

BEFORE THE
OSTEOPATHIC MEDICAL BOARD
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

DAVID STEENBLOCK, D.O.,

Osteopathic Physician and Surgeon License
No. 20A4160,

Respondent.

Case No. 00-2005-001536

OAH No. 2008030140

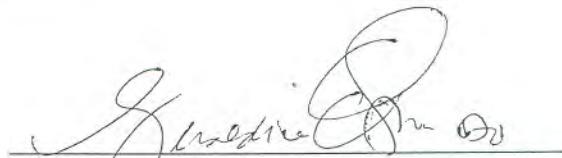
DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by
the Osteopathic Medical Board as its Decision in the above-entitled matter.

This Decision shall become effective September 25, 2009.

IT IS SO ORDERED.

Date: August 13, 2009



Geraldine O'Shea, D.O., President
Osteopathic Medical Board of California

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PROPOSED DECISION

Donald P. Cole, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on June 11, 12, 15, and 16, 2009, in San Diego, California.

Heidi R. Weisbaum, Deputy Attorney General, Department of Justice, State of California, represented complainant Donald J. Krpan, D.O., Executive Director, Osteopathic Medical Board of California, Department of Consumer Affairs, State of California.

Carlos F. Negrete, Attorney at Law, represented respondent David Steenblock, D.O., who was present throughout the hearing.

The matter was submitted on June 30, 2009.¹

FACTUAL FINDINGS

Jurisdictional Matters

1. On August 3, 1977, the Osteopathic Medical Board of California (the board) issued Osteopathic Physician and Surgeon License No. 20A4160 to respondent. The license is current and in active status, with an expiration date of January 31, 2011.

2. On January 30, 2008, complainant signed the accusation in his official capacity. On the same day, the accusation and other required jurisdictional documents were

¹ See footnote to Finding 3.

served on respondent. On or about February 14, 2008, respondent filed an amended notice of defense. On February 5, 2009, complainant served on respondent a notice of hearing.

3. On June 11, 2009, the record was opened and jurisdictional documents were received. On June 11, 12, 15, and 16, 2009, sworn testimony was given and documentary evidence was introduced. On June 16, 2009, closing argument was presented. On June 30, 2009, the matter was submitted.²

Introductory Matters

4. The accusation alleged gross negligence, repeated negligent acts, acts of clearly excessive prescribing and treatment, and a failure to maintain adequate records, all in connection with respondent's provision of hyperbaric oxygen and physical therapy treatment to stroke patient C.A.³

The accusation also alleged that respondent engaged in an act involving dishonesty, that he improperly held himself out as board certified, and that he disseminated a public communication containing a false, misleading, or deceptive statement, all in connection with a representation on his two websites that he was "board certified" by two particular entities.

Finally, the accusation alleged, as a "discipline consideration," that respondent's license had been previously disciplined in 1994 for failing adequately to document his examination and treatment of two patients.

5. C.A. suffered a stroke in July 2003. He first sought care with respondent in November 2004. C.A. was 77 years old at the time.

6. Hyperbaric oxygen therapy (HBO) is a process by which pure oxygen is administered to a patient under pressure, while the patient sits in a special chamber constructed for that purpose. The goal is to achieve a relatively high blood oxygen level in the patient's tissues. HBO has not reached "mainstream medicine," but has been found effective in wound management care and other areas. HBO has been used with stroke patients, though there is a difference of opinion as to its effectiveness in that context. The efficacy of HBO in the treatment of stroke victims is not at issue in this case.

7. Respondent treated C.A. in his capacity as Director of The Brain Therapeutics Medical Clinic in Mission Viejo, California, which he owns and operates.

² The record was left open at the conclusion of the hearing to permit the parties an opportunity to proffer excerpts from the transcript of the board's June 13, 2007, interview of respondent. The parties were given until June 30, 2009, to proffer such excerpts. On that date, the Office of Administrative Hearings received complainant's excerpts, which were marked and received as Exhibit 25. Respondent did not proffer any excerpts. Accordingly, on June 30, 2009, the record was closed and the matter deemed submitted.

³ Respondent provided two other forms of treatment to C.A., intravenous therapy and testosterone injections. No substantive allegations were made with regard to these latter modalities.

C.A. received his first HBO and physical therapy treatments from respondent's clinic on November 26, 2004. HBO treatment continued until about March 25, 2005, and physical therapy until about May 5, 2005. During these periods, C.A. underwent a total of about 87 HBO and about 84 physical therapy treatment sessions. The treatments were provided at respondent's clinic by an affiliated HBO technician and physical therapist.

Respondent's Medical Records⁴

8. Respondent's records for November 23, 2004, included what appears to be a patient history and physician orders for HBO, for 60 days, and physical therapy, for two months. The records for this date did not include a physical exam, a treatment plan, or an impression (i.e., a diagnosis).

9. Respondent's records for November 25, 2004, included a lengthy health appraisal questionnaire, and an additional form relating to the presenting medical condition, which was filled out by C.A.

10. Respondent's records for November 30, 2004, reflected that a physical examination was performed and a patient history taken on that date. The only reference in the physical exam notes relating to C.A.'s impairment is an entry stating, "L[eft] sided paralysis." Another document prepared on the same date, a "problems" sheet, identified various health problems of C.A. The records for this date did not include a treatment plan or an impression.

11. Respondent's records for December 29, 2004, stated, "good progress [with] walking – has acne & flashing – secondary to increased testosterone. Urination is OK. Sleeping OK. Has automove."⁵ Physician orders for that day included, "Add 1 more month of physical therapy. HBO, daily X 1 more month. HBO 1 ¾ atmospheres X 1.5 hours X 30." These orders thus represented (at most)⁶ an additional 30 days of HBO prescribed by respondent.

12. Respondent's records for January 18, 2005, stated, "some increased water retention secondary to testosterone. Rx dyazide twice daily X2 [for two days], then daily for 30 [days]."

13. Respondent's records for March 4 and 7, 2005, referred to C.A.'s swollen ankles, his failure to take complete dose of a diuretic, and the resolution of that problem. There is also a note, "Will check pt when he gets out of HBO" and a further note that appears to confirm the absence of any edema.

⁴ Physical Therapy and HBO progress notes and logs are described separately, below.

⁵ Automove refers to an electrical stimulation device.

⁶ The records were ambiguous: They could be construed as prescribing 30 additional days beyond December 29, 2004, or, instead, 30 additional days beyond the 60 days initially prescribed on November 23, 2004.

14. Respondent's records for March 22, 2005, contained information on C.A.'s pulse, an outbreak of acne, coated tongue, a fungal infection, and the notation, "No problem now with right hip." On the same date, there is a notation, "PT 2x/week."

HBO Treatment Log for C.A.

15. A log covering the entire course of C.A.'s HBO treatments included notations on each treatment date that C.A. did not have sinus or flu problems. The log otherwise contained no information concerning C.A.'s progress during or reaction to treatment.

Physical Therapy Progress Plan Records for C.A.

16. An "updated plan of progress for outpatient rehabilitation" (progress plan) prepared by C.A.'s physical therapist, dated November 26 to 30, 2004, provided an initial impression of C.A., which referenced right shoulder pain, the need for moderate to maximum assist with most functional tasks, performed with significant use of compensation/substituted movement, balance and safety concerns secondary to anxiety, and reliance on others for the activities of daily living. Physical therapy goals, including the reduction of impairments and achieving improvements in the ability to achieve tasks, and reduced dependency on others, were referenced. This document had a stamped signature of respondent.⁷

The progress plan for December 2004 provided an update, and stated that C.A. had yet to achieve "all/any" of the predicted treatment outcomes, but that progress had been made in reducing impairments in certain respects. It was also noted that functional levels lacked consistency and the ability to generalize outside the clinical setting.

The progress plan for January 2005 stated that C.A. had made "significant progress achieving" short term goals, "but has yet to achieve any of the predicted therapy outcomes." Progress was noted in reducing impairments and in movement strategies and functional activities, but quality of performance were said to lack efficiency and safety. C.A. was reported to be able to perform certain specified functional tasks with minimum or moderate assistance.

The progress plan for February 2005 stated that C.A. "has yet to achieve any predicted treatment outcomes. All initial short term goals have been achieved at minimum assist but lack consistency at times moderate assist and frequent loss of balance."

The progress plan for March 2005 stated that C.A. "has yet to achieve any predicted therapy outcomes. Client has progressed to a consistent minimum assist with occasional [illegible] assist during functional tasks." Loss of balance was again noted. The progress plan for April 2005 again stated that C.A. "has yet to achieve any predicted therapy outcomes," though some progress was noted.

⁷ Respondent testified that he did not recall whether he reviewed this or other physical therapy notes before they were stamped.

Respondent's Websites and Board Certification

17. Respondent was certified with the American Board of Family Medicine from 1977 to 1984. He is not currently certified with that board.

18. Respondent maintains two professional websites: Strokedoctor.com and stemcelltherapies.org. On January 29, 2009, respondent's strokedoctor.com website included the following representation:

Certification: American Board of Family Practice
Board Certified, August 1977
American Board of Chelation Therapy
Board Certified, 1990

At some point before June 14, 2009, references to these certifications were deleted from the website. The record did not reflect the date on which this occurred.

For an unknown period of time up to and including June 11, 2009, the first day of the hearing in this matter, the stemcelltherapies website contained the same certification information.

19. The American Board of Chelation Therapy was established in 1982. The name was later changed to the American Board of Clinical Metal Toxicology (ABCMT). Respondent is not currently a member of the ABCMT, and had not been a member for at least the past five years.

20. Neither the "American Board of Chelation Therapy" nor the "American Board of Clinical Metal Toxicology" is or has ever been a member board of the American Board of Medical Specialties.

Testimony of Jerome Stenehjem

21. Jerome Stenehjem, M.D., complainant's expert witness, received his medical degree from the University of Utah in 1982. He completed his internship from that institution in 1983, and his residency in physical medicine and rehabilitation from that institution's Medical Center in 1986. In 1985, he became licensed to practice in California, and, in 1988, he became board certified in physical medicine and rehabilitation.

Since 1986, Dr. Stenehjem has maintained a private practice in physical medicine and rehabilitation in San Diego. Since 1989, Dr. Stenehjem has served as Medical Director of Rehabilitation Services, Sharp Memorial Hospital, San Diego. He serves on the utilization review committee (since 1996), the medicine supervisory committee (since 2006), and the complimentary and integrative medicine committee (since 2002), among others. He currently spends about one-third of his time in direct patient care, one-third of his time in administrative work, and one-third of his time in connection with his research interests and forensic work.

Dr. Stenehjem does not currently hold any academic appointments. From 1989 to 2003, he served as clinical instructor, University of California, San Diego, School of Medicine Division of Neurosurgery. Stroke cases were among those in which he was involved in a teaching capacity. He has co-authored several published articles and given numerous oral presentations.

22. Dr. Stenehjem has had significant work-related exposure or contact with osteopathic physicians. For example, Sharp has several such physicians with privileges at its rehabilitation center. Some osteopaths have served on the Sharp rehabilitation committee. Dr. Stenehjem testified that he has found osteopaths to be competent and particularly good in the rehabilitation area.

Dr. Stenehjem has referred about four patients for HBO, and he has prescribed other alternative/complimentary therapies as well. He does not believe HBO is necessarily helpful to treat patients who have had a stroke, though it may have therapeutic value in (other) brain injury cases. He does not himself provide HBO in his own practice (e.g., he does not have an HBO chamber), and he has had no training with regard to HBO therapy. For his own patients for whom he has prescribed HBO, the therapy has lasted for about three to four months, at three to four times per week. In at least two of the four instances, he felt that the HBO helped the patient make progress.

Dr. Stenehjem did not seem to have a bias against osteopaths, against HBO, or against alternative therapies in general. While cautious as to the extent of the usefulness of alternative therapies, he seemed quite open and willing to consider their use in circumstances he considered appropriate.

23. Dr. Stenehjem sees stroke patients "many times a week." They comprise about 20 percent of his practice. He frequently orders physical therapy for his stroke patients.⁸ Physical therapy for stroke patients typically involves three stages: (i) Immediately after the stroke, and once the patient is medically stable, inpatient physical therapy may be provided twice per day, for about a month; (ii) when the patient is moved to outpatient status, physical therapy continues at about three times per week, for several months; (iii) the patient is then moved out of formal therapy into an exercise program with a community-based resource.

24. Dr. Stenehjem testified that he charts each formal encounter⁹ with a patient. He creates a chart note, and provides the date, patient name, statements by the patient, subjective comments, the patient's objective presentation, the diagnosis and any change in the diagnosis, and the change or lack of change of treatment.

⁸ He initiates new physical therapy prescriptions about twice per week; he always has multiple patients in physical therapy at any given time.

⁹ Dr. Stenehjem defined a "formal encounter" as essentially a face-to-face meeting with a patient in the context of a formal office visit.

25. Dr. Stenehjem testified that the standard of care for charting is the same for allopaths as for osteopaths. He testified that there is a “universally held belief” among medical practitioners (i.e., both allopaths and osteopaths) that the treatment prescribed and rendered by a physician can be monitored and outcomes measured, and that these matters are used as a basis for ongoing care and treatment. He noted that in his own hospital, the standard for recordkeeping is the same for both kinds of practitioners. These are generalized rules for recordkeeping that apply to all practitioners in all specialties.

26. Dr. Stenehjem testified that excessive treatment is treatment that is rendered either without an expected or measured benefit, or that goes beyond the point where there is evidence of continued benefit to the patient. Excessive treatment is determined by a review of the patient’s chart. The chart should document the expected outcome of the treatment before the treatment is rendered, the monitoring of that expected outcome during treatment, and any change in the desired outcome. Further, if a form of treatment is provided over a period of several months and significant functional improvement has not been observed, the treatment should be stopped. In other words, the issue for Dr. Stenehjem is not primarily how many times a mode of treatment is provided, or for how long a period of time, but instead whether there is measurable progress in terms of a patient’s functional improvement. Benchmarks of functional improvement that can be measured include, for example, mobility, self-care, and cognition/speech.

27. Dr. Stenehjem testified that the standard of care for prescribing physical therapy is the same for osteopaths as for allopaths.

28. Dr. Stenehjem testified that respondent’s failure to document C.A.’s condition, diagnosis, and rationale for treatment all constituted a simple departure from the standard of care.

According to Dr. Stenehjem, respondent’s records for November 23, 2004, did not provide adequate documentation for the prescription of HBO. Missing from the records were physical findings (based on a physical exam), an impression/diagnosis and a plan. Of these, the physical exam was the most critical.

According to Dr. Stenehjem, respondent’s records for November 30, 2004, were inadequate because they did not document a level of impairment or disability from which a treatment could be assessed, i.e., they did not quantify the level of C.A.’s paralysis adequately, so that it could serve as a benchmark for measuring the effects of treatment. With regard to progress notes dated the same day which stated, in greater detail, “L[eft] Sided hemiparesis, inability to use L[eft] Hand, unable to walk,” Dr. Stenehjem was of the view that those did not appear to be physical findings, but were instead references to the patient’s history or were taken from other medical records.

29. Dr. Stenehjem testified that respondent’s ongoing charting for C.A. represented an extreme departure from the standard of care because it was inadequate to justify continued HBO and physical therapy treatments for C.A. after January 2005. The records did not indicate the effects of these treatment modalities, or any continued benefit (in

terms of functional progress) C.A. was deriving from them, which could then provide a basis for further treatment. With regard specifically to physical therapy, the progress notes did not permit the reader to identify any measurable progress. While the wording of these notes might suggest some improvement or changes in C.A., the notes did not describe functional improvement of any meaningful sort, and thus did not show that C.A. was benefiting from the therapy.¹⁰

Dr. Stenehjem testified that where, as here, a physician provides a mode of treatment (e.g., HBO, physical therapy) directly through his own office, rather than simply prescribing the treatment, which the patient then secures through an outside source unrelated to the physician, the importance of keeping detailed charting is even more important, since the physician derives a direct financial benefit from the therapy prescribed.

Dr. Stenehjem did not elaborate with regard to why these matters constituted an extreme, instead of a simple, departure from the standard of care.

30. Dr. Stenehjem testified that the HBO and physical therapy treatments provided to C.A. after January 2005 were excessive, because of the absence of documentation showing any continuing benefit to be derived from these modalities. This excessive treatment constituted an extreme departure from the standard of care.

Dr. Stenehjem testified that with regard to physical therapy, one expects to see some improvement at least on a monthly basis. Accordingly, if one or two months pass without improvement, there is a concern about the efficacy of continued treatment. With regard to HBO, the standard is probably "a little looser." One would nonetheless expect to see some improvement within the first two months. If there is, it would be appropriate to prescribe two more months of HBO. If two to four months pass without any improvement, it is to be concluded that the HBO therapy is not working, and should thus be discontinued.

Dr. Stenehjem did not elaborate with regard to why these matters constituted an extreme, instead of a simple, departure from the standard of care.

31. Dr. Stenehjem testified that the representation contained on respondent's websites that respondent was board-certified in family practice and chelation therapy was incorrect, and that this constituted an extreme departure from the accepted standard of practice. He explained that board certification is a universally-recognized value that is intended to validate a particular level of training and clinical competency on which others can rely. Persons seeking medical care rely on representations of board certification, as do other physicians. Further, falsely holding oneself out as board certified is unfair to those physicians who in fact do receive and maintain such certification.

¹⁰ As an example of Dr. Stenehjem's concerns, he considered the statement, "improve patterns of muscular control along with increased awareness of normal/efficient movement has been noted" to be vague and unquantifiable, and, therefore, not useful in determining whether benefit was derived from the therapy.

Testimony of Dr. Kenneth Stoller

32. Kenneth Stoller, M.D., respondent's expert witness, received his medical degree from the American University of the Caribbean School of Medicine in 1982. He completed his residency in pediatrics at UCLA in 1986, and became board certified in that field in 1989. He practiced in California until 1999, when he relocated to New Mexico. He has been licensed in California since 1984. From 2002 to 2005, he was a Clinical Assistant Professor, Pediatrics, at the University of New Mexico School of Medicine.

Dr. Stoller became involved in hyperbaric medicine in the late 1990s. Since 2001, he has been a member of the American College of Hyperbaric Medicine and, since 2003, a Diplomat of the American Board of Hyperbaric Medicine. In 2002, after research and study, he opened up his first clinic, the Hyperbaric Medical Center of New Mexico, which he operates as Medical Director. He also owns two HBO clinics in California, which he visits on a monthly basis. He has published a number of articles relating to hyperbaric medicine.

33. Dr. Stoller testified that the standard of practice for charting HBO treatment consists of maintaining treatment logs, with a "comments" section. Charting is done by the HBO technician, not the physician. Dr. Stoller would be "a little disappointed" if a technician failed to make notations on the chart. It would be appropriate to note in the patient's chart a prescription for additional treatments.

34. Dr. Stoller testified that respondent is "respected" in the HBO community as "being one of the pioneers."

35. Dr. Stoller testified that when a patient presents at his clinic, he talks to the patient about the potential benefits of HBO therapy, and what the patient can expect. He does not generally perform a physical examination, since the patient has usually been pre-evaluated, diagnosed and examined elsewhere.

36. Dr. Stoller testified that the standard protocol for treating stroke patients with HBO is about 80 treatments (two sets of 40 treatments with a one-month break in between, if a 100 percent concentration of oxygen is used). After 80 treatments, "it becomes highly individualized." The goal is to treat the patient until he reaches a "clinical plateau." If improvement, but not complete resolution, has been achieved with regard to some deficits, the practitioner can prescribe additional treatments beyond the initial 80. Dr. Stoller expressed his "hope" that all relevant positive responses to treatment during the initial 80 sessions would be recorded, but stated the standard of care does not require this. If additional HBO treatments after the initial set are ordered, the physician should note the additional treatments that are to be provided.

Dr. Stoller testified that he did not see any indication in C.A.'s treatment logs that respondent had signed off on the logs. Dr. Stoller added that that is not, however, unusual. He explained that once the physician has noted the order for HBO therapy, there is no continuing obligation to sign off on treatment logs.

Dr. Stoller testified that the 87 HBO treatments provided to C.A. were not excessive, because this is a "patient-driven" therapy, i.e., if a clinical plateau has not yet been reached, and if the patient feels that he is continuing to benefit from HBO and that more treatments will assist him, it is not inappropriate to exceed 80 treatments. Dr. Stoller conceded that he did not recall seeing any notation in C.A.'s progress notes concerning a specific patient response to the HBO treatments.

37. Dr. Stoller testified that he sometimes refers stroke patients to physical therapy. More commonly, however, his patients are already receiving physical therapy when they come to him.

Dr. Stoller testified that a physician does not need to sign off on physical therapy progress notes. The physician may, however, need to write a prescription for additional physical therapy.

38. Dr. Stoller testified that respondent's charting was not outside the standard of care. Respondent's consultation notes and initial evaluation were exemplary, and were within the standard of care. In support of this opinion, Dr. Stoller drew a distinction between a primary care physician or non-specialist, such as respondent, and a psysiatrist, such as (by implication) Dr. Stenehjerm. He explained that the function of a psysiatrist is to create a treatment plan and strategy for the patient. A primary care physician would not go into the same level of detail or be required to understand all the nuances of the patient's deficits or strengths that would be required of a psysiatrist. Thus, Dr. Stoller's view was that respondent's charting of C.A. was within the standard of care for a non-specialist, even if it would not have been for a psysiatrist.

Dr. Stoller conceded that patient records should include some documentation explaining the rationale for the treatment prescribed.

39. Dr. Stoller testified that if an individual is board certified and the board certification subsequently ends, the individual's CV should so state. It is inaccurate under these circumstances to simply provide the fact and date of board certification. He testified more specifically, however, that the two certifications listed in respondent's CV were not deceptive, "standing on its own."

40. Dr. Stoller referred to the American Board of Chelation Therapy as a "vanity board," i.e., an entity not embraced by the American Board of Medical Specialties or the American Board of Physician Specialties.

Respondent's Testimony

41. Respondent received his Doctor of Osteopathy degree from the University of Osteopathic Medicine and Surgery in Des Moines, Iowa in 1970. He completed a rotating internship at Providence Hospital in Seattle, Washington in 1971. He completed his residency in Clinical Pathology at the University of Oregon in 1977. He has practiced in the southern Orange County, California area since 1978. He has published 40 to 50 articles and

two books. His published work and his practice have dealt primarily with the treatment of chronic degenerative diseases. He has written articles, made presentations, and taught courses on hyperbaric oxygen treatment. He has prescribed HBO to an estimated 2,000 to 3,000 patients. Stroke victims have constituted a particular emphasis in respondent's practice. The majority of his stroke patients were chronic and stable at the time he first saw them, i.e., they had not made progress over the preceding twelve-month period based on the therapeutic modalities previously provided to them.

42. Respondent testified that his provision of care to C.A. was as a general physician, not, for example, as a physiatrist. Respondent saw his role as being to supervise C.A. in terms of his medical problems, and to address and treat medical problems, if any, that C.A. had while undergoing HBO and physical therapy.

Respondent testified that C.A. came to him 16 months after suffering his stroke. Respondent's typical practice in cases when a patient comes to him that long after the stroke is to prescribe 60 90-minute HBO treatments, at 1.5 atmospheres. Respondent explained that during the first year after a stroke, the patient often experiences improvement, as the body is repairing itself to the extent that it can. Later, the damaged tissue becomes stable, healing levels off. Using HBO, i.e., placing the individual in a chamber and administering him a high concentration of oxygen, helps to stimulate renewed growth in the damaged areas. Generally this renewed growth continues and is most effective over the course of 60 treatments. Respondent came to this conclusion based on his own tests conducted on 100 to 120 of his patients.

43. Respondent testified that in his initial consultation with C.A., on November 23, 2004, he took a history, which was recorded by a neuropath in training with him. Respondent also discussed, as is his practice with new patients, prospective therapies that he was recommending to C.A. If (as was the case here) the patient agreed with respondent's recommendations, the patient would return for a full evaluation. Respondent explained his prescription of HBO prior to conducting the full evaluation of C.A. by stating that HBO therapy is an "unregulated medical procedure" that anyone can perform without a prescription. Additionally, there is very little "downside" or risk to the procedure. Respondent also claimed that he had "standing orders" that HBO can be initiated for a patient before respondent conducts a physical examination.

Accordingly, the limited evaluation respondent conducted on November 23, 2004, was sufficient as a basis for the prescription. Respondent added that only three HBO treatment sessions took place before the full evaluation was conducted on November 30, 2004.

44. Respondent testified that he wrote two HBO orders for C.A., the first for 60 treatments, the second for 30 more. He explained that he prescribed the latter based on the

request of C.A. and C.A.'s wife.¹¹ Such a request was not, however, recorded in respondent's records.

45. Respondent testified that he monitored C.A.'s progress in three ways: (i) The HBO technician was to report back to him if any problems were encountered during the course of therapy; (ii) the physical therapist, who saw C.A. weekly for an hour, was to report back to him if any problems arose; and (iii) respondent saw C.A. informally every week or two. Respondent did not record these latter encounters with C.A., since he did not charge C.A. for such informal "consults." Respondent conceded that in this case, the HBO technician did not provide respondent with progress reports, but added that the physical therapist did. Respondent reviewed these reports and discussed them with C.A.

46. Respondent testified that his function with regard to C.A.'s care was to document any medical problems C.A. experienced while undergoing rehabilitation, not to document what progress C.A. was making.

47. Respondent testified that his two board certifications were in effect at the time he added them to his CV. He had a family practice from 1978 to 1991. In 1991, he ceased that practice in order to focus on the treatment of stroke patients. The following year, he ended his chelation therapy practice.

Respondent testified that he "believed" that his family practice certification lapsed, but that he did not know when that had occurred. He stated he did not know when his chelation therapy certification would end.

Respondent testified that three to four years ago he instructed his secretary to remove the references to board certification from his strokedoctor website, but that he did not follow up to see if she made this change. He explained his failure to follow up on the basis that he is very busy and the issue of board certification was a "very minor point," since he no longer accepted family practice or chelation therapy patients. He testified that he did not know with certainty, even as of the time of the hearing, whether the board certification references had been removed from this website.

48. Respondent considers the chelation therapy board to be a "pseudo-board," or, as Dr. Stoller called it, a "vanity board."

49. Respondent testified that he did not intend to misrepresent his credentials. He added that he had a First Amendment right to include the matters in question on his CV.

Ultimate Findings

50. It is found based on the foregoing and the applicable burden of proof as follows:

¹¹ Respondent justified the continuation of HBO on the additional ground that C.A. did not have sinus or flu issues during the course of treatment.

a. Respondent failed, during his initial assessments of C.A., adequately to document C.A.'s condition, diagnosis, and rationale for treatment. This failure constituted a simple departure from the standard of care.

Respondent prescribed HBO and physical therapy on November 23, 2004, before he had conducted a physical examination of C.A. His records for that date — and for November 30, 2004 — did not include a treatment plan or explanation as to why he considered HBO and physical therapy appropriate treatment modalities for C.A., and what he hoped to achieve by means of those therapies. Dr. Stenehjem provided a reasoned, specific explanation as to why respondent's records were inadequate in this regard. Dr. Stenehjem's testimony concerning the identity and, in fact, universality of the standard of care required of physicians, whether allopaths or osteopaths, in connection with medical records, was persuasive.¹² Dr. Stoller's attempt to distinguish the standard of care required of a primary care physician and a psychiatrist was not convincing. In Dr. Stoller's own practice, patients generally come to him with a physical therapy referral, and having already had a physical examination, a very different context than involved in the present case; his testimony must be viewed as coming from this differing perspective. Dr. Stoller in any event conceded that patient records should include some documentation explaining the rationale for prescribed treatment. Further, Dr. Stenehjem's credentials were stronger than those of Dr. Stoller *as to this issue*. Respondent's reliance on the claim that HBO is an "unregulated medical procedure" with little "downside," even if true, seemed an unsatisfactory rationalization for inadequate charting,¹³ as did his claim—unsupported by any documentation—concerning his "standing orders" for the initiation of HBO. Finally, and as Dr. Stenehjem pointed out, respondent's deriving of a direct financial benefit from the prescription of HBO and physical therapy to C.A. constitutes an additional reason to expect a clear explanation of the justification for these treatments.

b. Respondent failed, during the course of his ongoing treatment of C.A., adequately to document C.A.'s continuing need for HBO and physical therapy after January 2005. This failure constituted an extreme departure from the standard of care.

With regard to HBO, respondent's treatment log provided virtually no information about C.A.'s progress, condition or reaction to treatment. The additional month of HBO prescribed on December 29, 2004, was not supported by any rationale whatsoever. Dr. Stenehjem articulated a reasonable basis for his opinion that respondent's charting was inadequate, and his expertise is considered greater than that of Dr. Stoller with regard to records. Even Dr. Stoller conceded that there should have been a "comments" section to the HBO treatment log, adding that he "hoped" that all relevant positive responses would be recorded therein. Since the HBO technician worked under respondent's direct control and used log forms that (it may be inferred) respondent provided and approved, the contention

¹² In contrast, and as discussed below, Dr. Stoller's far greater expertise with regard to HBO itself was relevant to a determination of the distinct question whether respondent excessively prescribed that treatment modality to C.A.

¹³ This contention would not, in any event, apply to respondent's prescription of physical therapy.

that respondent was not responsible for inadequacies in the logs is unavailing. It also ignores the substantial absence in *other* medical records (e.g., progress notes prepared by respondent himself) of information about C.A.'s condition and progress while undergoing HBO, and especially of a justification or rationale for the December 29, 2004, prescription of additional HBO to C.A. Though Dr. Stoller referred to HBO as a "patient-driven" therapy, there is also no documentation that respondent actually discussed with C.A. the need for continuing HBO and that, as respondent claimed at the hearing, C.A. requested that the therapy continue. Finally, respondent's last prescription for HBO was entered on December 29, 2004. Even if this ambiguous entry¹⁴ is construed as prescribing an additional month of therapy after the initial two-month period, that would extend treatment only to late February 2005. However, HBO continued until March 25. No prescription for this additional month of treatment appears in respondent's records.

With regard to physical therapy, the progress plan records did not reflect substantial, if any, progress after January 2005. Again, Dr. Stenehjem articulated a reasonable basis for his opinion that respondent's charting was inadequate. Though Dr. Stoller testified that a physician need not sign off on physical therapy notes, he did not directly address the adequacy of those notes or the specific concerns Dr. Stenehjem identified. As noted above, respondent is ultimately responsible for the content of documentation prepared by persons under his direct supervision and control, as he is also responsible for preparing whatever additional documentation may be necessary pursuant to the standard of care. As with HBO, respondent's records did not even reflect prescriptions of physical therapy that cover the entire period from November 2004 to early May 2005. Instead, the only prescriptions recorded were: The November 23, 2004, prescription for two months of physical therapy; the December 29, 2004, prescription for one additional month; and the open-ended March 22, 2005, prescription for additional therapy on a twice weekly basis.

Dr. Stenehjem's testimony that the deficiencies in respondent's records was an extreme departure from the standard of care and thus constituted gross negligence was supported by the record as a whole and is credited.

c. Respondent committed acts of clearly excessive prescribing of treatment and clearly excessive use of treatment facilities by virtue of the continuation of C.A.'s physical therapy after January 2005. These acts constituted a simple departure from the standard of care. Respondent did not, however, prescribe clearly excessive HBO for the period after January 2005.

Respondent's records did not provide a rationale for his December 2004 and March 2005 physical therapy prescriptions. Further, the physical therapy progress plan records did not reflect significant improvement in C.A.'s condition after January 2005. Dr. Stenehjem's testimony reasonably and specifically supported his opinion that physical

¹⁴ The ambiguity of this entry itself constitutes additional evidence of the inadequacy of respondent's records.

therapy after January 2005 was excessive.¹⁵ However, he did not clearly or persuasively explain his conclusion that the departure from the standard of care was extreme. With regard to HBO, on the other hand, Dr. Stoller's expertise was clearly and substantially greater than that of Dr. Stenehjem. Dr. Stoller testified that the standard HBO protocol for the treatment of stroke patients is 80 sessions, and that the number of sessions, not the time period during which they occur, is critical. Even though respondent exceeded that number slightly (by providing 87 HBO treatments), the additional seven sessions were not "clearly excessive." Dr. Stoller's testimony in this regard is credited over the contrary testimony of Dr. Stenehjem.

d. Respondent failed to maintain adequate records of his treatment of C.A., and this failure constituted an extreme departure from the standard of care. This finding follows necessarily from Findings 50(a) and (b).

e. Respondent committed a dishonest act by falsely representing on his two websites that he was board certified by the American Board of Family Practice and the American Board of Chelation Therapy.

Despite respondent's contention to the contrary, the websites clearly implied that respondent was *currently* certified by the two boards in question. In fact, he had not held certification from the American Board of Family Practice since 1984, and he had not held certification from the American Board of Clinical Metal Toxicology for at least five years prior to the hearing. Dr. Stenehjem's explanation of the significance of board certification was enlightening and persuasive. Even Dr. Stoller seemed to have a difficult time supporting the propriety of respondent's website claims, since he could do no better than to state that the reference to certification was not deceptive, "standing on its own." He conceded that it is "inaccurate" for an individual's CV not to note the termination of board certification. Respondent's vague, unsupported, almost flippant testimony that he instructed his secretary to remove the references from his CV, and that she failed to do so did not, even if true, absolve him of the responsibility for ensuring that his websites remained accurate.

f. Respondent held himself out to be board certified by the American Board of Chelation Therapy and the American Board of Family Practice without such certification having been granted by these two boards. This finding necessarily follows from Finding 50(e).

g. Respondent disseminated and caused to be disseminated a public communication through an internet website containing a deceptive or misleading statement for the purpose or with the likely effect of inducing the rendering of professional services in connection with the professional practice for which he is licensed. This finding follows from Finding 50(e).

¹⁵ Dr. Stoller did not, in fact, directly and explicitly testify that respondent's prescription of physical therapy after January 2005 was appropriate. Instead, his testimony that respondent's treatment of C.A. was not excessive focused on HBO.

Prior Proceeding

51. On or about February 7, 1994, respondent entered into a Stipulation in Settlement and Decision with the board's executive director, which arose out of an accusation filed against with regard to his care of two patients. Respondent stipulated that the charges and allegations of the accusation constituted cause for the imposition of discipline against his license. He admitted that, in violation of Business and Professions Code section 2234, subdivisions (b) and (d), he had "failed to adequately document his examinations and treatment in the charts of Ariann W. and James C., and that he failed to warn the family of patient Ariann W. about the possible side effects of the iron injectable medication." In a Decision and Order effective on March 21, 1994, the board adopted the stipulation and related order, pursuant to which respondent was placed on probation for five years. The terms of probation included, *inter alia*, the completion of courses in pharmacology, medical charting, and ethics.

Costs of Investigation and Enforcement

52. A Certification of Costs of Investigation and Enforcement established that 21.6 hours were spent investigating this matter, at an hourly rate of \$107.94, for a total cost of \$2,331.50. The cost of expert review and evaluation, report writing, hearing preparation and examinations was \$1,000. Total costs were thus \$3,331.50. It is found that these costs were reasonable.

53. A Certification of Prosecution Costs: Declaration of Heidi R. Weisbaum, established that the Attorney General's Office billed the board for 141.25 hours of legal services at the rate of \$158 per hour.¹⁶ In addition, two hours were billed for work performed by a senior legal analyst at a rate of \$101 per hour. The total amount billed was thus \$22,835. The amount billed was reasonable.

CONCLUSIONS OF LAW

Burden and Standard of Proof

1. "The purpose of an administrative proceeding concerning the revocation or suspension of a license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners." (*Ettinger v. Board of Medical Quality Assurance* (1982) 139 Cal.App.3d 853, 856.)

2. Absent a statute to the contrary, the burden of proof in disciplinary administrative proceedings rests upon the party making the charges. (*Parker v. City of*

¹⁶ This total includes an anticipated eight hours that counsel estimated would be billed in connection with her preparation for the hearing between the date of the declaration and the date of the hearing.

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Fountain Valley (1981) 127 Cal.App.3d 99, 113; Evid. Code § 115.) The burden of proof in this proceeding is thus on complainant.

3. The standard of proof in administrative disciplinary proceedings brought against professional licensees is “clear and convincing proof to a reasonable certainty.” (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1105.)

4. “The key element of clear and convincing evidence is that it must establish a high probability of the existence of the disputed fact, greater than proof by a preponderance of the evidence.” (*People v. Mabini* (2001) 92 Cal.App.4th 654, 662.) This standard is less stringent than proof beyond a reasonable doubt. (*Ettinger v. Board of Medical Quality Assurance, supra*, 135 Cal.App.3d at 856.) ‘Clear and convincing’ evidence “requires a finding of high probability.” The evidence must be “so clear as to leave no substantial doubt” and “sufficiently strong to command the unhesitating assent of every reasonable mind.” (*In re Angelina P* (1981) 28 Cal.3d 908, 919; citations omitted.)

Motion to Dismiss

5. Respondent moved to dismiss the accusation on several grounds. These motions are denied.

a. Respondent asserted that the board did not comply with pre-accusation obligations and requirements. This assertion is based on the existence of a Settlement Agreement and Release executed by respondent, as plaintiff, and certain individuals, including then executive director of the board Linda Bergmann, as defendants, in a 1998 civil action. Pursuant to that agreement, in the event of any future disciplinary proceedings against respondent, the board was, inter alia, to “act by and through an osteopathic physician member of the Osteopathic Medical Board rather than by Executive Director Linda Bergmann with regard to issues relating to policy decisions on whether to investigate or prosecute.” Further, “said board member will be recused from participating in any decision making process that may result from the initiation of disciplinary action.”

Linda Bergmann was not executive director at the time of the accusation in the present matter. Accordingly, the board could not have acted and did not act through Ms. Bergmann in the capacity specified in the settlement. Neither did respondent establish that the board acted through Ms. Bergmann in any other capacity.¹⁷ Most importantly, respondent provided no authority in support of his implicit position that a settlement in a civil action may bind the board with regard to administrative disciplinary proceedings. To conclude that it may would be utterly antithetical to the board’s statutory obligation to protect the public, and, thus, to the public interest itself.

b. Respondent asserted that the Medical Board of California (MBOC) previously determined that this matter had no merit and should not go forward. While it is

¹⁷ This observation assumes *arguendo* that having done so would constitute a violation of the settlement agreement, a conclusion which is not reached.

true that the MBOC previously conducted an investigation against respondent and decided not to take action him, respondent provided no legal authority in support of the assertion that the decision of one board not to proceed acts as a bar to another board to do so. Further, no evidence was adduced in support of respondent's related contention that the board's investigation of and proceeding against respondent was politically motivated, based on bias or otherwise brought for improper reasons.

c. Respondent asserted that the board may not proceed, pursuant to Business and Professions Code section 2234.1. That section provides that a physician shall not be subject to discipline pursuant to section 2234, subdivisions (b), (c) or (d) *solely* on the basis that the treatment rendered is alternative or complementary. As reflected in the facts found above, the board does not seek to discipline respondent's license solely (if at all) on the basis that the treatment rendered to C.A. is alternative or complementary in nature. Accordingly, respondent's assertion is without merit.¹⁸

Statutory Authority

6. Business and Professions Code section 3600-2 provides:

"The Osteopathic Medical Board of California shall enforce those portions of the Medical Practice Act identified as Article 12 (commencing with Section 2220), of Chapter 5 of Division 2 of the Business and Professions Code, as now existing or hereafter amended, as to persons who hold certificates subject to the jurisdiction of the Osteopathic Medical Board of California, however, persons who elect to practice using the term or suffix "M.D." as provided in Section 2275 of the Business and Professions Code, as now existing or hereafter amended, shall not be subject to this section, and the Medical Board of California shall enforce the provisions of the article as to persons who make the election. After making the election, each person so electing shall apply for renewal of his or her certificate to the Medical Board of California, and the Medical Board of California shall issue renewal certificates in the same manner as other renewal certificates are issued by it."

7. Business and Professions Code section 2234 provides in pertinent part:

"The Division of Medical Quality 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.

¹⁸ In closing argument, respondent made reference to certain additional grounds for dismissal, including freedom of speech and the impropriety of the MBOC conducting an investigation on behalf of the board. No legal authority in support of these additional grounds was provided, and they are without merit.

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(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. . . .

(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.”

8. Business and Professions Code section 2266 provides:

“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.”

9. Business and Professions Code section 725 provides in pertinent part:

“(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.”

10. Business and Professions Code section 2453.5 provides:

“Individuals possessing physician's and surgeon's certificates issued by the Osteopathic Medical Board of California shall not hold themselves out to be board certified unless the board certification has been granted by the appropriate certifying board, as authorized by the American Osteopathic Association or the American Board of Medical Specialties, or is the result of a postgraduate training program approved by the Accreditation Council for Graduate Medical Education.”

11. Business and Professions Code section 651 provides in pertinent part:

“(a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A ‘public communication’ as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication. . . .

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.”

12. Negligence is conduct falling below the standard of care. The standard of care varies in different situations, but it remains constant in principle, and involves due care, taking into consideration all relevant circumstances. The standard of care for professionals is articulated in terms of exercising “the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing. . . .” (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998.)

13. The standard of care is a matter peculiarly within the knowledge of experts; it presents the basic issue that can only be proved by their testimony, unless the conduct required by the particular circumstances is within the common knowledge of the layman. A professional must exercise the degree of skill or care usual in the profession. (*Williamson v. Prida* (1999) 75 Cal.App.4th 1417, 1424.)

In determining what weight, if any, to give the opinions of expert witnesses, the finder of fact is permitted to consider the credibility of the experts, the reasons given for their opinions, and the facts and other matters upon which their opinions are based. (*People v. Prince* (1988) 203 Cal.App.3d 848, 858.)

Final Conclusions

14. To summarize the foregoing authority in the context of this proceeding, disciplinary action may be taken against respondent only if complainant has established by clear and convincing evidence that respondent engaged in gross negligence or repeated negligent acts, committed a substantially-related act involving dishonesty, failed to maintain adequate patient records, committed repeated acts of clearly excessive prescribing, held himself out to be board certified without having been granted certification by the appropriate certifying board, or disseminated a public communication containing a false, fraudulent, misleading or deceptive statement for the purpose of or likely to induce the rendering of professional services. (Bus. & Prof. Code, §§ 651, 725, 2234, subds. (b), (c) and (e), 2266, 2453.5, and 3600-2.)

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15. By reason of Factual Findings 1 through 51, and Legal Conclusions 1 through 14, and based on the applicable burden of proof as set forth above, it is concluded that:

a. Respondent engaged in gross negligence, in violation of Business and Professions Code section 2234, subdivision (b).

b. Respondent engaged in repeated negligent acts, in violation of Business and Professions Code section 2234, subdivision (c).¹⁹

c. Respondent committed acts of clearly excessive prescribing of treatment and clearly excessive use of treatment facilities, in violation of Business and Professions Code section 725, subdivision (a).

d. Respondent failed to maintain adequate records relating to the provision of services to C.A., in violation of Business and Professions Code section 2266.

e. Respondent committed an act involving dishonesty which was substantially related to the qualifications, functions, and duties of a physician, in violation of Business and Professions Code section 2234, subdivision (e).

f. Respondent held himself out as board certified, without board certification having been granted by the appropriate certifying board, in violation of Business and Professions Code section 2453.5.

g. Respondent disseminated or caused to be disseminated a form of public communication containing a false, misleading, and deceptive statement and claim for the purpose or likely result of inducing the rendering of professional services in connection with the professional practice for which respondent was licensed, in violation of Business and Professions Code section 651, subdivision (a).

16. By reason of Factual Findings 1 through 51, and Legal Conclusions 1 through 15, cause exists to take disciplinary action against respondent. The imposition of discipline pursuant to the board's guidelines is appropriate and necessary for the protection of the public and the rehabilitation of respondent.

¹⁹ While the precise meaning of "repeated negligent acts" may not always be clear, the facts found above constitute multiple, distinct, and repeated failures on respondent's part to document the treatment of C.A. Respondent's contention that complainant seeks to "dissect one episode of care into distinct parts and deem them 'repeated'" is without merit.

Costs of Investigation and Enforcement

17. Business and Professions Code section 125.3 provides in pertinent part:

“(a) . . . in any order issued in resolution of a disciplinary proceeding before any board within the department . . . the board may request the administrative law judge to direct a licentiate found to have committed a violation . . . of the licensing act to pay a sum not to exceed the reasonable costs of investigation and enforcement of the case.

* * *

(d) The administrative law judge shall make a proposed finding of the amount of the reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). . . .”

18. Cause exists under Business and Professions Code section 125.3 to issue an order requiring respondent to pay the board’s reasonable costs of investigation and enforcement in the amount of \$ 25,166.60.

This conclusion is based on Factual Findings 52 and 53, and on Legal Conclusion 17.

Accordingly, there issues the following:

ORDER

Osteopathic Physician and Surgeon License No. 20A4160, issued to respondent David Steenblock, D.O., is revoked. However, revocation stayed and respondent is placed on probation for five years upon the following terms and conditions.

1. 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.

2. Quarterly reports

Respondent shall submit to the Board quarterly declaration under penalty of perjury on the Quarterly Report of Compliance Form, OMB 10 (5/97) which is hereby incorporated by reference, stating whether there has been compliance with all the conditions of probation.

3. Probation surveillance program

Respondent shall comply with the Board's probation surveillance program. Respondent shall, at all times, keep the Board informed of his or her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Board. Under no circumstances shall a post office box serve as an address of record.

Respondent shall also immediately inform the Board, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

4. Interviews with medical consultants

Respondent shall appear in person for interviews with the Board's medical consultants upon request at various intervals and with reasonable notice.

5. Cost recovery

The respondent is hereby ordered to reimburse the Board the amount of \$25,166.60 within 180 days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Board's cost of its investigation and prosecution shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan because of financial hardship.

6. License surrender

Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his/her certificate to the Board. The Board reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

7. Tolling for out-of-state practice or residence, or in-state non-practice (inactive license).

In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the board or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Section 2051 and/or 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Board or its designee in or out of state shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or

practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

8. 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, at respondent's expense, approved in advance by the Board. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

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, be accepted towards the fulfillment of this condition if the course would have been approved by the Board had the course been taken after the effective date of this Decision.

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

9. Medical ethics course

Within 60 days of the effective date of this decision, respondent shall submit to the Board for its prior approval a course in medical ethics which respondent shall successfully complete during the first year of probation.

10. Probation violation/completion of probation

If respondent violates probation in any respect, the Board may revoke probation and carry out the disciplinary order that was stayed after giving respondent notice and the opportunity to be heard. If an Accusation and/or Petition to revoke 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. Upon successful completion of probation, respondent's certificate will be fully restored.

DATED: 7/30/09

A handwritten signature in black ink, appearing to be "DPC", followed by the word "for" written in a cursive script.

DONALD P. COLE
Administrative Law Judge
Office of Administrative Hearings