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

In the Matter of the Accusation Against: Nader Oskooilar, M.D. Physician's & Surgeon's Certificate No A48369 Respondent	Case No. 800-2016-022486

DECISION

The attached Proposed Decision 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 March 10, 2021.

IT IS SO ORDERED February 8, 2021

MEDICAL BOARD OF CALIFORNIA

By: Richard E. Thorp MD

Richard E. Thorp, M.D., Chair
Panel B

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In the Matter of the Accusation Against:

NADER OSKOOILAR, M.D., Respondent

Physician's and Surgeon's Certificate No. A 48369

Case No. 800-2016-022486

OAH No. 2019060967

PROPOSED DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by video conference on November 9 through 10, November 12 through 13, 2020, and November 16, 2020, pursuant to the September 11, 2020, order converting the hearing to a videoconference due to the COVID-19 pandemic.

Joseph F. McKenna, III, Deputy Attorney General, represents complainant William J. Prasifka, Executive Director of the Medical Board of California (board).

Raymond McMahon, Attorney at Law, Doyle Schafer McMahon, represents respondent Nader Oskooilar M.D., who was present.

The matter was submitted on November 16, 2020.

SUMMARY

Complainant asserts that respondent's license should be disciplined because he committed gross negligence, and repeated negligent acts in his care and treatment of three patients. Complainant also asserts that respondent excessively prescribed dangerous drugs to them, failed to maintain adequate and accurate records, violated laws applicable to the prescription of dangerous drugs, and engaged in unprofessional conduct. For the reasons stated in this decision, complainant proved by clear and convincing evidence only that respondent failed to maintain adequate records for the three patients in violation of Business and Professions Code section 2266. Based on the evidence of record as a whole, a public reprimand with the condition that respondent take and successfully complete a medical record keeping course will ensure public protection. The remaining causes for discipline are dismissed.

FACTUAL FINDINGS

Jurisdiction

1. On April 18, 2019, Kimberly Kirchmeyer, who was then Executive Director of the Medical Board of California (board), filed the accusation in this matter. Respondent timely filed a Notice of Defense.

Complainant alleges seven causes to impose discipline against respondent's license: respondent committed gross negligence regarding his treatment of patients A, B, C, and E (First Cause for Discipline) and repeated negligent acts regarding his treatment of patients A, B, and C (Second Cause for Discipline), he prescribed dangerous drugs without a good faith prior exam and/or medical indication (Third

Cause for Discipline), he repeatedly prescribed excessive drugs to patients A, B, C, (Fourth Cause for Discipline), he violated statutes regulating drugs (Fifth Cause for Discipline), he failed to maintain accurate and adequate records (Sixth Cause for Discipline) and he engaged in unprofessional conduct (Seventh Cause for Discipline).

2. During the hearing, complainant asked to amend the accusation and move paragraph 17(b) at page 13 in the accusation under allegations regarding Patient A to the paragraph regarding Patient C and to recharacterize it as subparagraph "(G)" under paragraph 21, as an allegation of gross negligence regarding respondent's treatment of Patient C. The motion was granted, and the change has been made to the accusation by interlineation.

3. The investigation into this matter was initiated by an online complaint filed with the board on April 4, 2016. The complaining party asserted that respondent was the "drug go to doctor in Newport Beach" and was prescribing her daughter Xanax and Adderall. Both these drugs are controlled substances under the Uniform Controlled Substances Act (Health and Safety Code §§ 11000-11651) and dangerous drugs under Business and Professions Code section 4022.[1] Xanax is the brand name

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[1] The Uniform Controlled Substances Act classifies controlled substances according to schedules identified, for the drugs discussed in this decision, as Schedule II (Health and Safety Code section 11055), Schedule III (Health and Safety Code section 11056) and Schedule IV (Health and Safety Code section 11057.) Combination synthetic opioid drugs are classified as Schedule II drugs; stimulants such as Adderall are classified as Schedule III drugs; and narcotic drugs, which include the class of drugs known as benzodiazepines, are classified as Schedule IV drugs.

for the generic drug alprazolam, a benzodiazepine, which is a class of drugs that have a sedating effect and are used to treat anxiety. The complaint is considered only as a matter of background, and that complainant's expert considered the complaint as part of his evaluation of the matter.

License History

4. On June 18, 1990, the board issued Physician's and Surgeon's Certificate Number A 48369 to respondent. The certificate is current and will expire on August 31, 2021, unless renewed. Respondent has no history of discipline.

Complainant's Prehearing Motion

5. Complainant filed a motion in limine to bar respondent's expert, Daniel Chueh, M.D., from testifying because he did not respond to a subpoena served upon him for certain documents. Respondent filed an opposition to this motion and complainant filed a reply brief. After giving due to consideration to the parties' submissions and hearing from the parties at the start of the hearing, complainant's motion was denied.

Summary of Respondent's Treatment of Patients A, B, and C and Prescription of Controlled Substance

6. Respondent's care and treatment of Patients A, B, and C are found in respondent's progress notes for these patients and are summarized, in pertinent part, as follows:

PATIENT A

7. Patient A was 65 years old at the time respondent was treating her during the period at issue in this matter. Respondent was treating her for Generalized Anxiety Disorder (GAD). Complainant obtained authorization from Patient A for the release of her records, dated March 3, 2018, for the period January 2016 to February 2018, although respondent was treating Patient A before January 2016. Respondent complied with the subpoena for A's records, and A's handwritten records consist of 11 pages. A Controlled Substance Utilization Review and Evaluation System (CURES) report for the period November 1, 2014, through February 22, 2018, dated February 22, 2018, was obtained which identifies the medications respondent and other providers prescribed A. CURES is an online database that practitioners and prescribers of dangerous drugs use to monitor prescriptions of Schedule II, III and IV controlled substances.

8. The notes, in large part, are legible with certain exceptions. Where the writing is difficult to discern, an effort has been made to decipher A's records. To do this, respondent's testimony has been considered in addition to the statements he made regarding A's treatment at his January 15, 2019, interview with the Health Quality Investigation Unit (HQIU).

9. The notes document the following:

The March 23, 2016, note records that Patient A's husband was retired, and she is on disability. He documented that she has Chronic Obstructive Pulmonary Disease (COPD) and was on oxygen which she carries with a portable oxygen unit; she quit smoking, has atrial fibrillation with stents; had three heart attacks, and sees six different doctors including her primary care doctor. Her primary doctor had prescribed

her the benzodiazepines, alprazolam and clonazepam (respondent referenced the latter medication by its brand name Klonopin), but the primary care doctor became reluctant to prescribe these meds to her. The patient notes show that respondent reminded himself to contact the primary care doctor. There is a description regarding something referred to as "mild". On this date, A filled her prescription for both medications. Prior to this, A's primary care doctor was prescribing these meds to her.

On May 25, 2016, respondent was sent a release of A's medical records to a doctor treating Patient A. The purpose of these records was for continuity of care or discharge planning.

On June 17, 2016, respondent charted that A was seeing him for follow up; there were no changes in her medications. He noted that A described her "challenges" going to pharmacies, her "physical limitation[s]" "and the like." He added that A continued with counseling and physical therapy. He further noted A appeared to be at "baseline." He further noted she was not depressed, and he didn't prescribe her a medication for depression. The remaining three lines of notes are difficult to read but reference that A was "OK" with medications until her next visit but can contact him sooner if needed.

Respondent next saw A on December 27, 2016. Respondent noted that A was "passionate about her cats" and she showed him pictures of her cats. She said she was "'coming along good,'" possibly with reference to the physical therapy she was having. A appeared at the visit with an oxygen canister. He checked how she was doing on her medications.

A's next note was on February 15, 2017. This note documents that A left a message for respondent, and respondent and A then exchanged messages. She said

her primary care doctor was lowering the dosage of clonazepam, she was taking and was discontinuing the alprazolam, and her doctor was not "ok" with her taking a muscle relaxant. It appears that one note reads that lowering the medications created more problems than it solved. According to CURES, this muscle relaxant is Soma and another doctor prescribed it to Patient A. Soma is a controlled substance and dangerous drug.

On February 22, 2017, respondent recorded he talked to A's primary care doctor, who respondent noted was reluctant to prescribe A clonazepam and alprazolam due to A's COPD. Respondent stated A had "split issues" and as of February of the prior year he was prescribing A the clonazepam and alprazolam. Respondent documented that he was aware of A's COPD.

A's next visit was on July 12, 2017. Respondent again noted that she was carrying oxygen, she had been hospitalized and discharged to a nursing home for physical therapy. He noted she "doesn't take Xanax" and he lowered the clonazepam from 1 mg to 0.5 mg. Respondent also noted that the carisoprodol (Soma), which was prescribed by another doctor, was also being lowered. He said he discussed "in detail" the problems she was having with her husband, and her husband was blaming her for her panic attacks. He noted that A was "on her feet", "driving" and "able to do chores". He wrote that she was "lively" and "animated" and "not depressed."

On January 16, 2018, respondent saw A and he described her as pleasant and euthymic and not depressed. She talked about her medical problems; her husband was not "moody," and she appreciated that; she said she "occasionally" was taking a Xanax. She said she doesn't like her primary care doctor.

The last note documenting respondent's treatment of A is dated July 30, 2018. In this note, A said she was going to Hoag Hospital for outpatient care; she was still carrying oxygen. He discussed at length her anxieties. A reported she gets very tired. Respondent wrote that A received "supportive therapy," she was taking Xanax as needed only for panic attacks, and clonazepam TID [three times a day].

10. In addition to these progress notes, A's record includes a July 30, 2018, printed "Medication List" which identifies, as of July 18, 2018, A's medications. Patient A stated she is allergic to Cymbalta (bad nausea and hives), which is a non-controlled substance, antidepressant, serotonin-norepinephrine reuptake inhibitor (SNRI). The list includes Soma 350 mg, 1 a day, which she takes at night and Neurontin. Neurontin is a medication used for pain.

11. In the records there are copies of prescription scripts respondent wrote for A on the following dates in the following dosages and quantities as follows: March 23, 2016, alprazolam 0.5 mg, 90 pills, with two refills, clonazepam 1 mg, 90 pills, also with two refills; June [copy illegible], clonazepam 1 mg, 90 pills, with five refills and alprazolam 0.5 mg, 90 pills, also with five refills; December 27, 2016, clonazepam 1 mg, 90 pills, with five refills and alprazolam 0.5 mg, 90 pills, with five refills; July 12, 2017, only clonazepam 0.05 mg, 90 pills, with five refills; January 16, 2018, alprazolam 0.5 mg, 45 pills, with one refill and clonazepam 0.5 mg, 90 pills, no refills; and July 30, 2018, clonazepam 90 pills, 0.5 mg, with five refills and alprazolam 45 pills, 0.5 mg, with two refills.

12. According to CURES, for the period November 3, 2014, to February 2, 2018, A's doctor, G.A.,M.D, prescribed carisoprodol (Soma), 350 mg, 90 pills for a 30-day supply, clonazepam, 1 mg, 120 pills for a 30-day supply, and alprazolam to A, 0.5 mg, 90 pills for 30 days (which he added around September 15, 2015) from November

3, 2014, to February 25, 2015. A filled these prescriptions at a single pharmacy multiple times on a monthly basis. A second doctor, A.A., M.D., wrote Patient A a prescription for Soma, which A filled at the same pharmacy on March 18, 2016. During this time, A consistently filled the Soma prescriptions on a monthly basis. A third doctor, W.O., M.D., wrote a prescription for 14 pills of clonazepam 0.5 mg for a 14 day supply and another prescription for 28 pills of clonazepam 1 mg also for a 14 day supply, which A filled at a different pharmacy, Superior Care Pharmacy, on April 24, 2017. This doctor also wrote a prescription for 28 pills of Soma, 350 mg, for a 30-day supply. Patient A also filled this prescription on April 24, 2017, at Superior Care Pharmacy.

13. As further documented in CURES, on July 12, 2017, respondent started prescribing the clonazepam to Patient A but reduced the dose from 1 mg to 0.5 mg, as also documented in respondent's progress note of this same date. From April 14, 2017, through February 22, 2018, Patient A filled only one prescription for alprazolam. On January 16, 2018, A obtained a prescription for 45 pills of alprazolam for a 22-day supply. At this time, according to A's progress notes, A was only occasionally taking alprazolam. Respondent thus reduced the amount of alprazolam he was prescribing Patient A and also reduced the amount of clonazepam he was prescribing A from 1 mg to 0.5 mg starting in July 12, 2017.

14. Between March 23, 2016, and February 22, 2018, A filled prescriptions written by respondent on a monthly basis. CURES documents that these prescriptions routinely included refills for both medications and the number of refills used for each medication. Patient A took her medications as prescribed. Patient A did not fill prescriptions early or ask respondent for early refills of the medications.

PATIENT B

15. Patient B was approximately 55 years old during the time at issue in this matter. The records complainant obtained consist of 28 pages and are for the January 2014 to March 13, 2018, time frame, per the release of information authorization HQIU obtained from Patient B dated March 13, 2018. The progress notes record 23 office visits with respondent.

16. Per respondent, in his testimony, he has been treating B since 2008. B's wife was also a long-term patient and treated with respondent before B treated with him. Patient B suffered from GAD, panic attacks, Obsessive Compulsive Disorder (OCD), and Attention Deficit Hyperactivity Disorder (ADHD) with symptoms of this condition being: procrastination, distraction, and impatience. Respondent said Patient B had ADHD for a long time; this condition affected his performance in school and work, and Patient B was not functioning at his full potential because of it.

17. The first progress note introduced at hearing documenting Patient B's visits with respondent is dated November 13, 2013. The handwritten note for this progress note is difficult to discern. Patient B told respondent "I love my job."

His next recorded visit is dated February 22, 2014. Again, the handwriting is difficult to decipher. Patient B told respondent he lost 14 pounds. He had a tough week. He doesn't talk to "M" but talks to "B". He said he was "ok" with medications, it appears. Patient B also said he was "ok" with "anxiety."

After this visit, B's next recorded note is dated March 10, 2014. It is not clear, but it appears the note records a communication respondent received from B.

At his May 24, 2014, visit with respondent, B said he was happy with his medications, and they were without side-effects. He said something was good and things were good with his wife. The remaining six lines of notes are not decipherable.

B's next recorded visit is dated November 8, 2014. B stated he was taking on more responsibility at work and traveling more which was wearing him out. He said he was "ok" with his medications, and he was having no side-effects from the medications. B also said he was taking half a medication whose name is not able to be discerned. Several of the lines from the note are not readable.

B saw respondent on May 23, 2015. He said he was promoted, was covering a bigger territory, and was doing well on the medications with no side-effects. It appears the last note reads "continue with medications".

Notes on July 1, 2015, and August 2, 2015, record that respondent authorized prescriptions for 75 pills of Xanax. This note correlates with prescriptions for alprazolam B filled on July 1, 2015, and August 2, 2015, according to CURES.

At his August 29, 2015, visit with respondent, B told respondent he was "successful at work". He said there were no side-effects from the medications. Respondent appeared to record that it was "ok" to continue the medications for B.

A note dated August 22, 2015, is hard to read, but it appears to reference lab results from a lab report respondent obtained from B's primary doctor. Respondent recorded B's "TG", triglycerides, and cholesterol levels per this lab report. Per this lab report, B's "ALT" and "AST" levels were marked as "high." These results measure liver functioning and refer to "alanine aminotransferase" and "aspartate aminotransferase", which are enzymes. (https://www.mayoclinic.org/tests-procedures/liver-function-tests/about/pac-20394595 [as of December 9, 2020].)

B's next recorded visit is dated November 21, 2015. He told respondent he was doing well, and he had a successful business trip. His weight and height were documented. His medications were "ok" with no side-effects.

The progress note for B is dated February 20, 2016. B again stated he was doing well with the medications without any side-effects.

The May 18, 2016 note states that B was doing well on the medications without side-effects. He noted that his job was stressful, and he was traveling a lot. B stated he takes half of some medication, possibly alprazolam, and has "supply" and "doesn't take it home." Remaining parts of the note are difficult to read.

On August 4, 2016, respondent saw B. This note documents that respondent talked with him about test results from a lab report dated June 7, 2016, that respondent obtained from B's primary care doctor. This test again records that B's ALT and AST levels were high and he had high cholesterol levels. Respondent circled the levels in the lab report and dated it August 13, 2016, so it appears respondent was referring to the earlier lab. This progress note references B's primary care doctor. B said he was he "ok" with the medications and wasn't experiencing any side-effects.

The progress note dated October 8, 2016, documents that B was again doing well on the medications and was not having side-effects. B told respondent his family moved into a smaller place, and he was having conflicts with his wife's son.

The November 4, 2016, progress note details that B was cutting "'way way back on drinking' last week" but his wife continued to drink. The note documents that B's liver functioning test levels were high, and B was going to see a liver specialist. The note also documents that B was undergoing a procedure on his knee. The note further

records that B was also having problems with his wife, and that he had stopped a medication that is hard to read.

Respondent's plan for B was recorded as follows: B and his wife were to discontinue the use of alcohol and follow specific recommendations regarding addressing the personal issues involving his wife.

The next progress note is dated January 20, 2017. B told respondent he was doing well on the medications without side-effects. He also had had a surgical procedure on his knee and was undergoing physical therapy. B also said he lost 15 pounds, and he discussed issues with his wife.

The progress note for March 24, 2017, references 100 pills of Abilify 5 mg, a non-controlled substance used to treat different mental health conditions, and the November 4, 2016, script. B said he was doing well the medications and his "job situation" seemed improved.

The progress note for April 28, 2017, records that B started a new job, got a signing bonus, and was doing well on the medications.

A lab dated June 29, 2017, reported that B's AST and ALT levels were still "high" and respondent reviewed the report on July 28, 2017, per his signature.

Per the progress note dated July 28, 2017, Patient B reported that he was doing well on his medications, with no side-effects, he was oriented times three and Patient B said he liked his new job. There was a reference to his labs being "ok" and B was put on cholesterol and blood pressure medicines and his cholesterol levels lowered.

A note date October 28, 2017, records B's blood pressure, and pulse and states that B was following up with his primary care doctor.

A note dated January 27, 2018, states that B was doing well on his medications without side-effects and references a pain blocking procedure he had. Respondent wrote that B was "ok" to continue with medications.

After the January 27, 2018, visit, Patient B was not recorded to have seen respondent until it appears April 9, 2018, though the date is not entirely legible. B reported he was doing well, going to therapy and was seen with his wife. Respondent wrote "ok to continue meds."

At his July 7, 2018, visit Patient B reported he has worked at Starbucks in sales for a year, had some kind of conflict with his boss, and was depressed over something that is not legible. Patient B said his wife is going on disability and is changing jobs. He noted he is working to improve his high blood pressure and wants to increase the Abilify but it gives him the "twitches." Patient B denied suicidal ideation. Respondent wrote "supportive therapy."

The last note complainant obtained is dated October 29, 2018. Patient B reported that "they let go of" his boss, he was "not as stressed as last visit," he was "ok" with meds, he was on blood pressure medications, has a follow-up with his primary care regarding his labs, and the "combination with Vyvanse helps a lot." Respondent recorded Patient B's blood pressure as 130/85, per Patient B.

18. Copies of prescription scripts respondent wrote for Patient B document that respondent prescribed 70 mg of Vyvanse, a controlled substance, dangerous drug and a long acting stimulant used to treat B's ADHD, in 30-day supplies, 1 mg of 75 pills of alprazolam, in 25 day supplies, 300 mg of Wellbutrin, a non-controlled medication used to treat depression, in 30-day supplies. The Vyvanse and Wellbutrin were to be taken in the morning and the alprazolam was to be taken twice to three

times a day as needed. In addition to these medications, respondent was prescribing B Abilify.

19. The CURES report dated February 22, 2018 shows that Patient B filled these prescriptions at the same pharmacy consistently on a monthly basis. Respondent prescribed alprazolam and Vyvanse, between November 2, 2014, and February 12, 2018, in the following amounts and in the following doses: Vyvanse, 30 pills of 70 mg, for a 30-day supply, 75 pills of 1 mg alprazolam, for a 25 day supply. These prescriptions included refills.

20. During this time, per CURES, several other doctors and a physician assistant were prescribing the following combination opioid medication to Patient B: (from Dr. M.D.) Acetaminophen hydrocodone bitartrate, 325 mg/5 mg. Patient B filled the prescription for this opioid on May 13, 2015, August 10, 2015, October 29, 2015, and May 25, 2016. Patient B filled these prescriptions at the same pharmacy where he filled all of his prescriptions.

21. Patient B also filled, again per CURES, prescriptions for a second combination opioid medication oxycodone acetaminophen to Patient B: (from A.R., M.D.) 325mg/10 mg on December 30, 2015; (from B.B., M.D.) on August 26, 2016; (from B.B., M.D.) November 4, 2016; (from C.W.,P.A.) on December 14, 2016; (from A.R., M.D.) January 12, 2017; (from A.R.,M.D.) on March 21, 2017; (from B.B.,M.D.) on July 21, 2017; (from A.R., M.D.) on August 31, 2017; (from A.R., M.D.) on November 17, 2017; (from J.C.,M.D.) on January 8, 2018; (from A.R.,M.D.) on January 12, 2018; and (from A.R.,M.D.) on February 12, 2018. These prescriptions were filled at the same pharmacy where Patient B filled all of his prescriptions. Patient B also filled a prescription for a third opioid, oxycodone 19 mg, on January 30, 2018, also at this same pharmacy.

PATIENT C

22. Patient C was a 49-year-old female who was also treating with respondent before the records obtained by complainant indicated. Respondent stated at his HQIU interview that she was dealing with a lot of anxiety and was unable to function without the diazepam he was prescribing her daily. Diazepam is a benzodiazepine and a controlled substance and dangerous drug. Patient C also had panic disorder for which respondent prescribed alprazolam. Respondent diagnosed her with GAD and panic disorder with agoraphobia. He said she also suffered from chronic insomnia. He prescribed her Intermezzo to take at night to help her sleep. Intermezzo is a controlled substance and dangerous drug. Patient C saw respondent for medication management and supportive therapy. Complainant sought records in the subpoena he issued for the period January 2017 through November 15, 2018, the date of the subpoena.

23. Patient C's records consist of 15 pages and are for the period January 3, 2017, to July 10, 2018, per the subpoena the HQIU investigator served upon respondent.

The first record is a prior authorization request form dated January 3, 2017, that respondent completed for 30 pills of 3.5 mg Intermezzo, in sublingual form, known by its generic name zolpidem, that is a controlled substance and dangerous drug used to help patients with sleep problems. The authorization references a refill dated October 16, 2016. In this form, respondent identified Patient C's diagnosis as "Anxiety Disorder" and "Panic Disorder." (Exhibit 8, AGO 0127.) Respondent further stated that Patient C had an inadequate response to generic Ambien and generic Lunesta, two other medications with the same ingredient as Intermezzo. In a letter dated January 6, 2017, Patient C's health insurer authorized the Intermezzo prescription for the January 4,

2017 to January 6, 2018 time period. (Exhibit 8, AGO 0126.) Patient C's insurer subsequently approved the medication, again in sublingual form, on February 23, 2018. (Exhibit 8, AGO 0120.)

The next record is a March 13, 2017, progress note. This note records that Patient C said she doesn't go out much or socialize for fear of having a panic attack. She was "ok", was taking Lexapro, a non-controlled substance medication used to treat depression. She started with 2.5 mg and the dosage was changed to 0.5 mg. She reported she was able to sleep but wakes up easily and can't go back to sleep. Patient C said she was "ok" with trying a tranquilizer like Ambien, which is fast acting, and Patient C was "ok" with trying Intermezzo. Patient C reported she was "ok" with her job and she "gets very stressed with Trump news." Side-effects of medications, which are not readable, and Lexapro are referenced.

The progress note dated June 16, 2017, records that Patient C participated in a bike ride from San Francisco to Los Angeles and "had much fun." The note is hard to read but with effort certain words and phrases are understandable. She reported she wasn't drinking alcohol but "Todd" drinks bourbon. She noted her son "is healthy," had a job and was sober. She found it difficult to get near people except for relatives. She was noted to be positive for "social anxiety." She did not take Lexapro. Patient C was quoted as saying,"Want to figure it out." Patient C said she was "heading for Hawaii."

On June 22, 2017, Patient C cancelled her appointment due to food poisoning possibly from salmon she ate.

Her next recorded visit is on June 26, 2017. At this visit Patient C said that she hasn't seen her brother in years, and he was in prison but he calls occasionally. She also said she never knew her father; she met him once when she was 22 years old.

Patient C reported she was going to Hawaii to prepare for her "business exam," referring per respondent's testimony to her master's degree in business administration. The remaining nine lines of the note are difficult to understand except for certain phrases: "panic", "fear", "anxiety", "inhibition".

At Patient C's August 22, 2017, visit with respondent, Patient C was seen with her daughter. There is a reference to cosmetic breast surgery she had in Arizona, and that the surgeon who performed the surgery abused patients and pain medications.

A note dated October 17, 2017, documents that respondent faxed a prescription for 60 pills of Diazepam 2 mg to Patient C's pharmacy.

The note dated October 24, 2017, is readable for the most part. Nevertheless, respondent was asked to read it at the HQIU interview. In pertinent part, Patient C reported she had a bacterial infection and bronchitis and she was in a legal action with "Todd" over a lease and time share where they reached an agreement but the attorney handling the agreement was fired. She also noted a "David," whom she was seeing, has two daughters who don't speak to him. Patient C further noted she doesn't experience anxiety around her "gay" friends. The rest of the note records relationship issues she was having.

The February 22, 2018, progress note is fairly extensive and reflects that respondent engaged Patient C in psychotherapy and a medication check. The note records that Patient C was doing well on her medications and at her job. Most of the note records Patient C's relationship issues with her new boyfriend. There are International Classification of Diseases (ICD) codes 300.2, 300.21, and 300.23, which refers to general anxiety disorder, panic attacks, and agoraphobia.

The last progress note from the records complainant obtained is dated July 10, 2018. The note records that Patient C was seen with "David" and they were married four days before the visit and were happy; she showed respondent their wedding photos. They discussed an issue involving a person close to Patient C who "relapsed." Respondent noted that Patient C "was ok with meds."

Patient C's records also contain copies of eleven prescription scripts respondent wrote for Patient C.

24. The CURES report for this period shows that Patient C filled monthly prescriptions respondent wrote for 2 mg and 5 mg diazepam in quantities of 60 and 45 pills for 23 and 30-day periods starting April 26, 2017, and continuing monthly through January 29, 2018, which included refills.

25. During this April 26, 2017, to January 29, 2018, time period, respondent also prescribed 60 doses in solution form of 0.5 mg alprazolam to Patient C for 30-day supplies each month during this period, and each month 30 pills of 3.5 mg zolpidem tartrate, or Intermezzo, to Patient C. In addition, respondent prescribed 60 pills of 1 mg lorazepam to Patient C on April 26, 2017, May 24, 2017, October 28, 2017, November 24, 2017, and December 28, 2017, in 30-day supplies. Respondent wrote a prescription for 30 pills of 3.5 mg Intermezzo for Patient C for a 30-day supply, which she filled on January 30, 2017, as a second refill. According to her records, as noted, Patient C's insurance authorized this medication on January 6, 2017, for reimbursement for a one-year period although CURES identifies this medication after January 30, 2017, by its generic name zolpidem tartrate.

26. Also during this April 26, 2017, to December 28, 2017, time frame, Patient C filled the following prescriptions for opioids and, one time, carisoprodol (Soma) from

providers other than respondent: on July 25, 2017, 15 pills of 350 mg carisoprodol for a six day supply written by J.P., M.D.; this same doctor also wrote a prescription for 60 pills of 325 mg/6 mg oxycodone HCL acetaminophen for a 30-day supply, which Patient C filled on July 25, 2017. In addition, Patient C filled prescriptions on April 17, 2015, and on November 3, 2015, for 30 pills of 325mg/10 mg acetaminophen hydrocodone bitartrate for a 5 day supply from a doctor C.C.; she filled a prescription on July 20, 2017, for 325 mg/6 mg of 15 pills of acetaminophen hydrocodone bitartrate for a 3-day supply written by a J.N., a physician assistant; and she filled a prescription on October 28, 2017, for 5 pills of the same combination opioid for 5 days from a B.B.; Patient C also filled a prescription on October 22, 2017, for codeine phosphate in solution form in a quantity to be used for 7 days from a S.S., who appears to be a physician assistant.

Testimony of Complainant's Expert, Dr. Kirsten

27. Complainant called Markham Kirsten, M.D., as an expert. Dr. Kirsten prepared a report dated February 24, 2019, and an addendum report December 15, 2019, in which he stated that the three patients suffered no harm, as respondent documented it, due to respondent's alleged misconduct.[2] In his report he cited articles

[2] Dr. Kirsten wrote the following regarding this: "[Regarding the three patients] I found no documentation that harm had occurred. That does not mean that there was no harm, but only that [respondent] did not document that his treatment was causing harm." (Exhibit 12, A151.) Regardless of his cryptic qualifying language regarding harm, in his hearing testimony Dr. Kirsten did not dispute that the patients suffered no harm.

from journals, different sources and a 1972 United States Court of Appeals decision. (Exhibits 13 to 23.) These materials were admitted.

28. Dr. Kirsten obtained his medical degree from the New York School of Medicine in 1975, and completed a medical internship and psychiatric residency at New York Medical College, Metropolitan Hospital, New York in 1979. He became licensed to practice medicine in California in 1978, and practiced in Fresno until 2014, when he retired and moved to Southern California. Dr. Kirsten worked as a psychiatrist with the Fresno County Department of Mental Health in various capacities beginning in 1979. He was a consulting psychiatrist with the Central Valley Regional Center from 1981 to 1991, the Mentally Ill Offender Program from 1985 to 1987 and the Homeless Mentally Ill Program from 1986 to 1990. From 1987 through 2014, Dr. Kirsten practiced outpatient psychiatry as a staff psychiatrist with The Permanente Medical Group in Fresno, and served as chief of the Permanente's psychiatry department from 1987 through 1994. He is currently a per diem psychiatrist with the Kaiser Permanente, Southern California, Behavioral Health Clinic, and since 2018 holds privileges at ten hospitals to work as a tele-psychiatrist. Since the onset of the COVID-19 pandemic Dr. Kirsten works full-time at Kaiser. Dr. Kirsten has also conducted independent utilization chart reviews as a consulting psychiatrist for Maximus Federal Services. He stopped working for Maximus in June 2019.

Dr. Kirsten has been certified by the American Board of Psychiatry and Neurology since 1981. He is also certified in addiction psychiatry, and forensic psychiatry; he has been enrolled in California's Controlled Substance Utilization and Review system since September 2015. His honors include being a Fellow and a Life Fellow of the American Psychiatric Association.

Dr. Kirsten has been an expert reviewer for the board since 2012. Dr. Kirsten has evaluated about 50 physicians for the board, six of those matters have gone to hearing.

29. In forming his opinions regarding respondent's treatment of the three patients, Dr. Kirsten reviewed the initial complaint filed in this matter, the patients' medical records, CURES reports sent to him, the transcript of respondent's HQIU interview, and he listened to the digital recording of that interview. On his own initiative, and against the board's directive to its experts, Dr. Kirsten downloaded contemporaneous CURES reports for the patients.

30. In framing his opinions in this matter, Dr. Kirsten identified numerous issues, which he identified in his report and which he referenced in the course of his testimony by their numerical designations, "Medical Issues" 1 to 14, in his report. The accusation does not include all the issues he identified in his report, and most of the issues apply to all three patients.

31. Dr. Kirsten identified the standards of care and the degrees of departure from the standard of care: He defined a simple departure as a small lapse that a doctor trying his best may have skipped something, a "lacunae" in his knowledge, not a terrible error he has committed. He identified as an extreme departure as a doctor showing very minimal attention to the standard of care, not utilizing current knowledge, deficient in his care with very little attention to providing good care.

32. For organizational purposes in this decision, the issues are identified as summarized in the accusation, which correspond to the issues Dr. Kirsten identified in his testimony and in his report. In certain instances, the accusation characterizes the issues Dr. Kirsten identified in his report differently and these differences are noted.

Respondent's expert, Dr. Chueh, referenced in his testimony and in the report the numerical issues Dr. Kirsten identified in his report accordingly. Most of the issues identified in the accusation are common to all three patients. Where the issues are specific to a patient, the summary is characterized to reflect this distinction.

33. Each of the issues in the accusation are identified in turn as described in the headings as follows:

RESPONDENT'S CLINICAL NOTES FOR ALL THREE PATIENTS ARE EITHER MISSING, ILLEGIBLE, DISORGANIZED, AND/OR MISSING TIME ANNOTATIONS (MEDICAL ISSUE #1)

34. Dr. Kirsten testified that the standard of care requires that medical records be legible medical records both as a matter of the standard of care to communicate to other clinicians information concerning the history and condition of patients and, also, he emphasized, as a matter of reflecting the state of mind of the clinician. As Dr. Kirsten wrote in his report "[a] sloppy haphazard records [*sic*] reflects [*sic*] on the state of mind and effort of the treating physician." (Exhibit 11, AGO 0193.)

35. Dr. Kirsten emphasized that the rule is that if it is not in the records, it did not happen. Legible records with understandable abbreviations are a significant tool in helping the psychiatrist assess patients and reach diagnoses and, also, for insurance and "legal" purposes.

36. Based on his review of all three records, Dr. Kirsten found, for all three patients, respondent's records illegible except for select words and phrases. In particular, he faulted respondent for failing to note the time duration of his patient consultations. Dr. Kirsten felt such notations were important for insurance billing purposes. Paradoxically, given his inability to read respondent's handwritten records,

Dr. Kirsten found that the progress notes for all three patients do not identify that respondent conducted mental status exams (MSEs) for the patients, and that he failed to provide them informed consent concerning the risks and benefits of the controlled medications he was prescribing them.

37. Dr. Kirsten concluded that respondent departed from the standard of care required for accurate and adequate medical record keeping, under Business and Professions Code section 2266, because, as he wrote in his report, the records "are absent, illegible, chaotic, and were missing time annotations." He concluded that the departure was extreme.

RESPONDENT REPEATEDLY AND CLEARLY EXCESSIVELY PRESCRIBED, FURNISHED, DISPENSED, AND/OR ADMINISTERED SEDATIVES TO PATIENTS A, B, AND C (MEDICAL ISSUE # 3)

38. Dr. Kirsten identified the issue somewhat differently in his report as follows: Respondent excessively prescribed excessive and unnecessary quantities of controlled substances to Patients A, B, and C resulting in polypharmacy.

Dr. Kirsten articulated the applicable standard of care as follows: the physician should "[k]eep it simple" because the use of many medications increases the risk of error and dosing; limit the use of sedating medications to a short period of time, then tapering and stopping the medications to lessen the risk of intoxication, sedation, abuse and addiction; avoid polypharmacy such as not prescribing both long acting and short acting benzodiazepines at the same time; and avoid prescribing short acting benzodiazepines; avoid the use of zolpidem (a controlled substance used to treat sleep problems and insomnia) and other sedatives due to the risk of overdosing; and know the risks of withdrawal with anxiety, dependence, addiction, diversion and

dangerous combinations of sedatives with other medications and other substances. Dr. Kirsten recognized that sometimes the use of sedatives may be prolonged where the patient has "difficulty switching to the preferred SSRI medication." SSRI is the acronym for "selective serotonin reuptake inhibitors" which are a class of non-controlled substance drugs used to treat depression.

39. In his report, Dr. Kirsten found it notable that the initial complaint against respondent alleged that respondent overprescribed controlled substances to his patients. He then cited the CURES search he performed, on his own initiative, and the CURES reports he obtained through the HQIU investigator as foundations for his opinion concerning respondent's prescribing of controlled substances to all three patients. Based on his review of these materials Dr. Kirsten stated there was no evidence that respondent attempted to taper the sedatives he was prescribing to all three patients "recently." (Exhibit 11, AGO 0197.)

40. Regarding Patient A, Dr. Kirsten found that respondent's prescribing of clonazepam and alprazolam constituted an excessive supply of these medications during the 2016 to 2017 time frame, and an extreme departure from the standard of care.

41. Dr. Kirsten articulated his reasons for his conclusion as follow: Respondent prescribed excessive dosages of clonazepam and alprazolam from 2016 to 2017 to Patient A, sometimes for six months at a time, which placed her health at risk because these medications, with the carisoprodol she was taking, could suppress her respiratory drive. Further, respondent continued to prescribe to her these medications without tapering or switching her to an SSRI. At the same time Dr. Kirsten stated that respondent didn't taper her medications, he criticized respondent for "suddenly" reducing the clonazepam by half to her without explanation. He commented here that

respondent was not "controlling" Patient B's use of the medications. He commented that Soma is considered to be one of the three drugs in "the Holy Trinity" of drugs that substance abusers use.

42. As part of his analysis of his prescription of the medications respondent prescribed to Patient A in general, Dr. Kirsten cited "the Beers criteria", which refers to the "Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." (Exhibit 13.)

Patient A, he stressed, was over 65 years old and was diagnosed with COPD and carried oxygen. The Beers criteria warns doctors to avoid medications to patients who are 65 years or older. Alprazolam, clonazepam and zolpidem are on this list due to the risk of cognitive impairments, respiratory depression, delayed metabolism, and accidents.

43. Regarding Patient B, Dr. Kirsten testified that respondent committed an extreme departure from the standard of care when he prescribed alprazolam, in the amounts and for the duration he prescribed this medication, to B. He said that he considered as a factor that "informed" his opinion that B was an "alcoholic" and it was "extremely dangerous" for respondent to prescribe alprazolam to B because sedatives in general can "kill" a patient who is an alcoholic. As the basis for his opinion that Patient B was an alcoholic, Dr. Kirsten cited the lab reports that showed B had elevated liver enzymes to support his opinion that Patient B was an alcoholic.

In his report, regarding his inappropriate prescribing of medications to B, Dr. Kirsten cited the "paradoxical effects" of prescribing alprazolam with the stimulant Vyvanse and that alprazolam as the reason the prescription was excessive. (Exhibit 11, AGO 0197.) He further cited respondent's statement at his HQIU interview where he

said that the patient "didn't want to change anything" as "an indication of his addiction" and that respondent was enabling Patient B. (*Ibid.*)

44. In his report, Dr. Kirsten characterized the issue regarding B's possible alcoholism as he found it somewhat differently than he did in his testimony, as a matter of respondent's failure to consider "simultaneous alcohol use disorder, addiction and diversion of the large quantity of sedatives he was prescribing". (Exhibit 11, AGO 0205.) He wrote, incorrectly as B's records show, that respondent did not know Patient B's alcohol use and did not follow up with his own laboratory testing. (*Ibid.*)

45. With respect to Patient C, Dr. Kirsten found that respondent was prescribing "large quantities" of clonazepam and diazepam in high doses to her without a rationale from March 2017 through July 2018. Dr. Kirsten stated that there needs to be a rationale to explain why he was prescribing the two benzodiazepines and the Intermezzo, all of which can cause cognitive problems. As part of his analysis concerning the issue, Dr. Kirsten felt that Patient C was addicted to these medications. His concern about these large quantities was that C may have "squirreled" away, as a matter of misuse or diversion, these medications because of their street value. It is noted here that there is no evidence that Patient C was "squirreling" away these medications.

RESPONDENT FAILED TO OBTAIN CURES REPORTS FOR A REVIEW OF PATIENT A'S, B'S, AND C'S THEN CURRENT DRUG PRESCRIPTION PROFILE (MEDICAL ISSUE # 2)

46. Dr. Kirsten testified that the standard of care "on an elective basis" "for several years," as he wrote in his report, has been that doctors are required to utilize

CURES prior to prescribing controlled substances. However, Health and Safety Code section 11165.4 required physicians to consult CURES under such situations starting October 2018, although CURES was available to doctors before that date. In his testimony, Dr. Kirsten restated the standard as requiring, for several years, physicians to utilize CURES prior to prescribing large, prolonged quantities of controlled substances or when there is a concern regarding the use of controlled substances.

With respect to each of the patients at issue, respondent did not check CURES before October 2018. He did pull CURES reports, however, after October 2018 for each of the three patients.

RESPONDENT MAINTAINED PATIENT A ON THE LONG-TERM USE OF SEDATIVES DESPITE HER AGE (> 65 YEARS OLD) AND COPD, AND WITHOUT DOCUMENTING A RATIONALE FOR SAID PRESCRIPTION REGIMEN (MEDICAL ISSUE # 6)

47. Dr. Kirsten identified the issue this way in his report: Respondent prescribed sedatives to Patient A for three years at high doses although she was external oxygen dependent, had COPD, and received concurrent polypharmacy of the sedative carisoprodol from another doctor.

Dr. Kirsten stated that the applicable standard of care is to avoid the long-term use of sedatives for persons with COPD, especially persons carrying oxygen. When there is no alternative to prescribing sedatives to such patients a risk benefit analysis must be documented. The concern is that sedatives increase the amount of carbon-dioxide in the blood and brain.

48. Dr. Kirsten testified that respondent's prescription going back to 2016 of the two benzodiazepines constituted "large quantities" of sedatives and was an extreme departure from the standard of care. He gave as reasons for his conclusion that A's use of these sedatives with her impaired lung function might have created a "synergistic" effect from carbon dioxide and sedatives accumulating and posed a risk to her ability to drive safely. He noted that respondent documented that Patient A was driving. Respondent also failed to recognize the effects of A's simultaneous use of carisoprodol because he did not check CURES. This issue of respondent's failure to consult CURES is a recharacterization of the issue identified above. Dr. Kirsten's summary of the applicable standard of care and his conclusion regarding respondent's departure from the standard of care are discussed above.

RESPONDENT FAILED TO ATTEMPT TO UTILIZE SSRI MEDICATION TO REPLACE THE PROLONGED USE OF SEDATIVES BY ALL THREE PATIENTS (MEDICAL ISSUE # 5)

49. Dr. Kirsten identified this issue in his report as follows: Respondent prescribed sedatives to all three patients for years instead of utilizing SSRIs or alternative therapy.

Dr. Kirsten stated that after 1987, when Prozac was first developed, the standard of care for the pharmacological treatment of anxiety disorders has been the prescription of SSRIs. Before 1987, prescription of sedatives for such disorders was the standard of care.

Dr. Kirsten found that respondent committed extreme departures in respondent's care and treatment of all three patients when he failed to use SSRIs "*in lieu*" (his emphasis) of more dangerous drugs over many years.

RESPONDENT PRESCRIBED THE LONG-TERM USE OF SEDATIVES TO ALL THREE PATIENTS WITHOUT PERFORMING AND/OR DOCUMENTING A MENTAL STATUS EXAM (MEDICAL ISSUE # 7); AND/OR DOCUMENTING ANY DISCUSSION REGARDING SUICIDAL IDEATION; AND/OR FAILING TO OBTAIN DOCUMENTATION OF INFORMED CONSENT REGARDING THE RISKS OF PROLONGED USE OF SEDATIVES (MEDICAL ISSUES # 9 AND # 10)

50. Dr. Kirsten framed the issues as follows in his report: Respondent treated and prescribed sedatives to all three patients without documenting suicide or homicide risk. (Medical Issue # 9) He prescribed sedatives to all three patients going back to 2015 "without receiving informed consent." (Medical Issue # 10) Going back as far as 2015 respondent treated all three patients and prescribed sedatives to them without mental status examinations and without a good faith prior examination. (Medical Issue # 7) Here, it is noted that complainant does not allege that respondent committed gross negligence because he failed to conduct prior good faith examinations as required under Business and Professions Code section 2422 before prescribing the drugs he prescribed them. (*See* "Medical Issue # 7" Exhibit 11, AGO 0200-0201.) Under the Third Cause for Discipline, however, complainant alleges that respondent prescribed dangerous drugs without an appropriate prior examination and/or medical indication to all three patients.

51. The standard of care regarding receiving informed consent requires all doctors to have the patients informed of the benefits and risks of any medication. Informed consent does not need to be signed on a separate document, but there should be a statement that the patient was informed of both the risks and benefits of treatment and medication. The patient can only be treated or prescribed medication after he is informed of the benefits, as well as the risks of the treatment or medication.

52. Dr. Kirsten found that respondent failed to document that he informed the patients of the risks and benefits of the medications he prescribed to them. He concluded that respondent departed from this standard of care and the departure was extreme.

53. With respect to the issue of his failure to conduct a mental status examination, Dr. Kirsten noted that the records were "illegible", and he was unable to read them. He further found, incorrectly, that the first "intake" note for Patient A was March 23, 2016. In fact, Patient A was a long-term patient of respondent, which he noted in his HQIU interview and March 23, 2016, was not, thus, respondent's initial intake of Patient A. Dr. Kirsten similarly noted incorrectly that respondent's first note for Patient B was February 22, 2014, and for Patient C was March 17, 2017. Per the notes received into evidence, Patient B's first visit with respondent was November 30, 2013, although respondent had been treating him since 2008. Similarly, Patient C's March 17, 2017, note does not record her first visit with respondent; she had been seeing him before March 17, 2017. In his testimony, Dr. Kirsten acknowledged that he mistakenly considered the first visits recorded in the records complainant obtained as the first time these patients saw respondent.

54. With regard to the standard of care for conducting a mental status examination, Dr. Kirsten cited Business and Professions Code section 2242, subdivision (a), which requires a physician to conduct an "appropriate prior examination" with a medical indication" before prescribing dangerous drugs. He further stated that a mental status examination describes in detail the patient's "dimensions" in terms of thought processes, judgment, cognitive abilities, mood, impulses, suicidal or homicidal ideation. The mental status exam is a necessary part of an appropriate examination

and should also include complaint, history, laboratory tests, diagnosis and treatment plan.

55. Dr. Kirsten stated that respondent did not conduct mental status examinations for any of these patients. At the same time, Dr. Kirsten acknowledged both in response to a question posed to him on cross-examination and in his report, that he was unable to read respondent's progress notes. Despite his inability to read these notes, for the most part, Dr. Kirsten nevertheless found that respondent departed from the standard of care and the departure was extreme.

RESPONDENT FAILED TO DISCUSS AND/OR DOCUMENT DISCUSSION WITH PATIENT A ABOUT WHETHER HER ONGOING MEDICAL CONDITIONS WERE INFLUENCING HER PSYCHIATRIC DIAGNOSIS (MEDICAL ISSUE # 12)

56. The issue is framed in Dr. Kirsten's report as follows: Respondent did not consider non-psychiatric medical issues for Patient A. He did not document contact with outside specialists, keep copies of other physician records, or order appropriate laboratory tests for these three patients. Dr. Kirsten identified the standard of care as requiring a doctor to recognize medical conditions that can influence a patient's psychiatric condition, and he found that respondent departed from the standard of care and the departure was extreme.

57. During his testimony, Dr. Kirsten stated that he did not find any discussion between respondent and Patient A, as opposed to A's primary care doctor, regarding whether her medical conditions were affecting her psychiatric condition. In his report, Dr. Kirsten recognized that respondent stated in his interview he knew she had COPD. (Exhibit 11, page AGO 0199.) In fact, respondent documented in A's progress notes that he discussed with Patient A's primary care doctor her medical

condition in the context of her continued use of benzodiazepines. Her primary care doctor was prescribing her these medications before respondent took over prescribing them. Respondent also noted in A's progress notes that A had COPD, carried oxygen, was hospitalized and was receiving physical therapy. Further, respondent contacted Patient A's primary care doctor, who had been prescribing her the benzodiazepines. He also reduced the dosages of the benzodiazepines he was prescribing her.

RESPONDENT FAILED TO APPROPRIATELY MONITOR AND/OR VERIFY WHETHER PATIENT A, B, AND C WERE "TAKING HIS PRESCRIPTIONS FOR CONTROLLED SUBSTANCES AS PRESCRIBED"

58. Dr. Kirsten in his report did not characterize the issue as stated in the accusation, and the allegation in the accusation does not relate, directly, to a specific issue Dr. Kirsten identified in his report. In fact, his report does not mention the words "monitor" or "monitoring". In his testimony, however, Dr. Kirsten stated that respondent was not "monitoring" the patients' use of the medications he prescribed. Dr. Kirsten may have been referencing respondent's failure to use CURES to monitor the patients' use of the prescriptions he prescribed. That issue, as framed, is identified above and this allegation is thus considered a part of the allegation that respondent failed to consult CURES.

ON OR ABOUT AUGUST 18, 2017, RESPONDENT ISSUED MULTIPLE PRESCRIPTIONS FOR SEDATIVES TO PATIENT C WITHOUT DOCUMENTING ANY DISCUSSION REGARDING THE SERIOUS RISKS OF CONCURRENT USE OF SEDATIVES AND OPIOIDS (MEDICAL ISSUE # 8)

59. In his report, Dr. Kirsten articulated the issue as follows: Per CURES, respondent prescribed sedatives to Patient C on August 18, 2017, immediately after

Patient C received a large quantity of an opiate from another physician on July 25, 2017. (Medical Issue # 8.)

60. Dr. Kirsten wrote in his report that, as the standard of care, the combination of sedatives and "opiates" is to be avoided. He added he did not know why respondent deemed safe a combination of these medications with "opiates" (hydrocodone with acetaminophen is a combination "opioid" medication) and that his prescribing of the diazepam and zolpidem tartrate when Patient C was being prescribed opioids was an extreme departure from the standard of care.

DR. KIRSTEN'S BELIEF THAT THE THREE PATIENT MAY HAVE BEEN ADDICTS

61. In his report and in his testimony Dr. Kirsten referred to all three patients as either "addicts" or possible "addicts" in the context of assessing whether respondent excessively prescribed the medications at issue to them. Dr. Kirsten wrote specifically in his report that Patient A "may be addicted" to the benzodiazepines he was prescribing her and criticized respondent for continuing to prescribe her these medications without tapering the medications and without switching her to an SSRI. He wrote that Patient B's use of the medications respondent prescribed him "indicated" he was an addict because respondent said in the HQIU interview Patient B didn't want to change his medications. Regarding Patient C, he said respondent fed "his" (Patient C is a female) addiction because he allowed Patient C to make the decision to continue taking controlled substances.

62. Dr. Kirsten recognized the factors in Diagnostic and Statistical Manual (DSM) requiring that a clinician is to consider to assess whether a person is a substance abuser, but he did not recite the specific DSM factors. (In his report Dr. Kirsten offered that the DSM uses the "politically correct" term "substance abuser"

instead of addict.) Despite referencing the DSM factors, Dr. Kirsten does not appear to have applied these factors in his analysis concerning whether the patients can be deemed substance abusers or possible substance abusers.

DR. KIRSTEN'S BELIEF THAT RESPONDENT MAY HAVE COGNITIVE PROBLEMS OR A SUBSTANCE ABUSE PROBLEM

63. Dr. Kirsten also suggested that respondent himself may be a substance abuser. Indeed, he went so far, as he wrote in his report, to recommend that the board have respondent examined by another doctor to "ensure" that he does not suffer from cognitive or substance abuse problems.[3] He further recommended that he undergo toxicology and other testing.

64. As bases for his recommendation Dr. Kirsten cited respondent's statement at his HQIU interview that he suffered, like Patient C, from chronic insomnia, his illegible and chaotic progress notes, his "confused," "rambling," and "tangential" statements at his interview, and that he forgot the date when he completed his residency. In fact, respondent was not confused about the date he completed his residency as a review of the transcript of the interview indicates. Dr. Kirsten, when asked about this during the hearing, explained that there was "more confusion in the audio" than there was in the transcript. A review of the digital recording does not support Dr. Kirsten's understanding here or that respondent was confused. Respondent's answers here were clear and direct and he was not confused about the

[3] There is nothing in the record to indicate that the board followed Dr. Kirsten's recommendation.

date he completed his residency. Likewise, respondent's answers are found to not have been confused, rambling or tangential.

65. During the hearing, in response to a question posed to him on cross examination regarding his recommendation to have respondent examined, Dr. Kirsten sought to clarify his belief that respondent may be a substance abuser. His response is quoted in full as follows:

> Well, in my experience, the blindness of clinicians to the substance abuse issues of their patients often reflects their lackadaisical attitude towards medications which can be abused, and many, many physicians, not only psychiatrists, who over-prescribe, have prescription problems themselves and over-use.
>
> Now, I don't know. That is speculation on my point, and I did not make a diagnosis. It was not my role to make a diagnosis of Dr. Oskooilar, and maybe he is at his -- he's a perfectly healthy man. However, I am raising issues for the Medical Board to follow up on. He may be fine. I am not making a diagnosis of Dr. Oskooilar. I am solely addressing his clinical issues, but I am trying to explain why he may have such a lack of any caution in prescribing these medications and one of the possibilities - - and we talked about his lack of keeping up with the times- - is that he may have a substance abuse problem, which would be relevant, and the Medical Board can pursue it or not pursue

it, but I have no idea what Dr. Oskooilar does in his private life and whether he uses or does not use substances.

DR. KIRSTEN'S COMMENTS ABOUT RESPONDENT'S STYLE OF PRACTICE

66. In his report summary, in addition to recommending that respondent be examined by a doctor appointed by the board, based on respondent's prescribing practices, Dr. Kirsten concluded that respondent has an "atavistic" practice of psychiatry that resembles the style of the practice of psychiatry in the 1980s as opposed to today. He directed pointed criticism towards respondent for this style of practice and despite recognizing he reviewed just a "small sample" of respondent's records, concluded that he believed it highly probable that respondent would repeat the same departures from standards of care with his other patients. He recommended specific courses to address respondent's deficient knowledge in the areas of diagnosis, elements of a psychiatric examination, and psychopharmacology.

Testimony of Respondent's Expert, Daniel Chueh, M.D.

67. Dr. Chueh was called as an expert on respondent's behalf. Dr. Chueh obtained his medical degree from the State University of New York at Buffalo in 1989, and he completed an internship at the University of California Irvine School of Medicine in 1990 and a psychiatric residency at this school in 1993. Dr. Chueh has been licensed as a doctor in California since 1990 and has been board certified by the American Board of Psychiatry and Neurology since 1999. Since 1996 he has been Medical Director of Advantage Neuropsychiatric Associates, since 1994 Director of Psychiatric Services at Coastal Communities Hospital, Department of Psychiatry, and since 2002 Medical Director of NRC Research Institute where he has been investigator on clinical drug trials.

68. Dr. Chueh reviewed the relevant materials in this matter and talked to respondent about his treatment of all three patients, and he prepared a report dated January 29, 2020, which was received into evidence. His testimony is consistent with the opinions he expressed in his report. In his testimony and in his report he identified the issues according to Dr. Kirsten's numerical sequence of the issues; these issues in turn correspond to the allegations in the accusation. He also defined in his report the definition of the standard of care but in his testimony, initially, he had difficulty reciting the definition. Dr. Chueh's opinions are summarized by these issues as follows:

69. Medical Issue # 1. Inadequate medical records.

Dr. Chueh disagreed with Dr. Kirsten's opinion that respondent's notes were absent, illegible, chaotic, and missing time notations and as a result respondent departed from the standard of care and committed an extreme departure. Dr. Chueh found respondent's notes legible and noted that respondent treated all three patients some time before the dates identified in the subpoenas for the patients' records and Dr. Kirsten did not have the initial intake notes for these three patients. There is a difference between notes which document initial visits and progress notes. The initial visit should reflect what problems the patient came in with; progress notes should reflect what is going on since then; these progress notes should detail how the patient has "evolved" over time. Dr. Chueh added that there is no strict time for follow-up with a patient; sometimes it depends on what the patient's insurance will cover. The length of time for each visit varies from 10 to 15 minutes to an hour and for a medication check from 15 to 30 minutes.

Based on his review of respondent's progress notes, as he put it, respondent was having an "ongoing dialogue" with the three patients to assess their lives and what was going on in their lives. Respondent's style of recording was a narrative to

assess how his treatment was affecting their lives. Mental status exams, he noted, are a subset of the initial evaluation; 90 percent of the time the MSE is done at the first visit. At the same time, Dr. Chueh stated that by talking to the patient, a doctor can obtain a lot of information regarding the patient as a whole through the patient's speech, actions, and history.

In terms of the quality of respondent's handwriting Dr. Chueh described his handwriting as a little below average, but the progress notes were legible "for the most part" and consistent with the many handwritten records of other doctors he has seen. In these progress notes, respondent was able to get his message across. As a matter of the standard of care, which he identified in his report as what would a reasonable physician do in his community, Dr. Chueh stated that respondent complied with the standard of care noting that respondent's notes are more legible than most of the handwritten records he has reviewed.

Regarding the progress notes' value to other psychiatrists, Dr. Chueh stated that in general psychiatrists do not ask for the progress notes of other psychiatrists because these notes are colored by the other psychiatrists' view of the patients. Psychiatrists want a "blank slate" when they see a patient especially when the patient is switching psychiatrists.

In terms of the treatment of patients in general, Dr. Chueh stressed that as a fundamental matter, a "therapeutic alliance" must exist between the patient and the psychiatrist. Without this, it is very difficult to treat any patient.

70. Medical Issue # 2. CURES Consultation.

Dr. Chueh did not find any departure from the standard of care regarding respondent's failure to use CURES.

Regarding the question at what point in time were doctors required to check CURES as a matter of the standard of care when prescribing controlled substances, Dr. Chueh stated that doctors were not required to check CURES until October 2018, consistent with the enactment of Health and Safety Code section 11165.4. It was not mandated until then and, thus, in his view, it was not the standard of care to check CURES. He found no departure from the standard of care accordingly.

71. Medical Issue No. 3. Excessive Prescribing.

Dr. Chueh disagreed with Dr. Kirsten's opinion that respondent prescribed excessive dosages of benzodiazepines to the three patients. In summary, he found that respondent weighed the risks and benefits of prescribing the benzodiazepines to each of the patients and monitored them closely by checking the effectiveness of the medications in treating their anxiety disorders. He stated that the prescribed dosages of the medications were within Food and Drug Administration (FDA) guidelines, the FDA has approved the use of benzodiazepines to treat GAD, each of the patients reported that the benzodiazepines were effective in treating their anxiety disorders and they had no side-effects from the medications and respondent evaluated the efficacy of the medications. Dr. Chueh also noted in his report that, because the medications were working without side-effects, it would not have been the standard of care to stop the benzodiazepines. Ideally, he noted that benzodiazepines should be used for just short periods of time, but longer periods of prescribed use may be in order depending on the patient's needs.

In terms of measuring the efficacy of the medications the patients were prescribed and whether he was appropriately prescribing the benzodiazepines to Patient A specifically, Dr. Chueh cited a number of factors that led him to the conclusion respondent appropriately prescribed benzodiazepines to her and was

doing so within the standard of care. He stated that, per the progress notes, Patient A was able to drive, maintain her relationships, do chores, she was very active and she functioned at a very high level. There was no evidence that she was an addict. Respondent was aware of her COPD and medical problems, and he was in contact with her primary care provider regarding her use of the benzodiazepines, and he had an adequate understanding of her medical problems and the medications she was taking. Patient A was not medically unstable, and anxiety, as a comorbid condition, can cause bronchial spasms through panic attacks. He noted that SSRIs are not a "panacea," as he wrote in his report, given that they are not effective for a large percentage of the patient population and benzodiazepines are more effective in treating anxiety disorders. Dr. Chueh added that per Patient A's medication list, she tried an SNRI and SSRIs.

As additional considerations for his conclusion that respondent prescribed her the medications appropriately and within the standard of care, Dr. Chueh noted that Patient A was not taking a large amount of alprazolam; in fact, respondent was weaning her off the medication and prescribing the alprazolam only for "breakthrough" panic attacks. He noted that on April 14, 2017, Patient A had a prescription or 90 pills of alprazolam (Xanax) and she did not have another prescription until January 2018, a nine-month gap between prescriptions. Accordingly, she was using about 10 pills a month or one pill every three days. Further, by January 2018, respondent was prescribing 0.5 mg of clonazepam (Klonopin) to Patient A, which was a 50 percent reduction in the dosage.

Dr. Chueh added further that respondent knew that Patient A was receiving carisoprodol as a muscle relaxant from another doctor. There is no preclusion to

prescribe benzodiazepines to a patient taking carisoprodol. He added here that respondent was coordinating Patient A's care with her primary care doctor.

In all other regards, Dr. Chueh found that respondent acted within the standard of care in his treatment and prescribing of medications to Patient A. He disagreed with Dr. Kirsten that respondent should not have prescribed the benzodiazepines to Patient A based on the Beers' list, given her age, because that list is a guideline and does not represent a standard of care. An individualized assessment of a patient must be made, Dr. Chueh stressed, which respondent did.

Additionally, Dr. Chueh disagreed with Dr. Kirsten's opinion that respondent prescribed to Patient A excessive dosages of benzodiazepines both considering her medical problems and as a general matter. He said that the prescription for the benzodiazepines was within the FDA guidelines for dosages and that extended use of benzodiazepines is appropriate where a patient is not responsive to SSRIs for the treatment of GAD. While it is ideal to switch a patient to an SSRI, a lot of times SSRIs do not work and in general are not as effective as benzodiazepines for the treatment of anxiety. It was his understanding that Patient A tried Lexapro. In any case, per Patient A's medication list, Patient A identified that she was unable to take an SSNR, a class of drugs similar to SSRIs.

Dr. Chueh reached the same conclusion that respondent appropriately prescribed medications to Patient B and disagreed with Dr. Kirsten's conclusion to the contrary. In Patient B's case, respondent prescribed both a benzodiazepine and Vyvanse, a long acting stimulant, to Patient B. Patient B was diagnosed with OCD, depression and ADHD. Vyvanse was an appropriate medication to treat ADHD. Dr. Chueh stressed, as documented in the progress notes, Patient B was "doing very well" succeeding in his job as a salesperson with no deleterious side-effects.

Dr. Chueh considered the following factors in reaching his conclusion that respondent acted within the standard of care in his treatment of Patient B: respondent did not prescribe an excessive dose of Vyvanse to Patient B. The medication works over a 12-hour period, which is a very slowly released medication, and it is good clinical practice to switch a patient to this stimulant from a short acting medication. The medication is a time released version of Adderall with a "low street value" for purposes of abuse. To treat ADHD, stimulants are a first line treatment for ADHD and the medication in fact helps calm a patient with ADHD.

Moreover, and contrary to Dr. Kirsten's view, Dr. Chueh stated it was not improper to treat Patient B with both the Vyvanse and the benzodiazepine, as long as the dose of alprazolam was not increased, which was the case with Patient B. The 70 mg respondent was prescribing Patient B was a relatively high dose, Dr. Chueh recognized, but within FDA guidelines.

Dr. Chueh took issue with Dr. Kirsten's view that Patient B may have been an alcoholic based on the liver enzyme test results respondent obtained. Many things can cause an elevated liver test. To determine whether there is a chronic medical problem, liver test results need to show a "progression" and such a progression cannot be shown from one test. While he acknowledged that Patient's B's enzyme level was high, the single test did not indicate to Dr. Chueh that Patient B had a medical problem. He stated that the "144" level liver enzyme reading was an elevated reading and respondent took steps, as a precautionary matter, to have Patient B address it. Respondent counseled Patient B and his wife to discontinue their use of alcohol and for Patient B to see a liver specialist. Patient B in turn acknowledged respondent's concerns and appeared to have followed his plan.

Regarding Patient C, Dr. Chueh found no basis to support Dr. Kirsten's conclusion that respondent was excessively prescribing medications to her. He noted that she was very highly functioning, she was very successful in her personal life and was handling everything well. He emphasized that she was able to travel by bike from San Francisco to Los Angeles, her anxiety and insomnia diminished with the medications, and respondent monitored her closely. Dr. Chueh concluded that respondent's care and prescribing of the medications were within the standard of care.

With this stated, Dr. Chueh acknowledged that Patient C was taking an "unusual" combination of sedatives to help her sleep and control her anxiety. To help her sleep, she was taking Intermezzo, a fast-acting hypnotic, a low dose of diazepam, a long acting benzodiazepine, and alprazolam, a short acting benzodiazepine, for break-through anxiety. He termed the combination "unconventional" but "safe" with low doses of the medications within FDA guidelines. To demonstrate the safety of prescribing both benzodiazepines Dr. Chueh converted both medications to a single dosage measurement for diazepam. The overall level or load, he found, was well within FDA guidelines.

Dr. Chueh pointedly disagreed with Dr. Kirsten's conclusion that Patient C was an addict and termed his conclusion "baseless," noting that Dr. Kirsten didn't have Patient C's complete records. Following criteria to assess a person for substance abuse, Dr. Chueh stated that Patient C was able to maintain relationships, she was well groomed, had no DUIs or legal entanglements, and never reported she lost her meds.

In further disagreement with Dr. Kirsten, Dr. Chueh added that the standard of care did not require respondent to administer urinary drug screens (UDS). Typically, he noted, a UDS is not done unless there are corroborating indications of possible abuse like a report from a family member or other social or physical indications. He stated

that requiring such a test may damage the therapeutic alliance between a patient and the doctor.

72. Medical Issue # 4. Violation of the Beers Guideline.

As discussed above, Dr. Chueh found no departure from the standard of care because respondent did not follow the Beers guidelines. These guidelines are just that, guidelines, and are not a standard of care.

73. Medical Issue # 5. Respondent's Failure to Utilize SSRIs.

Dr. Chueh also found no departure from the standard of care regarding respondent's failure to use SSRIs in place of the benzodiazepines respondent prescribed all three patients. He emphasized here that prescription of medications is not a matter of a one size fits all assessment and SSRIs are not a "panacea" because they work on just 62 percent of the patient population with anxiety. He said that prescribing SSRIs does not represent the standard of care. Individualized consideration must be given to a patient's history, body mass to determine dosages, real life conditions, medical condition, real life efficacy of the benzodiazepine, and weighing the risks and benefits of prescribing the medications.

By these measures, Dr. Chueh believed that respondent acted within the standard of care with respect to each of the patients in his prescribing of the benzodiazepines.

74. Medical Issue # 6. Prescribing Sedatives to a Person with COPD.

Respondent's prescription of benzodiazepines to Patient A over three years was an extreme departure from the standard of care. Dr. Chueh found that respondent acted within the standard of care by prescribing the benzodiazepines to Patient A and

gave her "excellent care" for the reasons already discussed. He closely monitored Patient A, tapered both benzodiazepines he prescribed her, worked with her primary care provider. And, fundamentally, Patient A was highly functioning. She was able to drive and perform chores and look out after herself. Also, Dr. Chueh disagreed with Dr. Kirsten's view that her use of benzodiazepines made her a dangerous driver. In addition, as mentioned above, he stated that anxiety could exacerbate shortness of breath in patients with COPD and in Patient A's case.

75. Medical Issue # 7. Respondent did not perform MSEs on all three patients before prescribing them controlled substances. Dr. Chueh testified that Dr. Kirsten's opinion that respondent failed to conduct mental status exams is incorrect based on the information in the notes for all three patients. He found that respondent did not violate the standard of care accordingly.

Dr. Chueh stated that 90 percent of MSEs are performed at the initial intake and all three patients were seeing respondent before the period of time complainant requested records in the subpoenas. As he articulated, the standard of practice to require notes subsequent to the initial intake MSE, should reflect changes the patients experience over time. These notes should reflect the story how the patient evolves over time. From the progress notes for the three patients in this matter respondent described the patients very well and any changes they were experiencing.

76. Medical Issue # 8. Respondent prescribed sedatives to Patient C on August 18, 2017, after she received a large quantity of opiates on July 25, 2017.

Dr. Chueh found no departure from the standard of care because respondent was not required to review CURES before October 2018, in his opinion.

77. Medical Issue # 9. Respondent treated the three patients without documenting homicidal or suicidal risk.

Dr. Chueh testified that all three patients indicated they did not have suicidal ideation at their initial visits with respondent. After these initial visits, respondent was not required to ask them each time he saw them whether they were suicidal. He had been evaluating them over time and was able to discern they were not suicidal: For example, all three patients were making plans for the future, which indicates they were not suicidal. To continue asking patients if they are suicidal can create anxiety, Dr. Chueh commented.

78. Medical Issue # 10. Informed consent.

In response to Dr. Kirsten's opinion regarding the lack of documented informed consent, Dr. Chueh criticized Dr. Kirsten for suggesting that the patients were not safe with him and informed consent was required to document they were safe. He said that informed consent regarding the risks and benefits of the medications was not required because of the long-term therapeutic alliance respondent had with each of these patients. Regardless, whether he documented informed consent, Dr. Chueh commented that respondent discussed with and informed the patients, the pluses and minuses of the medications, consistent with his duty to do no harm, and the patients needed to make the decision to take the medications in light of their side-effects.

79. Medical Issue #12. Respondent did not consider non-psychiatric medical issues.

Dr. Chueh stated that respondent did not violate any applicable standard of care concerning this issue. Dr. Chueh stated that respondent documented that Patient A had COPD and was carrying oxygen. As he put it, the reason respondent

documented this was that he considered her medical condition. Dr. Chueh dismissed Dr. Kirsten's opinion because all three patients had primary care doctors.

80. Medical Issue # 13. Prescribing controlled substances to patients who may be substance abusers.

Dr. Chueh challenged Dr. Kirsten's view that the patients were either addicts or might be addicts. He noted that none of these patients had diagnoses of alcohol abuse. Patient B admitted he drank once or twice and this does not mean he "abused" alcohol. Dr. Chueh noted he stopped drinking. Dr. Chueh emphasized that Vyvanse is not a stimulant that can be abused because it is long acting and does not give the user a "rush." (Dr. Chueh commented here that respondent was a principal investigator on some of the trials of Vyvanse so he was well aware of the pharmacology of this stimulant.) He also noted, as discussed earlier, that respondent's prescription of the benzodiazepines to Patient C, when converted to a single measurement for diazepam, was well within FDA guidelines. Regarding his prescription of benzodiazepines to Patient C, she received a low dose of alprazolam over a nine-month period, 90 pills over 9 months.

Respondent's Testimony

81. Respondent's testimony is summarized as follows: He obtained a doctorate in psychology from Florida State University in 1978, taught psychology in Iraq, and earned his medical degree graduating in Medical Sciences from the University of Iran in 1986. He then completed a residency at the University of South Dakota and Washington University where he focused on biological psychiatry. His residency was three years and he completed it in 1991. In 1991 he moved to California and started in private practice, then he worked for Riverside County for 12 years in

outpatient and inpatient capacities. From 1991 to 1993 he was the attending staff psychiatrist for Riverside County Mental Health. Respondent is certified by the American Board of Psychiatry and Neurology with an added certification in Geriatric Psychiatry.

82. Starting in 2002 respondent became affiliated with the Pharmacology Research Institute (PRI) and is now its Medical Director. He has worked there since that time as both a primary and sub investigator in clinical trials run by pharmaceutical companies and the FDA. He has worked as principal investigator on over 200 drug trials. Respondent's curriculum vitae details over six pages his research experience in numerous drug trials. Respondent is also the author of numerous articles in the field of psychiatry. He is now Medical Director of PRI.

83. In addition to his work as an investigator in drug trials, respondent also maintains a private practice in Newport Beach. He performs both psychological therapy, or supportive therapy, and medication management. His work in private practice constitutes 50 percent of his professional time and he sees about 25 to 30 patients a week.

84. Respondent described his treatment of the three patients as follows:

85. Patient A. Regarding Patient A, he had been treating her before the records requested in this matter. She was diagnosed with GAD. In persons with this disorder respondent commented that the brain creates a lot of anxiety and Patient A worried about everything. It is not a curable condition. Patient A tried SSRIs but was not able to tolerate them. Respondent noted that for 80 percent of the patients with GAD SSRIs don't work and tranquilizers are appropriate to prescribe. Patient A was taking alprazolam and clonazepam for a long time through her primary care doctor

before he prescribed the medications to her. Respondent said he always informed patients of the risks of using the medications he prescribed; he discusses why a medication is indicated and the alternatives. He moreover follows the patient to see what works. There was no indication she was abusing the medications he prescribed her. He noted that she was allergic to narcotic medications. Respondent said he knew she was taking carisoprodol.

When Patient A first saw respondent he performed an MSE and subsequently did so at every visit. He said that it is "impossible" not to do an MSE because as a psychiatrist everything catches his eyes: he documented that she was "baseline", she was able to do chores, she wasn't staggering, she wasn't depressed and she wasn't having any side-effects from the medications he was prescribing her.

With regard to Patient A's COPD he recognized that use of benzodiazepines can increase the risk of respiratory depression but he stressed you have to look at the patient individually. Without treatment for anxiety panic attacks can worsen the symptoms of COPD. As long as Patient A was not abusing the medications respondent felt it was appropriate to prescribe her the medications. He also was actively engaging with Patient A's primary care doctor. Further, Patient A was doing well and she was only occasionally taking the alprazolam. She was not doctor shopping and took the medications as directed. He noted that he reduced the amount of both benzodiazepines he prescribed her and didn't reduce the clonazepam "suddenly" as Dr. Kirsten stated. Respondent commented that maybe he should have put this in writing to make it clear. Respondent noted he did not have to see Patient A monthly as a matter of the standard of practice even with the refills he approved.

In answer to the question whether he should have ordered UDS respondent said drug screens were not indicated.

86. Patient B. Patient B was respondent's patient since 2008. He was diagnosed with GAD OCD and "rule out" ADHD. He had some features of ADHD: procrastination, distraction, impatience, and wasn't performing at his potential. Respondent said testing indicated he had ADHD. Patient B also had knee problems and knee pain and was taking pain medications. He said he saw Patient B for one-hour visits and did not feel it was necessary to write the time of day of these visits. He said that overall the treatment he provided Patient B benefited him; Patient B had struggled at work and with his wife and he "overcame" these struggles, he improved and was able to provide for his family. He commented that Patient B was always thankful and he did not engage in "manipulation or game playing". Regarding his use of alcohol, respondent said Patient B stopped drinking, but this was not documented in Patient B's notes.

Respondent stated that Vyvanse doesn't have a street value because it is long acting. He regards it as a safe medication. For persons with ADHD, a stimulant doesn't make them anxious and it was not inappropriate for him to prescribe alprazolam to Patient B. The dosage he prescribed was a low dose, and Patient B was experiencing no side-effects from the medications and was doing well: he was promoted at his job.

During this testimony respondent went through Patient B's progress notes. These notes are summarized above and, for the most part, the material portions of the notes are legible. Respondent said he knew Patient B was taking pain medications but was taking them sporadically. He reviewed the combination of medications he was taking, Patient B was not abusing the medications, and he knew the risks of the medications. He also conducted MSEs of Patient B at every visit. He noted that per the MSE he conducted of Patient B at his July 8, 2018, visit, Patient B had increased

"situational" symptoms of depression, and he engaged Patient B with "supportive therapy", which he documented. He said he found such therapy "more reasonable."

87. Patient C. Respondent stated he started treating Patient B on March 23, 2011. Patient C had a good job and was functional. Her problems were GAD with panic attacks, agoraphobia, and social anxiety disorder. When Patient C first saw him she was taking 10 mg of Valium, she had tried SSRIs, which were not effective, had tried Lexapro specifically and she didn't like the medication. She had trouble returning to sleep and participated in a sleep study, but it was inconclusive. To address her sleep problem, Patient C tried Inderal and Trazadone, both of which didn't work, and respondent prescribed Intermezzo to help her fall asleep. Patient C's insurance approved her for Intermezzo after he send records and supporting documentation.

Respondent testified that the medications he prescribed her improved her life. He gave as an example the bike ride she took from San Francisco to Los Angeles. He disagrees pointedly with Dr. Kirsten's view that the bike ride was somehow dangerous due to the meds she was taking. Respondent said he considered the risks and complications of the medications he prescribed Patient C which he discussed with her "many times." He noted there were no problems with the medications he prescribed her. Patient C had no withdrawals or side-effects. He added that Patient C was not an addict.

Respondent further testified that the dosage amounts of the two benzodiazepines he prescribed Patient C did not exceed FDA guidelines. He added that both benzodiazepines worked differently and have different functions. He added there is nothing against prescribing two benzodiazepines at the same time. Respondent commented that Kaiser, where Dr. Kirsten has worked, has suggested as

an institution it is not appropriate to prescribe two benzodiazepines, but Kaiser's view does not represent the standard of care.

88. In general, regarding his care of all three patients, respondent said he believes he gave them good medical care. He started using CURES when it became mandated in October 2018 and he consulted CURES for each of the three patients after that date. In the community, none of the practitioners he knew consulted CURES before October 2018. Regardless, respondent said he was aware of the medications his patients were getting from other providers, was in contact with their doctors, and patients showed him the bottles of medications they were taking. He repeated, addressing Dr. Kirsten's concerns, that the three patients were not addicts.

89. Concerning Dr. Kirsten's characterization of the quality of respondent's responses to questions posed to him at the HQIU interview, respondent said he was nervous, did not have a lawyer with him, and mistakenly thought it was going to be a "friendly" interview for the board to gather information. He said he was surprised by the tone of the interview. As noted earlier, a review of both the transcript of the hearing and the audio of respondent's interview does not support Dr. Kirsten's characterization that respondent was "rambling", that his responses were not appropriate, or that his responses demonstrated, as Dr. Kirsten believed, that respondent may have a mental health issue that required the board to have him evaluated.

90. Concerning respondent's record keeping, respondent stated that since 2019, he has improved his record keeping and now has his notes typed so they are more readable. At his HQIU interview, respondent acknowledged that his notes are difficult to read.

91. Respondent's testimony is found fully credible.

Evaluation of Expert Testimony and Evidence

92. In resolving the conflicts in the expert testimony in this matter, Dr. Chueh's opinions are found more persuasive than Dr. Kirsten's opinions and given more weight, except in one area. In making this assessment, consideration has been given to the qualifications and credibility of both experts, including their biases that could color their opinions and review of the evidence, the reasons for their opinions, and the factual bases of their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

93. As a general matter, Dr. Chueh's opinions are deemed more persuasive than Dr. Kirsten's opinion because Dr. Kirsten held a clear bias against respondent that colored his testimony in all respects, including his analysis regarding respondent's alleged departures from standards of care, except for his view that respondent's record keeping was difficult to read in places and he failed to document he provided the three patients with informed consent.

94. In addition, Dr. Kirsten's characterization of respondent as possibly a substance abuser with a possible mental health disorder that requires the board to evaluate him, is without factual basis and suggests that he lacked the necessary dispassion to fairly evaluate the evidence of record in this matter. In addition, Dr. Kirsten's comment that respondent's practice of medicine was outdated and rooted in a 1980's style of practice further reflects his lack of objectivity and bias against respondent. This lack of dispassion was further on display when Dr. Kirsten, on his own

initiative, and contrary to the board's instructions to experts, researched CURES beyond the time frame of the HQIU investigation.

Moreover, and concerning as a matter of his review of this matter, Dr. Kirsten's analysis of the evidence was, as complainant candidly recognized in closing comments, "sloppy," "not careful," and he "went overboard in this analysis." It was also materially wrong in several places. Most notably, his casual view that the patients were addicts or possible addicts to controlled substances was not grounded in facts of record and did not utilize factors to assess whether persons are substance abusers. His blanket view that respondent's records are "illegible" is also incorrect. Dr. Kirsten, in addition, incorrectly thought that the patient records included initial "intake" notes when the records reflect only a select time period and respondent had been treating each of the patients before the time period of the records the HQIU investigator obtained and initial intake notes were not part of the records obtained. Further, respondent noted in his interview that he had been seeing the patients for longer periods of time than the dates of the records obtained. Given that Dr. Kirsten claimed to have listened to the interview, it was unclear how he missed that fact.

95. Further, Dr. Kirsten during his testimony on both direct and cross, seemed invested in the outcome of the action against respondent and acted like an advocate of a certain position. He often went beyond the scope of the questions to answer questions in a way that supported his view of respondent, and at times was defensive, interrupting respondent's counsel before questions were asked.

96. Dr. Chueh, while appearing more dispassionate than Dr. Kirsten in general, displayed a similar tendency to go beyond the scope of questions asked and at times seemed defensive. In addition, Dr. Chueh's failure to comply with the subpoena served upon him by complainant, suggests he had an adversarial posture

towards complainant. But, overall and certainly compared to Dr. Kirsten's analysis, he presented as a more dispassionate expert whose opinions were grounded in the record and are considered as such accordingly.

With these comments noted the following findings of fact have been reached based on the evidence of record.

FIRST AND SECOND CAUSES FOR DISCIPLINE

97. The accusation identifies specific instances of conduct constituting alleged gross and simple negligence in his care and treatment of Patients A, B, and C. Most of the allegations are common to respondent's treatment of all three patients though they are identified separately in the accusation. Based on the credible evidence of record the following findings are made with respect to each of the allegations:

98. First, with respect to all three patients, regarding the allegation in the accusation that respondent's clinical notes are either "missing, illegible, disorganized, and/or missing time annotations", this allegation is not supported by the persuasive evidence with one exception. Respondent's records are legible though certain words are difficult to read in places. The notes, for the most part, are not "missing" or "disorganized." Dr. Chueh's testimony that the standard of care did not require respondent to make time annotations in the patient records is found more persuasive than Dr. Kirsten's testimony that such time annotations are required by the standard of care.

But, respondent's records are missing documentation he provided the patients with information regarding the risks and benefits of the medications they were taking. It is noted here that his testimony that he gave the three patients this information is found credible. In his testimony, Dr. Chueh did not materially dispute that

documentation of informed consent should have been in the patient's records. He termed the issue as one concerning whether respondent's prescribing practices to the patients were "safe." With this stated, Dr. Kirsten's testimony that this failure to include this information represented an extreme departure from the standard of care is not found persuasive because respondent discussed with the patients the risks and benefits of the medications he was prescribing them, and followed them closely to ensure they were not having adverse side-effects. As a result, respondent's failure to document informed consent cannot be found to be "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) It also cannot be found that this failure to document informed consent represents a simple departure from the standard of care. Dr. Kirsten's evident bias against respondent is a factor in reaching the conclusion that respondent did not depart from the standard of care.

It is found, however, that respondent's failure to record that he gave patients informed consent constitutes a violation of Business and Professions Code section 2266. Such information should have been in the patients' records. Thus, as found below under the Sixth Cause for Discipline, respondent's failure to include information that he discussed with the patients the risks and benefits of the dangerous drugs he was prescribing them constitutes a failure to maintain adequate records in violation of Business and Professions Code section 2266.

99. Regarding the allegation that respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered sedatives to all three patients, Dr. Chueh's testimony is found more persuasive here than Dr. Kirsten's testimony. Respondent's prescriptions of benzodiazepines to the three patients were reasonable based on their conditions and was not excessive. Respondent's prescription

of the benzodiazepines to the three patients were within FDA guidelines and respondent prescribed these medications based on his assessments of each of the patients and his prescriptions were reasonable considering their individual conditions. Dr. Kirsten's testimony cannot be found persuasive due to his clear bias against respondent as discussed earlier.

100. With respect to the allegation that respondent failed to obtain CURES reports for a review of all three patients, Dr. Chueh's testimony that CURES consultation was not mandated and the standard of care until October 2018 is found more persuasive than Dr. Kirsten's testimony that use of CURES when prescribing controlled substances was required as a matter of the standard of care before this date. Here, Dr. Kirsten's testimony that reviewing CURES was required as a matter of the standard of care "on an elective basis" "for several years" was vague. Dr. Kirsten did not support his opinion with a discussion of the history, use, or accessibility of CURES to doctors statewide. Indeed, Health and Safety Code section 11165.4, which Dr. Kirsten cited in his report did not require physicians to use CURES when prescribing controlled substances until the Department of Justice "certifies" that "the CURES database is ready for statewide use. . . ." (Health & Safety Code, § 11165.4 subd. (e).) Mandatory CURES consultation under Section 11165.4 became effective on October 2, 2018, as Doctor Kirsten noted. (See https://oag.ca.gov/cures citing Medical Board publication https://www.mbc.ca.gov/Download/Documents/CURES-FAQ.pdf.)

101. Regarding the allegation that respondent maintained Patient A on the long-term use of sedatives despite her being over 65 years old and having COPD, and without documenting a rationale for said prescription regimen, Dr. Chueh's opinion is found more persuasive than Dr. Kirsten's and fully supported in the record. First, Dr. Chueh emphasized that notwithstanding her age and COPD, respondent's prescription

to Patient A of benzodiazepines was reasonable, respondent considered her COPD when prescribing the benzodiazepines, communicated with her primary care provider and followed her closely. Further, the Beers list, which Dr. Kirsten cited as the basis of his opinion that respondent should not have prescribed benzodiazepines to Patient A because she was over 65 years old, is a guideline and not the standard of care. Also, benzodiazepines prevented panic attacks, a comorbid condition which could have exacerbated Patient A's COPD. In addition, Patient A was fully functioning and displayed no adverse effects from the medications. Respondent recorded his treatment of Patient A and further substantially reduced the dosages of benzodiazepines to her.

102. Regarding the allegation that respondent failed to attempt to utilize SSRI medication to replace the prolonged use of sedatives by all three patients, Dr. Chueh's testimony is accepted for these reasons: use of SSRIs does not represent the standard of care, in general they are not as effective in treating GAD as benzodiazepines, and individual assessments needed to be made not a "one size fits all" approach to the use of SSRIs. Also, Patients A and C both had been on SSRIs and Patient A had a negative reaction to an SSNR medication. SSNR appears to be a class of medications similar to SSRIs.

103. Regarding the allegation that respondent prescribed the long-term use of sedatives to Patient A despite her COPD, this issue is addressed above and, as found, Dr. Chueh's testimony is deemed more persuasive than Dr. Kirsten's opinion for the reasons discussed.

104. Regarding the allegation that respondent prescribed the long-term use of sedatives to the three patients without performing and/or documenting a mental status exam; and/or documenting any discussion regarding suicidal ideation; and/or

failing to obtain documentation of informed consent regarding the risks of prolonged use of sedatives, Dr. Chueh's opinion is found more persuasive than Dr. Kirsten's for the most part for these reasons: Respondent in fact documented he conducted mental status exams of the three patients, which included his recording that Patient A was functioning at "baseline" and status checks he documented in their progress notes where he detailed their mental states and functionality; respondent's credible testimony that he performed complete mental status exams on the three patients at their intakes which predate the records complainant obtained; and his further credible testimony that he always performed MSEs. Dr. Chueh correctly noted that it would make no sense to constantly ask a fully functioning patient if he or she is suicidal. In fact, as evidence that respondent was conducting MSEs and mindful of his duty to monitor the patients for suicidal ideation, respondent recorded that Patient B was not suicidal when he reported to him the first time that he told respondent he was depressed.

With this stated, as found above, respondent did not document that he provided the three patients with informed consent for the controlled substances he was prescribing them, although as also found, respondent did discuss with them of the risks and benefits of taking these medications. As discussed below under the Sixth Cause for Discipline this failure to document the patient's records in this regard constitutes a violation of Business and Professions Code section 2266. Dr. Kirsten's testimony that this oversight constitutes an extreme departure from the standard or care is specifically found not persuasive.

105. Regarding the allegation that respondent failed to discuss and/or document any discussion with the three about whether their ongoing medical conditions were influencing their psychiatric diagnoses, Dr. Chueh's opinion here is

found more persuasive than Dr. Kirsten's. All three patients had primary care providers and respondent was aware of the patients' medical conditions and treatments. It is simply incorrect based on the record to conclude that respondent did not take into account their physical health issues given the degree to which he documented their conditions.

106. Regarding the allegations that respondent failed to appropriately monitor and/or verify whether the three patients were taking his prescriptions for controlled substances as prescribed, this allegation is not supported by the patient records and Dr. Chueh's opinion here is found persuasive. There is no evidence the three patients were abusing the prescriptions for the medications respondent prescribed them; they were not engaging in the behavior one would see in substance abusers which Dr. Chueh identified. They each were fully functioning and showed improvement during the time documented in the records complainant obtained. In addition, they were taking their medications as prescribed and respondent followed each of them closely.

107. With respect to the allegation that respondent issued on August 25, 2017, multiple prescriptions for sedatives to Patient A without documenting any discussion regarding the serious risks of concurrent use of sedatives and opioids this allegation is a recharacterization that respondent failed to review CURES before he prescribed the benzodiazepines to her on August 25, 2017. Because as found above, Dr. Kirsten's testimony that consulting CURES was required as a matter of the standard of care is not found persuasive, the allegation he departed from the standard of care for not checking CURES on August 25, 2017, is not accepted.

THIRD CAUSE FOR DISCIPLINE

108. The allegation under this cause for discipline alleges that respondent prescribed dangerous drugs without conducting an appropriate prior examination or medical indication. Dr. Kirsten's opinion in this regard is found not persuasive both as a matter of the bias he held against respondent because his opinion is not supported by the evidence of record. Dr. Chueh's testimony that respondent performed MSEs of each of the three patients is found persuasive and consistent with the evidence of record as detailed immediately above.

FOURTH CAUSE FOR DISCIPLINE

109. The allegation under this cause for discipline alleges that respondent committed repeated acts of clearly excessively prescribing drugs to Patients A, B, and C. Dr. Chueh's testimony is found persuasive and accepted over Dr. Kirsten's testimony to the contrary for the reasons stated above.

FIFTH CAUSE FOR DISCIPLINE

110. This allegation alleges that respondent prescribed controlled substances to Patients A, B, and C without consulting Health and Safety Code section 11165.4 as required. This allegation is dismissed because Health and Safety Code section 11165.4 became effective October 2, 2018, as noted above, a fact both parties acknowledged, and respondent consulted CURES after October 2, 2018, with respect to each of the three patients.

SIXTH CAUSE FOR DISCIPLINE

111. This allegation alleges that respondent failed to maintain adequate and accurate records in violation of Business and Professions Code section 2266.

Respondent failed to maintain adequate records in one respect because he did not document that he provided informed consent regarding the risks and benefits of the benzodiazepines and other controlled substances he prescribed Patients A, B, and C. It is noted that respondent's testimony he verbally advised these patients of the risks and benefits of the medications he prescribed to them is found credible.

Concerning the more general allegation that respondent's records were inadequate or inaccurate because they were "missing, illegible, disorganized, and/or missing time annotations" this allegation is not supported by the evidence. Respondent's records are legible, for the most part, and contain details about the mental states and conditions of all three patients. As found above, respondent was not required as a matter of the standard of care to time annotate the records based on Dr. Chueh's persuasive testimony. Dr. Kirsten's testimony to the contrary is not found persuasive accordingly.[4]

Character Evidence

112. Respondent called Don De Francisco Ph.D. M.D., Charles S. Wilcox Ph.D. M.P.A. M.B.A. as character witnesses and Daniel E. Grocz, M.D.

113. Dr. De Francisco holds a Ph.D. in psychology and a medical degree. He is Medical Director of PRI (at a different PRI facility) and has a private psychiatric practice. He is a Diplomate of the American Board of Psychiatry and Neurology and board

[4] The Seventh Cause for Discipline alleges that respondent engaged in general unprofessional conduct due to the violations as alleged. The disposition of this cause does not require a separate factual finding and is addressed later in this decision.

certified in Geriatric Psychiatry. He has been licensed to practice medicine in California since 1974, and he is a licensed psychologist.

Dr. De Francisco has known respondent through the psychiatric community since the 1990s and from 2002 when respondent joined PRI as a drug trial investigator. He has also at times shared patients with him.

Dr. De Francisco has a high regard for respondent, and respondent is one of only two psychiatrists he refers patients to. He described respondent as a very good psychiatrist who has very good knowledge and pharmacological medical usage based due in part to his work as drug trial investigator.

114. Dr. Wilcox holds degrees in the areas of public affairs marketing research and analysis applied behavioral sciences. His focus has been on healthcare. Since 1978 Dr. Wilcox helped to start the entity that became PRI and was its owner and executive director until 2019 when he sold the company.

Through PRI Dr. Wilcox came to know respondent. He hired him as a "stand out" candidate based on his experience in part as a psychologist and psychiatrist. He described respondent as a "very good fit." At PRI respondent performs an essential role as the "go to guy" as principal investigator due to his training, motivation and willingness to take on challenging studies. Dr. Wilcox said respondent is available to patients in these studies and in PRI's different offices six days a week.

As a researcher, Dr. Wilcox noted that respondent needs to know the current medications in the market and the medications on label and off label uses. He said respondent is very current on the medications. Personally and professionally respondent has shared with colleagues the latest medications.

Over the 19 years Dr. Wilcox worked with respondent, he noted that respondent capably interacted with pharmaceutical companies and inspectors and audits conducted by the FDA. As a result of the successful audits of PRI in which respondent participated, PRI got more work from pharmaceutical companies.

Dr. Wilcox regarded respondent so highly that he referred a close family member to him and respondent really helped this family member cope with depression. He also referred an employee to respondent and respondent also was able to help this employee. Dr. Wilcox described respondent as "extraordinary."

Dr. Wilcox emphasized that he hoped he had conveyed the amount of respect respondent has earned as both a clinician and researcher.

115. Dr. Grosz obtained his medical degree from the University of Buenos Aires School of Medicine in 1977 and is board certified, in Israel, in psychiatry and through the American Board of Psychiatry and Neurology with a sub certification in Child and Adolescent Psychiatry. Dr. Grosz works as a Principal and Sub-Investigator at PRI and has his own psychiatric practice. He is Medical Director of the Encino PRI office.

Dr. Grosz knows respondent through PRI and has collaborated with him in different drug trials. He has also asked respondent to cover for him when he is absent while traveling and has received only positive feedback from his patients whom respondent treated. He has also had the opportunity to consult with respondent regarding patient care and has learned to trust his judgment.

Dr. Grosz has a high regard for respondent's medical knowledge and practice of psychiatric medicine. He said respondent is on the forefront of psychopharmacology and pharmacology research and is "very knowledgeable" in these areas.

Parties' Arguments

116. In closing arguments complainant asserted that even though Dr. Kirsten's report was poorly written, "sloppy," and Dr. Kirsten was "not careful" and went "overboard" in his "analysis," nevertheless his opinions should be accepted because they are supported in the record. Complainant asserted all causes of discipline were established and asks that respondent be placed on three years' probation with terms and conditions that include 40 hours of education in the area of benzodiazepine prescribing, a prescribing practices course, a medical record keeping course, and a practice monitor. Complainant does not seek a restriction on respondent's ability to supervise physician assistants or not practice as a solo practitioner.

117. Respondent, in closing, argued that complainant's case has no merit and moved to have the entire action dismissed pursuant to Business and Professions Code section 2230.5 because the accusation was filed on April 18, 2019, and the consumer complaint was filed on April 4, 2016. Consistent with respondent's burden of going forward on this motion, based on this record, respondent's motion is denied. The board did not, it appears, discover that respondent may have committed acts or omissions alleged as the ground for the disciplinary action in the accusation regarding these three patients until it had received, subsequent to the initial complaint, the records for the three patients. (Business and Prof. Code, § 2230.5, subd. (a), Cal. Code Regs., § 1356.2, subd. (a)(2).) It was, thus, not established at hearing how the board learned of possible issues regarding the care rendered to these three patients.

On the merits, respondent argued further that Dr. Kirsten's opinions should be disregarded because he was biased and argued "points" instead of evidence and his bias permeated his testimony and the allegations in the accusation should be dismissed. Dr. Kirsten displayed his bias when he referred to "us" in his report,

referring to the board and him having a shared mission against respondent, when he went beyond the records he was reviewing to conduct his own research of respondent on CURES, and his suggestion that respondent had mental health problems and may be a substance abuser. Respondent also argued that Dr. Kirsten was influenced by the consumer complaint and conformed his analysis to the consumer's allegation that respondent excessively prescribed controlled substances. In short, respondent argued that Dr. Kirsten should never have served as an expert in this matter.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act (Chapter I, Division 2, of the Business and Professions Code) is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the first amended accusation are true.

The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical*

Quality Assurance (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Applicable Statutes Regarding Causes to Impose Discipline

3. Section[5] 2227, subdivision (a), states:

> 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

[5] References are to the Business and Professions Code unless otherwise stated.

complete relevant educational courses approved by the board.

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

4. Section 2234 provides in 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:

[¶] . . . [¶]

(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.

(d) Incompetence. . . .

5. Section 2266 provides:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

6. Section 4022 defines a dangerous drug 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.

7. Section 725, subdivision (a), provides, in part, "Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment . . . as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon . . . ."

8. Section 2238 provides that, "A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

9. Section 2266 provides that failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

Decisional Authority Regarding Standard of Care

10. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.)

Courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. (*Id.* at 1054).

Case Law Regarding Unprofessional Conduct

11. In *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575, the appellate court noted that "unprofessional conduct" as that term was used in Business and Professions Code section 2361 (now section 2234), included certain enumerated conduct. (*Id.* at p. 575.) The court further stated (*Ibid.*):

> This does not mean, however, that an overly broad connotation is to be given the term "unprofessional conduct;" it must relate to conduct which indicates an unfitness to practice medicine. [Citations.] Unprofessional

conduct is that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. [Citation.]

Disposition Regarding Causes for Discipline

CAUSE DOES NOT EXIST UNDER THE FIRST CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR CONDUCT CONSTITUTING GROSS NEGLIGENCE

12. Complainant failed to prove by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), based on the factual findings in this decision.

CAUSE DOES NOT EXIST UNDER THE SECOND CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR REPEATED NEGLIGENT ACTS

13. Complainant failed to prove by clear and convincing evidence that respondent committed repeated negligent acts in violation of Section 2234, subdivision (c), with respect to respondent's treatment and care of Patients A, B, and C based on the findings in this decision.

CAUSE DOES NOT EXIST UNDER THE THIRD CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE

14. Complainant did not prove by clear and convincing evidence that respondent prescribed dangerous drugs without conducting an appropriate prior

examination and/or medical indication to Patients A, B, and C, in violation of Sections 2242 and 4022 based on the findings reached in this decision.

CAUSE DOES NOT EXIST UNDER THE FOURTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR REPEATED ACTS OF CLEARLY EXCESSIVE PRESCRIBING

15. Complainant did not prove by clear and convincing evidence that respondent demonstrated incompetence in his care and treatment of Patients A, B, and C, in violation of Sections 725 and 2234 based on the findings reached in this decision.

CAUSE DOES NOT EXIST UNDER THE FIFTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE BECAUSE HE PRESCRIBED CONTROLLED SUBSTANCES TO PATIENTS A, B, AND C WITHOUT CONSULTING CURES

16. Complainant did not prove by clear and convincing evidence that respondent failed to consult CURES before he prescribed controlled substances to Patients A, B, and C in violation of Section 2238 and Health and Safety Code section 11165.4. Respondent was not required to consult CURES before prescribing controlled substances to Patients A, B, and C until October 2, 2018, and he consulted CURES after this date regarding each of the three patients.

CAUSE EXISTS UNDER THE SIXTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE BECAUSE HE FAILED TO MAINTAIN ADEQUATE RECORDS FOR PATIENTS A, B, AND C

17. Complainant proved by clear and convincing evidence that respondent failed to maintain adequate records for Patients A, B, and C in violation of Business and Professions Code section 2266. Respondent did not document that he discussed with Patients A, B, and C the risks and benefits of the controlled substances he prescribed them and, as a result, he failed to maintain adequate records for the three patients.

CAUSE EXISTS UNDER THE SEVENTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR UNPROFESSIONAL CONDUCT

18. Complainant proved by clear and convincing evidence that respondent engaged in unprofessional conduct in his care and treatment of Patients A, B, and C, in violation of Sections 2234 because he did not maintain adequate records for these patients as found immediately above. As found, respondent's conduct breached a statute applicable to a physician in good standing.

The Board's Disciplinary Guidelines and Evaluation Regarding the Degree of Discipline

19. With causes for discipline having been found, the determination now must be made regarding the degree of discipline and the terms and conditions to impose. In this regard, the board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016) states:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

20. For a failure to maintain adequate and accurate medical records, the board's disciplinary guidelines provide that revocation is the maximum discipline and provided the following minimum recommended terms and conditions:

For gross negligence and repeated negligent acts under Business and Professions Code section 2234, subdivisions (b) and (d), or failure to maintain adequate records under Business and Professions Code section 2266, revocation, stayed, and five years' probation, with conditions including an education course, prescribing practices course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, monitoring, solo practice prohibition, and prohibited practices. The guidelines recognize that under appropriate circumstances, for repeated acts of negligence, a public reprimand may be ordered.

Disciplinary Considerations and Disposition Regarding the Degree of Discipline

21. As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual, the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Fahmy, supra*, 38 Cal.App.4th at p. 817.) Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.)

22. The determination whether respondent's license should be revoked or suspended includes an evaluation of the nature and severity of the conduct and rehabilitation and mitigation factors as set forth under California Code of Regulations, title 16, section 1360.1, which provides as follows:

> When considering the suspension or revocation of a license, certificate or permit on the ground that a person holding a license, certificate or permit under the Medical Practice Act has been convicted of a crime, the division, in evaluating the rehabilitation of such person and his or her eligibility for a license, certificate or permit shall consider the following criteria:
>
> (a) The nature and severity of the act(s) or offense(s).
>
> (b) The total criminal record.

(c) The time that has elapsed since commission of the act(s) or offense(s).

(d) Whether the licensee, certificate or permit holder has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against such person.

(e) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(f) Evidence, if any, of rehabilitation submitted by the licensee, certificate or permit holder.

23. After considering the board's guidelines, and the factors under California Code of Regulations, title 16, section 1360.1, the evidence of rehabilitation, and mitigation, and the evidence of record as a whole, it is determined that a public reprimand is warranted with the condition that respondent take and successfully complete a medical record keeping course. A penalty greater than this would constitute unwarranted punishment and not serve the purpose of public protection. This disposition represents a departure from the board's recommended guidelines for the following reasons, and because the nature and severity of respondent's failure to document informed consent does not warrant the imposition of a penalty that requires probation in light of the record as a whole.

24. Respondent provided good care to each of the patients who were long-term patients of his. He was fully engaged in their treatment and care and developed a strong therapeutic bond with them where they trusted him and followed his recommendations. He knew about both their mental and physical conditions, their relationship challenges and personal and professional successes. As examples of the

care he provided them, respondent communicated with Patient A's doctor regarding her COPD and her medical condition and adjusted her medications downward such that she was only "occasionally" taking alprazolam; he was aware of her interests and her relationship issues with her husband; he was aware of the challenges and job changes and professional successes Patient B had and advised him and his wife to stop drinking as a protective measure due to his liver enzyme test; he was aware of Patient B's cholesterol levels and was concerned about his high blood pressure; respondent knew about Patient's C's relationship issues, her cosmetic treatment, and her sleep issues. During the course of the care documented in the progress notes complainant obtained, respondent's three patients were functioning well and succeeding both personally and, regarding Patients B and C, professionally. In addition to these considerations, respondent has no disciplinary history and is well-regarded in the community by people who know him based on the testimony of the three individuals who testified on his behalf. Respondent was also candid that his record keeping could have been better and he has changed his practice of record keeping. In light of these considerations, to impose a more severe penalty would not serve the interest of public protection and amount to impermissible punishment. (*Fahmy v. Medical Board*, 38 Cal.App.4th at p. 817.)

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ORDER

The Decision constitutes the Public Reprimand in this matter, and it is conditioned upon Dr. Oskooilar completing a board-approved Medical Record Keeping course within 90 days of the effective date of the Medical Board's decision.

DATE: December 15, 2020

Abraham M. Levy
Abraham M. Levy (Dec 15, 2020 13:31 PST)

ABRAHAM M. LEVY
Administrative Law Judge
Office of Administrative Hearings

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 18 2019
BY D. Richards ANALYST

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

In the Matter of the Accusation Against: **NADER OSKOOILAR, M.D.** **1601 Dove Street, Suite 290** **Newport Beach, California 92660** **Physician's and Surgeon's Certificate No. A48369,** Respondent.	Case No. 800-2016-022486 **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, and not otherwise.

2. On or about June 18, 1990, the Medical Board issued Physician's and Surgeon's Certificate No. A48369 to Nader Oskooilar, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on August 31, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code 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, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in relevant 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.

"..."

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

7. Section 2238 of the Code states, in relevant part:

"A violation of ... any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

8. 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."

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9. 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."

10. Section 725 of the Code states:

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

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

11. Section 4022 of the Code states:

"'Dangerous drug' or 'dangerous device' means 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."

12. Section 11165 of the Health and Safety Code states, in relevant part:

"(a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

"..."

13. Section 11165.1 of the Health and Safety Code states, in relevant part:

"(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the department. Upon approval, the department shall release to that practitioner the electronic history of

controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

"..."

14. Section 11165.4 of the Health and Safety Code states:

"(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

"(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

"(B) For purposes of this paragraph, 'first time' means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

"(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

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"(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

"(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

"(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

"(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

"(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

"(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

"(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

"(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

"(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

"(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

"(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

"(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

"(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

"(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

"(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

"(5)(A) If all of the following circumstances are satisfied:

"(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

"(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

"(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

"(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

"(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

"(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

"(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

"(d)(1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

"(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

"(e) This section is not operative until six months after the Department of Justice certifies[1] that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

"(f) All applicable state and federal privacy laws govern the duties required by this section.

"(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application."

[1] Certified April 2, 2018. *See* https://oag.ca.gov/cures.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent has subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patients A, B, and C,[2] as more particularly alleged hereinafter:

16. **Patient A**

(a) Between in or around 2016 through in or around 2018, Patient A saw Respondent, a psychiatrist, for psychiatric care related to her diagnosis of chronic generalized anxiety disorder. During this timeframe, Respondent also had Chronic Obstructive Pulmonary Disorder (COPD) and carried and utilized external oxygen to assist her breathing.

(b) Between in or around 2016 through in or around 2018, Respondent issued approximately thirty-two (32) prescriptions to Patient A for controlled substances, but the majority of the prescriptions are missing from this patient's medical record.

(c) Between in or around 2016 through in or around 2018, despite routinely prescribing controlled substances to Patient A, Respondent never performed and/or documented performing a mental status exam; never documented any discussion regarding suicidal ideation; and never obtained documentation of informed consent regarding the risks of prolonged use of sedatives to this patient.

(d) On January 15, 2019, Respondent was interviewed at the Health Quality Investigation Unit's San Diego Office regarding the care and treatment he had provided to Patient A. During the subject interview, Respondent admitted that he could not read his own notes at times. All of Respondent's charted notes for this patient are handwritten and mostly illegible, and do not record the duration or time of day of the interviews with the patient.

[2] Letters A, B, and C are used for the purposes of maintaining patient confidentiality.

(e) Patient A's medical records do not contain any CURES printouts. At the time Respondent prescribed controlled substances to Patient A, he was not informed of the drugs that this patient was also being prescribed from other physicians. Significantly, during his subject interview on January 15, 2019, Respondent stated that he did not use CURES to review patient history because he "couldn't get on line."

(f) Between in or around 2016 through in or around 2018, Respondent issued an excessive amount of sedatives to Patient A including, clonazepam and alprazolam. Respondent did not document any discussion with Patient A about the prescriptions from other physicians for controlled substances that she was filling, including additional sedatives from her primary care doctor. Furthermore, Respondent did not attempt to taper the amount of sedatives that he had been prescribing to Patient A for a prolonged period of time.

(g) Respondent maintained Patient A on the long-term use of multiple different sedatives despite the risks to this particular patient due to her age[3] and her COPD. Significantly, Respondent did not document in the medical record his rationale for his prescription regimen of the long-term use of sedatives for a patient over sixty-five (65) years old and suffering from a pulmonary condition.[4]

(h) Between in or around 2016 through in or around 2018, Respondent only prescribed sedatives to Patient A for treatment of her anxiety disorder. However, Respondent never attempted to prescribe this patient other drugs to treat the disorder, including "anti-depressants" such as selective serotonin reuptake inhibitors (SSRI). Respondent never documented his rationale for exclusively prescribing long-term use sedatives, and not attempting to trial the use of SSRI medication for this patient.

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[3] Patient A was born in 1950.

[4] *See* "Beers Criteria for Potentially Inappropriate Medication Use in Older Adults."; https://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf

(i) On or about August 18, 2017, Respondent issued multiple prescriptions for sedatives to Patient A. Patient A had recently filled prescriptions for other controlled substances from another physician including, oxycodone. Patient A's medical record does not contain any CURES print-outs, and Respondent did not document any discussion with this patient regarding the serious risks of concurrent use of sedatives and opioids.

(j) Respondent was aware that Patient A was taking thyroid medication and that she had been diagnosed with COPD. However, Respondent did not document in this patient's medical record any information or discussion with patient about whether her ongoing medical conditions were influencing her psychiatric diagnosis.

(k) Despite prescribing addictive controlled substances to Patient A for prolonged use, Respondent did not appropriately monitor this patient's drug compliance including, he never ordered a random drug toxicology screen of this patient to verify she was taking the drugs as prescribed; documentation of prescriptions in this patient's medical record is mostly missing, or illegible to the extent that prescriptions cannot be tracked; and no CURES print-outs were ever done for this patient.

17. Respondent committed gross negligence in his care and treatment of Patient A including, but not limited to, the following:

(a) Respondent's clinical notes for Patient A are either missing, illegible, disorganized, and/or missing time annotations;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered sedatives to Patient A;

(c) Respondent failed to obtain CURES reports for a review of Patient A's then current drug prescription profile;

(d) Respondent maintained Patient A on the long-term use of sedatives despite her age (> 65 years old) and COPD, and without documenting a rationale for said prescription regimen;

(e) Respondent failed to attempt to utilize SSRI medication to replace the prolonged use of sedatives by Patient A;

(f) Respondent prescribed the long-term use of sedatives to Patient A despite her COPD;

(g) Respondent prescribed the long-term use of sedatives to Patient A without performing and/or documenting a mental status exam; and/or documenting any discussion regarding suicidal ideation; and/or failing to obtain documentation of informed consent regarding the risks of prolonged use of sedatives;

(h) On or about August 18, 2017, Respondent issued multiple prescriptions for sedatives to Patient A without documenting any discussion regarding the serious risks of concurrent use of sedatives and opioids;

(i) Respondent failed to discuss and/or document discussion with Patient A about whether her ongoing medical conditions were influencing her psychiatric diagnosis; and

(j) Respondent failed to appropriately monitor and/or verify whether Patient A was taking his prescriptions for controlled substances as prescribed.

18. **Patient B**

(a) Between in or around 2014 through in or around 2018, Patient B saw Respondent for psychiatric care related to multiple diagnoses including, generalized anxiety disorder.

(b) Between in or around 2014 through in or around 2018, Respondent issued approximately seventy-seven (77) prescriptions to Patient B for controlled substances, but the majority of the prescriptions are missing from this patient's medical record.

(c) Between in or around 2014 through in or around 2018, despite routinely prescribing controlled substances to Patient B, Respondent never performed and/or documented performing a mental status exam; never documented any discussion

regarding suicidal ideation; and never obtained documentation of informed consent regarding the risks of prolonged use of sedatives to this patient.

(d) On January 15, 2019, Respondent was interviewed at the Health Quality Investigation Unit's San Diego Office regarding the care and treatment he had provided to Patient B. During the subject interview, Respondent admitted that he could not read his own notes at times. All of Respondent's charted notes for this patient are handwritten and mostly illegible, and do not record the duration or time of day of the interviews with the patient.

(e) Patient B's medical records do not contain any CURES printouts. At the time Respondent prescribed controlled substances to Patient B, he was not informed of the drugs that this patient was also being prescribed from other physicians. Significantly, during his subject interview on January 15, 2019, Respondent stated that he did not use CURES to review patient history because he "couldn't get on line."

(f) Between in or around 2014 through in or around 2018, Respondent issued an excessive amount of sedatives to Patient B including, alprazolam. Respondent also routinely prescribed the controlled drug Vyvanse, which is a stimulant used to treat Attention-deficit/hyperactivity disorder (ADHD). Significantly, Respondent never documented his rationale for prescribing the medication combination of a sedative (alprazolam) and a stimulant (Vyvanse) for Patient B's treatment. In addition, Respondent did not document any discussion with Patient B about the prescriptions from other physicians for controlled substances that he was filling, including multiple prescriptions for oxycodone and hydrocodone. Finally, Respondent did not attempt to taper the amount of sedatives that he had been prescribing to Patient B for several years.

(g) Between in or around 2014 through in or around 2018, Respondent only prescribed sedatives to Patient B for treatment of his anxiety disorder. However, Respondent never attempted to prescribe this patient other drugs to treat the

disorder, including SSRI medication. Respondent never documented his rationale for exclusively prescribing long-term use sedatives, and not attempting to trial the use of SSRI medication for this patient.

(h) Despite prescribing addictive controlled substances to Patient B for prolonged use, Respondent did not appropriately monitor this patient's drug compliance including, he never ordered a random drug toxicology screen of this patient to verify he was taking the drugs as prescribed; documentation of prescriptions in this patient's medical record is mostly missing, or illegible to the extent that prescriptions cannot be tracked; and no CURES print-outs were ever done for this patient.

19. Respondent committed gross negligence in his care and treatment of Patient B including, but not limited to, the following:

(a) Respondent's clinical notes for Patient B are either missing, illegible, disorganized, and/or missing time annotations;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered sedatives to Patient B;

(c) Respondent failed to obtain CURES reports for a review of Patient B's then current drug prescription profile;

(d) Respondent failed to attempt to utilize SSRI medication to replace the prolonged use of sedatives by Patient B;

(e) Respondent prescribed the long-term use of sedatives to Patient B without performing and/or documenting a mental status exam; and/or documenting any discussion regarding suicidal ideation; and/or failing to obtain documentation of informed consent regarding the risks of prolonged use of sedatives; and

(f) Respondent failed to appropriately monitor and/or verify whether Patient B was taking his prescriptions for controlled substances as prescribed.

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20. **Patient C**

(a) Between in or around 2017 through in or around 2018, Patient C saw Respondent for psychiatric care related to her diagnosis of anxiety disorder and panic disorder.

(b) Between in or around 2017 through in or around 2018, Respondent issued approximately forty-five (45) prescriptions to Patient C for controlled substances, but the majority of the prescriptions are missing from this patient's medical record.

(c) Between in or around 2017 through in or around 2018, despite routinely prescribing controlled substances to Patient C, Respondent never performed and/or documented performing a mental status exam; never documented any discussion regarding suicidal ideation; and never obtained documentation of informed consent regarding the risks of prolonged use of sedatives to this patient.

(d) On January 15, 2019, Respondent was interviewed at the Health Quality Investigation Unit's San Diego Office regarding the care and treatment he had provided to Patient C. During the subject interview, Respondent admitted that he could not read his own notes at times. All of Respondent's charted notes for this patient are handwritten and mostly illegible, and do not record the duration or time of day of the interviews with the patient.

(e) Patient C's medical records do not contain any CURES printouts. At the time Respondent prescribed controlled substances to Patient C, he was not informed of the drugs that this patient was also being prescribed from other physicians. Significantly, during his subject interview on January 15, 2019, Respondent stated that he did not use CURES to review patient history because he "couldn't get on line."

(f) Between in or around 2017 through in or around 2018, Respondent issued an excessive amount of sedatives to Patient C including, diazepam, lorazepam, alprazolam, zolpidem tartrate, and intermezzo. Respondent did not

document any discussion with Patient C about the prescriptions from other physicians for controlled substances that she was filling, including multiple prescriptions for hydrocodone, oxycodone, and carisoprodol. Furthermore, Respondent did not attempt to taper the amount of sedatives that he had been prescribing to Patient C for a prolonged period of time.

(g) Between in or around 2017 through in or around 2018, Respondent only prescribed sedatives to Patient C for treatment of her anxiety disorder and panic disorder. However, Respondent never attempted to prescribe this patient other drugs to treat the disorder, including SSRI medication. Respondent never documented his rationale for exclusively prescribing long-term use sedatives, and not attempting to trial the use of SSRI medication for this patient.

(h) Despite prescribing addictive controlled substances to Patient C for prolonged use, Respondent did not appropriately monitor this patient's drug compliance including, he never ordered a random drug toxicology screen of this patient to verify she was taking the drugs as prescribed; documentation of prescriptions in this patient's medical record is mostly missing, or illegible to the extent that prescriptions cannot be tracked; and no CURES print-outs were ever done for this patient.

21. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to, the following:

(a) Respondent's clinical notes for Patient C are either missing, illegible, disorganized, and/or missing time annotations;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered sedatives to Patient C;

(c) Respondent failed to obtain CURES reports for a review of Patient C's then current drug prescription profile;

(d) Respondent failed to attempt to utilize SSRI medication to replace the prolonged use of sedatives by Patient C;

(e) Respondent prescribed the long-term use of sedatives to Patient C without performing and/or documenting a mental status exam; and/or documenting any discussion regarding suicidal ideation; and/or failing to obtain documentation of informed consent regarding the risks of prolonged use of sedatives; and

(f) Respondent failed to appropriately monitor and/or verify whether Patient C was taking his prescriptions for controlled substances as prescribed.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

22. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

23. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

24. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

25. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs Without an Appropriate Prior Examination and/or Medical Indication)

26. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in sections 2242 and 4022, of the Code, in that Respondent prescribed, dispensed, or furnished dangerous drugs

without an appropriate prior examination and/or medical indication to Patients A, B, and C, as more particularly alleged hereinafter:

27. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

28. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

29. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

30. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in section 725, of the Code, in that Respondent has committed repeated acts of clearly excessive prescribing drugs or treatment to Patients A, B, and C, as determined by the standard of the community of physicians and surgeons, as more particularly alleged hereinafter:

31. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

32. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

33. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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FIFTH CAUSE FOR DISCIPLINE

(Violation of Statute Regulating Drugs)

34. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under section 2238, as defined in section 2238, of the Code, and, section 11165.4, of the Health and Safety Code, in that Respondent prescribed, ordered, administered, or furnished controlled substances to Patients A, B, and C, without first consulting the CURES database to review their controlled substance history before prescribing them a Schedule II, Schedule III, or Schedule IV controlled substance, as more particularly alleged hereinafter:

35. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

36. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

37. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

38. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

39. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

40. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

41. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

42. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 15 through 41, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A48369, issued to Respondent Nader Oskooilar, M.D.;

2. Revoking, suspending or denying approval of Respondent Nader Oskooilar, M.D.'s, authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Nader Oskooilar, M.D., to pay the Medical Board the costs of probation monitoring, if placed on probation; and

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

DATED: April 18, 2019

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

SD2019700758
Doc.No.71810480