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

In the Matter of the Accusation Against: Donald Myron Hilty, M.D. Physician's and Surgeon's Certificate No. G 75437 Respondent.	Case No.: 800-2021-084404

DECISION

The attached 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 March 6, 2026.

IT IS SO ORDERED: February 4, 2026.

MEDICAL BOARD OF CALIFORNIA

MD.

Veling Tsai, M.D., Chair
Panel A

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

In the Matter of the Accusation Against:

DONALD MYRON HILTY, M.D., Respondent

Agency Case No. 800-2021-084404

OAH No. 2025030309

PROPOSED DECISION

Wim van Rooyen, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter from November 17-21 and 24-25, 2025, in person from Sacramento, California with some witnesses appearing by videoconference.

Megan R. O'Carroll, Deputy Attorney General, represented Reji Varghese (complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs, State of California.

Nicole D. Hendrickson, Attorney at Law, represented Donald Myron Hilty, M.D. (respondent), who was present.

At the start of the hearing, the undersigned heard oral argument on the record concerning respondent's two fully-briefed motions: (1) a motion in limine objecting to evidence pertaining to a related probate case, except for limited purposes; and (2)

respondent's motion for sanctions. For the reasons stated on the record, respondent's motion in limine was granted, and respondent's motion for sanctions was denied.

Evidence was then received and the record left open until December 3, 2025, to allow the parties to submit written closing arguments. Complainant and respondent filed written closing arguments, marked as Exhibits 32 and RR, respectively, which were admitted as argument. On December 3, 2025, the record was closed and the matter submitted for decision.

On December 5, 2025, the record was briefly reopened to allow respondent to file a properly-redacted copy of respondent's written closing argument (Exhibit RR) without any substantive changes. That same day, the record was closed and the matter resubmitted for decision.

FACTUAL FINDINGS

Jurisdiction

1. On October 27, 1992, the Board issued respondent Physician's and Surgeon's Certificate No. G 75437 (license). The license will expire on October 31, 2026, unless renewed.

2. On December 19, 2024, complainant, in his official capacity, signed and later filed an Accusation in Case No. 800-2021-084404 (Accusation) against respondent, a board-certified psychiatrist. The Accusation asserts cause to discipline respondent's license for gross negligence, repeated negligent acts, and general unprofessional conduct. The Accusation is based on respondent's 2021 assessments of

Patient 1,[1] the [redacted] of respondent's [redacted] at the time. The Accusation seeks to discipline respondent's license and recover the Board's reasonable investigation and enforcement costs.

3. Respondent timely filed a Notice of Defense to the Accusation. Consequently, the matter was set for hearing pursuant to Government Code section 11500 et seq.

Events Giving Rise to Accusation

4. The record in this case includes a complaint Patient 1's [redacted]), filed with the Board; Patient 1's extensive outpatient, hospital, and home care records from Sutter Health (Sutter); respondent's records for Patient 1; a transcript of respondent's December 6, 2022 deposition in the related probate case; copies of the Superior Court and Third District Court of Appeal decisions in the related probate case; a transcript of respondent's June 10, 2024 Board investigation interview; respondent's additional correspondence with Board staff; and the testimony of several percipient witnesses, including [redacted]), Patient 1's oldest [redacted] Attorney [redacted], an attorney who was involved in the related probate matter; [redacted]), Patient 1's [redacted] and respondent's [redacted]; and respondent.

After carefully considering the record as a whole, and applying the appropriate rules of evidence, clear and convincing evidence supports the following factual

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[1] This decision refers to Patient 1 by numerical designation to protect her privacy.

findings. Any remaining allegations contained in the Accusation were not established by clear and convincing evidence.

PATIENT 1'S CARE AND TREATMENT IN 2021

5. In March 2021, Patient 1 was a 90-year-old widow who lived in the house she owned in [redacted], located approximately 22 miles from [redacted] with a 15-minute drive to the nearest medical facility. Until then, Patient 1 had generally been healthy. However, that month she started experiencing some concerning symptoms, including weakness, difficulty walking, and a left-sided facial droop.

6. On March 28, 2021, respondent and [redacted] attended a family gathering at Patient 1's home. Several people expressed concern about Patient 1. Respondent approached Patient 1, and she agreed to talk. Respondent initially suggested that Patient 1 seek evaluation of her symptoms by another treatment provider. However, Patient 1 was reluctant to do so and requested respondent to evaluate her. Respondent agreed and evaluated Patient 1 in a private space at her home. He took handwritten notes of his evaluation on Post-it notes and the next day drafted a formal treatment record of his March 28, 2021 assessment. The treatment record did not identify respondent's familial relationship with Patient 1.

As part of the March 28, 2021 assessment, respondent obtained a detailed history of Patient 1's symptoms, prior medical and psychiatric treatment, and current medications. He then performed a mental status exam, which included a mini-mental state examination (MMSE), a 30-points screening tool used to assess cognitive impairment by evaluating orientation, registration, attention and calculation, memory, and language.

On the MMSE, Patient 1 scored 10/10 for orientation, 3/3 for registration, 3/5 for attention and calculation, 3/3 for memory, and 7/8 for language, for a total score of 26/29 (respondent did not administer the last item of the test that involved copying a design). In the narrative description of the mental status exam, respondent documented that Patient 1 had no pain; was casually groomed; spoke at a regular rate but had a left-sided facial droop; had a "low but not bad" mood or affect; was distracted or focused on family and had some concerns about her health; was oriented to person, place, and time; had partially intact attention/calculation[2] and good concentration; had intact memory, both immediately and after five minutes; and had fair insight/judgment.

In his summary, respondent found that Patient 1 was a "90 year-old Hispanic American female with onset of L-sided arm, leg and foot weakness, coupled with a facial droop and gait disturbance, who presents with anxiety/concern about health and + cardiac history. Lateralization may suggest a CVA[3] or other disturbance." Respondent's diagnoses included unspecified anxiety and ruling out a stroke. He did not believe Patient 1 was experiencing a medical emergency but recommended that she follow up with her Sutter primary care provider the next morning for further work-up and neurological consultation as well as potential physical or occupational therapy.

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[2] The actual treatment note indicates "attention/calculation intact" but respondent testified at hearing that this was an error and should have been "attention/calculation partially intact" given the MMSE sub score.

[3] CVA is the medical abbreviation for cerebrovascular accident, colloquially referred to as a stroke.

Additionally, respondent called Patient 1's primary care provider on March 29, 2021, to discuss respondent's findings. However, the primary care provider was unavailable, and respondent left a message with support staff.

7. On March 29, 2021, Patient 1's family took her to the emergency room. Imaging studies revealed that Patient 1 had two frontal lobe brain tumors suspected to be glioblastomas, an aggressive form of cancer with a low survival rate. She was also diagnosed with hyponatremia (low sodium level in blood) attributable to the brain tumors. Patient 1 was hospitalized. After discussions between Patient 1, family members, and medical providers, Patient 1 declined treatment for the brain tumors. On April 1, 2021, the hospital discharged Patient 1 to be cared for at home by family members and Sutter home health providers.

8. On April 4, 2021, respondent and [redacted] visited Patient 1 at home to check on her. During the visit, respondent asked Patient 1 if she wanted to talk. Patient 1 agreed. He again took handwritten notes of his evaluation on Post-it notes. The next day, respondent drafted a formal treatment record of his April 4, 2021 assessment. The treatment record did not identify respondent's familial relationship with Patient 1.

As part of the April 4, 2021 assessment, respondent reviewed Patient 1's symptoms, prior medical and psychiatric treatment, and current medications. Patient 1 reported that she was tired but "able to think okay." Respondent documented that Patient 1 was "able to list basic information, answer questions and provide rational[e] of decisions related to healthcare, finances and other legal issues (e.g., home decisions)." Respondent then performed a mental status exam, which included the MMSE.

On the MMSE, Patient 1 scored 10/10 for orientation, 3/3 for registration, 5/5 for attention and calculation, 3/3 for memory, and 8/8 for language, for a total score of 29/29 (respondent again did not administer the last item of the test that involved copying a design). In the narrative description of the mental status exam, respondent's findings were largely unchanged from the March 28, 2021 assessment, except that Patient 1's attention/calculation had improved.

In his summary, respondent found that Patient 1 was a "90 year-old Hispanic American female with neoplasm [tumor], [status post] hospitalization, who has less anxiety/concern about health and appears to be doing better." His diagnoses included unspecified anxiety and a central nervous system tumor, and he documented that her cognition and decision-making were intact. He recommended supportive psychotherapy and education on illness and medication options.

9. Patient 1's post-discharge medical records generally indicate that she had fluctuating mental status. At times, her mental status was normal. At other times, providers noted issues. For example:

- On April 2, 2021, a visiting registered nurse noted that Patient 1 could identify the United States president but did not know what month it was. Patient 1 had "bouts of forgetfulness and confusion."

- On April 4, 2021, a visiting physical therapist found Patient 1 alert and oriented to person, place, and time but also forgetful with impaired problem solving and safety awareness.

- On April 5, 2021, a visiting licensed vocational nurse noted Patient 1 was alert and oriented with some forgetfulness but could be easily redirected.

- On April 9, 2021, a visiting speech therapist evaluated Patient 1's cognition by administering the St. Louis University Mental Status (SLUMS) examination. Patient 1 achieved a 12/30 score and could only recall one out of five words; demonstrated difficulty with problem solving, divergent naming, giving digits backward, and paragraph comprehension; could not identify basic shapes; and drew a distorted clock face with the numbers of the clock continuing to 16 instead of stopping at 12.

Additionally, when [redacted] visited Patient 1 on April 6, 2021, Patient 1 "could barely string along a sentence" and "just sat there, staring off to the side." At times, Patient 1 did not appear to acknowledge [redacted]'s presence. [redacted] found this unusual and upsetting but believed it was likely because Patient 1's tumors were growing.

10. In late May 2021, Patient 1's condition worsened, she experienced seizures, and she was placed on hospice care. Patient 1 died on June 5, 2021.

APRIL 2021 CHANGES TO PATIENT 1'S ESTATE PLAN

11. Patient 1 had 13 children, including [redacted], [redacted], [redacted], and [redacted]. [redacted] is [redacted]'s [redacted] and was respondent's [redacted] in 2021.

12. Patient 1 had a long-established estate plan that she previously created with her deceased husband. In short, Patient 1's house in [redacted] was the sole asset of a trust. Upon Patient 1's death, [redacted] was to inherit one half of the trust estate. The other 12 children, including [redacted], were to inherit the other half of the trust estate.

13. In the spring of 2021, several of Patient 1's children were engaged in a disagreement over the disposition of Patient 1's trust and home upon her death. One

group, led by [redacted], sought to maintain the status quo of Patient 1's estate plan. The other group, led by B[redacted], sought to change Patient 1's estate plan in favor of [redacted]. [redacted] was aligned with [redacted], and [redacted] was aligned with [redacted].

14. On April 11, 2021, [redacted] informed respondent that [redacted] would like to speak to respondent. Respondent called [redacted], who requested respondent prepare a letter to Attorney [redacted] to document respondent's assessments of Patient 1 and attest to her ability to make basic decisions related to her affairs. It was respondent's understanding that Attorney [redacted] would be reaching out to him about the letter. [redacted] then handed the phone to Patient 1, who confirmed that she wanted respondent to draft the letter and orally consented to the release of her medical information. Although respondent did not actually assess or treat Patient 1 that day, he nonetheless documented the substance of the telephone call in an April 11, 2021 treatment record. The treatment record did not identify respondent's familial relationship with Patient 1.

15. On April 11, 2021, after the telephone call with [redacted] and Patient 1, respondent prepared a letter to Attorney [redacted] dated that same day (April 11, 2021 Letter). The April 11, 2021 Letter stated:

> This is a letter of competency for [Patient 1, with date of birth]. I have examined Patient 1 on two dates, 03/28/21 and 04/04/21.
>
> The treatment relationship started 03/28/21. The medical records were reviewed from home and EHR login portal with Sutter.
>
> The patient's relevant medical diagnoses are:

- Hypertension: many years ago
- Arrhythmia with pacemaker: approximately 2018 (could have been before)
- Cancer of the brain: April, 2021
- Insomnia: off/on for a few years

A Mini-Mental Status Examination was performed: score was 29/29; one item not checked.

An assessment of the patient's ability to make independent decisions regarding key issues:

- Healthcare: intact
- Finances: intact
- Legal matters: intact

Thank you and sincerely,

Donald M. Hilty, M.D., MBA

Medical Director, Heritage Oaks Hospital

Northern California Veterans Administration Health Care System and Department of Psychiatry & Behavioral Sciences, UC Davis

The April 11, 2021 Letter did not identify respondent's familial relationship with Patient 1.

16. Respondent testified that he sent a copy of the April 11, 2021 Letter to Patient 1 via United States mail on April 12, 2021. He did not send a copy to Attorney [redacted] that day because he was still waiting for Attorney [redacted] to contact him.

17. On April 14, 2021, at [redacted]'s request, Attorney [redacted] spoke with Patient 1 over the telephone about amending her trust to appoint [redacted] as trustee and name [redacted] as the sole beneficiary of the trust. On April 15, 2021, Attorney [redacted] also met with Patient 1 in person. Attorney [redacted] still did not feel comfortable with proceeding and informed [redacted] he "would like a doctor's statement about her mental capacity, if possible." He requested that [redacted] bring Patient 1 to his law office the next day to execute any documents.

18. On April 16, 2021, [redacted] and two of his sisters brought Patient 1 to Attorney [redacted]'s office. Attorney [redacted] reviewed the documents amending the trust with Patient 1 but refused to have her sign the documents until a third sister arrived with the April 11, 2021 Letter. After Attorney [redacted] reviewed the April 11, 2021 Letter, he had Patient 1 signed the documents amending the trust.

At hearing, Attorney [redacted] credibly testified that, notwithstanding his prior comment that he wanted a doctor's capacity statement "if possible," he would not have let Patient 1 sign the legal documents without the April 11, 2021 Letter. At the time he made his prior comment to [redacted], he was still in the process of determining whether he could proceed with the amendment based on all the circumstances. But as of the April 16, 2021 in-office meeting, he had formed a firm opinion that a doctor's statement regarding Patient 1's mental capacity was necessary. Additionally, Attorney [redacted] clarified that he did not know of respondent's familial relationship with Patient 1 at the time Patient 1 signed the documents.

19. On April 18, 2021, respondent emailed a copy of the April 11, 2021 Letter directly to Attorney [redacted] and asked: "This okay?" Respondent did so because Attorney [redacted] had never reached out to respondent about the letter as respondent expected. At the time, respondent was unaware that Patient 1's family had already provided the April 11, 2021 Letter to Attorney [redacted] two days prior.

20. [redacted] and the siblings aligned with him did not know about the April 16, 2021 amendment of the trust. Around May 8, 2021, [redacted] discovered related documentation in the mail and learned that [redacted] would be "getting everything." She immediately informed [redacted], who confronted [redacted] and the siblings aligned with him. A bitter family dispute ensued, and many siblings aligned with [redacted] did not visit Patient 1 in the final weeks of her life, which upset Patient 1.

PROBATE CASE

21. Following Patient 1's June 2021 death, [redacted] filed a petition in Superior Court challenging the validity of the trust amendment. Respondent was deposed in the probate case in December 2022 and testified at a bench trial in probate court in January 2023.

22. After the bench trial, the probate judge issued a Statement of Decision dated March 21, 2023, granting the petition and invalidated the trust amendment. The Statement of Decision found that Patient 1 lacked the required capacity to execute the trust amendment, which was the result of undue influence by Benny. The Statement of Decision also made some adverse credibility determinations concerning respondent.

23. [redacted] appealed the Statement of Decision. On August 13, 2025, the Third District Court of Appeal affirmed.

BOARD COMPLAINT AND INVESTIGATION

24. On December 13, 2021, [redacted] signed a complaint against respondent with the Board. The Board received it on December 21, 2021. [redacted] testified that she filed the complaint because she believes respondent, through [redacted], knew about [redacted]'s plan to amend Patient 1's trust and inappropriately provided the April 11, 2021 Letter. The letter played a pivotal role in facilitating [redacted]'s misconduct. It harmed Patient 1 by fracturing her family in the last weeks before her death, when all her children should have been present to support her.

25. On April 7, 2023, a medical consultant for the Board's Central Complaint Unit (CCU) initially found no departure from the standard of care and closed the case. On April 14, 2023, [redacted] signed a document providing additional information and attaching a copy of the Superior Court's March 21, 2023 Statement of Decision. The Board received it on April 17, 2023. On August 4, 2023, the chief medical consultant for the CCU reopened the case and referred it to the Health Quality Investigative Unit (HQIU) for further investigation of whether respondent had a conflict of interest in performing a competency assessment of Patient 1.

26. HQIU special investigator Monica Peretto investigated the matter. She prepared an investigation report dated August 5, 2024, and testified consistent with that report at hearing. As part of her investigation, Ms. Peretto gathered all relevant documents, had a District Medical Consultant review the documents, and together with the District Medical Consultant interviewed respondent on June 10, 2024. Ms. Peretto then sent all case records for an expert opinion, which she received on July 30, 2024. She then finalized and submitted her August 5, 2024 investigation report. The Accusation followed.

Yvette's Additional Testimony

27. [redacted]

28. [redacted] testified that she had lived with her [redacted] (Patient 1) "off and on" as a child. She considered Patient 1's house "home" and felt safe there. According to [redacted], her family has "so many issues," and there were always disputes and "drama" between her aunts and uncles (Patient 1's children). She also had a fractured, sometimes non-existent relationship with her [redacted] Thus, [redacted] rarely brought respondent to family gatherings because she was embarrassed by their behavior. She rarely talked with respondent about her family. However, [redacted]'s family highly regarded respondent due to his intelligence and education.

29. On March 28, 2021, [redacted] decided to attend a family gathering at Patient 1's home. She had learned that Patient 1 was not feeling well and regretted not spending sufficient time with her [redacted] before he died. Thus, she wanted to make sure she did not repeat that mistake with Patient 1. [redacted] invited respondent to accompany her to the gathering but not with the intent of having respondent evaluate Patient 1. However, he ultimately did so at the request of family members who were concerned about Patient 1 and after his own observation of her left-sided facial droop.

30. After [redacted] learned of Patient 1's hospitalization and discharge, [redacted] and respondent visited Patient 1 at home on April 4, 2021. Respondent again evaluated Patient 1 during that visit.

31. Throughout April 2021, [redacted] visited Patient 1 on several occasions. Patient 1 sometimes "looked almost like a child" when [redacted] was helping her with activities of daily living. However, Patient 1 smiled a lot, was aware of her surroundings and appeared to understand [redacted], was talkative and conversing with multiple words, joked around, and told [redacted] she loved her. Her communication started to decline in May 2021, and she sadly passed away in early June 2021.

32. [redacted] testified that she knew about the April 11, 2021 Letter but never discussed its substance with respondent. She further testified that she and respondent were unaware of any dispute concerning the disposition of Patient 1's trust and home at the time of the April 11, 2021 Letter. She never heard any of her family members discussing the matter. As far as she was aware, neither she nor respondent stood to inherit anything from Patient 1. [redacted] "never promised anything" to [redacted].

33. [redacted] initially testified that she was not interested in the subsequent probate case involving Patient 1's trust. She never testified in the probate case and "stayed out of it." However, during cross-examination, [redacted]'s demeanor changed from calm and poised to highly emotional and angry. She admitted that she hosted a lunch at her home during the probate case trial for [redacted]; [redacted]'s aligned siblings, including her [redacted] and Attorney [redacted], who represented [redacted] at the trial. [redacted] then volunteered that Attorney [redacted] was an "idiot" who did not "take into consideration my family's questions," did not adequately represent "my family," and was "more concerned about which sandwiches he could take home" from the lunch. She subsequently apologized for the outburst at hearing and explained that she was getting tired.

34. [redacted] has remained friends with respondent since [redacted] They sometimes have coffee, and she has offered to take him clothes shopping. She

described respondent as highly intelligent, thoughtful, reflective, thorough, humble, kind, dedicated to his career and patients, and honest. She feels guilty that he still has to deal with this matter arising out of her family drama [redacted]

35. [redacted] believes patients and the public are safe with respondent's continued practice. She feels that she can express that opinion about respondent without any bias, other than "knowing who he is" and "how erroneous the allegations are." However, she conceded that respondent has [redacted] and that license discipline could affect his income and ability [redacted].

Respondent's Additional Testimony

36. Respondent testified at hearing as both a percipient and expert witness, as discussed below. His testimony was calm, professional, and responsive to questions from all parties.

37. Respondent graduated from medical school in 1991 and completed his residency in psychiatry in 1995. He has been board certified in general psychiatry since 1996. He also obtained a master's degree in business administration in 2018 to learn more about medical administration and leadership.

38. Respondent has approximately 30 years of experience as an attending psychiatrist. He has served as a professor of clinical psychiatry at the University of California, Davis (UC Davis) and the University of Southern California for many years. In addition to clinical work and teaching students/residents, he has published numerous peer-reviewed articles and books, served as an expert reviewer for several medical journals, and contributed to publications for the American Psychiatric Association.

Additionally, he served as Chair of Psychiatry and Addiction Medicine for the Kaweah Delta Health Care District and Medical Center from 2015-2017, as Associate Chief of Staff for Mental Health at the Veterans Administration (VA) Northern California Health Care System from 2017 through 2021, and as attending psychiatrist at Heritage Oaks Health System and Universal Health Services (Heritage Oaks) from 2020 through 2025 (with appointment as Chief Medical Officer from 2023 through 2025).

39. Respondent remains up to date on continuing medical education. He typically takes about twice the amount of required course hours.

40. Respondent's field of specialization is consultation liaison psychiatry. A consultation liaison psychiatrist primarily consults with primary care providers, other medical specialists, and hospital services to develop and implement a treatment plan for patients with comorbid general medical and psychiatric conditions. They help to educate medical teams about psychiatric conditions and assist with particularly challenging patients. Additionally, consultation liaison psychiatrists are frequently requested to evaluate a medical patient's capacity to make decisions. There are only approximately 1,500 consultation liaison psychiatrists in the United States.

41. Despite respondent's extensive experience as a consultation liaison psychiatrist, he is not board certified in consultation liaison psychiatry. Board certification in consultation liaison psychiatry is relatively new and only became available within the past 20 years. Because respondent was busy, he overlooked the deadline to grandfather into board certification by taking a written examination. To become board certified now, he would have to complete a fellowship for which he does not have the time.

42. Respondent also has a strong interest in telepsychiatry and telemedicine. He grew up in a rural area and became motivated to improve access to quality psychiatric care in remote areas. Consequently, he has conducted substantial research and collaborated in numerous projects involving telepsychiatry and telemedicine. Respondent also engages in significant volunteer work with professional organizations and societies, non-profit organizations, 12-step substance use recovery groups, and other self-help groups. He feels like he "gets a lot back" from meeting and helping other people.

43. Respondent has no history of license discipline. He has never been the subject of any patient complaints or malpractice suits. However, he lost his position at Heritage Oaks after his hospital privileges were not renewed due to the pending Accusation. Respondent is currently unemployed and finding it hard to obtain new employment while the Accusation remains unresolved.

44. Respondent first met [redacted] at work in 2000. [redacted]

45. While they were [redacted] seldom talked to respondent about her family. He saw [redacted] family at family gatherings he attended approximately once or twice a year at most. Over the years, he had met both [redacted] and Patient 1 on multiple occasions. Respondent's relationship with [redacted]'s family members was cordial, but not "super close." They were essentially acquaintances.

46. Respondent evaluated Patient 1 on March 28, 2021, and April 4, 2021, as a courtesy due to family concerns about Patient 1's health and to potentially connect her with appropriate follow-up care. As part of each evaluation, respondent performed

a clinical interview and administered the MMSE, which he has done countless times in clinical practice as a consultation liaison psychiatrist. Respondent does not recall if he specifically asked Patient 1 about whether she had a will or estate plan. If he did, he would not have inquired about the specifics. As was respondent's customary routine, he created formal treatment records of the evaluations soon after they occurred, in both cases the next day.

47. Respondent was skeptical about the speech therapist's April 9, 2021 SLUMS examination. He reasoned that it contained fewer questions, was more prone to errors, and was used much less compared to the MMSE. He also questioned whether the speech therapist was appropriately trained to administer the SLUMS.

48. Respondent drafted and provided the April 11, 2021 Letter at the request of Benny and Patient 1, not in response to an urgent medical matter. Respondent intended it as a general capacity letter by a treatment provider summarizing his visits with Patient 1 and confirming that she was able to make basic decisions about healthcare, finances, and legal matters. This is the type of evaluation respondent frequently performed in the healthcare context as a consultation liaison psychiatrist. Additionally, respondent intended the April 11, 2021 Letter to reflect Patient 1's basic decision making capacity as of April 4, 2021, because that is the last time he evaluated her.

Respondent understood that he was to direct the April 11, 2021 Letter to an attorney but never inquired about its purpose or asked for further information. He assumed it was primarily for making general health care decisions, including about palliative care and possibly obtaining an advance health care directive or medical power of attorney.

Although respondent acknowledged that the April 11, 2021 Letter stated it was a "letter of competency," he explained that was an inadvertent error. He never intended the April 11, 2021 Letter to be a letter of competency regarding Patient 1's ability to make changes to her will or estate plan. Respondent has performed such evaluations before but they are complex medical-legal matters and require a more in-depth assessment than what respondent performed on Patient 1.

Respondent testified he did not know of any dispute concerning the disposition of Patient 1's trust and home, any plans to amend the trust, or that the April 11, 2021 Letter would be used to amend the trust when he provided it. He never overheard [redacted]'s family members discussing such matters.

49. Respondent testified that he only learned about the dispute concerning Patient 1's trust and home at his June 10, 2024 Board investigation interview. However, during that interview, respondent stated that "some of that spilled out into family events I think late April or May [of 2021]." Additionally, respondent acknowledged he was deposed in the probate case in December 2022 and had testified in probate court in January 2023, but emphasized that he was not then represented by an attorney. Respondent also acknowledged receiving a copy of his deposition transcript after his deposition in the probate case. The transcript bears the caption "In Re the Matter of: THE [redacted] FAMILY TRUST," identified [redacted] and [redacted] as opposing parties, and contained specific questions about a family dispute concerning ownership of Patient 1's home.

50. Respondent maintains he did not have an inappropriate dual relationship with Patient 1 when he provided the April 11, 2021 Letter. He did not know about the plan to change Patient 1's trust. Additionally, neither respondent nor [redacted] had any financial interest in Patient 1's estate, whether under the original or amended trust. He

continues to believe that the April 11, 2021 Letter supported the best interests of Patient 1. He does not think a reasonable psychiatrist should have anticipated being embroiled in a legal battle based on the April 11, 2021 Letter. Nevertheless, respondent took the Accusation seriously and voluntarily completed PBI Education's Medical Ethics and Professionalism: Extended Edition course in the Fall of 2025. That course specifically addressed topics such as professional boundaries, conflicts of interest, and dual relationships.

51. Respondent strongly desires to return to practicing psychiatry, preferably in a public setting. He feels happy and fortunate to enjoy the work, is dedicated to his patients and community, has held many leadership positions in psychiatry, and believes he has "gone above and beyond the call of duty." The public would be safe with his continued unsupervised practice.

Character Witness Testimony and Letters

52. Peter Yellowlees, M.D., Ph.D., offered a June 30, 2025 letter in support of respondent and testified at hearing. Dr. Yellowlees is a board-certified psychiatrist and Distinguished Emeritus Professor of Psychiatry at UC Davis from where he retired in 2022. He is now the chief executive officer of AsyncHealth, a mental health digital health company. He has no record of license discipline.

Dr. Yellowlees and respondent worked together for many years at UC Davis, sharing patients and supervising residents. Additionally, telemedicine is a shared clinical and research interest for both. They co-authored about 20 peer-reviewed academic papers and several book chapters, taught seminars together, and attended conferences together. Dr. Yellowlees believes respondent is a careful and competent psychiatrist with excellent professional judgment. He is honest, ethical, dedicated to

his patients and volunteer work, and a good mentor to students and colleagues. Dr. Yellowlees was so impressed with respondent that he once referred a family member to respondent for psychiatric care.

Dr. Yellowlees is aware of the Accusation and its underlying allegations. They do not change his opinion of respondent. He believes the public is safe with respondent's continued unsupervised practice, and Dr. Yellowlees would not hesitate to refer patients to respondent in future.

53. James Alan Bourgeois, M.D., offered a July 31, 2025 letter in support of respondent and testified at hearing. Dr. Bourgeois is the Vice Chair of Hospital Psychiatry Services and a Professor of Clinical Psychiatry at UC Davis. He is board certified in general psychiatry and consultation liaison psychiatry with no record of license discipline.

Dr. Bourgeois and respondent worked together for many years on a shared clinical service at UC Davis, collaborated on telemedicine projects, taught and attended seminars together, and co-authored 23 peer-reviewed academic papers and two books. Dr. Bourgeois described respondent as a committed clinician, skilled educator, excellent leader and mentor to students, an "international leader and innovator in telemedicine," and "one of the most talented and committed academic psychiatrists I have worked with." He praised respondent's clinical skills and experience, dedication to patients, and volunteer work. According to Dr. Bourgeois, respondent is a consultation liaison psychiatrist highly experienced in performing decision making capacity assessments. Respondent is ethical and honest. Dr. Bourgeois would confidently send patients to respondent.

Dr. Bourgeois is aware of the Accusation and its underlying allegations. They do not change his opinion of respondent. Although he agreed that it is recommended for physicians to minimize or avoid involvement in care of family members, he explained:

> Terminally ill patients, esp. with cancer, are highly delirium-prone with frequent alterations in mental (including cognitive) status, such that decisional capacity determinations are particularly challenging. Formal cognitive assessments provide relatively validated data points, but, especially with [central nervous system] cancers, cognitive performance fluctuations are common, even within a single day, and definitive statements of persistent decisional capacity status for both informed consent and civil legal matters are challenging and can be ambiguous.

Dr. Bourgeois acknowledged that he was not expressing an opinion as an expert witness in the case but posited that "perhaps [respondent] was trying to make the best of a challenging situation by providing clinical input." He believes respondent is highly competent and can continue practicing unsupervised without any risk to the public.

54. At hearing, respondent presented several additional letters of support from colleagues; acquaintances from his volunteer work; friends; and his sister. All authors are aware of the Accusation and underlying allegations. They uniformly lauded respondent's intelligence, competence, professionalism, scholarship, compassion, generosity, hard work, honesty, and integrity. Respondent also submitted numerous cards from students, residents, and colleagues thanking him for his professional contributions.

Expert Witness Opinions

55. Complainant presented the testimony of retained expert Edward L. Spencer, M.D. Respondent presented his own expert testimony as well as the testimony of retained expert Mohan Nair, M.D.

56. All experts defined the applicable standard of care as the level of skill, knowledge, and care ordinarily possessed and exercised by other reasonably careful and prudent psychiatrists in the same or similar circumstances. All experts defined negligence as a simple departure from the standard of care, i.e., the failure to use the level of skill, knowledge, and care that other reasonably careful psychiatrists would use in the same or similar circumstances. All experts defined gross negligence as an extreme departure from the standard of care or "the want of even scant care."

EDWARD L. SPENCER, M.D.

57. Dr. Spencer obtained his medical degree in 2007 and completed a residency in psychiatry in 2011. During his residency, he served as a senior resident in geriatric psychiatry from 2010 to 2011. Dr. Spencer has been licensed by the Board since 2009 and has been a board-certified psychiatrist since 2011. He is not board certified in consultation liaison psychiatry. He has no record of Board discipline.

Since 2011, Dr. Spencer has maintained a solo general psychiatry practice in Beverly Hills, California. Additionally, he has served as a qualified medical examiner in worker's compensation cases, psychiatric disability examiner in disability cases, and a physician peer reviewer for health insurance companies.

From 2011 through 2023, Dr. Spencer also served on weekends as a staff attending physician on the adult and geriatric psychiatry inpatient and consultation

liaison service at the Resnick Neuropsychiatric Hospital at the University of California, Los Angeles (UCLA). As part of the consultation liaison service, he was frequently (at least 12 times per year) called upon to assess a patient's capacity to make basic decisions. However, the vast majority of those cases involved making medical decisions.

From 2016 through 2019, and again since 2022, Dr. Spencer has been an expert reviewer for the Board. In that capacity, he has reviewed approximately 20 cases since 2022, most of which involved allegations of excessive prescribing. In two to three of those cases he found no departures from the standard of care; in the remainder, he found some departures from the standard of care. He has only been required to testify at hearing on one prior occasion.

58. As part of his evaluation of this case, Dr. Spencer reviewed Dolores's complaint to the Board, Patient 1's Sutter records, respondent's records for Patient 1, the Superior Court decision in the related probate case, respondent's Board investigation interview transcript, respondent's additional correspondence with Board staff, and respondent's curriculum vitae. Dr. Spencer prepared an expert report dated July 30, 2024. The expert report briefly referenced the probate case as part of the history of events underlying Dolores's complaint to the Board but did not discuss the Superior Court's specific findings.

59. At hearing, Dr. Spencer testified consistent with his expert report. His testimony was responsive to questions by all parties. His demeanor was calm, dispassionate, and professional throughout the hearing.

60. Dr. Spencer clarified that although he had reviewed the Superior Court's Statement of Decision in the probate case, it did not influence or play any role in how

he reached his medical opinions in this case. For purposes of his analysis, he assumed the truth of respondent's representations that respondent had no knowledge of the plan to change Patient 1's trust and that respondent had no financial interest in the trust amendment. Additionally, Dr. Spencer confirmed that he did not have access to the CCU medical consultants' assessments when preparing his expert report. He has since reviewed them, but they do not change his opinions in this case.

61. Dr. Spencer identified three departures from the standard of care involving respondent's issuance of the April 11, 2021 Letter: (1) an improper dual relationship with Patient 1; (2) the March 28, 2021, and April 4, 2021 assessments were incomplete and inadequate to support the April 11, 2021 Letter; and (3) respondent failed to reevaluate Patient 1 before issuing the April 11, 2021 Letter. Each departure is discussed separately below.

(1) Improper Dual Relationship

62. Dr. Spencer explained that a dual relationship exists when a psychiatrist has another type of relationship, such as a family relationship, romantic relationship, or friendship, with the patient in addition to the physician-patient relationship. While not all dual relationships are inherently inappropriate or unethical, they risk conflicts between the psychiatrist's fiduciary obligations to the patient and pressures on the psychiatrist arising from the other relationship. Thus, the standard of care requires psychiatrists to avoid dual relationships unless there is a compelling clinical need, in which case care must be transferred to another psychiatrist once the compelling clinical need has ended.

In this case, respondent entered into a dual relationship with Patient 1 when he assessed her on March 28, 2021. Nevertheless, his March 28, 2021 and April 4, 2021

assessments were in response to genuine concerns of Patient 1 and her family. Thus, there was a compelling clinical need for the assessments and no departure from the standard of care in performing those assessments.

However, there was no compelling clinical need for respondent to issue the April 11, 2021 Letter. Issuing a letter to an attorney about a patient's ability to make independent decisions about health care, finances, and legal matters is not a routine component of a physician-patient relationship. Nor is it generally in response to a compelling clinical need. Given respondent's dual relationship with Patient 1, he should have referred her to another psychiatrist to make a determination regarding such abilities. Dr. Spencer opined that respondent's failure to do so amounted to an extreme departure from the standard of care.

(2) Incomplete and Inadequate Supporting Assessments

63. Dr. Spencer explained that the concept of decision-making capacity refers to the question of whether a patient has the ability to make a specific type of decision in a specific clinical situation. Although adult patients are generally presumed to have full decision-making capacity, this presumption cannot be applied in the presence of neurological conditions that can impair decision-making capacity. Additionally, some decisions warrant a higher level of decision-making capacity, such as when the decision involves high risk or is inconsistent with prior decisions. Thus, the standard of care requires the psychiatrist to be familiar with the facts surrounding the proposed decision before issuing a capacity determination. Moreover, the standard of care requires a psychiatrist to discuss the specific type of decision with the patient and evaluate the patient's ability to manipulate information related to that decision.

Dr. Spencer noted that respondent was aware of respondent's brain tumors based on his April 4, 2021 treatment record. Respondent issued the April 11, 2021 Letter based on his March 28, 2021 and April 4, 2021 assessments. Although respondent clinically interviewed Patient 1 and administered the MMSE as part of his assessments, the treatment records do not indicate that respondent asked Patient 1 any specific questions about a will, trust, or estate plan nor that he evaluated her ability to manipulate information related to any decision concerning such matters. Indeed, respondent never asked about the specific purpose for the April 11, 2021 Letter. Thus, Dr. Spencer opined that respondent's March 28, 2021 and April 4, 2021 assessments were incomplete and inadequate to support respondent's finding that Patient 1 could make independent decisions about health care, finances, and legal matters. Dr. Spencer deemed it a simple departure from the standard of care.

That respondent specializes in consultation liaison psychiatry does not change Dr. Spencer's opinion. Even though consultation liaison psychiatry now has its own subspecialty board certification, it is nonetheless a significant part of the general curriculum for all psychiatrists in residency. Based on Dr. Spencer's own experience in residency and while on the consultation liaison service at UCLA, the type of capacity consultation liaison psychiatrists typically evaluate is the ability to make decisions regarding medical care, not finances or legal matters. Regardless, Dr. Spencer believes respondent's assessments were insufficient to support the April 11, 2021 Letter under the standard of care that applies to all psychiatrists, including consultation liaison psychiatrists.

(3) Failure to Reevaluate

64. Dr. Spencer explained that the standard of care requires a psychiatrist to adequately and contemporaneously assess a patient's decision-making capacity before

rendering an opinion. Apart from the deficits in the assessments discussed above, respondent issued the April 11, 2021 Letter after he last assessed Patient 1 on April 4, 2021. Given her known diagnosis with brain tumors and documented fluctuating mental status between April 4, 2021 and April 11, 2021, a reasonable psychiatrist would have declined to issue such a letter without reviewing the patient's records and reexamining her. Dr. Spencer opined that respondent's failure to do so was an extreme departure from the standard of care under the circumstances of this case.

65. In sum, Dr. Spencer emphasized that the standard of care is designed to protect vulnerable patients from making poor decisions or being exploited by others. By issuing the April 11, 2021 Letter to an attorney, while having a dual relationship with Patient 1, without a proper supporting and contemporaneous assessment, and without making any inquiry about the purpose of the April 11, 2021 Letter, respondent placed Patient 1 at great risk of harm. In Dr. Spencer's view, someone with significant experience would view this as a fairly unequivocal "don't go there situation."

MOHAN NAIR, M.D.

66. Dr. Nair obtained his medical degree in 1975, completed a residency in psychiatry in 1981, and completed a clinical fellowship in child psychiatry in 1983. Dr. Nair has been licensed by the Board since 1979; has been a board-certified psychiatrist since 1981; and holds additional board certifications in child and adolescent psychiatry, forensic psychiatry, pain medicine, addiction medicine, brain injury medicine, and behavioral neurology and neuropsychiatry. Dr. Nair is not board certified in consultation liaison psychiatry. He has no record of Board discipline.

Dr. Nair has maintained a private psychiatry practice for most of his career, except when he served as an attending psychiatrist at Martin Luther King Community

Hospital in Los Angeles for eight months in 1983 or 1984 and worked as a child psychiatrist for the County of Kauai, Hawaii from February through October 1995. In addition to his private practice in Seal Beach, California focused on brain injury medicine, pain medicine, and psychiatry, he lectures in a forensic psychiatry fellowship program at UCLA. Dr. Nair has also served as an expert witness in numerous criminal, juvenile delinquency, child custody, medical malpractice, and worker's compensation cases. As an expert witness, he has been frequently called upon to make capacity determinations.

Dr. Nair has served as an expert reviewer for the Board since 2008. He has offered opinions in well over 40 standard of care cases. In about half of those, he assessed departures from the standard of care, including a handful of extreme departures from the standard of care.

67. As part of his evaluation of this case, Dr. Nair reviewed the Accusation; Dolores's complaint to the Board; the CCU medical consultants' assessments; Ms. Peretto's investigation report; Patient 1's Sutter records; respondent's records for Patient 1; Alberto's petition, respondent's deposition transcript, the Superior Court's decision, and the Third District Court of Appeal's decision from the probate case; respondent's Board investigation interview transcript; respondent's additional correspondence with Board staff; Dr. Spencer's expert report; respondent's curriculum vitae; and declarations from [redacted], [redacted], and [redacted]. Dr. Nair prepared an expert report dated August 26, 2025.

Dr. Nair's expert report includes significant discussion of the probate case, including his own personal commentary and impressions about the underlying events. Specifically, it contains opinions by Dr. Nair that [redacted] was untruthful, that [redacted]'s attorney did not adequately contest the claims made against him in the probate case,

and that the Superior Court's Statement of Decision was "rendered on flawed information, inconsistent information, and information not supported by [Patient 1's] medical records."

Dr. Nair's expert report also claimed Dr. Spencer did not carefully review the case materials and appeared to have been unduly influenced by findings in the probate case. However, he was unable to point to any specific portion of Dr. Spencer's report that supported his claim.

68. On direct examination, Dr. Nair generally testified calmly, responsively, and consistent with his report. On cross-examination, he became visibly irritated, defensive, unusually passionate, and argumentative.

69. Dr. Nair found no departures from the standard of care involving respondent's issuance of the April 11, 2021 Letter. He disagreed with each of Dr. Spencer's assessed departures from the standard of care, as discussed below.

(1) Improper Dual Relationship

70. Dr. Nair acknowledged that dual relationships pose challenges but observed that the standard of care permits psychiatrists to treat family members on a short-term basis as long as there is no financial or emotional interest. He added:

> A consultation-liaison psychiatrist familiar with medical-surgical settings, [respondent] recognized a medical problem and did what he believed was in the best interests of [Patient 1].
>
> It would be similar to a physician providing a letter excusing a distant cousin encountered at a family reunion who

strained his shoulder in a pick-up basketball game and felt he could not tend his job as a waiter later in the evening.

71. Dr. Nair emphasized that respondent's objectivity was not compromised because respondent had limited contact with Patient 1 and [redacted]'s family, neither respondent nor [redacted] had any financial interest in Patient 1's trust and estate, and respondent had no knowledge of the plans to change Patient 1's trust. Thus, Dr. Nair found no departure from the standard of care in respondent's dual relationship with Patient 1.

72. Dr. Nair acknowledged that if respondent had known about the plans to change Patient 1's trust when he issued the April 11, 2021 Letter, that would have been improper even if respondent had no financial interest in Patient 1's estate. A dual relationship may be improper even in the absence of a financial interest. An emotional, sexual, or other type of non-financial interest would suffice.

(2) Incomplete and Inadequate Supporting Assessments

73. Dr. Nair "totally disagreed" with Dr. Spencer that the March 28, 2021, and April 4, 2021 assessments were incomplete and inadequate to support the April 11, 2021 Letter. Dr. Nair agreed that decision-making capacity "is used to denote a professional clinical judgment as to whether an individual has the requisite minimum ability to carry out a specific task or make a specific decision." However, he claimed that there is no recognized standard of care in such matters.

74. Additionally, Dr. Nair believed Dr. Spencer was "mixing up" two different types of assessments—whether Patient 1 had the capacity to make basic decisions about healthcare, finances, and legal matters and whether Patient 1 had the specific capacity to make changes to her estate plan. The latter requires a more in-depth

assessment than what respondent performed on Patient 1. In Dr. Nair's view, respondent never intended to express an opinion regarding Patient 1's testamentary capacity. The April 11, 2021 Letter was merely a letter from a treating provider reiterating his findings on March 28, 2021 and April 4, 2021 that Patient 1 had basic decision-making capacity. However, Dr. Nair conceded that the April 11, 2021 Letter suggested that Patient 1 could independently make legal and financial decisions, which would include testamentary decisions.

75. Dr. Nair agreed that when a psychiatrist is asked to write a letter about a patient to an attorney, "you would want to know what the letter was for" . . . "you would have to ask questions." However, he then opined that respondent had no duty to inquire as to the specific purpose for the April 11, 2021 Letter. He believes it was the attorney's duty to clarify what was needed from respondent.

76. In sum, Dr. Nair opined that the April 11, 2021 Letter was adequately supported by respondent's assessments of Patient 1. To the extent Dr. Spencer suggested otherwise, he was just "making up stuff."

(3) Failure to Reevaluate

77. Dr. Nair also disagreed that the standard of care required respondent to reevaluate Patient 1 before issuing the April 11, 2021 Letter. According to Dr. Nair, the April 11, 2021 Letter was not intended to reflect Patient 1's decision-making capacity as of April 11, 2021, but instead as of April 4, 2021, the date respondent last assessed Patient 1.

78. Moreover, in Dr. Nair's view, continuing capacity must be assumed in the absence of compelling evidence, even in the case of a 90-year-old patient with brain tumors. Dr. Nair believed there was "no documentation of cognitive impairment prior

to April 9, 2021." He dismissed the miscellaneous notes by the visiting nurses and physical therapist as showing minor cognitive issues and discounted the visiting speech therapist's April 9, 2021 SLUMS examination as performed by an inappropriate specialty. Dr. Nair further posited that there was actually "no indication" that Patient 1 had lost capacity until late May 2021.

79. However, on cross-examination, Dr. Nair conceded that observations by nurses, physical therapists, and speech therapists are valuable data points for a psychiatrist to consider; Patient 1's brain tumors could have caused her mental capacity to fluctuate; "there may have been times in April 2021 when [Patient 1] didn't have capacity"; and no other provider had opined that Patient 1 had the ability to make independent decisions regarding health care, finances, and legal matters in April 2021. Nevertheless, Dr. Nair believes that Patient 1 "on the whole maintained capacity" during that time. In any event, in issuing the April 11, 201 Letter, respondent "was only attesting to what he knows."

RESPONDENT

80. As part of prehearing disclosures, respondent timely disclosed himself as an expert witness under Business and Professions Code 2334. In addition to his percipient witness testimony, he detailed his qualifications and experience in consultation liaison psychiatry, as discussed above. In his expert opinion, and for the same reasons discussed by Dr. Nair, he did not depart from the standard of care in his assessments and care of Patient 1.

Costs

81. Complainant seeks $13,034.50 in investigation costs. The investigation costs are supported by a Declaration of Investigative Activity by Michel Veverka,

Supervising Investigator, dated August 5, 2024, which identifies the investigator's hourly rates for different fiscal years and attaches an investigator log. The log identifies the investigation tasks performed by generic designation such as "Report/Subpoena Writing," "Communication," and "Records/Document Review"; the dates tasks were performed; and how much time was spent on each task in 15-minute increments.

Ms. Peretto testified that HQIU's billing software requires use of generic designations and does not allow for more detailed descriptions of tasks. When billing for case-related tasks, she picks the generic designation that best describes the task. She always bills for each task contemporaneously. Ms. Peretto further explained that not every task she bills for is necessarily reflected in the investigation report, which only contains the information she ultimately deemed relevant.

82. Complainant seeks $45,302 in prosecution costs. The prosecution costs are supported by a Certification of Prosecution Costs: Declaration of Deputy Attorney [General] Megan R. O'Carroll dated November 12, 2025. The declaration attaches billing logs showing the tasks performed by attorneys and other legal professionals, the dates tasks were performed, how much time was spent on each task in 15-minute increments, and the applicable hourly rates.

LEGAL CONCLUSIONS

1. "Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be

promoted, the protection of the public shall be paramount." (Bus. & Prof. Code, § 2001.1.)

Burden and Standard of Proof

2. Complainant bears the burden of proving by clear and convincing evidence that cause exists to discipline respondent's license. (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) "Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind." (*In re David C.* (1984) 152 Cal.App.3d 1189, 1208.)

3. If, and only if, complainant establishes cause for discipline, respondent must establish rehabilitation. Rehabilitation is akin to an affirmative defense. Consequently, respondent bears the burden of proving rehabilitation. (*Whetstone v. Bd. of Dental Examiners* (1927) 87 Cal.App. 156, 164.) The standard of proof for rehabilitation is a preponderance of the evidence (Evid. Code, § 115), which means "more likely than not." (*Sandoval v. Bank of America* (2002) 94 Cal.App.4th 1378, 1388.)

Non-Consideration of Probate Case

4. As discussed above, respondent's motion in limine objecting to evidence pertaining to the probate case, except for limited purposes, was granted. Except to explain the historical origins of [redacted]'s complaint to the Board, the probate case and any factual or credibility findings by the Superior Court were not considered for any purpose in deciding this case. In analyzing witness credibility, the existence of cause for discipline, and the appropriate degree of discipline, the undersigned relied solely on the independent evidence established in the record in this case.

Credibility Determinations

5. As an initial matter, it is necessary to evaluate the credibility of percipient witnesses and expert witnesses. Under the Evidence Code, the trier of fact:

> may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following:
>
> (a) His demeanor while testifying and the manner in which he testifies.
>
> (b) The character of his testimony.
>
> (c) The extent of his capacity to perceive, to recollect, or to communicate any matter about which he testifies.
>
> (d) The extent of his opportunity to perceive any matter about which he testifies.
>
> (e) His character for honesty or veracity or their opposites.
>
> (f) The existence or nonexistence of a bias, interest, or other motive.
>
> (g) A statement previously made by him that is consistent with his testimony at the hearing.
>
> (h) A statement made by him that is inconsistent with any part of his testimony at the hearing.

(i) The existence or nonexistence of any fact testified to by him.

(j) His attitude toward the action in which he testifies or toward the giving of testimony.

(k) His admission of untruthfulness.

(Evid. Code, § 780.)

6. "It is well-settled that the trier of fact may accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke, Davis & Co.* (1973) 9 Cal.3d 51, 67 [citations omitted].) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at 67-68, quoting from *Nevarov v. Caldwell* (1958) 161 Cal.App.2d 762, 777.) Moreover, the trier of fact may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The testimony of "one credible witness may constitute substantial evidence." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

PERCIPIENT WITNESSES

7. Much of the percipient witness testimony merely provided background and context to the circumstances giving rise to the Accusation. However, an important and necessary threshold determination is whether respondent knew about the plans to amend Patient 1's trust when he issued the April 11, 2021 Letter. [redacted] testified that she and respondent were unaware of any dispute concerning the disposition of Patient

1's trust and home at the time of the April 11, 2021 Letter. Respondent also testified that he had no knowledge about [redacted]'s plan to amend Patient 1's trust. [redacted] believes [redacted] and respondent knew about it at the time respondent issued the April 11, 2021 Letter.

8. [redacted]'s testimony that she had no knowledge of [redacted]'s plan to amend Patient 1's trust lacks credibility. [redacted] facilitated the call between respondent and [redacted], which resulted in issuance of the April 11, 2021 Letter. Although [redacted] initially testified that she was not interested in the subsequent probate case and "stayed out of it," she later contradicted herself by becoming highly emotional while discussing it. She also admitted hosting a lunch during the probate case trial for [redacted] and aligned siblings. Thus, it appears that [redacted]'s involvement with [redacted]'s faction was substantially greater than she initially represented. Additionally, [redacted] conceded that she has a financial interest in the outcome of this case because license discipline could affect respondent's income and respondent has [redacted] towards her.

9. That [redacted] may have known about [redacted]'s plan to amend Patient 1's trust does not necessarily establish that respondent knew about that plan, as [redacted] suggested. Some evidence potentially supports such an inference. Respondent's failure to disclose his familial relationship with Patient 1 in the treatment records of his assessments and the April 11, 2021 Letter could be viewed as an attempt to disguise it from Attorney [redacted] and others. Additionally, respondent's testimony that he only learned about the dispute concerning Patient 1's trust at his June 10, 2024 Board investigation interview strains credulity given his deposition and testimony in the probate case long before that interview. Also, [redacted] and respondent were having [redacted] difficulties in the Spring of 2021. Thus, even though neither he nor [redacted] had a

financial interest in Patient 1's trust, respondent arguably had an emotional and [redacted] interest in supporting [redacted] to effectuate [redacted]'s plan.

10. Nevertheless, respondent's knowledge about [redacted]'s plan to amend Patient 1's trust was not established by clear and convincing evidence. Thus, for purposes of evaluating cause for discipline and any degree of discipline, it is assumed that respondent had no knowledge of [redacted]'s plan to amend Patient 1's trust when he issued the April 11, 2021 Letter.

EXPERT WITNESSES

11. As board-certified and experienced psychiatrists, Dr. Spencer, Dr. Nair, and respondent are all appropriately qualified to render expert opinions in this matter. They all correctly identified the legal definitions of the standard of care, negligence, and gross negligence. However, their opinions were not of equal quality.

12. Dr. Spencer's expert report and testimony were clear, logical, dispassionate, and professional. He briefly referenced the probate case but did not consider it in forming his opinions. He confirmed that he assumed that respondent had no financial interest in Patient 1's estate and no knowledge of [redacted]'s plan to amend Patient 1's trust when respondent issued the April 11, 2021 Letter. Thus, Dr. Spencer's opinions were given great weight.

13. By contrast, Dr. Nair's report includes significant discussion of the probate case, including unsolicited comments about the underlying events, [redacted]'s credibility, and the effectiveness of [redacted]'s attorney; critique of the Superior Court's Statement of Decision; and insinuations about Dr. Spencer's professionalism. Additionally, his testimony on cross-examination was defensive, unusually passionate, and argumentative. In sum, Dr. Nair's expert report and testimony are not what one

expects of a professional, dispassionate expert. They call into question his impartiality in evaluating this case. As such, Dr. Nair's opinions were given substantially reduced weight.

14. Respondent's opinion as an expert witness and consultation liaison psychiatrist was carefully considered. His testimony was calm, professional, and responsive to questions from all parties. However, respondent does have an obvious bias in providing expert testimony in his own case that must be taken into account. (Evid. Code, § 780, subd. (f).)

Cause for Discipline

APPLICABLE LAW

15. The Board may discipline a licensee for unprofessional conduct. (Bus. & Prof. Code, § 2234.) Unprofessional conduct includes gross negligence (Bus. & Prof. Code, § 2234, subd. (b)) and repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)).

16. California law defines "standard of care" as the use of that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances at or about the time of the incidents in question. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998.) Ordinary negligence involves a simple departure from the standard of care. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Gross negligence involves an extreme departure from the standard of care. (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 198.) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl, supra*, 189 Cal.App.3d at p. 1052.)

17. The applicable standard of care is commonly established through expert witness testimony. (*Flowers v. Torrance Memorial Hospital Medical Center*, supra, 8 Cal.4th at p. 1001.) The standard of care may be established by statute, rule, or regulation. (See *Wheeler v. State Board of Forestry* (1983) 144 Cal.App.3d 522, 526-528.) However, a licensee cannot be disciplined without evidence "of an ascertainable standard of conduct" by which his conduct is to be measured. (*Id.* at p. 527.)

ESTABLISHED DEPARTURES FROM THE STANDARD OF CARE

18. Dr. Spencer clearly and convincingly opined that respondent had an improper dual relationship with Patient 1 when he issued the April 11, 2021 Letter. The standard of care requires psychiatrists to avoid dual relationships unless there is a compelling clinical need, in which case care must be transferred to another psychiatrist once the compelling clinical need has ended. Although respondent had a compelling clinical need to assess Patient 1 on March 28, 2021 and April 4, 2021, there was no such need to issue the April 11, 2021 Letter. As Dr. Spencer observed, the April 11, 2021 Letter to an attorney is not a routine component of a physician-patient relationship, and respondent himself conceded that he did not issue it in response to an urgent medical need. Given respondent's dual relationship with Patient 1, the standard of care required respondent to refer Patient 1 to another psychiatrist to obtain such a letter. His failure to do so was an extreme departure from the standard of care.

Dr. Nair's contrary opinion is unpersuasive. He acknowledged that the standard of care permits psychiatrists to *treat* family members on a short-term basis as long as there is no financial or emotional interest. Issuing the April 11, 2021 Letter was not treatment, regardless of whether respondent lacked a financial or emotional interest or whether respondent believed he could be objective. Additionally, contrary to Dr. Nair's

representation, a physician issuing a "letter of competency" to an attorney is a far cry from issuing a letter excusing a relative from work for a brief period incidental to short-term treatment.

19. Dr. Spencer also clearly and convincingly opined that respondent committed a simple departure from the standard of care because his March 28, 2021, and April 4, 2021 assessments were incomplete and inadequate to support the April 11, 2021 Letter.

Dr. Spencer explained that the standard of care requires a psychiatrist to be familiar with the facts surrounding the patient's proposed decision before issuing a capacity determination as to that decision. Moreover, the standard of care requires a psychiatrist to discuss the specific type of decision with the patient and evaluate the patient's ability to manipulate information related to that decision. Here, respondent's treatment records of his March 28, 2021 and April 4, 2021 assessments do not reflect that he asked Patient 1 any specific questions about a will, trust, or estate plan nor that he evaluated her ability to manipulate information related to any decision concerning such matters. That is unsurprising because respondent was not focused on assessing Patient 1's testamentary capacity on March 28, 2021 or April 4, 2021.

The problem only arose when respondent chose to issue the April 11, 2021 Letter without inquiring about its purpose. The plain language of the April 11, 2021 Letter stated that it was a "letter of competency" and represented to an attorney that Patient 1 was able to make independent decisions regarding health care, finances, and legal matters. Regardless of respondent's subjective intent in issuing the April 11, 2021 Letter, a reasonable reader would infer from it that Patient 1 had the capacity to make changes to her trust and estate. Even Dr. Nair conceded as much. As such, the March

28, 2021 and April 4, 2021 assessments were incomplete and inadequate to support the April 11, 2021 Letter.

Respondent and Dr. Nair's post-hoc attempts to recast the April 11, 2021 Letter as merely a letter from a treating provider indicating that Patient 1 had basic decision-making capacity are unpersuasive. Additionally, that respondent specializes in consultation liaison psychiatry and has extensive experience in performing capacity assessments does not aid respondent. If anything, a psychiatrist with respondent's expertise should have recognized the risk in issuing a letter to an attorney, for an unknown purpose, with language that amounts to what can be aptly described as a "blank check" regarding a 90-year-old brain cancer patient's capacity. Finally, Dr. Nair's attempt to blame Attorney [redacted] is misguided. Regardless of any duties owed by Attorney [redacted], respondent had an independent duty as a psychiatrist to issue the April 11, 2021 Letter only upon complete and adequate supporting assessments.

20. Dr. Spencer further clearly and convincingly opined that respondent improperly failed to reevaluate Patient 1 before issuing the April 11, 2021 Letter. Dr. Spencer explained that the standard of care requires a psychiatrist to adequately and contemporaneously assess a patient's decision-making capacity before rendering an opinion. In this case, respondent last assessed Patient 1 on April 4, 2021 before issuing the April 11, 2021 Letter. Given her known diagnosis with brain tumors and documented fluctuating mental status between April 4, 2021 and April 11, 2021, a reasonable psychiatrist would have declined to issue such a letter without reviewing the patient's records and reexamining her. Dr. Spencer opined that respondent's failure to do so was an extreme departure from the standard of care.

Respondent and Dr. Nair argued that the April 11, 2021 Letter was not intended to reflect Patient 1's decision-making capacity as of April 11, 2021, but instead as of

April 4, 2021, the date respondent last assessed Patient 1. But that argument again attempts to recast the plain language of the April 11, 2021 Letter. It states that it is a "letter of competency" for Patient 1 and is dated April 11, 2021. To be sure, it references respondent's assessments on March 28, 2021 and April 4, 2021. However, a reasonable reader would interpret the letter of competency to be valid as of April 11, 2021, absent a disclaimer that the opinion is only accurate as of the date of last assessment. Even if that gap in time may be appropriate for patients in general, Dr. Spencer convincingly explained that it was inappropriate for a 90-year-old patient with brain tumors and fluctuating mental status.

Dr. Nair's attempt to discount other providers' documentation of Patient 1's fluctuating mental status is unpersuasive. He ultimately conceded that Patient 1's brain tumors could have caused her mental capacity to fluctuate and "there may have been times in April 2021 when [Patient 1] didn't have capacity." Admittedly, the record in this case does not permit a conclusion of whether Patient 1 did or did not have capacity on a particular day in April 2021. That is not the point. The point is that a reasonable psychiatrist would not have issued the April 11, 2021 Letter without reevaluating Patient 1 under the circumstances here.

21. In sum, complainant established two extreme departures and one simple departure from the standard of care by clear and convincing evidence. Based on the established departures, the specific causes for discipline are analyzed next.

GROSS NEGLIGENCE

22. As discussed above, complainant established by clear and convincing evidence that respondent committed two extreme departures from the standard of care when he issued the April 11, 2021 Letter. Thus, there is cause to discipline

respondent's license for gross negligence under Business and Professions Code section 2234, subdivision (b).

REPEATED NEGLIGENT ACTS

23. Business and Professions Code section 2234 defines repeated negligent acts as follows:

> To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(Bus. & Prof. Code, § 2234, subd. (c).)

24. Here, complainant established three departures from the standard of care, i.e., three instances of negligence, by clear and convincing evidence. However, they all derive from the same act—issuance of the April 11, 2021 Letter. Thus, there is

no cause to discipline respondent for repeated negligent acts under Business and Professions Code section 2234, subdivision (c).

GENERAL UNPROFESSIONAL CONDUCT

25. As discussed above, complainant established by clear and convincing evidence that respondent committed three departures from the standard of care. Such departures constitute general unprofessional conduct. Thus, there is cause to discipline respondent under Business and Professions Code section 2234.

Appropriate Discipline

26. The existence of cause for discipline does not end the required analysis. It is also necessary to determine the appropriate degree of discipline. The purpose of a civil administrative licensing proceeding is not to punish but to protect the public. (See *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

27. The Board has promulgated a Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines). For cases involving gross negligence and general unprofessional conduct, the Guidelines specify a minimum discipline of stayed license revocation with five years of probation (with recommended probation conditions) and a maximum discipline of license revocation. Departures from the Guidelines' specifications must be supported by appropriate circumstances articulated in the decision.

28. Respondent's misconduct in this case was serious. It involved multiple departures from the standard of care, including two extreme departures, and an elderly relative and patient with a terminal diagnosis. It resulted in a bitter family dispute and probate litigation. To respondent's credit, the evidence showed that

respondent initially attempted to help Patient 1 and her family by assessing her on March 28, 2021 and April 4, 2021. There was no evidence that respondent had a personal financial interest in Patient 1's estate. Additionally, clear and convincing evidence did not establish that he knew about [redacted]'s plan to amend Patient 1's trust. Nevertheless, his grossly negligent act of issuing the April 11, 2021 Letter facilitated the scheme and failed to protect a vulnerable patient.

29. Respondent's lack of insight and failure to accept full responsibility for his gross negligence are concerning. (See *Seide v. Com. of Bar Examiners of the State Bar of Cal.* (1989) 49 Cal.3d 933, 940 ["Fully acknowledging the wrongfulness of [one's] actions is an essential step towards rehabilitation"].) Although a highly intelligent and exceptionally qualified consultation liaison psychiatrist, and despite recently taking a medical ethics and professionalism course, respondent continues to believe that the April 11, 2021 Letter supported the best interests of Patient 1.

30. Given the foregoing, it would be inappropriate to consider a public reprimand. On the other hand, evidence also suggests that outright license revocation would also be unduly harsh. Respondent has a distinguished career involving 30 years as an attending psychiatrist, professor, researcher, author, and peer reviewer. He is one of 1,500 consultation liaison psychiatrists practicing in the United States and a leader in telepsychiatry. He has no history of license discipline, nor has he been the subject of any patient complaints or malpractice suits. Respondent also engages in significant volunteer work with professional organizations and societies, non-profit organizations, 12-step substance use recovery groups, and other self-help groups. The character witnesses and authors of the letters of support, all aware of the Accusation, laud respondent's intelligence, competence, professionalism, scholarship, compassion, generosity, hard work, honesty, and integrity.

31. When the record as a whole is considered, it is appropriate to impose the discipline recommended by complainant—a stayed license revocation with five years of probation, including conditions requiring respondent to complete a professionalism program (ethics course) and have a practice monitor. Because this case does not involve issues with clinical competence, prescribing practices, billing practices, or recordkeeping, it is unnecessary to impose conditions related to such matters. The imposed discipline is consistent with the Guidelines and necessary to protect public health, safety, and welfare.

Costs

32. If cause for discipline is established, the Board may recover its reasonable investigation and enforcement costs for the case. (Bus. & Prof. Code, § 125.3.) In support of any cost recovery request, the Board must provide declarations and supporting documents that contain specific and sufficient facts to support findings regarding the actual costs incurred and the reasonableness of the costs, including a description of the general tasks performed, the time spent on each task, and the method of calculating the costs. (Cal. Code Regs., tit. 1, § 1042, subd. (b).)

33. Here, complainant provided documentation of its actual investigation and prosecution costs that complies with California Code of Regulations, title 1, section 1042, subdivision (b). The documentation provides specific and sufficient facts to support findings regarding the actual costs incurred and the reasonableness of the costs. They include a description of the general tasks performed, the time spent on each task, and the method of calculating the costs. Although the task descriptions are somewhat generic, Ms. Peretto explained that this is due to software limitations and that all time is nonetheless billed accurately, contemporaneously, and to the generic description that best matches the task. She also persuasively explained why not every

entry in the billing log will necessarily correspond to an item in the investigation report.

34. An independent review of complainant's actual investigation costs ($13,034.50) and prosecution costs ($45,302) for a total amount of $58,336.50, reveals that the requested costs are reasonable given the complexity and numerous issues in the case. Thus, those costs are properly awardable.

35. Even when costs sought are reasonable, the California Supreme Court has set forth additional guidelines to determine whether the costs should be assessed or reduced in the particular circumstances of each case. (*Zuckerman v. State Bd. of Chiropractic Examiners* (2002) 29 Cal.4th 32.) These factors include whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of his position, whether the licensee has raised a colorable challenge to the proposed discipline, the licensee's financial ability to pay, and whether the scope of the investigation was appropriate to the alleged misconduct.

36. Here, the scope of the investigation was appropriate. Respondent was successful in getting one of the three causes for discipline dismissed, but raised no colorable challenge to the proposed discipline. Other than testifying that he is currently unemployed, he did not provide any concrete evidence regarding his financial ability to pay. Finally, under the circumstances of this case, some further cost reduction is also appropriate given respondent's success on the motion in limine to exclude evidence related to the probate case. Considering all the relevant *Zuckerman* factors, a cost recovery reduction to $35,000 is warranted.

ORDER

Physician's and Surgeon's Certificate No. G 75437 issued to respondent Donald Myron Hilty, M.D., is revoked pursuant to the First Cause for Discipline (Gross Negligence) and Third Cause for Discipline (General Unprofessional Conduct) in Accusation No. 800-2021-084404, separately and for both of them. However, the revocation is stayed and respondent placed on probation for five years on the following terms and conditions:

1. PROFESSIONALISM PROGRAM (ETHICS COURSE)

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

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

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

2. MONITORING – PRACTICE

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

3. NOTIFICATION

Within seven (7) days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

4. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES

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

5. OBEY ALL LAWS

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. QUARTERLY DECLARATIONS

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. GENERAL PROBATION REQUIREMENTS

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or a patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

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

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

8. INTERVIEW WITH THE BOARD OR ITS DESIGNEE

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

9. NON-PRACTICE WHILE ON PROBATION

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United

States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing, if imposed.

10. COMPLETION OF PROBATION

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. VIOLATION OF PROBATION

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. LICENSE SURRENDER

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. PROBATION MONITORING COSTS

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an

annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

14. COST RECOVERY

Respondent shall pay a total of $35,000 in reasonable investigation and prosecution costs to the Medical Board of California pursuant to Business and Professions Code section 125.3. Payment may be pursuant to a Board-approved payment plan. Failure to make timely payments will be considered a violation of probation.

DATE: January 6, 2026

Wim van Rooyen

WIM VAN ROOYEN
Administrative Law Judge
Office of Administrative Hearings