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

In the Matter of the Accusation Against: Willliam Jarrett Conard, M.D. Physician's & Surgeon's Certificate No G24791 Respondent	Case No. 800-2017-030623

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 3, 2021.

IT IS SO ORDERED February 1, 2021.

MEDICAL BOARD OF CALIFORNIA

By: Ronald H. Lewis, MD

Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
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Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 800-2017-030623
WILLIAM JARRETT CONARD, M.D. **24532 County Road 95** **Davis, CA 95616-9459**	OAH No. 2020030688
Physician's and Surgeon's Certificate No. G 24791	**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**
Respondent.	

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Megan R. O'Carroll, Deputy Attorney General.

2. Respondent William Jarrett Conard, M.D. (Respondent) is represented in this proceeding by attorney Stephen M. Boreman, whose address is: One Embarcadero Center, Ste 400 San Francisco, CA 94111.

3. On or about July 2, 1973, the Board issued Physician's and Surgeon's Certificate No. G 24791 to William Jarrett Conard, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-030623, and will expire on December 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-030623 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 16, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-030623 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-030623. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-030623, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2017-030623, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 24791 to disciplinary action.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

13. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

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

action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

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

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 24791 issued to Respondent William Jarrett Conard, M.D., shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code, section 2227, subdivision (a)(4). This public reprimand, which is issued in connection with Respondent's care and treatment of three patients as set forth in Accusation No. 800-2017-030623, is as follows:

"Between approximately 2013 and 2017, you failed to adequately document the medical records of three patients with timely and accurate information of their diagnoses, examinations, medications, and response to treatment as more fully described in Accusation No. 800-2017-030623."

B. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course. Failure to provide proof of successful completion of the course to the Board or its designee within twelve (12) months of the effective date of this Decision, unless the Board or its designee agrees in writing to an extension of that time, shall constitute general unprofessional conduct and may serve as the grounds for further disciplinary action.

ACCEPTANCE

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

DATED: 12 September 2020

WILLIAM JARRETT CONARD, M.D.
Respondent

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

DATED: Sept. 12, 2020

STEPHEN M. BOREMAN
Attorney for Respondent

ENDORSEMENT

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

DATED: 9/14/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

MEGAN R. O'CARROLL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-030623

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO
BY: Anna Logan January 16 2020
ANALYST

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

In the Matter of the Accusation Against: **William Jarrett Conard, M.D.** **3301 C Street, Bldg. 1000, Ste. 5** **Sacramento, California 95816-3300** **Physician's and Surgeon's Certificate No. G 24791,** Respondent.	Case No. 800-2017-030623 **A C C U S A T I O N**

PARTIES

1. Christine J. Lally, (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 2, 1973, the Medical Board issued Physician's and Surgeon's Certificate Number G 24791 to William Jarrett Conard, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein, and will expire on December 31, 2021, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct which would have warranted the denial of a certificate.
>
> (g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program

described in Section 2052.5.

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

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

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

7. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in his care and treatment of three patients. The circumstances are as follows:

8. Respondent is Board-certified in anesthesiology with a subspecialty in pain management. He operated a pain management practice in Sacramento California called Asclepius Pain Management.

Patient 1

9. Patient 1, (Patient 1's identity will be provided in discovery), was referred to Respondent's pain management practice by his primary care provider for treatment of chronic pain. Patient 1 had a left knee injury, as well as back and joint pain. During the first half of 2014, Respondent prescribed 150 mg of oxycodone per day to Respondent. Beginning in approximately May of 2014, Respondent reduced Patient 1's oxycodone to 120 mg per day. Patient 1 died of a drug overdose on or about March 27, 2016.

10. Respondent's medical records do not accurately and adequately represent the care Patient 1 received, or his status and progress. Many records of the visits are almost completely cut and pasted from previous visits, including typos. For example, the initial descriptions and assessments of the quality of the pain states: "He describes him pain as electrical..[sic]" This typographical error is continued in each new note for the next several months. From January of 2015 through July of 2015, the progress notes are very similar.

11. Many of the visit notes lack documentation of a musculoskeletal examination. There are also multiple instances when part of the medical record is not included, such as the diagnosis or impression. There are frequent discrepancies between the prescribed medications and the list of medications Patient 1 was actually taking. The notes often lack specific interval changes or updates as to Patient 1's status.

Patient 2

12. Patient 2, (Patient 2's identity will be provided in discovery), began seeing Respondent in approximately September of 2013 for treatment of chronic pain. She had chronic pain in her neck and lower extremities. She had undergone lumbar surgery and had a cervical fusion. She carried diagnoses of myasthenia gravis, hypercholesterolemia, hypothyroidism, and a cardiac disease, requiring a pacemaker. She was on methadone, 10 mg, three times per day, as well as MS Contin 30 mg, at bedtime. She also took Soma, Lyrica, and Xanax. Respondent's treatment plan included nutritional counseling and an increase in exercise, which allowed her to lose approximately 40 pounds. After losing the weight, but before her last office visit in September of 2014, Patient 2 was able to reduce her methadone by one pill per day.

13. In July of 2014, Respondent ordered a medial branch block, which provided pain relief. Patient 2 expressed a desire to repeat the procedure, but this was not done. Patient 2's medical records do not state why the medial branch block was not repeated.

14. Respondent's medical records do not accurately and adequately represent the care Patient 2 received, or her status and progress. Many of the visit notes are repeated with little to no change in information from month to month, as for example, between January 16, 2014 through February 2015. Many of the notes lack necessary information of treatment such as diagnosis or impression. Overall, the records of Patient 2 fail to show interval change of Patient 2's progress or change over the course of treatment.

Patient 3:

15. Patient 3, (Patient 3's identity will be provided in discovery), was referred to Respondent in 2001 or 2002. During her treatment with Respondent, he referred Patient 3 to a pain medicine specialist in the Bay Area who managed her medications and inserted an

intrathecal pump and a spinal cord stimulator. In approximately 2008, Patient 3 returned to Respondent's practice for further treatment. Patient 3's intrathecal pump medications were a complex combination that included Dilaudid and bupivacaine.

16. During Respondent's care of Patient 3 between January of 2014 and December of 2017, Patient 3 continued to receive Dilaudid and bupivacaine through the intrathecal pump. Respondent also prescribed an additional 4 milligrams of hydrocodone by mouth to Patient 3, as well as Soma, Elavil, temazepam and hydroxyzine. The records show a few gradual attempts to reduce the amount of Dilaudid.

17. Respondent's records of Patient 3 over the three years between 2015 and December of 2017 have no or minimal specific interval change or update as to Patient 3's status. For example, every monthly progress note from December of 2014 through December of 2017 contains the following sentences, verbatim: "She has both a spinal cord stimulator and an intrathecal pump. The pump is most helpful for the back pain. She has problems with coverage from the spinal cord stimulator that was implanted by Dr. P[.]...She believes that it has made her fall many times."

18. Respondent's records of Patient 3 do not contain the necessary elements of her medical care and progress. Where Respondent notes changes to Patient 3's treatment plan, there is little to no reference of how the change affected her in subsequent visit notes. For those cases where Patient 3 was seen by a Physician Assistant or other mid-level practitioner, Respondent is responsible for ensuring the adequacy of the medical records, which he failed to do.

19. Respondent was repeatedly negligent for his acts and omissions, including but not limited to, the following:

(a) failing to maintain adequate and accurate records for Patient 1;

(b) failing to maintain adequate and accurate records for Patient 2; and

(c) failing to maintain adequate and accurate records for Patient 3.

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SECOND CAUSE FOR DISCIPLINE

(Inadequate Medical Recordkeeping)

20. Respondent William Jarrett Conard, M.D. is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records for Patient 1, 2, and 3. Paragraphs 7 through 19, above, are incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 24791, issued to William Jarrett Conard, M.D.;

2. Revoking, suspending or denying approval of William Jarrett Conard, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering William Jarrett Conard, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JAN 1 0 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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