

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

**In the Matter of the Petition to)
Revoke Probation Against:)
)
)
NICOLE BETH HLAVA, M.D.)
)
Physician's and Surgeon's)
Certificate No. A 87960)
)
Respondent)
_____)**

Case No. 800-2015-017771

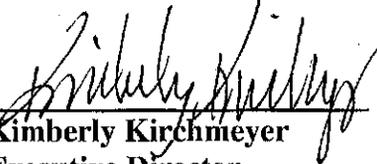
DECISION

The attached Stipulated Surrender of License and 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 August 11, 2016

IT IS SO ORDERED August 4, 2016

MEDICAL BOARD OF CALIFORNIA

By: 
Kimberly Kirchmeyer
Executive Director

1 KAMALA D. HARRIS
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2 JANE ZACK SIMON
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7

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the Petition to Revoke
12 Probation Against:

13 **NICOLE BETH HLAVA, M.D.**
14 221 HIGH ST.
Palo Alto, CA 94301

15 Physician's and Surgeon's Certificate
No. A87960

16 Respondent.

Case No. 800-2015-017771

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

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

21 PARTIES

22 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board
23 of California. She brought this action solely in her official capacity and is represented in this
24 matter by Kamala D. Harris, Attorney General of the State of California, by Brenda P. Reyes,
25 Deputy Attorney General.

26 2. Nicole Beth Hlava, M.D. (Respondent) is represented in this proceeding by attorney
27 Gregory Abrams, Esq., of Abrams Health Law, 6045 Shirley Drive, Oakland, CA 94611.

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1 CULPABILITY

2 8. Respondent understands that the charges and allegations in Petition to Revoke
3 Probation No. 800-2015-017771, if proven at a hearing, constitute cause for imposing discipline
4 on her Physician's and Surgeon's Certificate.

5 9. For purpose of resolving the Petition to Revoke Probation without the expense and
6 uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could
7 establish a factual basis for the charges in the Petition to Revoke Probation and that those charges
8 constitute cause for discipline. Respondent hereby gives up her right to contest that cause for
9 discipline exists based on those charges.

10 10. Respondent understands that by signing this stipulation she enables the Board to issue
11 an order accepting the surrender of her Physician's and Surgeon's Certificate without further
12 process.

13 CONTINGENCY

14 11. This stipulation shall be subject to approval by the Medical Board of California.
15 Respondent understands and agrees that counsel for Complainant and the staff of the Board may
16 communicate directly with the Board regarding this stipulation and surrender, without notice to or
17 participation by Respondent or her counsel. By signing the stipulation, Respondent understands
18 and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the
19 time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its
20 Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or
21 effect, except for this paragraph, it shall be inadmissible in any legal action between the parties,
22 and the Board shall not be disqualified from further action by having considered this matter.

23 12. The parties understand and agree that Portable Document Format (PDF) and facsimile
24 copies of this Stipulated Surrender of License and Order, including Portable Document Format
25 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

26 13. In consideration of the foregoing admissions and stipulations, the parties agree that
27 the Board may, without further notice or formal proceeding, issue and enter the following Order:
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ORDER

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2 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A87960, issued
3 to Respondent Nicole Beth Hlava, M.D., is surrendered and accepted by the Medical Board of
4 California.

5 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the
6 acceptance of the surrendered license by the Board shall constitute the imposition of discipline
7 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
8 of Respondent's license history with the Medical Board of California.

9 2. Respondent shall lose all rights and privileges as a physician and surgeon in
10 California as of the effective date of the Board's Decision and Order.

11 3. Respondent shall cause to be delivered to the Board her pocket license and, if one was
12 issued, her wall certificate on or before the effective date of the Decision and Order.

13 4. If Respondent ever files an application for licensure or a petition for reinstatement in
14 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
15 comply with all the laws, regulations and procedures for reinstatement of a revoked license in
16 effect at the time the petition is filed, and all of the charges and allegations contained in Petition
17 to Revoke Probation No. 800-2015-017771 shall be deemed to be true, correct and admitted by
18 Respondent when the Board determines whether to grant or deny the petition.

19 5. If Respondent should ever apply or reapply for a new license or certification, or
20 petition for reinstatement of a license, by any other health care licensing agency in the State of
21 California, all of the charges and allegations contained in Petition to Revoke Probation, No. 800-
22 2015-017771 shall be deemed to be true, correct, and admitted by Respondent for the purpose of
23 any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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Exhibit A

Petition to Revoke Probation No. 800-2015-017771

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO January 29 20 16
BY R. Firdaus ANALYST

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

In the Matter of the Petition to Revoke
Probation Against:

NICOLE BETH HLAVA, M.D.
221 High Street
Palo Alto, CA 94301

Physician's and Surgeon's certificate
No. A87960,

Respondent.

Case No. 800-2015-017771

PETITION TO REVOKE PROBATION

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Petition to Revoke Probation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).
2. On July 1, 2004, the Board issued Physician's and Surgeon's certificate Number A87960 to Nicole Beth Hlava, M.D. (Respondent). The Physician's and Surgeon's certificate is renewed and current with an expiration date of October 31, 2017.

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3. Ordering Respondent, if placed on probation, to pay the costs of probation monitoring; and,

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

Dated: January 29, 2016



KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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41458170.doc

Exhibit A

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

In the Matter of the Accusation Against:)
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)
)
NICOLE BETH HLAVA, M.D.) Case No. 03-2012-227170
) OAH No. 2015030180
Physician's and Surgeon's)
Certificate No. A 87960)
)
Respondent.)
_____)

DECISION AND ORDER

The attached Proposed Decision is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on August 27, 2015.

IT IS SO ORDERED July 28, 2015.

MEDICAL BOARD OF CALIFORNIA

By: _____


Jamie Wright, J.D., Chair
Panel A

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

In the Matter of the Accusation Against:

NICOLE BETH HLAVA, M.D.

Physician's and Surgeon's Certificate
No. A87960

Respondent.

Case No. 03-2012-227170

OAH No. 2015030180

PROPOSED DECISION

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter on June 18, 2015, in Oakland, California.

Vivian H. Hara, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Gregory Abrams, Attorney at Law, represented Respondent Nicole Beth Hlava, M.D., who was present.

The record closed on June 18, 2015.

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer issued the Accusation in her official capacity as Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On July 1, 2004, the Board issued Physician's and Surgeon's Certificate No. A87960 to Nicole Beth Hlava, M.D. (Respondent). It is scheduled to expire on October 31, 2015, unless renewed. Respondent is an anesthesiologist.

3. The Accusation alleges that Respondent committed unprofessional conduct by her misuse of controlled substances, commission of gross negligence or negligence, violation of drug laws, and practice of medicine while under the influence of narcotics. Respondent filed a notice of defense and a hearing was scheduled.

4. Prior to the hearing, the parties reached agreement regarding the issue to be decided and the truth of certain facts. It was understood and agreed that the sole issue for decision was the degree of license discipline that would be imposed. It was agreed that Respondent would testify and present evidence of extenuation, mitigation, and rehabilitation. She would explain the facts surrounding the conduct admitted and would be cross-examined. Respondent would also present witnesses attesting to her rehabilitation and current ability to practice medicine safely.

5. The standard of proof applied in making the factual findings is clear and convincing evidence to a reasonable certainty.

Agreed facts

6. The parties agreed that the following facts are true and undisputed.

RELEVANT DRUGS

7. Dilaudid is a trade name for hydromorphone hydrochloride. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule II controlled substance as defined by section 11055, subdivision (d), of the Health and Safety Code. Dilaudid is a hydrogenated ketone of morphine and is a narcotic analgesic. Its principal therapeutic use is relief of pain. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, usually assumes clinically significant proportions after several weeks of continued use. Side effects include drowsiness, mental clouding, respiratory depression, and vomiting. The usual starting dosage for injections is 1-2 mg. The usual oral dose is 2 mg every two to four hours as necessary. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system (CNS) depressants, including alcohol, may exhibit an additive central nervous system depression. When such combined therapy is contemplated, the use of one or both agents should be reduced.

8. Fentanyl is a potent narcotic analgesic. It is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c)(8), of the Health and Safety Code. A dose of .1 mg is approximately equi-analgesic to 10 mg of morphine. Injectable fentanyl is indicated for analgesic action of short duration during the anesthetic periods, premedication, induction and maintenance, and in the immediate postoperative period (recovery room) as the need arises; for use as a narcotic analgesic supplement in general or regional anesthesia; for administration with a neuroleptic as an anesthetic premedication for the induction of anesthesia and as an adjunct in the maintenance of general and regional anesthesia; for use as an anesthetic agent with oxygen in selected high risk patients, such as those undergoing open heart surgery or

certain complicated neurological or orthopedic procedures. Fentanyl's analgesic effect generally lasts from two to four hours. Other CNS depressant drugs will have additive or potentiating effects with fentanyl. Fentanyl can produce drug dependence of the morphine type and therefore has the potential for being abused.

9. Morphine sulfate is a potent opioid analgesic indicated for the treatment of moderate to severe pain. Morphine is a dangerous drug as defined in Business and Professions Code section 4022, and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1), of the Health and Safety Code. Morphine can produce drug dependence and has a potential for being abused. Tolerance and psychological and physical dependence may develop upon repeated administration. Abrupt cessation or a sudden reduction in dose after prolonged use may result in withdrawal symptoms. After prolonged exposure to morphine, if withdrawal is necessary, it must be undertaken gradually.

10. Suboxone is a trade name for buprenorphine and naloxone and is indicated for the treatment of opioid dependence. Buprenorphine is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule III controlled substance as defined by section 11056 of the Health and Safety Code. Buprenorphine is in a class of medications called opioid partial agonist-antagonists, and naloxone is in a class of medications called opioid antagonists. Buprenorphine alone (Subutex) and the combination of buprenorphine and naloxone prevent withdrawal symptoms when someone stops taking opioid drugs by producing similar effects to these drugs. Naloxone (also known by the trade name Narcan) is indicated for the complete or partial reversal of opioid depression, including respiratory depression, induced by natural and synthetic opioids. Chronic administration of Suboxone produces dependence of the opioid type, characterized by withdrawal upon abrupt discontinuation or rapid taper. If Suboxone is taken as directed (sublingually), the small amount of naloxone contained in the medication will have no noticeable effect. But an attempt to abuse Suboxone by injecting it will fully activate the naloxone creating a full state of withdrawal. This state of withdrawal cannot be reversed by taking heroin or other opiate drugs.

RESPONDENT'S DIVERSION AND USE OF DRUGS

11. In August of 2008, while working as an anesthesiologist and critical care specialist at Santa Clara Valley Medical Center in San Jose (SCVMC), Respondent experienced a particularly severe migraine headache. In order to be able to continue working, she injected Dilaudid, which she diverted from hospital stores and had not been prescribed for her. Respondent continued to have migraines and continued diverting and injecting Dilaudid, morphine sulfate, or fentanyl while working.

12. In January of 2009, Respondent sought psychiatric help from Gordon Wong, M.D., and later that month, Respondent was placed on Suboxone. She continued diverting opioids, however; until in or about March 2009. By the spring of 2009 her opioid dependency was in remission, and Suboxone was tapered down and discontinued in mid-June 2009. Respondent diverted fentanyl once after this time and consumed five Vicodin tablets for

migraine in July 2009. Suboxone resumption was recommended but declined. By the fall of 2009, Respondent was considered in full remission with no urges to use opioids.

13. In or about March 2010, SCVMC began an investigation of Respondent for suspected opioid diversion, and Respondent was placed on five months paid leave pending that investigation. In August of 2010, Respondent resigned from the staff of SCVMC while the investigation was pending at the request of SCVMC.

14. In mid-2011, after locum tenens positions, Respondent joined the anesthesia staff of Kaiser Foundation Hospital in Redwood City, and she continued on staff there until in or about September 2012. In May 2012, Respondent reported to her psychiatrist, Dr. Wong, that she had relapsed due to increased intensity of migraines and back pain, and that she had diverted and used fentanyl and morphine sulfate since the beginning of the month. Dr. Wong recommended that she cease working, but Respondent did not do so. Buprenorphine treatment was recommenced on May 22, 2012. By May 29, 2012, Respondent reported to Dr. Wong that the treatment was working and claimed that she was sober on buprenorphine. On or about September 6, 2012, Respondent indicated to Dr. Wong that, in fact, she had been diverting 250 mg fentanyl two to three times per week, in addition to taking Suboxone, for the prior two to three months. Dr. Wong advised her to stop working. In August of 2012, Kaiser had commenced an investigation into unusually high and inconsistent wasting of anesthesia by Respondent, and on September 27, 2012, Respondent resigned from the staff of Kaiser.

15. On or about September 28, 2012, Dr. Wong strongly urged Respondent to enter an inpatient drug rehabilitation program, and Respondent was ambivalent about doing so. Respondent became upset at her next appointment when Dr. Wong again recommended an inpatient drug treatment program. Respondent wanted to wait before going into such an inpatient program and left Dr. Wong's office after 15 minutes. After this appointment, Respondent did not respond to email and text correspondence from Dr. Wong, which included a list of several providers of drug rehabilitation treatment. Dr. Wong decided to terminate therapy with Respondent because of this non-compliance and agreed to taper her Suboxone and terminate the physician-patient relationship. The final session took place on November 2, 2012. Thereafter, Respondent entered a rehabilitation program at El Camino Hospital on November 15, 2012, and thereafter entered therapy with another psychiatrist, Maor Katz, M.D., in February of 2013.

Respondent's evidence

16. Respondent received a bachelor's of science degree and her medical degree from the University of Michigan. In 2001, she completed an internship in internal medicine at California Pacific Medical Center in San Francisco, and in 2004, a residency in anesthesiology, perioperative and pain medicine at Brigham and Women's Hospital in Boston. In 2005, Respondent completed a fellowship in critical care medicine at the University of California, San Francisco (UCSF).

17. Respondent experienced her first migraine headache while she was in high school. It lasted approximately 24 hours. In addition to pain, the symptoms included seeing lights in her visual field, numbness on the right side of her hand and mouth and nausea. She went on to have severe headaches two to three times a year, including during college and medical school. Respondent has consistently and continuously sought treatment for the migraines. She has seen many different specialists, including five different neurologists and pain specialists, with little notable success for many years.

18. Respondent described the anesthesia program at Brigham and Women's as "the best time of my life." She felt fulfilled and productive. The migraines were infrequent during that time period, and were mild in degree. She learned to associate the migraines with periods of increased stress.

19. While Respondent was at UCSF, her migraines intensified in frequency and severity. The atmosphere there was the opposite of her experience at Brigham and Women's, and she described it as "cutthroat." During one migraine, she vomited and was in severe pain. She went to UCSF's urgent care clinic and learned her blood pressure was 190. She was given intravenous anti-inflammatories and sent home with Vicodin, which seemed to help. She was able to function "even though there was a headache in the background." The pain was not removed, but it was similar to a "regular tension headache."

20. During Respondent's tenure at SCVMC, her migraines became more frequent and treatments were not helping. Respondent decided to try Botox, which she described as a treatment of last resort. Botox can prevent headaches for three months. But Respondent experienced side effects, including a drooping eye and heavy head. She then suffered a migraine, so did not continue with Botox.

Other treatments Respondent used during that time period included non-steroidal anti-inflammatories (NSAID's), Vicodin, triptans (Imitrex) and Neurontin. She also tried over-the-counter medications such as magnesium, acupuncture and de-stressing techniques such as meditation. None of these treatments or practices was very successful.

21. In mid-2008, when she diverted Dilaudid for the first time at SCVMC, Respondent had been having increasing numbers of migraines. She had been working many hours, providing emergency anesthesia care to patients with major traumatic injuries. She had more migraines that lasted over one week. Most of the time, Respondent coped with the pain, taking NSAID's and Zofran for nausea, and sitting in the call room in the dark if she needed to.

22. One day in August 2008, Respondent was at work and trying to cope with a migraine that she had awakened with that morning. About one hour into her first case, the headache increased in intensity. She experienced nausea and vomited into a garbage can. She was very distracted by the pain and the nausea, and felt that she was not able to take care of the patient. She called the surgical floor supervisor because she thought she needed to be sent home. The supervisor came, but returned and said there was no one to take over. Respondent felt pale and shaky. She felt that she could not concentrate enough to care for the patient and

she was very concerned about the patient's care. Respondent took some Dilaudid that was in the vial for her patient and injected approximately 2 mg into her thigh. No one saw her, as she was screened from the rest of the surgical team. Respondent felt better in less than ten minutes. Although she still had the headache "in the background," the narcotic "brought me back to normal functioning." She was not relieved from duty, but did not use narcotics again that day.

23. After this experience worked for her, Respondent repeated her actions a few months later when again she had a migraine while at work. By late 2008, she felt that she had started to be addicted, and felt a lot of shame and worry about being caught. The shame resulted in her failure to admit to anyone that she needed help.

24. After three or four months of using drugs daily, Respondent felt out of control and contacted a therapist she had seen while in high school when her parents divorced. The therapist referred her to Dr. Wong, an addiction specialist, who prescribed Suboxone. She saw Dr. Wong once or twice each week beginning in January 2009. He also treated Respondent for depression. By June 2009, Respondent had tapered off Suboxone and felt "great." She did not have urges or cravings for narcotics, and the drug screenings instituted by Dr. Wong had negative results. Although her job was still stressful, Respondent was sober for five months.

25. In August 2009, Respondent relapsed. She was in the same situation as before, in surgery and feeling there were no options. She told Dr. Wong at their next meeting. He offered Suboxone again, but she refused, feeling that she could "do it again on my own." She had only used drugs the one time, and the cost of Suboxone (about \$500 per month) was high.

26. Respondent believed she was "on track" when the SCVMC investigation began in March 2010. An anesthesiologist thought medication had been diluted and told the head of the surgery department. Respondent had been in the room at the time, and she was suspected because of changes in mood the previous year. Respondent was still sober at that time, and a urine test was negative, but she was placed on paid leave, and subsequently resigned at the end of August 2010.

27. Respondent sought new employment and continued to see Dr. Wong. She worked for a locum tenens firm for a time, and then obtained a non-staff position at Kaiser Permanente in Redwood City.

28. In May of 2012, Respondent again relapsed after experiencing a migraine, and diverted drugs at work. She was let go from the Kaiser position. Respondent became very depressed at that juncture, and met with Dr. Wong several times. He recommended a more intensive program, and she agreed, but she felt she could not afford an inpatient center out of state. She terminated her relationship with Dr. Wong in November 2012.

29. Respondent reports that her depression then "took over for quite a while." She had trouble leaving her house and did not contact anyone. She did not tell any friends, and her parents were away. Respondent knew that she needed a higher level of care. She found a partial hospital treatment program at El Camino Hospital in Mountain View and enrolled. It is

an intensive, albeit outpatient program, held five days a week for two weeks. Although she was admitted with the dual diagnosis of depression and addiction, it was determined early on that the depression was not a major component, and Respondent focused on addiction recovery. It was difficult for Respondent at first to admit her problems and be open about discussing them with others, but this changed and she became an active participant.

30. From the El Camino program and the group meetings, Respondent gained a greater insight and understanding of addiction. Although shame is still a big issue for her, it took "a lot of weight off of my shoulders to be active in that process." She has learned effective tools to use in various situations. Also, Respondent brought friends and family into sessions, to help her build a supportive structure for her life.

Aftercare is included in the program, and Respondent continued with weekly meetings run by a therapist. She also utilized SMART, which is a cognitive behavioral therapy (CBT) program led by peers. Respondent met psychiatrist Maor Katz, M.D., at the program, and began therapy with him within two weeks after completing it. Dr. Katz utilizes CBT and also requires urine screening. All of her tests have been negative.

31. Respondent has used prescribed narcotics since completing the program. In August 2014, she had a migraine while working in a surgery center in San Ramon. She used her current regimen of Zofran, ibuprophen and Tylenol, but received no relief. Respondent went to an urgent care clinic, but was not relieved by an injection. She requested five Vicodin tablets, but was given 30. She took two, and it seemed to help and she went to sleep on a Friday night. As she did not work the weekend, she continued to take them even after the main migraine (these are followed by less severe "hangover" migraines) was over on Monday, until the 30 pills were gone.

32. Respondent told Dr. Katz about the Vicodin use at their next meeting. They developed a plan for use of medications, including that he would be the only prescriber. If she needed medication, she would tell him as soon as possible and he would make sure that she had a limited amount and continue to screen her. For the following month, they met every week.

33. Respondent still experiences migraine headaches. There is pain and also nausea and occasional vomiting. Respondent carries medications with her, and they are sufficient most days. Dr. Katz has twice prescribed narcotics, and the system has worked well.

34. Respondent has suffered from depression over the years. She had an episode in college that lasted about two months, and was treated with medication. She has used Lamictal for many years, and recently added in Wellbutrin. Respondent believes that her depressive episodes have a situational component. She understands that many times depression and drug use go together, but in her case, she becomes depressed after using drugs. This leads to feelings of shame and avoiding contact with other people. Although the dual diagnosis at El Camino was helpful, tackling the addiction has relieved her depression.

35. Respondent anticipates being treated for addiction to some extent for the rest of her life. The rehabilitation program and therapy have opened her eyes and given her more insight into the disease of addiction as well as her own thought processes. At this point, she does not see herself going back to hospital work, but wants to continue working as an anesthesiologist. Respondent credibly asserted that she has systems in place to support her sobriety and to manage the pain from her migraine headaches.

EXPERT OPINION EVIDENCE AND CURRENT TREATMENT

36. Respondent continues in treatment with Dr. Katz. He authored a report of treatment and testified at hearing. Dr. Katz received his medical degree in 2004 from Hebrew University – Hadassah School of Medicine in Jerusalem. In 2006, he completed a fellowship in psychiatry neuroscience at Stanford University Medical School and in 2010, he completed a residency in psychiatry, also at Stanford.

37. Since completing his formal education, Dr. Katz has focused on psychiatry and addiction medicine. He worked as a staff psychiatrist for the Santa Clara County correctional facilities (2009-2014), and for El Camino Hospital in behavioral health (2011-present). Dr. Katz has been the Medical Director for Addiction Treatment Services at El Camino since 2013. He has been an adjunct clinical instructor at Stanford in aspects of mental health care since 2011.

38. In 2010, Dr. Katz formed the Feeling Good Institute, a clinic in Mountain View dedicated to treatment and training in advanced CBT for patients and therapists. He serves as the Director. Dr. Katz explained that the clinic is named after the book *Feeling Good*, by psychiatrist David D. Burns, M.D. In general, CBT looks at how thought affects moods and feelings. If the thoughts can be changed, that is, the way something is thought about, mood can be changed, and anxiety and fear lessened. In addiction work, tempting thoughts are examined as negative thoughts; for example, “I will only have one” or “I deserve it,” and changed to, for example, “For me there is never only one,” and “What I deserve is to be sober.”

39. Dr. Katz met Respondent at the El Camino program. He noted that she was three months sober at that point, but struggling with depression. Respondent was a good fit for the dual diagnosis program. A full psychiatric assessment was done, a diagnosis made and treatment plan devised.

Dr. Katz observed that Respondent had already paid a huge price for her addiction. She was there on her own accord, and he was impressed. She was clearly able and hardworking, and strong in her intent to succeed. He noted that it is difficult for a successful physician to admit an addiction problem to peers; it feels humiliating. This can delay recovery, as it can prevent the person from reaching out to a support network. Dr. Katz was also impressed that Respondent had gone back to see Dr. Wong during a relapse. He believes that Respondent is a very honest person.

40. Following her completion of the El Camino program, in February 2013 Dr. Katz began seeing Respondent as a private patient for therapy and medication management. His diagnoses were opiate dependence in early remission, major depressive disorder, and chronic migraines.

The treatment goals were to maintain remission of opiate misuse, decrease shame to allow further development of a supportive system for recovery, and remission of depression. Drug screening was employed, and there have been no positive tests.

41. Dr. Katz described Respondent's treatment course with him, in pertinent part, as follows.

[Respondent] and I have met numerous times for therapy and medication treatment in the past few years. [Respondent] is a more private person and shame around her opiate addiction was targeted specifically as a key factor in helping her maintain sobriety. [Respondent] severed ties with many people in her life due to feelings of shame about her addiction and the major setbacks it created in her life. During the course of treatment [Respondent] was able to reach out and reconnect with several of these key people in her life. She was able to also form new supportive relationships and became involved in her community with her Sunday Assembly program. She was able to find work and maintain excellent relationships within it with high satisfaction from her peers and managers. She also has been able to form long lasting supportive relationships.

During the course of the treatment she always showed up on time to our appointments or would let me know if she is running late coming from work. Under my care she has always been reliable, pleasant, cooperative, and well groomed. There have been no signs of active drug use.

[¶] . . . [¶]

Summary and current diagnosis, treatment goals and plans.

Opiate Dependence which is in Full Sustained Remission:⁽¹⁾

It has been my pleasure to work with [Respondent] and have her under my care for well over two years. During the course of her treatment [Respondent] has made significant progress in the management of her opiate dependence including maintenance of

¹ Dr. Katz defined sustained remission as over one year in duration.

sobriety, creation of a supportive recovery system, decrease in shame and increase in her ability to form and maintain meaningful personal and work relationships in her life. Furthermore, during the course of her treatment [Respondent] has never given up finding a better source of relief for her migraine headache pains. As a result of that, and with the introduction of hormonal treatment in the past year, these pains have decreased significantly.

Her level of function is clearly very high, she appears to be doing very well at work. She appears to value her work and care for others very seriously.

Major Depressive Disorder:

Symptoms of depression continued to mild during the course of her treatment. Lamotrigine and Wellbutrin appear to be a good combination for her symptoms. Despite significant stressors, there hasn't been a full blown relapse of depression symptoms during the course of her treatment under my care.

Further Treatment Recommendations

- Continue with SMART Recovery and the maintenance of a recovery oriented support system.
- Continue with current medication treatment for depression and migraine prevention.
- Psychotherapy targeting shame and creation of meaningful relationships as well as coping skills with severe pain.

42. Dr. Katz opined that Respondent can safely practice anesthesia at this time if she is monitored. Although he characterized her addiction as a "milder form," it will never go away and she will always need to be careful. Concerns about her exposure to narcotics can be addressed with mandates for continuing with the SMART meetings, random testing, and other forms of practice monitoring. Dr. Katz's opinion was well-reasoned and supported by his expertise and knowledge of Respondent. It was persuasive.

CURRENT EMPLOYMENT

43. Robin Dennings, M.D., currently employs Respondent. He was licensed to practice in California in 1994, and worked for many years as a staff anesthesiologist, with a Part-time practice in pain management. Dr. Dennings began to work at outpatient surgery centers and found that he enjoyed the environment. In 2007, he formed Empire Anesthesia, Inc., to help staff surgery centers with anesthesiologists.

44. Empire employs a core group of approximately six to seven physicians, and has another 10 to 20 who "float in and out." They are all independent contractors, and provide services at various types of surgery centers, including those specializing in plastic surgery, fertility and orthopedics. Dr. Dennings occasionally works at a surgery center as an anesthesiologist as well.

45. Dr. Dennings first met Respondent in 2012 when he was recruiting staff. Respondent was "up front" about her problems with drug diversion and addiction, and that she was in treatment for addiction issues. He was very impressed at her candor; she did not minimize her problems as others have done. Dr. Denning obtained her credentialing information and found everything well explained. He decided to give Respondent a try.

46. Dr. Dennings did not want Respondent to have access to narcotics initially, so he assigned her to work in gastro-endoscopy centers. The other physicians were informed of her history. She did well and was well liked, so he decided to try Respondent in an operating room. He sent her to centers in Fremont and Benicia and again, the experience was positive, despite the more hospital-like and stressful environments. There were never any discrepancies with the medications.

47. When the accreditation authorities came to examine the surgery centers, they would call about Respondent and her history. Dr. Denning gave them information, including how Respondent was monitored. Peer performed, random chart reviews were conducted, and no problems were identified with Respondent's charts.

48. The only complaint Dr. Denning has received is about speed; and he was fine about receiving such a complaint. He explained that there is an ongoing tension between surgeons, who want to get on with the operation, and anesthesiologists, who are safety oriented. The complaint was that Respondent takes too long sometimes in going over the charts.

49. In sum, Dr. Denning would like to "clone" Respondent and "send her everywhere." She has excellent skills, is very reliable, and is not opposed to traveling where she is needed. He remains concerned about her addiction, but he is experienced with addiction. He has worked with nurses who have the same issues, and finds that there are telltale signs. Also, the drugs need to be carefully monitored, and they are. He is willing to be Respondent's practice monitor and believes it would be workable.

50. Respondent greatly enjoys her work at the surgery centers. She was started at centers where only propofol was given, then advanced to centers with more variety of cases and medications. Respondent has worked on orthopedic cases, plastic surgery procedures, and pacemaker implants, among others. Each case has a pain management requirement, and Respondent writes orders for the recovery room for nausea and vomiting, as well as pain control. At each center, a drug count is made correlating the amounts ordered and received with the amounts used. She receives a box containing the drugs she requests for the day, and it is signed out by the nurse. At the end of the day, she returns the box to the nurse and they both verify that the numbers match. She does any wastage together with the nurse.

Other matters

51. Complainant moved into evidence, without objection from Respondent, records from the Oregon Medical Board. The records demonstrate that on January 30, 2012, the Oregon Medical Board issued license number MD153761 to Respondent and that Respondent surrendered her Oregon license effective October 3, 2014. There is no corresponding allegation in the Accusation addressing this documentary evidence.

52. The circumstances of the surrender are that the Oregon Board opened an investigation on December 23, 2013, regarding Respondent's "non-compliance with mandatory reporting requirement on her initial license application and other possible violations of the Medical Practice Act." Respondent and the Oregon Board agreed to close the investigation pursuant to a Stipulated Order, under which Respondent agreed to surrender her license while under investigation. She did not admit or deny the allegations, but the Oregon Board found that she had committed unprofessional or dishonorable conduct as defined in ORD 677.188(4)(a), and 677.190(8), fraud or misrepresentation in applying for or procuring a license to practice medicine.

53. Respondent explained that she applied for licenses in other states while working for the locum tenens firm. She denies misrepresenting any information to the Oregon Board; she now believes she may have misread something on the application. Respondent did not see that she would be working there in the future, so working with an attorney, decided to end the matter by a stipulation. Respondent's explanations were credible.

LEGAL CONCLUSIONS

1. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes misuse of controlled substances (Bus. & Prof. Code, § 2239, subd. (a)), gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)), violation of drug laws (Bus. & Prof. Code, § 2238), and the practice of medicine while under the influence of narcotics (Bus. & Prof. Code, § 2280).

2. The evidence established that Respondent misused controlled substances. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2239, subdivision (a), by reason of the matters set forth in Findings 11 through 15 and 21 through 28.

3. The evidence established that Respondent was grossly negligent in that she used controlled substances while working as an anesthesiologist during surgical procedures. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings 11 through 15 and 21 through 28.

4. The evidence established that Respondent committed repeated negligent acts, in that she used controlled substances while working as an anesthesiologist during surgical procedures. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Findings 11 through 15 and 21 through 28.

5. The evidence established that Respondent violated drug laws. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2238 by reason of the matters set forth in Findings 11 through 15 and 21 through 28.

6. The evidence established that Respondent practiced medicine while under the influence of narcotics. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2280 by reason of the matters set forth in Findings 11 through 15 and 21 through 28.

7. As cause for discipline has been established, it remains to determine the appropriate level of discipline to impose. In this regard, it is noted that the purpose of these proceedings is not to punish physicians, but to protect the public. Respondent requested a term of probation under appropriate conditions. Complainant agreed she was a good candidate for probation, but was unsure what terms would be appropriate and was concerned that the need for monitoring would never end.

This is a challenging case, in that it concerns a young, hard-working, personable, and able anesthesiologist with opioid addiction and a chronic pain condition. The fact that Respondent diverted drugs and used them during a surgical procedure is a highly aggravating factor. On the other hand, her drug use began in desperate response to her own medical condition. Respondent's mental state is also of concern, but the assertion that her depression is mild and situational was convincing.

Respondent now has in place a comprehensive support system for her continued recovery. This includes not only the work she continues to do to maintain sobriety such as group support sessions and her therapy with Dr. Katz, but strategy for coping with her migraines, and her employment in surgery centers with oversight by Dr. Denning. The fact that addiction is a life-long condition does not militate against probation; it is reasonable to foresee that a physician of Respondent's character and tenacity will be successful on probation, and as time passes require a less formal structure to ensure her sobriety continues. The facts warrant granting her a chance to try. All things considered, the public will be sufficiently protected in this case by a term of license probation pursuant to relevant conditions such as a practice monitor and drug and therapy conditions. Five years is the appropriate length of time in these circumstances.

ORDER

Physician's and Surgeon's Certificate No. A87960, issued to Respondent Nicole Beth Hlava, M.D., is revoked; however, revocation is stayed and Respondent is placed on probation for five years pursuant to 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. Controlled Substances - Abstain From Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to Respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed medications, Respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, strength, and quantity; and issuing pharmacy name, address, and telephone number.

If Respondent has a confirmed positive biological fluid test for any substance (whether or not legally prescribed) and has not reported the use to the Board or its designee, Respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. Respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If Respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide Respondent with a hearing within 30

days of the request, unless Respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide Respondent with a hearing within 30 days of such a request, the notification of cease practice shall be dissolved.

3. Biological Fluid Testing

Respondent shall immediately submit to biological fluid testing, at Respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. Prior to practicing medicine, Respondent shall contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, biological fluid testing. The contract shall require results of the tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and Respondent.

If Respondent fails to cooperate in a random biological fluid testing program within the specified time frame, Respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. Respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If Respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide Respondent with a hearing within 30 days of the request, unless Respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide Respondent with a hearing within 30 days of such a request, the notification of cease practice shall be dissolved.

4. Psychotherapy

Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, Respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require Respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, Respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy services.

5. Monitoring - Practice

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

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

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

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

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

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

6. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

7. Notification

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

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

8. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

9. 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.

10. 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.

11. Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

12. 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).

13. 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.

14. License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

15. 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 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.

16. 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.

17. 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 in California 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 years.

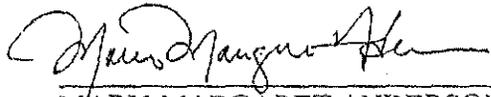
Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice 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 and General Probation Requirements.

18. 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.

DATED: July 1⁶, 2015



MARY-MARGARET ANDERSON
Administrative Law Judge
Office of Administrative Hearings