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

In the Matter of the Accusation Against: Markus Rashad Jamar Jackson, M.D. Physician's & Surgeon's Certificate No. A 165519 Respondent.	Case No. 800-2023-095716

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 September 25, 2025.

IT IS SO ORDERED: August 26, 2025.

MEDICAL BOARD OF CALIFORNIA

MD.

Veling Tsai, M.D., Vice Chair
Panel A

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In the Matter of the Accusation Against:

MARKUS RASHAD JAMAR JACKSON, M.D., Respondent

Agency Case No. 800-2023-095716

OAH No. 2024110127

PROPOSED DECISION

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter on May 12 through 16 and 23, 2025, by videoconference from Sacramento, California.

John S. Gatschet, Deputy Attorney General, represented complainant Reji Varghese, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs, State of California.

Derek F. O'Reilly-Jones of the law firm Bonne, Bridges, Mueller, O'Keefe & Nichols represented respondent Markus Rashad Jamar Jackson, M.D., who appeared.

Evidence was received, the record closed, and the matter submitted for decision on May 23, 2025.

FACTUAL FINDINGS

Jurisdictional Matters

1. The Board issued respondent Physician's and Surgeon's Certificate Number A 165519 on September 17, 2019. The certificate expires September 30, 2025, unless renewed. There is no history of prior discipline of the certificate.

2. Complainant authorized the filing of the Accusation against respondent on September 25, 2024, solely in his official capacity. The Accusation involves respondent's treatment of Patient 1, a woman for whom he performed a spinal cord stimulator (SCS) procedure to address her chronic pain. Complainant alleged respondent failed to timely document in Patient 1's medical records three telephone calls they had regarding a headache she developed after the procedure. Complainant further alleged respondent negligently failed to adequately inform Patient 1 and her family of all potential risks and complications of such a headache. Finally, complainant alleged respondent failed to adequately document providing adequate informed consent to Patient 1, a treatment plan or rationale for prescribing a controlled substance, or Patient 1's refusal of treatment. Based on those alleged acts and omissions, complainant seeks to discipline respondent's certificate for gross negligence, repeated negligent acts, and keeping inadequate and inaccurate records.

3. At hearing, a Protective Order Sealing Confidential Records and a First Amended Protective Order Sealing Confidential Records were issued. Additionally, complainant's motion to amend the Accusation to conform to proof was granted over respondent's objection. Paragraph 27 was amended by striking the words "informed consent" at the end of line 24 and the beginning of line 25 on page 9 and replacing them with "information related to potential risks and complications." Finally,

complainant conceded during closing argument that respondent adequately documented a treatment plan or rationale for prescribing a controlled substance.

Background

PATIENT 1[1]

4. Patient 1 and her husband of almost 50 years lived in Sonora, California. Patient 1 and Husband[2] lived on the second floor of a two-story house, and one of their grandchildren and his family lived on the first floor. The second floor was approximately 1,800 square feet. There were separate entrances and exits for each level. They had two children together, a son and a daughter, and two grandchildren.

5. Patient 1 suffered chronic back pain due to a childhood car accident. She was the office manager for Husband's small general dentistry practice prior to his retirement in 2013. She generally worked two or three days a week. She needed to take more frequent breaks because of pain toward the end of her career. Patient 1 would stand or go for walks during her breaks. Also, she and Husband owned the building which housed the dental practice, so she would sometimes walk around and water the plants or visit the other tenants.

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[1] The patient whose treatment and care is the subject of the Accusation is referred to as "Patient 1" for consistency with the Accusation. However, she is the subject of the protective orders, and she is referred to by her initials in the transcript.

[2] Patient 1's family members are referred to by their relationships to her rather than their names to protect their privacy and Patient 1's.

RESPONDENT

6. Respondent earned his Bachelor of Arts in biology from Yale University in 2009 and his Doctor of Medicine from University of Rochester School of Medicine six years later. He completed a four-year anesthesiology residency at University of Wisconsin School of Medicine and Public Health in 2019 and an interventional pain medicine fellowship at Brigham and Women's Hospital the following year.

7. The Board issued respondent a license to practice medicine in California in September 2019. He is not licensed to practice in any other state. He has held board certifications from The American Board of Anesthesiology in anesthesiology and pain medicine since 2021. Respondent has worked at Darroch Brain & Spine Institute in Modesto, California, as an interventional pain specialist since 2020.

Worsening of Patient 1's Back Pain

8. Patient 1's back pain worsened after retirement. She loved gardening, going to the movies, and taking long rides in the car. She was able to perform these activities less and less as her pain worsened. She had to take breaks and sit with ice packs for 20 minutes every hour. As the pain worsened, Patient 1 had to stop and ice more frequently. Eventually, the pain radiated to between her shoulder blades.

9. Hiking reduced Patient 1's back pain. She and Husband used to drive long distances to explore new places while hiking. As her pain worsened, she was no longer able to tolerate long car rides, and she was limited to hiking the same places closer to home.

10. Patient 1's primary care physician referred her to respondent around November 2020. She previously treated with two other pain management specialists.

Treatment included epidural injections in 1965, 2015, and 2020 and radiofrequency ablation in 2016 and 2020. Those treatments provided only temporary relief. At the time of the referral to respondent, Patient 1 had completed six weeks of physical therapy on three different occasions with no long-term relief.

Respondent's Conservative Treatment

11. Patient 1 first treated with respondent on November 3, 2020. During the visit, they formulated a treatment plan for respondent to perform an intercostal nerve block at T-6 through T-9 on the right side. He performed the procedure the following day.

12. Patient 1 returned for a follow-up visit almost three weeks later and reported 85 percent pain relief for about a day. Therefore, she and respondent formulated a new plan to perform an intercostal nerve block in the same location and add a steroid for longer relief. Respondent performed the procedure December 2, 2020.

13. Depending on the medication used, an intercostal nerve block with a steroid provides pain relief from several hours to several months. It can take up to two weeks to start working. Patient 1 returned about two weeks later and reported 80 percent pain relief, but again only for about a day. Respondent told her to return in another two weeks.

14. Patient 1 returned as instructed and still reported pain relief for only one day. She was not getting the relief respondent had hoped for, so he ordered a thoracic medial branch block at T-6 through T-9 on the right side. He performed the procedure January 20, 2021. Patient 1 returned approximately two weeks later and reported 90 percent pain relief but for only one day.

15. Patient 1 and respondent formulated a new treatment plan for radiofrequency ablation at T-6 through T-9 on the right side. Respondent performed the procedure April 14, 2021. Patient 1 returned May 6, 2021, and reported no pain relief after the procedure. Respondent documented the following plan in Patient 1's medical records:

> - No relief from thoracic RFL [radiofrequency lesion, also known as radiofrequency ablation]. Can consider repeating thoracic RFL in the future but using COOLED RFA as it is able to make a larger lesion which may be better given the variability of the thoracic medial branch nerves
>
> - Patient continues to have thoracic back pain. She has failed several therapies both medication management and interventional therapies. Will try spinal cord stimulator at this time.
>
> - Patient has history with PONV [postoperative nausea and vomiting] thus will likely need pre-medications such as meclizine and scopolamine, zofran post op, and compazine
>
> - Can consider buprenorphine derived product in future as patient is currently taking tramadol

Spinal Cord Stimulator

16. An SCS is an electronic pain management device that sends signals through wire leads inserted into the epidural space on either side of the vertebra associated with the nerve root associated with the patient's pain. The other ends of the

leads are connected to a battery. The brain can process only so many electrical signals at once, and the intent is for the SCS's electrical signals to "compete" with pain signals so the brain interprets them as a "tingling" sensation instead of pain.

17. Using an SCS consists of two steps – a "trial" stimulator, and a "permanent" one. For the trial simulator, an epidural needle is inserted into the epidural space on either side of the targeted vertebra, and the leads are fed through the needle. When the needle is withdrawn, the leads hang out the patient's back. The leads connect to a battery that the patient wears on a belt. The patient has an external remote to control the location, frequency, and intensity of the electrical signals.

18. The trial stimulator is generally used for about one week, after which the physician removes the leads to avoid infection and evaluates the patient's response to the SCS. If the response was favorable, the physician obtains any insurance approvals and authorizations necessary for proceeding with a permanent stimulator.

19. The permanent stimulator also involves feeding the leads into the epidural space through an epidural needle, but the leads are tunneled under the patient's skin. The leads are attached to a battery which is tucked into a pocket made in the patient's low back or one of her buttocks. The battery is either rechargeable through the patient's skin or needs to be replaced every few years.

20. Common risks of the SCS include infection, bleeding, and permanent nerve damage. A post-dural headache is a well-known risk of an SCS. Rarely does an SCS result in the patient's death.

21. Respondent used SCSs manufactured by Nevro. Nevro's protocols required patients to undergo a psychological evaluation prior to using the trial stimulator. Ashour Badal, Ph.D., Psy.D., AMFT, and Cynthia Vincent, Ph.D., held a

comprehensive psychological consultation with Patient 1. The consultation included a mental status examination. After, Drs. Badal and Vincent concluded Patient 1 "is aware of the risks associated with [spinal cord simulator] surgery" and "that the surgery may be ineffective." They also concluded she "is able to understand the effects of this procedure along with the risks/benefits associated with it." Additionally, "she is capable of making decisions regarding [her] healthcare." Drs. Badal and Vincent recommended Patient 1 for an SCS.

22. Patient 1 had a preoperative appointment with respondent on June 11, 2021, to discuss proceeding with the trial SCS. The trial was scheduled for June 28, 2021, at Doctors Medical Center (DMC). Respondent documented the following in Patient 1's medical records after the appointment:

> - All patient questions about spinal cord stimulator answered. Patient interested in proceeding with the trial. Will plan on placing lead around T1 to cover thoracic back pain
>
> [¶] . . . [¶]
>
> - Risk of procedure explained to patients, including but not limited to: bleeding, infection, potential to make pain worse, and risk of permanent nerve damage. Please see the consent form to be signed on the day of the procedure for a more detailed list of possible procedural complications.

(Grammar original.)

23. Patient 1 went to DMC for the trial as scheduled. She was provided a written consent for treatment and conditions for admissions, which she read and signed as attested to by a member of her healthcare team who signed as a witness. Patient 1 was also provided a written consent specifically for the trial. The document provided, in relevant part:

> 3. All operations and procedures carry the risk of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to the results or cure. **You have the right to be informed of: the nature of the operation or procedure, including other care, treatment, or medications; potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur during recuperation; the likelihood of achieving treatment goals; reasonable alternatives and relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; as well as, any independent medical research or significant interests your doctor may have related to the performance of the proposed operation or procedure.**
>
> Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed operation or procedure at any time prior to its performance.

[¶] . . . [¶]

8. **Your signature on this form indicates that: (1) you have read and understood the information provided in this form, (2) the operation or procedure and the anesthesia set forth above, and its risks, benefits and alternatives have been adequately explained to you by your doctor, (3) you have had a chance to ask your doctor(s) questions, (4) you have received all of the information you desire concerning the operation or procedure and the anesthesia, and (5) you authorize and consent to the performance of the operation or procedure and the anesthesia, (6) you understand you have the right to refuse this operation or procedure and understand the consequences of such refusal.**

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

(Emphasis and grammar original.)

Patient 1 certified that she read the document, received a copy, and accepted its terms by signing it, as witnessed by a member of her healthcare team.

24. The procedure included respondent placing one lead at the top, and just to the right, of Patient 1's T-1 vertebra by feeding it through a needle inserted into the adjacent epidural space. He withdrew the needle and repeated the process for the

second lead at the top, and just to the left, of the same vertebra. The opposite ends of the leads remained outside Patient 1's body, and respondent connected them to the stimulator which Patient 1 wore on a belt.

25. Respondent documented in his operative report that Patient 1 "tolerated the procedure well and no complications were encountered." She was discharged to home in good condition once she met discharge criteria. He also noted, "The procedure, its benefits, and its risks were explained and written informed consent was obtained from the patient."

26. Patient 1 returned to respondent's office July 6, 2021. Respondent removed the leads by pulling them through her skin. Elizabeth Donovan, a Nevro device representative, was present and answered all Patient 1's questions. Patient 1 was very happy with the trial and wanted to proceed with a permanent SCS.

27. Respondent scheduled the permanent SCS at DMC. He noted the following in Patient 1's medical records:

> Risk of procedure explained to patients including but not limited to: bleeding, infection, potential to make pain worse, and risk of permanent nerve damage. Please see the consent form to be signed on the day of the procedure for a more detailed list of possible procedural complications.

(Grammar original.)

28. Patient 1 had a preoperative appointment with respondent on October 5, 2021. Ms. Donovan was also present at the appointment and answered all Patient 1's questions. Respondent explained the procedure and discussed its risks, benefits, and

alternatives. He included the following note in her medical records: "Risk of procedure explained to patients [*sic*] including but not limited to: bleeding, infection, potential to make pain worse, and risk of permanent nerve damage. Please see the consent form to be signed on the day of the procedure for a more detailed list of possible procedural complications."

29. On October 22, 2021, Patient 1 signed a general consent form like the one she signed prior to the trial. Three days later, she went to DMC. Respondent met with Patient 1 prior to her being anesthetized and explained the procedure he was going to perform and its risks and benefits. He obtained her written informed consent to proceed by having her sign a consent form specific to the permanent SCS but otherwise like the one she signed for the trial. Respondent wrote in Patient 1's records: "The procedure, its benefits, and its risks were explained and written informed consent was obtained from the patient."

30. The permanent SCS was implanted in Patient 1 in a similar fashion to the trial, except respondent made a small incision in her back prior to inserting the needle for the first lead. He placed both leads in the epidural space adjacent to either side of the middle of Patient 1's C-7 vertebra, created a pocket for the stimulator in her left buttock, connected the other ends of the leads to the battery, tucked the slack in the leads under her skin through the incision and the battery in the pocket, and sealed the pocket and closed the incision.

Respondent noted that the procedure went well and there were no complications. Patient 1 was discharged home after meeting the discharge criteria.

Post-Surgery

31. The permanent SCS was implanted on a Monday. Patient 1 was discharged from DMC at 2:40 p.m. according to medical records. Husband drove her home. She had a headache, some nausea, and some pain in the surgical site. She rested the remainder of the day.

32. Patient 1 and respondent discussed by telephone the symptoms she was experiencing each day on Tuesday, Wednesday, and Thursday (October 26 through 28, 2021). There were discrepancies over what specifically was said as discussed further below. However, all three conversations occurred while Patient 1 was lying on a couch, she used the hands-free feature on her telephone, and Husband sat on a coffee table adjacent to the couch and overheard the conversations. He also participated in some. The couch was in the living room approximately 25 feet from the master bedroom. Husband had moved a coffee table adjacent to the couch and moved the telephone to the table so it would be within Patient 1's reach while she lay on the couch.

33. Respondent prescribed butalbital-acetaminophen-caffeine 50 mg-325 mg-40 mg tablets Thursday. Husband went to Walmart Pharmacy to pick up the prescription and another store to pick up a caffeinated beverage Patient 1 requested in response to respondent's instruction to drink caffeinated beverages. When he returned, he gave her one of the tablets and sodas he had picked up. He asked how she was doing, and she said her head still hurt.

34. About an hour later, Husband went outside to do chores. When he came back inside, Patient 1 was upset and accused him of moving a stool she said she had tripped over while he was outside. He asked her why she had gotten up, and she

explained she needed to answer the telephone. Husband looked and saw the stool in the same place he placed it when he had moved the coffee table earlier in the week.

35. Rather than argue with Patient 1 and risk her getting more upset, Husband went downstairs to do laundry and allow her time to calm down. Later, Daughter arrived and found Husband in the laundry room. He asked why she was there, and she explained she was talking to Patient 1 on the telephone when she began slurring her speech and dropped the telephone. She asked if Patient 1 was on any new medication, and he said she was. Daughter attributed Patient 1's behavior during their conversation to the new medication because Patient 1 had a history of not tolerating medication well.

36. Daughter went upstairs to check on Patient 1, and Husband followed almost immediately thereafter. When he got upstairs, Patient 1 was asleep and snoring on the couch. He asked Daughter if that was how she found Patient 1, and she said it was. Daughter also found the telephone on the floor near the couch with the line still open. She picked up the telephone, turned it off, and put it back on the coffee table.

37. Neither Husband nor Daughter disturbed Patient 1 because they thought she had finally gotten comfortable enough to fall asleep. Daughter, however, tickled Patient 1's face with her hair but received no response. Daughter then researched Patient 1's medication in Husband's book of medications.

38. Sometime later, Patient 1 spontaneously raised both arms up in the air while her eyes were still closed. Husband walked over, lifted one of her eyelids, saw the pupil was dilated, and instructed Daughter to call 911. According to records, Daughter called 911 at 7:33 p.m., an ambulance arrived 10 minutes later, it drove Patient 1 to

Adventist Health Sonora (AHS) 22 minutes after that, and she arrived within 15 minutes.

39. Joseph Protacio, D.O., was the attending physician on duty in AHS's Emergency Department when Patient 1 arrived. His notes indicated he began examining her at 8:28 p.m. She was unconscious throughout the examination, and Dr. Protacio relied entirely on Husband for Patient 1's history.

40. Husband reported that respondent performed the permanent SCS procedure three days prior, and Patient 1 had a postural headache ever since. Respondent told them the headache was due to a cerebrospinal fluid (CSF) leak, and he was scheduled to perform an epidural blood patch to repair the leak on Friday. Husband further reported Patient 1 told him she had tripped over a stool around 7:00 p.m. that evening. Approximately an hour later, Daughter arrived and told Husband she had been talking to Patient 1 on the telephone when Patient 1 began slurring her speech. Husband and Daughter went upstairs to check on Patient 1, found her unresponsive, and called 911.

41. The Glasgow Coma Scale (GCS) is a numeric scale used to evaluate a patient's level of consciousness. The physician uses a scale from 3 to 15 to evaluate the patient's visual, verbal, and physical responses to various commands and progressively more painful stimuli. Higher scores are more favorable. Dr. Protacio gave Patient 1 a GCS score of 3 to 4 because she was "very much minimally responsive."

42. Dr. Protacio described Patient 1 as "aphasic," which meant she was not talking or making any sounds. Both pupils were "blown and fixed," "a very grave prognostic indicator [that] is one of the things that we check" prior to declaring a patient deceased. A subsequent computed tomography (CT) scan of Patient 1's head

revealed "a large right hemispheric hyperdense subdural hematoma with moderate subfalcine herniation." Dr. Protacio explained during his deposition that a subdural hematoma is "a collection of blood between the skull and the brain." He described Patient 1's "entire brain [as] essentially swollen." "[T]he overall picture paint[ed] a catastrophic traumatic injury and neurosurgical emergency."

43. Dr. Protacio's examination revealed the need for a neurosurgical evaluation. However, AHS did not have a neurosurgeon on staff. Therefore, he contacted DMC and requested that Patient 1 be transferred for a higher level of care on an emergent basis. His request was granted, and she was flown by helicopter to DMC.

44. Medical records indicate Patient 1 arrived at DMC shortly after 11:00 p.m. The emergency room attending physician immediately requested a neurosurgical consultation, and Benjamin Remington, M.D., the neurosurgeon on call, examined Patient 1. Dr. Remington recommended no neurosurgical intervention because the results of diagnostic imaging and his examination were "not compatible with life."

45. The neurosurgical and critical care teams informed Husband and Daughter of Patient 1's dire prognosis and answered their questions. Husband and Daughter requested that Patient 1 be placed on life support and admitted to DMC's Critical Care Unit (CCU). She was admitted Friday. It was noted in medical records, "Family remains hopeful and has difficulty understanding the severity of insult to [Patient 1's] brain and that prognosis remains extremely poor."

46. Patient 1's healthcare team continued to update Husband and Daughter extensively over the next several days. They remained hopeful that she would show

signs of improvement despite her remaining in a persistent coma and no change in her prognosis.

47. On November 6, 2021, Husband and Daughter requested withdrawal of life support and that Patient 1 be made as comfortable as possible. She passed away later that day with them at her side.

Complaint to the Board

48. Husband signed a Consumer Complaint Form on February 5, 2023, which the Board received three days later. He complained about the quality of respondent's care following the procedure for the permanent SCS. Husband explained that the procedure was performed Monday, October 25, 2021. After the procedure, Patient 1 experienced general discomfort in the surgical area, nausea and upset stomach, and a severe headache for the remainder of the day.

49. Patient 1's severe headache continued the following morning (Tuesday), "she felt something was wrong," and she called respondent "around lunch time." She told him "the headache got even worse when she sat up or stood up." He responded, "That is a postural headache. It is caused by loss of cerebrospinal fluid, it happens but it is not serious, [and] don't worry about it. To fix it I will have to place a blood patch in the area. Call me tomorrow." Respondent prescribed over-the-counter ibuprofen and acetaminophen.

50. Patient 1 called respondent Wednesday around lunchtime and told him she had "the same severe persistent 'postural' headache as diagnosed by [him] over the phone in that brief conversation that he had with her on Tuesday." He replied, "Now, it's an emergency." However, respondent expressed no sense of urgency and

said he could see Patient 1 the following day at 6:00 a.m. or 6:00 p.m. He also said he had availability Friday at 2:00 p.m.

Patient 1 last spoke with respondent on Thursday, and "he prescribed Esgic 50-325-40 and a caffeinated beverage."

51. Husband identified several symptoms of a CSF leak according to Mayo Clinic and the Cleveland Clinic but did not describe Patient 1 as having experienced any of them other than a headache. He questioned respondent's awareness of those symptoms and why he was allowed to perform surgeries if he was unfamiliar with them. He criticized respondent for not treating Patient 1's headache as the emergency it was, not offering to perform a blood patch prior to Thursday, and not telling her on Tuesday, Wednesday, or Thursday to go to the emergency room or call 911.

52. Husband concluded his narrative with the following:

> My statements are those of a lay person [*sic*] and not of any medical professional and are solely based upon my opinion and knowledge gained by me from medical records and percipient witnessing of the events. I would hope that the professionals of your institution will undertake a comprehensive fact [*sic*] finding investigation to determine if the standard of care was breached in my wife's treatment by [respondent]. Please investigate this thoroughly. Please prevent this tragedy from happening to other patients and their families. Disciplinary action should be taken to appropriately deal with his doctor. Don't let my wife's death by [*sic*] in vain.

53. Daughter also submitted a narrative statement complaining about respondent's treatment of Patient 1. She stated Patient 1 returned home from surgery on Monday complaining of a severe headache. Respondent was notified, said it was normal, and said it would go away in a few days. Husband went to Daughter's house the following day and told her Patient 1 was leaking CSF. Daughter immediately responded, "That sounds like and [*sic*] emergency to me!" However, Husband assured her respondent was aware of the leak, said it was nothing serious, and told Patient 1 not to worry about it.

54. Daughter was talking to Patient 1 on the telephone Thursday evening when Patient 1 "lost consciousness mid [*sic*] conversation." Daughter immediately rushed over to Husband and Patient 1's home and found her unconscious with the telephone on the ground and the telephone line still open.

55. Daughter speculated:

> My mom's headache did not go away and was becoming increasingly more painful as the days passed. This was a medical emergency! Doctor Jackson should have treated my mom in a timely manner with a blood patch to stop the leaking cerebrospinal fluid. Had he done so, I feel that my mom would still be alive today. He should have explained to her that this **was a serious** matter, and made it a priority that she be seen immediately. This was confirmed by Natalie Slowik MD, Benjamin J. Remington MD, and even Dr. Jackson himself as well as several others. The procedure to place a blood patch is a procedure that could have saved

my mom's life. I believe, had this been done in a timely manner, she would still be with us today.

(Emphasis and grammar original.)

56. Daughter concluded with the following statement:

> My statements are those of a lay person and not of any medical professional and are solely based upon my opinion and knowledge gained by me from medical records and percipient witnessing of the events. I would hope that the professionals of your institution will undertake a comprehensive fact finding investigation to determine if the standard of care was breached in my mom's treatment by [respondent]. Please investigate this thoroughly. Please prevent this tragedy from happening to other patients and their families. Disciplinary action should be taken to appropriately deal with his doctor. Don't let my mom's death by in vain.

(Grammar original.)

Respondent's Written Response

57. Respondent responded in writing to Husband's complaint on April 3, 2023. He described the history of his treatment of Patient 1 as previously discussed. He also wrote the following about the treatment plan formulated and discussed during her initial visit in November 2020:

The initial assessment was chronic lower back pain secondary to lumbar spondylosis and the diagnoses were: intercostal neuralgia, thoracic spondylosis, lumbar spondylosis, lumbosacral spondylosis without myelopathy, chronic low back pain, lumbar facet joint pain and arthropathy of lumbar facet joint. I noted the case was challenging as the patient had undergone several different previous treatments which included thoracic epidurals, thoracic medial branch blocks and thoracic medial branch radiofrequency ablations. I explained my treatment recommendations to the patient, including the potential risks, benefits and alternatives to the patient in detail and all of her questions were answered. The treatment recommendations included intercostal nerve blocks initially for levels T6-T9 on the right side. If the patient obtained significant relief from the right side injections, the treatment plan may include the same procedure on the left side. If the right sided intercostal nerve blocks were not effective, trigger point injections along with radiofrequency ablation would be considered, as well as paravertebral blocks and erector spinae blocks in the future. If these treatment modalities were not effective a spinal cord stimulator trial or trial with peripheral nerve stimulator would be considered.

(Grammar original.)

58. Respondent described having discussed with Patient 1 during her June 2021 visit the lack of significant improvement in her pain despite conservative treatment. He recommended proceeding with the SCS trial phase and "explain[ed] the spinal cord stimulator trial, including the potential benefits and risks and answered all questions to the Patient's satisfaction." He provided a consent form for the procedure and asked her to review it prior to the procedure. The form "included a detailed list of potential procedural complications."

59. Respondent wrote the following about Patient 1's visit when the trial leads were removed in July 2021:

> A physical examination was performed and the spinal cord stimulator trial leads were removed and were intact. A device representative was also available and all of the patient's questions were answered to her satisfaction. He husband was also in attendance. I noted that the justification for the interventional procedure was the patient had failed conservative management and her pain score was greater than 6/10. The potential benefits and risks of the procedure were explained to the patient, including but not limited to: bleeding, infection; potential to increase pain severity; permanent nerve damage; and the possibility of a post-dural puncture headache. She was referred to the surgical consent form which described a more detailed list of potential procedural complications.

(Grammar original.)

60. Respondent performed the procedure for the permanent SCS on October 25, 2021. Patient 1 tolerated the procedure well, and there were no complications. She was discharged "after the discharge criteria were met."

61. Respondent summarized three post-surgery telephone conversations with Patient 1 as follows:

> On October 26, 2021, I was informed by my medical assistant at approximately 1:00 p.m. that the patient was on the phone stating she was having pain and elevated temperature. I spoke with the patient and her husband. She complained of a positional headache that was worse when sitting up and better when laying down. She denied true fever and instead said that her body temperature was slightly elevated compared to normal. No neurologic deficits were reported. I explained to the patient and her husband that she was most likely suffering from a post-dural puncture headache. I offered the patient an epidural blood patch and conservative care. The patient and her husband declined the epidural blood patch and stated they wanted to try to avoid this procedure and instead opted for conservative care for the headache. I instructed the patient to lay flat as much as possible, drink as much fluid as possible, take Tylenol 1000 mg 3 times daily and Ibuprofen 600 mg 3 times daily. The patient and her husband confirmed that they had my office number and my direct number and would contact me for further issues.

On October 27, 2021, I called the patient at approximately 1:00 p.m. to discuss her headache. She was still having the positional headache suggestive of a post-dural puncture headache. I advised the patient that the epidural blood patch should be performed and that I was available that day. However, she wanted to do another day of conservative care. I told the patient to keep lying flat as much as possible, drink plenty of fluids, and drink caffeinated beverages. I advised her that I would call the next day to coordinate the epidural blood patch.

On October 28, 2021, I called the patient around 12:00 p.m. to discuss her headache. She continued to have a headache that was worse when sitting up and better when lying down. I told the patient and her husband that we needed to do the epidural blood patch and that we could do it that day at 6:00 p.m. or on October 29, 2021 at 2:00 p.m. The patient and her husband elected to have the procedure done on October 29, 2021 at 2:00 p.m. They inquired about how much Ibuprofen she should be taking and I stated 600 mg 3 times per day. The patient and her husband stated that she had been taking Ibuprofen 600 mg every 3 hours. I instructed them to stop taking Ibuprofen and Tylenol, lay flat as much as possible, and drink plenty of fluids. I ordered butalbital for the patient and confirmed that the procedure would be performed on October 29, 2021. I

instructed them to contact me if she experienced any problems in the interim.

(Grammar original.)

62. Respondent denied all of Husband's allegations of wrongdoing. He explained, "As soon as I was notified that [Patient 1] called complaining of a headache, I paused my clinic and spoke with her and her husband immediately." Respondent performed "a detailed history and review of systems over the phone," including asking "about the severity of her headache." Patient 1 described it as a moderate headache that was worse when standing up and better when lying down. Respondent inquired about other symptoms, "and neither [Patient 1] nor her husband reported any." He did the same Wednesday and Thursday, and Patient 1 and Husband never reported any new symptoms.

63. Respondent concluded Patient 1's "likely diagnosis was a post-dural puncture headache which is believed to be caused by a loss of cerebrospinal fluid." He explained that to her and Husband. "I did not state that there was nothing to worry about. Instead, I told her that many of these headaches get better with time and conservative treatment. But sometimes we need to do a special procedure called a blood patch to help with the headache called an epidural blood patch." Respondent offered to perform a blood patch that evening, but Patient 1 and Husband chose conservative treatment instead. He recommended the blood patch on Wednesday, but they wanted to try another day of conservative treatment. They finally accepted his recommendation on Thursday, but opted to have the procedure performed Friday afternoon instead of Thursday evening.

64. Respondent denied prescribing pain medication on Tuesday. Instead, after Patient 1 chose conservative treatment over a blood patch, he told her to take Tylenol 1000 mg and ibuprofen 600 mg each three times a day. No prescription was necessary because both were over-the-counter medications. Although respondent prescribed pain medication on Thursday, it was only after Patient 1 and Husband reported that she was taking ibuprofen more often than recommended. Additionally, the medication prescribed was "one of the recommended medications for the treatment of post-dural puncture headaches."

65. Lastly, respondent provided the following explanation why he did not order any diagnostic testing to confirm his diagnosis of a post-dural headache:

> I called the Patient and her husband on Wednesday, October 27 and Thursday, October 28 and inquired about any symptoms or issues she was experiencing. No additional symptoms aside from a positional headache were ever reported to me. Given that no other systemic issues, neurologic deficits, or changes were reported to me, I did not feel any diagnostic tests were indicated at that time. Further, the medical care in question occurred during the COVID pandemic and I was aware the patient was at higher risk for adverse outcomes if she contracted COVID given her age. Finally, I offered the patient an epidural blood patch on three separate occasions: Tuesday, October 26; Wednesday, October 27th, and Thursday, October 28. I advised the patient of the potential risks of delayed treatment of a post-dural puncture headache/CSF leak but

> she declined to undergo the procedure until Friday, October 29. I was not advised of any interim developments until she presented to the emergency department following an unwitnessed fall at home.

(Grammar original.)

The Board's Investigation

66. Stacie Barrera was an investigator with the Department of Consumer Affairs, Division of Investigations, Health Quality Investigations Unit. She was assigned Husband's complaint for investigation on June 20, 2023. She documented her investigation in a written report, which was admitted into evidence as administrative hearsay. Investigator Barrera did not testify at hearing.

INTERVIEW OF HUSBAND AND DAUGHTER

67. Investigator Barrera interviewed Husband and Daughter in person together on August 1, 2023. She reviewed their respective written narratives with them. They added that Patient 1 called respondent the day after the SCS procedure (Tuesday) and told him about her headache. He explained he may need to perform a blood patch, but Patient 1 and Husband agreed to take over-the-counter pain medication and call respondent the next day as he requested. Husband told Investigator Barrera he did not know if Patient 1 was warned that a CSF leak was a potential risk of the SCS procedure.

68. Husband listened to Patient 1 and respondent's telephone call on Wednesday. Respondent offered to see Patient 1 the following day at 6 a.m. or 6 p.m. He also offered Friday at 2 p.m. He did not specify the reason for the visit or where it

would take place. However, Husband assumed it was for a blood patch, and it would be at DMC. Respondent did not express any sense of urgency for seeing Patient 1, so she chose the Friday appointment.

69. Respondent prescribed Esgic during his conversation with Patient 1 on Thursday. She took only one dose prior to losing consciousness later that evening/night.

70. Husband said someone from respondent's office called Friday after Patient 1 had already been admitted to DMC and asked to move her appointment scheduled for that afternoon. He told the caller she was in the hospital and had suffered a hemorrhage the evening before. Husband and Daughter did not see respondent until approximately Sunday or Monday (six or seven days after the procedure) when he came by Patient 1's room in the CCU.

71. Respondent stopped by Patient 1's room and spoke with Husband, Daughter, and other family members for approximately five minutes. He said, "I'm sorry you folks are going through this." Daughter asked if the CSF leak could have caused the hemorrhage, and he said it was possible. As respondent was leaving, he said, "Remember, I offered you an appointment."

PATIENT 1'S MEDICAL RECORDS

72. Husband provided Investigator Barrera some of Patient 1's medical records. The records included discharge orders for the October 25, 2021 procedure reminding Patient 1 to schedule a follow-up appointment with respondent in five to seven days. They also included educational materials explaining common symptoms following the procedure included mild pain, bruising, swelling, headaches, and soreness in the back. Instructions explaining Patient 1 should call respondent if she

had a headache that did not go away were included. A scheduling form indicated that on October 28, 2021, respondent scheduled an "urgent blood patch" for Patient 1 for October 29, 2021, at 2:15 p.m.

Deposition of Husband

73. Husband was deposed on September 12, 2023, in a medical malpractice lawsuit he and his children filed against respondent and others. He estimated he had a total of three or four face-to-face conversations with respondent during Patient 1's appointments. Although Husband could not recall the specifics of any discussions, he believed respondent answered all questions, and tried to address any concerns, he or Patient 1 raised.

74. Husband also attended Patient 1's appointments with respondent when Ms. Donovan discussed the benefits of Nevro's SCS. He did not recall if Ms. Donovan also discussed the risks of the device. He estimated he attended "two maybe" appointments where Ms. Donovan was present.

75. Husband explained that on October 26, 2021, Patient 1 had a headache that worsened when she stood up and improved when she lay down, she was worried, and she thought something was wrong. Therefore, they called respondent and described her headache. Respondent explained she was suffering a postural headache caused by a CSF leak, but it was not serious and they need not worry about it. He told her to lie down as much as possible, stay hydrated with caffeinated drinks, and take over-the-counter pain medication. He further explained he may need to perform a blood patch if the headache does not resolve on its own. Respondent did not offer to perform a blood patch that day, and he did not provide any instructions on what to do if Patient 1's headache worsened.

76. Husband's recollection was that Patient 1 called respondent Wednesday and explained she still had the postural headache. Respondent replied, "Now it's an emergency." However, "in the same breath without expressing any emotion he said that he had appointments available Thursday morning at 6:00 a.m. or Thursday at 6:00 p.m." Husband expressed concern about the timing of the appointments and asked if there were others available that would make it easier for them to get there. Respondent offered Friday at 2:00 p.m., and Patient 1 took that appointment.

77. Husband was adamant that neither he nor Patient 1 declined any appointments with respondent. He explained:

> No. If he would have said I have to see her, then we would have made - - we would have seen him. So they [Thursday appointments] were not declined.
>
> I just - - what I had said was those are difficult appointments for us to make. We live hour and a half to two hours away. He knew that. And she's suffering with a headache which was getting worse.
>
> So, no, they weren't declined.
>
> [¶] . . . [¶]
>
> I just asked if - - or I just stated those are difficult appointments for us to make. And he stated that he was more flexible and could see her on Friday.

> So, no, I did not decline any appointments. She did not decline any appointments. It was decided by him that he had more time on Friday, and we trusted his judgment.

(Grammar original.)

78. Husband was unsure who called whom Thursday. However, Patient 1 described her headache to respondent as constant when lying down and increased when standing or sitting up. She did not disclose any other symptoms, and Husband did not talk during the conversation. Respondent said he would call a prescription for Esgic into Walmart Pharmacy for pain. He also recommended Patient 1 continue to drink caffeinated beverages.

79. Husband left Patient 1 alone while he picked up her prescription and the caffeinated beverages she had requested. He estimated he was gone about two to two and a half hours because Walmart did not have the caffeinated beverages she wanted. When Husband returned, Patient 1 was lying on the couch, alert, and talking to him. She took one of her new pills and drank one of the beverages. He asked how she was doing, and she said her head still hurt. She did not describe the severity of her pain or any other symptoms she was experiencing.

80. Later that evening, Husband went outside to finish some chores. When he came back in, Patient 1 told him she had tripped over a stool and her head really hurt. She got mad at him for moving the stool that she tripped over. Husband estimated Patient 1 tripped between 5:30 and 6:00 p.m. She did not say she hit her head when she fell, and he did not notice any signs she had fallen, such as altered consciousness, slurred speech, or physical injuries. Nor did he see any physical signs she had fallen such as an overturned stool.

81. Rather than risk Patient 1 getting more upset, Husband told her he was going downstairs to take care of the laundry and would return a few minutes later. Unbeknownst to him, Daughter called shortly after he went downstairs.

82. Daughter came over while Husband was still downstairs. She explained she was talking to Patient 1 on the telephone when Patient 1 began slurring her speech and suddenly dropped the phone. Daughter asked if Patient 1 was taking any new medications, Husband said she was, and Daughter figured that explained Patient 1's behavior during their conversation.

83. Daughter went upstairs shortly before Husband. They both saw Patient 1 asleep on the couch. Everything was in its place, except the telephone was on the floor and the line was still open. Daughter hung up the telephone and put it back on the table. Neither wanted to disturb Patient 1 because she appeared to be resting peacefully, and they figured that meant she was not in a lot of pain.

84. Around 7:00 p.m., Husband and Daughter saw Patient 1 raise both arms up toward the ceiling while her eyes were still closed. Husband went over and lifted one of her eyelids and noticed her pupil was dilated. He immediately told Daughter to "call 911."

Interview of Respondent

85. Investigator Barrera interviewed respondent on February 2, 2024, and summarized his interview in her report. The interview was digitally recorded, and a copy of the recording was admitted into evidence at hearing. A written transcript of the recording was also admitted.

86. Respondent was shown a copy of his April 3, 2023 written response to husband's complaint and provided an opportunity to add or clarify anything in it. He confirmed he had reviewed his written response and there was nothing he needed to add or clarify.

87. Respondent recalled discussing the potential risks of the SCS procedure with Patient 1, including infection, bleeding, nerve injury, and increased pain. He also explained the possibility of having a post-dural puncture headache.

88. Respondent confirmed he offered to perform an epidural blood patch Tuesday, Wednesday, and Thursday, but Patient 1 chose conservative treatment the first two days. He explained the risks of delaying treatment after recommending the procedure on Wednesday, which included a continued headache and the possibility of infection. Patient 1 never reported any symptoms beyond her headache.

89. Respondent further confirmed his intention was to document his three post-surgery telephone conversations with Patient 1 in her medical chart as part of the indication for the epidural blood patch when he performed that procedure. Therefore, he had not documented them when she was admitted to AHS on October 28, 2021.

Deposition of Respondent

90. Respondent was deposed in Patient 1's family's civil action on March 22, 2024. He did not recall talking to Husband on October 25, 2021, but he spoke with Patient 1 prior to the procedure. Although respondent did not recall the exact substance of their conversation, he recalled explaining the procedure, giving her discharge instructions, reminding her of the discharge instructions, and discussing post-operative care. He provided informed consent and a document with his office telephone number and his personal cell phone number.

91. Respondent first spoke with Patient 1 after the procedure the following day (Tuesday). His medical assistant told him that Patient 1 was on the telephone complaining about pain and an elevated temperature. Respondent spoke with Patient 1 and Husband. She complained of a headache that was worse when sitting up but better when lying down. She denied having a fever and explained she just felt warmer than usual. She did not describe any other symptoms.

92. Respondent told Patient 1 and Husband she was most likely experiencing a post-dural puncture headache. He did not recall specifically explaining the headache was likely caused by a CSF leak. He did not tell them post-dural puncture headaches happen but were not serious or something they should worry about. Nor did he tell them he would need to perform an epidural blood patch to fix the CSF leak or to call him the following day. Rather, respondent offered conservative care or an epidural blood patch. Patient 1 chose conservative care. He told her to lay as flat as possible, drink plenty of fluids, and take 1,000 mg of acetaminophen and 600 mg of ibuprofen, three times a day.

93. Respondent next spoke with Patient 1 when he called Wednesday to check the status of her headache. He recommended an epidural blood patch, but he did not remember the exact dates or times he offered. However, she wanted to continue with conservative care. Respondent said he would call the next day to coordinate the epidural blood patch. He did not know where Patient 1 and Husband lived at the time of the conversation.

94. Respondent called Patient 1 Thursday, and she explained the headache was essentially the same: "a headache that was worse when sitting -- sitting up and better when lying down." He again recommended an epidural blood patch and provided the option of scheduling it for that evening at 6:00 p.m. or the following

afternoon at 2:00 p.m. Patient 1 chose the latter appointment. Respondent prescribed Esgic. He explained he did not prescribe it sooner because it was prescribed only when other medication did not work, and he initially told her to take acetaminophen and ibuprofen.

95. Respondent did not document any of the three post-surgery telephone conversations in Patient 1's medical records until November 8, 2021. He initially intended to document the conversations "as part of the indication for the epidural blood patch procedure that [he] anticipated performing," but the procedure never took place because she was admitted to the hospital. His surgeries were exclusively outpatient procedures, and he did not "know the protocol for entering outpatient information into the chart for a patient that is, kind of, in the in-patient, so I just had to figure out what the procedure was regarding that." "[O]nly once I figured out the procedure to doing that, did I enter into the patient's medical chart as a late entry." (Diction and grammar original.)

96. Respondent explained there was no reason he could not have documented each telephone call after it occurred. He did not take simultaneous notes of any of the conversations, but he later made mental notes of them in preparation for adding them to the notes for the epidural blood patch he ordered October 28, 2021. He also wrote notes of the conversations the following day so he could refresh his recollection if there was ever a peer review or his office requested additional information in the future.

97. During the deposition, respondent was shown an October 28, 2021 procedure request form that stated, "Dr. Jackson would like this patient scheduled ASAP for tomorrow, 10/29/2021, around 2:00 p.m." The request was to schedule

Patient 1's "Urgent blood patch procedure" at DMC. The form identified the procedure as a "priority," and a box indicating "this task is urgent" was marked.

98. Respondent explained he did not know who completed the form, but it was someone in his office who did so at his request. He further explained he did not consider Patient 1's epidural blood patch to be "urgent," but asked that the document indicate it was because he wanted to perform the procedure the following day because Patient 1 had been experiencing a headache for a prolonged period of time. Procedure request forms were sent to a general inbox for staff responsible for scheduling outpatient procedures to handle as they were able. However, priority was given to those for "urgent" or "priority" procedures. Respondent was concerned the epidural blood patch would not be scheduled as requested if he completed the form otherwise.

99. Respondent first learned Patient 1 was at DMC at about 10:00 a.m. on Friday, October 29, 2021. One of the nurses told him during a procedure for an unrelated patient. Respondent finished his procedure and then went to see Patient 1 in the CCU. He did not recall seeing any family members when he was there. He believed he spoke with Husband by telephone later that day. Although respondent did not recall the specifics of their conversation, he remembered Husband saying something about waiting too long and then needing to go before hanging up.

100. Respondent's next and last conversation with any of Patient 1's family members was the following day at the hospital. He stopped by to see Patient 1, and Husband, Daughter, and two other people whom he assumed were family members were in her room. Although he did not recall the specifics of their conversation, he explained they told him the event leading up to her admission to the hospital. They asked several questions about SCSs, CSF leaks, and Patient 1's prognosis. Husband

explained Patient 1 had fallen and later had slurred speech. She had spoken with Daughter by telephone, Daughter became concerned, and Daughter came over.

101. Respondent's recollection was that he learned Patient 1 had passed away from Ms. Donovan. It was his understanding Ms. Donovan had contacted Husband, and he informed her of Patient 1's passing.

Relevant Medical Records

INFORMED CONSENT

102. As previously discussed, respondent developed a detailed treatment plan for Patient 1 during her initial visit in November 2020. He discussed the plan with Patient 1 in detail and answered all her questions. He explained the risks and benefits of each procedure and possible alternatives. He documented their discussion in her medical records as: "Specifics of procedure explained to patient in detail and all questions answered." Additionally, respondent noted, "Expressed to patient that in addition to decreasing pain improving function is one of the primary goals of chronic pain treatment."

103. Patient 1 had a follow-up visit with respondent six months later after he performed a right-sided thoracic medial branch radiofrequency ablation. She reported no pain relief. Having exhausted conservative treatment options, he recommended proceeding with a trial SCS. Respondent discussed the risks and benefits of the procedure as well as alternatives with Patient 1 and received her informed consent. He documented their discussion in her medical records.

104. Patient 1 had a preoperative appointment with respondent the following month. He again described the SCS procedure, and "all patient questions about spinal

cord stimulator [were] answered." He discussed the risks and benefits of the procedure as well as alternatives. He documented their discussion in her medical records in the same manner he did for their previous visit. Respondent also noted: "Patient interested in proceeding with the trial."

105. Respondent performed the trial SCS procedure at DMC. Prior to the procedure, he met with Patient 1 and explained the procedure, its risks and benefits, and its alternatives. She subsequently acknowledged their discussion by signing a Consent to Surgery/Special Procedures. Respondent countersigned the Consent. He also documented their discussion in Patient 1's medical records.

106. Patient 1 went to a follow-up visit with respondent a week after the procedure. Ms. Donovan was also present. Respondent removed the wire leads without any complications. Patient 1 reported significant pain relief during the trial phase, was "very pleased with the trial phase[,] and [was] interested in going forward with a permanent spinal cord stimulator implant." Ms. Donovan answered all her questions, and respondent explained the procedure, its risks and benefits, and alternatives. He documented their discussion in Patient 1's medical records.

107. Patient 1 attended a preoperative appointment with respondent about three weeks prior to the procedure. Ms. Donovan was also present and answered all her questions. Respondent explained the procedure, its risks and benefits, and alternatives. He documented his explanation in Patient 1's medical records.

108. Respondent performed the permanent SCS procedure at DMC. Prior to the procedure, he met with Patient 1 and explained the procedure, its risks and benefits, and its alternatives. She subsequently acknowledged their discussion by

signing a Consent to Surgery/Special Procedures. Respondent countersigned the Consent. He also documented their discussion in his operative report.

ORDER FOR EPIDURAL BLOOD PATCH

109. On October 28, 2021, respondent signed an electronic order for an epidural blood patch for Patient 1 the following day at DMC. The order included his diagnoses of "Post [*sic*] dural puncture headache" and "Other reaction to spinal and lumbar puncture."

PRESCRIPTION FOR ESGIC

110. Respondent sent a prescription for "butalbital-acetaminophen-caffeine 50 mg-325 mg-40 mg tablet" (trade name Esgic) for Patient 1 to Walmart Pharmacy on October 28, 2021. At hearing, the parties stipulated that the prescription included in the record did not contain all the information depicted on the prescription in Patient 1's electronic medical records. During closing argument, complainant conceded that respondent adequately documented a treatment plan or rationale for prescribing Esgic.

AHS'S RECORDS

111. AHS's Emergency Department Triage/Initial Assessment notes and Emergency Department Physician notes indicate, "Family states patient tripped and fell around 7 pm." The latter notes further provide, "Tonight around 7 pm, husband reports she tripped over a small stool in the kitchen, however this fall was unwitnessed."

DOCUMENTATION OF TELEPHONE CONVERSATIONS

112. Respondent documented his three telephone conversations with Patient 1 in her medical records on "11/08/21" at "08:43pm." (Spacing original.) He wrote:

> 10/26/2021
>
> Informed by my medical assistant at approximately 1 pm that the patient was on the phone stating she was having pain and elevated temperature. Talked with the patient and her husband. She complained of a positional headache that was worse when sitting up and better when laying down. She denied true fever and instead said that her body temperature was slightly elevated compared to normal. No other symptoms were reported. Explained to the patient and her husband that she was most likely suffering from a post-dural puncture headache. Offered patient epidural blood patch and conservative care for this headache. The patient opted for conservative care. Told patient to lay flat ask [sic] much as possible, drink as much fluid as possible, take Tylenol 1000 mg 3 times daily and ibuprofen 600 mg 3 times daily.
>
> 10/27/2021
>
> Called the patient at approximately 1 pm to discuss her headache. She was still having the positional headache suggestive of a post-dural puncture headache. I recommended the epidural blood patch but the patient

wanted to do another day of conservative care. Told the patient to keep laying flat as much as possible, drink plenty of fluids, and drink caffeinated beverages. Told the patient I would call the next day to coordinate the epidural blood patch.

10/28/2021

Called the patient around 12 pm to discuss her headache. She continued to have a headache that was worse when sitting up and better when laying down. I told the patient and her husband that we needed to do the epidural blood patch and that we could do it on 10/28/2021 at 6 pm or Friday 10/29/2021 at 2 pm. Patient and her husband elected to have the procedure done on 10/29/2021 at 2 pm. Patient told me that she had not been taking ibuprofen 600 mg three times per day but instead had been taking it every three hours. I told them to stop taking ibuprofen and Tylenol, lay flat as much as possible, and drink plenty of fluids. Ordered butalbital for the patient.

Hearing Testimony

HUSBAND

113. Husband followed Patient 1's treatment for chronic back pain closely, but he did not recall meeting respondent until just before the trial SCS because of COVID restrictions. Husband's familiarity with her treatment was based largely on what she had told him. For instance, Patient 1 always told him she liked respondent. She

believed the trial was "extremely successful" and thought "very highly" of respondent afterward because she was able to perform physical tasks she was unable to the previous three years. Husband estimated the trial improved Patient 1's back pain by 80 percent and described her as "elated" during the trial and "disappointed" when it ended.

114. Husband recalled picking Patient 1 up when she was discharged from DMC after the procedure for the permanent SCS. He went to get the car as a nurse brought her downstairs in a wheelchair. After helping Patient 1 into the car, the nurse handed Husband postoperative instructions and then left without explaining them. He recalled the instructions said something about headaches and to call respondent if there was a persistent headache. There were no warnings of any other neurological symptoms to watch out for.

115. Husband typically got up in the morning about two hours before Patient 1. When she awoke the morning following the procedure for the permanent SCS (Tuesday), she called for him to help her to the bathroom because she felt dizzy and had a bad headache. He helped her by walking on her left side with his right arm around her back and under her right arm pit to stabilize her. Husband helped Patient the same way from the bathroom to the living room couch where she lay all day, except for trips to the bathroom.

116. Patient 1 did not experience a headache during the trial, so she and Husband decided to call respondent. She called during the lunch hour and told respondent she had a headache that was more painful than anything else she had experienced. She said it was constant but worse when she stood or sat up.

117. Respondent explained Patient 1 was experiencing a post-dural headache caused by a CSF leak, which happens after procedures such as hers but was not serious or anything to worry about. He further explained post-dural headaches often healed on their own, but he could perform an epidural blood patch if Patient 1's did not. Respondent described the procedure as using a syringe to withdraw blood from her body to inject near the site of the leak. He analogized the procedure to plugging a hole.

118. Respondent told Patient 1 to take Tylenol 1,000 mg and ibuprofen 600 mg every eight hours. He also said to drink caffeinated beverages and call him the next day. Husband told respondent that Patient 1 had trouble swallowing medicine and asked if she could stagger the medication so she had to take only one at a time. Respondent agreed to her doing so. Husband put Patient 1's first dose on a saucer on the coffee table so she would not have to worry about which medication she was supposed to take or opening the bill bottle. After she took it, he replenished the saucer with the next dose. He did the same for all subsequent doses.

119. Husband went to Daughter's home after the telephone call to get a flexible straw so Patient 1 would not need to lift her head when drinking. He was gone for approximately 15 minutes. Otherwise, Husband was with Patient 1 the entire day. He brought her toast and tea as needed throughout the day and placed them on the coffee table.

120. Husband could not recall who called whom on Wednesday, but Patient 1 spoke with respondent and said her headache was worse than on Tuesday and she was also experiencing dizziness. Husband believed she also said she needed help walking. Respondent replied, "Now, it's an emergency," and he said he could see her Thursday at 6:00 a.m. or 6:00 p.m. Husband asked if there were any other

appointments available, and respondent said he had no others Wednesday but had one Friday at 2:00 p.m. Patient 1 took that appointment. Respondent did not explain why he wanted to see Patient 1, but she and Husband assumed it was to perform an epidural blood patch.

121. Husband explained at hearing that he and Patient 1 lived at least a 90-minute drive from DMC. If they had accepted the appointment at 6:00 a.m., they would have needed to be at DMC by 5:00 a.m. That would have required them to leave their home at 3:00 a.m. It would have been dark outside, there were steps outside their house, she was dizzy, and he was blind in one eye. Husband would have had to hold onto Patient 1, the handrail, and a flashlight at the same time, and it could have ended in "disaster." They would have faced similar challenges when coming home if they accepted the appointment at 6:00 p.m.

122. Patient 1 called for Husband when she woke on Thursday. He removed the covers, helped her sit up on the edge of the bed, and assisted her into a standing position. He provided about as much assistance as he had Wednesday. After helping Patient 1 to the restroom, Husband helped her to the living room couch where she lay all day, except for trips to the restroom. She said her headache was worse than before and described it as constant but worse when sitting or standing up. She also felt dizzier than before.

123. Husband did not recall who called whom that day, but Patient 1 spoke with respondent around 12:00 p.m. while she lay on the couch. She told him her headache and dizziness were worse. Respondent did not ask any questions about her symptoms but said he would prescribe a stronger medication for the headache. He also repeated his previous instructions to drink caffeinated beverages.

124. Husband initially testified he did not recall Patient 1 telling respondent she was taking ibuprofen every three hours instead of three times a day. He then explained there was no way she took more ibuprofen than recommended because he set out only one dose at a time. Husband then denied that Patient 1 told respondent she took too much ibuprofen.

125. Husband went to Walmart Pharmacy Thursday afternoon to pick up Patient 1's prescription. Additionally, she had requested a specific caffeinated beverage in response to respondent's recommendation to drink caffeinated beverages, and Husband wanted to buy some. When he returned, he gave her one of the new pills and drinks.

126. Approximately one hour later, Husband went outside to finish some chores. When he came back inside, Patient 1 was upset and accused him of moving the stool she had tripped over while he was outside. He asked her why she had gotten up, and she explained she had to answer the telephone. Husband had found her explanation odd because he found the stool in the same location he had put it earlier in the week. He also found the telephone on the coffee table within Patient 1's reach. Nonetheless, he did not want to upset her further by arguing with her, and he told her he was going downstairs to do the laundry.

127. Daughter arrived while Husband was still downstairs. He asked why she was there, and she explained she was talking to Patient 1 on the telephone when Patient 1 began slurring her speech and then dropped the phone. Daughter went upstairs, and Husband followed shortly thereafter. When he got upstairs, he found Patient 1 asleep on the couch. Daughter explained she found Patient 1 in the same condition shortly before.

128. After watching Patient 1 sleeping for a while, Husband saw her spontaneously move her left arm while her eyes were still closed. He went over and lifted one of her eyelids and saw her pupil was dilated. He told Daughter to call 911. An ambulance arrived and transported Patient 1 to AHS while Husband followed by car. Upon arrival, he told the emergency room staff Patient 1 had tripped earlier that evening, but he did not see it happen. He did not say she had fallen, because he did not know. Patient 1 was eventually transported to DMC by helicopter for a higher level of care.

129. Respondent visited Patient 1 at DMC only once. Husband did not recall the date, but he said it was sometime between November 1 and 6, 2021. He recalled respondent speaking very softly and having trouble hearing him. Daughter had to move closer to respondent to hear, and they later continued their conversation in the hallway. Before respondent left, he walked part way into the room and said, "Remember, I offered you an appointment."

130. Patient 1 spoke with respondent during each of the three telephone calls using a speakerphone as Husband sat nearby and listened. Husband estimated each call lasted approximately five minutes. Respondent never explained the cause of the CSF leak or described any neurological symptoms Patient 1 and Husband should watch for. He also never offered to perform the epidural blood patch the same day. Had he done so, they would have gone in right away. Although respondent said "it's an emergency" on Wednesday, he did not tell Husband to call 911, take Patient 1 to the emergency room, or he wanted to see her that day. He did not say any of those things Tuesday or Thursday, either.

131. Husband and Patient 1 interpreted respondent's statement on Wednesday and offering appointments over the next two days as an indication she

was not experiencing a true emergency. Indeed, respondent had said Tuesday that CSF leaks often heal on their own and recommended waiting to see if that would happen with hers. Husband and Patient 1 trusted him.

DAUGHTER

132. Daughter did not attend any of Patient 1's appointments with respondent, but Patient 1 sometimes discussed them with her afterward. Daughter knew respondent was performing the SCS procedure on October 25, 2021, but she had to work all day and could not attend the procedure. She did not talk to Patient 1 until the following day. Daughter called Tuesday morning, and Patient 1 explained she had a bad headache. She called again that afternoon, and Patient 1 said she had spoken with respondent. He had told her to lay flat as much as possible.

133. Daughter called Wednesday morning, and Patient 1 said her headache was worse, she was dizzy, and she needed help walking to the bathroom. She also said she had not spoken with respondent yet, but she planned to. Daughter called again that afternoon after Patient 1 had spoken with respondent. Patient 1 explained she had told respondent about her symptoms, and he scheduled an epidural blood patch for Friday at 2:00 p.m.

134. Daughter's work schedule on Thursday prevented her from calling Patient 1 until the evening. During the call, Patient 1 "was in horrible pain" and said her headache really hurt. Daughter described the call as "a very alarming phone call" because Patient 1 began slurring her speech part way through the call. Patient 1 reported she had fallen when getting up to answer the telephone. She suddenly dropped the telephone shortly thereafter. Daughter hung up and immediately rushed over to Husband and Patient 1's home.

135. Daughter found Husband in the laundry room when she arrived and told him about her telephone conversation with Patient 1. She then went upstairs to check on Patient 1. The dog started barking when Daughter came upstairs. She saw Patient 1 lying on the couch and spontaneously lift both arms up to the ceiling while her eyes were still closed. Daughter thought Patient 1 was reacting to the dog barking, so she calmed the dog as she walked closer. Patient 1 appeared to be asleep. Daughter tickled Patient 1's face with her hair but received no reaction.

136. Husband came upstairs after Patient 1 spontaneously raised her arms. However, she made the same movement again, Husband lifted her eyelid and saw her pupil was dilated, and he told Daughter to call 911. Daughter drove herself to the hospital after the ambulance left with Patient 1.

137. Daughter met respondent for the first time when he visited Patient 1 in the CCU. He spoke very softly when answering questions, and she had to move closer to hear him. They never spoke outside in the hallway. As respondent was leaving the room, he stopped, turned, and said, "Remember, I offered you an appointment" before walking away.

RESPONDENT

138. Respondent's testimony was substantially the same as his written response to Husband's complaint, interview with Investigator Barrera, deposition, and November 8, 2021 note. Additionally, he denied telling Patient 1 during their conversation on Tuesday that a post-dural headache was not a big deal and was not something she needed to worry about. He said he took all complications seriously and would never make either statement about any complication. Respondent also denied

stating, "Now, it's an emergency" during any of their conversations. He explained an epidural blood patch "was not an emergent procedure."

139. Patient 1 needed to stop taking ibuprofen prior to respondent performing an epidural blood patch. Therefore, his discussion on Thursday about scheduling the procedure included his asking if she was taking ibuprofen as instructed. He recalled her saying she was taking ibuprofen every three hours. Respondent told Patient 1 she was taking too much, instructed her to stop taking Tylenol and ibuprofen, and said he would prescribe Esgic.

140. Respondent agreed he never provided Patient 1 a list of symptoms she should watch for and call him if she experienced. He explained his general "custom and habit" was not to provide a list of symptoms to watch for under such circumstances because such list would be too long for a patient to remember. For example, a list of all neurological symptoms relevant to Patient 1 would have probably been "at least two pages printed." Additionally, respondent feared that providing a list would give patients a false sense of security by thinking a symptom not listed was benign and need not be reported. Instead, he told Patient 1, and other patients, to contact him if there was any change in symptoms.

141. Respondent was performing surgery on another patient Friday morning when a nurse on the surgical team told him Patient 1 was in the CCU. Respondent finished his surgery and went to see Patient 1. He saw a neurology physician assistant, who told him Patient 1 had fallen and suffered a subdural hematoma. Dr. Remington was the neurosurgeon on call, so respondent contacted him directly and discussed the October 25, 2021 SCS procedure and respondent's three subsequent telephone conversations with Patient 1.

142. Respondent did not see Husband or Daughter when he visited Patient 1, so he called Husband from the CCU. Husband said something about waiting too long, became emotional, and hung up. Respondent assumed Husband and Daughter had questions, and he wanted to make himself available to answer their questions. He stopped by the nurses' station on his way out of the CCU, left his telephone number with a nurse, and asked someone to call him when Patient 1's family next visited.

143. A nurse called the next day when Patient 1's family visited, and respondent came to talk to them. Husband, Daughter, and two other family members were in Patient 1's room. He introduced himself, expressed his condolences for Patient 1's condition, and spent the next three to five minutes giving the family "space" to explain what happened. He then summarized his care, after which Daughter asked several questions which he answered the best he could.

144. Respondent's entire conversation with Patient 1's family occurred in her room, and he never spoke with Daughter in the hallway. That was the first time he met Daughter. When he left Patient 1's room, he did not stop and remind the family that he offered Patient 1 an appointment. Respondent expressed confidence that he would never say that or something even remotely close to it.

145. Respondent visited Patient 1 again five days later, but none of her family was present. He documented his visit in her medical records the following day. He also noted:

> Engaged in an extensive discussion with the patient's husband and daughter on 10/30/21 regarding the patient's condition. All the families [*sic*] questions were answered[,]

and I provided them with my contact information in the event additional questions or concerns arise.

Respondent had no further interaction with Patient 1 or her family until after her passing.

146. Respondent explained he had a "pretty good" independent recollection of his interactions with Patient 1, of their three telephone conversations in particular. He described the circumstances surrounding her passing as one of his more "catastrophic occurrences" with a patient. He explained people tend to remember such tragedies, analogizing it to most people remembering where they were "on 9/11."

147. Respondent explained whenever he proposed a new treatment procedure to a patient, he explained the procedure, its risks and benefits, and alternatives. If the patient agreed to the procedure, respondent provided the same information during each subsequent visit including when he performed the procedure. He developed this process based on his experience that different patients take away different information from a conversation. By repeating the same information over multiple visits, he hoped to provide the patient a better understanding of her procedure.

148. Respondent also strived to provide pertinent information as soon as possible because patients often discussed their medical care with close family and friends. Those family and friends frequently asked questions the patient had not raised. By providing information early and often, respondent provided patients the opportunity to ask those additional questions with the goal of providing them all the information they needed.

149. Once the patient agreed to the recommended procedure, respondent tried to schedule a preoperative appointment "several weeks" before the procedure. He has found that scheduling the appointment any sooner increased the likelihood of the patient forgetting the information discussed during the appointment. If he scheduled the appointment much later, it did not provide the patient with sufficient time to process the information provided and discuss it with others.

150. Respondent discussed with Patient 1 the possibility of developing a post-dural puncture headache each time he discussed the trial or permanent SCS. He often referred to it as a "special kind of headache" because it is worse when standing or sitting up but better when lying down. "Each time" he also provided her his discharge instructions, which included his office telephone number and his cell phone number. Respondent was "very certain" he provided his cell phone number on multiple occasions because he wanted Patient 1 to feel supported and have a way of contacting him directly because the SCS can be complicated.

151. Respondent went over the discharge instructions line by line during Patient 1's preoperative appointments before both SCS procedures. He recalled her being very involved in her health care and asking a lot of questions, which he fully answered to the best of his ability.

152. Respondent expressed confidence that he treated Patient 1 to the best of his ability, and he did not engage in gross negligence, repeated negligent acts, or inadequate or inaccurate record keeping during her treatment. Nonetheless, he admitted there is always "room for improvement." He created a new document entitled "Pain Management Procedures Risk and Complications" in response to Husband's allegations of misunderstanding Patient 1's treatment. The document describes the risks, benefits, and alternatives to interventional pain procedures in

general. It also itemizes different procedures followed by the specific risks associated with each. Respondent provides the document to every new patient and again when a patient elects one of the procedures listed.

153. In September 2024, respondent attended the Western Institute of Legal Medicine (WILM) Physician Assessments & Clinical Quality Improvement Program's Medical Recordkeeping Course. It was a two-day teleconference sponsored by University of California, Irvine School of Medicine. Three months later, he attended University of California, San Diego School of Medicine PACE Office's (PACE) two-day Ethics for Medical Professionals Course. In January 2025, respondent attended PACE's Client-Patient Communication Course. Two months later, he attended WILM's Prescribing Practices and Management of Chronic Pain and Substance Abuse Disorder CME Course. It was a two-day teleconference.

154. Respondent explained he obtained a lot of beneficial information from the above courses, much of which he has incorporated into his practice. For example, he learned valuable tools and techniques for effective communication with patients. Techniques include asking patients to repeat what he told them to assess their comprehension and breaking down what he tells them into smaller bits of information and "circle back" more often. One activity during the communication course he found particularly enlightening was when he paired with a partner, told his partner something he was passionate about, and his partner was responsible for repeating what respondent had told him to the rest of the class. These activities required him to focus not only on what he said, but how he said it.

Expert Witnesses

SIMON DARDASHTI, M.D., M.S.

Background

155. Complainant retained Simon Dardashti, M.D., M.S., to analyze respondent's treatment of Patient 1. Dr. Dardashti earned his Bachelor of Arts in political science from University of California, Berkeley, in 2005. He earned his Master of Science in physiology and biophysics from Georgetown University the following year. He earned his Doctor of Medicine from Chicago Medical School four years after that.

156. Dr. Dardashti completed his internship and residency in anesthesiology at University of California, Irvine Medical Center. He then completed a one-year fellowship with the Department of Anesthesiology in Perioperative Medicine at Interventional Spine and Chronic Pain Management at University of California, Los Angeles. He has been licensed to practice medicine in California since August 5, 2011.

157. Dr. Dardashti is duly boarded in anesthesiology and pain medicine by the American Board of Medical Specialties. He worked as an attending faculty member at Interventional Spine and Chronic Pain Management for one year before becoming an interventional pain specialist. Dr. Dardashti has worked as an interventional pain specialist for Facey Medical Group since 2018. He also serves as an expert witness regarding pain management. He has experience reviewing documents, evaluating the merits of cases, determining whether a physician committed medical negligence, and testifying at depositions and trials.

158. Dr. Dardashti documented a summary of respondent's treatment of Patient 1 and his opinions and conclusions about treatment in a written report. The report was admitted into evidence, and Dr. Dardashti testified at hearing. His report is discussed first, followed by his testimony.

Summary of Respondent's Treatment

159. In his report, Dr. Dardashti summarized respondent's treatment of Patient 1 as follows:

> On October 25, 2021, [Patient 1] underwent a spinal cord stimulator implantation surgery at Doctors Medical Center of Modesto. The procedure, performed by [respondent], aimed to manage her chronic pain. Postoperative instructions were provided. On October 26, 2021, the day following the surgery, [Patient 1] reported experiencing a positional headache, a common indication of a post-dural puncture headache caused by a cerebral spinal fluid (CSF) leak. [Respondent] offered an epidural blood patch to address the CSF leak, but [Patient 1] and her husband opted for conservative treatment, including bed rest, increased fluid intake, and over-the-counter pain medications. [Respondent] states, "I offered the patient an epidural blood patch and conservative care. The patient and her husband declined the epidural blood patch and stated they wanted to try to avoid this procedure and instead opted for conservative care for the headache." On October 27, 2021, [respondent] spoke again over the phone with [Patient 1].

She continued to experience the positional headache but did not report any new neurological symptoms. [Respondent] reiterated the offer for an epidural blood patch, which [Patient 1] again declined, preferring to wait another day before proceeding with the more invasive procedure. [Respondent] states, "I advised the patient that the epidural blood patch should be performed and that I was available that day. However, she wanted to do another day of conservative care. I told the patient to keep lying flat as much as possible, drink plenty of fluids, and drink caffeinated beverages." On October 28, 2021, [Patient 1's] condition had not improved, and she agreed to schedule the blood patch procedure for the next day. However, later that same day, [Patient 1] suffered an intracranial hemorrhage. [Patient 1] did have an unwitnessed fall over a stool in her kitchen. She was urgently hospitalized, but despite medical efforts, she passed away on November 6, 2021.

Following [Patient 1's] death, her husband, [Husband], filed a complaint with the Medical Board of California, alleging that [respondent] had not adequately communicated the urgency of treating the CSF leak and that earlier intervention with a blood patch or a referral to the emergency room might have prevented the fatal hemorrhage. During the subsequent investigation, [respondent] defended his treatment approach,

> highlighting that the occurrence of a intracranial hemorrhage following a spinal cord stimulator implantation is exceedingly rare. [Respondent] explained that he had advised [Patient 1] and her husband of the potential risks of a CSF leak and had offered appropriate medical interventions based on her reported symptoms and preferences.
>
> The investigation revealed the complexities and challenges of [Patient 1's] case, emphasizing the difficulty in predicting such rare complications and the importance of thorough communication between physicians and patients regarding potential risks and treatment options.

(Grammar original.)

Medical Record Keeping

160. Dr. Dardashti articulated the standard of care applicable to medical record keeping as "the physician and surgeon should keep accurate and complete records." He explained, "Records should include the discussions with the patient about diagnosis and treatment, medical history, new symptoms, physical examination, treatment plan objectives, informed consent, results of risk assessment, including discussions of risks and benefits with the patient and any significant others."

161. Dr. Dardashti observed that it was undisputed that respondent spoke with Patient 1 by telephone on Tuesday, Wednesday, and Thursday. It was also undisputed he did not document any of the conversations in her medical records until November 8, 2021. Dr. Dardashti opined that although respondent intended to

document the conversations when he performed an epidural blood patch, "a physician is expected to document conversations with patients within a reasonable time after it occurs."

162. Dr. Dardashti concluded respondent's failure to timely document his three conversations with Patient 1 constituted an extreme departure from the applicable standard of care. He explained:

> Although [respondent] offered an epidural blood patch which he states the family refused, the lack of immediate documentation and follow up contributed to the perception that the situation was not handled with the appropriate urgency. Proper adherence to medical documentation to fully understand the nature of conversations between physician and patient is important in this case but was insufficiently executed.

(Grammar original.)

Management of Post-Dural Puncture Headache

163. Dr. Dardashti explained, "A post-dural puncture headache is a recognized complication following procedures that involve puncturing the dura matter, such as spinal anesthesia, epidural anesthesia, or spinal cord stimulator implantation." The standard of care for treating such complication "involves recognition, accurate diagnosis, and timely intervention to alleviate symptoms and prevent further complications." Within 24 hours of the procedure, the physician should identify the symptoms of a post-dural puncture headache, which include: (1) a headache that

worsens when sitting upright and improves when lying down; (2) neck stiffness; (3) nausea; (4) vomiting; (5) auditory disturbances; and (6) visual changes.

164. For the first 48 to 72 hours, conservative treatment, "including bedrest, increased oral hydration, caffeine intake, and over-the-counter pain medications," is often the initial treatment. If conservative treatment fails, an epidural blood patch is generally the next option. "This procedure, which involves injecting a small amount of the patient's blood into the epidural space to seal the CSF leak, should be scheduled promptly."

165. Dr. Dardashti opined, "[Respondent's] management of [Patient 1's] post-dural puncture headache largely conform[ed] to the standard protocols for diagnosing and treating this condition, despite some notable deficiencies in documentation and urgency." However, he was critical of respondent for not recognizing that Patient 1's headache was not improving with conservative treatment. He further criticized respondent for not considering the need for a neurosurgical consultation to determine if the headache was due to misplacement of one or both the SCS leads instead of a puncture of the dura. Dr. Dardashti explained:

> A reasonable and prudent physician would have thought of alternative diagnoses, considered getting imaging when the patient did not respond to conservative treatment, request that the patient get evaluated in person either in his own clinic or an emergency room given her lack of improvement. [Respondent] explains he asked the patient to come into the clinic but the patient refused. An against medical advice (AMA) form or some form of informed

> consent would be considered at this time, to be documented or signed by the patient.

(Grammar original.)

166. Dr. Dardashti concluded respondent committed a simple departure from the applicable standard of care while managing Patient 1's post-dural headache. He made clear that respondent's recognition of the headache and provision of conservative treatment met the applicable standard of care. However:

> The treatment could have been improved by considering other diagnoses, considered a neurosurgeon consultation, ordering urgent imaging to rule out other diagnoses, conducting immediate and thorough documentation, perform a telehealth visit, evaluating the patient in person and if she refused having the patient go to the emergency department, sign or document an against medical advice form, consider lead malposition, and emphasizing the urgency of addressing the cerebrospinal fluid leak to the family if they refused treatment.

(Grammar original.)

Informed Consent

167. Dr. Dardashti explained that the standard of care for obtaining a patient's informed consent to a procedure requires the physician to provide "a clear explanation of the potential risks involved and anticipated benefits of the procedure." He must accurately and adequately document his discussion with the patient. "This

documentation should capture the discussions with patients about the risks and benefits of the procedures, ensuring that patients are fully informed before giving their consent."

168. Dr. Dardashti noted that several records he reviewed indicated respondent "discussed [with Patient 1] the potential risks and benefits of the spinal cord stimulator procedure, including the possibility of a post-dural puncture headache." Respondent also explained "the potential risks of delaying treatment for a post-dural puncture headache/CSF leak" when he offered and epidural blood patch post-surgery. However, he "did not inform the family of the possibility of death or intracranial hemorrhage" from the post-dural puncture headache. Nor did he "explain the urgency for treatment."

169. Dr. Dardashti concluded respondent committed a simple departure from the applicable standard of care by not obtaining informed consent to pursuing conservative treatment for Patient 1's post-dural puncture headache rather than an epidural blood patch. He explained:

> [Respondent] did not inform the patient and family of all the potential risks and complications of a post-dural puncture headache which include intracranial hemorrhage and death. He did not discuss alternative diagnoses. He did not encourage that the patient sign an AMA form. Had this potential risk and the urgency of the situation been explained to the patient and family they may have made a different decision.

(Grammar original.)

Testimony

170. Dr. Dardashti explained that the standard of care for a physician who is a specialist requires the physician to exercise the standard of skill, knowledge, and care generally exercised by other reasonably careful and prudent specialists in the same or similar circumstances. A simple departure occurs when the specialist fails to exercise such skill, knowledge, and care. The difference between a simple departure and an extreme departure is the degree of departure from the applicable standard of care.

171. The dura is the outermost protective membrane surrounding the brain and spinal cord. It is a tough, fibrous, and thick membrane that adheres to the inner surface of the skull and vertebrae. The brain and spinal cord are surrounded by CSF, which acts as a shock absorber. If the dura is punctured, as can happen when SCS leads are inserted into the epidural space, CSF leaks through the puncture.

172. A telltale sign of a CSF leak is a post-dural puncture headache, which is also referred to as a positional headache. This is a type of headache that is worse when the patient is vertical and better when she is horizontal. This is because gravity causes the CSF supporting the brain to drain from the skull when the body is vertical. The weight of the brain, which is no longer supported by CSF, causes the cranial nerves, which emerge from the brain and pass through openings in the skull, to stretch.

173. Post-dural puncture headaches are initially treated conservatively, which includes laying flat as much as possible, increasing fluid intake, including caffeinated beverages, monitoring, over-the-counter pain medication, and sometimes a prescription for butalbital. If the headache does not improve within a few days, an epidural blood patch is performed. This is an "extremely successful" treatment that

involves injecting blood into the epidural space where the dura was punctured. The blood clots and plugs the puncture site.

174. Dr. Dardashti agreed that the standard of care for informed consent does not require the physician to explain every potential risk of a procedure. However, he would expect the common, general risks to be discussed. He criticized the consent Patient 1 signed for the permanent SCS as "too general" to provide proper notice of the potential risks of the procedure. For example, it did not mention CSF leaks. He reviewed the Pain Management Procedures Risk and Complications form respondent currently uses, and explained it was "more in line with what he would expect" because it specifies risks of the different procedures listed.

175. Dr. Dardashti criticized the belatedness of respondent's November 8, 2021 entry in Patient 1's medical records documenting his telephone calls with her. He opined each conversation should have been documented within three days. He explained the goal of record keeping is to create an accurate record of what occurred, and it is natural for one's memory to fade over time. Therefore, timely documentation is essential to ensuring accuracy of the note. Dr. Dardashti opined respondent's lack of contemporaneous documentation supported Husband's complaint that respondent minimized his concerns.

176. Dr. Dardashti also criticized the content of respondent's November 8, 2021 entries. He opined respondent should have documented discussing with Patient 1 the likely cause of her post-dural puncture headache, the fact that the risks of a post-dural puncture headache include intracranial hemorrhage and death, what a CSF leak was, its likely cause, new or worsening symptoms she should have watched for and reported, and under what circumstances she should have sought immediate medical care. He further opined respondent should have explained Patient 1 had the

option of seeking treatment at AHS or DMC. Finally, Dr. Dardashti opined respondent should have explained to Patient 1 the risks of choosing conservative treatment over the epidural blood patch.

177. Dr. Dardashti concluded respondent's delay in documenting his conversations with Patient 1 constituted an extreme departure from the standard of care for record keeping. He further concluded the content of respondent's documentation constituted a simple departure from the standard of care for obtaining informed consent to conservative treatment.

178. Dr. Dardashti explained he reviewed both of respondent's experts' reports and disagreed with them. He concluded the factual bases for the experts' respective opinions were derived solely from respondent's November 8, 2021 documentation of his conversations with Patient 1. However, Dr. Dardashti explained that respondent documented that Patient 1 never disclosed any symptoms beyond a positional headache. Dr. Dardashti found that inconsistent with records he reviewed.

179. Dr. Dardashti was also critical of respondent's experts' conclusions that a SCS resulting in a subdural hematoma is so unlikely that it need not be disclosed as a potential risk. He explained the cause of Patient 1's subdural hematoma was unknown. However, her medical records indicated respondent never explained what a subdural hematoma was, how it occurred, or what symptoms she should have watched for and sought immediate medical treatment for when he provided the options of conservative treatment or an epidural blood patch. Dr. Dardashti explained the purpose of informed consent is to provide the patient with sufficient information to make an informed choice on how to proceed with her medical care. Respondent did not do that with Patient 1, regardless of the ultimate cause of her subdural hematoma.

LAWRENCE R. POREE, M.D., PH.D., M.P.H.

Background

180. Respondent retained Lawrence R. Poree, M.P.H., Ph.D., M.D., to analyze respondent's treatment of Patient 1. Dr. Poree earned his Bachelor of Arts in pharmacology from University of California, Santa Barbara, in 1981. He earned his Master of Public Health in toxicology/environmental health sciences from University of California, Berkeley, three years later. He also earned his Doctor of Philosophy in the same subject from the same university four years after that.

181. Dr. Poree completed a postdoctoral fellowship in biomedical engineering and neuroscience at The Johns Hopkins University School of Medicine prior to attending Stanford University School of Medicine. He earned his Doctor of Medicine in 1997. He completed a transitional internship at Santa Clara Valley Medical Center and an anesthesia residency at Stanford University Medical Center. Dr. Poree completed a pain management fellowship at University of California, San Francisco.

182. Dr. Poree has been licensed to practice medicine in California since July 24, 1998. He is a board-certified anesthesiologist with a certificate in pain management. He worked in private practice at the Pain Clinic of Monterey Bay from 2002 to 2023. Dr. Poree has been the Director of Neuromodulation Service in the Department of Anesthesia and a professor at University of California, San Francisco, since 2015.

183. Dr. Poree documented a summary of respondent's treatment of Patient 1 and his opinions and conclusions about that treatment in a written report. The report was admitted into evidence, and Dr. Poree testified at hearing. His report is discussed first, followed by his testimony.

Summary of Respondent's Treatment

184. Dr. Poree summarized respondent's treatment as follows:

> The aspects of the patient's care relevant to the Accusation and its allegations are as follows: On November 3, 2020, the patient, a 69-year-old woman, presented to [respondent] at [Darroch Brain and Spine Institute] DBSI, upon referral by her primary care physician. Her chief complaint was thoracic back pain that she reported as constant, sharp, and aching. She also reported poor sleep secondary to pain, which was exacerbated by standing and bending. She had a medical history that included epidural injections in 1965, 2015, and 2020, as well as radiofrequency ablations in 2016 and 2020. As of November 2020, she had completed six weeks of physical therapy on three separate occasions. Nevertheless, her pain persisted.
>
> [Respondent] evaluated her and provided treatment directly from approximately November 2020 to November 2021. Specifically, on June 28, 2021, he performed a spinal cord stimulator trial with Nevro, resulting in 80% pain relief. The patient was very pleased with the trial [and] consented to a permanent spinal cord stimulator implant.
>
> On July 6, 2021, [respondent] removed the spinal cord stimulator trial leads, which were intact. The patient was continued on Tramadol, 50 mg tablet up to 3 times daily,

PRN for pain. She reiterated her wish to proceed with a permanent spinal cord stimulator implant. A device representative for the permanent spinal cord stimulator implant was available and answered all her questions about the implant and implantation procedure to her satisfaction. The justification for the interventional procedure was the failure of her prior conservative management, in particular her pain score of greater than 6/10, despite all previous interventions. [Respondent] also explained all the potential benefits, risks, and alternatives to the procedure to the patient, which included but were not limited to bleeding, infection, a potential increase in pain severity, and [*sic*] permanent nerve damage, and post-dural puncture headache. The patient also reviewed and signed a procedure-specific surgical consent form on October 23, 2021.

On October 25, 2021, the patient presented to DMC for permanent spinal cord stimulator implantation. Prior to surgery, [respondent] explained the procedure again, as well as its benefits, risks, and alternatives, and obtained the patient's informed consent to proceed, which he confirmed via countersigning the patient's already signed written consent form.

The permanent spinal cord stimulator implantation with Nevro was performed successfully under general

anesthesia, without complications. The patient tolerated the procedure well, and her postoperative vital signs were stable. [Respondent] prescribed Oxycodone 5 mg, 1–2 tablets up to 4 times/day, PRN for pain.

The patient was discharged home in stable condition with a postoperative office appointment and detailed written post-procedural discharge instructions. They advised her, among other things, to expect mild pain, bruising, and swelling, along with headaches and soreness in her back. She was advised to contact her health care provider if she had a fever, severe pain, or persisting headaches.

The patient first notified [respondent] by phone the next day on Tuesday, October 26, 2021, at approximately 1:00 p.m., that she had a headache. Upon receiving this information, [respondent] paused his clinic appointments and returned her call immediately. He spoke with the patient and her husband and obtained a detailed history and review of systems over the phone, noting complaints of pain, elevated temperature, and a positional headache. He explained to the patient and her husband that she was most likely suffering from a post-dural puncture headache. He explained that a conservative treatment plan involved lying flat, increased fluid intake, and [*sic*] [over-the-counter] OTC pain medication (Tylenol 1000 mg and ibuprofen 600 mg every 8 hours), and watching to see if the headache

resolved on its own. He also offered her an epidural blood patch, which is a second line treatment typically employed after conservative treatments fail. The patient and her husband declined the blood patch and opted for conservative care.

On Wednesday, October 27, 2021, at approximately 1:00 p.m., the patient called [respondent] again. She reported that her positional headache persisted. [Respondent] again offered an epidural blood patch, but the patient elected another day of conservative care. [Respondent] reminded her to lay flat as much as possible and to drink plenty of fluids, including caffeinated beverages, and advised her to follow-up with him the following day to coordinate an appointment for an epidural blood patch.

On Thursday, October 28, 2021, [respondent] called the patient around 12:00 p.m. to inquire as to whether she was experiencing any new or worsening symptoms or experiencing other issues. She reported that she continued to have a headache that got worse when sitting up and better when lying down, which was consistent with her past reports. She did not report any new or worsening symptoms. [Respondent] advised her and her husband that he wanted to proceed with the epidural blood patch and offered to do it at 6:00 p.m. that evening or the following day, Friday, October 29, 2021, at 2:00 p.m. The patient

chose Friday at 2:00 p.m. Over the course of this conversation, the patient also told [respondent] that, contrary to his recommendation to take 600 mg of ibuprofen three times daily, i.e. every 8 hours, she had instead been taking it every 3 hours, resulting in her ingesting more than two and a half times the total daily dose he had prescribed. He advised her to immediately discontinue all Tylenol and ibuprofen, and prescribed butalbital (Esgic) to assist with her ongoing head pain instead. He also advised her to lay flat as much as possible, to continue drinking plenty of fluids, and to contact him if she experienced any new issues before the scheduled procedure.

Around 8:30 p.m. that night, the patient tripped over a stool at home and fell. Roughly an hour later, her family noticed she was exhibiting slurred speech, and she was emergently transported to AHS. Upon arrival, the patient was unresponsive and had fixed and dilated pupils. A head CT showed a large, right subdural hematoma with midline shift, so she was emergently transferred to DMC for a higher level of care and neurosurgery consultation for intracerebral hemorrhage.

Upon arrival at DMC, she remained intubated with a GCS of 3 and had fixed and dilated pupils at 6 mm. The admitting physician sought a neurosurgical consultation, but the

neurosurgeon did not recommend neurosurgical intervention due to the catastrophic nature of the bleed. He noted the patient's CT scan and exam were not compatible with life, and the neurosurgery and critical care teams informed her family of her poor prognosis.

According to DMC's ER records, the patient's family had a very hard time accepting the information regarding her poor prognosis and declined to withdraw care. Consequently, she was admitted to the Intensive Care Unit at DMC.

Between October 29, 2021[*sic*] and November 6, 2021, the patient was extensively monitored and evaluated by neurosurgical and critical care teams. Her prognosis remained unchanged, but her family continued to have difficulty accepting the severity of insult to her brain. [Respondent] visited the patient at DMC on November 5, 2021 [*sic*] and spoke with the family about her prognosis, entering an addendum in her DMC chart on that date. The next day, on November 6, 2021, the family agreed to allow life support to be removed [*sic*] and the patient expired from hypoxic respiratory failure secondary to her intracranial hemorrhage thereafter.

In his interview, [respondent] acknowledged that he did not document his phone conversations with the patient on October 26, 27, or 28, 2021 [*sic*] in any of her charts

contemporaneously. He has expressed that he originally intended to document them as part of his epidural blood patch procedure note at DMC on Friday, October 29, 2021. It is undisputed that the conversations he documented occurred, as the patient's husband has confirmed that they did.

Medical Record Keeping

185. Dr. Poree agreed with Dr. Dardashti that the standard of care for record keeping is to "keep accurate and complete records and that salient discussions with patients should be included in such records." He further agreed patient encounters should be documented "within a reasonable time." However, Dr. Poree was unaware of any written standard requiring documentation to occur within a specific timeframe. Additionally, he explained what constitutes a "reasonable time" varies with context. For example, it is typical for operative reports and office visits to be documented within 24 hours. However, many agree telephone conversations outside a formal visit about non-urgent matters may be documented during the next visit.

186. Dr. Poree noted that each of respondent's conversations with Patient 1 were outside a formal visit, he was scheduled to see her on October 29, 2021, and he was going to document the conversations at that time. Her condition was not emergent, so it would have been reasonable for him to do so.

187. Dr. Poree explained respondent found himself in a unique situation on October 29, 2021, when he learned Patient 1 was in the hospital. At that point, she had received care at two different hospitals, and respondent was no longer caring for her. Additionally, he did not anticipate her returning to his care. Respondent did not use

the same record keeping software as either hospital, so he sought legal guidance on where and how to document the prior telephone calls. Dr. Poree opined it was reasonable for respondent to do so.

188. Dr. Poree further explained the information discussed during the telephone calls was irrelevant to Patient 1's treatment and care once she was hospitalized, which was driven by her subdural hematoma. The substance of those conversations would not have affected her evaluation or treatment in the hospital, so documenting it in her medical records was not an urgent matter.

189. Dr. Poree noted that Dr. Dardashti opined the family believed respondent did not treat Patient 1's continuing headache with sufficient urgency because there was a miscommunication caused by respondent's untimely documentation of the telephone calls. Dr. Poree responded, "The purpose of medical documentation is not to avoid future misperceptions by a patient's family members as they retrospectively review records in contemplation of legal action."

190. Dr. Poree agreed respondent's and Husband's recollections of what was said during the telephone conversations differed. However, he found those differences "not terribly disparate." They agreed Patient 1 described her symptoms, respondent diagnosed a post-dural puncture headache, conservative treatment was pursued, there was no significant change in her condition, and respondent offered and scheduled an epidural blood patch for October 29, 2021. Dr. Poree concluded, "It is unclear how a more timely entry of the note in question would have cured the minor disparities between these two accounts."

191. Based upon the above, Dr. Poree found the timing of respondent's notes of his three telephone conversations with Patient 1 did not deviate from the applicable

standard of care. Therefore, respondent did not commit gross negligence by not documenting his conversations in Patient 1's medical records until November 8, 2021.

Informed Consent

192. Dr. Poree disagreed with Dr. Dardashti's opinion that "the standard of care requires that physicians disclose all known risks of the procedure 'in their entirety' as part of a consent discussion with the patient." He explained risks associated with procedures fall within one of three categories: (1) those which are "so common they are better described as possible side effects"; (2) those that "have an incidence rate in the single digits or low double digits"; and (3) those that "occur in less than one percent of cases, sometime[s] just a fraction of a percent of cases." Those which fall within the first two categories should be part of "informed consent discussions and documentation." Those within the third category "are typically so numerous and so unlikely that their inclusion would not only be impractical but might also needlessly frighten or deter patients from consenting to medically justified procedures."

193. Dr. Poree explained post-dural puncture headaches occur in only about one percent of permanent spinal cord stimulator procedures. He characterized such risk as falling "somewhere between the second and third categories." He concluded, "It is common enough that it can be considered for inclusion in an informed consent discussion, but it would also be reasonable to omit it from the discussion." Dr. Poree noted respondent said he discussed the risk of a post-dural puncture headache with Patient 1 prior to the SCS procedure. He concluded, "Given the low incidence and severity of the complication, it certainly was not necessary to document separately that it was discussed as part of the informed consent discussion."

194. Dr. Poree further explained that of the one percent of permanent SCS procedures that result in a post-dural puncture headache, the best evidence indicates only four tenths of one percent result in a subdural hematoma. Additionally, he found little to no evidence that such subdural hematomas are severe enough to be considered emergent or life-threatening. Therefore, "A reasonably prudent physician would not be expected to raise the risk of subdural hematoma or death under these circumstances[,] and [respondent] did not fail to provide an adequate informed consent discussion by omitting reference to these remote risks."

195. Because Patient 1's headache was not urgent or emergent one, two, or three days after surgery, "there was also no need to mention the option of going to the emergency room of [*sic*] an urgent work up and no need to force the patient to sign an AMA form in an attempt to encourage her to take more urgent action."

Management of Post-Dural Puncture Headache

196. Dr. Poree observed that Dr. Dardashti agreed in his report that respondent's treatment of Patient 1's post-dural puncture headache complied with the applicable standard of care. He noted, however, that "[Dr. Dardashti] also concludes that [respondent] should have considered alternate diagnoses, obtained a neurosurgical consult, and considered ordering urgent imaging." Dr. Poree observed, "The Accusation did not include allegations based on these conclusions."

197. Dr. Poree agreed respondent's treatment "complied with all applicable standards of care." He opined respondent's diagnosis was supported by the history taken and review of systems performed over the telephone. "[T]he patient's condition was sufficiently stable that seeking alternative diagnoses at this stage was not medically necessary and would not have been medically appropriate."

198. Dr. Poree explained that if Patient 1's condition worsened or respondent performed an epidural blood patch that failed, "further work [*sic*] up and consideration of alternatives diagnoses may have been appropriate. However, on October 26, 27, and 28, 2021, with no new or changing symptoms, post-dural puncture headache remained by far the most likely culprit [*sic*] and [respondent's] plan of care would have either treated it or, if it failed, justified moving on to another diagnosis." It was unnecessary for respondent to consult with a neurosurgeon, and imaging would have been unjustified for the same reason.

Testimony

199. Dr. Poree testified consistently with his report. He also reiterated the rarity with which intracranial hemorrhages, which include subdural hematomas, occur after a permanent SCS. He has implanted at least 100 permanent SCSs, and none of his patients has suffered an intracranial hemorrhage. Furthermore, he has never heard of any patient of his former practice group experiencing an intracranial hemorrhage after a permanent SCS.

200. Dr. Poree explained he read an appellate decision discussing the difference between a simple departure from the standard of care and an extreme departure. His understanding is that the two concepts differ only in the degree of the departure. A simple departure occurs whenever there is any deviation from the applicable standard of care that results in an adverse outcome. An extreme departure requires a more significant deviation.

201. Dr. Poree described a phenomenon he referred to as "attention fatigue": a patient's ability to remember and understand a list of risks of a procedure is limited. If a physician explains more than the patient can remember, she can suffer "attention

fatigue" and forget all risks. Therefore, it is critical for the physician to limit the list to those risks he most wants the patient to be aware of and understand.

AARON L. BERKOWITZ, M.D., PH.D., F.A.A.N.

Background

202. Respondent retained Aaron L. Berkowitz, M.D., Ph.D., F.A.A.N., to analyze respondent's treatment of Patient 1. Dr. Berkowitz earned his Bachelor of Arts in music and Bachelor of Science in biological sciences from George Washington University in 1999. He earned his Doctor of Philosophy in music from Harvard University 10 years later. He earned his Doctor of Medicine from The Johns Hopkins University School of Medicine the following year. Dr. Berkowitz completed his internship in internal medicine at Bringham and Women's Hospital and his residency in neurology at Partners Neurology Residency at Massachusetts General Hospital. He served as Chief Resident for one year after that.

203. Dr. Berkowitz is a board-certified neurologist. He has been licensed to practice medicine in Massachusetts since September 11, 2013, and in California since October 18, 2019. He has been a Professor of Clinical Neurology at University of California, San Francisco, and an attending neurologist at San Francisco VA Medical Center and San Francisco General Hospital since 2022. Prior to that, Dr. Berkowitz taught and practiced neurology at Kaiser Permanente Southern California, Bringham and Women's Hospital, and Harvard Medical School.

Summary of Respondent's Treatment

204. Dr. Berkowitz summarized respondent's treatment of Patient 1 as follows:

> In brief, this is a case of a 70-year-old woman who underwent implantation of a spinal cord stimulator by [respondent] in November 2021, after which she developed a positional (orthostatic) headache and reported this to [respondent] by phone. The diagnosis of post-dural puncture headache was made by [respondent] over the phone, and he proposed conservative measures (lying flat, drinking fluids, and taking over-the-counter medications), with an epidural blood patch proposed if the condition did not improve. Over subsequent days, the condition did not improve with conservative measures [*sic*] and an epidural blood patch was scheduled. Unfortunately, prior to this procedure, the patient fell and developed a large subdural hematoma that was ultimately fatal.

Management of Post-Dural Headache

205. Dr. Berkowitz agreed with Dr. Dardashti's conclusion that respondent's management of Patient 1's post-dural puncture headache met the applicable standard of care for diagnosing the condition and providing appropriate treatment. He explained that there are conflicting studies about the appropriate timing for an epidural blood patch, and some studies indicate that performing the procedure to soon "is associated with a higher risk of failure of the epidural blood patch."

206. Dr. Berkowitz disagreed with Dr. Dardashti's conclusion that respondent failed to recognize Patient 1's headache was not improving with conservative measures. The records indicated respondent recognized the lack of improvement and recommended an epidural blood patch. Dr. Berkowitz also disagreed with Dr.

Dardashti's opinion that respondent should have considered other diagnoses besides a post-dural puncture headache. Dr. Berkowitz explained, "[T]he patient did not report focal neurologic symptoms, back pain, neck stiffness, fever, confusion, or any symptoms beyond positional headache, arguing against any diagnosis other than post-dural puncture headache in this case." Finally, Dr. Berkowitz disagreed that respondent should have ordered diagnostic imaging for Patient 1. He cited guidelines for treating post-dural puncture headaches that imaging is not required for post-dural puncture headaches unless the nature of the headache changes from positional to non-positional. That did not happen with Patient 1.

Informed Consent

207. Dr. Berkowitz disagreed with Dr. Dardashti's opinions that respondent should have evaluated Patient 1 in person in his office or referred her to the emergency room, explained the urgency for undergoing an epidural blood patch, and considered having her sign an "against medical advice" form if she refused treatment. The only symptom Patient 1 reported to respondent was a positional headache, which suggested she was suffering a post-dural puncture headache. Reported symptoms indicated her condition was not emergent or urgent, and a physician did not need to immediately evaluate her in person.

208. Dr. Berkowitz explained the following about the rarity of suffering a clinically significant subdural hematoma after a dural puncture:

> Although subdural hematomas can occur due to dural puncture, they are usually asymptomatic and only noted on radiologic studies such as CT or MRI as part of a constellation of radiologic features seen in intracranial

> hypotension. A clinically significant – let alone fatal – subdural hematoma is an exceedingly rare complication of dural puncture. In a large series of over 20 million patients undergoing epidural anesthesia for childbirth (one of the most common causes of dural puncture), only 342 developed as subdural hematoma (1.5 per 100,000) of which only 10 were fatal; of over 68,000 deliveries resulting in post-dural puncture headache specifically, there were just 100 subdural hematomas (147 per 100,000). Clinically significant subdural hematoma after dural puncture as was seen in the current case is sufficiently rare to have been described only in isolated case reports in other contexts such as myelogram, spinal surgery, and lumbar puncture. I could only find one case reported after spinal cord stimulator implantation, indicating the rarity of this outcome (the patient reported also fell as in the current case, though prior to the procedure). Anecdotally, I personally have never seen a case of clinically significant subdural hematoma following dural puncture in 10 years of neurology practice.

(Footnotes omitted.)

209. Based on intracranial hemorrhage and death being "exceedingly rare complications of post-dural puncture headache," Dr. Berkowitz concluded respondent was not required to explain either as a risk of Patient 1 choosing conservative treatment over an epidural blood patch. Nor was he obligated to explain the urgency

of performing an epidural blood patch. Dr. Berkowitz referenced the guidelines indicating premature performance of an epidural blood patch is associated with the risk of the procedure failing. He also explained:

> Although it is common to list the risk of death from a medical procedure at the time of the informed consent for that procedure (however rare such a complication would be for a given procedure, and as was done in the consent form for the spinal cord stimulator in this case), it would be unlikely that a physician would describe extremely rare risks to a patient related to a medical condition (i.e., as opposed to an invasive procedure), such as case reportable events like the unfortunate but extremely rare outcome in this case.

Record Keeping

210. Dr. Berkowitz agreed with Dr. Dardashti that the standard of care requiring medical records to be "adequate and accurate" requires timely documentation of patient encounters, which did not happen regarding respondent's three post-procedure telephone conversations with Patient 1. He noted respondent's explanation that he intended to document the conversations when he performed the epidural blood patch and subsequently was unsure of the protocol for documenting the conversations once Patient 1 was hospitalized and no longer under his care. Dr. Berkowitz then explained:

> While contemporaneous documentation is ideal, in practice, documentation may be delayed due to the many clinical

and administrative demands on a physician's schedule. In this case, the physician's documentation (albeit delayed) and the husband's description of what occurred in these conversations appear aligned, and earlier documentation would not have changed the diagnosis, treatment, or outcome in the patient's case. Therefore, I would not characterize delayed documentation as an extreme departure from the standard of care in this case.

Testimony

211. Dr. Berkowitz testified consistently with his written report. Additionally, he explained the standard of care requires physicians to adhere to evidence-based guidelines by recognized societies where available. A physician's treatment need not result in harm for it to have been a deviation from the applicable standard of care. Although Dr. Berkowitz was not familiar with the precise definition of a simple departure, he analogized it to treatment that is "slightly off from what would be decided by a quorum." An extreme departure occurs when all other physicians asked agree the treatment provided was improper. A simple departure is "within the standard deviation" from the standard of care, whereas an extreme deviation is "more than one standard deviation" from the standard of care.

212. Dr. Berkowitz also explained that neurology is the field of medicine concerning the brain, spine, and peripheral nerve disease. Post-dural puncture headaches and subdural hematomas are two conditions neurologists frequently diagnose and treat. A post-dural puncture headache feels worse when the patient stands or sits up because gravity causes the CSF surrounding the brain to drain from

the skull, which causes the brain to "sag." The sagging of the brain stretches the dural veins, which causes pain.

213. An intracranial hemorrhage is bleeding inside the brain or the surrounding areas. A subdural hematoma is a type of intracranial hemorrhage; "subdural" refers to bleeding in the area under the dura matter, and "hematoma" refers to a collection of blood outside of blood vessels. Not all subdural hematomas are "equal."

214. Dr. Berkowitz has never seen, heard, or read about a patient suffering a "clinically significant" subdural hematoma due to a post-dural puncture. Most clinically significant subdural hematomas are due to trauma, are usually unilateral, and occur on the side of the brain that sustained trauma. On the other hand, a subdural hematoma caused by a post-dural puncture is usually bilateral. Had Dr. Berkowitz known nothing about Patient 1 when he saw her CT scan, he would have assumed she sustained trauma to her head because her subdural hematoma was unilateral.

Character Witnesses

215. Three character witnesses testified for respondent, and two of them also wrote character letters. Two others only wrote letters.

216. Dr. Remington, the neurosurgeon who evaluated Patient 1 at DMC, has practiced in Texas for just over one year. Prior to that, he practiced in Modesto for 23 years, during which he was the Chair of Neurosurgery for 18 years, Chair of Surgery for two years, Chairman of the Board of Governors for three years, and a member of the Board of Governors for 12 years at DMC. He founded Darroch Brain and Spine Institute and recruited respondent to join the practice.

217. Dr. Remington testified at hearing. He first met respondent when he recruited him to join Darroch Brain and Spine Institute. Since then, Dr. Remington and respondent have referred patients to one another, and they occasionally "shared" patients. Respondent has referred patients after treating them, so Dr. Remington has had the opportunity to review respondent's medical notes and charts.

218. Dr. Remington opined that respondent is "absolutely" trustworthy and a "fantastic" physician. He has found respondent to be "very transparent" and "very straightforward" with patients. He described respondent as one with great bedside manner who quickly forms a bond with his patients and their families. Dr. Remington further opined that a lot of physicians are "pill factories," but respondent is careful about what and for whom he prescribes.

219. Dr. Remington also wrote a character letter for respondent. He confirmed he read the allegations in the Accusation. Regarding the allegation of gross negligence, he explained, "[Respondent] is known for his thoroughness and attention to detail, and I have never observed any pattern of carelessness or neglect in his documentation practices. I trust that the delay was an unfortunate but isolated issue that does not reflect his usual standard of care."

220. Dr. Remington also disagreed with the allegations that respondent did not disclose all potential risks and complications of a post-dural puncture headache to Patient 1. He wrote, "[Respondent] consistently demonstrates transparency with his patients. In my experience, he is diligent in discussing treatment options and associated risks with patients, ensuring that they have all necessary information to make informed decisions."

221. Finally, Dr. Remington found the allegations regarding documentation of informed consent, a treatment plan, and the prescription for a controlled substance inconsistent with his experience with respondent's documentation. He explained, "I have found [respondent] to be meticulous and professional in his clinical practice. He adheres to best practices when it comes to prescribing controlled substances and ensures that patient care is appropriately documented."

222. Renia Younadem has been in the medical field for about 15 years. She has worked at DMC as a referral coordinator since 2019. When a patient wants an appointment with a neurosurgeon or pain management physician, she obtains a referral from the patient's primary care physician and then coordinates scheduling the patient's appointment. She met respondent when he joined Darroch Brain and Spine Institute. Prior to that, there was only one pain management physician to whom she could refer patients.

223. Ms. Younadem explained at hearing that respondent previously treated her father and brother. She credited him with extending her father's life. She described him as an honest doctor who is compassionate and caring. Ms. Younadem explained new patients frequently call and request appointments with respondent based on recommendations from family and friends.

224. Ms. Younadem also wrote a character letter confirming she read the allegations in the Accusation. She wrote, "I do not believe these allegations reflect [respondent's] typical practice or behavior, and I have never witnessed any actions on his part that would suggest gross negligence or failure to provide informed consent." [Respondent] is a dedicated and conscientious physician who always acts in the best interests of his patients." Indeed, she explained he "always took the time to explain the

procedures in great detail to my father, including the risks, complications, and other relevant factors, ensuring that he understood all aspects of his treatment plan."

225. Victoria Wallace was the third character witness who testified for respondent. She was working at Darroch Brain and Spine Institute when he joined the practice. She became his medical assistant and was responsible for taking patients' vital signs and "rooming" them. She later became his surgery scheduler and was responsible for coordinating his surgical procedures and postsurgery appointments.

226. Ms. Wallace explained she has never received or become aware of any patient complaints about respondent. She has witnessed his interactions with patients and opined he has good bedside manner and always answers patients' questions. Indeed, she explained he sometimes runs behind schedule because he answers questions as patients are leaving the examination room.

227. Ms. Wallace said respondent shows the same patience and willingness to explain things with staff. When she became his scheduler, she told him she wanted to understand what she tells patients rather than just repeat what he wants her to tell them. He invited her to observe one of his surgical procedures. He always solicits questions.

228. Ms. Wallace confirmed she read the Accusation. None of the allegations changed her opinions about respondent.

229. William Pearson, M.D., and Davis Openda, N.P., wrote character letters but did not testify. Dr. Pearson is an anesthesiologist who has worked closely with respondent in the operating room for over three years. He has also been respondent's patient. He explained respondent "took the time to thoroughly explain the risks, benefits, and alternatives to the treatment, ensuring that [he] had all the necessary

information to make an informed decision." Dr. Pearson confirmed respondent does the same with all other patients.

230. Ms. Openda is a nurse practitioner at Darroch Brain and Spine Institute who has worked closely with respondent for the last five years. She has "developed a deep respect for his clinical acumen, dedication to patient care, and commitment to ethical medical practice." She attested to his ability to explain medical conditions and treatment options in a manner that provides patients and their families a complete understanding of the risks, benefits, and alternatives to treatment.

231. Ms. Openda read the Accusation and found its allegations inconsistent with respondent's practice. She explained, "His clinical notes are consistently complete, well-organized, and timely." Additionally, respondent "has made it a priority to ensure patients and their families are fully informed of the potential risks associated with their treatment." Last, Ms. Openda wrote, "I can attest to the fact that he consistently documents informed consent and treatment plans with exceptional detail."

Analysis

GROSS NEGLIGENCE

232. Complainant alleges respondent committed gross negligence by not timely documenting in Patient 1's medical records their three telephone conversations. It was undisputed the conversations occurred on October 26, 27, and 28, 2021, but were not documented until November 8, 2021.

233. The clear and convincing evidence established that respondent deviated from the applicable standard of care by not documenting his telephone conversations with Patient 1 until November 8, 2021. Both Drs. Dardashti and Poree agreed the

standard for adequate and accurate records includes an element of timeliness. Although they disagreed on what specifically constitutes "a reasonable time," a precise definition is not necessary here.

234. Respondent documented the conversations between 11 and 13 days after they occurred. Those timeframes are unreasonable because it is axiomatic that memories fade with time, and 11 to 13 days was a substantial amount of time for respondent's memory of the details of each conversation to fade. Although Patient 1's admission to the hospital, DMC's use of different record keeping software, and his need to seek guidance on how to document the conversations may justify delaying entry into Patient 1's records at DMC, it does not justify delaying entry into her records at Darroch Brain and Spine Institute.

235. Nonetheless, respondent's belated documentation of the telephone conversations did not constitute an extreme departure from the standard of care or the want of even scant care. (See, e.g., *Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052–1053 ["The use of the disjunctive in the definition indicates alternative elements of gross negligence—both need not be present before gross negligence will be found"].) Dr. Dardashti explained one purpose of medical records is to accurately document what occurred. The clear and convincing evidence established that respondent's November 8, 2021 note, albeit untimely, accurately documented his three telephone conversations with Patient 1.

236. Respondent's note described him stopping what he was doing when notified of Patient 1's call on Monday and talking to her. He notated the symptoms she described, his diagnosis and treatment options, her choice of treatment, and his treatment provided. Respondent also described his telephone conversation with Patient 1 on Wednesday, including her symptoms, his recommended treatment, her

election of conservative care, and his treatment. Finally, respondent wrote that he called Patient 1 Thursday, she described the same symptom as the previous two days, he told her she needed an epidural blood patch, she had been taking more ibuprofen than recommended, and he prescribed Esgic.

237. Respondent's explanation why he remembered the details of the conversations were credible and persuasive. Additionally, he described the conversations in substantially the same manner in his written statement to the Board, during his deposition, at his interview, and while testifying at hearing. Although there may have been some inconsistency about who called whom Tuesday, any such inconsistency was insignificant. Respondent consistently explained his medical assistant notified him about Patient 1's concerns, and he interrupted what he was doing to talk to her. Whether she was still on the telephone or he called her back was irrelevant.

238. Husband described the substance of the telephone conversations differently. For example, he alleged in his complaint that respondent said, "Now, it's an emergency" in response to Patient 1's description of her headache on Wednesday. But Husband also said respondent did not say the headache was an emergency. He told Investigator Barrera, "[Respondent] never expressed any urgency to them."

239. Husband consistently explained in his complaint, during his interview, and at his deposition that the only symptom Patient 1 disclosed during the conversations was a headache that worsened when sitting or standing upright and improved when laying horizontal. At hearing, however, Husband said she also disclosed dizziness on Wednesday that worsened on Thursday.

240. Daughter also described in her statement, during her interview, and at hearing some of the symptoms Patient 1 was experiencing after the procedure for the permanent SCS. However, she admitted she did not participate in any of the telephone conversations between respondent and Patient 1. The relevant information is the symptoms Patient 1 shared with respondent, regardless of what she actually experienced.

241. Dr. Dardashti explained another purpose of medical records is to maintain continuity of care by providing physicians pertinent information about their patients' prior treatment. However, he also agreed respondent's belated documentation of the telephone conversations did not jeopardize Patient 1's continuity of care. Dr. Poree explained Patient 1's care once hospitalized was driven by her subdural hematoma, and information about her prior conversations with respondent would not have affected her evaluation or treatment.

REPEATED NEGLIGENT ACTS

Untimely Documentation of Telephone Conversations

242. Complainant also alleges respondent had a separate and distinct duty to timely document each telephone conversation with Patient 1, and his failure to do so constitutes three separate negligent acts. Respondent credibly explained he intended to document his telephone conversations with Patient 1 as an indication for the epidural blood patch in his procedure notes on October 29, 2021. Dr. Dardashti opined that a single entry documenting all three conversations would have met the standard of care for accurate and adequate medical records. Therefore, the clear and convincing evidence established respondent's untimely documentation of the three conversations constituted a single negligent act.

Nondisclosure of Risk of Intracranial Hemorrhage or Death

243. Complainant further alleges respondent committed a negligent act by not telling Patient 1 and Husband that intracranial hemorrhage and death are potential risks of a post-dural puncture headache when offering conservative care or an epidural blood patch to treat her post-dural puncture headache. It was undisputed respondent never told Patient 1 or Husband about either potential risk.

244. Dr. Poree's opinions and conclusions were more persuasive than Dr. Dardashti's to the contrary. Dr. Poree submitted reference articles supporting his opinions and conclusions. Additionally, Dr. Berkowitz's explanation of the rarity of subdural hematomas due to dural puncture supported Dr. Poree's conclusion that respondent did not deviate from the standard of care.

FAILURE TO MAINTAIN ADEQUATE AND ACCURATE MEDICAL RECORDS

Documentation of Potential Risks and Complications

245. Complainant alleged respondent failed to maintain adequate and accurate medical records of Patient 1's treatment because he did not document discussing the potential risk of her post-dural puncture headache causing an intracranial hemorrhage or death. For the reasons explained above, he was not required to have that discussion or document having done so.

246. It was unclear whether complainant's motion to amend the Accusation was intended to encompass Dr. Dardashti's opinion that respondent did not obtain adequate informed consent to pursue conservative treatment rather than an epidural blood patch. Assuming it was, Dr. Dardashti's opinion was not supported by clear and convincing evidence.

247. Dr. Dardashti opined respondent should have: (1) discussed with Patient 1 alternative diagnoses to post-dural puncture headache; (2) considered ordering diagnostic imaging when Patient 1 did not respond to conservative treatment; (3) requested that she be evaluated in person either at his clinic or an emergency room; and (4) asked her to sign an AMA form if she refused. Dr. Dardashti further opined respondent's failure to document in Patient 1's medical records having done the above constituted a simple departure from the standard of care.

248. Dr. Berkowitz disagreed with Dr. Dardashti's opinion that respondent should have considered diagnoses other than a post-dural puncture headache. He explained Patient 1's lack of symptoms other than a positional headache "argu[ed] against any diagnosis other than post-dural puncture headache." Additionally, Dr. Dardashti agreed "a post-dural puncture headache is a recognized complication following procedures that involve puncturing the dura matter." He further agreed a post-dural puncture headache was "the most likely diagnosis."

249. Dr. Berkowitz also disagreed that respondent should have considered ordering diagnostic imaging when Patient 1 did not respond to conservative treatment. He cited guidelines for treating post-dural puncture headaches that explain imaging is not required unless the headache changes from positional to non-positional, which did not happen with Patient 1.

250. Dr. Dardashti explained that conservative treatment for the first 48 to 72 hours is the recommended treatment for post-dural puncture headaches. He also explained that an epidural blood patch is generally the next option if conservative treatment fails. Such explanations supported Dr. Berkowitz's opinion that diagnostic imaging was unnecessary.

251. Finally, Dr. Berkowitz explained Patient 1's reported symptoms indicated her condition was not emergent or urgent. Therefore, there was no need for a physician to immediately evaluate her in person.

252. For the reasons discussed above, Dr. Berkowitz's opinions were supported by clear and convincing evidence. Therefore, respondent did not fail to document adequate informed consent when offering Patient 1 conservative treatment or an epidural blood patch for her post-dural puncture headache.

Documentation of Treatment Plan or Rationale for Esgic

253. As previously explained, complainant agreed respondent's prescription for Esgic in Patient 1's electronic medical records contains more information than the one in the record. Such information includes a treatment plan or rationale for prescribing Esgic. Therefore, he properly documented a treatment plan or rationale for prescribing Esgic.

Documentation of Patient 1's Refusal of Treatment

254. It is unclear what treatment complainant alleges Patient 1 refused and respondent should have documented in her medical records. For the reasons previously explained, respondent's description of his three telephone conversations with Patient 1 was supported by clear and convincing evidence, whereas Husband's and Daughter's descriptions were not.

255. Patient 1 never refused treatment. Instead, she was given the choice between conservative treatment and an epidural blood patch on Tuesday. She chose the former. Although he recommended the latter on Wednesday and she elected to continue with another day of conservative treatment, she did not refuse treatment.

Patient 1 took respondent's recommendation of the epidural blood patch on Thursday. He gave her the choice between undergoing the procedure that evening or the following afternoon, and she chose the latter. Again, Patient 1 did not refuse treatment.

Documentation of Telephone Conversations with Patient 1

256. As previously discussed, respondent's obligation to maintain adequate and accurate medical records of Patient 1's treatment included the obligation to timely document their three telephone conversations. He did not do so. Therefore, respondent failed to maintain adequate and accurate medical records of his telephone conversations with Patient 1.

APPROPRIATE DISCIPLINE

257. The Board's highest priority is "protection of the public." (Bus. & Prof. Code, § 2229, subd. (a).) However, the California Legislature has expressed an intent that physicians who have engaged in misconduct be rehabilitated when possible. "In exercising his . . . disciplinary authority an administrative law judge of the Medical Quality Hearing Panel . . . shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other means, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." (*Id.* at subd. (b).) The Board is required to "seek out" physicians who have committed misconduct but may be rehabilitated through "further education, restrictions from practice, or other means," when rehabilitation is consistent with public protection. (*Id.* at subd. (c).)

258. The Board has adopted disciplinary guidelines recommending a range of discipline for different violations of the Medical Practice Act (Bus. & Prof. Code, § 2000,

et seq.). The recommended discipline for failure to maintain adequate and accurate medical records ranges for stayed revocation with five years' probation, to revocation. The guidelines recommend the same range of discipline for general unprofessional conduct, gross negligence, repeated negligent acts, and incompetence. However, they recognize that a public reprimand may be appropriate for repeated negligent acts with one patient. However, the Board maintains discretion to deviate from the recommended range of discipline when "the facts of the particular case warrant such a deviation." (Cal. Code Regs., tit. 16, § 1361, subd. (a).)

259. Respondent's sole act of misconduct was not timely documenting in a single patient's medical records their telephone conversations which occurred over the course of three days. He documented the conversations 13, 12, and 11 days after the fact. The clear and convincing evidence established respondent's documentation, albeit late, was accurate. The clear and convincing evidence further established respondent's belated documentation had no effect on the patient's continuity of care.

260. Respondent voluntarily participated in more than 63 hours of continuing education in less than six months. Such coursework included medical recordkeeping, prescribing practices and management of chronic pain and substance abuse disorder, medical ethics, and clinician-patient communication. The last two were sponsored by UC San Diego School of Medicine's Physician Assessment and Clinical Education Program. Respondent incorporated some of what he learned from those courses into his practice. Dr. Dardashti opined respondent's updated general informed consent form meets the standard of care for informed consent.

261. When all the evidence is considered, a public letter of reprimand provides sufficient public protection from respondent's misconduct. The Board expressly recognizes the propriety of such discipline for repeated negligent acts

involving a single patient under certain circumstances, and respondent's misconduct is no more egregious than that. In fact, complaint alleged, but did not prove, repeated negligent acts involving a single patient.

262. Although including a requirement for specific training or education in the public letter of reprimand may be appropriate under certain circumstances, such circumstances do not exist here. Respondent completed the prescribing practices, medical record keeping, and ethics courses the guidelines recommend as terms of probation when probation is imposed for failing to maintain adequate and accurate medical records. Requiring him to retake any of those courses, or take others, would not further public protection and would be unduly punitive.

Request for Investigation and Enforcement Costs

263. Complainant requested that respondent be ordered to pay the Board $12,417 for investigation costs and $44,769.25 for enforcement costs, for a total of $57,186.25, pursuant to Business and Professions Code section 125.3. He submitted Statements of Services indicating Dr. Dardashti charged the Board $4,200 for his time. Each Statement itemizes his time by date, number of hours, and amount. Dr. Dardashti certified the accuracy of the itemization by signing the Statement of Services under penalty of perjury.

264. Complainant also submitted a Declaration of Investigative Activity in which Michel M. Veverka, a supervising investigator, certified under penalty of perjury that the Board incurred $8,217 in costs for Investigator Barrera's time. The Declaration itemizes those costs by fiscal year, hourly rate, fiscal year total cost, and overall total cost. An attached Investigator Log further itemizes those costs by date, hours spent, and task.

265. Last, complainant submitted a Certification of Prosecution Costs: Declaration of John S. Gatschet (covering costs incurred through April 4, 2025) and a Supplemental Certification of Prosecution Costs: Declaration of John S. Gatschet (covering costs incurred April 5 through May 9, 2025) certifying that the Office of the Attorney General incurred a total of $44,769.25 for the time staff spent prosecuting this matter. Attached to each Certification is a document entitled Matter Time Activity By Professional Type itemizing those costs by employee, date, task performed, hours worked, hourly rate, and amount incurred.

266. Respondent did not object to complainant's request for costs. Nor did he introduce evidence of his ability to pay costs, other than his continued employment at Darroch Brain and Spine Institute. The reasonable costs of investigation and enforcement in this matter are discussed further in Legal Conclusions 8 through 14.

LEGAL CONCLUSIONS

Applicable Burden/Standard of Proof

1. Complainant has the burden of proving the grounds for discipline alleged in the Accusation by clear and convincing evidence to a reasonable certainty. (*Daniels v. Dept. of Motor Vehicles* (1983) 33 Cal.3d 552, 536 ["When an administrative agency initiates an action to suspend or revoke a license, the burden of proving the facts necessary to support the action rests with the agency making the allegation"]; *Realty Projects, Inc. v. Smith* (1973) 32 Cal.App.3d 204, 212 [the standard of proof applicable to proceedings to discipline a professional license is clear and convincing evidence to a reasonable certainty].) "The courts have defined clear and convincing evidence as evidence which is so clear as to leave no substantial doubt and as

sufficiently strong to command the unhesitating assent of every reasonable mind. [Citations.] It has been said that a preponderance calls for probability, while clear and convincing proof demands a *high probability* [citations]." (*In re Terry D.* (1978) 83 Cal.App.3d 890, 899, italics original.)

Applicable Law

2. The Board may discipline a physician's and surgeon's certificate if the physician has committed unprofessional conduct. (Bus. & Prof. Code, § 2234.) "Unprofessional conduct" includes gross negligence. (*Id.* at subd. (b).) It also includes repeated negligent acts. (*Id.* at subd. (c).) "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." (*Ibid.*) "The failure of a physician . . . to maintain adequate and accurate records relating to the provision of services to their patients . . . constitutes unprofessional conduct." (Bus. & Prof. Code, § 2266.) A physician found to have engaged in unprofessional conduct may have his certificate revoked, suspended, placed on probation, or publicly reprimanded. (Bus. & Prof. Code, § 2227, subd. (a)(1)-(4).)

Conclusion

GROSS NEGLIGENCE

3. Complainant did not prove by clear and convincing evidence that respondent's failure to timely document in Patient 1's medical records their three telephone conversations constituted gross negligence for the reasons explained in Factual Findings 232 through 241. Therefore, no cause exists pursuant to Business and

Professions Code section 2234, subdivision (b), as it relates to Business and Professions Code section 2227, to discipline respondent's certificate.

REPEATED NEGLIGENT ACTS

4. Complainant did not prove by clear and convincing evidence that respondent's failure to timely document in Patient 1's medical records their three telephone conversations constituted three separate negligent acts for the reasons explained in Factual Finding 242. Nor did he prove by clear and convincing evidence that respondent's failure to disclose the risks of intracranial hemorrhage and death constituted a negligent act for the reasons explained in Factual Findings 243 and 244. Therefore, no cause exists pursuant to Business and Professions Code section 2234, subdivision (c), as it relates to Business and Professions Code section 2227, to discipline respondent's certificate.

INADEQUATE AND INACCURATE RECORD KEEPING

5. Complainant did not prove by clear and convincing evidence that respondent failed to maintain adequate and accurate medical records of Patient 1's treatment by not documenting: (1) potential risks and complications of a post-dural puncture headache; (2) a treatment plan or rationale for prescribing Esgic; or (3) Patient 1's refusal of treatment for the reasons explained in Factual Findings 245 through 255. Therefore, no cause exists pursuant to Business and Professions Code section 2234, subdivision (a), as it relates to Business and Professions Code sections 2227 and 2266, to discipline respondent's certificate based on those allegations.

6. However, complainant proved by clear and convincing evidence that respondent failed to maintain adequate and accurate medical records of Patient 1's treatment by not timely documenting their three telephone conversations as explained

in Factual Finding 256. Therefore, cause exists pursuant to Business and Professions Code section 2234, subdivision (a), as it relates to Business and Professions Code sections 2227 and 2266, to discipline respondent's certificate based on that allegation.

7. When all the evidence is considered, public protection is adequately served by issuing respondent a public letter of reprimand for the reasons explained in Factual Findings 257 through 262. Such discipline properly balances the Board's duty to protect the public with its obligation to assist physicians who have engaged in misconduct.

Award of Costs

8. An agency may be awarded "the reasonable costs of investigation and enforcement of the case" if it prevails in a license disciplinary proceeding. (Bus. & Prof. Code, § 125.3, subd. (a).) "A certified copy of the actual costs . . . shall be prima facie evidence of reasonable costs of investigation and prosecution of the case." (*Id.* at subd. (c).) "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." (*Ibid.*)

9. Costs may be proven at hearing "by Declarations that contain specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs." (Cal. Code Regs., tit. 1, § 1042, subd. (b).) If the services are provided by an agency employee, "the Declaration may be executed by the agency or its designee and shall describe the general tasks performed, the time spent on each task and the method of calculating the cost." (*Id.* at subd. (b)(1).) If the services are provided by someone other than an agency employee, "the Declaration shall be executed by the person providing the service and describe the general tasks

performed, the time spent on each task and the hourly rate or other compensation for the service." (*Id.*, at subd. (b)(2).) Alternatively, "the agency may attach to its Declaration copies of the time and billing records submitted by the service provider." (*Ibid.*)

10. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth factors for evaluating the reasonableness of the costs sought pursuant to statutory provisions like Business and Professions Code section 125.3. These factors include: 1) the licentiate's success in getting the charges dismissed or the severity of the discipline imposed reduced; 2) the licentiate's subjective good faith belief in the merits of his position; 3) whether the licentiate raised a colorable challenge to the proposed discipline; 4) the licentiate's financial ability to pay; and 5) whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Zuckerman v. Bd. of Chiropractic Examiners, supra*, 29 Cal.4th at p. 45.)

11. Complainant introduced prima facie evidence that the Board's reasonable costs of investigation and enforcement in this matter are $57,186.25. (Bus. & Prof. Code, § 125.3, subd. (c); Cal. Code Regs., tit. 1, § 1042, subd. (b)(1), (2).) Respondent did not rebut that evidence. However, respondent presented a strong defense, held a subjective good-faith belief in its merits, was successful in getting most of the allegations of misconduct dismissed, and the appropriate discipline for the allegation proven is a letter of public reprimand. He introduced no evidence of his finances, other than his continued employment at Darroch Brain and Spine Institute. There was no evidence to suggest the scope of the investigation was unreasonable.

12. Considering the pertinent *Zuckerman* factors, a substantial reduction in complainant's costs of investigation and enforcement is warranted. Although

Dr. Dardashti's opinions had some relevance to the allegation proven, they were substantially related to those not proven. A 75 percent reduction to his costs is appropriate, and the total costs awarded for his time is $1,050. A similar reduction to Investigator Barrera's costs is appropriate, and the total costs awarded for her time is $2,054.25.

13. The Office of the Attorney General billed 176.75 hours at $228 per hour for time a Supervising Deputy Attorney General or a Deputy Attorney General spent on this matter ($40,299), 20.75 hours at $213 per hour for time a Paralegal spent on this matter ($4,419.75), and 0.25 hours at $202 per hour for time a Legal Analyst spent on this matter ($50.50). It is appropriate to reduce only the time spent by a Supervising Deputy Attorney General or a Deputy Attorney General by 75 percent to $10,074.75. The total cost awarded for the Office of the Attorney General's time is $14,545.

14. Based upon the above, the Board is awarded costs of investigation of $3,104.25 and costs of prosecution of $14,545. The total cost award is $17,649.25.

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ORDER

Physician's and Surgeon's Certificate Number A 165519 issued to respondent Markus Rashad Jamar Jackson, M.D., is hereby publicly reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4). This Decision shall serve as Dr. Jackson's Public Reprimand in this matter, and it is conditioned upon him paying the costs associated with the investigation and prosecution of this matter in the amount of $17,649.25 within 90 days of the Decision or as arranged with the Board.

DATE: July 16, 2025

Coren D. Wong (Jul 16, 2025 15:34 PDT)

COREN D. WONG

Administrative Law Judge

Office of Administrative Hearings