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

In the Matter of the First Amended Accusation Against: William Ross Dobkin, M.D. Physician's and Surgeon's Certificate No. G 42153 Respondent.	Case No.: 800-2018-045886

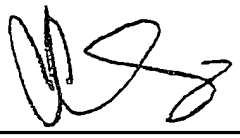
DECISION

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 September 16, 2022.

IT IS SO ORDERED: August 19, 2022.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the First Amended Accusation Against: **WILLIAM ROSS DOBKIN, M.D.** **3900 W. Coast Hwy., Ste. 300** **Newport Beach, CA 92663-4093** **Physician's and Surgeon's Certificate No. G 42153,** Respondent.	Case No. 800-2018-045886 OAH No. 2021090255 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. 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 Rob Bonta, Attorney General of the State of California, by Karolyn M. Westfall, Deputy Attorney General.

2. Respondent William Ross Dobkin, M.D. (Respondent) is represented in this proceeding by attorneys Dennis Ames, Esq., and Pogey Henderson, Esq., whose address is: La

Follette, Johnson, DeHaas, Fesler & Ames, 2677 North Main Street, Suite 901, Santa Ana, CA 92705-6632.

3. On or about June 26, 1980, the Board issued Physician's and Surgeon's Certificate No. G 42153 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2018-045886, and will expire on January 31, 2024, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2018-045886, which superseded the Accusation filed on May 26, 2021, was filed before the Board on February 22, 2022, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on February 22, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of First Amended Accusation No. 800-2018-045886 is attached hereto as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2018-045886. 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 First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent admits that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in First Amended Accusation No. 800-2018-045886, and agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. G 42153 to disciplinary action.

10. Respondent further agrees that if he ever petitions for modification or early termination of probation, or if an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2018-045886 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

11. 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.

CONTINGENCY

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

13. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 42153 issued to Respondent William Ross Dobkin, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years from the effective date of the Decision on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. 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.

3. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the 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. During probation, Respondent is prohibited from supervising physician assistants.

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. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $14,475.00 (fourteen thousand four hundred seventy-five dollars and zero cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs.

7. 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.

8. 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, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or 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.

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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.

9. 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.

10. 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..

11. 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.

12. 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.

13. 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 or her 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.

14. 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.

ACCEPTANCE

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

DATED: 3/8/2022

WILLIAM ROSS DOBKIN, M.D.
Respondent

I have read and fully discussed with Respondent William Ross Dobkin, 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: 3/8/2022 Pogey Henderson

DENNIS AMES, ESQ.
POGEY HENDERSON, ESQ.
Attorneys for Respondent

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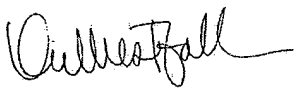
ENDORSEMENT

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

DATED: 3/8/22

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General



KAROLYN M. WESTFALL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2018-045886

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BEFORE THE
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STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **WILLIAM ROSS DOBKIN, M.D.** **3900 W. Coast Hwy., Ste. 300** **Newport Beach, CA 92663-4093** **Physician's and Surgeon's Certificate No. G 42153,** Respondent.	Case No. 800-2018-045886 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about June 26, 1980, the Board issued Physician's and Surgeon's Certificate No. G 42153 to William Ross Dobkin, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2024, unless renewed.

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JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation that was filed on May 26, 2021, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> ...

5. Section 2234 of the Code, states, in pertinent part:

> 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.

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(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.

...

COST RECOVERY

6. Section 125.3 of the Code states:

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

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

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

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

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

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

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

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

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. G 42153 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patient A,[1] as more particularly alleged hereinafter:

8. On or about May 5, 2015, Patient A, a then twenty-five year old male, presented to the emergency department at Hoag Memorial Hospital (Hoag ED) with complaints of numbness and tingling in both of his legs. A CT scan of Patient A's lumbar spine performed that day revealed no acute abnormality.

9. On or about May 23, 2015, Patient A presented to Hoag ED with complaints of urinary and fecal incontinence, and he was admitted to the hospital for presumed cauda equina syndrome.[2] An MRI of his cervical spine performed on or about May 24, 2015, revealed C2-C3 and C3-C4 moderate foraminal stenosis,[3] but was otherwise normal. An MRI of his thoracic

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[1] To protect the privacy of the patient involved, the patient's name has not been included in this pleading. Respondent is aware of the identity of the patient referred to herein.

[2] Cauda equina syndrome is a rare but serious condition that describes extreme pressure and swelling of the nerves at the end of the spinal cord, and disrupts motor and sensory function to the lower extremities and the bladder. It is a medical emergency that calls for urgent surgical intervention.

[3] Foraminal stenosis is the narrowing or tightening of the openings between the bones in the spine.

spine performed on or about May 24, 2015, revealed congenital stenosis[4] most notably at T11-T12. Patient A was treated with steroids and discharged from the hospital on or about May 25, 2015.

10. On or about May 28, 2015, Patient A presented to Hoag ED with complaints of intermittent urinary and stool incontinence, left lower extremity numbness, and difficulty standing, and he was admitted to the hospital. MRIs of Patient A's lumbar and thoracic spine performed on or about May 29, 2015, revealed mild stenosis and no new acute abnormality. On or about May 30, 2015, Patient A was evaluated by neurosurgeon, M.R., M.D. (Dr. M.R.). Due to Patient A's relatively mild stenosis, Dr. M.R. did not recommend a surgical intervention because he did not believe a decompression would help the patient's symptoms. Throughout his 48 hour hospitalization, the patient did not exhibit any incontinence of bowel or bladder and the patient was discharged from the hospital on or about May 30, 2015.

11. On or about June 8, 2015, Patient A presented to Hoag ED with complaints of back pain and continued intermittent incontinence, and he was admitted to the hospital. An MRI of Patient A's lumbar spine performed that day revealed stable diffuse congenital spinal stenosis. An MRI of his thoracic spine performed that day revealed stable congenital narrowing of the spinal canal with mild diffuse degenerative disc disease causing trace spinal stenosis. Respondent performed a neurosurgical evaluation of Patient A and determined the imaging showed "marked compression" of the thoracic spine at the thoracolumbar junction that was "not severe." Despite the results of the repeated imaging, Respondent diagnosed the patient with "fairly significant spinal stenosis," and recommended decompression and stabilization of the spine.

12. On or about June 9, 2015, an MRI of Patient A's cervical spine revealed stable moderate left C2-C3 and C3-C4 neural foraminal stenosis. On that same day, Patient A was evaluated by neurologist, D.B., M.D. (Dr. D.B.). Dr. D.B. determined that the patient's pain in

[4] Spinal stenosis occurs when the canal within the vertebrae, or spinal bones, narrow. This narrowing compresses the spinal canal, causing it to pinch on the spinal cord and nerve roots. It may result in pain, weakness, or numbness, often in the legs and feet. Spinal stenosis may be congenital or acquired. Congenital spinal stenosis is present from birth. It is usually the result of having a small spinal canal. Acquired spinal stenosis develops either as a result of age-related changes to the spine or as a symptom of another medical condition.

the mid-thoracic level may be related to disc herniation or stenosis at that level; however, he determined the imaging showed no clear cord compression, edema, or intrinsic lesion.

13. On or about June 13, 2015, Respondent performed a laminectomy,[5] medial fascetectomy,[6] and pedicle screw and rod arthrodesis on Patient A at T6-T8, and T10-T12.

14. On or about June 17, 2015, Patient A was discharged from the hospital.

15. On or about June 18, 2015, Patient A presented to Hoag ED with complaints of low back pain. A CT scan performed that day revealed congenital stenosis with no injury or fluid collection, and the patient was discharged home.

16. Between on or about June 23, 2015, and on or about August 20, 2105, Patient A presented to Respondent for multiple post-operative visits, during which Respondent determined the patient was relatively pain free and his urinary and bladder function had returned back to normal.

17. On or about November 22, 2015, Patient A presented to Hoag ED with complaints of pain and numbness of the bilateral legs. An MRI of Patient A's lumbar spine performed that day revealed a congenitally narrowed central canal from short pedicles[7] without significant disc herniation. An MRI of his thoracic spine performed that day revealed no central canal or significant neural foraminal narrowing, and the patient was discharged on or about November 23, 2015.

18. On or about December 3, 2015, Patient A presented to Respondent for a follow-up visit. Respondent noted Patient A had "fairly significant" congenital spinal stenosis and recommended a myelogram CT and EMG nerve conduction tests.

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[5] Laminectomy is a type of surgery in which the surgeon removes part or all of the vertebral bone (lamina) to ease pressure on the spinal cord or the nerve roots that may be caused by injury, herniated disk, narrowing of the canal (spinal stenosis), or tumors.

[6] Medial facetectomy is a spinal procedure that partially removes one or both of the facet joints on a set of vertebrae. The procedure intends to decompress the spinal nerves being pinched by degenerated facet joints.

[7] The pedicle is a stub of bone that connects the lamina to the vertebral body to form the vertebral arch. Two short, stout processes extend from the sides of the vertebral body and joins with broad flat plates of bone (laminae) to form a hollow archway that protects the spinal cord.

19. On or about December 7, 2015, a myelogram performed on Patient A revealed a small posterior disc protrusion at L5-S1, but no significant spinal stenosis or focal lumbar nerve root compression.

20. On or about December 8, 2015, Patient A presented to Respondent for a follow-up visit. At that time, Respondent determined that the source of the patient's symptoms was unclear.

21. On or about December 14, 2015, an EMG nerve conduction study performed on Patient A revealed a minimally abnormal study, with findings suggestive for very mild and chronic bilateral L4 radiculopathy. Patient A was evaluated by neurologist, K.S., M.D. (Dr. K.S.) that day, who determined that the source of his subjective symptoms may be pain-related.

22. On or about December 21, 2015, Patient A presented to Hoag ED with complaints of lower extremity pain and urinary incontinence, and he was admitted to the hospital. Respondent evaluated Patient A that day and determined the source of his symptoms was unclear.

23. On or about December 22, 2015, an MRI of Patient A's thoracic spine was performed that revealed no definite central stenosis or cord compression.

24. On or about December 23, 2015, an MRI of Patient A's cervical spine was performed that revealed an unremarkable cervical cord with minimal left neural foraminal narrowing at C2-C4.

25. On or about December 24, 2015, Patient A was discharged from the hospital.

26. On or about April 25, 2016, an EMG nerve conduction study was performed on Patient A that revealed an essentially normal study with no electrophysiologic evidence for compressive neuropathy or cervical radiculopathy in either upper extremity.

27. On or about May 27, 2016, Patient A presented to Hoag ED with complaints of bilateral leg pain and numbness, and twitching in his arms and legs, and he was admitted to the hospital. MRIs of Patient A's cervical and lumbar spine performed on or about May 27, 2016, revealed no acute findings, and the patient was discharged on or about May 29, 2016.

28. On or about May 30, 2016, Patient A presented to Hoag ED with complaints of numbness in his hands, and pain and weakness in his legs, and he was admitted to the hospital.

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29. On or about May 31, 2016, Respondent evaluated Patient A and determined that the source of his problems was unclear and recommended a neurology consultation.

30. On or about June 1, 2016, neurologist, A.L., M.D, (Dr. A.L.) evaluated Patient A and determined the patient had no gross pathology that correlated with the patient's symptoms. In addition, his neurologic exam demonstrated good strength testing in all muscles of the bilateral lower extremities with intact reflexes and proprioception without revealing any evidence of radiculopathy or peripheral neuropathy. Dr. A.L. recommended pain management, and Patient A was discharged on or about June 2, 2016.

31. On or about June 13, 2016, Patient A presented to Hoag ED with complaints of urinary incontinence and he was admitted to the hospital. MRIs of Patient A's lumbar and thoracic spine performed that day revealed no significant changes from prior imaging or evidence of acute abnormality, and the patient was discharged on or about June 17, 2016.

32. On or about June 28, 2016, Patient A presented to Hoag ED with complaints of low back pain and urinary incontinence, and he was admitted to the hospital.

33. On or about June 29, 2016, Patient A was evaluated by psychiatrist, P.D., M.D. (Dr. P.D.) who determined that a conversion disorder[8] shall remain a diagnosis of exclusion for this patient. On that same day, Respondent evaluated Patient A and determined he had "very severe congenital spinal stenosis." Because the patient's pain was primarily below the area of his prior fusion, Respondent recommended decompression and extension of the fusion down another couple levels.

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[8] Conversion disorder is a mental condition in which a person experiences physical symptoms of a health problem but has no injury or illness to explain them.

34. On or about July 2, 2016, Respondent performed an exploration of Patient A's prior fusion, removal of the T10-T12 instrumentation, a T12-L2 laminectomy, medial fascetectomy and foraminotomy,[9] and pedicle screw and rod instrumented arthrodesis at T10-L2 with a partial correction of kyphosis.[10]

35. On or about July 6, 2016, Patient A was discharged from the hospital.

36. Between on or about July 12, 2016, and on or about July 26, 2016, Patient A presented to Respondent for multiple post-operative visits, during which Respondent determined the patient was doing well and had almost returned to normal.

37. On or about October 6, 2016, Patient A presented to Hoag ED with complaints of back pain and bowel incontinence, and he was admitted to the hospital. MRIs of Patient A's lumbar and thoracic spine performed that day revealed mild congenital narrowing but no acute findings.

38. On or about October 7, 2016, a CT scan of Patient A's lumbar spine was performed that revealed no gross central stenosis at the T12-L1 levels and minor disc bulges were seen at L2-L3. The patient was discharged from the hospital that day.

39. On or about October 11, 2016, Patient A presented to Hoag ED with complaints of low back pain and urinary incontinence. A CT of the lumbar spine was performed that revealed no acute findings and the patient was discharged.

40. On or about October 14, 2016, Patient A presented to Hoag ED with complaints of low back pain, numbness, and urinary and bowel incontinence, and he was admitted to the hospital.

41. On or about October 15, 2016, an MRI of Patient A's lumbar spine was performed that revealed congenitally short pedicles and prominence of the posterior epidural fat causing mild stenosis within the lumbar spine, but no acute abnormality.

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[9] Foraminotomy is a decompression surgery involving the removal of bone and tissue obstructing the neuroforamen to release the pressure on the spinal nerve roots. In severe cases, the entire facet joint is removed which is referred to as lumbar facetectomy.

[10] Kyphosis is a spinal disorder in which an excessive outward curve of the spine results in an abnormal rounding of the upper back.

42. On or about October 17, 2016, Respondent diagnosed Patient A with "severe congenital spinal stenosis," and performed an exploration of the prior fusion, laminectomy at L1-L4, medial fascetectomy at L2-L4, bilateral foraminotomy at L1-L4, and posterior spinal fusion from T12-L4 using autograft and allograft.[11]

43. On or about October 22, 2016, Patient A was discharged from the hospital.

44. On or about November 15, 2016, Patient A presented to Respondent for a post-operative visit, during which Respondent determined the patient was much improved with no leg pain, limited back pain in the cervical spine, and occasional incontinence.

45. On or about November 16, 2016, an x-ray of Patient A's lumbar spine was performed that revealed anatomic alignment of the lumbar spine. An x-ray of his cervical spine also performed that day revealed mild bony neural foraminal narrowing in the upper cervical spine bilaterally, otherwise unremarkable.

46. On or about November 20, 2016, an MRI of Patient A's cervical spine was performed that revealed stable mild bilateral C3-C4 foraminal encroachment, but was otherwise unremarkable.

47. On or about November 29, 2016, Patient A presented to Respondent for a post-operative visit, during which Respondent determined the patient was "much better in his legs," and his occasional incontinence was much improved. Respondent further noted that the patient had been experiencing increasing weakness in his hands, the source of which was not clearly known to him.

48. On or about November 30, 2016, Patient A presented to Hoag ED with complaints of numbness and tingling in his hands, neck pain, and incontinence, and he was admitted to the hospital.

49. On or about December 1, 2016, Patient A was evaluated by Respondent, who determined the source of the patient's symptoms was unclear, and he recommended a neurology consultation. On that same day, Patient A was evaluated by neurologist, J.P., M.D. (Dr. J.P.). Dr.

[11] An autograft is a bone or tissue that is transferred from one spot to another on the patient's body. An allograft is a bone or tissue that is transplanted from one person to another. They typically come from a donor, or cadaver bone.

J.P. determined Patient A's MRI did not suggest syrinx or cervical cord involvement, and recommended an EMG nerve conduction study.

50. On or about December 4, 2016, despite the imaging results, Respondent diagnosed Patient A with congenital spinal stenosis and cervical myelopathy,[12] and performed a bilateral resection of ligamentum flavum at C2-C5, and fusion and laminoplasty utilizing titanium implants at C3-C4.

51. On or about December 6, 2016, Patient A was discharged from the hospital.

52. Between on or about December 15, 2016, and on or about January 10, 2017, Patient A presented to Respondent for multiple post-operative visits, during which he determined the patient was markedly improved in his upper extremity function with no more incontinence.

53. On or about February 15, 2017, Patient A presented to Hoag ED with complaints of pain and numbness in his neck and left arm. An x-ray of his cervical spine performed that day revealed stable postoperative fixation devices and no acute bony injury. An MRI of his cervical spine performed that day revealed diffuse narrowing of the central canal due to congenitally short pedicles, mild disc desiccation at C2-C4 with mild left disc osteophyte complex, and unconvertebral arthropathy, resulting in mild left-sided neural foraminal stenosis. The patient was treated for pain and discharged.

54. On or about February 25, 2017, Patient A presented to Hoag ED with complaints of upper back pain radiating down his left arm, and he was admitted to the hospital. Respondent evaluated Patient A that day and due to his ongoing symptoms in his left upper extremity, Respondent recommended surgical stabilization. Respondent did not order a CT scan of the cervical spine at that time to evaluate the hardware and fusion. On that same day, Respondent performed an anterior cervical discectomy, fusion, and foraminotomy at C3-C5 with cervical spine plating at C3-C5.

55. On or about February 27, 2017, Patient A was discharged from the hospital.

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[12] Myelopathy is an injury to the spinal cord due to severe compression that may result from trauma, congenital stenosis, degenerative disease or disc herniation.

56. On or about March 14, 2017, Patient A presented to Respondent for a post-operative visit, during which Respondent determined the patient was dramatically better and relatively symptom-free.

57. On or about May 3, 2017, Patient A presented to Hoag ED with complaints of a syncopal episode secondary to back pain and bilateral lower extremity numbness. An MRI of his lumbar spine performed that day revealed no definite canal stenosis and no significant abnormality. The patient was treated for pain and discharged.

58. On or about May 6, 2017, Patient A presented to Hoag ED with complaints of low back pain with numbness and tingling in the lower extremities and urinary incontinence, and he was admitted to the hospital. A CT scan of Patient A's lumbar spine performed that day revealed intact hardware, anatomic alignment, and no acute fracture.

59. On or about May 8, 2017, Respondent evaluated Patient A and determined that the source of his symptoms was unclear and recommended injections for pain. The patient was discharged on or about May 10, 2017.

60. On or about May 17, 2017, Patient A presented to Hoag ED with complaints of back pain and occasional urinary incontinence. The patient was admitted to the hospital for pain control, received a lumbar steroid injection, and was discharged on or about May 22, 2017.

61. On or about May 25, 2017, Patient A presented to Hoag ED with complaints of low back pain and he was admitted to the hospital.

62. On or about May 26, 2017, Respondent evaluated Patient A and determined that imaging of his spine and pelvis showed no acute fractures or new injuries, and no stenosis distally. Due to the patient's ongoing problems and pain, Respondent recommended the implantation of a dorsal column stimulator.[13] On that same day, Respondent performed a laminectomy on Patient A at T9-T10 and implantation of a dorsal column stimulator. Respondent did not perform a trial on Patient A prior to the procedure because he believed it to be

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[13] A spinal cord stimulator is an implanted device that sends low levels of electricity directly into the spinal cord to relieve pain.

unnecessary and too dangerous to utilize percutaneous leads in this patient due to his prior surgeries.

63. On or about May 27, 2017, Patient A was discharged from the hospital.

64. On or about May 29, 2017, Patient A presented to Hoag ED with complaints of abdominal pain, and he was admitted to the hospital. A CT scan of the patient's lumbar spine performed that day revealed no obvious intraspinal or spinal column abnormality. A CT scan of the patient's abdomen and pelvis performed that day revealed unremarkable findings.

65. On or about May 31, 2017, Respondent evaluated Patient A and recommended repositioning and reprogramming of the stimulator by the manufacturer. This was subsequently performed and the patient was discharged from the hospital on or about June 1, 2017.

66. On or about June 3, 2017, Patient A presented to Hoag ED with complaints of abdominal pain and he was admitted to the hospital. A CT scan of Patient A's thoracic spine performed that day revealed no acute bony abnormality and intraspinal stimulators with tip at the level of T8.

67. On or about June 4, 2017, Respondent evaluated Patient A and recommended exploration of the stimulator and possible decompression.

68. On or about June 5, 2017, Respondent performed an exploration of the dorsal column stimulator on Patient A. During the surgery, Respondent identified and removed a large postoperative hematoma in the thoracic spine and in the area of the pulse generator, which was removed and the spinal cord decompressed. Respondent removed and replaced the implantable pulse generator and the stimulator leads with thinner percutaneous leads.

69. On or about June 6, 2017, Patient A was discharged from the hospital.

70. On or about June 19, 2017, Patient A presented to Hoag ED with complaints of abdominal pain and he was admitted to the hospital. Respondent evaluated Patient A that day and because the stimulator was not providing the patient any relief and possibly causing untoward effects, Respondent recommended removal of the dorsal column stimulator.

71. On or about June 21, 2017, Respondent performed an exploration and removal of the dorsal column stimulator on Patient A. Respondent did not obtain any new imaging studies prior

to performing this procedure, but diagnosed the patient with myelopathy, probably secondary to compression of spinal cord from adjacent stimulator wires.

72. On or about June 22, 2017, Patient A was discharged from the hospital.

73. On or about June 27, 2017, Patient A presented to Respondent for a post-operative visit during which Respondent determined the patient was relatively asymptomatic and his previous severe sacral pain was gone.

74. On or about July 10, 2017, Patient A presented to Hoag ED with complaints of back pain. The patient was treated for pain and discharged.

75. On or about July 11, 2017, Patient A presented to Hoag ED with complaints of back pain radiating down his left leg, numbness, and abdominal pain. The patient was treated for pain and discharged.

76. On or about July 12, Patient A presented to Hoag ED with complaints of back pain and he was admitted to the hospital. The next day, CT scans of Patient A's cervical, thoracic, and lumbar spine were performed that revealed no acute abnormality. MRIs of Patient A's lumbar and cervical spine were also performed and revealed no acute abnormality and no significant stenosis. The patient was discharged on or about July 14, 2017.

77. On or about July 27, 2017, Patient A presented to Respondent for a follow-up visit with complaints of continued severe pain in the lumbrosacral spine. Respondent determined there were no signs of instrumentation failure or malposition, but suggested that the fusion may be exerting stress on the caudal spine and recommended facet injections at L4-S1.

78. On or about July 29, 2017, Patient A presented to Hoag ED with complaints of back pain. The patient was provided L4-5 facet joint injection and discharged.

79. On or about July 31, 2017, Patient A presented to Hoag ED with complaints of back pain. The patient was treated for pain, placed on a pain contract, and discharged.

80. On or about August 9, 2017, Patient A presented to Hoag ED with complaints of bilateral lower extremity weakness, numbness, and tingling. The patient had no physical exam findings concerning for acute spinal cord process and was discharged.

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81. On or about August 11, 2017, Patient A presented to Hoag ED with complaints of bilateral leg numbness and urinary incontinence, and he was admitted to the hospital.

82. On or about August 12, 2017, an MRI of Patient A's lumbar spine was performed that revealed no gross abnormality.

83. Sometime between on or about August 11, 2017, and on or about August 14, 2017,[14] Respondent evaluated Patient A. Respondent noted that facet injections had only provided the patient with temporary relief. Respondent did not order or obtain any new CT scans, but determined that the patient's symptoms may be a result of some areas of nonunion and loosening instrumentation coupled with hypermobility at the areas adjacent to his fusion. Despite his prior surgeries failing to provide Patient A with any long term improvement, Respondent recommended surgical exploration, further decompression, and stabilization.

84. On or about August 14, 2017, Respondent performed an exploration of the previous fusion on Patient A, removal of unincorporated bone and scar from T8-L4, removal of pedicle screws from T8-L4, bilateral L4-S1 laminotomy, medial facetectomy, and foraminotomy, placement of pedicle screws at T6-pelvis, and posterior spinal fusion of T6-pelvis utilizing autograft and allograft. The operative report did not describe a finding of pseudoarthroses or loosened hardware during the procedure.

85. On or about August 17, 2017, Patient A was discharged from the hospital.

86. On or about August 31, 2017, Patient A presented to Respondent for a post-operative visit during which Respondent determined the patient was pain-free for the first time. However, due to Patient A's body habitus and osteoporosis, Respondent recommended an anterior fusion to increase his chance of healing.

87. On or about September 6, 2017, Patient A presented to Hoag ED with complaints of leg weakness and he was admitted to the hospital. An MRI of Patient A's lumbar spine performed that day that revealed large amounts of postsurgical fluid posterior to the lumbar spine.

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[14] Respondent completed a consultation note for this visit that indicates his evaluation occurred on August 15, 2017, which is not possible based upon a surgical date of August 14, 2017.

The fluid was aspirated, the patient was prescribed IV antibiotics, and he was discharged on or about September 10, 2017.

88. On or about September 13, 2017, Patient A presented to Hoag ED with complaints of hip pain and he was admitted to the hospital. An MRI of Patient A's lumbar spine performed that day revealed stable large posterior paraspinal fluid collection within the laminectomy bed from T12-L5. The fluid was aspirated and subsequently tested positive for mycobacteria.

89. On or about September 23, 2017, Respondent performed an exploration, irrigation, and debridement of unincorporated bone graft at T12-sacrum on Patient A, and found no evidence of acute infection. Patient A was discharged from the hospital on or about September 27, 2017.

90. On or about October 5, 2017, Patient A presented to Hoag ED with complaints of intermittent fevers and possible infection, and he was admitted to the hospital. MRIs of Patient A's lumbar spine, cervical spine, and thoracic spine were performed and revealed no acute changes other than postsurgical fluid collection. Patient A was prescribed antibiotics and was discharged from the hospital on or about October 8, 2017.

91. On or about October 10, 2017, Patient A presented to the emergency department at St. Jude Hospital (St. Jude ED) with complaints of back pain. Imaging studies taken that day revealed no acute pathology and no fluid collection, and he was discharged.

92. On or about October 14, 2017, Patient A presented to Hoag ED with complaints of hip and back pain. The patient was treated for pain and discharged.

93. On or about October 17, 2017, Patient A presented to Respondent for a follow-up visit with continued complaints of severe pain mostly in the buttock region. Respondent reviewed the patient's CT scans from St. Jude ED and determined there was no clear evidence of loosening of the screws in the pelvis, but determined the screws may be a cause for his problems. Respondent recommended hardware injections for his pain, which were performed on or about October 21, 2017.

94. On or about October 24, 2017, Patient A presented to Respondent for a follow-up visit with complaints of continued severe pain over the screws in his ileum and urinary

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incontinence. Respondent noted the absence of stenosis and normal L5-S1 disc and recommended removal of the L5-pelvic hardware.

95. On or about October 31, 2017, Patient A presented to Hoag ED with complaints of lumbar pain and he was admitted to the hospital.

96. On or about November 1, 2017, Respondent performed an exploration of the previous lumbosacral pelvic fusion, removal of the pelvic hardware, placement of pedicle screws at S1, and instrumented arthrodesis at L3-S1. During the procedure, Respondent noted the screws in the ileum were "extremely loose."

97. On or about November 3, 2017, Patient A was discharged from the hospital.

98. On or about November 14, 2017, Patient A presented to Respondent for a post-operative visit, during which Respondent determined the patient was doing well. Due to Patient A's osteoporosis and high risk for failure, Respondent recommended an expeditious anterior interbody fusion at least in the patient's lower three segments of the spine.

99. On or about November 28, 2017, Patient A presented to Hoag ED for admission for surgery by Respondent. Respondent evaluated Patient A that day and due to the patient's osteoporosis and likelihood of failure in the lower spine, he determined it was "mandatory" to perform an anterior column support and interbody fusion.

100. On or about November 29, 2017, Respondent performed an L3-S1 anterior lumbar interbody instrumented arthrodesis on Patient A.

101. On or about November 30, 2017, Patient A was discharged from the hospital.

102. Between on or about December 12, 2017, and on or about February 6, 2018, Patient A presented to Respondent for multiple post-operative visits, during which Respondent found the patient had good stability, improved bladder function, and was almost pain-free.

103. On or about March 19, 2018, Patient A presented to Hoag ED with complaints of back pain and lower extremity weakness. MRIs of Patient A's cervical, lumbar, and thoracic spine performed that day revealed no acute abnormality or fluid collection. The patient was treated for pain and discharged.

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104. On or about May 9, 2018, Patient A presented to Hoag ED with complaints of back pain and was admitted to the hospital. An MRI of Patient A's lumbar spine performed that day revealed nonspecific posterior paraspinal fluid collection at L4-L5. The fluid was aspirated and the patient was discharged on or about May 11, 2018.

105. On or about May 14, 2018, Patient A presented to Hoag ED with complaints of back pain. MRIs of Patient A's thoracic and lumbar spine revealed no significant stenosis and a decrease in fluid collection, and the patient was discharged on or about May 15, 2018.

106. On or about May 16, 2018, Patient A presented to Hoag ED with complaints of upper back pain and he was admitted to the hospital.

107. On or about May 17, 2018, Respondent evaluated Patient A. Respondent did not order or obtain any new CT scans, but determined the patient's symptoms may be a result of loosening instrumentation or hernia. Despite his prior surgeries failing to provide Patient A with long term improvement, Respondent recommended surgical exploration, and possible extension of the fusion.

108. On or about May 18, 2018, Respondent performed an exploration of the thoracolumbar fusion on Patient A, removal of the T4-T8 hardware on the left and the T4-T6 hardware on the right, debridement of unincorporated bone scar from T4-L2, and instrumented arthrodesis on the left and right at T3-T10. During the procedure, Respondent noted the screws proximally were found to be "quite loosened."

109. On or about May 22, 2018, Patient A was discharged from the hospital.

110. Between on or about May 26, 2018, and on or about June 21, 2018, Patient A presented to Hoag ED approximately eight (8) times and to St. Jude ED one (1) time with various complaints, including but not limited to, left-sided chest heaviness, tingling and numbness in his arms, numbness in his legs, back pain, neck pain, headache, nausea, and urinary and bowel incontinence.

111. On or about June 24, 2018, Patient A presented to Hoag ED with complaints of back pain, nausea, leg weakness and urinary incontinence, and he was admitted to the hospital. An MRI of Patient A's thoracic and lumbar spine performed that day revealed no significant stenosis

or intraspinal mass or fluid. Respondent evaluated Patient A that day and determined there was no clear etiology for his symptoms and recommended a myelogram. A myelogram performed that day revealed unremarkable results with no evidence of significant stenosis.

112. On or about June 25, 2018, Patient A was evaluated by psychiatrist, Dr. P.D., who determined that conversion disorder was a diagnosis of exclusion for this patient, and if all neurological workup has been exhausted and there was no objective evidence to indicate an organic cause of his current deficits, further procedures should be avoided.

113. On or about June 28, 2018, Patient A was evaluated by pain management physician assistant, M.S., P.A. (M.S.). M.S. determined Patient A may benefit from a narcotic intrathecal pump, and recommended a trial before permanent implantation of a pump.

114. On or about June 29, 2018, Respondent performed a microsurgical implantation of an intrathecal pump on Patient A. Respondent did not perform a trial of the pump prior to implantation. During this procedure, Respondent dissected down to the dura and removed heavy scar and epidural fibrosis in the region. The pump was set with Dilaudid[15] 1 mg per day, and was to be managed by Patient A's pain management physician, C.C, M.D. (Dr. C.C.).

115. On or about June 30, 2018, Patient A was discharged from the hospital.

116. On or about July 5, 2018, Dr. C.C. reprogrammed Patient A's pump to .48 mg of Dilaudid per day due to the patient's complaints of nausea.

117. On or about July 6, 2018, Dr. C.C. refilled and reprogrammed Patient A's pump with morphine .8 mg per day due to the patient's complaints of continued nausea.

118. On or about July 13, 2018, Patient A presented to Hoag ED with complaints of nausea, headache, and pain around the incision site of the intrathecal pump, and he was admitted to the hospital. A CT scan of Patient A's abdomen and pelvis performed that day revealed no acute findings. Respondent evaluated Patient A and suspected a cerebrospinal fluid (CSF) leak. Respondent did not order a trial of bedrest with flat head-of-bed posture, but recommended exploration of the system. On that same day, Respondent performed an exploration and widening

[15] Dilaudid (brand name for hydromorphone), is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

of the laminectomy on Patient A and further closure of the dura with use of TachoSil and Duraseal. During the procedure, Respondent identified some CSF leaking proximally. After the surgery, Respondent did not order an appropriate period of post-operative bedrest with flat head-of-bed posture.

119. On or about July 15, 2018, Patient A was discharged from the hospital.

120. On or about July 17, 2018, Patient A presented to Hoag ED with complaints of dizziness, nausea, and abdominal pain, and he was admitted to the hospital. A myelogram performed on Patient A on or about July 20, 2018, revealed no obvious extravasation of contrast, and the patient was discharged on or about July 21, 2018.

121. On or about July 25, 2018, Patient A presented to Hoag ED with complaints of dizziness and abdominal pain, and he was admitted to the hospital. Patient A's pain pump settings were decreased to the lowest settings and the patient was discharged on or about July 26, 2018.

122. On or about July 27, 2018, Patient A presented to St. Jude ED unresponsive, febrile, tachycardic, and bradypneic. Patient A was treated for morphine overdose with Narcan and was discharged on or about July 28, 2018. Labs taken prior to Patient A's discharge subsequently revealed a positive result for bacteremia with streptococcus. Patient A was then readmitted to St. Jude on or about July 29, 2018, treated for the infection, and discharged on or about August 1, 2018.

123. On or about August 9, 2018, Patient A presented to Respondent with complaints of continued headache and requested removal of the pain pump.

124. On or about August 11, 2018, Respondent performed a lumbar laminectomy on Patient A, removed a tumor, widened the laminectomy, repaired the dura, and removed the pain pump.

125. Between on or about August 16, 2018, and on or about September 23, 2018, Patient A presented to Hoag ED approximately thirteen (13) times with various complaints, including but not limited to, abdominal pain, fever, urinary incontinence, back pain, numbness in his back,

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numbness in his hands, headache, right leg weakness, heaviness in his chest, bilateral upper extremity weakness, and neck pain.

126. On or about September 20, 2018, MRIs of Patient A's cervical and thoracic spine were performed that revealed no significant stenosis and no evidence of an acute abnormality.

127. On or about October 2, 2018, Patient A presented to Respondent for a follow-up with complaints of neck pain, discoloration and weakness of his hands, and incontinence. Respondent noted that the source of Patient A's problems was unclear, informed him that he believed no further surgery was indicated, and recommended he obtain another neurosurgical opinion.

128. On or about March 6, 2019, as a result of chronic pain related to his hardware, neurosurgeon M.O., M.D., removed Patient A's instrumentation from T3-L2.

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

A. Performing an instrumented arthrodesis on Patient A on or about June 13, 2015, without indication;

B. Repeatedly performing therapeutic interventions on Patient A based upon suspected but unproven diagnoses; and

C. Failing to perform standard diagnostic testing on Patient A prior to implanting a spinal cord stimulator on or about May 26, 2017, and an intrathecal pump on or about June 29, 2018.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

130. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 42153 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged hereinafter:

A. Paragraphs 7 through 129 (C), above, are hereby incorporated by reference and realleged as if fully set forth herein;

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B. Failing to order a trial of bedrest with flat head-of-bed posture prior to performing a surgical exploration and repair of possible CSF leak on or about July 13, 2018.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 42153, issued to Respondent, William Ross Dobkin, M.D.;

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

3. Ordering Respondent, William Ross Dobkin, M.D., to pay the Board the costs of the investigation and enforcement of this case, and 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: FEB 22 2022

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

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