed and continued to issue a prescription for #200 oxycodone.

31. Respondent's last documented visit with Patient B that was in the records produced to the Board is dated February 9, 2018. Respondent documented that the patient had not tapered medication and that he might need a referral to physical therapy, acupuncture, or pain management. There is no evidence in the records that any referrals or consultations were made. There are also no records of lab tests, urine drug screens, or of any imaging studies for Patient B.

32. According to the CURES database, Respondent prescribed to Patient B #200 oxycodone Hcl 30 mg. on an approximate monthly basis from October 7, 2016 (before the first documented visit) through about March 14, 2018 and then prescribed #180 oxycodone Hcl 30 mg. in April and in May of 2018.

33. In summary, Respondent's overall conduct, through his acts and omissions, regarding Patient B, as set forth in Paragraphs 26 through 32 herein, constitutes unprofessional conduct under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication] and/or section 725 [excessive prescribing] and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient B as follows:

a. Respondent's documentation of the patient's medical history and physical examination failed to include an appropriate assessment of the patient's pain, including physical and psychological status and function, substance abuse history, history of prior pain treatment and assessment of any other underlying or coexisting conditions, and documentation of recognized medical indications for the use of controlled substances, esp. the use of opiates for pain control. Respondent did not attempt to obtain the patient's previous medical records.

b. During the course of his treatment of Patient B, Respondent failed to document an appropriate treatment plan and objectives and periodic review of his treatments. More specifically, Respondent: did not further evaluate the patient's underlying conditions; did not

attempt to taper medications; did not seek pain management or addiction medicine consultations; and, did not order periodic blood tests to screen for end-organ damage.

c. Respondent failed to document a discussion with Patient B regarding the risks associated with his chronic prescribing of controlled substances, particularly with a very high MED.

d. Respondent continued to prescribe controlled substances at each visit without documenting appropriate periodic review and evaluation of the effectiveness of the treatment. There is no documented indication that Respondent seriously considered alternate treatment, tapering of medications, or obtaining a consultation regarding Patient B.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient C: Gross Negligence, Repeated Negligent Acts, Prescribing without Appropriate Examination and Medical Indication, Excessive Prescribing)

34. Respondent William Kenneth Ebert, M.D. is subject to disciplinary action for unprofessional conduct under Business and Professions Code sections 2234, subdivision (b) and/or subdivision (c), and/ or section 2242 and/or section 725 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient C constitutes gross negligence and/or repeated negligent acts and/or prescribing without an appropriate prior examination and medical indication and/or excessive prescribing, as more fully described herein below.

35. Patient C, a male born in March 1986, first saw Respondent on or about October 15, 2015. Respondent noted that the patient reported that, two years prior, he had dropped some concrete and fractured his right foot. The patient continued to have pain and reported that he had tried pain relief with gabapentin and Norco but they did not work. It was noted that Patient C reported using oxycodone up to 6 per day but stated that he sometimes needed more. Respondent documented an order for a urine drug screen but, according to the records, the lab order expired without a collection/submission of the patient's urine and without any follow-up by Respondent. Respondent noted in the records that Patient C was to return in one month to review records and to sign a pain contract. There is no evidence that prior treatment records were ever obtained or

reviewed. According to the CURES database, Patient C filled a prescription from Respondent for #195 oxycodone Hcl on October 14, 2015, which was one day prior to the first documented visit. There is no documentation that Respondent performed an appropriate prior examination and had a medical indication for issuing the prescription.

36. From November 16, 2015 through February 9, 2018, Respondent documented visits with Patient C occurring about every two to four months. Respondent continued to prescribe to Patient C, on an approximate monthly basis, #200 oxycodone Hcl 30 mg., which is a very high morphine equivalent dose (MED) of about 270.

37. Although there is a reference in the records to a pain agreement being signed on December 17, 2015, there is no copy of such an agreement in the medical records for Patient C.

38. Respondent's last documented visit with Patient C in the records produced to the Board is dated February 9, 2018. Respondent noted in the chart that Patient C had not tapered medication and that he might need a referral to physical therapy, acupuncture, or pain management. There is no evidence in the records that Respondent decreased the quantity or dosing of his prescription for oxycodone and/or that any referrals or consultations were made by Respondent. There are also no records of lab tests, urine drug screes, or of any imaging studies for Patient C that were ordered by Respondent.

39. According to the CURES database, Respondent issued to Patient C monthly prescriptions for #200 oxycodone that were filled for a period of about two and a half years, from November 16, 2015 through May 25, 2018.

40. In summary, Respondent's overall conduct, through his acts and omissions, regarding Patient C, as set forth in Paragraphs 34 through 39 herein, constitutes unprofessional conduct under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication] and/or section 725 [excessive prescribing] and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient C as follows:

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a. Respondent's documentation of Patient C's medical history and physical examination failed to include an appropriate assessment of the patient's pain, including physical and psychological status and function, substance abuse history, history of prior pain treatment and assessment of any other underlying or coexisting conditions, and documentation of recognized medical indications for the use of controlled substances, esp. the use of opiates for pain control. Respondent did not attempt to obtain the patient's previous medical records.

b. During the course of his treatment of Patient C, Respondent failed to document an appropriate treatment plan and objectives and periodic review of his treatments. More specifically, Respondent: did not further evaluate the patient's underlying conditions; did not attempt to taper medications; did not seek pain management or addiction medicine consultations; and, did not order periodic blood tests to screen for end-organ damage.

c. Respondent failed to document a discussion with Patient C regarding the risks associated with his chronic prescribing of controlled substances, particularly with a high MED. Although there is a pain management agreement in the records, it was not signed by the patient.

d. Respondent continued to prescribe controlled substances at each visit without documenting appropriate periodic review and evaluation of the effectiveness of the treatment. There is no documented indication that Respondent seriously considered alternate treatment, tapering of medications, or obtaining a consultation regarding this patient.

e. Respondent did not attempt to refer Patient C for pain management or addiction consultation when the patient presented with complex pain problems.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patents A, B, C: Failure to Maintain Adequate and Accurate Medical Records)

41. Respondent William Kenneth Ebert, M.D. is subject to disciplinary action, jointly and severally, for unprofessional conduct under Business and Professions Code section 2266 for his failure to maintain adequate and accurate medical records regarding his treatment of Patient A and/or Patient B and/or Patient C.

42. Paragraphs 18 through 40 are incorporated herein by reference, as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE (Alternative)

(Unprofessional Conduct: Patients A, B, C: Dishonesty; Making False Statements in Medical Records)

43. As an alternative cause for discipline with regard to Respondent's conduct regarding Patient A and/or Patient B and/or Patient C, Complainant alleges that Respondent William Kenneth Ebert, M.D. is subject to disciplinary action for unprofessional conduct, jointly and severally, for dishonest conduct and for making false statements in medical records under section 2234, subdivision (e), and/or section 2261, which circumstances are described herein below.

44. The allegations in Paragraphs 18 through 40 are incorporated by reference, as if fully set forth.

45. Based on an internal review of Respondent's patient charts, Respondent's employer PAFMG found evidence of multiple inconsistencies and discrepancies in his patients' charts and that support a conclusion that the medical records are false or "phantom" charts. With regard to Patients A, B, and C, there is no documented evidence that these patients ever appeared at the clinic and/or that they ever saw Respondent, other than the note for each patient's first visit to register at the clinic. The three patients were never identified in Respondent's daily electronic (EPIC) schedule and Respondent always created or documented the patients' "visits" during his administrative time instead of during clinic time. Also, Respondent personally documented the patients' vital signs when PAFMG's routine procedure was for a medical assistant to chart vital signs during in-person patient visits. In the patients' charts, Respondent used "stickers" with the dates of service that were different from the date on the corresponding medical records. Moreover, none of the three patients were ever billed for their office visits because Respondent closed their records with an erroneous encounter code that resulted in the patients not being billed for Respondent's services. Respondent also did not use the PAFMG electronic system to record and issue the prescriptions for oxycodone but instead always issued a paper prescription, which he did not photocopy into the patients' electronic medical records and which represented a departure from PAFMG's and Respondent's custom and practice.

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46. For each of the three patients, Respondent had an inconsistent prescribing pattern of documenting in the patient's chart that he prescribed six pills per day of oxycodone 30 mg. (180 pills per month) while he issued prescriptions for 200 pills each month. For each of the three patients, Respondent failed to perform or confirm a medical workup, conduct health care maintenance, and obtain lab work, as required by PAFMG protocols and by the community standards when prescribing controlled substances on a chronic basis.

PETITION TO REVOKE PROBATION

47. At all times after March 3, 2017, the effective date of the Board's Decision, Probation Condition No. 15 "Violation of Probation" stated:

> "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."

FIRST CAUSE TO REVOKE PROBATION

(Non-practice in excess of two years during probation)

48. Respondent William Kenneth Ebert, M.D.'s license is subject to revocation for violation of Probation Condition No. 13 in that Respondent has not practiced medicine in California for more than two years during the period of the probation ordered by the Board's Decision in Case No. 03-2013-230884, as described in more detail herein below.

49. At all times after March 3, 2017, the effective date of the Board's Decision, Probation Condition No. 13 "Non-Practice While On Probation" stated:

> "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 in California 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state of 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 a clinical training 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 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 probations: Obey All Laws; and General Probation Requirements." (Emphasis added.)

50. Respondent's period of non-practice in California exceeded two years as of May 25, 2020. The facts and circumstances regarding this violation of Probation Condition No. 13 are as follows:

a. Respondent reported to the Board's Probation Unit that his last day of practice was May 24, 2018, that he retired and would no longer practice medicine in California.

b. On April 17, 2019, the Board's Probation Unit sent Respondent via electronic mail two letters that had been sent to him and to which he had not responded. The letters were dated March 05, 2019 and March 12, 2019. In both letters, Respondent was informed that his probation is in non-practice status, that his license had expired and had not been renewed, that payment was

overdue on 2018 probation costs, and that he had not submitted two quarterly declarations, for October – December 2018 and for January – March 2019. No communications or response were received from Respondent.

c. On April 15, 2020, the Board's Probation Unit sent a letter to Respondent at his address of record and advised him of the following probation violations: (1) failing to be in contact with the Board's probation monitor and not responding to the Board's correspondence and communications; (2) letting his license expire without renewal; (3) failing to submit quarterly declarations after October 4, 2018; (4) not paying the outstanding probations costs for the year 2018 ($1874). The letter also advised Respondent that his period of non-practice would exceed two years on May 25, 2020, in violation of Probation Condition No. 13 and that the Board would seek further disciplinary action. Respondent was asked to contact the Board's probation monitor by April 25, 2020, which he never did.

51. Respondent's period of non-practice while on probation exceeded two years on May 25, 2020 and Respondent continues to be in non-practice. Respondent, therefore, is in violation of the terms of Probation Condition No. 13 and cause exists for carrying out the disciplinary Decision and Order which provides for a revocation of the probation and the license for failure to fully comply with any term or condition of probation, after giving Respondent notice and the opportunity to be heard.

SECOND CAUSE TO REVOKE PROBATION

(Failure to Maintain a Current Address of Record and Failure to Respond to Board Communications)

52. Respondent William Kenneth Ebert, M.D.'s license is subject to revocation for violations of Probation Condition No. 11 because he has not maintained a current and renewed license, he has not informed the Board of his change of address, and he has not responded to the Board's communications and attempts to contact him regarding his probation, as described herein below.

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53. At all times after March 3, 2017, the effective date of the Board's Decision, Probation Condition No. 11 "General Probation Requirements" stated, in pertinent part:

"Compliance with Probation Unit. Respondent shall comply with the Board's probation unit and all terms and conditions of the Decision."

"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(b)."

"License Renewal. Respondent shall maintain a current and renewed California Physician's and Surgeon's license."

54. The allegations in Paragraph 50 are incorporated herein, as if fully set forth.

55. The Board's Probation Unit has made numerous attempts to contact Respondent by sending correspondence to his address of record and also by sending e-mail messages. Attempts have also been made to contact Respondent at an address in Las Vegas that was discovered through an internet search. Respondent has been out of contact with the Board for over two years.

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. Imposing the disciplinary order that was stayed by the Medical Board of California in Case No. 03-2013-230884, thereby lifting the stay and revoking Physician's and Surgeon's Certificate No. G 7739 issued to William Kenneth Ebert, M.D.;

2. Revoking or suspending Physician's and Surgeon's Certificate Number G 77739 issued to William Kenneth Ebert, M.D.;

2. Revoking, suspending or denying approval of William Kenneth Ebert, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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3. Ordering William Kenneth Ebert, M.D., if placed on a probation, to pay the Board the costs of probation monitoring; and

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

DATED: JUN 17 2021

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

SF2021401041

Exhibit A
Decision and Order

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

In the Matter of the Accusation Against:	)	
WILLIAM KENNETH EBERT, M.D.	)	Case No. 03-2013-230884
Physician's and Surgeon's Certificate No. G77739	)	OAH No. 2016090876
Respondent	)	

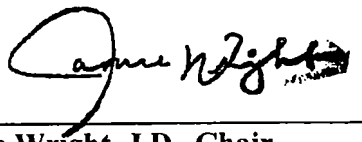
DECISION

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 March 3, 2017.

IT IS SO ORDERED: February 2, 2017.

MEDICAL BOARD OF CALIFORNIA



Jamie Wright, J.D., Chair
Panel A

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

In the Matter of the Accusation Against: **WILLIAM KENNETH EBERT, M.D.** 2025 Soquel Avenue Santa Cruz, CA 95062 Physician's and Surgeon's Certificate No. G77739 Respondent.	Case No. 03-2013-230884 OAH No. 2016090876 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by David Carr, Deputy Attorney General.

2. William Kenneth Ebert, M.D. is represented in this proceeding by Morgan A. Muir and Robert Sullivan, of Nossaman LLP, 50 California Street, 34th Floor, San Francisco, CA 94111.

3. On or about October 14, 1993, the Board issued Physician's and Surgeon's Certificate No. G77739 to William Kenneth Ebert, 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. 03-2013-230884, and will expire on March 31, 2017, unless renewed.

JURISDICTION

4. Accusation No. 03-2013-230884 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 March 16, 2016. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 03-2013-230884 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. 03-2013-230884. Respondent has also carefully read, fully discussed with 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.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 03-2013-230884, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. 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 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 probationary terms as set forth in the Disciplinary Order below. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in the Accusation shall be deemed true and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

13. 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.

14. 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.

15. 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 Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G77739 issued to Respondent William Kenneth Ebert, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. 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.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program 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 prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices 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.

4. 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 equivalent to

the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program 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.

5. PROFESSIONALISM PROGRAM. 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. 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.

6. PRACTICE MONITOR. 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. 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 equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, 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.

STANDARD CONDITIONS OF PROBATION

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. During probation, Respondent is prohibited from supervising physician assistants.

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 and all terms and conditions of this Decision.

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(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.

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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 in California 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 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; and General Probation Requirements.

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, 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 his or 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Morgan A. Muir. 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: 12-30-16 William K Ebert MD

WILLIAM KENNETH EBERT, M.D.
Respondent

I have read and fully discussed with Respondent William Kenneth Ebert, 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: 12/30/2016

MORGAN A. MUIR CALLAHAN
Attorney for Respondent

ENDORSEMENT

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

Dated: December 30, 2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

DAVID CARR
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 03-2013-230884

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Mar. 16 20 16
BY ANALYST

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

In the Matter of the Accusation Against: **WILLIAM KENNETH EBERT, M.D.** 2025 Soquel Avenue Santa Cruz, CA 95062 Physician's and Surgeon's Certificate No. G77739, Respondent.	Case No. 03-2013-230884 **A C C U S A T I O N**

Complainant alleges:

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 October 14, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number G77739 to William Kenneth Ebert, 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 March 31, 2017, 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 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 or her 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.

"(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 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 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

7. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

8. 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."

9. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

10. All of the events described herein occurred at the Palo Alto Medical Foundation Clinic in Soquel, California.

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FIRST CAUSE FOR DISCIPLINE

Patient RL

(Unprofessional Conduct/Gross Negligence and or Repeated Negligent Acts)

11. Based on prescription records and the medical records from the Palo Alto Medical Foundation Clinic where Respondent was then employed, Respondent assumed primary care responsibility for patient RL on June 8, 2012. Respondent prescribed 200 tablets of 30 mg Oxycodone IR[1] to patient RL on that date. Nothing in Respondent's records indicate that Respondent saw RL on that date. Prescription records indicate Respondent had already prescribed 200 tablets of Oxycodone IR to patient RL on May 31, 2012. The prescription record reveals Respondent also prescribed 200 more tablets to patient RL July 12, 2012; and again on August 14, 2012. There is no indication in the medical record that Respondent saw RL prior to issuing any of these prescriptions.

12. Respondent's first chart notes for patient RL are dated September 18, 2012. Respondent noted RL's complaint of low back pain and a reported history of spondylolisthesis with radiating leg pain. Respondent's notes state that Oxycodone is effective for RL's pain, with no adverse effects. Vital signs and physical exam are reported normal. There is no neurological examination documented. At this visit Respondent again prescribes 200 tablets of Oxycodone IR, 1-2 tablets four times per day.

13. From the first prescription Respondent wrote for RL on May 31, 2012, until his last documented prescribing to RL on May 10, 2013, Respondent prescribed and re-filled his orders for 200 tablets of Oxycodone IR to patient RL 28 times, a total of 5600 tablets, an average of almost 16 tablets per day, twice Respondent's recommended dose for patient RL. Respondent's medical record reflects only ten prescriptions for Oxycodone IR to patient RL during this period.

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[1]. Oxycodone is a semisynthetic narcotic analgesic, an opiate with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code. Oxycodone is habit forming an produce drug dependence of the morphine type and has a high potential for being abused. Oxycodone IR is the immediate release, short-acting form of the drug. Like all opiates oxycodone can cause life-threatening respiratory suppression, particularly at high doses.

14. Respondent's care and treatment of patient RL included the following departures from the standard of care: Respondent prescribed very high doses of Oxycodone IR to RL before ever documenting an adequate history or physical examination of this patient. Respondent began RL on high dose opioid therapy without verifying prior treatment or consulting with prior treating physicians. At no point in the year's course of treatment did Respondent document RL's prior medical history. Respondent never documented a neurological examination, despite RL's reported back pain and spondylolisthesis, with back pain radiating down his legs. Respondent failed to document any consideration of nerve compression or spinal stenosis or clinical exclusion of other possible pathology before or during his course of prescribing very high dose opioid therapy. The record is devoid of any documentation that Respondent obtained informed consent to use opioid medications to treat RL's pain. There is nothing in the medical record suggesting Respondent made any effort to detect or deter aberrant drug behavior by patient RL.

15. Respondent has subjected his license to discipline for unprofessional conduct in that his care and treatment of patient RL included multiple departures from the standard of care, extreme departures constituting gross negligence in violation of section 2234(b) and/or repeated negligent acts in violation of section 2234 (c).

SECOND CAUSE FOR DISCIPLINE

Patient RL

(Prescribing Without Prior Examination)

16. The allegations of paragraphs 11 through 14 above are incorporated by reference. Respondent has subjected his license to discipline for unprofessional conduct by prescribing controlled substances to RL without an appropriate prior examination and medical indication, in violation of section 2242(a).

THIRD CAUSE FOR DISCIPLINE

Patient RL

(Failure to Maintain Adequate and Accurate Records)

17. The allegations of paragraphs 11 through 14 above are incorporated by reference. Respondent has subjected his license to discipline for unprofessional conduct in that he failed to

maintain adequate and accurate records pertaining to his care and treatment of patient RL, in violation of section 2266.

FOURTH CAUSE FOR DISCIPLINE

Patient RL

(Excessive Prescribing)

18. The allegations of paragraphs 11 through 14 above are incorporated by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing of Oxycodone IR to patient RL was clearly excessive as determined by the standards of the community of physicians and surgeons, in violation of section 725.

FIFTH CAUSE FOR DISCIPLINE

Patient ED

(Unprofessional Conduct/Gross Negligence and or Repeated Negligent Acts)

19. Respondent's medical records indicate he first saw patient ED on April 18, 2012. The record of that visit presents only patient information obtained by the Palo Alto Medical Foundation Clinic prior to that date. There is no physical examination recorded. Respondent prescribed 200 tablets of 30 mg Oxycodone IR to patient ED on that date, but that prescription is not reflected in Respondent's medical record. Respondent's first chart entries for ED are dated April 27, 2012. Respondent's documentation of ED's medical history on April 27 is notable only for prior unspecified back surgery. It is also noted that ED takes Oxycodone for pain, but the dose and frequency are not specified. No prior treatment records were sought and no informed consent for treatment with opioid medications is recorded.

20. Respondent's record for ED contains a message, dated May 2, 2012, stating that a local CVS pharmacy requested clarification of an early refill request by ED. Respondent's initials appear after the notation "reviewed with pharmacist." 200 tablets of Oxycodone IR were dispensed to ED on May 2, 2012. A telephone inquiry from Lucky Pharmacy is noted on May 10, 2012, indicating that a prescription for 200 tablets of Oxycodone IR is pending.

21. On July 12, 2012, low back pain is entered on the problem list of ED's medical records, though it appears no visit occurred that day. The chart entries for that date also note

another message from Lucky Pharmacy requesting clarification of a refill of Oxycodone IR. Instructions for the Oxycodone IR prescription are recorded in the chart: "Take 30 mg by mouth every 4 hours as needed." A prescription for 300 tablets of Oxycodone IR is documented for that date. Taken as directed, that quantity of Oxycodone IR would have been sufficient to last until August 31, 2012.

22. On August 14, 2012, Respondent prescribed 300 more tablets of Oxycodone IR to ED, again without an office visit. The next office visit is documented as occurring September 18, 2012. Respondent notes that ED's condition is unchanged. A history and physical examination are entered in the record; pain with movement is also noted. Musculoskeletal examination shows "rigid lumbar with tender spasm". The recorded plan of treatment is "Continue current treatment. Follow up 3-6 months if no change." There is still no informed consent present in the chart.

23. According to prescription records, between Respondent's first prescription of Oxycodone IR to patient ED on April 18, 2012 and Respondent's first adequate chart entries at the September 18, 2012 visit patient ED received 24 packets of 200 tablets of Oxycodone IR and 5 packets of 300 tablets of Oxycodone IR, a total of 6,300 tablets of the opiate. At the dose directed by Respondent for ED—12 tablets per day—6,300 tablets should have lasted 525 days, more than a year after the September 18, 2012 visit, instead of the 5 month period in which they were given to ED. When interviewed about his care of patient ED by Board investigators, Respondent was unable to discern from his chart entries why this overage had occurred or what had transpired in his clarification of prescriptions inquired about by local pharmacists.

24. Respondent's care and treatment of patient ED included numerous departures from the standard of care: Respondent failed to obtain a medical history and failed to make any effort to confirm ED's prior treatment prior to prescribing high doses of opiates; Respondent failed to perform an adequate physical examination prior to prescribing opioid medication; there was no informed consent obtained for treatment with opiates; Respondent failed to recognize or act on the multiple indications of aberrant drug use by ED; and it was a departure from the standard of care for Respondent to fail to formulate a detailed plan of treatment with measurable benchmarks.

25. Respondent has subjected his license to discipline for unprofessional conduct in that his care and treatment of patient ED included multiple departures from the standard of care, comprising extreme departures constituting gross negligence in violation of section 2234(b) and/or repeated negligent acts in violation of section 2234 (c).

SIXTH CAUSE FOR DISCIPLINE

Patient ED

(Excessive Prescribing)

26. The allegations of paragraphs 19 through 23 above are incorporated by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing of Oxycodone IR to patient ED was clearly excessive as determined by the standards of the community of physicians and surgeons, in violation of section 725.

SEVENTH CAUSE FOR DISCIPLINE

Patient ED

(Prescribing Without Prior Examination)

27. The allegations of paragraphs 19 through 23 above are incorporated by reference. Respondent has subjected his license to discipline for unprofessional conduct by prescribing controlled substances to ED without an appropriate prior examination and medical indication, in violation of section 2242(a).

EIGHTH CAUSE FOR DISCIPLINE

Patient ED

(Failure to Maintain Adequate and Accurate Records)

28. The allegations of paragraphs 19 through 23 above are incorporated by reference. Respondent has subjected his license to discipline for unprofessional conduct in that he failed to maintain adequate and accurate records pertaining to his care and treatment of patient ED, in violation of section 2266.

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NINTH CAUSE FOR DISCIPLINE

Patient ND

(Unprofessional Conduct/Gross Negligence and or Repeated Negligent Acts)

29. Respondent had been treating patient ND at the Soquel clinic since 2009 for, among other conditions, low back pain and spondylosis. Respondent's care of ND considered here spans the period of July 29, 2010 until April 19, 2013. The first chart notes in this period reflect Respondent's receipt of an inquiry from a local pharmacist regarding ND's request for an early refill of Norco, which Respondent was prescribing for ND's back pain. Respondent's chart entries for this three year period reflect varying recommendations as to the appropriate dose of Norco[2] which Respondent was prescribing for ND, between six and twelve tablets of Norco 10/325 daily. Respondent prescribed sufficient Norco 10/325 tablets for ND to take more than 14 tablets per day every day for this time period.

30. Respondent's chart notes indicate that the patient insisted only the Norco was effective for her back pain. Although Respondent repeatedly noted his concern about the high dosage of Norco ND was receiving and recorded his intent to refuse to refill the Norco, Respondent either routinely refilled the Norco prescription or resumed prescribing it after brief periods of prescribing alternative opiates. Respondent was regularly prescribing other controlled substances as well, including Soma[3] and various benzodiazepines.[4] Respondent was informed by ND's sister that ND had been admitted to the emergency room for overdosing on Soma in January

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[2] Norco is the trade name of the combination of the short-acting opiate hydrocodone and acetaminophen. It is a dangerous drug as defined in section 4022 and a Schedule III controlled substance as defined by section 11056 of the Health and Safety Code. Like other opiates, it carries a risk of tolerance, dependence, abuse, or diversion. Norco has a rigid dose ceiling because of the acetaminophen component: it is unsafe to take more than 4 grams of acetaminophen per day (12 tablets per 24 hours).

[3] Soma (carisoprodol) is a potent muscle relaxant with sedative properties. It is a dangerous drug as defined in section 4022. Soma is indicated for the short term treatment of muscle spasms. In combination with opiates, it carries the risk of additive central nervous system depressions. Soma is frequently used as a drug of abuse as potentiating the euphoric effect of opiates.

[4] Benzodiazepines are sedative-hypnotic agents often used to treat insomnia. Benzodiazepines are dangerous drugs as defined in section 4022 and are Schedule IV controlled substances per section 11057 of the Health and Safety Code. At high doses benzodiazepines produce a euphoric effect and are highly habit forming. When combined with opiates, benzodiazepines can result in profound hypotension and respiratory suppression.

of 2011, while Respondent was prescribing Soma and opiates to ND. Respondent's chart notes state that, at the office visit on January 24, 2011, Respondent discussed the overdose incident with ND and the fact she was receiving more than 16 tablets of Norco per day. Respondent nonetheless prescribed more Soma and more Norco for ND at that visit, and for the first time prescribed methadone[5] to her as well. When queried by Board investigators about the apparent inconsistency between his chart entries expressing intent to taper the amount of Norco he was prescribing to ND and his continued, even increased, prescribing, Respondent stated that he couldn't discern from his records what had determined his course of treatment.

31. Respondent was aware that ND was admitted to the emergency room for overdoses on at least two subsequent, additional occasions while he was treating her. In his reply to Medical Board investigators asking the significance of his September 26, 2011 chart entry stating "This concerns me..."Respondent stated that he then knew "she was probably abusing medication." Respondent continued to prescribe Norco and other controlled substances to ND for another 18 months. On December 10, 2012, Respondent stopped all prescription to ND and cancelled all refills of her Norco, in favor of methadone as a substitute. He resumed prescribing Norco to ND 9 days later.

32. Respondent's medical record reflects ND's complaint of symptomatic tachycardia in early 2011, soon after she began taking the prescribed methadone. Respondent apparently told patient ND her rapid heart rate was probably an adverse reaction to the methadone, but there is no indication of any clinical evaluation of ND's tachycardia. On 8 of the 17 documented office visits with ND over the period of treatment, ND's heart rate was measured above 100 beats per minute, yet this vital sign was recorded as "normal."

33. Respondent's care and treatment of patient ND included the following departures from the standard of care: Respondent prescribed extremely high doses of opiate medications

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[5] Methadone is a potent long-acting synthetic opioid with a high potential for adverse respiratory effects. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by section 11055 of the Health and Safety Code. Methadone increases the risk of lethal cardiac arrhythmia and ventricular tachycardia. Methadone should only be prescribed in adherence with a fixed dosing schedule under supervision.

even after he was made aware of her having overdosed on prescription medications while under his care; Respondent provided ND with long term high dose Norco containing dangerous amounts of acetaminophen; Respondent failed to adequately document the clinical bases for his prescribing to ND; Respondent failed to adequately respond to clear indications that ND was abusing her prescription medication; and Respondent failed to evaluate ND's documented tachycardia.

34. Respondent has subjected his license to discipline for unprofessional conduct in that his care and treatment of patient ND included multiple departures from the standard of care, extreme departures constituting gross negligence in violation of section 2234(b) and/or repeated negligent acts in violation of section 2234 (c).

TENTH CAUSE FOR DISCIPLINE

Patient ND

(Excessive Prescribing)

35. The allegations of paragraphs 29 through 32 above are incorporated by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing of Norco to patient ND was clearly excessive as determined by the standards of the community of physicians and surgeons, in violation of section 725.

ELEVENTH CAUSE FOR DISCIPLINE

Patient ND

(Failure to Maintain Adequate and Accurate Records)

36. The allegations of paragraphs 29 through 32 above are incorporated by reference. Respondent has subjected his license to discipline for unprofessional conduct in that he failed to maintain adequate and accurate records pertaining to his care and treatment of patient ND, in violation of section 2266.

TWELFTH CAUSE FOR DISCIPLINE

Patient ND

(Prescribing to an Addict)

37. The allegations of paragraphs 29 through 32 above are incorporated by reference. Respondent has subjected his license to discipline for unprofessional conduct for prescribing

controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose, in violation of section 2241.

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 G77739, issued to William Kenneth Ebert, M.D.;

2. Revoking, suspending or denying approval of William Kenneth Ebert, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering William Kenneth Ebert, 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: March 16, 2016

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

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