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

In the Matter of the First Amended
Accusation Against:

EDWARD SVADJIAN, M.D. Case No. 17-2013-231670

Physician's and Surgeon's
Certificate No. A 36685

Respondent.

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order 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 May 20, 2016.

IT IS SO ORDERED April 21, 2016.

MEDICAL BOARD OF CALIFORNIA

By: Howard Krauss, M.D., Chair
Panel B
In the Matter of the First Amended Accusation Against:

EDWARD SVADJIAN, M.D.
4454 Ventura Canyon Ave., #207
Sherman Oaks, CA 91423

Physician's and Surgeon's Certificate No. A 36685

Respondent.

Case No. 17-2013-231670
OAH No. 2014110928

STIPULATED SETTLEMENT AND DISCIPLINARY ORDER

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

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Trina L. Saunders, Deputy Attorney General.

2. Respondent Edward Svadjian, M.D. ("Respondent") is represented in this proceeding by attorney Art Kalantar, Esq., whose address is 150 South Rodeo Drive, Suite 260 Beverly Hills, California 90212
3. On or about May 11, 1981, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 36685 to Edward Svdjian, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 17-2013-231670 and will expire on October 31, 2016, unless renewed.

JURISDICTION

4. First Amended Accusation No. 17-2013-231670 was filed before the Medical Board of California (Board), and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on May 15, 2015. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 17-2013-231670 is attached as Exhibit A and is incorporated herein by reference.

ADVIEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 17-2013-231670. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

9. Respondent understands and agrees that the charges and allegations in First Amended
Accusation No. 17-2013-231670, if proven at a hearing, constitute cause for imposing discipline
upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the First Amended Accusation without the expense and
uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could
establish a factual basis for the charges in the First Amended Accusation, and that Respondent
hereby gives up his right to contest those charges.

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

CONTINGENCY

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

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

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

IT IS HEREBY ORDERED that Physician’s and Surgeon’s Certificate No. A 36685 issued to Respondent Edward Svadjian, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category 1 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. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent’s initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent’s expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

3. **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 equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent’s initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent’s expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

4. **CLINICAL TRAINING PROGRAM.** Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of
California - San Diego School of Medicine ("Program"). Respondent shall successfully complete
the Program not later than six (6) months after Respondent's initial enrollment unless the Board
or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-
day assessment of Respondent's physical and mental health; basic clinical and communication
skills common to all clinicians; and medical knowledge, skill and judgment pertaining to
Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum,
a 40 hour program of clinical education in the area of practice in which Respondent was alleged
to be deficient and which takes into account data obtained from the assessment, Decision(s),
Accusation(s), and any other information that the Board or its designee deems relevant.
Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical
education, the Program will advise the Board or its designee of its recommendation(s) for the
scope and length of any additional educational or clinical training, treatment for any medical
condition, treatment for any psychological condition, or anything else affecting Respondent's
practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall
submit to and pass an examination. Determination as to whether Respondent successfully
completed the examination or successfully completed the program is solely within the program's
jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training
program within the designated time period, Respondent shall receive a notification from the
Board or its designee to cease the practice of medicine within three (3) calendar days after being
so notified. The Respondent shall not resume the practice of medicine until enrollment or
participation in the outstanding portions of the clinical training program have been completed. If
the Respondent did not successfully complete the clinical training program, the Respondent shall
not resume the practice of medicine until a final decision has been rendered on the accusation
and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

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

Within 60 calendar days of the effective date of this Decision, and continuing throughout the first three years of probation, Respondent’s practice shall be monitored by the approved monitor. Following the third year of probation, upon the recommendation of the practice monitor, and a determination by the practice monitor, that monitoring of Respondent’s practice is no longer necessary or useful, this term will be considered fulfilled. If such a recommendation and determination are not made Respondent will be required to comply with all of the requirements of the practice monitor condition throughout the remainder of his probation.

Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.
If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

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

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent’s expense during the term of probation.

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

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

7. **SUPERVISION OF PHYSICIAN ASSISTANTS.** During probation, Respondent is prohibited from supervising physician assistants.

8. **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.

9. **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.

10. **GENERAL PROBATION REQUIREMENTS.**

    **Compliance with Probation Unit**

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

    **Address Changes**

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

    **Place of Practice**

    Respondent shall not engage in the practice of medicine in Respondent’s or patient’s place

STIPULATED SETTLEMENT (17-2013-231670)
of residence, unless the patient resides in a skilled nursing facility or other similar licensed
facility.

License Renewal

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

Travel or Residence Outside California

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

In the event Respondent should leave the State of California to reside or to practice
Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of
departure and return.

11. 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.

12. 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 (2) 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.

13. **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.

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

15. **LICENSE SURRENDER.** Following the effective date of this Decision, if
Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy
the terms and conditions of probation, Respondent may request to surrender his or her license.
The Board reserves the right to evaluate Respondent’s request and to exercise its discretion in
determining whether or not to grant the request, or to take any other action deemed appropriate
and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
shall within 15 calendar days deliver Respondent’s wallet and wall certificate to the Board or its
designee and Respondent shall no longer practice medicine. Respondent will no longer be subject
to the terms and conditions of probation. If Respondent re-applies for a medical license, the
application shall be treated as a petition for reinstatement of a revoked certificate.
16. **PROBATION MONITORING COSTS.** Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

**ACCEPTANCE**

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

DATED: **11/10/15**

EDWARD SVADJIAN, M.D.
Respondent

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

DATED: **11/10/15**

ART KALANTAR
Attorney for Respondent
ENDORSEMENT

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

Dated: November 16, 2015

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

[Signature]

TRINA L. SAUNDERS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 17-2013-231670
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation
Against:
EDWARD SVADJIAN, M.D.
4454 Ventura Canyon Avenue, #207
Sherman Oaks, California 91423

Physician's and Surgeon's Certificate No. A
36685,

Respondent.

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California ("Board").

2. This First Amended Accusation supplants the original Accusation in this matter and includes the charges brought in that pleading herein.

3. On May 11, 1981, the Board issued Physician's and Surgeon's Certificate number A 36685 to Edward Svadjian, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2016, unless renewed.
4. This First Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code states:
"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence - 4 Patients)

8. Respondent is subject to disciplinary action under section 2234(b) in that Respondent was grossly negligent in his care and treatment of patients S.S., D.A., S.A., and D.P. The circumstances are as follows:

Patient S.S.

9. On or about July 7, 2011, Patient S.S., a forty-six year-old female, presented to Respondent. Boxes on a pre-printed medical history form were checked for dizzy spells, asthma/wheezing, shortness of breath on exertion, chest pain, high blood pressure, irregular pulse/palpations, leg pain/walking, indigestion or heartburn, chronic fatigue, GERD, muscle weakness, numbness/tingling sensations, arthritis/rheumatism, back pain recurrent, foot pain/cold numb feet, sleeping difficulty, and nervousness/depression. Hypertension and obesity are written in this section. The synopsis states “pain in her epigastric area, chest pain (angina), palpitations, coronary artery disease, dizziness seen with loss of balance, insomnia, nervousness & anxiety & depression, severe headaches.” The medication allergy section is blank. The medication section states “continue all meds as ordered before.” There is no medication list reviewed on this date. The record indicates that the patient is 5’2”, 144 pounds (BMI 26.3), has a blood pressure of 120/80, a pulse of 69, respiratory rate of 16 and a temperature of 98.5. Her general appearance is noted, “satisfactory.” There is no other documented history. The synopsis and plans section is blank. A twelve-lead electrocardiogram (EKG) was performed. Respondent’s interpretation of the EKG is “ST-T wave abnormalities.” No referral to a cardiologist was made and no additional cardiac testing was ordered. Blood and urine samples were collected. The patient’s cholesterol was 242, triglycerides were slightly elevated at 205 and the patient’s low density lipoprotein was elevated at 150.

10. On or about August 15, 2011, Patient S.S. presented to Respondent with complaints of “severe lightheadedness and dizziness (seen with loss of balance), chest pain (angina),
palpitations, severe neck pain and lower back pain, bilateral leg and foot pain, severe nocturia (2-3x).” The physical examination documentation states only that the patient is 5’2”, and weighs 142 pounds (BMI 26). The diagnosis section lists, “hypertension, depression, degenerative arthritis, chest pain (angina), palpitations, coronary artery disease, severe dizziness with nausea, vomiting (seen with loss of balance), migraine headaches, insomnia, nervousness & anxiety. The written order states, “D/C Lipitor,” “Abilify 5 mg BID,” and “continue all meds as ordered earlier.” No medication list included in the progress note.

11. On or about October 3, 2011, patient S.S. presented for her next visit. The patient’s documented history is, “46 year old with c/o severe lightheadedness and dizziness (seen with loss of balance), chest pain (angina), palpitations, severe neck pain, right shoulder pain, severe lower back pain, bilateral leg and foot pain, severe bilateral knee pain.” Nocturia (2-3x) is written in the margin. The physical exam includes normal vital signs, an oxygen saturation of 99%, weight of 141 pounds, height of 5 foot 2 inches, and an “R sided carotid artery bruit.” The remainder of the physical exam is illegible. The diagnoses are hypertension, general weakness, chest pain, palpitations, coronary artery disease, morbid obesity, “Mediterranean disease,” and asthma. Respondent made orders for colchicine 0.6 mg and indomethacin 25 mg, Naprosyn 600 mg after food twice daily. There is a note to, “continue all meds as ordered before.” Additionally, Silvadene cream was ordered to apply to a burn on the anterior chest. A carotid ultrasound was performed. Respondent read it as 20-40% blockage.

12. On or about November 21, 2011, patient S.S. again presented at the clinic. The note includes all of the complaints listed on the October 3, 2011, note. In addition, it states, “painful varicose veins” and “nocturia x 2”. Normal vital signs are documented. In addition, physical exam elements such as lungs, cardiac, abdomen, neck and general are checked. Diagnoses include hypertension, arthritis, chest pain, palpitations, coronary artery disease, morbid obesity, asthma, and “Mediterranean Disease.” There are orders to continue Naprosyn, indomethacin, and colchicine. A venous Doppler ultrasound is referenced which was consistent with “reduced augmented flow consistent with chronic valvular incompetence.”

13. On November 21, 2011, the EKG was repeated. The results were unchanged.
14. The first medication list appears in the chart on December 8, 2011. It is from Hye Pharmacy and is a refill request. The medications for refill include: Actonel 150 mg, Advair 0.25-0.50 inhaler, Altenolol 25 mg, Detrol LA 4 mg, Diovan HCT 12.5-160 mg, Cymbalta 50 mg, Teximex 85-500 mg, Nasonex 50 mcg nasal inhaler, Singular 10 mg, Zetia 10 mg, Abilify 5 mg, and Acyclovir 400 mg. Requests for Nexium 40 mg and Ambien 5 mg were crossed out.

15. On or about December 13, 2011, patient S.S. presented to Respondent. The progress note indicates that the patient is to continue all medications as ordered before. An arterial study was conducted.

16. On or about March 26, 2012, patient S.S. presented to Respondent. The progress note indicates that the patient is to continue all medications as ordered before. A number of blood tests used to diagnose rheumatologic disease were ordered without specific documented symptoms to indicate the need for them.

17. On March 26, 2012 an EKG was performed. It showed no change.

18. On or about April 2012, Respondent performed a second carotid ultrasound.

19. On or about May 8, 2012, the patient presented to Respondent for severe lightheadedness with dizziness and loss of balance, chest pain (angina), palpitations, severe low back pain, bilateral leg and foot pain with difficulty walking. The patient also had varicose veins. The patient’s blood pressure was 140/80. There was no repeat blood pressure, change in blood pressure treatment, nor follow-up planned.

20. On or about June 11, 2012, a note identical to the one on May 8, 2012, was written, with one significant addition. The addition was an order for a colonoscopy. No clinical reason for the colonoscopy was noted. However, the order itself contains a comment that the patient had a history of a previous colonoscopy where a polyp was found and that the patient was currently complaining of abdominal pain. GERD is also written on the note. However, there was no historical information on this progress note to support such a diagnosis.

21. On June 11, 2012, an EKG was performed. It showed no change.

22. On or about July 10, 2012, patient S.S. presented to Respondent. The complaint list was copied verbatim from the previous notes. “Intermittent claudication” was written in the left
margin without clarifying history. This was ruled out on previously repeated ultrasounds of the leg. There is no documentation of physical examination of the leg or foot pulses. Medications were not changed at this visit. Another venous ultrasound was performed. No significant problems were noted.

23. On or about August 13, 2012, patient S.S. presented to Respondent. She was prescribed Dexilant. There is no history of GERD referenced, nor are symptoms of same contained in the progress note. No thyroid abnormality is described on physical exam and the thyroid blood testing of June 12, 2012, was normal. Respondent performed a thyroid ultrasound, which identified a thyroid nodule.

24. On or about September 17, 2012, patient S.S. presented to Respondent. Thyroid nodule was not listed as a diagnosis on this visit.

25. On or about October 5, 2012, patient S.S. presented to Respondent. The progress note was again copied verbatim from prior notes. Atenolol 25 mg, meclizine 25 mg, Trilipix 135 mg, and Ambien 5 mg, were prescribed.

26. There are notes copied verbatim from the October 15, 2012, visit on both November 14, 2012, and January 7, 2013. The medications were not changed on these visits.

Summary of Testing

27. EKG's were performed on July 7, 2011, and repeated on November 21, 2011, March 26, 2012, June 11, 2012 and November 15, 2012. The results were consistently unchanged. The test demonstrated low QRS voltages in precordial leads, and non-specific ST-T wave changes. All of the results were essentially normal.

28. On November 21, 2011, pulmonary functioning tests were performed. There was no evidence of asthma. Results of another undated pulmonary functioning test are contained in the patient chart. The undated test did not show evidence of asthma.

29. The following laboratory testing was completed:

(A) On July 7, 2011, a large amount of blood testing was ordered. The results of all routine testing, as well as testing with no specific documented indication were normal, with the exception of lipids, which was a little elevated.
(B) November 21, 2011, laboratory testing was repeated. All tests were normal, with the exception of ASO titer being high with a possible recent strep infection (no clinical significance), and cholesterol which had no major change.

(C) On March 26, 2012, laboratory testing was repeated. All tests were normal, with the exception of ASO titer being high with a possible recent strep infection (no clinical significance), and cholesterol which had no major change.

(D) On June 12, 2012, laboratory testing was repeated. All tests were normal, with the exception of ASO titer being high with a possible recent strep infection (no clinical significance), and cholesterol which had no major change.

(E) On October 16, 2012, laboratory testing was repeated. All tests were normal, with the exception of ASO titer being high with a possible recent strep infection (no clinical significance), and cholesterol which had no major change.

30. Venous studies of the lower extremities were performed on November 21, 2011, May 8, 2012, and November 12, 2012. All results were clinically insignificant.

31. Carotid Doppler ultrasound testing was completed on November 3, 2011 and September 17, 2012. All results were clinically insignificant.

32. Lower extremity arterial ultrasound testing was performed on December 13, 2011 and July 10, 2011. None of the results of this testing was clinically significant.

33. Thyroid ultrasound testing was performed on August 13, 2012. The results of the test were clinically insignificant.

April 15, 2014, Medical Board Interview of Respondent

34. On April 15, 2014, Respondent was interviewed by Medical Board personnel regarding Medical Board Investigation No. 17-2013-231670. Respondent indicated the following during that interview:

   (A) That he contacted the patient’s pharmacy and requested that they refill all medications that the patient was already taking before seeing him;

   (B) If a patient likes the medicines they are on, he refills them. He assumes that the medications being previously prescribed are appropriate;
(C) He did not request the patient’s prior treatment records. He does not request a patient’s prior medical records, nor does he contact the patient’s prior physician because he finds no benefit in doing so. In this instance he indicated that he did not request the records from the patient’s prior physician because she looked healthy in spite of the medications she was being prescribed;

(D) During the course of treating the patient, Respondent discontinued prescribing Nexium, Plavix and Lipitor to her. However, he does not know the reason(s) he did so;

(E) He saw the patient on multiple visits without conducting an examination of the patient because she “looked healthy.” In addition, he refused to perform appropriate portions of the exam (breast, rectal, pelvic, etc.) because he assessed that the patient, “wouldn’t want them”;

(F) When patients have epigastric pain they have GERD;

(G) He determined that the patient had coronary artery disease because she complained of chest pain. He indicated that everyone with chest pain has coronary artery disease;

(H) The patient’s dizziness/loss of balance was due to her changing positions. (i.e. laying down to standing). He determined that there was no need to try to identify the cause of the dizziness since it was determined that it occurred from her changing positions and he knew of nothing else to evaluate this.

(I) It was unnecessary to conduct a physical examination because the patient was in good shape. However, he did do an ultrasound on her carotid arteries and an echocardiogram.

(J) With respect to the December 13, 2011, arterial study results, he stated, “it wasn’t bad.” The test results proved that he was right in assessing that the patient’s leg pain was not due to poor circulation. He also stated that to determine the existence of a neurological etiology would require a neurological test. However, no such test was conducted because he does not have the equipment for that in his office.

(K) Detrol was prescribed to control the amount of times the patient went to the bathroom. No pelvic exam was conducted and the patient was not referred to a gynecologist because, “they don’t do anything” for this. With respect to the possibility of cancer he indicated,
"I have seen more than anyone else in the world." "She isn't a smoker." He indicated that cancer is for those over 65 years old.

(L) A thyroid ultrasound was conducted to see what was causing the patient's nervousness. Respondent stated that any kind of thyroid problem could cause nervousness.

(M) A repeat carotid ultrasound was conducted six months after the first one because he continued to hear a carotid bruit. The test was repeated despite there being no other new symptoms.

(N) On November 21, 2011, Respondent conducted a repeat EKG. It was without change. It showed some ST-T abnormalities. Respondent compared different leads to show there was a difference/change.

(O) When patients have epigastric pain they have GERD. All patients with upper abdomen pain have GERD. When asked about other problems that could cause upper abdomen pain, he said, "it's GERD."

(P) In response to the patient's complaints of dizziness and loss of balance a carotid artery ultrasound was conducted. He did not know what else to do for the patient's symptoms. He made comments about labyrinthitis being rare and a condition of the elderly and not a possibility for this patient. Additionally, he did not take a thorough history and physical, reduce any of the patient medications, or consider neurological etiologies in response to the patient symptoms.

(Q) Respondent stereotypes patients and their health based on age, nationality, size, and gender.

Departures from the Standard of Care

35. Respondent was grossly negligent in his care and treatment of S.S. and committed the following extreme departures from the standard of care:

A. Respondent's failure to perform and document an adequate history and physical examination and examine the patient on an ongoing basis, in spite of multiple symptoms over a prolonged time, constitutes gross negligence.
B. Respondent’s failure to appropriately evaluate, diagnose and manage the patient’s chest pain and his diagnosis of coronary artery disease with no basis is an extreme departure from the standard of care.

C. Respondent ordered unnecessary diagnostic tests without medical indication to do so, and without adequate history taking and examination to justify. This is an extreme departure from the standard of care.

Patient D.A.

36. On or about October 18, 2012, Patient D.A., a thirty year-old female, presented to Respondent. The history and physical documented on this day is difficult to read. The synopsis lists severe abdominal pain, severe light headedness and dizziness (seen with loss of balance), diabetes mellitus, nervousness and anxiety, depression, history of pancreatitis, chest pain, palpitations, coronary artery disease, loss of balance (dizziness related), hypertension, and morbid obesity. Medical history documented the following: recurrent back pain, headaches, muscle weakness, indigestion or heartburn, bronchitis-chronic cough, high blood pressure, irregular pulse palpitations, leg pain/walking, shortness of breath on exertion, recurrent back pain, dizzy spells, memory loss and nervousness/depression are marked under medical history. No history of present illness is documented. A right sided carotid artery bruit is documented. A carotid ultrasound did not show any significant stenosis. Respondent wrote, “continue all meds as ordered before” and lists Lantus 30 U AM 30 U PM and Novolog 50 U AM and none PM, clonazepam 0.5 mg US, famotidine 20 mg twice daily, Tylenol #3 twice daily, meclizine 25 mg daily, Ambien controlled release 12.5 mg at bedtime, Tricor 12.5 mg tab daily. Respondent does not associate these medications with specific diagnoses in his note nor does he indicate specifically if any of these are new prescriptions for the patient, if the patient was receiving them for the first time, or if there were any dosage changes.

37. Patient D.A. had blood work drawn. A vitamin D deficiency and poorly controlled diabetes were noted. There is no evidence that the patient was notified of these results, nor were any additions or changes made to the patient’s medical therapy.
38. On November 8, 2012, Respondent wrote a new prescription for Vicodin ES 7.5-750 mg #30 tabs for patient D.A. to take every six hours as needed for pain. There is no documented visit or examination of the painful condition, which Respondent noted to be “chronic pancreatitis.”

39. On January 23, 2013, patient D.A. saw Respondent. She had complaints of severe left sided chest pain after falling at home one week prior. X-rays showed a left upper rib fracture. Severe pain and some shortness of breath were noted. No additional history was documented. Physical examination of the chest revealed tenderness but was otherwise normal. Nocturia x 2 was documented. There is a list of diagnoses: chronic pancreatitis, diabetes mellitus, asthma, hypertension, degenerative arthritis (site not specified), chest pain, coronary artery disease, severe left sided chest pain with shortness of breath (status post falling down at home). The patient was advised to “continue all meds as ordered before.” Vicodin 5.0/350 mg twice daily was prescribed. The prescription quantity is listed as “#30 or #45 or #60.” The patient’s blood pressure was recorded at 140/80.

40. On March 1, 2013, Respondent prescribed clonazepam 0.5 mg #30 for bedtime use and Ambien CR 12.5 mg #30 for bedtime use.

41. On May 2, 2013, Respondent prescribed Ambien 10 mg for bedtime #30.

42. On June 3, 2013, Vicodin extra strength 7.5-750 mg every six hours for pain as needed #30 was prescribed to patient D.A.

43. On July 18, 2013, patient D.A. was seen with essentially the same list of complaints and no clarification of symptoms. The patient additionally complained of “painful varicose veins.” Creon, Indocin 25 mg twice daily, and Glucophage 1000 mg twice daily were prescribed. The record references Humalog insulin 60 units twice daily. A leg venous Doppler ultrasound was done showing “reduced augmented flow” on both legs but also says “normal augmented flow.”

44. Primary care physicians are required to evaluate through appropriate history and physical examination, every reasonable concern brought up by a patient and his or her caregivers. Documentation of this discussion is required to ensure safe and beneficial continuity of care.
When further evaluation and management of a patient requires the input of specialist physicians, a referral should be made.

**Departures from the Standard of Care**

45. Respondent was grossly negligent in his care and treatment of D.A. and committed the following extreme departures from the standard of care:

A. Respondent failed to evaluate multiple, potentially serious patient complaints made by the patient, including those of chest pain, shortness of breath and abdominal pain. He failed to perform and document an adequate history and physical examination, conduct appropriate diagnostic testing, and use analytic reasoning to assess the origin of the patient's complaints.

B. Respondent prescribed opiates, and controlled substances including benzodiazepines and sedatives, which taken together have the ability to suppress a patient's ability to breathe. The medications were prescribed without medical justification and in a manner that was excessive.

C. Respondent failed to perform and document an adequate history and physical exam prior to prescribing and/or refilling controlled substances. He inadequately evaluated and managed the patient's symptoms and diseases.

**Patient S.A.**

46. Patient S.A., a 33-year-old male, presented to Respondent for the first time on September 7, 2013. He had complaints of “attention deficit hyperactivity disorder (ADHD), occasionally he acts impulsively doing things which are not very appropriate for his age. Inattention is seen to some things at the same time.” Also, “insomnia, nervousness, and anxiety is seen, likes to develop some kind of risk condition. Major depression has been seen in his life.”

47. The physical examination was documented with check marks on a pre-printed sheet. Patient S.A.'s vital signs were normal.

48. Patient S.A. was diagnosed with ADHD and prescribed Adderall 30 mg daily #30.

49. Patient S.A.'s next visit was on October 5, 2013. The patient's previous condition was repeated. Respondent diagnosed the patient with “Attention Deficit Hyperactivity disorder,
insomnia is seen with some depression like condition, nervousness and anxiety is seen." Patient
S.A. was prescribed Adderall XR 30 mg caps daily #30.

50. Patient S.A. was next seen by Respondent on November 12, 2013. He had
complaints of lower back pain after falling down while horsing around at home with friends. His
vital signs were normal. Physical examination indicated that the patient was in distress due to
pain and there was back tenderness. No further detail was given as to the location of the pain.
No imaging was ordered. The patient was prescribed hydrocodone/acetaminophen 10/325 #90
for back pain. Physical therapy was recommended. No physical therapy notes appear in the
patient chart.

51. Patient S.A. was seen on twenty occasions between November 12, 2013 and October
6, 2014. On each visit either ADHD, severe lower back pain, or both are documented without
clarification. There is no documentation indicating whether either condition or function are
improved. On almost every visit, if not all, Respondent prescribed Norco 10/325 #90. There is
no documented discussion of the risks, benefits, treatment alternatives, or potential side effects of
the drug. There is no clarification of any substance abuse, or alcohol history documented. There
is no referral to physical medicine and rehabilitation, pain management, or psychiatry.

Departures From the Standard of Care

52. Respondent was grossly negligent in his care and treatment of patient S.A. and
committed the following extreme departures from the standard of care:

A. Respondent failed to evaluate the complaints made by the patient. He did not
perform and document an adequate history and physical examination, conduct appropriate
diagnostic testing, and use analytic reasoning to assess the origin of the patient's complaints and
then treat the symptoms and or disease.

B. Respondent prescribed excessive quantities of opiate pain medications without
a medical justification or proper clinical documentation, failed to determine the level of risk of
misuse by the patient before prescribing same, and did not obtain documented consent from the
patient or devise a plan of treatment.
Patient D.P.

53. Patient D.P., a 36 year-old female, saw Respondent for the first time on June 9, 2008. No history of present illness was documented. There is a general synopsis which states, “36 year old female is here c/o general weakness, severe headache, sore throat, cough with expectoration, sob, dyspnea, CP/angina, palpitation, severe dizziness, loss of balance, occasional blurred vision, morbid obesity, chest pain (angina), degenerative arthritis, sore throat. A past surgical history of spinal surgery, and rotator cup (sic) surgery, in 2007 and C-section (2x) in 1989.”

54. The medication list is diazepam 10 mg BID, Norco 10/325 TID, Abilify, Promethazine with codeine TID, Augmentin 500 mg BID for 7 days, Diflucan 150 mg daily and Nistatin [sic] BID.

55. The physical examination documented clear lungs and a normal cardiac exam. There is tenderness on the back and knees and an illegible comment about the ankles/feet. Vital signs include a blood pressure of 135/80, pulse 72, and respiratory rate of 14, normal temperature and weight of 267 pounds. There is a second page synopsis which repeats all of the above listed symptoms and adds bipolar disorder.

56. The plan is documented as spirometry, blood test with urinalysis, EKG, carotid artery ultrasound and instruction to return in 2-4 weeks. The carotid ultrasound notes, “no abnormalities were identified.” The EKG is interpreted as sinus rhythm, ST-T wave abnormality. The office spirometry lists “mild restriction, FEV1-100%.”

57. On June 25, 2008, patient D.P. presented to Respondent’s clinic with a chief complaint of, “severe suprapubic pain, mid-back pain, painful/frequent urination, nocturia for 2 days. Lightheadedness, chest pain and palpations, and severe neck pain are documented.

58. The physical exam section has innumerable overlapping check marks and circles, indicating the patient had distress from pain, neck tenderness and reduced range of motion, bruits, back tenderness, decreased range of motion and muscle spasm. Her blood pressure was 140/80. Range of motion abnormalities of arms and legs, without further explanation is documented.

59. Respondent made the following diagnosis: hypertension, anterior fusion of the cervical spine, morbid obesity, degenerative arthritis, chest pain, palpitation, coronary artery
disease, and UTI. A renal ultrasound was completed in the office with normal results. The patient was to, “continue all meds as ordered before.” In addition, Vytorn 10/10 daily, Percusate (presumably Percocet) 5/325 one three times daily and promethazine with codeine one teaspoon three times daily, were prescribed. The patient was to return in 2-3 weeks.

60. The lab results collected on June 9, 2008, revealed elevated total cholesterol of 268 and LDL cholesterol of 181. An ALT was 9 and hemoglobin was 11.9, with a normal reference range of 12-14.9 gm/dL.

61. Patient D.P. presented on August 15, 2008, with a chief complaint of severe chest discomfort, CP, palpitation, and severe dizziness. A strong family history of heart disease is noted. The patient had a blood pressure of 140/80 and pulse 72.

62. The record of physical examination has several overlapping circles and hand written check marks which make it impossible to understand the findings. “Clear to auscultation” is checked under the lung exam but shortness of breath, wheezing, rhonchi and rales are either checked, circled, or both. Respondent completed an echocardiogram which showed left atrial enlargement and an ejection fraction of 58%. Hyperlipidemia, hypertension, morbid obesity, chest pain, palpitation, and coronary artery disease is noted. Vytorn is discontinued. Lipitor 20 mg is prescribed for high cholesterol with Zetia 10 mg separately without explanation. A weight loss program was recommended. Patient D.P. was advised to return in 2-4 weeks. No referrals to specialists were made.

63. On October 20, 2008, patient D.P. presented with severe headaches, severe dizziness, chest pain, URI and flu-like condition, acute cough, severe lower back pain, and anxiety. Mild swelling of the ankles and feet, painful varicose veins, hypertension, degenerative arthritis, morbid obesity, chest pain, palpitations, coronary artery disease are documented. A leg ultrasound performed in Respondent’s office showed no deep venous thrombosis. The patient was to continue all medications as previously ordered.

64. On November 19, 2008, patient D.P. presented with continued complaints of severe headaches, severe dizziness, and cold and numb legs and feet. The patient had a blood pressure of 130/80. Respondent diagnosed the patient with painful bilateral leg pain, intermittent
claudication, chest pain and palpitation, morbid obesity, and degenerative arthritis. Respondent performed a leg artery ultrasound which he reported was normal and the patient was instructed to continue all medications as before.

65. On December 22, 2008, patient D.P. was seen. She had a right side carotid bruit, in addition to the complaints made on her prior visit. A carotid ultrasound was performed, with normal results. Percocet, promethazine with codeine and Diazepam were prescribed. In addition, patient D.P. was instructed to continue all medications as before.

66. On January 26, 2009, patient D.P. presented with the same symptoms previously identified, as well as complaints of insomnia. Her blood pressure was 140/90. The documented physical examination is unintelligible. Respondent documented the following diagnoses: hypertension, morbid obesity, chest pain, anxiety and nervousness, severe degenerative arthritis, palpitation, and severe back pain. The patient was advised to continue all medications and prescribed Soma 350 mg to be taken at bedtime.

67. On March 4, 2009, patient D.P. presented with the same symptoms as on her initial visit. Respondent’s primary diagnosis was bipolar disease, along with his previously listed diagnoses. No medication changes were made.

68. On April 10, 2009, patient D.P. presented with the same symptoms as reported on her March 4, 2009, visit, and the added complaint of nocturia. Respondent performed another out of office kidney ultrasound. The results were normal. Patient D.P. had normal vital signs. No urine lab tests were ordered and no antibiotic was prescribed. Percocet 7.5/325 was prescribed to be taken three times daily. Bipolar disease was not documented.

69. On May 22, 2009, patient D.P. presented with similar symptoms as those she had on April 10, 2009. Her vital signs were normal. Respondent documented that the patient had a history of sleep apnea and chronic cough. An echocardiogram showed an ejection fraction of 71%. The previous diagnoses are listed with the addition of tachycardia, although the pulse rate is documented as 80 beats per minute. Percocet was discontinued. Valium and Norco 10/325 to be taken three times daily were prescribed. Promethazine with codeine was prescribed to be taken three times daily.
70. Patient D.P. presented on July 10, 2009, with no change in symptoms or diagnoses. Respondent documented prescription plans for Valium, Phenergan with codeine and Norco 10/325, but wrote a prescription for OxyContin 40 mg to be taken twice daily. Nova Pharmacy records indicate that on the day the OxyContin prescription was written, patient D.P. also had prescriptions dispensed for Soma, Phenergan with codeine, Norco 10/325 #90, Valium 10 mg twice daily #60.

71. Patient D.P. presented on August 14, 2009, with no change in symptoms or diagnoses. Respondent repeated a leg artery ultrasound. No significant findings were revealed.

72. Patient D.P. presented on September 11, 2009, with no change in symptoms or diagnoses.

73. On July 7, 2010, another echocardiogram was performed. Respondent stated that it showed some left ventricular wall enlargement and an ejection fraction of 67%.

74. On or about August 8, 2010, Respondent repeated the carotid ultrasound. It was unchanged.

75. On December 17, 2010, Respondent did a venous leg ultrasound. It did not show any obstruction.

76. On July 1, 2011, Respondent notes insomnia, nervousness, anxiety and depression. No referral is made for counseling or psychiatric consultation. No changes in medication were made.

77. On October 3, 2011, Respondent diagnosed D.P. with asthma without any documented history of pulmonary issues. He prescribed inhalers (Advair and Xopenex) and Singulair. The patient chart does not indicate why so many medications were prescribed at this time or how severe the patient’s symptoms were. The patient was prescribed meclizine 25 mg daily as needed for her dizziness, told not to drink cold drinks from the refrigerator, and prescribed Macrobid 100 mg twice daily and Benadryl 25 mg to be taken at bedtime.

78. On February 10, 2012, patient D.P. was referred for gastric bypass surgery for weight loss. She was 286 pounds.
79. On March 2, 2012, Patient D.P. had a blood pressure of 150/100. Opioids and other medications were continued. Respondent ordered a Venous Peripheral Doppler. Patient D.P.’s results were normal.

80. On April 2, 2012, Patient D.P. had a blood pressure of 140/85. Respondent ordered a Venous Peripheral Doppler. Opioids and other medications were continued. Patient D.P. had an unchanged leg ultrasound.

81. On May 2, 2012, patient D.P. had a blood pressure of 135/80. Diovan 160 mg daily was prescribed. No new symptoms were documented. An Arterial Peripheral Doppler was ordered. Respondent prescribed Xanax 1 mg to be taken at bedtime.

82. On June 1, 2012, patient D.P. had a blood pressure of 160/90. Opioids and other medications were continued. Respondent ordered a Carotid Doppler.

83. On October 12, 2012, patient D.P. had a blood pressure of 150/90. It was not repeated. No adjustment was made to the patient’s medications.

84. On November 9, 2012, patient D.P. had a blood pressure of 150/80. It was not repeated. No adjustment was made to the patient’s medications.

85. On April 17, 2013, patient D.P.’s medications were continued. A Thyroid ultrasound was ordered without justification.

86. On August 16, 2013, patient D.P. presented with a weight of 141 pounds, following her weight loss after a bariatric surgery. Respondent continued to diagnose patient D.P. with morbid obesity, continued her muscle relaxers and opiates, without any attempt at weaning or referral to a specialist.

87. On April 18, 2014, patient D.P. was seen in clinic with a blood pressure of 90/80. She complained of two weeks of feeling really tired. Respondent diagnosed her with hypertension and started Lisinopril 20 mg daily. No holding parameters are documented. Respondent also prescribed Xanax, Soma, Percocet 10/325 to be taken three times daily, as well as documented that the patient is to continue all medications as before. Patient D.P. received a vitamin B12 injection. A repeat echocardiogram showed no valvular problems in the heart and a normal ejection fraction.
88. On May 21, 2014, patient D.P. returned to the clinic with severe light headedness, dizziness, chest pains, palpitations, severe neck pain, lower back pain, and foot pain. No further work-up was completed and no referrals were made. Patient D.P. was prescribed Percocet 10/650 to be taken three times daily and Norco 10/325 three times daily.

89. Patient D.P.'s last documented visit occurred on September 24, 2014. The change in symptoms from her first visit in 2008 were minimal. An echocardiogram was ordered without justification.

Departures from the Standard of Care

90. Respondent was grossly negligent in his care and treatment of patient D.P. and committed the following extreme departures from the standard of care:

A. Respondent failed to evaluate the complaints made by the patient, including but not limited to headaches, palpitations, chest pain, dizziness, abdominal pain. He did not perform and document an adequate history and physical examination, conduct appropriate diagnostic testing, and use analytic reasoning to assess the origin of the patient’s complaints and then treat the symptoms and or disease. Each complaint for which Respondent failed to evaluate the patient is a separate and distinct extreme departure from the standard of care and the failure to treat the patient’s complaints as a whole is an extreme departure from the standard of care.

B. Respondent prescribed multiple opiates in combination with other respiratory depressants without completing a complete history and physical examination, obtaining informed consent, without an on-going surveillance for side effects, functional decline, escalation of dose and trials of non-opiate therapies, and did not devise a plan of treatment. His prescribing was both without justification and excessive.

C. Respondent repeatedly performed clinically unnecessary diagnostic testing.

D. Respondent wrongly diagnosed hypertension and inappropriately prescribed blood pressure medication to the patient.

E. Respondent’s overall management of patient D.P. constitutes an extreme departure from the standard of care.
February 18, 2015, Medical Board Interview of Respondent

91. On February 18, 2015, Respondent was interviewed by Medical Board personnel regarding the care and treatment he provided to patients D.A., S.A. and D.P. Respondent indicated the following during that interview:

(A) That he contacted the patient’s pharmacy and requested that they refill all medications that the patient was already taking before seeing him;

(B) When asked about his listing chest pain on the chart and the diagnosis of Coronary Artery Disease (CAD), he indicated that he diagnosed CAD in a young patient with chest pain because he felt the EKG showed abnormalities. However, the minor ST-T wave changes are not diagnostic of CAD;

(C) Respondent indicated that dizziness in his patient was due to obesity;

(D) Respondent stated that he needs to see a patient for a few years to get to know them before knowing what is causing their symptoms;

(E) Respondent stated that codeine is not a narcotic and confirmed this when questioned about this for clarification;

(F) Respondent stated that patient D.A. had diabetic management type 1 and started the patient on Glucophage, and insulin. Glucophage is not used in type 1. Further the patient had type 2 DM;

(G) Respondent attributed numerous problems of patient D.P. to her obesity. The patient’s loss of significant weight did not change the patient’s multiple symptoms. The source of her symptoms was never investigated or determined.

SECOND CAUSE FOR DISCIPLINE

(Repealed Negligent Acts)

92. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code in that in that Respondent committed repeated negligent acts in the care and treatment of patients S.S, D.A., S.A., and D.P. The circumstances are as follows:

93. Paragraphs 8 through through 91 are incorporated by reference as though fully set forth.
Patient S.S.

94. Respondent’s failure to appropriately evaluate, diagnose, and manage patient S.S.’s shortness of breath and making a diagnosis without a documented basis is a simple departure from the standard of care.

95. Respondent’s failure to appropriately manage patient S.S.’s high blood pressure is a simple departure from the standard of care.

Patient D.A.

96. Respondent’s failure to appropriately evaluate and manage the following patient complaints and conditions in patient D.A., constitute departures from the standard of care:

97. Respondent’s failure to appropriately evaluate and manage patient D.A.’s chest pain constitutes a departure from the standard of care.

98. Respondent’s failure to appropriately evaluate and manage patient D.A.’s shortness of breath constitutes a departure from the standard of care.

99. Respondent’s failure to appropriately evaluate and manage patient D.A.’s chronic pain constitutes a departure from the standard of care.

100. Respondent’s failure to appropriately evaluate and manage patient D.A.’s abdominal pain constitutes a departure from the standard of care.

101. Respondent’s failure to appropriately evaluate and manage patient D.A.’s dizziness and loss of balance constitutes a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE
(Incompetence)

102. Respondent is subject to disciplinary action under section 2234 subdivision (d) in that he demonstrated a lack of knowledge in his care and treatment of patients S.S., D.A., S.A. and D.P. and with respect to his general breadth of medical knowledge. The circumstances are as follows:

103. Paragraphs 8 through 101 are incorporated by reference as though fully set forth.

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FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

104. Respondent is subject to disciplinary action under section 2266 in that Respondent failed to maintain adequate and complete medical records for patients S.S., D.A., S.A., and D.P. The circumstances are follows:

105. Paragraphs 8 through 101 are incorporated by reference as though fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 36685, issued to Edward Svadjian, M.D.

2. Revoking, suspending or denying approval of Edward Svadjian, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Edward Svadjian, M.D. to pay the Medical Board of California the costs of probation monitoring, if placed on probation;

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

DATED: May 15, 2015

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

Complainant

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