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

In the Matter of the Accusation Against Bijan Farah, M.D. Physician's and Surgeon's License No. A35772 Respondent.	Case No. 800-2017-029089

DECISION

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

This Decision shall become effective at 5:00 p.m. on October 16, 2020.

IT IS SO ORDERED: September 18, 2020.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
JOSHUA M. TEMPLET
Deputy Attorney General
State Bar No. 267098
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6688
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **BIJAN FARAH, M.D.** **Encino Town Medical Group** **17130 Ventura Boulevard** **Encino, CA 91316** **Physician's and Surgeon's Certificate No. A 35772,** Respondent.	Case No. 800-2017-029089 OAH No. 2019071119 **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. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, via Joshua M. Templet, Deputy Attorney General.

2. Respondent Bijan Farah, M.D. (Respondent) is represented in this proceeding by attorney Robert B. Packer, 505 North Brand Boulevard, Suite 1025, Glendale, CA 91203.

3. On August 25, 1980, the Board issued Physician's and Surgeon's Certificate No. A 35772 to Bijan Farah, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-029089, and will expire on October 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-029089 (Accusation) was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent, on November 27, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of the Accusation is attached as **Exhibit A** and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the Accusation. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in the Accusation, if proven at a hearing, constitute cause for imposing discipline on his Physician's and Surgeon's Certificate.

///

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in the Accusation, and that Respondent has thereby subjected his Physician's and Surgeon's Certificate to disciplinary action. 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 Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board 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. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an Accusation and/or Petition to Revoke Probation is filed against him before the Board, all of the charges and allegations contained in the Accusation shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 35772 issued to Respondent Bijan Farah, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three years with 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. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the 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 approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the 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. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of California Code of Regulations, title 16, section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom

component. The professionalism program shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

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

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

5. PRACTICE MONITORING. 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. 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 and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, 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 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 ten 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.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee 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 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 in hospitals, other facilities, or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

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 ten 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.

Address Changes

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

///

///

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

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

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.

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 as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or federal jurisdiction while on probation

with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

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 Board 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, Robert B. Packer. 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: 05/28/2026

BIJAN FARAH, M.D.
Respondent

I have read and fully discussed with Respondent Bijan Farah, 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: _____

ROBERT B. PACKET
PACKER, O'LEARY & CORSON
Attorney for Respondent

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 Board 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, Robert B. Packer. 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: _____

BIJAN FARAH, M.D.
Respondent

I have read and fully discussed with Respondent Bijan Farah, 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: 5/28/2020

ROBERT B. PACKER
PACKER, O'LEARY & CORSON
Attorney for Respondent

ENDORSEMENT

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

DATED: May 28, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

Joshua M. Templet

JOSHUA M. TEMPLET
Deputy Attorney General
Attorneys for Complainant

LA2018501907
34100947

Exhibit A

Accusation No. 800-2017-029089

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
CHRISTINA SEIN GOOT
Deputy Attorney General
State Bar No. 229094
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6481
Facsimile: (213) 897-9395
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Bijan Farah, M.D.** **PO BOX 260496** **ENCINO, CA 91426** **Physician's and Surgeon's Certificate No. A 35772,** Respondent.	Case No. 800-2017-029089 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about August 25, 1980, the Board issued Physician's and Surgeon's Certificate Number A 35772 to Bijan Farah, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2019, unless renewed.

JURISDICTION

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

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

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

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

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

"(b) Gross negligence.

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

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

"(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.

"...."

6. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional

conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

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."

FACTUAL BACKGROUND

8. At all times relevant to the charges herein, Respondent was a licensed physician and surgeon practicing internal medicine, urgent care, and general primary care.

///

///

Patient 1[1]

9. Patient 1 is a female born in 1981. From approximately January 2014 through at least October 2016, Respondent treated her for Depression, Anxiety, Insomnia, and Attention Deficit Disorder (ADD). He prescribed Adderall,[2] clonazepam,[3] and Ambien[4] on a regular basis. During this time period, Patient 1 also received prescriptions for Adderall, clonazepam, Ambien, and alprazolam[5] from at least three other physicians, using four or more pharmacies on a regular basis.

10. Vital signs were recorded at each visit and were significant for frequent reports of tachycardia with heart rates ranging from 100 to 116, which were never addressed by Respondent. Although Patient 1 was tachycardic on a number of occasions, Respondent often checked the box "Vital signs normal."

11. During this time period, no CURES reports were included or referenced in Patient 1's medical record. There was no controlled substances agreement, electrocardiograms (EKG), or lab results and orders on file. Urine toxicology screening was not performed. Preventative care, such as flu shots and Pap smears were also not performed. Respondent did not question Patient 1 regarding tobacco, alcohol, caffeine, or illicit drug use, and no family history or review of systems were ever noted. There were also no referrals to psychology.

12. With respect to Patient 1's ADD, there was no mention in the medical record of any specific symptoms of ADD. Routine scales or questionnaires were not reviewed or recorded, nor was there any documentation regarding the age of diagnosis or how the symptoms affected Patient 1's function. There was no other workup performed to rule out other causes of Patient 1's symptoms, such as thyroid testing, and there was no mention of what type of work Patient 1 did

---

[1] Patients are referred to by number to protect privacy.

[2] Adderall is a mixture of d-amphetamine and l-amphetamine salts in the ratio of 3:1 and is a central nervous system stimulant. It is a Schedule II controlled substance and a dangerous drug.

[3] Clonazepam is a benzodiazepine. It is a Schedule IV controlled substance and a dangerous drug.

[4] Ambien is a brand name for zolpidem, a sedative. It is a Schedule IV controlled substance and a dangerous drug.

[5] Alprazolam is a benzodiazepine. It is a Schedule IV controlled substance and a dangerous drug.

to necessitate daily medication. There was no effort to address or recommend behavioral modifications and no documentation of how the medications specifically improved the patient's function.

13. With respect to Respondent's charting, no social or family history was ever documented, nor was there any review of systems. There was minimal documentation regarding Patient 1's specific symptoms. For example, Respondent treated her for depression and anxiety yet never assessed suicidal thoughts, provoking factors, triggers, etc. Physical examinations were often minimal and Patient 1 presented on two occasions with specific complaints of a scab and hand pain, which were never addressed or examined.

Patient 2

14. Patient 2 is a female born in 1972. She referred herself to Respondent for chronic low back pain, anxiety, and chronic nausea. Respondent treated Patient 2 from 2014 through 2017. He prescribed Norco,[6] Soma,[7] Valium,[8] and Zofran regularly.

15. In the medical records, most of the "Chief Complaints" were repeated as "re-evaluation of current medication." The History of Present Illness is typically noted only as the list of diagnoses and medications "helping." Most of the assessments were noted as "Low Back, Chronic Pain Syndrome, Anxiety, Nausea" and the majority of the physical examinations are noted as reporting some tenderness and spasm in the low back. No CURES reports were included in the chart nor referenced in the chart notations.

16. Respondent prescribed Soma and Norco on a monthly basis. During the same time period, Patient 2 was receiving controlled substances, including Norco and diazepam from another physician and utilizing at least three different pharmacies on a regular basis. Respondent also prescribed Zofran (ondansetron) 4 mg one tab twice a day as needed for nausea.

17. In or about July 2014, Patient 2 reportedly began seeing a pain management physician

[6] Norco is a combination of acetaminophen and hydrocodone. Hydrocodone is an opioid pain medication. It is a Schedule II controlled substance and a dangerous drug.

[7] Soma is a brand name for carisoprodol, a muscle relaxer. It is a Schedule IV controlled substance and a dangerous drug.

[8] Valium is a brand name for diazepam, a benzodiazepine. It is a Schedule IV controlled substance and a dangerous drug.

and had been treated with Suboxone.[9] On or about April 17, 2015, Respondent diagnosed Patient 2 with opioid dependence. However, at the next visit, on or about July 10, 2015, Respondent prescribed Norco, Soma, and Valium. Respondent continued to prescribe these controlled substances at the following visits. In or about September 2015, Respondent advised Patient 2 to see a pain management specialist, however, he continued to prescribe Norco, Soma, and Valium until April 2017. There was no discussion of opiate dependence other than the diagnoses of "opioid dependence" on April 17, 2015.

18. Patient 2's medical record did not contain a controlled substances agreement or any laboratory studies. Blood testing and urine toxicology screenings were never performed. There were no specific referrals to any physical therapists, counselors, psychiatrists, orthopedic or neurosurgeons.

19. Over the course of the care, Respondent never addressed or evaluated Patient 2's nausea and there was little mention of any symptoms of anxiety other than "anxiety," "insomnia," or "Valium helping." Preventative care such as Pap smears, vaccinations, or lab studies were never discussed, ordered, or performed.

Patient 3

20. Patient 3 is a male born in 1982. Respondent treated him approximately every month for chronic knee pain for the time period of February 2014 through July 2016. On or about February 7, 2014, Patient 3 indicated that he "would like to go back on the 'Norco' for knee pain." At this visit and each subsequent visit, Respondent prescribed Norco (10 mg x 30 tablets).

21. During this time period, Patient 3 was also receiving alprazolam from another provider, and from February 2016 through June 2016, he was receiving prescriptions for Norco from both Respondent and another provider on a monthly basis. There was no controlled substance agreement in the medical record. No CURES reports were included or referenced in Patient 3's medical record.

22. Over the course of Respondent's treatment, Patient 3 intermittently took ibuprofen

[9] Suboxone contains a combination of buprenorphine and naloxone. Buprenorphine is an opioid medication. Suboxone is a Schedule III controlled substance and a dangerous drug.

and, although there was mention of physical therapy, there were no referrals or therapy notes included in Patient 3's chart. Respondent's treatment plan was for Patient 3 to use the Norco as needed and follow up with an orthopedic surgeon. There were no documents from any other providers, such as surgeons or physical therapists. in Patient 3's medical record.

23. On or about May 30, 2014, Patient 3 reported being unemployed, uninsured, and unable to afford a repeat MRI of his knee. Respondent's diagnoses of Patient 3 included left knee pain, chronic meniscus tear, chronic ACL tear and chondromalacia, however, prior MRI revealed a normal meniscus and no resulting ligament damage.

24. Respondent treated Patient 3 with antibiotics on two occasions. On or about December 16, 2015, Patient 3 reported coughing without mucus, sore throat, congestion and fatigue for two days. His vital signs were normal without fever and his examination was significant for "alert and oriented" appearance, red throat, and clear lungs. Respondent did not examine the sinuses. The patient was diagnosed with "acute sinusitis, cough" and prescribed azithromycin and Flonase. On or about February 5, 2016, Patient 3 reported sore throat and sinus congestion. His vital signs were normal with no fever and his examination was notable only for a limp and knee pain. The chest, lung, head, and neck examinations were noted as "unremarkable." Respondent diagnosed the patient with acute pharyngitis and acute sinusitis and prescribed azithromycin 500 mg for 3 days.

25. With respect to Respondent's charting, no social or family history or review of systems was ever documented and the History of Present Illness is often brief. The physical examinations are often inconsistent such as the patient's height varying 1 to 2 inches between visits. There are a number of different handwritings found in Patient 3's chart and it is difficult to tell exactly who took the history and made the chart notations.

Patient 4

26. Patient 4 is a female born in 1986, who was employed by Respondent in his medical spa. She treated with Respondent monthly from 2014 through September 2017. Respondent diagnosed her with generalized anxiety disorder and depression. Most of the physical examinations noted only "General: alert, calm. Exam normal." Respondent claimed he was not

Patient 4's primary care physician.

27. Respondent prescribed clonazepam (Klonopin), lorazepam[10] (Ativan), and alprazalom (Xanax) to Patient 4 on a regular basis. From June 2016 through January 2017, Respondent prescribed Klonopin 1 mg #60 per month. From July 2014 through January 2016, he prescribed Ativan 1 mg #60 per month. From March through May 2016, he prescribed Xanax 1 mg #60 per month. Respondent also dispensed 60 Xanax tablets from his office on February 5, 2016. In May 2016, Patient 4 was receiving lorazepam and clonazepam from another physician within four days of filling a prescription from Respondent.

28. On or about October 23, 2014, Patient 4 had one episode of heart palpitations with a heart rate of 132. The history noted "re-evaluation on current medical condition. Reassessment GAD [generalized anxiety disorder] and depression. Currently on Ativan and Celexa." An EKG was performed, which was essentially normal. Respondent diagnosed palpitations, generalized anxiety disorder, and depression and advised the patient to "continue current medications."

29. On or about October 14, 2016, Patient 4 complained of sore throat and nasal congestion. Her temperature was normal and an examination was notable only for red throat, nasal congestion, and clear lungs. No sinus examination was noted. Respondent diagnosed her with acute sinusitis and dispensed azithromycin. On or about May 31, 2016, she complained of cough, sore throat, phlegm, sinus congestion and fatigue for three days. Vital signs were notable for a temperature of 98.0°F and pulse of 95 bpm. The exam was notable only for throat and nasopharynx congestion, erythematous, and clear lungs. No sinus examination was noted. Respondent diagnosed her with acute sinusitis and acute pharyngitis, and dispensed amoxicillin.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Patients 1, 2, and 3)

30. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

---

[10] Lorazepam is a benzodiazepine. It is a Schedule IV controlled substance and a dangerous drug.

31. Complainant refers to and, by this reference, incorporates Paragraphs 8 through 25, above, as though set forth fully herein.

32. Controlled substances, including benzodiazepines and stimulant/amphetamine medications used for the treatment of ADD, are pharmaceutical agents with an inherent potential for abuse and misuse.

33. Under the standard of care for prescribing controlled substances, methods of monitoring for abuse and diversion include:

a. the use of a Stimulant or Controlled Substance Agreement which details the risks of the medications, including the agreement that the patient will not abuse or divert the medication, nor receive medications from other providers, as well as alternatives to the high-risk medications;

b. routine monitoring of CURES reports to ensure the patient is not prescribed medications by other providers;

c. random urine toxicology/drug screens to ensure both that the patient is taking the prescribed medications and is not mixing it with other illicit medications;

d. regular visits (typically every 2-3 months for Attention Deficit disorder) to assess the patient's response to treatment and ensure that the medication is working, as well as offering adjunct or alternative treatments if appropriate; and

e. prescribing of only small quantities at a time (typically 30 days per prescription).

34. Respondent's care and treatment of Patient 1, as set forth above in Paragraphs 9 through 13, includes the following act and/or omission which constitutes an extreme departure from the standard of care: Respondent's failure to monitor for abuse or misuse of three different controlled substances.

35. The standard of care for prescribing opiates is to prescribe these medications only when all safer alternative agents have been tried and are unsuccessful, and the benefits clearly outweigh the risks. They are typically used only short-term and at the lowest doses possible given the significant risks associated with narcotics.

36. The standard of care in prescribing opiates includes the following principles:

a. discussion of risks and benefits of therapy with patients, including alternatives;

b. evaluation of risk factors for opiate-related harms and ways to mitigate/reduce patient risks;

c. review of prescription drug monitoring program (PDMP) data [the CURES system in California];

d. use of urine drug testing (typically every 6-12 months);

e. screening for and arranging for treatment of opioid use disorder; and

f. avoid prescribing doses more than 90 Morphine milligram equivalents (MME)/day without good justification.

37. Because of the potential risks associated with narcotics, the standard of care for treating chronic back pain is to use other modalities, such as anti-inflammatories, physical therapy, topical patches, ice, heat, stretching, and occasional interventions such as nerve ablation or epidurals, depending on the underlying etiology.

38. The standard of care requires a physician to consider opioid dependence/use disorder in all patients taking chronic opiates, especially those on multiple medications. If a standardized screening assessment or tool is not used, the physician should question the patient regarding symptoms of dependence and misuse on a regular basis.

39. Patients with suspected opiate use disorder or addiction are typically treated with Suboxone/buprenorphine, Methadone, or a detox program in conjunction with an addiction specialist or mental health provider. Continuing high dose opiates in a patient with a known addiction disorder is contraindicated and further perpetuates the addiction. Therefore, it is the standard of care to wean patients with a known addiction off of all controlled substances in a controlled manner and treat the underlying psychological aspects of the patient's addiction.

40. The standard of care is to avoid prescribing benzodiazepines when possible and when they are used, to prescribe sparingly (e.g., one to two times per week) or very short term (e.g., less than 6 weeks), and only after notifying the patient of the risks of the medication and having considered all safer alternatives.

41. Respondent's care and treatment of Patient 2, as set forth above in Paragraphs 14 through 19, includes the following acts and/or omissions which constitute extreme departures from the standard of care:

a. Respondent prescribed opiates without monitoring for abuse, misuse or diversion. Respondent also did not counsel the patient regarding the risks of opiates or offer safer alternatives.

b. Respondent prescribed narcotics and other controlled substances to a patient with a known opiate use disorder.

c. Respondent prescribed benzodiazepines long term without any counseling regarding the associated risks or efforts to offer safer alternatives.

42. Respondent's care and treatment of Patient 3, as set forth above in Paragraphs 20 through 25, includes the following act and/or omission which constitute an extreme departure from the standard of care: Respondent prescribed opiates without monitoring for abuse, misuse or diversion. Respondent also did not counsel the patient regarding the risks of opiates or offer safer alternatives.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patients 1, 2, 3, and 4)

43. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

44. Complainant refers to and, by this reference, incorporates Paragraphs 8 through 29, above, as though set forth fully herein.

45. The allegations of the First Cause for Discipline are incorporated by reference as if fully set forth herein.

46. The standard of care in the diagnosis of ADD includes reviewing standard DSM criteria, which include a minimum of five symptoms of inattention (with or without hyperactivity and impulsiveness) that have persisted for at least 6 months to a degree that they are impacting daily activities. The symptoms must have presented prior to age 12, be present in two or more

settings, and not be due to another condition. The symptoms include inattention to detail, careless mistakes, difficulty sustaining attention to tasks, poor listening skills, lack of follow through, difficulty with organization of tasks and activities, avoiding activities that require sustained attention, losing items, being easily distracted, and forgetfulness.

47. The diagnosis of ADD is often made by a primary care physician using these standard criteria, often in conjunction with a psychologist or psychiatrist, especially if the diagnosis is not clear-cut. Monitoring of patients on medications for ADD typically includes asking specifically about the above symptoms and how they are affecting the patient's daily functioning, as well as any side effects of the medications. Many practitioners use a standardized questionnaire such as the Adult Attention Deficit Hyperactivity Disorder (ADHD) Self-Report Scale (ASRS-v1.1) Symptom Checklist.

48. The standard of care requires a physician to keep timely, legible, and accurate medical records. This includes a description of the History of Present Illness, pertinent review of systems, social and family history, and accurate physical examinations pertinent to the presenting complaints or diagnoses addressed. It is the responsibility of the treating physician to review and take into account all documentation entered by medical assistants, students, or other providers and correct any errors.

49. Standard vital signs include the measurement of a patient's heart rate, which is normally between 60 and 90 beats per minute. Measurements over 100 beats per minute are considered elevated and termed "tachycardia." Tachycardia can be a sign of other disease including hyperthyroidism, intrinsic heart disease, arrhythmia, excess caffeine or stimulant intake including cocaine or amphetamines, anemia, electrolyte disturbances, dehydration, infection or withdrawal from addictive substances. Standard workup of tachycardia includes thorough physical examination of the heart, lungs, and pulses, as well as examination of the thyroid. In patients with persistent tachycardia, a workup including EKG and lab work to asses for anemia, thyroid disease, electrolyte abnormalities, and illicit drug use is the standard of care.

50. Respondent's care and treatment of Patient 1, as set forth above in Paragraphs 9 through 13, includes the following acts and/or omissions which constitute repeated negligent acts:

a. Respondent's failure to monitor for abuse or misuse of three different controlled substances.

b. Respondent did not confirm or monitor Patient 1's diagnosis of ADD with standard DSM criteria.

c. Respondent did not record accurate documentation and did not address or acknowledge pertinent examinations or findings, or address patient complaints.

d. Respondent's failure to address Patient 1's recurrent tachycardia.

51. The standard of care is to avoid prescribing Soma, especially in combination with opiates and benzodiazepines, given there are safer alternatives available. It is indicated only for acute pain or spasm to be used for a maximum of three weeks. Muscle spasms are typically treated in standard practice with mechanical means such as physical therapy, ultrasound therapy, stretching, yoga, heat, or treating the underlying cause of the spasm. Muscle relaxants are used sparingly in the treatment of back and neck pain and typically only for short periods of time.

52. The standard of care for the diagnosis and treatment of lumbar disc disease is to treat the underlying cause which involves removing or repairing the underlying derangement in the disk and/or spine. In patients where surgery is contraindicated or not appropriate, the basics of treatment include physical rehabilitation such as exercises, increasing core strength, physiotherapy to reduce pain and spasm, as well as to increase function. Other alternatives include non-narcotic medications such as Ibuprofen, Tylenol, topical patches or gels, neuropathic treatments such as Neurontin, Duloxetine, Lyrica or epidural injections, nerve ablation, or acupuncture. Opiate medications are indicated only when patients have true contraindications for surgery or for short-term (i.e., a few months) while awaiting surgery.

53. Primary care physicians identified by the patients as their primary care providers are responsible for ensuring patients receive appropriate preventative screening measures such as immunizations, Pap smears, and mammograms. Consultants who are not a patient's primary care physician typically report back to the patient's "primary" physician with regular consultation notes. Any physician who prescribes medications is responsible for following up on any abnormal results and monitoring kidney and liver function in patients taking chronic medications.

54. The standard of care in the evaluation of abdominal pain includes a thorough history and physical including assessing the severity and duration of the pain, provoking or palliating factors, associated symptoms, as well as any pertinent past medical or surgical history. Standard physical examination includes assessment of the overall appearance of the patient including vital signs (especially pulse, blood pressure, and temperature), hydration status, possibility of pregnancy, and degree of pain. Assessment should include a thorough physical examination. In women, it is also important to rule out pregnancy and perform a pelvic examination.

55. Chronic nausea can be a sign of serious disease including pancreatic dysfunction, gallbladder disease, *Helicobacter pylori* (*H. pylori*) infection, medication side effects or kidney infection. The standard of care for treatment of nausea beings with an effort to determine an underlying cause or etiology. Evaluation typically includes a thorough abdominal examination, questioning regarding associated symptoms, provoking and palliating factors, over-the-counter medications, illicit drug use, etc. Testing often includes measurement of pancreatic and liver enzymes, testing for *H. pylori*, and in some cases imaging.

56. Respondent's care and treatment of Patient 2, as set forth above in Paragraphs 14 through 19, includes the following acts and/or omissions which constitute repeated negligent acts:

a. Respondent prescribed opiates without monitoring for abuse, misuse or diversion. Respondent also did not counsel the patient regarding the risks of opiates or offer safer alternatives.

b. Respondent prescribed narcotics and other controlled substances to a patient with a known opiate use disorder.

c. Respondent prescribed benzodiazepines long term without any counseling regarding the associated risks or efforts to offer safer alternatives.

d. Respondent prescribed Soma long-term without attempting safer alternatives or counseling the patient regarding the risks of the medication.

e. Respondent's lack of further evaluation or attempting safer alternative treatments for the patient's subjective back pain.

f. Respondent did not offer or recommend preventative measures such as Pap

smears or flu shots, did not monitor the patient's kidney or liver function, and did not make any effort to communicate with any of the patient's concurrent or past providers.

g. Respondent did not record accurate or thorough documentation and it is unclear in the record who exactly is performing the elements of the patient visits.

h. Respondent's substandard management of the patient's abdominal pain, pelvic pain, and nausea.

57. Knee pain in a young person is typically caused by trauma and overuse and surgical repair is usually successful. Knee pain in a young person is rarely severe enough to warrant opiate use and pharmacologic treatment typically includes acetaminophen, oral NSAIDs, topical NSAIDs, intra-articular corticosteroid injections, physical therapy, and in some cases, surgical intervention. The standard of care provides that, only if these modalities have failed and the patient is not a candidate for surgery, should opiates be used, and in that case, with caution and only for short periods of time.

58. The standard of care is that antibiotics should only be prescribed for cough in patients with documented pneumonia or pertussis. Sinus infections should be treated with antibiotics only when they are severe or lasting more than 10 days without improvement. When antibiotics are indicated, macrolides such as azithromycin are not recommended. Instead, Amoxicillin or Augmentin are recommended first-line as they have better penetration into the sinuses. Sore throat or "pharyngitis" should be treated with antibiotics only when there is a positive test for Streptococcus.

59. Respondent's care and treatment of Patient 3, as set forth above in Paragraphs 20 through 25, includes the following acts and/or omissions which constitute repeated negligent acts:

a. Respondent prescribed opiates without monitoring for abuse, misuse or diversion. Respondent also did not counsel the patient regarding the risks of opiates or offer safer alternatives.

b. Respondent's treatment of the patient's knee pain with narcotics without attempting safer alternatives or insisting on a more definitive treatment by a

surgeon.

c. Respondent's prescription of antibiotics.

d. Respondent did not record accurate or thorough documentation and it is unclear in the record who exactly is performing the elements of the patient visits.

60. The standard of care is to avoid prescribing benzodiazepines when possible and when they are used, to prescribe sparingly (e.g., one to two times per week) or very short term (e.g., less than 6 weeks), and only after notifying the patient of the risks of the medication and having considered all safer alternatives. Anxiety is typically treated with cognitive therapy, relaxation techniques such as meditation or deep breathing exercises, exercise, and SSRI medications such as Celexa or Buspar.

61. Respondent's care and treatment of Patient 4, as set forth above in Paragraphs 26 through 29, includes the following acts and/or omissions which constitute repeated negligent acts:

a. Respondent's prescribing of benzodiazepines long term without any counseling regarding the associated risks or efforts to offer safer alternatives.

b. Respondent's prescription of antibiotics.

c. Respondent did not record accurate or thorough documentation and it is unclear in the record who exactly is performing the elements of the patient visits.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without an Appropriate Prior Examination – Patients 1, 2, 3, and 4)

62. Respondent's license is subject to disciplinary action under section 2242, subdivision (a), of the Code in that he prescribed, dispensed, and/or furnished "dangerous drugs"[11] to Patients 1, 2, 3, and 4 without an appropriate prior examination and a medical indication.

63. Complainant refers to and, by this reference, incorporates Paragraphs 8 through 29,

[11] "Dangerous drug" is defined as "any drug or device unsafe for self-use in humans or animals, and includes the following: (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import. (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____;" "Rx only," or words of similar import. the blank to be filled in with the designation of the practitioner licensed to use or order use of the device. (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

above, as though set forth fully herein.

64. The allegations of the First Cause for Discipline are incorporated by reference as if fully set forth herein.

65. Complainant refers to and, by this reference, realleges the allegations set forth in Paragraphs 46, 47, 50(a) and (b), 51, 52, 56(a) through (d), 57 through 59(c), 60 through 61(b), above, as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records - Patients 1, 2, 3, and 4)

66. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate records concerning the care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

67. Complainant refers to and, by this reference, incorporates Paragraphs 8 through 29, above, as though set forth fully herein.

68. Complainant refers to and, by this reference, realleges the allegations set forth in Paragraphs 48, 50(c), 56(g), 59(d), and 61(c).

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 35772, issued to Bijan Farah, M.D.;

2. Revoking, suspending or denying approval of Bijan Farah, M.D.'s authority to supervise physician assistants and advanced practice nurses:

3. Ordering Bijan Farah, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

///

///

///

///

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

DATED: November 27, 2018

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

LA2018501907
53055132.docx