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

In the Matter of the Accusation Against: Ernest Lincoln Bonner, Jr., M.D. Physician's & Surgeon's Certificate No. A 30477 Respondent.	Case No. 800-2020-069020

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 SEP 0 6 2024.

IT IS SO ORDERED: AUG 0 9 2024.

MEDICAL BOARD OF CALIFORNIA

Michelle Bholat, M.D., Interim Chair
Panel A

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

In the Matter of the Accusation Against:

ERNEST LINCOLN BONNER, JR., M.D.,

Physician's and Surgeon's Certificate No. A 30477

Respondent.

Agency Case No. 800-2020-069020

OAH No. 2023080061

PROPOSED DECISION

Administrative Law Judge Holly M. Baldwin, State of California, Office of Administrative Hearings, heard this matter on December 4 through December 6, 2023, and April 9 through April 11, 2024, by videoconference.

Deputy Attorney General Harriet Newman represented complainant Reji Varghese, Executive Director of the Medical Board of California, Department of Consumer Affairs.

Respondent Ernest Lincoln Bonner, Jr., M.D., represented himself.

The record was held open for submission of closing briefs, which were received and marked for identification: Exhibit 28 (complainant's closing argument), Exhibit R87 (respondent's closing argument), Exhibit R88 (respondent's email to complainant's counsel), and Exhibit 29 (complainant's reply to respondent's closing argument).

The record closed and the matter was submitted for decision on June 7, 2024.

FACTUAL FINDINGS

1. The Medical Board of California (Board) issued Physician's and Surgeon's Certificate Number A 30477 to respondent Ernest Lincoln Bonner, Jr., M.D., on September 27, 1976. The certificate was in full force and effect at all times relevant to the allegations in this matter, and is renewed through September 30, 2025. Respondent's certificate was previously placed on probation by the Board, as described further in Factual Finding 111.

2. Acting in his former official capacity as Deputy Director of the Board, complainant Reji Varghese issued an accusation against respondent on February 1, 2023. Varghese subsequently became Executive Director of the Board. Complainant alleges that respondent committed repeated negligent acts and failed to keep adequate and accurate medical records in his treatment of six patients.

3. Respondent filed a notice of defense, and this hearing followed.

4. Voluminous evidence was presented at hearing. The pertinent evidence is discussed below.

Respondent's Education, Training, and Medical Practice

5. Respondent graduated from medical school in 1975. He then completed an internship from 1975 to 1976 and an internal medicine residency from 1976 to 1978, followed by a fellowship in nephrology from 1978 to 1980. Respondent received his California certificate during his residency. Respondent is not board certified.

6. Since 1980, respondent has worked in private practice in the San Francisco Bay Area. He also served as staff physician for a methadone clinic in 1989, and as staff physician in charge of pain management for a workers' compensation firm in 1990 and 1991. Respondent's medical practice focuses on internal medicine and pain management.

7. In 2015, respondent received a DEA (Drug Enforcement Administration) certificate for buprenorphine treatment of opiate use disorder, which required him to take an approximately 12-hour course.

8. Respondent completed law school in 1996. He is not admitted to the bar.

Patients A, B, C, D, E, and F

9. This matter concerns respondent's treatment of six patients in his private practice, over the course of several years. The patients are identified in this decision as Patients A, B, C, D, E, and F, to protect their privacy. As described more fully below, respondent treated these six patients for chronic pain, and for some patients he also provided primary care services.

Complaint to the Board and Investigation

10. This matter came to the attention of the Board when a pharmacist, Alexandra Coults, submitted a complaint to the Board by email on July 5, 2020. Coults raised concerns regarding respondent's prescribing practices, which triggered an investigation. The Board's Central Complaint Unit referred the matter to the Division of Investigation, Health Quality Investigation Unit (HQIU).

11. HQIU investigator Michael Denobriga was assigned the matter in October 2020. He interviewed Coults by telephone, obtained and reviewed a CURES[1] Prescriber Report for respondent's prescriptions, and submitted the matter to the Board's medical consultant, Howard Slyter, M.D., for review. Dr. Slyter identified several patients of respondent's for further review. Denobriga obtained CURES patient activity reports, and requested patient releases for medical records.

12. The matter was reassigned to HQIU investigator Stacie Barrera in September 2021. Barrera requested additional patient releases for medical records, interviewed Patient D by telephone, and obtained patient medical records and patient pharmacy records. On August 30, 2022, Barrera conducted an interview with respondent, which was also attended by respondent's attorney and Dr. Slyter. Respondent stated that he was participating in the interview under protest, because he had wished to answer questions via written interrogatory rather than by interview.

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[1] "CURES" refers to the Controlled Substance Utilization Review and Evaluation System, a statewide database of prescriptions for Schedule II, III, IV, and V controlled substances dispensed in California.

Respondent answered some questions, but as to other questions, declined to answer on advice of counsel. Barrera issued an investigation report on September 22, 2022.

13. The matter was assigned to Andre Loftis, an analyst in the HQIU Expert Procurement Unit, in September 2022. Loftis located and retained an expert reviewer for the Board (see Factual Finding 14 regarding Dr. Huang), provided the expert with case information and materials for review, and received the expert's written report. Loftis signed a supplemental investigation report on November 8, 2022. Loftis testified briefly at hearing, having been called as a witness by respondent. Loftis selected Dr. Huang from among the Board's approved expert reviewers.

Expert Opinion

14. James J. Huang, M.D., was retained as an expert witness for complainant. Dr. Huang reviewed records, wrote a lengthy and detailed report dated October 30, 2022,[2] and testified credibly and persuasively at hearing regarding his opinions and the bases therefor.

15. Dr. Huang graduated from medical school in 1990, received his California certificate in 1991, completed an internal medicine residency in 1993, and completed a gastroenterology fellowship in 1994. Dr. Huang is board-certified in internal medicine. He practices at the Loma Linda Veterans Affairs (VA) Medical Center in San Bernardino, where he has served as an attending physician for the primary care service since 2000,

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[2] Dr. Huang's expert report discussed respondent's treatment of seven patients, but the accusation in this matter alleges cause for discipline arising only from treatment of the six patients identified as Patients A, B, C, D, E, and F. Accordingly, the portions of Dr. Huang's report regarding the seventh patient were not considered.

and has also served as an attending physician for the hospitalist inpatient service since 2017. Dr. Huang has held a variety of leadership and committee roles over the years. He supervises medical residents. Since 2001, he has held an appointment as assistant professor of medicine at the Loma Linda University School of Medicine. Prior to joining Loma Linda, Dr. Huang worked in private practice from 1994 to 2000.

Dr. Huang has served as an expert reviewer for the Board since 2003. During that time, he has reviewed over 100 cases for the Board with issues arising from various areas of internal medicine, including management of pain, prescribing of controlled substances, and treatment of diabetes and hypertension.

16. About 40 percent of Dr. Huang's patients are on medications for management of chronic pain; he notes that veterans have a disproportionately high incidence of chronic pain conditions compared to the general population. In treating this population, Dr. Huang has been required to remain up to date on the standards of practice for management of chronic pain. He has also treated many opiate addicts among this patient population. Dr. Huang is not an addiction medicine specialist, but he co-manages the care of such patients together with addiction physicians at the VA. Dr. Huang has three patients with hemophilia, whom he treats for chronic pain and hypertension management.

Regarding buprenorphine, Dr. Huang explained that the DEA formerly required a physician to take a class and receive a certificate to prescribe buprenorphine, but that since December 2022, all physicians with active DEA certificates are authorized to prescribe this medication. Dr. Huang has prescribed buprenorphine to his patients.

17. Dr. Huang identified numerous departures by respondent from the standard of care, most of which he characterized as simple departures. He classified a

few items as extreme departures. The accusation alleged cause for discipline based on repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)), but did not allege cause for discipline based on gross negligence (*id.*, subd. (b)). Dr. Huang did not opine that any of respondent's departures from the standard of care caused direct physical harm to any patient.

18. Dr. Huang identified recurring themes in respondent's treatment of Patients A through F, and he categorized his findings into the following five areas:

- Evaluation and non-opiate management of chronic pain;
- Initiation and monitoring of chronic opiate pain medication;
- Maintenance of medical records;
- Informed consent and pain care agreements; and
- Hypertension management in primary care.

STANDARDS OF CARE

19. Dr. Huang discussed the standards of care applicable to the above areas of patient care. Both the Board and the Centers for Disease Control (CDC) have issued guidelines relating to evaluation and management of chronic pain ("Pain Guidelines"). The Board's 2014 Pain Guidelines and the CDC's 2016 Pain Guidelines are the versions applicable to the conduct at issue in this matter, although both bodies have subsequently revised their guidelines (the Board in 2023 and the CDC in 2022). Dr. Huang explained that the Pain Guidelines are simply guidelines for physicians to refer to, and do not by themselves represent the standard of care, which is based on the practices of prudent physicians in the community under similar circumstances.

(a) Evaluation and non-opiate management of chronic pain:

Dr. Huang explained that for non-cancer chronic pain, opiate therapy is not the first line of treatment due to its risks of addiction, drug overdose, and respiratory depression. Non-opiate medications can often significantly reduce pain and restore functionality. Non-pharmacologic therapies can improve pain. Surgical consultations for joint injections are other treatment options. Not all non-opiate therapies need to be tried and failed before prescribing narcotics, if the benefits of narcotics outweigh the dangers. Even if opiate therapy is chosen, it is most beneficial when combined with non-opiate medications (which provide synergistic effects) and non-pharmacologic therapy. A multidisciplinary pain management program may include addiction medicine specialists, mental health clinicians who can provide cognitive behavioral therapy (CBT), orthopedic surgeons, anesthesiologists who can provide spinal injections or nerve blocks, or ancillary treatments like physical therapy, acupuncture, or chiropractic. Dr. Huang also noted that prior failure of any particular therapy does not mean that such a therapy could not be effective in the future.

(b) Initiation and monitoring of chronic opiate pain medication:

Opiates with the lowest potency and addiction potential should be tried first for a defined period while monitoring the patient's progress. To justify continuing opiate therapy, there should be fulfillment of the patient's functional goals. Ideally, the MEDD, or morphine equivalent daily dose, for opiate therapy should not exceed 80 to 90 mg. Risks of drug overdose, death, and adverse effects increase significantly beyond this dosage.

The patient's risk of drug addiction and aberrancy should be assessed prior to starting long-term opiate therapy, to mitigate potentially adverse consequences. This

can be done using a questionnaire such as the Opioid Risk Tool (ORT) or other standardized tools, which include questions about family history of substance abuse, and personal history of substance abuse, preadolescent sexual abuse, and psychological disease. Based on the scores, such a tool provides a rating of whether a patient is low risk, moderate risk, or high risk. Patients with above-average risk of addiction can benefit from opioid risk mitigation strategies such as referrals to psychiatry physicians who are adept in addiction treatment; closer monitoring with regular urine drug testing; and consultations with the state prescription drug monitoring program.

Once a patient's pain is adequately controlled on a safe dosage of opiate medication, the patient must be monitored every one to three months. Periodic assessments allow the physician to determine if the medication is meeting the patient's goals of improved pain and functional status, and to discontinue or taper the patient off opiates if the harms outweigh the benefits. Regular assessments in clinic visits should include analgesia, activities of daily living, adverse side effects of opiates, and aberrant behaviors. Strategies for monitoring compliance include consulting the CURES database, urine drug testing, and pill counting. If drug abuse or diversion is confirmed, the physician should meet with the patient to re-evaluate the treatment plan and taper off opiate therapy if appropriate. For patients on opiate therapy at a dosage above 80 to 90 mg MEDD, physicians should prescribe and educate patients about use of naloxone as an antidote to overdoses. Naloxone is also strongly recommended for patients with sleep apnea, chronic respiratory illness, and concurrent use of benzodiazepines, because these other conditions and drugs also increase toxicity risks in opiate dependent patients. Finally, if pain reduction and functional improvement are not realized, the physician should strongly consider tapering the patient off opiates.

(c) Maintenance of medical records:

Physicians must maintain accurate and adequate medical records. For a patient treated with controlled substances, an adequate medical record includes documenting medical history, results of physical examination, and all necessary laboratory and radiologic tests. Vital signs should be clearly recorded for every visit. The records should reflect all treatments provided, including all prescribed medications and consultations. Controlled substance medications and dosages should be clearly documented. Results of ongoing monitoring of patient progress in response to controlled substances should be documented. The records should include any steps taken to address aberrant behaviors in opiate usage, the results of CURES searches, and urine drug testing results. The medical records should be up to date and maintained in an accessible manner to be readily available for review.

(d) Informed consent and pain care agreements:

When considering long-term use of opiate medications, the physician should discuss the risks and benefits with the patient. Informed patient consent addresses the risks and side effects of opiate medications and medical evidence questioning the benefit of long-term opiate therapy.

Using a pain care agreement improves narcotic patients' compliance with treatment goals and objectives, and reduces their risk of aberrant behaviors. Pain care agreements outline the joint responsibilities of physician and patient, including replacement and early refills of lost medications; emphasize the patient's responsibility to obtain prescribed opiate medication from only one physician or practice; and highlight the patient's agreement to periodic drug testing and CURES monitoring.

Patient informed consent and a pain care agreement may be combined into one document for convenience.

(e) Hypertension management in primary care:

Hypertension is considered a "silent killer" disease that can damage the heart and kidneys without symptoms, and is the top diagnosis managed in the primary care setting. Because blood pressure is variable, a diagnosis of hypertension often requires at least two separate clinic visits for confirmation. Home blood pressure monitoring is often recommended, to assess for "white coat" hypertension (blood pressure higher at healthcare visits than in other settings). Diet changes, weight loss, and exercise are initial therapies for managing elevated blood pressure and hypertension. Medications that potentially raise blood pressure should be stopped if possible. If blood pressures do not respond to the above measures, hypertension medications are often required. Periodic additional testing (e.g., urinalysis, blood chemistry, electrocardiogram) should be done to assess for complications of chronic hypertension.

PATIENT A

20. Patient A was a 40-year-old woman suffering from chronic low back pain (following a motor vehicle accident in 2011), chronic shoulder tendonitis, and chronic leg and ankle pain (due to prior tibia and ankle fractures). Her medical history also included prior illicit drug use, obstructive sleep apnea, generalized anxiety disorder, and tobacco addiction. Patient A established care with respondent in early 2018 for treatment of her chronic pain. Patient A was receiving high doses of oxycodone and methadone (at least 700 mg MEDD) from her previous physicians in 2016 and 2017, as well as benzodiazepines.

21. Respondent recommended tapering Patient A off methadone therapy, and successfully weaned her off methadone in two months. Respondent maintained Patient A on oxycodone. Patient A signed a pain care agreement. In 2018, Patient A had functional assessments and joint examinations at her visits with respondent for opiate refills. Patient A had occasional early refills.

22. Patient A had multiple inconsistent urine toxicology test results from 2018 to 2020, showing either the presence of other non-prescribed narcotics or benzodiazepines (hydrocodone, morphine, temazepam, alprazolam, oxazepam), or the absence of oxycodone, the medication prescribed by respondent. Many urine samples also showed the presence of marijuana and alcohol metabolites. Respondent warned Patient A that he may need to taper her off oxycodone due to the aberrant behaviors revealed in the urine test results. Patient A reported that she often used more opiates than were prescribed and thus ran out of medications early.

23. By August 2018, respondent had diagnosed Patient A with opiate use disorder and started her on buprenorphine/naloxone (Suboxone) therapy. However, she could not tolerate the medication side effects and respondent discontinued it after one month. Respondent did not refer Patient A to an addiction medicine specialist or mental health clinician. Patient A's average daily dosage of oxycodone in 2018 was 100 mg daily (MEDD 150 mg).

24. Respondent continued to see Patient A throughout 2019 for opiate refills and pain management, averaging about 120 mg daily of oxycodone (MEDD 180 mg). Patient A had three inconsistent urine test results in the summer of 2019, raising a suspicion of diversion behaviors or taking more medication than prescribed, but respondent did not address these results with the patient. Respondent did prescribe naloxone antidote therapy in 2019 to minimize risks of accidental overdose.

Respondent continued to prescribe oxycodone to Patient A throughout 2020, averaging about 130 mg daily (MEDD 195 mg). Despite frequently documenting the need to taper Patient A's oxycodone, respondent did not do so, and Patient A's daily oxycodone dosage increased from 100 mg daily in 2018 to 130 mg daily by 2020.

Evaluation and Non-Opiate Management of Chronic Pain

25. Dr. Huang identified three simple departures by respondent from the standard of care in this area for Patient A.

(a) In evaluating this middle-aged woman with persistent lower back pain, respondent should have considered additional evaluations besides the prior MRI (magnetic resonance imaging) and X-rays, to search for potential alternative causes such as pelvic infection or malignancy, chronic spinal infection, or intrabdominal gastrointestinal tumors. Such evaluations could include a pelvic examination by respondent or the patient's primary care physician, further CT (computed tomography) imaging of the abdomen and lower spine, and laboratory testing to check for infection or inflammatory causes. Respondent did not perform such evaluations in 2018 to 2020. He did refer Patient A to an orthopedist for an ankle fracture.

(b) Respondent did not concurrently prescribe safer non-opiate medications to Patient A while she was on long-term oxycodone therapy. Respondent documented that Patient A had tried NSAIDs (non-steroidal anti-inflammatory drugs) including ibuprofen, naproxen, celecoxib, and diclofenac without pain improvement; and that she had also failed gabapentin, pregabalin, non-addictive muscle relaxants, and topical analgesic creams. Failure of these safer non-opiate medications was respondent's main justification for prescribing long-term opiate therapy. However, a review of Patient A's pharmacy profiles did not show that any of the above medications were prescribed by

respondent or other physicians (apart from respondent prescribing ibuprofen). Dr. Huang was questioned about records showing Patient A was prescribed hydroxyzine,[3] fluoxetine,[4] and psychiatric medications by another provider, Dr. Mains, but opined respondent's non-narcotic pharmacotherapy for Patient A was insufficient.

(c) Respondent documented in 2020 that Patient A had previously failed physical therapy, acupuncture, and chiropractic treatment, and that she had CBT and epidural injections without much improvement. However, these non-pharmacologic therapies could not be corroborated because respondent's medical records for Patient A from 2018 to 2020 did not include treatment or consultation notes.

Initiation/Monitoring of Chronic Opiate Pain Medication

26. Dr. Huang commended respondent for successfully tapering Patient A off methadone. However, Dr. Huang identified four simple departures by respondent from the standard of care, as discussed below. He also opined that these simple departures combined to form an extreme departure from the standard of care in initiation and monitoring of long-term opiate therapy.

(a) Respondent did not perform and document a formal opioid risk assessment of Patient A prior to beginning long-term opiate therapy. Dr. Huang opined that Patient A was clearly at high risk of addiction given her history of illicit drug use, anxiety, age, alcohol use, and tobacco addiction. This elevated risk was

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[3] Respondent characterized hydroxyzine as a muscle relaxer, but Dr. Huang stated persuasively that it is an antihistamine sometimes used off-label for anxiety.

[4] Fluoxetine is an SSRI-class antidepressant.

confirmed by subsequent multiple aberrant urine toxicology results and early refills of opiate medications.

(b) Respondent did not refer Patient A to addiction medicine and mental health specialists to treat her addiction, after he discontinued the Suboxone therapy due to the patient's intolerance for its side effects.

(c) Respondent did not perform thorough and meaningful functional assessments during 2018 to 2020. Respondent's records documented that he performed such assessments, but they appeared copied and pasted from templates. Moreover, Patient A admitted to respondent that she was taking more oxycodone than prescribed and often ran out early, using leftover other opiates to manage her pain. This confirmed that she was not achieving her functional goals in taking oxycodone, despite respondent's documentation of assessments.

(d) After diagnosing Patient A with opioid use disorder, respondent continued to prescribe high and gradually increasing doses of oxycodone in 2019 and 2020, even while he repeatedly documented a need to taper down the oxycodone use.

Maintenance of Medical Records

27. Dr. Huang identified four simple departures by respondent from the standard of care in this area for Patient A.

(a) Respondent failed to document reasons for early refill of opiates.

(b) Respondent's documented functional assessments were inconsistent with Patient A's actions and needs for more opiate medication.

(c) Respondent failed to properly document the prescribing of safer non-opiate medications by respondent or Patient A's primary care physician.

(d) Respondent's medical records for Patient A lacked details of ancillary treatments (epidural injections, physical therapy, and acupuncture) she was reported to have tried and failed.

Informed Consent and Pain Care Agreement

28. Dr. Huang identified one simple departure by respondent in this area. Patient A signed a pain care agreement in January 2018. However, respondent did not enforce the agreement and hold Patient A accountable for her aberrant behaviors, taper her opiate use, or offer additional treatments for opiate addiction.

PATIENT B

29. Patient B was a 31-year-old woman with chronic low back pain (after a motor vehicle accident in 2001). She also suffered from chronic anxiety, obesity, asthma, and irregular menstrual bleeding. Patient B began treatment with respondent in February 2019 for pain management. At that time, she was already dependent on long-term opiate therapy. During Patient B's initial visit, respondent obtained a history and performed a physical examination. Respondent did not document obtaining Patient B's prior medical records or any discussion by telephone with prior physicians.

30. Respondent continued Patient B on oxycodone at a dose of 60 mg daily (MEDD 90 mg). Respondent ordered X-rays in July 2019 and later ordered MRI imaging, but Patient B did not obtain these diagnostic studies. Patient B continued to see respondent for regular opiate refills during 2019 and 2020. She frequently informed respondent she ran out of oxycodone early, and the monthly quantity was

quickly increased from 40 tablets to 60 tablets, and eventually to 90 tablets in the first quarter of 2020. Respondent documented performing functional assessments and evaluations during Patient B's clinic visits, but these appeared copied and pasted.

31. During a period of 20 months in 2019 and 2020, respondent ordered a number of urine toxicology tests, but Patient B only completed four urine tests, all in 2019. This testing had two inconsistent results, showing presence of methadone and benzodiazepines that had not been prescribed by respondent. When respondent confronted Patient B with these aberrant findings, she denied ever taking those medications. Patient B did admit taking her friend's oxycodone in February 2020 when she ran out of her own monthly refills.

32. Respondent also provided primary care services to Patient B. Because of Patient B's irregular menstrual bleeding, respondent referred her to a gynecologist to remove her intrauterine device (IUD). Because of Patient B's bilateral leg edema and swelling, respondent ordered an echocardiogram and referred her to a cardiologist for assessment of possible heart failure syndrome.

33. Throughout her nearly two years of clinic visits with respondent, Patient B had elevated blood pressure readings. Respondent did not offer any medical interventions or assessments of Patient B's hypertension or warn the patient regarding her uncontrolled hypertension, despite referring her to a cardiologist for other reasons (leg swelling).

Evaluation and Non-Opiate Management of Chronic Pain

34. Dr. Huang identified six simple departures by respondent from the standard of care in this area for Patient B, as discussed below. He also opined that these simple departures combined to form an overall extreme departure from the

standard of care in diagnosis and non-opiate management of chronic low back pain. Dr. Huang noted that due to Patient B's young age, it was in her best interest to take as little narcotic medication as possible and to try all non-opiate treatment modalities.

(a) Respondent appropriately referred Patient B to gynecology, as IUD infection or endometriosis could have been the cause of her low back pain. However, more detailed diagnostic evaluations should have been done (including orthopedic and/or rheumatology consults and serological blood testing for rheumatological disease). Respondent ordered MRI imaging but Patient B never complied. Thus, the cause for her ongoing low back pain remained unclear. Without a clear diagnosis, Dr. Huang found it difficult to justify respondent's prescribing high doses of oxycodone (MEDD 60-90 mg) to this young patient for two years. He opined that respondent should have been more adamant with the patient about the need to comply with imaging orders, warning her that failure to do so would result in his inability to continue prescribing oxycodone.

(b) Because of the chronic nature of Patient B's low back pain, respondent should have recommended consultations with orthopedic and/or rheumatology specialists for second opinions or evaluation of alternative diagnoses.

(c) Respondent did not prescribe safer non-opiate medications concurrently with the oxycodone. Respondent documented that Patient B had failed various NSAIDs and other opiate pain medications with less potency than oxycodone. However, review of the pharmacy profiles showed only ibuprofen was prescribed, and no other safer non-opiate medications (e.g., gabapentin, pregabalin, tricyclics, non-addictive muscle relaxants, topical creams).

(d) Respondent failed to strongly recommend further ancillary therapies such as physical therapy and acupuncture. He documented that Patient B had failed physical therapy, massage, and acupuncture, but no details were found in the records.

(e) Respondent failed to refer Patient B to a mental health clinician for CBT, for her chronic anxiety and to help her better cope with chronic low back pain.

(f) Respondent failed to strongly recommend weight loss programs and aerobic exercise to this obese patient to reduce stress on her low back.

Initiation/Monitoring of Chronic Opiate Pain Medication

35. Dr. Huang identified six simple departures by respondent from the standard of care in this area for Patient B, as discussed below. He also opined that these simple departures combined to form an overall extreme departure from the standard of care in the initiation and monitoring of chronic opiate therapy.

(a) Respondent failed to thoroughly review Patient B's prior pain management records before initiating long-term high-dosage oxycodone therapy.

(b) Respondent did not perform and document a formal opioid risk assessment of Patient B prior to beginning long-term opiate therapy.

(c) Multiple factors should have alerted respondent to Patient B's high risks of addiction and dependency: aberrant behaviors of taking a friend's narcotics and noncompliance with tests, chronic anxiety, young age, and inconsistent urine tests. To mitigate these risks, respondent should have offered Patient B a multidisciplinary pain management approach, which could include orthopedic consultations, non-invasive procedural interventions by pain management specialists, addiction specialists, CBT

with mental health clinicians, physical therapy, and primary care coordination of these services.

(d) Respondent failed to recognize Patient B's addiction to opiates and refer her to an addiction medicine specialist.

(e) Respondent did not perform thorough and meaningful functional assessments, instead copying and pasting assessments that were inconsistent with Patient B's needs for more opiate medications.

(f) Because Patient B had elevated risks of accidental overdose due to her asthma condition and high MEDD, respondent should have prescribed a naloxone antidote.

Hypertension Management in Primary Care

36. Dr. Huang identified four simple departures by respondent from the standard of care in this area for Patient B, as discussed below. He also opined that these simple departures combined to form an overall extreme departure from the standard of care in management of hypertension at the primary care level.

(a) Respondent failed to recognize and diagnose Patient B's hypertension. Dr. Huang noted that general internists should be skilled in managing hypertension, and he was surprised by the failure of respondent, an internal medicine physician by training, to recognize and address Patient B's ongoing hypertension. Dr. Huang also opined that if respondent was not interested in managing Patient B's hypertension, he should have reminded her to schedule appointments with other physicians to do so.

In discussing respondent's care for Patient B, and the other patients with hypertension (Patients C, D, and F), Dr. Huang noted that multiple doctors can

collaborate in managing a patient's hypertension, but no evidence showed that respondent did so. Dr. Huang also opined that even if respondent was not the primary care physician, if respondent's patient had ongoing elevated blood pressure readings, respondent was obligated to address those findings, either by managing the patient's hypertension himself or referring the patient to another physician for such management.

(b) Respondent failed to prescribe medication to manage hypertension.

(c) Respondent also failed to recommend self-monitoring of blood pressure or dietary changes.

(d) Respondent failed to obtain routine metabolic blood testing and electrocardiogram monitoring for potential long-term complications of hypertension.

Maintenance of Medical Records

37. Dr. Huang identified two simple departures from the standard of care.

(a) Respondent's records documented that Patient B had failed various NSAIDs and lower-potency opiate medications, but contained no details of the dates, dosages, and quantity of such medications. Moreover, the pharmacy profiles did not confirm dispensing of such medications.

(b) Respondent's records documented that Patient B had failed ancillary therapies such as physical therapy, massage, and acupuncture, but had no details regarding those therapies.

Informed Consent and Pain Care Agreement

38. Dr. Huang identified one simple departure by respondent in this area, for failure to have a signed pain care agreement for Patient B's long-term opiate therapy.

PATIENT C

39. Patient C was a 60-year-old man with chronic low back, neck, and knee pain. He had chronic headaches due to prior head trauma (hammer attack to the skull). Patient C also had a history of hypertension and chronic anxiety disorder.

40. As reflected by CURES reports, in 2016 and 2017, Patient C was already dependent on long-term opiate therapy, receiving oxycodone 90 mg daily, from six different providers. In April 2017, Patient C received a single prescription from respondent for oxycodone 90 mg daily, and also methadone, for reasons that were not established in the records reviewed. Patient C did not return again to respondent in 2017, continuing to receive oxycodone and methadone from Dr. Anthony Riley.

41. Patient C returned to respondent's care in early 2018. Respondent successfully tapered Patient C off methadone within two months, and maintained him on oxycodone of 90 mg daily (MEDD 135 mg). In the latter months of 2018, Patient C received his oxycodone refills from other physicians, Dr. James and Dr. Hubbard.

42. In 2019, Patient C continued to be prescribed oxycodone by respondent (six prescriptions), and also received oxycodone from other physicians, Dr. Kamdar and Dr. Dambroso, as well as one prescription for hydrocodone from Dr. James.

43. In 2020, respondent refilled Patient C's oxycodone at 90 mg daily.

44. Patient C was prescribed alprazolam (a benzodiazepine) for anxiety from 2016 to 2020 by his neurologist, Dr. Economou. Respondent's records documented repeated informed consent discussions with Patient C about the health risks of taking both benzodiazepines and opiates.

45. Patient C had multiple inconsistent urine toxicology test results. In January 2018, his urine testing showed presence of hydrocodone although CURES reports showed he had not been prescribed this medication in 2017 or 2018 to date. In March 2018, his urine test showed presence of methamphetamine metabolites despite not being prescribed any stimulants. From July to December 2019, he had six urine tests, of which five showed presence of non-prescribed opiates (hydrocodone or hydromorphone). Respondent appropriately addressed one inconsistent test result that showed methadone metabolites, and was satisfied with Patient C's explanation of accidentally taking his old methadone tablets. However, Patient C continued to have inconsistent test results, and respondent did not take action to address them.

46. Patient C consistently had elevated blood pressures at his office visits with respondent in 2018 to 2020. Medical records showed Patient C was taking hypertension medication (Lisinopril) at 20 mg daily since 2018. In late 2018, respondent increased Patient C's dosage slightly, by 5 mg. However, respondent made no further changes to the dosage or medication despite Patient C's ongoing uncontrolled hypertension in 2019 and 2020. Respondent did refer Patient C to cardiology in early 2018 for pre-operative medical evaluation after noticing abnormalities on an electrocardiogram, but the records did not reflect whether respondent had also referred Patient C's hypertension management to cardiology.

Evaluation and Non-Opiate Management of Chronic Pain

47. Dr. Huang identified one simple departure by respondent from the standard of care in this area, for failing to prescribe sufficient non-opiate medications to reduce Patient C's oxycodone dependency. Respondent justified the long-term use of oxycodone by noting Patient C had previously tried non-opiates without success (ibuprofen, naproxen, celecoxib, pregabalin, gabapentin, baclofen). However, Dr. Huang opined that respondent should have concurrently prescribed these non-opiates together with the oxycodone due to their synergistic effects, in hope of reducing the patient's narcotic dependency. Dr. Huang conceded that respondent had prescribed gabapentin for Patient C in early 2018, but opined it was at a non-therapeutic dosage, which was not titrated. He also saw that respondent prescribed pregabalin briefly but discontinued it due to side effects. Dr. Huang noted there were many other non-opiate medications that could have been tried by respondent and were not.

48. Dr. Huang found no departure from the standard of care in the diagnostic evaluation of Patient C's chronic back pain.

Initiation/Monitoring of Chronic Opiate Pain Medication

49. Dr. Huang identified three simple departures from the standard of care in initiating and monitoring Patient C's chronic opiate medication.

(a) Respondent did not perform and document a formal opioid risk assessment of Patient C prior to beginning long-term opiate therapy in 2018 or 2019. Dr. Huang opined that Patient C's pattern of obtaining narcotic prescriptions from multiple providers in 2016 and 2017 was a warning sign of increased risk of addiction, and that his tobacco addiction, male gender, and anxiety disorder also increased his opioid risks. Respondent administered an opioid risk assessment tool in March 2021.

(b) Respondent refilled high-dosage methadone therapy in 2017. Dr. Huang found this ill-advised because methadone's long half-life creates a high risk of accidental drug overdose. In mitigation, Dr. Huang noted respondent tapered Patient C off methadone in 2018 and recommended multi-disciplinary pain management, including spine clinic evaluations, joint injections by pain management specialists in rehabilitation medicine, anxiety management by a neurologist, and physical therapy.

(c) Respondent failed to recognize Patient C's opiate addiction/misuse despite ongoing inconsistent urine toxicology results. Respondent should have started tapering the patient off oxycodone and referred him to drug treatment programs.

Hypertension Management in Primary Care

50. Dr. Huang identified three simple departures from the standard of care.

(a) Respondent slightly increased Patient C's dosage of Lisinopril from 20 mg to 25 mg, but took no further action despite ongoing high readings indicating uncontrolled hypertension. He failed to add new medication or further titrate the Lisinopril during three years of treatment.

(b) Respondent failed to encourage home monitoring of blood pressure and modification of diet and exercise.

(c) Respondent failed to perform routine blood testing to monitor for hypertension complications. In mitigation, Dr. Huang noted that respondent did refer Patient C to cardiology in 2018 for pre-operative assessment of cardiovascular health.

Maintenance of Medical Records

51. Dr. Huang identified two simple departures from the standard of care.

(a) Respondent's records documented that Patient C had failed various NSAIDs and non-opiate medications, but contained no details of the dates, dosages and quantities. Moreover, the pharmacy profiles did not confirm dispensing of such medications.

(b) Respondent's records documented that Patient C had failed ancillary therapies such as physical therapy and chiropractic, but included no dates or details.

Informed Consent and Pain Care Agreement

52. Dr. Huang identified one simple departure by respondent in this area, for failure to have a signed pain care agreement for Patient C's long-term opiate therapy from 2018 to 2020. Dr. Huang noted that Patient C signed a pain care agreement in March 2021, but opined such an agreement should have been signed much earlier, especially given this patient's multiple aberrant behaviors.

PATIENT D

53. Patient D was a 55-year-old woman with multiple chronic medical issues including hypertension, asthma, interstitial lung disease, depression, and attention deficit disorder. She also suffered from complicated and chronic pain due to fibromyalgia (a debilitating rheumatologic condition leading to total body pains); degenerative disc disease; complex regional pain syndrome affecting all four extremities after an acupuncture nerve injury in 2006; spinal fusion surgery; and vertebral osteomyelitis (spinal bone infection).

54. Patient D was already dependent on high doses of opiate medications (MEDD more than 300 mg) before establishing care with respondent in March 2019. From 2017 to 2018, Patient D was prescribed oxycontin 80 mg daily, with oxycodone

120 mg daily and tramadol 200 mg daily, by three physicians. Respondent performed a detailed history and examination, and decided to refill the same opiate regimen for pain management.

55. Patient D was hospitalized from April to June 2019, for treatment of acute vertebral osteomyelitis. She was discharged with a higher dosage of opiates due to the chronic infection: oxycontin 240 mg daily, with oxycodone 80 mg daily and tramadol 200 mg daily (total MEDD 480 mg). Respondent evaluated Patient D for post-hospitalization follow-up in late June 2019, and continued this opiate regimen as the patient's pain seemed stable. Over the next several months, Patient D had multiple MRI imaging scans and consultations with infectious disease, orthopedic, and pain management specialists at Stanford University Hospital. Because the imaging showed inflammatory changes of the spine, Patient D was advised to take oral antibiotics on a long-term basis. She was also referred for physical therapy, joint injections, back braces, and yoga exercises.

56. Patient D continued to see respondent for pain management and opiate medication refills from June 2019 through December 2021. Respondent added pregabalin in June 2020. He also prescribed gabapentin, meloxicam, cyclobenzaprine, citalopram, buspirone, and topical diclofenac gel for pain management. Respondent further documented that Patient D received psychological counseling for her depression and pain management. Respondent frequently consulted CURES and performed urine toxicology tests. Respondent was able to taper down Patient D's opiate dosage in July 2021 to the same dosage that had been prescribed in early 2019 (MEDD 300 mg) prior to the spine infection.

57. Respondent noted Patient D's chronic hypertension diagnosis at their first encounter in March 2019; at that time she was medicated with a clonidine patch.

Throughout 30 months of subsequent pain management and primary care by respondent, Patient D often had elevated blood pressure readings at her office visits. Respondent did not document any assessment of Patient D's uncontrolled hypertension, prescribe any hypertension medication, or recommend other interventions or home blood pressure monitoring. It was unknown if Patient D was still taking her previous medication via clonidine patch, as respondent's chart notes did not list the medication. Respondent documented that Patient D had elevated serum creatinine (a marker of chronic kidney disease) in a 2019 blood test report.

Evaluation and Non-Opiate Management of Chronic Pain

58. Dr. Huang found no departure from the standard of care in this area.

Initiation/Monitoring of Chronic Opiate Pain Medication

59. Dr. Huang found one simple departure from the standard of care in this area, for failure to perform and document a formal opioid risk assessment of Patient D prior to continuing her pre-existing opioid therapy. Dr. Huang noted, however, that absence of this assessment did not negatively impact Patient D's chronic pain management, and she did not show any aberrant behaviors in 2019 to 2021 despite high oxycodone dosage. Dr. Huang also found that Patient D benefited greatly from the multidisciplinary pain management coordinated by respondent.

Hypertension Management in Primary Care

60. Dr. Huang found that respondent should have done much more to manage and stabilize Patient D's hypertension. He opined that the following items combined to form an overall extreme departure from the standard of care:

(a) Respondent failed to consider hypertension medication.

(b) Respondent failed to provide dietary counseling about salt restriction.

(c) Respondent failed to recommend home blood pressure monitoring.

(d) Respondent failed to perform more frequent and regular blood testing and electrocardiograms for this patient with chronic kidney disease.

Maintenance of Medical Records

61. Dr. Huang found two simple departures from the standard of care.

(a) Respondent failed to maintain adequate records documenting close collaboration between respondent and Patient D's mental health providers, such as names of therapists, dates of treatment, and further mental health recommendations.

(b) Respondent's chart notes regarding mostly normal findings upon musculoskeletal and neurological examination were inconsistent with his documentation of Patient D's frequent debilitating pain that caused her to be bedridden at home. The examination findings often appeared copied and pasted, and did not truly reflect the intensity and severity of the pain described by the patient.

Informed Consent and Pain Care Agreement

62. Dr. Huang identified one simple departure by respondent in this area, for failure to have a signed pain care agreement for Patient D's long-term opiate therapy from 2019 to 2021. Dr. Huang did note that respondent appropriately had informed consent discussions with Patient D on a regular basis, given her high dosage MEDD.

PATIENT E

63. Patient E was a 70-year-old man with chronic low back and neck pain (after a 2006 motor vehicle accident), hypertension, osteoporosis, and hepatitis C.

64. Patient E was dependent on high dosage oxycodone of 360 mg daily (MEDD 540 mg) in 2016 and 2017 while under the pain management care of Dr. Riley. Respondent saw Patient E in June 2016 and April 2017 and authorized refills at similar doses. By early 2018, respondent became Patient E's main prescriber of narcotic medications for pain management. Respondent also prescribed non-opiate medications: gabapentin; fluoxetine; naproxen; and pregabalin.

65. MRI scans were performed on Patient E's lumbar and cervical spine in 2015 and 2018, confirming degenerative changes, disc protrusions, and foraminal stenoses, common findings in elderly patients. Respondent referred Patient E to orthopedic surgeons in 2019 and 2020, but the patient was reluctant to see them due to fear of surgery. Patient E was referred for a bone density scan in 2019, but results were not available. He was also referred for a rheumatology evaluation. Respondent did not document referrals to pain management or anesthesiology specialists for non-invasive interventions. Respondent documented that Patient E had psychological counseling for his chronic pain syndrome and depression, but provided no details. Similarly, he documented that Patient E failed physical therapy and acupuncture, without details.

66. Respondent continued prescribing high doses of oxycodone (oxycontin and oxycodone) at 360 mg daily (MEDD 540 mg) throughout 2018. He discontinued oxycontin in March 2019, because Patient E's health insurance would no longer pay for this extended-release medication. Patient E's MEDD was thus reduced to 247 mg

(oxycodone and hydrocodone). Due to increasing pain, within the next six months respondent increased Patient E's MEDD to 300 mg (oxycodone 180 mg daily with hydrocodone 30 mg daily). Respondent continued this dosage throughout 2020.

67. Respondent performed and documented functional assessments and physical examinations, checked CURES, and performed urine testing. Patient E had multiple inconsistent urine toxicology results in 2018 and 2019, showing presence of non-prescribed methadone, hydromorphone, hydrocodone, or morphine in separate tests. Most urine tests included alcohol metabolites. A urine test in October 2019 showed traces of heroin. Respondent confronted Patient E about the abnormal results, and the patient admitted buying additional narcotics from friends or off the streets, and admitted using heroin in October 2019 due to great physical pain.

68. Patient E committed suicide by firearm in February 2021.

Evaluation and Non-Opiate Management of Chronic Pain

69. Dr. Huang found no departure from the standard of care in diagnostic evaluation of Patient E's chronic back pain.

70. However, he found two simple departures in non-opiate pain management, opining that respondent was too reliant on oxycodone monotherapy to manage this elderly patient's chronic low back pain.

(a) Respondent failed to prescribe sufficient non-opiate mediations, which could have reduced Patient E's opiate dependency when used concurrently with oxycodone. Dr. Huang commended respondent for prescribing naproxen (NSAID) and gabapentin (anti-convulsant) for better pain control, but opined that respondent could have tried other more potent NSAIDs as the naproxen was not working. Respondent

prescribed gabapentin at 300 mg daily as a trial, but discontinued it after one month, instead of titrating the dosage, which could have been increased to a maximum of 3600 mg daily. Pharmacy records also showed Patient E did not regularly refill his prescribed fluoxetine. Respondent did not try other safer non-opiate medications, such as tricyclic antidepressants, SNRI antidepressants, non-addictive muscle relaxants, and topical creams.

(b) Respondent failed to refer Patient E to anesthesiology/pain management specialists despite the patient's excessive MEDD requirements for opiates.

Initiation/Monitoring of Chronic Opiate Pain Medication

71. Dr. Huang identified six simple departures by respondent from the standard of care in this area for Patient E, as discussed below. He also opined that these simple departures combined to form an overall extreme departure from the standard of care in the initiation and monitoring of long-term opiate therapy.

(a) Respondent failed to perform and document a formal opioid risk assessment of Patient E prior to continuing his pre-existing opioid therapy. Dr. Huang opined that Patient E's alcohol use, depression, and excessively high MEDD since 2016 were warning signs of elevated opiate risks.

(b) Respondent failed to provide a multidisciplinary pain management approach despite Patient E's high risks from long-term high-dose opiate treatment. Dr. Huang opined that respondent should have been more insistent that Patient E consult with an orthopedist, and should have considered anesthesia/pain management consultations early in the course of treatment.

(c) Respondent failed to recognize Patient E's opiate addiction and to refer him to drug treatment programs after aberrant behaviors of buying methadone, morphine, and heroin.

(d) Respondent decided to prescribe long-term opiate therapy despite the opiate risks clearly outweighing the benefits for Patient E, who was elderly and suffered from depression and osteoporosis. Dr. Huang cited literature finding that long-term opiate therapy is harmful for geriatric patients due to the risks of memory impairment, cognitive dysfunction, depression, and increased risks of falls and vehicle accidents.

(e) Respondent prescribed two short-acting opiate medications concurrently (hydrocodone and oxycodone), which is not recommended due to increased risks of addiction and toxicity. Dr. Huang noted that if two opiates are prescribed concurrently, one should be short-acting and one long-acting.

(f) Patient E did not have adequate pain control despite an excessive dosage of oxycodone, and thus respondent should have tapered down the oxycodone. Dr. Huang explained that most guidelines for opiates provide that an MEDD of 120 mg is the maximum safe dose, and that an MEDD of 300 or more is excessive due to the high risk of overdose. Patient E was on oxycodone of over twice the safe dosage and was still resorting to buying illegal drugs, so the medication should have been reduced and other pain management strategies should have been attempted.

Maintenance of Medical Records

72. Dr. Huang found one simple departure for failure to maintain adequate medical records. Respondent documented that Patient E had psychological counseling for his chronic pain syndrome and depression, and that he had failed physical therapy

and acupuncture, but provided no details such as dates of treatments, names of therapists, or further recommendations.

Informed Consent and Pain Care Agreement

73. Dr. Huang found no departure from the standard of care in this area, finding that respondent appropriately documented informed consent discussions on a regular basis during Patient E's high-dosage opiate therapy, and that Patient E signed a pain care agreement in May 2019.

PATIENT F

74. Patient F was a 28-year-old man with hemophilia, a congenital blood clotting disorder that leads to spontaneous hemorrhages into joints. He had joint pain in his weight-bearing joints, especially his knees and hips, and chronic inflammations that would likely require eventual joint replacement surgeries. Patient F was regularly monitored and treated by hematology and orthopedic specialists at the University of California, San Francisco (UCSF). As a result of his degenerative joint disease, Patient F was largely required to use a wheelchair.

75. Prior to beginning treatment with respondent, Patient F was prescribed methadone and hydromorphone in 2016 and 2017 by his Kaiser physicians. He then transferred his care to non-Kaiser physician Dr. Riley, who prescribed oxycontin and oxycodone totaling 340 mg daily with intermittent prescriptions of methadone.

76. Respondent began treating Patient F in February 2018. Respondent referred Patient F to Dr. Hubbard, a pain management specialist, for a second opinion about the narcotic regimen, but it did not appear that the patient complied. Respondent continued Patient F on opiate therapy, prescribing oxycontin 160 mg daily

with oxycodone 180 mg daily and methadone 20 mg daily (total MEDD 590 mg). For several months in 2019, Patient F was unable to fill his oxycontin prescriptions due to pharmacy back-order issues. These issues were resolved by August 2019, and Patient F was continued on oxycontin 120 mg daily, oxycodone 180 mg daily, and methadone 20 mg daily (total MEDD 530 mg).

77. Patient F had multiple inconsistent urine toxicology results. In February 2018, urine results showed presence of non-prescribed hydrocodone, hydromorphone, and ketamine. In March 2018, urine testing showed no presence of his prescribed methadone or oxycodone, raising suspicion of diversion behaviors. In January 2019, urine testing again showed no presence of his prescribed oxycodone. Patient F admitted trying different pain medications from his friends when running out of his own medication. Respondent took no further steps to address these inconsistencies, and did not refer Patient F for addiction medicine evaluation or treatment.

78. Respondent documented prescribing gabapentin and cyclobenzaprine (muscle relaxant) medications for pain control, but Patient F's pharmacy profiles did not show him receiving these medications.

79. Respondent's records documented that Patient F received physical therapy but contained no details. Respondent did not refer Patient F for CBT with mental health providers.

80. Patient F had elevated blood pressure readings at nearly half of his visits with respondent from 2018 to 2020, without a history of chronic essential hypertension. Respondent did not assess or provide interventions for hypertension.

Evaluation and Non-Opiate Management of Chronic Pain

81. Dr. Huang found two simple departures in this area for Patient F.

(a) Respondent failed to use safer non-opiate pharmacotherapy to optimize Patient F's pain management. Respondent documented prescribing gabapentin and cyclobenzaprine, but pharmacy records did not show Patient F filling the prescriptions. Respondent failed to try other non-opiates such as pregabalin, antidepressants, non-addictive muscle relaxants, and topical creams.

(b) Respondent failed to offer CBT for treatment of Patient F's chronic pain and depression.

Initiation/Monitoring of Chronic Opiate Pain Medication

82. Dr. Huang identified seven simple departures by respondent from the standard of care in this area for Patient F, as discussed below. He also opined that these simple departures combined to form an overall extreme departure from the standard of care in the initiation and monitoring of long-term opiate therapy.

(a) Respondent failed to perform and document a formal opioid risk assessment of Patient F prior to initiating and continuing opiate therapy in 2018. Patient F's excessively high opiate dosage, young age and male gender, tobacco addiction, depression, and aberrant urine toxicology tests were all warning signs and indicators of increased risks of opiate addiction and dependency.

(b) Respondent did not provide multidisciplinary pain management. Patient F was receiving hematology and orthopedics care at UCSF, but did not follow up on the pain management consultation ordered by respondent. Respondent should

have also referred respondent for mental health treatment and monitoring for addiction, ancillary therapies, and coordinated these services.

(c) Respondent failed to recognize Patient F's opioid-induced hyperalgesia syndrome, and thus failed to taper his opiate medications. Dr. Huang explained that some patients on high-dose narcotics develop opioid-induced hyperalgesia, in which increased doses of opiates paradoxically sensitize pain receptors more, leading to increasing pain perceptions. This phenomenon often co-exists with opioid tolerance. Treatment would be to taper the opiate medications and rotate medications. Given that Patient F was having increasing total body pains with an excessive MEDD of more than 500 mg, respondent should have considered opioid tolerance and hyperalgesia.

(d) Respondent prescribed two different long-acting opiate medications concurrently (oxycontin and methadone), which was inappropriate due to increased risk of respiratory failure.

(e) Respondent prescribed ongoing methadone from 2018 to 2020 despite its high risks of overdose and toxicity. Dr. Huang opined that respondent should have tried to taper Patient F off methadone as soon as possible upon assuming care. Dr. Huang explained that methadone is among the most difficult of long-acting opioids to prescribe and manage, with a fast onset of analgesic effect lasting six to eight hours, but a long elimination half-life of 15 to 30 hours. Thus methadone is associated with many overdose deaths. Dr. Huang cited American Pain Society guidelines stating that methadone should be the opioid medication of last resort for chronic pain.

(f) Methadone also carries risks of fatal cardiac arrythmias. Respondent failed to obtain baseline and periodic electrocardiogram monitoring of Patient F.

(g) Respondent did not document detailed relevant musculoskeletal examinations of Patient F's joint pains while monitoring his opiate therapy, with findings often appearing copied and pasted, and based on limited knee and thumb examinations despite the patient having a systemic condition affecting all joints.

Hypertension Management in Primary Care

83. Dr. Huang identified four simple departures by respondent from the standard of care in this area for Patient F, as discussed below. He also opined that these simple departures combined to form an overall extreme departure from the standard of care in management of hypertension in the primary care setting.

(a) Respondent failed to recognize or assess Patient F's potential essential hypertension, despite high blood pressure readings at almost half of the clinic visits.

(b) Respondent failed to offer advice about dietary modifications and exercise to manage Patient F's blood pressure.

(c) Respondent failed to recommend home monitoring of blood pressure.

(d) Respondent did not obtain routine blood testing to monitor for complications of hypertension.

Maintenance of Medical Records

84. Dr. Huang found one simple departure for failure to maintain adequate medical records. Patient F was not actually taking oxycontin for at least six months in 2019, but respondent's charts continued to list it as an active medication prescribed during each clinic visit.

Informed Consent and Pain Care Agreement

85. Dr. Huang opined that respondent appropriately documented informed consent discussions with Patient F on a regular basis, but found a simple departure from the standard of care for failing to obtain a signed pain care agreement.

Respondent's Evidence and Argument

86. No expert witness was presented on behalf of respondent. Respondent testified regarding his patient care and recordkeeping practices. He disputed the opinions of Dr. Huang. Respondent does not concede he has done anything wrong.

87. Respondent testified that in his opinion, he prescribed the minimum necessary amount of opiate medications to Patients A, B, C, D, E, and F.

88. Respondent spent a great deal of time at hearing and in his brief attacking Dr. Huang as biased and non-credible, and arguing that Dr. Huang lied, fabricated findings, and intended to mislead the Attorney General's Office and the Board. However, the testimony of Dr. Huang is found to be credible and without any evidence of bias or intent to mislead.

89. Respondent questioned Dr. Huang about the complaint made by pharmacist Coults, and investigator Denobriga's report about interviewing Coults. Dr. Huang credibly testified that although he reviewed these items, his opinions were not based on them, and were instead formed based on his review of the medical records.

90. Respondent questioned Dr. Huang about the investigative reports of Barrera and Loftis that listed various sections of the Business and Professions Code as "charges." Dr. Huang credibly testified that he ignored the list of "charges" and they

did not influence his opinions, which were formed based on his own review of the medical records.

91. Respondent provided copies of the Board's July 2023 Guidelines for Prescribing Controlled Substances for Pain, and the March 2022 Expert Reviewer Guidelines, as well as the Opioid Risk Tool referenced by Dr. Huang.

92. Respondent also provided documents relating to his federal lawsuit against the Board's former Executive Director, Board members, and associated other persons, which are not relevant to consideration of the present matter.

93. Respondent offered no other evidence of mitigation or rehabilitation.

94. Respondent questioned Dr. Huang at length about the terms "opiate use disorder" versus "opiate addiction." Dr. Huang stated that opiate use disorder is an addiction. Respondent pointed to the Board's July 2023 Pain Guidelines, which list separate definitions of "addiction" and "opioid use disorder." Dr. Huang noted that this was not the version of the guidelines applicable to the time period in this matter, and also noted that opioid use disorder is a diagnosis based on criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). However, in Dr. Huang's opinion, the two terms overlap and Patient A and Patient E met the description of addiction. Dr. Huang explained that regardless of whether a patient is labeled as having opiate addiction or opioid use disorder, the clinical approach is similar and requires multidisciplinary management. That testimony was persuasive.

95. Dr. Huang stated that respondent should have referred patients to mental health professionals for CBT. Respondent pointed to chart notes stating he provided "counseling" to his patients, contending that this counseling constituted CBT. That testimony was not credible. When respondent was asked whether he was

qualified to provide mental health therapy, respondent stated he had taken some courses, but admitted he has no degree in therapy and is not qualified to provide CBT.

96. Respondent disputed whether the Opioid Risk Tool is a reliable assessment tool, but he provided no evidence of using any other standardized tool, or of making and documenting individualized assessments of patient risk. Respondent pointed to his patient history chart notes documenting family history, social history, and mental health, items encompassed within the questions on such an assessment tool. However, respondent's records do not reflect any assessment of the patient's risk level for opiate therapy, which is the point of using a standard tool.

97. Respondent pointed to his chart notes that included notations of "I/C" and "warned," and stated that this was meant to reflect informed consent discussions with the patient and warning of the consequences of taking pain medications. However, as persuasively explained by Dr. Huang, the notation "I/C" does not show the patient understood their responsibilities while receiving long-term opiate therapy, and does not take the place of a signed pain care agreement.

98. Respondent contended he was not the primary care physician for Patients B, C, D, or F, and that he thus did not have the responsibility of diagnosing or managing their hypertension. However, respondent did not clearly document that the patients had other doctors providing primary care, and his progress notes contain fields for "Other Physicians/Medical Practices Involved in Care," which were blank.

99. Respondent testified that he did not treat his patients' hypertension because he thought the elevated blood pressure readings were due to pain or other factors, but his records do not reflect this analysis. Respondent also testified it is his habit to communicate with a patient's primary care physician if blood pressure or

another problem needs to be addressed. For example, respondent stated he had communicated with Dr. James and Dr. Myint about their mutual patients, but admitted he did not document these conversations "for various reasons."

100. Respondent contends that the accusation in this matter must be verified. Respondent also contends that the Board is required to provide a copy of the accusation with the word "filed" stamped on it. Respondent provides no authority for that proposition, and it is unpersuasive. The accusation was signed by a designee of the Board's then-Deputy Director in their official capacity in compliance with Government Code section 11503, and was properly served on respondent and respondent's former counsel the same day. Respondent also contends, based on the same argument regarding "filing" of the accusation, that this matter should be dismissed as being beyond the three-year statute of limitations contained in Business and Professions Code section 2230.5. That argument is meritless. The Board began its investigation into respondent after receiving a complaint on July 5, 2020, and the accusation was issued on February 1, 2023, within three years.

PATIENT A

101. Respondent questioned Dr. Huang about William Mains, M.D., who is listed as one of Patient A's prescribers in the CURES reports (prescribing zolpidem, a sedative used to treat insomnia), and whether he is a psychiatrist or addiction specialist. Dr. Huang explained that he was instructed by the Board not to perform his own investigation or look up other providers, but to render his opinions based on the records provided. Dr. Huang also testified persuasively that respondent had a responsibility to clearly document in his own charts which providers are prescribing what medications to his patients, and how he is consulting with those providers. Dr. Huang noted sleeping pills such as zolpidem are problematic for patients on opiates.

PATIENT B

102. Respondent stated that he had no way to force Patient B to comply with his referral to obtain MRI's. He stated he discussed this need with the patient multiple times, and counseled her to comply, but admitted he did not specifically document those discussions.

103. Respondent contended he was not Patient B's primary care physician, and stated that Dr. Myint was. He pointed to a chart note stating "f/u with PCP." Respondent also pointed to chart notes from 2020, reporting that the patient stated her PCP refuses to request cardiology evaluation. The records reflect that respondent referred Patient B to specialists.

104. Respondent questioned Dr. Huang regarding possible causes for elevated blood pressure readings, including pain, obesity, stimulant use, and age (essential hypertension). Dr. Huang opined that even if elevated blood pressure readings are due to pain, it is still considered hypertension and must be addressed if it occurs on an ongoing basis.

105. In discussing Dr. Huang's opinions regarding respondent's failure to diagnose and manage Patient B's hypertension, respondent pointed to his prescription of hydrochlorothiazide (a diuretic). Dr. Huang stated that this medication may be prescribed for blood pressure or edema, but noted that at the dosage prescribed by respondent it was not sufficient to affect the patient's blood pressure, suggesting it was prescribed only for her leg swelling. Similarly, respondent prescribed furosemide, another diuretic, but Dr. Huang noted that respondent did not document that he was trying to use diuretics to manage blood pressure, and that furosemide is not currently seen as a first-line treatment for hypertension due to its risk of causing kidney issues.

PATIENT C

106. Respondent questioned Dr. Huang about whether Patient C's high blood pressure readings could have been caused by pain. Dr. Huang noted that respondent documented Patient C's pain as stable and well-controlled, but the high blood pressure readings persisted.

PATIENT D

107. Respondent contended that Patient D's elevated blood pressure readings were due to pain and that her blood pressure improved after treatment for her bone infection (which occurred in mid-2019). The records show that Patient D continued to have elevated blood pressure readings throughout the remainder of 2019, and in 2020 and 2021.

PATIENT E

108. Respondent disputed Dr. Huang's characterization of Patient E as having chronic hepatitis C, stating that the patient was status post chronic hepatitis C, showing he had gotten over the illness.

109. Respondent testified that in his clinical judgment it was appropriate to prescribe opiates to Patient E, despite his elderly status.

PATIENT F

110. Respondent disputed Dr. Huang's opinions regarding non-opiate medications and contended that medications such as NSAIDs, SNRI antidepressants, muscle relaxants, and topical creams were contraindicated due to Patient F's medical conditions.

Disciplinary Considerations: Prior Disciplinary Proceedings

111. An accusation was filed against respondent on November 4, 2009, and an amended accusation was filed on September 5, 2012. After an administrative hearing, the Board issued a Decision and Order effective April 18, 2013, in which respondent's certificate was revoked, the revocation was stayed, and respondent was placed on probation for three years on terms and conditions including standard conditions, practice monitoring, an education course, a medical record keeping course, an ethics course, and a clinical training program. Cause for discipline was based on respondent's failure to maintain adequate and accurate records in treating multiple patients, which also constituted repeated negligent acts. The Board did not find that respondent's actual treatment of the patients departed from the standard of care. Respondent unsuccessfully challenged the Board's Decision in the Superior Court of California, Court of Appeal, and California Supreme Court.

A petition to revoke probation was filed on June 9, 2014. After an administrative hearing, the Board issued a Decision and Order finding that respondent violated his probation by failing to enroll in the clinical training program or the ethics course; revoking the stay of prior discipline; and imposing the stayed discipline of revocation. The Decision and Order became effective on December 4, 2014.

Respondent filed a petition for writ of mandate, and the Superior Court of California, County of Sacramento, granted a temporary stay on February 27, 2015. The Superior Court partially granted the petition for writ on mandate on January 19, 2016, and remanded the matter to the Board to afford respondent a hearing on his petition for modification of probation, which the Board had previously refused to consider.

Respondent completed his period of probation on April 18, 2016.

Costs

112. The Board seeks to recover prosecution and enforcement costs. These claimed costs include $42,148.75 for attorney and paralegal time actually billed by the Department of Justice; $10,388.50 for investigator time; and $9,900 for expert reviewer time. These claimed costs are supported by declarations that comply with California Code of Regulations, title 1, section 1042, and are found to be reasonable, in a total amount of $62,437.25.

The declaration regarding prosecution costs also included an estimate of $660 for additional attorney time to be incurred prior to hearing, but no explanation was offered as to why actual cost information was not available, in compliance with California Code of Regulations, title 1, section 1042, subdivision (b)(3). The additional $660 is not found to be reasonable.

LEGAL CONCLUSIONS

1. It is complainant's burden to establish the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The burden of establishing mitigation or rehabilitation is on respondent and the standard of proof is a preponderance of the evidence. (*Whetstone v. Board of Dental Examiners* (1927) 87 Cal.App. 156, 164; Evid. Code, §§ 115, 500.)

2. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code sections 2227 and 2234. Unprofessional conduct includes committing repeated negligent acts (Bus. & Prof.

Code, § 2234, subd. (c)), and failing to maintain adequate and accurate patient records relating to the provision of services (Bus. & Prof. Code, § 2266).

3. Under Business and Professions Code section 2241, a physician may prescribe prescription drugs including controlled substances to an addict under the physician's treatment, for purposes other than maintenance on, or detoxification from, prescription drugs or controlled substances. Under Business and Professions Code section 2242, prescribing dangerous drugs without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

First Cause for Discipline (Repeated Negligent Acts)

4. Complainant established by clear and convincing evidence that respondent's treatment of Patients A, B, C, D, E, and F departed from the standard of care, and that respondent was repeatedly negligent in his treatment of these patients. (Factual Findings 17-19, 25-28, 34-38, 47, 49-52, 59-62, 70-72, 81-85.) Cause for discipline exists pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c).

5. The accusation also alleges that respondent's treatment of these patients violated Business and Professions Code sections 2241 and 2242, but no expert opinion was presented to establish violations of those sections. Accordingly, cause for discipline does not exist based on Business and Professions Code sections 2241 and 2242.

Second Cause for Discipline (Failure to Maintain Adequate and Accurate Records

6. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate medical records for Patients A, B, C, D, E, and F. (Factual Findings 27, 37, 51, 61, 72, 84.) Cause for discipline exists pursuant to Business and Professions Code sections 2227, 2234, and 2266.

Other Matters

7. All contentions raised by the parties were considered, and to the extent those contentions are not expressly addressed in this decision, they were found to be without merit.

Disposition

8. Cause for discipline having been established, the remaining issue is the appropriate level of discipline. In exercising its disciplinary functions, protection of the public is the Board's paramount concern. (Bus. & Prof. Code, § 2229, subd. (a).) At the same time, the Board is charged with taking disciplinary action that is calculated to aid the rehabilitation of the licensee whenever possible, as long as the Board's action is not inconsistent with public safety. (Bus. & Prof. Code, § 2229, subds. (b), (c).)

9. The Medical Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines) (12th ed., 2016)[5] recommends, at a minimum, stayed revocation and five years' probation for unprofessional conduct including

[5] The Board's Disciplinary Guidelines are incorporated in California Code of Regulations, title 16, section 1361.

repeated negligent acts and failure to maintain adequate and accurate medical records. The maximum discipline is revocation.

10. Respondent has committed repeated negligent acts and failures of recordkeeping with respect to six patients over a period of several years. He has also previously been placed on probation by the Board. It is concerning that respondent does not acknowledge any deficiencies in his practice, and did not offer evidence of rehabilitation. However, it was not established that respondent's departures from the standard of care resulted in any direct patient harm, and some aspects of respondent's patient care were praised by complainant's expert.

Upon consideration of all circumstances in this matter, it is determined that outright revocation of respondent's license is not required for public protection. Placing respondent on probation for a period of five years, on conditions that include educational courses aimed at rectifying his practice deficiencies (Conditions 1-3), will protect the public by ensuring that respondent possesses the skills and judgment to practice within the standard of care, while aiding in respondent's rehabilitation.

Costs

11. A licensee found to have committed a violation of the licensing act may be required to pay the Board the reasonable costs of its investigation and prosecution of the case. (Bus. & Prof. Code, § 125.3.) Respondent has committed violations of the licensing act. (Legal Conclusions 4 & 6.) As set forth in Factual Finding 112, the reasonable costs of prosecution and enforcement in this matter are $62,437.25.

12. In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45, the California Supreme Court set forth standards for determining whether costs should be assessed in the particular circumstances of each case, to ensure that

licensees with potentially meritorious claims are not deterred from exercising their right to an administrative hearing. Those standards include whether the licensee has been successful at hearing in getting the charges dismissed or reduced, the licensee's good faith belief in the merits of his or her position, whether the licensee raised a colorable challenge to the proposed discipline, financial ability of the licensee to pay, and whether the scope of investigation was appropriate to the alleged misconduct. None of these considerations support reducing the Board's cost recovery in this case.

ORDER

Physician's and Surgeon's Certificate Number A 30477, issued to respondent Ernest Lincoln Bonner, Jr., M.D., is revoked; however, revocation is stayed, and respondent is placed on probation for five years under the following terms and conditions:

1. 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.

2. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but before 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 if 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 of the Decision, whichever is later.

3. 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 approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education 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.

4. Notification

Within seven days of the effective date of this Decision, 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.

5. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

6. 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.

7. 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.

8. 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.

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 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.

9. 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.

10. 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. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. 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 the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment 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 years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, 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; General Probation Requirements; and Quarterly Declarations.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, 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.

12. 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.

13. 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 certificate. 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.

14. Cost Recovery

Respondent is hereby ordered to reimburse the Medical Board of California the amount of $62,437.25 for its enforcement costs, pursuant to Business and Professions Code section 125.3. Respondent shall complete this reimbursement within 90 days from the effective date of this decision, or pursuant to a payment plan authorized by the Board.

15. 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.

DATE: 07/08/2024

Holly M. Baldwin

HOLLY M. BALDWIN
Administrative Law Judge
Office of Administrative Hearings