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

In the Matter of the Accusation Against: Jonathan Louis Baker, M.D. Physician's and Surgeon's Certificate No. A 64312 Respondent.	Case No.: 800-2021-079481

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 7, 2025.

IT IS SO ORDERED: January 10, 2025.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

Michelle Anne Bholat M.D., Chair
Panel A

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

In the Matter of the Accusation Against: **JONATHAN L. BAKER, M.D.** **3992 Inglewood Blvd., Unit 3** **Los Angeles, CA 90066-4689** **Physician's and Surgeon's Certificate No. A 64312** Respondent.	Case No. 800-2021-079481 OAH No. 2024060272 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Jason J. Ahn, Deputy Attorney General.

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2. Respondent Jonathan L. Baker, M.D. (Respondent) is represented in this proceeding by attorney David M. Balfour Esq., whose address is: 655 W. Broadway, Ste. 1600 San Diego, CA 92101-8484.

3. On or about January 16, 1998, the Board issued Physician's and Surgeon's Certificate No. A 64312 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-079481, and will expire on January 31, 2026, unless renewed.

JURISDICTION

4. On April 8, 2024, Accusation No. 800-2021-079481 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on or about April 8, 2024. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-079481 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2021-079481. Respondent has also carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2021-079481, a copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. A 64312to disciplinary action.

10. Respondent agrees that if an accusation is ever filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2021-079481. shall be deemed true, correct, and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A 64312 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2021-079481 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

ADDITIONAL PROVISIONS

14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

15. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

1. PUBLIC REPRIMAND.

IT IS HEREBY ORDERED that Respondent Jonathan L. Baker, M.D., holder of Physician's and Surgeon's Certificate No. A 64312, shall be and hereby is Publicly Reprimanded pursuant to Business and Professions Code section 2227. This Public Reprimand, which is issued in connection with the allegation as set forth in Accusation No. 800-2021-079481, is as follows:

In 2020-2021, Respondent was deficient in his documentation of care and treatment provided to Patient A, Patient B, and Patient C, as more fully described in Accusation No. 800-2021-079481.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, 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 hour. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. 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 (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the

Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation as determined by the program for the assessment and clinical education and evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

6. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, legal reviews, and investigation(s), in the amount of $40,000.00 (forty-thousand dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

7. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2021-079481 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

8. FAILURE TO COMPLY. Any failure by Respondent to comply with terms and conditions of the Stipulated Settlement and Disciplinary Order set forth above shall constitute unprofessional conduct and grounds for further disciplinary action.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, David M. Balfour Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and fully agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/21/2024

Signed by:
[signature]
JONATHAN L. BAKER, M.D.
Respondent

I have read and fully discussed with Respondent Jonathan L. Baker, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11/21/2024

[signature]
DAVID M. BALFOUR ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: November 22, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

JASON J. AHN
Deputy Attorney General
Attorneys for Complainant

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Jonathan Louis Baker, M.D.** **3992 INGLEWOOD BLVD, UNIT 3** **LOS ANGELES CA 90066-4689** **Physician's and Surgeon's Certificate No. A 64312,** Respondent.	Case No. 800-2021-079481 **ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about January 16, 1998, the Medical Board issued Physician's and Surgeon's Certificate No. A 64312 to Jonathan Louis Baker, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2026, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

7. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

COST RECOVERY

8. Business and Professions Code section 125.3 states that:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not

limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 64312 to disciplinary action under sections 2227 and 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A,[1] Patient B, and Patient C, as more particularly alleged hereinafter:

Patient A

10. On or about April 16, 2020, Patient A conducted her first telehealth encounter with Respondent. At that time, Patient A was a fifty (50) year-old female, with a chief concern for rib pain, following a fall down a set of stairs. Respondent failed to document whether or not Patient A had suffered head or neck injury or a loss of consciousness that would warrant a transfer to the Emergency Room (ER), and/or an in-person evaluation. Respondent advised use of ibuprofen, an over the counter pain medication.

11. On or about April 17, 2020, Patient A conducted her second telehealth encounter with Respondent, with a chief concern for shortness of breath. Respondent recommended a transfer to the ER for an in-person evaluation.

12. On or about April 30, 2020, Patient A conducted her third telehealth encounter with Respondent, with a chief concern for "rib contusion[2] ancl improved with naproxen[3]." According to the medical records, it states that Patient A's ER records from the April 18, 2020 ER visit have been scanned in to Respondent's electronic medical records of Patient A. However, Respondent failed to document whether he actually reviewed Patient A's ER records from her April 18, 2020 ER visit. The medication list on Respondent's medical records for the April 30, 2020 telehealth encounter does not list naproxen or any other medications prescribed on April 18, 2020, by the

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[1] The patients herein are identified as Patient A, Patient B, and Patient C, in order to maintain patient confidentiality.

[2] Contusion is the medical term for a bruise.

[3] Naproxen is a nonsteroidal anti-inflammatory drug, which can treat fever and pain.

ER physician, including, but not limited to, hydrocodone.[4] The medication list also does not mention verapamil[5] or lisinopril[6], which were documented on the April 13, 2020 office encounter, signed by a nurse practitioner. In addition, the impression and plan section of the medical records state four diagnoses identified by Respondent that do not have supporting documentation: obesity, essential hypertension, uncomplicated asthma, and anemia.[7] At a minimum, an encounter addressing obesity should have included documentation of weight, BMI,[8] and current activity. An encounter addressing hypertension should have included, at a minimum, documentation of the blood pressure, the name and dose of anti-hypertensive medication(s), and adherence to the medication(s). An evaluation of asthma should have included, at a minimum, a review of the frequency of symptoms, triggers, smoking history, and use of medications. At a minimum, an encounter addressing anemia should have included the actual lab results of the hemoglobin and

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[4] Hydrocodone Products - On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to Schedule II of the Controlled Substances Act, which became effective October 6, 2014. HCPs are pharmaceutical drugs containing specified doses of hydrocodone in combination with other drugs in specified amounts. There are several hundred brand name and generic hydrocodone products marketed in the United States with the most frequently prescribed combination being hydrocodone and acetaminophen (e.g., Vicodin, Norco, and Lortab.). Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. After considering the analysis and rescheduling recommendation of the Department of Health and Human Services and reviewing available data, the DEA found that HCPs meet the statutory definition of a Schedule II controlled substance. Various drug abuse indicators for HCPs indicate that HCPs are widely diverted and abused at rates largely similar to that of oxycodone products (Schedule II). The data indicated that HCPs have an abuse potential similar to Schedule II opioid analgesics such as oxycodone and their abuse is associated with severe psychological or physical dependence. Abuse of HCPs is also associated with large numbers of individuals being admitted to addiction treatment centers. Individuals are taking these drugs in sufficient quantities to create a hazard to their health, and abuse of HCPs is associated with large numbers of deaths.

[5] Verapmil is a calcium channel blocker and anti-hypertenstive drug, which can be used to treat high blood pressure, severe angina [a type of chest pain caused by reduced blood flow to the heart], and arrhythmia [improper beating of the heart, whether irregular, too fast, or too slow].

[6] Lisinopril is a medication which can be used to treat high blood pressure and heart failure.

[7] Anemia is a condition in which the blood does not have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body.

[8] Body Mass Index (BMI) is a persons' weight in kilograms divided by the square of height in meters. A high BMI can indicate body fatness.

hematocrit, and corpuscular volume, which was not included. An encounter addressing dietary counseling should have included, at a minimum, the patient's dietary goals, such as weight loss, lowering cholesterol, lowering blood pressure and dietary advice. Regarding essential hypertension, there is documentation stating "controlled at home 125." There was no documentation of any anti-hypertensive medication but the impression states, "essential hypertension stable. Continue med." There is no documentation of the frequency of asthma symptoms or use of asthma medication. However, according to the medical records, it states that asthma is stable.

13. On or about August 5, 2020, Patient A conducted her next telehealth visit with Respondent, for low back pain. According to the medical records, it stated, among other things, "low back pain X 1 week, dull, int, 2/10 no weakness. Worse with bending, better with rest, no weakness." For this visit, Respondent failed to document standard back pain history such as prior back pain, trauma, fever, incontinence, dysuria,[9] urinary frequency, urinary urgency or blood in the urine. There was no documentation of prior evaluation or imaging of the back. There is no documentation of whether Respondent was aware of and/or reviewed records from Patient A's May 26, 2020 Emergency Room visit. Under the Impression Plan section of the medical records, lumbar pain is noted and x-ray examination of the lumbar spine and hand were ordered. However, there was no documentation of any concerns regarding Patient A's hands and/or reason(s) why an x-ray examination of Patient A's hand was ordered. For example, any history of hand trauma, and pain and/or swelling, if any. According to the medical records, a number of other impression(s) and/or diagnose(s), without supporting documentation are noted, including: obesity, essential hypertension, uncomplicated asthma, anemia, abnormal weight gain, dietary counseling, abnormal liver functions, hyperglycemia,[10] fatigue, and red streaked stool. At a minimum, an encounter addressing obesity should include documentation of weight, BMI, and current activity. An encounter addressing hypertension should include, at a minimum, documentation of the blood pressure, the name and dose of anti-hypertensive medication(s), if

[9] Dysuria refers to pain or a burning sensation during urination.

[10] Hyperglycemia refers to high blood sugar.

any, and adherence to the medication(s). An evaluation of asthma should include, at a minimum, a review of the frequency of the symptoms, triggers, smoking history, and use of medications. An encounter addressing anemia should include, at a minimum, the actual lab results of the hemoglobin[11] and hematocrit,[12] and mean corpuscular volume.[13] An encounter addressing abnormal weight gain and dietary counseling should have included, at a minimum, Patient A's dietary goals such as weight loss, lowering cholesterol, lowering blood pressure, and dietary advice. An encounter addressing abnormal liver functions should have included, at a minimum, documentation of a review of symptoms such as nausea, adnominal pain, bleeding, and prior laboratory or imaging results. At a minimum, an evaluation of hyperglycemia should have included documentation of the actual blood glucose level and review of symptoms such as excessive thirst, excessive urination, nausea, vomiting, and lightheadedness. An encounter addressing fatigue, should have included, at a minimum, documentation of sleep pattern and review of physical activity. At a minimum, an encounter addressing red streaked stool should have included documentation of prior abnormal stool color, review of symptoms such as rectal pain, rectal swelling, abdominal pain, and recent ingestion of red pigmented foods. There is no documentation of the glucose test results or the liver function test results. Based on the documentation for this telehealth visit, it is unclear what communication and/or counseling, if any, occurred between Respondent and Patient A on this date.

14. On or about August 19, 2020, Patient A attended her next telehealth visit with Respondent, with the chief concern of "pain multiple sites, no weaknesses. Polyneuropathy[14] was listed under impression and the plan was to refer Patient A to neurology. The review of symptoms stated normal gait, but did not include documentation of trauma, sensory symptoms, numbness or incontinence. According to the medical records, essential hypertension and obesity

[11] Hemoglobin is a protein in the red blood cells.

[12] Hermatocrit test measures the proportion of red blood cells in the blood.

[13] Mean Corpuscular Volume (MCV) blood test measures the average size of your red blood cells.

[14] Polyneuropathy is the simultaneous malfunction of many peripheral nerves throughout the body.

are noted, without supporting documentation. At a minimum, an encounter addressing obesity should have included documentation of estimated weight, BMI, and current activity. At a minimum, an encounter addressing hypertension should have included documentation of the blood pressure, the name and dose of anti-hypertensive medication(s), if any, and adherence to them. The medication list does not contain any anti-hypertensive medication, but under the "plan" section of the medical records, it states, "continue med."

15. On or about August 20, 2020, Patient A had another telehealth visit with Respondent, with the chief concern of "pain in multiple sites, new back pain today, dull, int, 2/10 no weakness. Worse with lifting, better with rest." According to the medical records, the following impressions were listed, without supporting documentation: essential hypertension, obesity, and dietary counseling. An encounter addressing hypertension should have included, at a minimum, documentation of the blood pressure, the name and dose of anti-hypertension medication(s), if any, and adherence to them. At a minimum, an encounter addressing obesity and dietary counseling should have included Patient A's dietary goals such as weight loss, current activity, and dietary advice. The "medication list" section of the medical records does not contain any anti-hypertension medication, but under the "plan" section of the medical records for essential hypertension, it states, "continue med."

16. On or about August 26, 2020, Patient A conducted another telehealth visit with Respondent for PAP screening[15] and mammography.[16] According to the medical records, documented by an individual other than Respondent [Medical Assistant], it states, "pain in hands and feet 10/10" and a normal blood pressure. However, Respondent failed to document any comments regarding "10/10 hand and foot pain" or any references to Patient A's two (2) telehealth visits with Respondent from the prior week regarding "pain in multiple sites." At a minimum, a sentence clarifying that the Medical Assistant's entry was erroneous and a statement that Patient A denied any current hand and foot pain would be expected or a sentence about

[15] A Pap smear is a safe way to screen for cervical cancer.

[16] A mammogram is an x-ray picture of the breast, which can be used to check for breast cancer in women who have no signs or symptoms of the disease.

duration and aggravating factors for the hand and foot pain. Respondent failed to recommend and/or failed to document having recommended a colon cancer screening or a referral for colon cancer screening and/or colonoscopy,[17] which is a standard recommendation after age 50. According to the medical records, there are impression(s) and/or diagnoses noted, with no supporting documentation including obesity, dietary counseling, and BMI = 28. The medication list section of the medical records does not contain any anti-hypertensive medication, but under essential hypertension, the plan states, "continue med."

17. According to the medical records, on September 2, 2020, Respondent purportedly notified Patient A, via a telephone call, of an abnormal PAP test result and provided a referral and contact information for a gynecologist.

18. On or about October 21, 2020, Patient A conducted another telehealth visit with Respondent, with a chief concern of "follow up on HGSIL [abnormal PAP result] – will see gyn[ecologist] in two weeks." According to the medical records, essential hypertension and dietary counseling were noted, without supporting documentation. At a minimum, an encounter addressing hypertension should have included documentation of the name and dose of the anti-hypertensive medication(s), if any, and adherence to them. An encounter addressing dietary counseling should have included, at a minimum, Patient A's dietary goals such as weight loss, lowering cholesterol, lowering blood pressure, and dietary advice. The medication list section of the medical records does not contain any anti-hypertensive medication, but the "plan" section states, "continue med."

19. On or about November 13, 2020, Patient A conducted another telehealth visit with Respondent with a chief concern for "elevated transaminases,[18] viral hep negative, overweight." Respondent failed to document Patient A's alcohol use, which can cause elevated transaminases, which may signify liver injury or inflammation. The medication list included acetaminophen,[19]

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[17] Colonoscopy is a procedure for checking the inside of a person's entire colon (large intestine).

[18] Transaminase is an enzyme that catalyzes a particular transamination reaction.

which can cause transaminase elevation. At a minimum, an encounter addressing elevated transaminases should have included documentation of the frequency and amount of alcohol use and listed current medications as well as over-the-counter supplements or herbs that may be associated with liver injury. Respondent failed to document the actual elevated transaminase (abnormal liver function tests) or any prior baseline transaminase results. Respondent also failed to document prior liver disease, elevated transaminases, or prior evaluation of this problem. The medication list section of the medical records included Lisinopril, which is a blood pressure lowering medication. According to the medical records, impression(s) and/or diagnoses were noted, without supporting documentation including "essential hypertension, controlled, continue med, and dietary counseling." An encounter addressing hypertension should have included, at a minimum, documentation of the name and dose of anti-hypertension medication(s) and adherence to them. At a minimum, an encounter addressing dietary counseling should have included Patient A's dietary goals such as weight loss, lowering cholesterol, lowering blood pressure, and dietary advice.

20. On or about December 10, 2020, Patient A conducted another telehealth visit with Respondent, with a chief concern of "ext hemorrhoid[20], dilated vein, pain and mild bleeding." At a minimum, an encounter addressing bleeding should have included documentation of review of symptoms including lightheadedness, fainting, loss of appetite, weight loss, or prior anal or hemorrhoidal disease, or prior colonoscopy. The plan was to apply triamcinolone[21] to the affected area. According to the medical records, essential hypertension and dietary counseling were noted, with no supporting documentation. At a minimum, an encounter addressing hypertension should have included documentation of the name and dose of anti-hypertensive medication(s), if any, and adherence to them. An encounter addressing dietary counseling should have included Patient A's dietary goals such as weight loss, lowering cholesterol, lowering blood

[19] Acetaminophen is an analgesic drug used to relieve mild or chronic pain and to reduce fever, often as an alternative to aspirin.

[20] Hemorrhoid refers to a swollen vein or a group of veins in the region of the anus.

[21] Triamcinolone is a medication used to treat a variety of skin conditions such as eczema, dermatitis, allergies, rash).

pressure, and dietary advice. The medication list included two anti-hypertensive medications, verapamil and lisinopril. The "plan" section of the medical records states, "continue med."

21. On or about December 17, 2020, Patient A conducted another telehealth visit with Respondent, for a follow up visit on "ext hemorrhoid." Chief concern was "ext hemorrhoid improved with triamcinolone." Respondent failed to document prior colonoscopy results or a referral for colonoscopy, which is a standard screening recommendation for patients over 50 years of age or for unexplained rectal bleeding.

22. On or about January 19, 2021, Patient A conducted another telehealth visit with Respondent, with a chief concern for "R shoulder pain X 1 week, dull, int, 2/10, no weakness." At a minimum, an evaluation addressing right shoulder pain should have included documentation of prior shoulder problem(s), if any, neck pain, neck stiffness, trauma, fever, swelling, bruising, and prior evaluation(s), if any. According to the medical records, impression(s) and /or diagnoses were noted, without supporting documentation: essential hypertension, dietary counseling, and unspecified asthma. At a minimum, an encounter addressing hypertension should have included documentation of the name and dose of anti-hypertensive medication(s), if any, and adherence to them. An encounter addressing dietary counseling should have included, at a minimum, Patient A's dietary goals such as weight loss, lowering cholesterol, lowering blood pressure, and dietary advice. At a minimum, an evaluation of asthma should have included a review of the frequency of symptoms, triggers, smoking history, and use of medications, if any. Respondent also failed to document a pneumococcal vaccine[22] recommendation.

23. On or about February 5, 2021, Patient A conducted another telehealth visit with Respondent, with a chief concern for "vagina itching," which was documented by a health care provider other than Respondent. Respondent failed to comment on this entry and documented "htn – compliant, home bp 150, no CP." The "impression" section of the medical records states, "uncontrolled bp, continue med, diet and exercise, keep bp log, follow up." The "impression" section also listed a diagnosis, without supporting documentation of unspecified asthma. At a

[22] Pneumococcal conjugate vaccine helps protect against bacteria that cause pneumococcal disease, which refers to any infection caused by Streptococcus pneumoniae, or pneumococcus.

minimum, an evaluation of asthma should have included a review of the frequency of symptoms, triggers, smoking history, and use of medication(s), if any. Respondent failed to document anything regarding the "vaginal itching" issue noted by the other health care provider.

24. Respondent committed gross negligence in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Respondent failed to maintain adequate and/or accurate medical records of his treatment of Patient A.

Patient B

25. On or about June 12, 2020, Patient B conducted his first telehealth visit with Respondent. At that time, Patient B was a twenty-five (25) year-old male with a chief concern for "recurrent flank pain X years. No urinary and no fever." According to the medical records, the review of symptoms was all negative, including constipation and urinary symptoms. Respondent ordered blood and urine analysis and referred Patient B for an abdominal pelvic CT urogram[23], and scheduled him for a follow-up visit. According to the medical records, Respondent listed various impression(s) and/or diagnoses, without supporting documentation, including, abnormal weight gain, abnormal liver functions, hyperglycemia,[24] malnutrition, and fatigue. At a minimum, an encounter addressing abnormal weight gain and dietary counseling should have included Patient B's dietary goals such as weight loss, lowering cholesterol, lowering blood pressure, and dietary advice. At a minimum, an encounter addressing abnormal liver functions should have included documentation of a review of symptoms such as nausea, abdominal pain, bleeding, and prior laboratory or imaging results, if any. An evaluation of hyperglycemia should have included, at a minimum, documentation of the actual blood glucose level and review of symptoms such as excessive thirst, excessive urination, nausea, vomiting, and lightheadedness. There is no documentation of the glucose test results or liver function

[23] A CT urogram is used to examine the kidneys, ureters, and bladder.

[24] Hyperglycemia refers to high blood sugar levels.

test results. At a minimum, an encounter addressing malnutrition should have included estimated weight, BMI, and dietary history. At a minimum, an encounter addressing fatigue should have included documentation of sleep pattern and review of physical activity. Based on the medical records, it is unclear, what communication and/or counseling, if any, occurred between Respondent and Patient B. At a minimum, an encounter addressing obesity should have included documentation of weight, BMI, and current activity.

26. On or about July 10, 2020, Patient B conducted another telehealth visit with Respondent, with a chief concern for "flank pain-stable. CT in 2 days." According to the medical records, the review of symptoms was all negative. The "impression" section of the medical records only listed flank pain.

27. On or about July 14, 2020, Patient B conducted another telehealth visit with Respondent, with a chief concern for "flank pain stable. CT showed constipation and incidental lung nodules.[25]" The review of symptoms was all negative, including no constipation. The impression/plan section stated, 1) constipation miralax, 2) lung nodules ref pulmonary. There were no other diagnoses listed.

28. Respondent committed gross negligence in his care and treatment of Patient B which included, but was not limited to, the following:

(a) Respondent failed to maintain adequate and/or accurate medical records of his treatment of Patient B.

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[25] Lung nodule is a small single mass in the lungs that is usually benign.

Patient C

29. On or about November 15, 2019, Patient C conducted his first telehealth visit with Respondent, with a chief concern of nausea X 2 months, which was ultimately determined to be caused by gallbladder stones.[26] At that time, Patient C was a fifty-eight (58) year-old male. The review of systems was negative. Respondent ordered an abdominal CT[27] and referred Patient C to a gastroenterologist.[28] For unclear reason(s), Patient C did not undergo an abdominal CT scan or consult with a gastroenterologist specialist.

30. On or about February 17, 2020, Patient C presented to a local Emergency Department for an anxiety attack, during which an abdominal CT scan was performed. The abdominal CT scan identified multiple gallstones as well as a right kidney mass.

31. On or about March 6, 2020, Patient C had an in-person visit with Respondent to review the February 17, 2020 ER visit and the CT scan results. The chief concerns were stated as "anxiety attack one week ago seen in ER ro MI, chole mild pain, kidney stones no pain." According to the medical records, the review of systems was negative including no abdominal pain and the physical examination was normal, including normal blood pressure and no abdominal tenderness. In addition, according to the medical records, the first impression for this office visit was depression, not in remission, with the comment "no SI[29]." Respondent prescribed Gabapentin[30] as a treatment for anxiety, in addition to Patient C's maintenance anti-depressant

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[26] Gallstones are hard, pebble like pieces of materials, usually made of cholesterol or bilirubin, that form in a person's bladder. Bilirubin is a yellowish substance made during a person's normal process of breaking down old red blood cells.

[27] An abdominal CT scan is an imaging method, which uses x-rays to create cross-sectional pictures of the belly area.

[28] Gastroenterologists are specialists in gastrointestinal diseases.

[29] Suicidal ideation, also known as suicidal thoughts, are thinking about or planning a suicide.

[30] Gabapentin is an anticonvulsant and nerve pain medication, which can be used to treat pain.

medications, sertraline[31] and bupropion.[32] Regarding Patient C's depression, Respondent failed to document Patient C's mental status, mood, and presence of suicidal thoughts and/or plans and/or intentions. Respondent failed to document presence or lack of substance use such as alcohol or other recreational substances which can alter Patient C's response to anti-depressants and can be mistaken for and/or contribute to "anxiety attacks." Respondent failed to discuss and/or failed to document having discussed with Patient C, that use of substances such as Gabapentin can cause sedation, which can be worsened with use of alcohol or other sedatives and may impair safe driving. According to the medical records, under the "impression" section, it states, among other things, "cholecystitis[33] refer to general surgeon." However, this is inaccurate because according to the CT imaging from the ER visit, Patient A had gallstones (choledocolinthiasis)[34], not cholecytitis. In addition, under the "impression" section, Respondent also noted, among other things, "kidney stone," which was not accurate. The CT imaging from the ER visit, a kidney mass, not a kidney stone, was present.

32. On or about April 17, 2020, Patient C had another telehealth visit with Respondent, with chief concern of "follow up on chole-mild pain will make appointment with surgery today" and "kidney mass will make an appointment with urology[35] today." Respondent referred Patient C for renal ultrasound, as recommended by the radiologist who reported finding of a kidney mass

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[31] Sertraline (common brand Zoloft) is a Selective Serotonin Reuptake Inhibitor (SSRI), which can be used to treat depression, obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD), premenstrual dysphoric disorder (PMDD), social anxiety disorder, and panic disorder.

[32] Bupropion (common brand Wellbutrin XL) is an antidepressant, which can be used to treat depression.

[33] Cholecystitis refers to inflammation of the gallbladder, a small, digestive organ beneath the liver.

[34] Choledocholithiasis, also known as common bile duct stone, is the presence of gallstones in the common bile duct (CBD), which is a tube that carries bile from the liver and gallbladder, through the pancreas, and into the small intestine. Bile is a bitter greenish-brown alkaline fluid that aids digestion and is secreted by the liver and stored in the gallbladder.

[35] Urology is a part of health care that deals with diseases of the male and female urinary tract (kidneys, ureters, bladder and urethra).

on the abdominal CT scan from February 17, 2020. It is unclear, from the medical records, why there was a delay with follow-up imaging.

33. On or about April 28, 2020, a general surgeon purportedly consulted with Patient C and arranged a laparoscopic[36] removal of the gall bladder. According to Respondent's medical records of Patient C, it is unclear why it took five (5) months for Patient C, who had constant nausea and symptomatic gallstones, to see a surgeon.

34. On or about May 13, 2020, Patient C returned to Respondent for another telehealth encounter, with chief concern noted as "bilateral foot pain-request podiatry and renal lesion-has appt with urology." According to the "impression" section of the medical records, depression, cholecystitis, and abnormal liver functions are listed, without supporting documentation. At a minimum, an encounter addressing depression should have included mood, presence of suicidal ideation, use of alcohol or other substances that can worsen depression, name and dose of anti-depressant medicine, and adherence to medication(s), if any. An encounter evaluating cholecystitis should have included location and severity of pain, presence or absence of nausea, vomiting, fever, chills, and lightheadedness. At a minimum, an encounter addressing abnormal liver functions should have included actual liver enzyme test results, current alcohol use [if any], prior liver disease [if any], and prior evaluation of abnormal liver functions [if any].

35. On or about August 20, 2020, Patient C conducted another telehealth visit with Respondent, with chief concern noted as "L ear bleeding and derm pain with burning thoracic both armpits." According to the medical records, there were two impressions not supported by documentation: "Major depression-partial remission continue med" and "Mixed hyperlipidemia[37]." At a minimum, an encounter addressing depression should have included mood, presence of suicidal ideation, use of alcohol or other substances that can worsen depression, name and dose of anti-depressant medicine and adherence to them. At a minimum, an encounter addressing mixed hyperlipidemia should have included actual lipid levels, dietary

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[36]Laparoscopy is a type of keyhole surgery used to diagnose and treat conditions.

[37] Hyperlipidemia is a condition in which there are high levels of fat particles (lipids) in the blood.

recommendations, risk assessment, and consideration of lipid lowering medication(s). According to the medical records, the ear exam and skin exam were normal and there was no mention of the ear or skin pain concern in the impression.

36. Respondent committed gross negligence in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Respondent failed to maintain adequate and/or accurate medical records of his treatment of Patient C.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

37. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 64312 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patient A, Patient B, and Patient C, as more particularly alleged herein.

38. Respondent committed repeated negligent acts in his care and treatment of Patient A, Patient B, and Patient C, which included, but was not limited to, the following:

(a) Paragraphs 9 through 36, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to maintain adequate and/or accurate medical records of his treatment of Patient A;

(c) Respondent failed to maintain adequate and/or accurate medical records of his treatment of Patient B; and

(d) Respondent failed to maintain adequate and/or accurate medical records of his treatment of Patient C.

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

39. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 64312 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in his care and treatment of Patient A, Patient B, and Patient C, as more particularly alleged in paragraphs 9 through 38, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

40. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 64312 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 9 through 39, above, which are hereby incorporated by reference as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 64312, issued to Respondent Jonathan Louis Baker, M.D.;

2. Revoking, suspending or denying approval of Respondent Jonathan Louis Baker, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Jonathan Louis Baker, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: APR 0 8 2024

JENNA JONES for
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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