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

In the Matter of the First Amended Accusation Against: **Stephen John Ronan, M.D.** **Physician's and Surgeon's Certificate No. A 72320** Respondent.	**Case No.: 800-2019-054621**

ORDER CORRECTING NUNC PRO TUNC CLERICAL ERROR IN "CASE NUMBER" IN CLAUSE 4: "FUTURE ADMISSION CLAUSE" ON PAGE 4 OF THE STIPULATED SETTLEMENT

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the "Case Number" in clause 4: "Future Admission" on page four (4) of the Stipulated Settlement in the above-entitled matter and that such clerical error should be corrected.

IT IS HEREBY ORDERED that the case number in clause 4: "Future Admission" on page four (4) of the Stipulated Settlement in the above-entitled matter be and hereby is amended and corrected nunc pro tunc on the date of entry of the decision to read as "***800-2019-054621***".

August 19, 2025

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

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

In the Matter of the First Amended Accusation Against: Stephen John Ronan, M.D. Physician's and Surgeon's Certificate No. A 72320 Respondent.	Case No. 800-2019-054621

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 August 15, 2025.

IT IS SO ORDERED July 17, 2025.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
GREG W. CHAMBERS
Supervising Deputy Attorney General
THOMAS OSTLY
Deputy Attorney General
State Bar No. 209234
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3871
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **STEPHEN JOHN RONAN, M.D.** **3600 Blackhawk Plaza Circle** **Danville, CA 94506-4623** **Physician's and Surgeon's Certificate No. A 72320** Respondent.	Case No. 800-2019-054621 OAH No. 2024030096 **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 Thomas Ostly, Deputy Attorney General.

2. Respondent Stephen John Ronan, M.D. (Respondent) is represented in this proceeding by attorney Robert W. Hodges, Esq., whose address is: 3480 Buskirk Avenue, Suite

240 Pleasant Hill, CA 94523. On or about June 29, 2000, the Board issued Physician's and Surgeon's Certificate No. A 72320 to Stephen John Ronan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2019-054621, and will expire on May 31, 2026, unless renewed.

JURISDICTION

3. First Amended Accusation No. 800-2019-054621 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on August 12, 2022. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

4. A copy of First Amended Accusation No. 800-2019-054621 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2019-054621. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended 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.

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

CULPABILITY

8. 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 First

Amended Accusation No. 800-2019-054621. 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 72320 to disciplinary action.

CONTINGENCY

9. 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.

10. 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 agreement of the parties in this above entitled matter.

11. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

12. 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

IT IS HEREBY ORDERED that Respondent Stephen John Ronan, M.D., holder of Physician's and Surgeon's Certificate No. A 72320, 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 First Amended Accusation No. 800-2019-054621, is as follows:

An investigation by the Medical Board of California revealed that in 2015 your care and treatment of a single patient deviated from the standard of care; records do not document medical clearance was obtained from your former patient's primary care physician prior to elective surgery.

1. 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), as applicable, in the amount of $34,590.00 (thirty-four thousand five hundred ninety dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall constitute unprofessional conduct and grounds for further disciplinary action.

2. 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 constitute unprofessional conduct and grounds for further disciplinary action.

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

4. 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 First Amended Accusation No. 800-2020-067286 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.

5. 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.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert W. Hodges, 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 agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8/22/2024

STEPHEN JOHN RONAN, M.D.
Respondent

I have read and fully discussed with Respondent Stephen John Ronan, 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: 8/22/2024

ROBERT W. HODGES, 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: August 22, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
GREG W. CHAMBERS
Supervising Deputy Attorney General

/s/ Thomas Ostly

THOMAS OSTLY
Deputy Attorney General
Attorneys for Complainant

ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
LYNNE K. DOMBROWSKI
Deputy Attorney General
State Bar No. 128080
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3439
Facsimile: (415) 703-5480
E-mail: Lynne.Dombrowski@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **STEPHEN JOHN RONAN, M.D.** **3600 Blackhawk Plaza Circle** **Danville, CA 94506** **Physician's and Surgeon's Certificate No. A 72320,** Respondent.	Case No. 800-2019-054621 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended 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 June 29, 2000, the Medical Board issued Physician's and Surgeon's Certificate Number A 72320 to Stephen John Ronan, 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 May 31, 2024, unless renewed.

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3. At all times relevant to the allegations herein, Respondent maintained a private practice, Blackhawk Plastic Surgery, in Danville, CA. Respondent is also the sole owner of the Blackhawk Surgery Center, where he performed the surgery on Patient A[1] that is described herein below.

JURISDICTION

4. This First Amended 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.

5. 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.

6. 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:

[1] The patient is referred to as Patient A to preserve privacy and confidentiality.

(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.

7. 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.

COST RECOVERY

8. Effective January 1, 2022, Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

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FIRST CAUSE FOR DISCIPLINE

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

9. Respondent is subject to disciplinary action for unprofessional conduct for gross negligence and/or repeated negligent acts, pursuant to sections 2234, subdivision (b) and/or subdivision (c) of the Code for his acts and/or omissions with regard to Patient A, as described herein.

10. On or about June 29, 2015, Patient A, a male born in 1955, saw Respondent to seek a consultation about having excess skin removed from his body, which was the result of his weight loss of 175 pounds.

11. During the June 29, 2015 visit with Respondent, Patient A was accompanied by his wife. He completed a health history form and noted, among other things, that he had a history of diabetes, hypertension, and that he had not taken insulin. There was no list of the patient's current medications in Respondent's visit notes. Respondent noted in the patient's records that Patient A reported taking two anti-hypertensive medications, not identified, and said that he was being weaned off of them following his weight loss. Respondent also noted that the patient had a history of diabetes that was corrected by the weight loss. Respondent noted that he discussed with the patient several procedures to reduce the patient's skin redundancies.

12. On July 10, 2015, Patient A and his wife returned to Respondent's office for a pre-operative visit. A nurse practitioner documented the exam. She noted that the patient was on three anti-hypertensive medications (lisinopril, hydrazaline, and clonidine). She documented the patient's blood pressure (159/88) and his hemoglobin level (10.7). It was noted that Patient A had received a blood transfusion, without any further details or explanation. An EKG was ordered and the results showed "sinus bradycardia."

13. Prior to performing the surgery, Respondent failed to obtain copies of Patient A's medical records and did not seek to obtain a pre-operative clearance from the patient's primary care physician.

14. On Friday, July 17, 2015, Patient A arrived for surgery at the Blackhawk Surgery Center, to be performed by Respondent. In the patient's pre-op nursing assessment, the following

information was noted: the patient was taking three anti-hypertensive medications; the patient received a blood transfusion in January 2015; his hemoglobin level was recorded as 10.7; and his blood pressure was listed as 159/88. The patient was evaluated by an anesthesiologist who classified the patient as an ASA Class 2.[2]

15. On July 17, 2015, Respondent performed surgery on Patient A to remove the redundant skin circumferentially from the patient's lower torso and axillary chest. The surgery was completed in 5 hours and 30 minutes. The patient had a total of six self-suction drains which were placed in each of the operative sites bilaterally (lower abdomen, lower back, lateral chest).

16. From about 12:55 p.m. to 4:05 p.m., Patient A was monitored in the recovery area of the surgery center. The patient's total drainage was noted to be 300cc/ml of "B Red" fluid, without any differentiation of how the drain output varied among the six drains. It was noted that the patient received 4300cc/ml of IV fluid during the procedure and that an additional 3700cc/ml of IV fluids were given post-operatively.

17. Sometime after 4 p.m. on July 17, 2015, Patient A's wife picked him up from the surgery center. It was documented that Patient A 'ambulated' to his car when discharged. A surgical technician, in a separate car, followed Patient A and his wife to their home. The surgical technician assisted Patient A into a recliner, connected the sequential compression devices, and instructed the patient's wife on drain care. The patient's wife was given a cell number to call, should she have any questions.

18. At around 8:00 a.m. on Sunday, July 19, 2015, Patient A's wife called and left a message for Respondent's surgical technician and received a return call within about five minutes. The patient's wife reported that the patient was very sleepy and not responding to verbal stimulation. The surgical technician told her to call Respondent's office. The patient's wife then called and left a message on Respondent's office phone line and her call was returned a few minutes later by a nurse practitioner. The nurse practitioner told the patient's wife to call 911.

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[2] American Society of Anesthesiologists Classification (ASA): ASA 1 is a normal healthy patient; ASA 2 is a patient with mild systemic disease; and, ASA 3 is a patient with a severe systemic disease that is not life-threatening. There is no specific ASA classification for a patient with a moderate systemic disease.

19. Patient A was transported by ambulance to the Kaiser Hospital Emergency Department, where he was admitted to the Intensive Care Unit, on July 19, 2015. It was noted that the patient had a low hemoglobin level of 4, was obtunded, and had to be intubated and transfused.

20. In his records for Patient A, Respondent noted that on July 19, 2015, he spoke with an ICU Intensivist at Kaiser who informed Respondent that the patient had a history of renal insufficiency and was now in acute renal failure. Respondent was also told that the patient had a history of Obstructive Sleep Apnea and had not used his CPAP[3] machine on Saturday night (July 18, 2015).

21. It was determined that Patient A suffered an anoxic brain injury with subsequent personality changes. He underwent rehabilitation and requires a walker for support when ambulating.

22. On or about April 2, 2019, the Medical Board received a Report of Settlement from insurer The Doctors Company, as is required under section 801 of the Business and Professions Code ("801 Report"). It reported a settlement of $225,000 between Patient A and Respondent of a civil medical malpractice complaint that was filed in the California Superior Court of Contra Costa County.

23. During an interview with the Board's investigator on November 9, 2020, Respondent stated that Patient A told him that he was receiving his regular health care through Kaiser. Respondent also stated that the patient told him that he had received a pre-operative clearance from Kaiser to have the surgery performed but that Kaiser deemed the surgery to not be medically necessary. Respondent failed to document this information about a pre-operative clearance from Kaiser in the patient's records and Respondent failed to make any efforts to obtain a copy of the pre-operative clearance from Kaiser prior to his performing the surgery.

24. During the November 9, 2020 interview, Respondent also explained that he believed that the patient's chronic (iron deficiency) anemia was because of the patient's massive weight

[3] A Continuous Positive Airway Pressure ventilator.

loss, without acknowledging that the patient's weight loss was through diet and exercise and not by bariatric surgery that results in malabsorption of nutrients.

25. In summary, Respondent's overall conduct, through his acts and omissions, regarding Patient A, as set forth in paragraphs 9 through 24 herein, constitutes unprofessional conduct under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent acts] of the Code, and he is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient A as follows:

a. Respondent failed to conduct an appropriate pre-operative evaluation and obtain a medical clearance from the patient's primary care physician and/or failed to request and obtain the patient's prior medical records before proceeding with a major elective surgery;

b. Respondent failed to appropriately evaluate a major risk factor prior to surgery by not evaluating the patient's anemia (continuing low hemoglobin) and/or the medical indication for his blood transfusion in January 2015. Respondent's attribution of the patient's anemia to the weight loss indicates a lack of medical knowledge;

c. Post-operatively, Respondent, through his supervised staff, administered excessive intravenous fluid to the patient which may have exacerbated the patient's condition of renal insufficiency.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate and Accurate Medical Records)

26. Respondent is subject to disciplinary action for unprofessional conduct under section 2266 of the Code for his failure to maintain adequate and accurate medical records regarding his care and treatment of Patient A.

27. Paragraphs 9 through 25 are incorporated herein by reference, as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 72320, issued to Stephen John Ronan, M.D.;

2. Revoking, suspending or denying approval of Stephen John Ronan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Stephen John Ronan, 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

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

DATED: AUG 12 2022

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

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