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

In the Matter of the Second Amended Accusation and Petition to Revoke Probation Against: Ernestina Maria Howell Saxton, M.D. Physician's & Surgeon's Certificate No. G 52068 Respondent.	Case No. 800-2021-082038

DECISION

The attached Proposed Decision 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 July 19, 2024.

IT IS SO ORDERED: June 24, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

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In the Matter of the Second Amended Accusation and Petition to Revoke Probation Against:

ERNESTINA MARIA HOWELL SAXTON, M.D., Respondent

Agency Case No. 800-2021-082038

OAH No. 2022080084

PROPOSED DECISION

Marcie Larson, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on April 29, 30, and May 1, 2024, by telephone and videoconference, from Sacramento, California. This matter was consolidated for hearing with *In the Matter of the Notification of Violation and Imposition of Civil Penalty*, OAH Case Number 2022080073, for which a separate Proposed Decision is issued.

Kalev Kaseoru, Deputy Attorney General, represented complainant Reji Varghese, Executive Director, Medical Board of California (Board), Department of Consumer Affairs (Department).

Benjamin Fenton and Henry Fenton, Attorneys at Law, represented respondent Ernestina Maria Howell Saxton, M.D., who was present.

Evidence was received, the record was closed, and the matter was submitted for decision on May 1, 2024.

FACTUAL FINDINGS

Jurisdictional Matters

1. On March 19, 1984, the Board issued respondent Physician's and Surgeon's Certificate Number G 52068 (license). The license expired on August 31, 2023, and has not been renewed. The expiration of a license issued by a 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." (Bus. & Prof. Code, § 118.)

2. On January 6, 2022, complainant, on behalf of William Prasifka, a former Board Executive Director, signed and thereafter filed an Accusation and Petition to Revoke Probation. A First Amended Accusation and Petition to Revoke Probation was signed and thereafter filed on April 19, 2022. A Second Amended Accusation (Second Accusation) and Petition to Revoke Probation (Petition), the operative pleading, was signed and thereafter filed on March 28, 2024. Complainant contends that grounds exist to revoke respondent's probation and impose the stayed order of revocation due to her care and treatment of a patient and failure to comply with the terms and conditions of her probation.

Generally, complainant alleges that respondent engaged in gross negligence and repeated acts of negligence related to inappropriately prescribing high doses of controlled substances, without medical indication, to a patient over a prolonged period. Complainant also alleges that respondent engaged in unprofessional conduct

by failing to comply with a court order issued in the enforcement of a subpoena for the patient's records. Additionally, complainant alleges respondent failed to comply with several terms of her probation. Complainant seeks revocation of respondent's license and reimbursement of investigation and prosecution costs.

3. Respondent timely filed a Notice of Defense, pursuant to Government Code section 11506. The matter was set for an evidentiary hearing before an Administrative Law Judge of the OAH, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

Respondent's Background

4. Respondent is 79 years old. She was born and raised in Panama. She moved to the United States in 1966, to complete her undergraduate degree in biology at St. Olaf College, Northfield, Minnesota. In 1973, respondent completed her Doctor of Philosophy (Ph.D.) in Medical Microbiology and Immunology at the University of California (USC) School of Medicine in Los Angeles, California. She completed several fellowships between 1973 and 1978.

5. Between 1978 and 1982, respondent completed her medical degree at the USC School of Medicine. She spent one year completing an internal medicine internship. Between 1983 and 1986, she completed a residency in neurology at the USC School of Medicine. In 1984, respondent became licensed by the Board. In 1995, she obtained her certification with the American Board of Psychiatry and Neurology.

6. Between 1986 and 2005, respondent worked as an Associate and then Clinical Professor in the Department of Neurology at USC. In 2005, respondent created the Comprehensive Headache and Migraine Clinic, a private practice located in Los Angeles, California. In 2011, she began working in a private practice under University

Neurology Associates (UNA), which is a part of the parent company Central California Faculty Medical Group (CCFMG). She also began serving as a Health Sciences Clinical Professor in the Neurology Department at the University of California, San Francisco.

In approximately 2018, respondent left CCFMG and worked for the Fresno Geriatric Medical Group in Fresno, California, where respondent treated patients until December 2022, when a Cease Practice Order was issued. Respondent's medical practice focused on caring for patients with neurological issues, including migraine headaches.

Prior Discipline

7. On or about November 13, 2017, a First Amended Accusation, Case Number 800-2014-002731, was filed against respondent alleging cause to discipline her license under Business and Professions Code sections 2234, subdivision (b), 2234, subdivision (c), and 2266. Generally, complainant alleged respondent engaged in gross negligence, repeated acts of negligence, and inadequate recording keeping for seven patients whom she treated with high doses of controlled substances.

8. On March 2, 2018, respondent signed a Stipulated Settlement and Disciplinary Order (Disciplinary Order) which became effective June 22, 2018. Respondent's license was revoked. The revocation was stayed, and she was placed on probation for five years, under specific terms and conditions. Respondent agreed that "if the board ever petitions for revocation of probation, all of the charges and allegations" in the First Amended Accusation "shall be deemed true, correct and fully admitted by respondent."

Anonymous Complaint and Investigation

9. On April 22, 2019, the Board received an anonymous online complaint that respondent was prescribing large daily doses of "Dilaudid" to a patient for infrequent migraine headaches. The patient lived in Los Angeles, but traveled to Fresno, California to be treated by respondent. The complaint also indicated the patient had a history of substance abuse and was "dangerously abusing the prescription medication." The patient's name was not provided. However, two pictures of a prescription bottle for the medication were attached to the complaint. The bottle listed the medication as hydromorphone, the generic name for Dilaudid, respondent's name, the prescription number, and the filling pharmacy.

10. On May 30, 2019, Todd Baker, an Investigator with the Department's Division of Investigation, Health Quality Investigation Unit, was assigned to investigate the anonymous complaint. Mr. Baker prepared an investigation report and testified at hearing. Mr. Baker explained that as part of his investigation, he reviewed a Controlled Substance Utilization Review and Evaluation System (CURES) report for controlled substance prescriptions respondent issued between May 1, 2016, and May 1, 2019. CURES is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California.

Using the CURES information, Patient A was identified as the patient who was the subject of the anonymous complaint. The CURES reports showed that Patient A had been receiving controlled substance prescriptions from respondent on a regular basis during the reviewed period. The medications included monthly prescriptions of short and long-acting hydromorphone, a Schedule II controlled substance under Health and Safety Code section 11055, and a dangerous drug as defined in Business and Professions Code section 4022.

ATTEMPTS TO OBTAIN PATIENT A'S MEDICAL RECORDS

11. On November 13, 2019, Mr. Baker sent Patient A, by certified mail, a request that he sign and return releases to allow the release of his medical records from respondent and her former employer CCFMG. Mr. Baker did not receive a response from Patient A. Between December 2019 and April 2020, Mr. Baker made various attempts to locate Patient A and obtain releases. Mr. Baker was unsuccessful.

12. On May 1, 2020, an Investigational Subpoena Duces Tecum (SDT) was sent to respondent and CCFMG. The SDT directed respondent and CCFMG to provide Mr. Baker a copy of Patient A's medical records for a specified time frame by May 29, 2020. On the same day, SDT notification packets were sent to Patient A.

13. On May 22, 2020, Mr. Baker received from CCFMG a letter from Charlotte Stoffel-Quinn, Corporate Compliance Manager, explaining that the requested records were subject to protection of the "Confidentiality of Substance Use Disorder Patient Records" and could not be provided unless Patient A consented or a court ordered the release of the records.

14. On May 26, 2020, Mr. Baker received from respondent's attorney a letter and a Consumer's Objection to Production of Records signed by Patient A. The letter explained that Patient A informed respondent that he objected to production of his records and instructed respondent not to produce his records in response to the SDT.

COURT ORDER MANDATING THE RELEASE OF PATIENT A'S RECORDS

15. On April 27, 2021, a Petition to Compel Compliance With Department of Consumer Affairs/Medical Board Investigational Subpoena Duces Tecum (Petition to

Compel) was filed with the Superior Court, County of Fresno, against respondent and CCFMG. The Petition to Compel sought production of Patient A's medical records.

16. On June 15, 2021, a hearing occurred concerning the Petition to Compel. Respondent and CCFMG appeared through counsel. The same day, the court issued an Order Granting the Petition to Compel (Court Order). The Court Order stated that good cause existed to grant the Petition to Compel and ordered respondent and CCFMG to comply with the subpoenas by providing a certified copy of Patient A's medical records with a completed Declaration of Custodian of Records to a Board Investigator no later than July 9, 2021.

17. On June 22, 2021, Mr. Baker received from CCFMG a certified copy of Patient A's records and a letter from CCFMG's attorney, advising the records were being provided pursuant to the Court Order.

18. On July 23, 2021, the Board's counsel contacted respondent's counsel concerning the failure to provide Patient A's records pursuant to the Court Order. Respondent's counsel responded to the email the same day indicating that she believed CCFMG would be producing the records. In response, the Board's counsel explained that there were two subpoenas at issue and enforced pursuant to the Court Order, and that respondent's failure to produce the records was in violation of the Court Order. The same day, respondent's counsel informed the Board's counsel that she had reached out to respondent about the subpoenaed records and explained that the records needed to be produced immediately but received no response.

19. On August 4, 2021, respondent's counsel informed Board counsel that she spoke with respondent and respondent would deliver the subpoenaed records to

the Board no later than August 11, 2021. However, respondent did not produce any records to the Board on that date.

20. On August 12, 2021, respondent's counsel explained to Board counsel that respondent did not produce the records the day prior because she could not get to the FedEx office before closing. Respondent's counsel stated that respondent would hand deliver the records to the Board on August 12, 2021. Later that day, respondent delivered an uncertified copy of the subpoenaed records to the Board. Mr. Baker determined that the records were not compliant with the terms of the Court Order, which required that the subpoenaed records include a Certification of Records. Mr. Baker notified Board counsel regarding the issue.

21. On August 13, 2021, the Board's counsel notified respondent's counsel about the failure to include a Certification of Records with the subpoenaed records. The Board's counsel provided respondent's counsel with a blank Certification of Records form, along with instructions on how to properly complete the form. The same day respondent faxed an incomplete Certification of Records form to the Board that failed to identify the facility/business producing the records or the complete number of pages provided.

Mr. Baker immediately notified Board counsel of the issue with the Certification of Records, and Board counsel then notified respondent's counsel. Later the same day, respondent's counsel provided the Board with an accurate Certification of Records for the subpoenaed records.

INVESTIGATION BY INVESTIGATOR GINA LEYVA

22. On February 4, 2022, the investigation regarding respondent's treatment of Patient A was reassigned to Gina Leyva, an Investigator with the Department's

Division of Investigation, Health Quality Investigation Unit. The reassignment was due to Mr. Baker's retirement. Ms. Leyva prepared a supplemental investigation report and testified at hearing. As part of her investigation, Ms. Leyva reviewed the records Mr. Baker obtained, including the anonymous complaint, CURES reports, and Patient A's medical records.

23. On March 4, 2022, Ms. Leyva sent a letter, Mr. Baker's investigation report, a draft supplemental report she prepared, CURES information, Patient A's medical records, and additionally supporting documents to Board expert reviewer Richard M. Green, M.D. On March 13, 2022, Dr. Green issued a report in which he opined that respondent's care and treatment of Patient A departed from the standard of care.

24. On March 14, 2022, Ms. Leyva interviewed respondent regarding her treatment of Patient A. Thereafter, she provided a transcript and audio recording of the interview to Dr. Green to consider for purposes of reanalyzing the care respondent provided to Patient A. On June 6, 2023, Dr. Green issued an addendum to his report stating that his opinions expressed in his March 13, 2022 report did not change.

Respondent's Treatment of Patient A

NEW PATIENT CONSULTATION

25. On April 16, 2008, respondent began treating Patient A, at the Comprehensive Headache and Migraine Clinic in Los Angeles. At the time, Patient A was a 49-year-old man living and working as an attorney in Los Angeles. He was referred to respondent by his primary care physician for an evaluation regarding chronic headaches. Patient A reported to respondent that he had a 15-year history of chronic headaches. He used several drugs to treat his headaches, including Lyrica, an

antiepileptic drug, and Duragesic, a transdermal fentanyl, 50 micrograms (mcg) patch every 48 hours. Fentanyl is a dangerous drug as defined by Business and Professions Code section 4022 and a Schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055. Respondent did not note who had prescribed the Duragesic, or the reason that it was prescribed.

26. Patient A also reported a history of taking various medications to treat his headaches including antidepressants, antiepileptic drugs, medications specific to treating migraine headaches, and Demerol, a dangerous drug as defined by Business and Professions Code section 4022 and a Schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055, used to treat pain. Patient A told respondent that these drug therapies were not effective.

27. Patient A reported to respondent that he had a history of alcohol abuse and used recreational drugs from ages 18 through 30. Respondent noted that Patient A had participated in Alcoholics Anonymous (AA) and that he "spent some time at Betty Ford Clinic." Respondent did not note when Patient A was at the Betty Ford Clinic, or the reason. Patient A also reported that in September 2004, he was in a motor vehicle accident. His liver was lacerated. He spent 75 days in the hospital. Thereafter, he was provided pain medication. Before that, he had not used pain medication since 1987.

28. Respondent completed a physical examination of Patient A. She noted a "mild left hemiparesis." Her assessment of Patient A was that his "headache seems most descriptive of migraine without aura, intractable. Patient has been treated with preventative medications, singly and in combination but still has frequent attacks." Respondent ordered laboratory studies, an MRI, and directed Patient A to continue his

current medications. Patient A also signed an "Agreement Regarding Medications and Shared Information," and was directed to return in four weeks.

TREATMENT BETWEEN 2011 AND 2012

29. There are no treatment records for Patient A after the New Patient Consultation until January 10, 2011, when Patient A saw respondent at the Comprehensive Headache and Migraine Clinic. Patient A complained of right heel pain from a healed decubitus ulcer. Respondent noted that Patient A's current prescriptions were Duragesic 75 mcg every 48 hours, and Dilaudid 4 mg every four to six hours as needed for breakthrough pain, for a total of 270 pills per month.

Respondent conducted a physical examination of Patient A which revealed "tenderness in the area of the decubitus" and "positive gradient to cold, sharp-mild sensory neuropathy." Respondent referred Patient A to Orthotics for a right heel cushion and directed him to continue his medications.

30. Respondent continued to see Patient A each month in 2011. Patient A reported good control of his headaches and intermittent pain in his right heel and numbness in his legs. Respondent prescribed Duragesic and Dilaudid for Patient A each month.

31. In 2012, respondent began working in an office in Fresno, California. Patient A traveled to Fresno to see respondent. By June 16, 2012, respondent signed and predated triplicate prescriptions for Patient A for three to four months in advance. Respondent's documentation of the examination and Patient A's complaints remained unchanged.

TREATMENT BETWEEN 2015 AND 2019

32. On May 23, 2015, respondent saw Patient A in her Fresno office for a follow-up appointment. She noted that Patient A had been doing well and that he had no recent migraine triggers. Respondent noted in the medication list for the visit that she prescribed Patient A Exalgo, a long-acting hydromorphone, a Schedule II controlled substance under Health and Safety Code section 11055, and a dangerous drug as defined in Business and Professions Code section 4022. The Exalgo was prescribed in addition to the Dilaudid and Duragesic. She did not explain in her notes the reason for the additional medication.

33. During a follow-up visit on August 28, 2015, Patient A told respondent that he stopped taking Duragesic. Respondent noted Patient A was still taking Dilaudid. However, she did not document Patient A's use of Exalgo.

34. On October 31, 2015, Patient A saw respondent for a follow-up visit. Patient A reported that he was having "problems managing Dilaudid 2 cycles ago" but was able to get his pain under control. He also reported having a hiatal hernia and an internal gastrointestinal bleed. Respondent prescribed Patient A Exalgo, in addition to the Dilaudid. Following this visit, respondent maintained Patient A on Exalgo 12 mg daily; Dilaudid 4 mg tablets for a total of 270 pills per month; trazadone, which is an anti-depressant; and Lyrica.

35. Patient A's CURES report shows that from May 1, 2016, through March 2019, respondent concurrently prescribed Patient A Dilaudid 4 mg for a quantity of 270 pills per month, Exalgo 12 mg for a quantity of 30 pills per month, and Lyrica 150 mg for a quantity of 90 pills per month.

36. On or about April 6, 2018, Patient A saw respondent at her clinic in Fresno, complaining of right heel pain and numbness. Respondent noted that Patient A may have Complex Regional Pain Syndrome. Respondent also noted Patient A was seeing a therapist and treating his pain with acupuncture.

37. On July 24, 2018, Patient A saw respondent at the CCFMG in Fresno. Respondent documented for the visit that Patient A had continued issues related to migraine headaches and neuropathic pain from a healed decubitus ulcer on the lateral aspect of the right ankle and sole. Respondent noted that the heel injury occurred when Patient A fell in the shower on a visit to London. Patient A became unconscious for several days, developing a decubitus ulcer on his ankle and the sole of his foot.

Respondent also noted that Patient A complained of neck pain from past motor vehicle accidents and strength training. Respondent's examination of Patient A revealed "cervical paraspinous muscle spasms with decreased ROM [range of motion] and tenderness with passive rotation and to deep palpation." Respondent continued to prescribe Patient A Dilaudid 4 mg for a quantity of 270 pills per month, Exalgo 12 mg for a quantity of 30 pills per month, and Lyrica 150 mg for a quantity of 90 pills per month.

38. On October 16, 2018, Patient A saw respondent for a follow-up visit. Patient A reported that his migraine attacks continued but were "better controlled with Lyrica and trazodone." Respondent's assessment was that Patient A's migraines were improved on Lyrica, but he was still taking hydromorphone for severe migraine attacks. Respondent wrote that Patient A's right ankle pain was improved, but he required more medication for breakthrough pain.

39. On or about December 10, 2018, Patient A saw respondent for his last visit. Patient A reported to respondent that he had four migraines since his last visit and did not know why the migraines continued to recur. Patient A also complained of severe pain related to his neuropathy.

40. Through March 2019, Patient A's CURES report shows that he continued to fill prescriptions written by respondent for Dilaudid 4 mg for a quantity of 270 pills per month, Exalgo 12 mg for a quantity of 30 pills per month, and Lyrica 150 mg for a quantity of 90 pills per month.

Complainant's Expert's Opinions

41. Dr. Green is a board-certified neurologist. In 1986, he obtained his medical degree from University of Michigan Medical School. The following year he completed an internship in internal medicine at the University of Michigan, Department of Internal Medicine. In 1990, Dr. Green completed a three-year neurology residency in the University of Michigan, Department of Neurology. In 1990, Dr. Green obtained his California Medical license. In 1993, Dr. Green became certified in neurology by the American Board of Psychiatry and Neurology. In 1996, he obtained an added certification in the subspecialty of Clinical Neurophysiology.

42. Between 1990 and 2004, Dr. Green worked for Los Angeles County University of Southern California Medical Center. He treated patients and served as a Clinical Assistant and Associate Professor of Neurology. From 1997 until 2003, Dr. Green served as the Chief of Service and Director of Neurology Residency Training Program at the Kaiser Permanente-Los Angeles Medical Center, Department of Neurology (Kaiser). Since 2003, Dr. Green has served as Director, Neuro-oncology Program at Kaiser. Dr. Green has approximately 34 years of clinical practice experience

treating patients with headache pain. In 1997, Dr. Green became an expert reviewer for the Board. Since that time, he has written approximately 15 expert reports for the Board.

43. On March 13, 2022, following a referral from Ms. Leyva, Dr. Green prepared an initial report concerning his evaluation of respondent's conduct related to whether respondent's treatment and prescribing practices related to Patient A departed from the standard of care. On June 3, 2023, after receiving the interview transcript of respondent's Board interview, Dr. Green issued a supplemental report. Dr. Green testified at hearing consistent with his reports.

44. Dr. Green listed in his reports the information and documents he reviewed and relied upon to reach his opinions and conclusions. He reviewed over 27 items of information including the investigation reports, the anonymous online complaint, CURES reports for respondent and Patient A, and Patient A's medical records. Based on his review of all the information, Dr. Green found that respondent departed from the standard of care by her excessive prescribing of opiates to Patient A and prescribing opiates without medical indications.

45. Dr. Green defined the standard of care as the level of skill, knowledge and experience in the diagnosis and treatment of a patient that is exercised by a reasonable and prudent physician practicing in the same area. An extreme departure from the standard of care occurs when a physician fails to provide care, or the care provided is or can be harmful to the patient. A simple departure is a departure from the standard of care.

EXCESSIVE PRESCRIBING OF OPIATES

46. Dr. Green explained in his report that "before prescribing opiate analgesics to a patient with a history of substance abuse, the standard of care is to obtain a detailed drug history and copies of relevant medical records." Dr. Green further explained that "it is especially important to obtain these records when prescribing opiates for a patient who states he is already taking them." The standard of care also requires the treating physician to "consult with an Addiction Medicine specialist, since exposure to opiates may harm the patient by triggering relapse."

Dr. Green explained that "the use of opiate analgesics is considered a last resort in patients with substance abuse; opiates should only be prescribed in this setting for objectively serious problems for which all alternatives have been exhausted." Additionally, "periodic urine drug screens should be obtained to exclude the use of other drugs of abuse. The standard of care is also to take every precaution to avoid excessive prescribing, since opiates can be diverted into the illegal drug market."

Additionally, Dr. Green explained that the Center for Disease Control (CDC) guidance recommends that opioid doses greater than or equal to 90 morphine milligram equivalents (MMEs) per day "should be avoided or carefully justified" and to take precautions "when increasing from 50 MME per day and to avoid increasing past 90 MMEs per day." Also, the Board recommends a physician proceed cautiously once 80 MMEs per day is reached. The fentanyl and hydromorphone prescriptions respondent prescribed Patient A January 2015 through August 2015 amounted to 360 MMEs per day. The hydromorphone prescriptions which respondent prescribed Patient A from September 2015 through March 2019 amounted to 180 MMEs per day.

47. Dr. Green opined that respondent "prescribed and continued to refill high doses of opiates to a migraine" patient, who had a "history of a severe substance abuse disorder." His history of substance abuse was disclosed to respondent when he reported that he attended the Betty Ford Clinic, a residential drug treatment program. At no time during respondent's treatment of Patient A did she obtain a "detailed substance abuse history and medical records" or "consult with an Addiction Medicine specialist." He also found no evidence of the results of urine drug screens to monitor for drugs of abuse in Patient A's medical records.

Additionally, for years Patient A traveled from Los Angeles to Fresno to obtain the prescriptions, which Dr. Green opined was likely because it was difficult for him to find another physician to prescribe him the same high amount of opioids respondent prescribed. Dr. Green also opined that "the prescriptions appear to have facilitated and exacerbated an addiction to opiates."

48. Dr. Green concluded that respondent's "evaluation and management" of Patient A, including the "prescribing of fentanyl and hydromorphone and the failures to obtain medical records, to consult with an Addiction Medicine specialist, to screen for other drugs of abuse, and to take all precautions to prevent opiate diversion, constitute an extreme departure from the standard of care." Dr. Green opined that "it is likely that patient harm did occur, since he appears to have been addicted to opiates." He further opined that Patient A's "multiple chronic pains may have been related to the hyperalgesia of opiate addiction."

PRESCRIBING OPIATES WITHOUT MEDICAL INDICATIONS

49. Dr. Green opined that respondent departed from the standard of care by prescribing Patient A opiates without medical indications for chronic migraines, sensory polyneuropathy, and post-traumatic heel or ankle pain.

Chronic Migraine

50. Dr. Green explained in his report that "[w]hen selecting pharmacologic therapy, the standard of care is to obtain a detailed history and records of abortive and prophylactic therapy used in the past by the patient. Moreover, the standard of care in treatment of migraine is to never use opiate analgesics on a chronic prophylactic basis." Dr. Green further explained that the "use of analgesics is well known to worsen chronic migraine by triggering analgesic overuse headaches." Furthermore, "[o]piates should only be used for migraine in an emergency setting as an abortive therapy of last resort. These principles of migraine therapy are especially true when treating a migraine patient with a history of substance abuse."

51. Dr. Green opined that the "prophylactic treatment of chronic migraine with high dose opiates is ineffective and very commonly worsens headaches." He further opined that "chronic treatment of migraine with fentanyl and high doses of hydromorphone is an extreme departure from the standard of care" and respondent likely caused harm to Patient A, because "chronic opiates are well known to worsen migraine."

Sensory Polyneuropathy

52. Dr. Green opined that the "standard of care is to use non-opiate pharmacologic agents to treat painful sensory polyneuropathy." He explained that

"[o]piates are not indicated to treat uncomfortable numbness associated with sensory polyneuropathy." In fact, sensory polyneuropathy is not treated with opioids, because the condition does not respond to opioids.

53. Additionally, Dr. Green opined that "[h]igh dose opiate analgesics are not indicated in the setting of sensory neuropathy in a patient with a history of substance abuse." Dr. Green explained that Patient A's records "only sporadically reflect pain as a symptom" of his neuropathy. Yet, respondent maintained Patient A on high doses of opiates, with no evidence of tapering. Dr. Green opined that respondent's prescribing of opiates for Patient A to treat his sensory polyneuropathy is an extreme departure from the standard of care.

Post-Traumatic Heel Pain

54. Dr. Green explained in his report that when treating a patient's heel pain, the "standard of care is to obtain medical records, followed by a specialist evaluation and detailed focused imaging studies." Additionally, "heel pain is more appropriately managed by Orthopedic Surgery, Podiatry, or Physical Medicine specialists rather than a Neurologist." If after evaluation and imaging studies reveal no cause of the heel pain, "local nonpharmacologic measures or non-opiate pharmacologic agents can be used." Dr. Green opined that there is "no role for chronic high dose opiates in the treatment of post-traumatic heel pain."

Additionally, Dr. Green explained that although respondent noted in Patient A's medical records the possibility of Complex Regional Pain Syndrome, it did not appear to have been a serious consideration, since the standard of care for this diagnosis would involve extensive testing and imaging. Regardless, the standard of care

treatment for treatment of Complex Regional Pain Syndrome does not include high dose opiates.

55. Dr. Green further opined that "[o]piates are not indicated to treat chronic posttraumatic heel pain, especially in a patient with a history of substance abuse." He explained that Patient A should have been treated for this condition by treaters from other medical specialties who are "better suited to evaluate and manage this problem." Dr. Green opined that respondent's treatment of Patient A's post-traumatic heel pain with opiates is an extreme departure from the standard of care.

Respondent's Expert's Opinions

56. Respondent retained Jack M. Berger, M.D., a board-certified anesthesiologist, to render an opinion concerning whether her treatment of Patient A complied with the standard of care. In 1978, Dr. Berger obtained his medical degree from the University of Bologna, Italy. Thereafter, he completed an internship and residency in Anesthesiology at the University of Southern California (USC) and University of California, Los Angeles (UCLA) Medical Centers. In 1984, Dr. Berger obtained his board certification in anesthesiology by the American Board of Anesthesiology. In September 1994, he received a certificate of added qualification in Pain Management from the American Board of Anesthesiology.

57. From 1995 until 2020, Dr. Berger served as the Program Director for Regional Anesthesia Fellowship Department of Anesthesiology at the Keck School of Medicine, Los Angeles County (LAC) and USC Medical Center. From 2002 until 2020, he was also the Director of Regional Anesthesia Resident Training. From 2007 until January 2020, he also served as Professor of Clinical Anesthesiology in the Department of Anesthesiology, Keck School of Medicine of USC.

Since January 2020, he has served as Professor Emeritus of Clinical Anesthesiology, Department of Anesthesiology, Keck School of Medicine of USC. Dr. Berger also worked in private practice for 15 years performing anesthesiology and pain management. He still operates a small private practice treating pain management patients. Dr. Berger has never practiced neurology and is not board-certified in neurology.

58. On December 16, 2022, Dr. Berger prepared a report evaluating whether respondent's treatment and prescribing practices related to Patient A departed from the standard of care. Dr. Berger listed the information and documents he reviewed and relied upon to reach his opinions and conclusions. Specifically, he reviewed Patient A's medical records and Dr. Green's report. Dr. Berger opined that respondent did not depart from the standard of care in her treatment of Patient A. Dr. Berger did not define the standard of care in his report or during his testimony at hearing.

EXCESSIVE PRESCRIBING OF OPIATES

59. Dr. Berger disagreed with Dr. Green's opinion that respondent departed from the standard of care by prescribing Patient A excessive amounts of opiates. Dr. Berger explained that Dr. Green failed to "recognize that there is a difference between 'addiction,' and 'opioid dependance.'" Dr. Berger opined that Patient A was "certainly dependent upon opioids to remain functional and control his chronic headaches." Dr. Berger opined that in chronic pain management there is no such thing as excessively high doses as long as the patient is followed and there is justification for the dosage and drugs prescribed. Dr. Berger further opined that respondent was "prescribing multimodal medications to treat the migraine headaches and chronic heel (neuropathic) pain" and that Patient A "needed daily opioid therapy to control his pain to the level that he could function."

60. Dr. Berger opined that respondent completed a comprehensive new patient consultation with Patient A which included "a very extensive past history, social history, examination, and plan, including laboratory work, MRI scan, an opioid agreement/consent, and initial plan to continue current medications." She completed another similar evaluation on July 24, 2018. Respondent noted that Patient A had attended the Betty Ford Clinic. However, Dr. Berger opined that Patient A had "been sober for many years since 1987 and was only using prescribed medications."

61. Additionally, respondent informed Dr. Berger she performed urine screenings of Patient A. Dr. Berger acknowledged there were no urine screening results in Patient A's medical records. Dr. Berger also opined that there was no evidence that Patient A was diverting the drugs, such as requesting early refills or demanding a higher dosage. In fact, Dr. Berger found that respondent was "clearly decreasing the dosage of opioids over time, albeit very slowly." Dr. Berger described Patient A as a "legacy patient" due to his longtime use of opioids. Dr. Berger explained that legacy patients "often require very slow tapering in order to avoid harm of withdrawal and decreasing symptomatology as control of pain is obtained." Dr. Berger explained that respondent had reduced Patient A's MMEs from 360 MMEs per day in 2011, to 180 MMEs per day by 2018.

62. Dr. Berger also disagreed with Dr. Green's opinion that respondent should have referred Patient A to an Addiction Medicine specialist. Dr. Berger opined that such a referral "would not have been of any benefit in this patient." Rather, Dr. Berger opined that Patient A needed "careful follow-up and continued prescriptions with a very slow tapering of opioids as non-opioid medications were trialed and adjusted to the minimal dose that would control the pain without adverse side effects." Dr. Berger further opined that the care respondent provided Patient A was

effective because although he continued to have migraine headaches, without the use of opioids the pain may have been much more severe or incapacitating.

PRESCRIBING OPIATES WITHOUT MEDICAL INDICATIONS

63. Dr. Berger also disagreed with Dr. Green's opinion that respondent departed from the standard of care by prescribing Patient A opioids without medication indication. Dr. Berger opined that Patient A had "multiple different diagnoses" and different reasons for having chronic pain. Dr. Berger explained that when treating a patient with chronic pain and multiple diagnoses the treating physician must "categorize which problem to deal with and deal with each problem in a coordinated manner." Dr. Berger explained that Patient A first presented to respondent using fentanyl patches which were not an adequate way to treat his pain and conditions. Over time, respondent changed Patient A's medications and found a balance that helped address his issues and allowed him to function.

Analysis of Second Accusation Allegations

64. Complainant established by clear and convincing evidence that respondent engaged in gross negligence and repeated acts of negligence related to inappropriately prescribing high doses of controlled substances, without medical indication, to Patient A between January 2015 and March 2019. This is the time period within the seven years preceding the filing of the original Accusation. (Bus. & Prof. Code, § 2230.5, subd. (a).)

65. Dr. Green's opinions that respondent departed from the standard of care in her care and treatment of Patient A were more persuasive than Dr. Berger in all respects. Dr. Green is a board-certified neurologist who has treated neurology patients for over 30 years. He clearly articulated the standard of care for the treatment of a

patient with opioids when the patient has a history of substance abuse. He also articulated the standard of care for the treatment of chronic migraines, sensory polyneuropathy, and post-traumatic heel pain.

66. In contrast, Dr. Berger did not define the standard of care in his report or during his testimony. Dr. Berger is a board-certified anesthesiologist, with no experience working as a neurologist. Dr. Berger's opinions were focused on how to prescribe opiates to a patient who has a long history of opioid dependency, rather than the standard of care for a neurologist treating a patient with a history of migraine headaches, sensory polyneuropathy, and heel pain. As a result, Dr. Berger's opinions were given no weight.

67. The evidence established that respondent prescribed Patient A excessive amounts of opiates between 2015 and early 2019. As Dr. Green explained, the standard of care required respondent to obtain from Patient A a detailed drug history and copies of relevant medical records. Due to Patient A's history of substance abuse and treatment, respondent needed to consult with an Addiction Medicine specialist and conduct regular urine screenings of Patient A to screen for other drugs of abuse, and to take all precautions to prevent opiate diversion.

Respondent failed to meet the standard of care. Other than noting Patient A's history of substance use and attendance at AA and the Betty Ford Clinic, there is no evidence in Patient A's medical records that respondent reviewed Patient A's medical records from other providers or consulted with an Addiction Medicine specialist despite prescribing Patient A high doses of opiates monthly for several years. There is also no evidence of the results of urine screening to ensure Patient A was not abusing other drugs or diverting his medication. As a result, her conduct was an extreme departure from the standard of care.

68. Additionally, respondent departed from the standard of care by prescribing Patient A high doses of opioids, despite no medical indication. Dr. Green explained that the standard of care for treating migraine headaches is to never use opiate analgesics on a chronic prophylactic basis. Such use can worsen chronic migraines by triggering analgesic overuse headaches. Instead, opiates should only be used for migraine in an emergency setting as a last resort.

Between 2015 and early 2019, respondent prescribed Patient A high doses of opiates monthly to treat his occasional migraines, despite the medication being ineffective and very likely causing Patient A worse overuse headaches. Respondent's conduct constituted an extreme departure from the standard of care.

69. Concerning Patient A's sporadic reports of sensory polyneuropathy, the standard of care is to use non-opiate pharmacologic agents. Dr. Green persuasively opined that opiates are not indicated to treat uncomfortable numbness associated with sensory polyneuropathy because the condition does not respond to opioids. Despite not being indicated, respondent maintained Patient A on high doses of opiates to treat his sensory polyneuropathy. Her conduct is an extreme departure from the standard of care.

70. Additionally, Dr. Green persuasively opined that Patient A's heel pain should have been managed by an orthopedic surgeon, podiatrist, or physical medicine specialist rather than respondent. Treatment of the pain should have included local nonpharmacologic measures or non-opiate pharmacologic agents. The use of chronic high dose opiates in the treatment of post-traumatic heel pain is not within the standard of care. Additionally, if Patient A had Complex Regional Pain Syndrome, the standard of care does not include high dose opiates. Respondent's treatment of

Patient A's post-traumatic heel pain with opiates is an extreme departure from the standard of care.

71. Complainant also established that respondent engaged in unprofessional conduct by failing to comply with the Court's Order to produce to the Board Patient A's medical records and a Declaration of Custodian of Records by July 9, 2021. Respondent did not produce the records and a properly completed Declaration of Custodian of Records until August 13, 2021.

Probation Terms and Violations

72. The Disciplinary Order which became effective on June 22, 2018, includes the following relevant probation conditions:

> [¶] ... [¶]
>
> Condition No. 2. 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 of the following: 1) the name and address of the 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.

Condition No. 3. 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 programs(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.

[¶] ... [¶]

Condition No. 6. MONITORING - PRACTICE/BILLING. 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, 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 First Amended Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), First Amended Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and First Amended 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 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 approved in advance by the Board or its designee 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.

[¶] ... [¶]

Condition No. 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.

Condition No. 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.

Condition No. 11. GENERAL PROBATION REQUIREMENTS. Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

[¶] ... [¶]

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

[¶] ... [¶]

Condition No. 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 a First Amended 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.

[¶] ... [¶]

Condition No. 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.

73. Paulette Romero, Enforcement Program Manager for the Board, issued a Non-Compliance Report dated December 14, 2022, regarding respondent's failure to comply with the terms of her probation. Ms. Romero testified at hearing consistent with the report. Ms. Romero served as respondent's probation monitor after Inspector Susan Dvorak, respondent's original probation monitor, left the Board.

74. On July 3, 2018, respondent met with Inspector Dvorak. The purpose of the meeting was to complete an intake interview. Inspector Dvorak explained to respondent the terms and conditions of her probation. Respondent signed an Acknowledgment of Decision form and was provided a copy. Respondent also signed

a Quarterly Declarations Due Dates form and was provided with a copy. After the meeting, Inspector Dvorak sent respondent an intake interview follow-up letter, which outlined the information discussed at the meeting. After the meeting, respondent elected to enroll with the University of California, San Diego Physician Enhancement Program (PEP Program) to serve as her practice monitor.

75. On July 21, 2021, Inspector Dvorak sent respondent a non-compliance letter due to her failure to submit a Quarter II 2021 Quarterly Declaration. Inspector Dvorak directed respondent to submit the Quarterly Declaration by July 26, 2021. Inspector Dvorak informed respondent that failure to submit the Quarterly Declaration could result in disciplinary action against her license. Respondent submitted the Quarterly Declaration by July 26, 2021.

76. On February 2, 2022, Ms. Romero sent respondent a non-compliance letter due to respondent's failure to submit several items required by her probation terms. The specific items are listed in the letter as follows:

- Proof of completion of education courses totaling 65 hours for probation year 2020-2021 by June 22, 2021.
- Controlled substance logs for Quarter II (April, May, June) 2021 by July 10, 2021.
- Controlled substance logs for Quarter III (July, August, September) 2021 by October 10, 2021.
- A Quarter III (July, August, September) 2021 Quarterly Declaration by October 10, 2021, and

- A Notification form from your new malpractice insurance company, The Doctors Company, within 15 days of issuance of the new policy.

Ms. Romero also informed respondent that the Quarterly Declarations for Quarter I 2021, Quarter II 2021, and Quarter I 2022 were received late. Ms. Romero gave respondent until February 16, 2022, to submit the information. Ms. Romero informed respondent that failure to submit the information by the due date could result in referral for citation and fine. Respondent did not submit the information by the due date. A citation and fine was issued.

77. On April 7, 2022, Ms. Romero conducted respondent's Quarter II 2022 quarterly interview. During the interview Ms. Romero reminded respondent she did not provide proof of completion of education courses totaling 65 hours for probation year 2020-2021; controlled substances logs for Quarters II and III 2021; a Quarter III 2021 Quarterly Declaration; and a Notification form from The Doctors Company. Respondent informed Ms. Romero that she would submit the information. She did not.

78. On August 24, 2022, Ms. Romero received two emails from Staci Hurst with the PEP Program. Ms. Hurst informed Ms. Romero that the PEP Program had not received any patient charts from respondent since January 2021. Respondent had also not made any payments to the PEP Program. Ms. Hurst explained that the PEP Program sent respondent a suspension warning letter but had not yet issued an actual suspension letter.

79. On August 25, 2022, respondent's PEP Program Case Manager, Adrienne Diggs, emailed respondent regarding her overdue PEP submissions. Ms. Diggs asked

respondent to provide all outstanding charts and fees by August 31, 2022. Respondent failed to do so.

80. On August 25, 2022, Ms. Romero conducted respondent's Quarter III 2022 quarterly interview. During the interview, Ms. Romero reminded respondent that she still had not provided the following items: controlled substances logs for Quarters II and III 2021; proof of completion of education courses totaling 65 hours for probation year 2020-2021; proof of completion of education courses totaling 65 hours for probation year 2021-2022; patient charts to the PEP Program for the months of February 2021 through July 2022; a Notification form from The Doctors Company; a Quarter III 2021 Quarterly Declaration; and payment of her 2021 Probation Monitoring Costs in the amount of $6,483.

During the interview, respondent provided Ms. Romero completion certificates for 100 hours of CME. Ms. Romero reviewed the information and discovered that respondent's total CME for probation year 2020-2021 was still short five hours and her total for probation year 2021-2022 was still short 35 hours.

At the end of the interview, Ms. Romero provided respondent with a non-compliance letter listing the items that respondent failed to submit. Respondent was given until August 31, 2021, to provide all requested items. Respondent was informed that failure to submit the information by the due date could result in a referral for a citation and fine. The letter also stated that failure to provide patient charts to the PEP Program for February 2021 through July 2022, by August 31, 2022, would result in the issuance of a cease practice order, which would remain in effect until all outstanding charts are submitted to the PEP Program.

81. On September 1, 2022, Ms. Diggs emailed respondent to confirm the PEP Program had not yet received her outstanding submissions and payments. Ms. Diggs informed respondent that, effective immediately, she was suspended from participation in the PEP Program until these issues were resolved. The same day the PEP Program notified Ms. Romero of respondent's suspension from the PEP Program.

82. On September 2, 2022, Ms. Romero sent respondent a non-compliance letter regarding her suspension from the PEP Program. Specifically, Ms. Romero explained that:

> [P]ursuant to Condition #5 [sic] of your Decision and Order, if your monitor resigns or is no longer available, you must, 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 assume that responsibility within 15 calendar days. If you fail to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, you will receive a notification from the Board to cease the practice of medicine within three (3) calendar days after being so notified.

Respondent was given until September 7, 2022, to either submit the name and qualifications of a replacement monitor to Ms. Romero or send the PEP Program her outstanding submissions and payments and have her suspension lifted by November 1, 2022.

83. On November 28, 2022, Ms. Romero conducted respondent's Quarter IV 2022 quarterly interview. During the interview, Ms. Romero reminded respondent she still had not provided the following items: controlled substances logs for Quarters II and III 2021; proof of completion of education courses totaling 65 hours for probation year 2020-2021; proof of completion of education courses totaling 65 hours for probation year 2021-2022; the name and qualifications of a replacement practice monitor; a Notification form from The Doctors Company; and a Quarter III 2021 Quarterly Declaration. In addition, respondent had not submitted her Quarter III 2022 Quarterly Declaration which was due October 10, 2022.

At the end of the interview, Ms. Romero provided respondent with a non-compliance letter, dated November 28, 2022. Respondent was given until December 6, 2022, to submit the requested items. Respondent was informed that failure to submit the information would result in a cease practice order being issued.

84. On December 6, 2022, respondent sent Ms. Romero a facsimile stating that she found a practice monitor. Respondent requested Ms. Romero to send her a copy of a controlled substances log and practice monitor paperwork. That same day, Ms. Romero emailed respondent the requested documents.

85. On December 14, 2022, complainant issued a Cease Practice Order, due to respondent's failure to comply with Probationary Condition No. 6 Monitoring - Practice/Billing. Respondent failed to obtain approval of a replacement monitor within 60 days of being suspended from the PEP Program. Respondent was prohibited from practicing medicine "until a replacement monitor is approved and assumes monitoring responsibility."

86. Ms. Romero has not communicated with respondent since the Cease Practice Order was issued. Respondent has failed to submit all outstanding items discussed during her Quarter IV 2022 quarterly interview and listed in the November 28, 2022 non-compliance letter. As a result, her license has been suspended since December 14, 2022. Respondent's license expired on August 31, 2023, and has not been renewed.

Respondent's Additional Testimony

87. Respondent explained that in late 2020 and early 2021, she began experiencing health issues that affected her ability to comply with probation or timely submit Patient A's medical records to the Board. In 2021, respondent had a reaction to the Covid vaccine, which caused respondent to suffer a heart condition. Her condition is exacerbated by stress, and complying with probation and the Board's demands was stressful to respondent.

Respondent explained that Inspector Dvorak gave her time to submit required information. However, Ms. Romero was less "empathetic" and "wrote her up" for not providing requested information. Respondent explained that "it could not be helped." Respondent continued to practice medicine and see patients at least three days per week until the Cease Practice Order was issued. However, addressing probation issues with the Board caused her stress, which exacerbated her condition. Respondent did not submit a letter to the Board from any treating physician stating that she could not comply with the terms of her probation due to a medical condition.

88. Regarding the allegation that respondent engaged in excessive prescribing of opiates, respondent stated that "everybody has their opinion." Respondent contends that she appropriately treated Patient A's conditions.

Respondent explained that she regularly performed urine screening of Patient A and reviewed his CURES reports. Respondent noted that Patient A was a successful lawyer, and she had no reason to believe he was abusing opiates or any other drugs. Respondent believes she helped Patient A function. The fact Patient A continued to suffer from migraines was not an indication her care was not successful. Rather, her treatment was focused on helping to reduce the pain of his migraines and other conditions.

89. Respondent also disagreed with the allegation that she prescribed opiates without medical indications. Respondent stated that she tried different medications to treat Patient A's conditions. She decided to "bring out the big guns" to help him function, although she was able to taper his opioid medication over time.

90. Respondent wants to begin practicing medicine again. Respondent has not complied with the terms of her probation since the Cease Practice Order was issued. However, she is now willing to comply with the terms of her probation. Respondent identified a practice monitor, although she has not submitted his name or qualifications to the Board. Respondent has not renewed her license because "it did not occur" to her to do so. Respondent also has not completed continuing education because it was too stressful. However, she is now on medication which helps her condition, and she can begin completing continuing education.

Appropriate Discipline

91. Pursuant to California Code of Regulations title 16, section 1361, subdivision (a), the Board has adopted a Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th ed. 2016) (Disciplinary Guidelines) setting forth recommended discipline based on specific violations. The maximum discipline that

should be imposed for an extreme departure from the standard of care, repeated acts of negligence, unprofessional conduct, and violation of probation is revocation. (Disciplinary Guidelines, pp. 24, 28.) There is no basis to deviate from the Board's maximum discipline in this matter.

92. Respondent's conduct is extremely serious. She was placed on probation in 2018 for engaging in gross negligence, repeated acts of negligence, and inadequate recording keeping for seven patients whom she treated with high doses of controlled substances. She engaged in similar conduct in her treatment of Patient A. Respondent's excessive prescribing of controlled substances, without medical indication, constitutes gross negligence and repeated acts of negligence.

Respondent took no responsibility for her conduct. Respondent claimed that she considered Patient A's substance abuse history and regularly conducted urine screening to check for abuse. However, there is no evidence in Patient A's medical records for any such screening. Respondent also could not explain why high daily doses of opioids were needed for Patient A's occasional migraines and other conditions which do not respond to opioids.

93. Most concerning is respondent's repeated failure to comply with the terms of her probation. Pursuant to the Disciplinary Order, respondent agreed to five years of probation with specific terms designed to protect the public. Respondent was given many warnings and opportunities to comply with the terms of her probation. She failed to do so. Since the Cease Practice Order was issued, respondent has made no effort to comply with probation or address the deficiencies. She has not renewed her license or completed any continuing education.

94. Respondent contended that her failure to comply with probation and the Court Order requiring the release of Patient A's records was due to her health issues. However, respondent continued to treat patients and operate her practice until the Cease Practice Order was issued. She produced no evidence that her medical conditions prevented her from complying with probation.

95. The purpose of a license discipline proceeding is not to punish, but to protect the public. (*Fahmy v. Medical Bd. of Cal.* (1995) 38 Cal.App.4th 810, 817.) When the record as a whole is considered, the evidence demonstrates that respondent is not safe to practice as a physician. As a result, revocation of her license is necessary to protect public health, safety, and welfare, and thus the appropriate discipline.

Costs

96. Pursuant to Business and Professions Code section 125.3, complainant requested that respondent be ordered to reimburse the Board for the reasonable costs of the investigation and enforcement of the case. Complainant submitted a Declaration of the Deputy Attorney General with an attached computer printout that lists the amounts charged by the Attorney General's Office by time, date, and task. The Declaration and computer printout show that the Attorney General's Office billed the Board $60,193.75 for prosecuting the case. Complainant also submitted a certification of investigation costs totaling $6,805.50. These costs, totaling $66,999.25, are reasonable in light of the allegations and the extensive evidentiary record in this matter.

LEGAL CONCLUSIONS

1. "Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount." (Bus. & Prof. Code, § 2001.1.)

2. Business and Professions Code section 2220.5 authorizes the Board to commence disciplinary actions against the holder of a license for violations of the Medical Practices Act. Furthermore, pursuant to Business and Professions Code section 2227, a licensee who has been "found guilty" of violation of the Medical Practices Act may have her certificate disciplined by the Board.

Accusation

3. In an Accusation seeking to revoke, suspend, or otherwise discipline respondent's professional license, the Board has the burden of proof to establish the allegations in the Accusation by "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 855-856.) The clear and convincing evidence standard requires a finding of high probability, or evidence "so clear as to leave no substantial doubt" and "sufficiently strong to command the unhesitating assent of every reasonable mind." (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

4. Business and Professions Code section 2225.5, subdivision (d), provides that "failure or refusal of a licensee to comply with a court order, issued in the

enforcement of a subpoena, mandating the release of records to the board constitutes unprofessional conduct and is grounds for suspension or revocation of their license."

5. Business and Professions Code section 2230.5, subdivision (a), provides in relevant part that:

> Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.

6. Business and Professions Code section 2234 provides in relevant part that:

> 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:
>
> [¶] ... [¶]
>
> (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.

7. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care applicable in a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) Simple negligence is merely a departure from the standard of care.

8. Cause exists for discipline under Business and Professions Code section 2227, as defined by Business and Professions Code section 2234, subdivision (b).

Respondent committed acts and omissions amounting to gross negligence in the care and treatment of Patient A, by prescribing Patient A high doses of controlled substances, without medical indication, from 2015 until March 2019.

9. Cause exists for discipline under Business and Professions Code section 2227, as defined by Business and Professions Code section 2234, subdivision (c). Respondent committed acts and omissions amounting to repeated acts of negligence in the care and treatment of Patient A, by prescribing Patient A high doses of controlled substances, without medical indication, from 2015 until March 2019.

10. Cause exists for discipline under Business and Professions Code section 2227 and 2234, as defined by Business and Professions Code section 2225.5, subdivision (d). Respondent failed or refused to comply with the Court Order, issued in the enforcement of a subpoena, mandating the release of Patient A's records to the Board with a Declaration of Custodian of Records by July 9, 2021. Respondent did not produce the records and a properly completed Declaration of Custodian of Records until August 13, 2021.

Petition to Revoke Probation

11. In a petition to revoke probation, complainant must show by a preponderance of evidence that respondent's license should be revoked. (*Sandarg v. Dental Board of California* (2010) 184 Cal.App.4th 1434). This evidentiary standard requires complainant to produce evidence of such weight that, when balanced against evidence to the contrary, is more persuasive. (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.) In other words, complainant must prove it is more likely than not that respondent violated the conditions of her probation. (*Lillian F. v. Superior Court* (1984) 160 Cal.App.3d 314, 320.)

12. Respondent violated Probation Condition 2 of the Disciplinary Order when she failed to maintain records/logs of controlled substances and prescriptions. Therefore, cause exists to set aside the stay order and impose the stayed discipline of revocation of respondent's license, pursuant to Business and Professions Code section 2227 and Condition 15 of the Disciplinary Order.

13. Respondent violated Probation Condition 3 of the Disciplinary Order when she failed to submit proof of her required CME coursework. Therefore, cause exists to set aside the stay order and impose the stayed discipline of revocation of respondent's license, pursuant to Business and Professions Code section 2227 and Condition 15 of the Disciplinary Order.

14. Respondent violated Probation Condition 6 of the Disciplinary Order when she failed to have a practice/billing monitor. Therefore, cause exists to set aside the stay order and impose the stayed discipline of revocation of respondent's license, pursuant to Business and Professions Code section 2227 and Condition 15 of the Disciplinary Order.

15. Respondent violated Probation Condition 9 of the Disciplinary Order when she failed to obey all laws. Therefore, cause exists to set aside the stay order and impose the stayed discipline of revocation of respondent's license, pursuant to Business and Professions Code section 2227 and Condition 15 of the Disciplinary Order.

16. Respondent violated Probation Condition 10 of the Disciplinary Order when she failed to submit quarterly declarations. Therefore, cause exists to set aside the stay order and impose the stayed discipline of revocation of respondent's license,

pursuant to Business and Professions Code section 2227 and Condition 15 of the Disciplinary Order.

17. Respondent violated Probation Condition 11 of the Disciplinary Order when she failed to renew her license. Therefore, cause exists to set aside the stay order and impose the stayed discipline of revocation of respondent's license, pursuant to Business and Professions Code section 2227 and Condition 15 of the Disciplinary Order.

18. Respondent violated Probation Condition 15 of the Disciplinary Order when she violated the conditions of her probation. Therefore, cause exists to set aside the stay order and impose the stayed discipline of revocation of respondent's license, pursuant to Business and Professions Code section 2227 and Condition 15 of the Disciplinary Order.

19. Respondent violated Probation Condition 17 of the Disciplinary Order when she failed to pay her probation monitoring costs. Therefore, cause exists to set aside the stay order and impose the stayed discipline of revocation of respondent's license, pursuant to Business and Professions Code section 2227 and Condition 15 of the Disciplinary Order.

Costs Recovery

20. Pursuant to Business and Professions Code section 125.3, a licensee found to have violated a licensing act may be ordered to pay the reasonable costs of investigation and prosecution of a case. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth factors to be considered in determining the reasonableness of costs sought pursuant to statutory provisions like Business and Professions Code section 125.3. These factors include

whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate in light of the alleged misconduct.

21. Here, the scope of the investigation was appropriate to the alleged misconduct. Respondent was not successful at hearing in having charges dismissed or reduced. She raised no colorable challenge revocation of her license. Respondent did not establish a basis to reduce or eliminate the costs in this matter. However, she should be permitted to pay the costs imposed in installments.

Conclusion

22. When all the evidence is considered, to protect the health, safety, and welfare of the public, respondent's license must be revoked.

ORDER

1. The Petition to Revoke Probation is GRANTED. The order of revocation, stayed, in Board Case Number 800-2014-002731 is vacated and Physician and Surgeon's Certificate No. G 52068 issued to Ernestina Maria Howell Saxton, M.D. is REVOKED.

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2. Respondent Ernestina Maria Howell Saxton, M.D. is ordered to reimburse the Board $$66,999.25 for its costs of investigation and prosecution. The Board may, in its discretion, enter into a payment plan with respondent Ernestina Maria Howell Saxton, M.D. for the payment of the costs if investigation and prosecution.

DATE: May 22, 2024

Marcie Larson
Marcie Larson (May 22, 2024 12:24 PDT)

MARCIE LARSON

Administrative Law Judge

Office of Administrative Hearings