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

In the Matter of the Accusation Against: Emil Soorani, M.D. Physician's and Surgeon's Certificate No. A 37184 Respondent.	Case No.: 800-2015-011341

DECISION

The attached Stipulated Settlement 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 February 11, 2022.

IT IS SO ORDERED: January 14, 2022.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EMIL SOORANI, M.D.** **P.O. Box 1107** **Topanga, California 90290** **Physician's and Surgeon's Certificate No. A37184,** Respondent.	Case Nos. 800-2015-011341; 800-2019-055308; 800-2020-067224 OAH No. 2021010789 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Christina Sein Goot, Deputy Attorney General.

2. Respondent Emil Soorani, M.D. (Respondent) is represented in this proceeding by attorney Joel Bruce Douglas, whose address is: 355 South Grand Ave., Ste. 1750, Los Angeles, CA 90071-1562.

3. On or about July 27, 1981, the Board issued Physician's and Surgeon's Certificate No. A37184 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-011341, and will expire on July 31, 2023, unless renewed.

4. The parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of Accusation No. 800-2015-011341 and Medical Board of California Case No. 800-2019-055308 and Case No. 800-2020-067224.

JURISDICTION

5. Accusation No. 800-2015-011341 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 26, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

6. A copy of Accusation No. 800-2015-011341 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

7. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-011341. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

10. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2015-011341, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

11. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2015-011341, that he has thereby subjected his license to disciplinary action and hereby gives up his right to contest those charges.

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

CONTINGENCY

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

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2015-011341 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile

copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 37184 issued to Respondent EMIL SOORANI, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess the following controlled substances, as defined by the California Uniform Controlled Substances Act: Schedule II controlled substances identified in California Health and Safety Code section 11055, subdivisions (b), (c), (e), and (f).

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so

informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the initials and date of birth of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 20 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider

with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring

responsibility.

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

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

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

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

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

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

9. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the

application shall be treated as a petition for reinstatement of a revoked certificate.

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2015-011341 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

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

DATED: Sept 21, 2021

EMIL SOORANI, M.D.
Respondent

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

DATED: Sept. 21, 2021

JOEL BRUCE DOUGLAS, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 9/22/21

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

CHRISTINA SEIN GOOT
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-011341

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

In the Matter of the Accusation Against: **Emil Soorani, M.D.** **P.O. Box 1107** **Topanga, CA 90290** **Physician's and Surgeon's Certificate No. A 37184,** Respondent.	Case No. 800-2015-011341 **ACCUSATION**

PARTIES

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

2. On July 27, 1981, the Board issued Physician's and Surgeon's Certificate Number A 37184 to Emil Soorani, M.D. (Respondent). The certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed.

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JURISDICTION

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

4. Section 2004 provides that the Board shall have the responsibility for the enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

5. Section 2227 authorizes the Board to take action against a licensee who has been found guilty under the Medical Practice Act by revoking his or her license, suspending the license for a period not to exceed one year, placing the license on probation and requiring payment of costs of probation monitoring, or taking such other action as the Board deems proper.

6. At all times relevant to this matter, Respondent was licensed and practicing medicine in California.

STATUTORY PROVISIONS

7. Section 2234 states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> . . .

8. Section 2238 states: "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 2242 states, in pertinent part, that "[p]rescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

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

FACTUAL ALLEGATIONS

11. From 2012 to 2017, Respondent practiced psychiatry in Santa Monica and Los Angeles, California. Respondent also provided treatment for physical and chronic pain.

Patient P-1

12. Respondent treated P-1[1] from approximately September 14, 2007, through May 16, 2017. Respondent's records of his treatment of P-1 consist of handwritten progress notes, which are illegible apart from the dates of the notes. Among the records are two typed letters by Respondent dated October 31, 2014, and April 17, 2015, summarizing his care of the patient. According to his letters, Respondent had been treating P-1 "for psychopharmacologic management purposes," since September 14, 2007, and had diagnosed her with "Pain Disorder" and depression. Respondent's treatment included prescribing the patient methadone[2] for pain. The letters do not mention that Respondent had also prescribed the patient Ambien[3] and clonazepam.[4] According to Respondent's letters, as of April 17, 2015, the patient's depression and panic were

[1] The patients are designated in this document as P-1 through P-6 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

[2] Methadone is a narcotic used to treat moderate to severe pain. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c), and a dangerous drug as defined in Business and Professions Code section 4022.

[3] Zolpidem (Ambien®) is a hypnotic and sedative used to treat insomnia. It is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(32), and a dangerous drug as defined in Business and Professions Code section 4022.

[4] Clonazepam is a benzodiazepine and sedative used to treat anxiety and panic disorder. It

in remission, and she no longer needed an antidepressant. At that time, she remained on a medication for anxiety and stress. Respondent also noted that the patient had been sober from alcohol for a long time, suggesting a history of alcohol abuse.

13. A legible note in the patient's records, dated August 29, 2013, indicates that Respondent was notified that another provider was prescribing the patient Ambien, and that the patient had sought an early refill of her medication. A few months later, Respondent began prescribing the patient Ambien while she was also receiving it from the other provider. The patient filled prescriptions for Ambien by the other provider on December 11, 2013 and January 27, 2014. She also filled Ambien prescriptions from Respondent on January 3, 2014, February 5, 2014, and March 5, 2014.

14. Respondent resumed prescribing the patient Ambien, in February 2016, and by May 2016 the patient was again obtaining early refills of her medication. The patient's early refills of her medications and her seeking simultaneous prescriptions from more than one provider indicated that she was taking more medication than directed, a sign that she may have developed tolerance to and withdrawal from the medication and that she had become addicted to it. Ambien is addictive, particularly to an individual who is predisposed to addiction, as this patient appears to have been, given her history of alcohol abuse. In addition, Ambien is a sedative that can synergistically interact with the many opiates that Respondent was also prescribing this patient, resulting in a potentially dangerous combined sedative effect on the patient.

15. Respondent's failure to maintain adequate records of his treatment of P-1 was a departure from the standard of care. His progress notes are illegible, and his summary-of-care letters do not provide an accurate and complete account of his treatment.

16. Respondent's diagnosis of the patient with "Pain Disorder," without documenting any evaluation of the patient's pain and without specifying whether its etiology was psychological, physical, or both, was a departure from the standard of care.

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is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in Business and Professions Code section 4022.

17. Respondent's continued prescribing of Ambien to this patient despite warning signs of her addiction to it, and his failure to document taking steps to address her potential addiction or to justify his continued prescribing was a departure from the standard of care.

Patient P-2

18. Respondent treated P-2 from approximately January 8, 2005, through at least September 2, 2016. Respondent's records of his treatment of P-2 consist of handwritten progress notes, which are illegible apart from the dates of the notes. Among the records are two typed letters by Respondent dated September 14, 2012, and July 10, 2014, summarizing his care of the patient. According to his letters, Respondent had been treating P-2 for Major Depressive Disorder, not otherwise specified, and Anxiety Disorder, not otherwise specified. Both letters conclude that the patient remained totally disabled from all occupational functioning. The July 10, 2014, letter states that his disability was in part physical due to "severe injury to right arm with permanent nerve damage."

19. The July 10, 2014, letter notes some improvement in the patient's Major Depressive Disorder. The letter does not document any pharmacological treatment for the patient's Major Depressive Disorder, such as an antidepressant medication. The letter notes that Respondent prescribed the patient Ambien, but Respondent did not document any basis for this medication, such as the patient's diagnosis with a sleep disorder.

20. The treatment that Respondent documented in his summary-of-care letters conflicts with Controlled Substance Utilization Review and Evaluation System (CURES)[5] reports of his prescribing. Respondent's July 10, 2014, letter states that Respondent prescribed the patient two 10 mg tablets of dextroamphetamine[6] in the morning and one to two tablets in the evening, "for focus." CURES reports, however, show that Respondent prescribed the patient a higher daily dose of dextroamphetamine, and that the dose and timing of the prescriptions fluctuated.

[5] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California, serving regulatory oversight agencies, law enforcement, public health, and health care providers.

[6] Dextroamphetamine (Dexedrine®) is a stimulant used to treat ADHD and narcolepsy. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug as defined in Business and Professions Code section 4022.

Respondent did not document an explanation for these fluctuations. There were also times when P-2 filled his prescription for dextroamphetamine early. Respondent did not document his acknowledgment or an explanation of this. In addition, although Respondent states in his letters that he prescribed the patient 1 mg of Klonopin[7] as needed for anxiety, CURES reports show that in fact he prescribed the patient a 4 mg daily dose of Klonopin, a much higher dose, at a level that causes tolerance and withdrawal.

21. Respondent treated the patient with an aggressive and risky combination of psychiatric medications, including Abilify, an antipsychotic medication; dextroamphetamine for attention deficit hyperactivity disorder (ADHD); Klonopin for anxiety; Ambien for unknown reasons; and Synthroid, which is used to augment the antidepressant effects of antidepressant medications. Such a large number of psychiatric medications taken concurrently poses the risk of detrimental interactions between the drugs. In addition, three of the medications are addictive: dextroamphetamine, Klonopin, and Ambien. Respondent did not justify the risks of these medications, given the patient's lack of improvement from being totally disabled from all occupational functioning. In addition, while Respondent diagnosed the patient with Major Depressive Disorder, according to his July 10, 2014, summary-of-care letter, Respondent did not treat him with an antidepressant medication.

22. Respondent's failure to maintain adequate records of his treatment of P-2 was an extreme departure from the standard of care. His progress notes are illegible, and his summary-of-care letters do not provide an accurate and complete account of his treatment.

23. Respondent's failure to justify the risks of the medication regimen he prescribed to P-2, given the patient's lack of response to the medication, and his cessation of prescribing an antidepressant medication for the patient's Major Depressive Disorder was a departure from the standard of care.

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[7] Klonopin® is a brand name of clonazepam, described above, at footnote 4.

Patient P-3

24. Respondent treated P-3 from approximately February 2, 2012, through January 2, 2016. Respondent's records of his treatment of P-3 consist of handwritten progress notes, which are illegible apart from the dates of the notes. Also among the records are some typewritten documents and psychological tests, which are legible.

25. The February 2, 2012, initial evaluation form completed by Respondent includes check marks next to "Pain Disorder," and "296.22," which is a DSM-IV-TR code for Major Depressive Disorder, Single Episode, Moderate. While legible portions of the records, including the patient's complaints and the findings of a mental status examination by Respondent, support the presumed diagnosis of Major Depressive Disorder, there is no basis to support the presumed diagnosis of "Pain Disorder."

26. CURES reports show that Respondent prescribed the patient Ambien and Klonopin for years, over the course of his treatment of the patient. Respondent continued to prescribe these medications to the patient through April 2016, months after the date of the last record of his treatment of the patient, on January 2, 2016.

27. Respondent prescribed the patient excessive amounts of Ambien, by simultaneously prescribing him two different formulations of the medication (immediate release and controlled release), each at the highest daily dose. The patient in turn was regularly obtaining early refills of these prescriptions. The patient's early refills indicated that he was taking more medication than directed, a sign that he may have developed tolerance to and withdrawal from the medication and that he had become addicted to it.

28. Respondent's failure to maintain adequate records of his treatment of P-3 was an extreme departure from the standard of care. His progress notes are illegible, the records do not provide an accurate and complete account of his treatment, and there are no records supporting the final months of his prescribing of controlled substances to this patient.

29. Respondent's diagnosis of the patient with "Pain Disorder," without documenting any evaluation of the patient's pain and without specifying whether its etiology was psychological, physical, or both, was a departure from the standard of care.

30. Respondent's prescribing of excessive amounts of Ambien to this patient despite warning signs of his addiction to it, and his failure to document taking steps to address his potential addiction and to justify his continued prescribing was a departure from the standard of care.

Patient P-4

31. Respondent treated P-4 from approximately April 19, 2013, through July 21, 2016. Respondent's records of his treatment of P-4 consist of handwritten progress notes, most of which are illegible apart from the dates of the notes. There appear to be different authors of records throughout the chart, based on varying legibility of the handwritten records. Also, among the records are some typewritten documents, which are legible, including a letter from Respondent dated January 3, 2014, summarizing care of the patient. According to his letter, Respondent had been treating P-4 for "pain management purposes, secondary to a diagnosis of Severe Chronic Pain."

32. According to pharmacy records obtained by the Board, Respondent prescribed the patient a number of psychiatric medications over the course of his treatment. He also prescribed the patient opiates, such as fentanyl[8] and oxycodone.[9]

33. Respondent's failure to maintain adequate records of his treatment of P-4 was an extreme departure from the standard of care. His progress notes are illegible, the records do not provide an accurate and complete account of his treatment, and it is impossible to determine for which psychiatric conditions Respondent treated the patient.

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[8] Fentanyl is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug as defined in Business and Professions Code section 4022.

[9] Oxycodone is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as defined in Business and Professions Code section 4022.

Patient P-5

34. Respondent treated P-5 from approximately May 8, 2012, through March 18, 2016. Respondent's records of his treatment of P-5 consist of handwritten progress notes, most of which are illegible apart from the dates of the notes, and copies of prescriptions. Also, among the records are some typewritten documents, including several letters from Respondent summarizing care of the patient.

35. During his initial evaluation, the patient completed a Beck Depression Inventory and a Beck Anxiety Inventory, scoring zero on each, which is within normal limits. P-5 also completed an Adult ADHD Self-Report Scale. The patient scored 22 on this—scores of 11 points or higher indicate symptoms that may be consistent with adult ADHD. The patient noted no psychiatric complaints in his initial evaluation paperwork.

36. Respondent diagnosed P-5 with ADHD based on his first visit, when he was 39 years old. The only basis for this diagnosis appears to be the Adult ADHD Self-Report Scale, which is an insufficient basis to diagnose ADHD. There is no documentation that the patient was suffering from active ADHD, that he had had a clinical course indicative of the condition, or that he had been previously diagnosed with ADHD. This is not indicative of an individual who suffers from ADHD in adulthood, as the condition first emerges in childhood (and in most patients resolves by adulthood).

37. In August 2013, the patient injured his knee in a skiing accident, after which Respondent treated him for pain, including by prescribing him opiates like oxycodone and fentanyl.

38. In December 2012, six months after the patient's first visit, pharmacy records obtained by the Board show that Respondent began prescribing P-5 a high dose of Klonopin, which Respondent later confirmed was used to treat the patient's anxiety. But just a few months earlier, at his initial evaluation, the patient had no complaints of anxiety, and he had a negative inventory for anxiety. Respondent did not explain the origin of the patient's apparent

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new anxiety. One explanation that Respondent should have considered was that the high doses of stimulants that Respondent had begun prescribing the patient after his first visit were causing the patient to exhibit symptoms consistent with anxiety.

39. Respondent also diagnosed the patient with excessive daytime sleepiness, but Respondent's records do not document any consideration that the patient was simply sedated from the high-dose opiates and Klonopin that Respondent prescribed him. Nor did Respondent explain the origin of his diagnoses of the patient with depression or PTSD.

40. During the course of his treatment of P-5, Respondent prescribed him excessive amounts of addictive stimulants. For example, Respondent prescribed P-5 Vyvanse[10] at the FDA maximum dose of 70 mg daily, concurrently with a high dose of Dexedrine[11] 10 mg two tablets three times a day, for a daily dose of 60 mg. While prescribing this aggressive treatment for ADHD, Respondent was giving the patient an additional stimulant—Nuvigil[12] 250 mg in the morning. When combined with the two other stimulant medications, Nuvigil can have a synergistic effect that could cause increased anxiety and insomnia, and even lead to psychosis in some patients. Moreover, this was coupled with the stimulating antidepressant Wellbutrin[13] at a high dose of 450 mg in the morning. This exceeds the typical dose, but it is not uncommon by itself. However, in the context of the three other stimulant medications, this amount of Wellbutrin was extremely aggressive, could have been dangerous, and almost surely provoked anxiety in the patient.

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[10] Lisdexamfetamine (Vyvanse®) is a stimulant used to treat ADHD. It is a Schedule II controlled substance as defined by section 1308.12, subdivision (d)(5), of Title 21 of the Code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

[11] Dexedrine® is a brand name of dextroamphetamine, described above, at footnote 6.

[12] Armodafinil (Nuvigil®) is a stimulant used to treat narcolepsy. It is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (f), and a dangerous drug as defined in Business and Professions Code section 4022.

[13] Bupropion (Wellbutrin®) is an antidepressant used to treat depression. It is a dangerous drug as defined in Code section 4022.

41. According to Respondent's summary-of-care letters, by 2016, he was prescribing the patient some 17 medications. The patient's condition does not appear to have improved as a result of Respondent's treatment, as Respondent continued to report through 2016 that the patient remained totally disabled and was unable to work fulltime.

42. After his last visit with Respondent, on or about May 18, 2016, P-5 sought treatment from a pain management physician and then entered a rehabilitation facility, where he was weaned off of opiate medications.

43. Respondent's failure to maintain adequate records of his treatment of P-5 was a departure from the standard of care. His progress notes are illegible, and his summary-of-care letters do not provide a complete account of his treatment, including the basis for his assessment and the reasoning supporting his treatment.

44. Respondent's unsupported diagnoses of the patient with ADHD, anxiety, depression, PTSD and excessive daytime sleepiness and his failure to consider whether his prescribed medication regimen, numbering some 17 medications at one point, was causing the symptoms underlying these diagnoses was an extreme departure from the standard of care.

45. Respondent's failure to justify the risks of the medication regimen he prescribed to P-5, which included excessive amounts of addictive stimulants, given the patient's lack of response to the medication, was an extreme departure from the standard of care.

Patient P-6

46. Respondent treated P-6 from approximately November 1, 2012, when she was 40 years old, through March 23, 2016. Respondent's records of his treatment of P-6 consist of handwritten progress notes, most of which are illegible apart from the dates of the notes, and copies of prescriptions and correspondence with health insurance companies.

47. A March 25, 2014, disability insurance form and related letter from Respondent indicates that Respondent diagnosed the patient with Bipolar Disorder, Severe, Depressed with Psychotic Features; ADHD; and Pain Disorder of neck, feet, and wrist. The letter continues, "Patient continues to exhibit morbid depression, impulse behavior and delusional thinking. She is currently on several psychotropic medications and sees me regularly."

48. There is no legible documentation of any test results, history, or current symptomatology to support the patient's diagnosis with ADHD. Also, P-6 completed a patient questionnaire at the start of her treatment, in which she reported no prior history of being diagnosed with ADHD. This is not indicative of an individual who suffers from ADHD in adulthood, as the condition first emerges in childhood (and in most patients resolves by adulthood). The patient also indicated in the questionnaire that she used methamphetamine[14] off and on. Respondent did not document whether the patient was actively using methamphetamine during the time she was receiving care from him or whether he had considered the impact of the patient's history of methamphetamine in reaching his diagnosis of ADHD.

49. Respondent prescribed P-6 multiple benzodiazepines[15] concurrently, the prescriptions for which she filled early. The benzodiazepines prescribed by Respondent also overlapped with those prescribed by other providers. For example, on May 21, 2015, P-6 filled a prescription written by Respondent for Ativan[16] 1 mg, dispense 60 for a 15-day supply, which corresponds to 4 mg daily, a high dose. Just eight days later, on May 29, 2015, P-6 filled a prescription by another provider for the benzodiazepine Xanax[17] 2 mg dispense 60 for a 30-day supply, which is 4 mg daily and a high dose. Then, four days later, on June 2, 2015, P-6 filled a prescription by Respondent for Ativan 1 mg dispense 60 for a 15-day supply. Ten days later, on June 12, 2015, P-6 filled a prescription by Respondent for the benzodiazepine Klonopin 1 mg dispense 60 for a 15-day supply, which is 4 mg daily and is again a high dose. Then, on June 16, 2015, P-6 filled a

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[14] Methamphetamine is a powerful, highly addictive stimulant that affects the central nervous system. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(2), and a dangerous drug as defined in Business and Professions Code section 4022.

[15] Benzodiazepines are a controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug as defined in Business and Professions Code section 4022.

[16] Lorazepam (Ativan®), a benzodiazepine, is a centrally acting hypnotic-sedative. It is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug as defined in Business and Professions Code section 4022.

[17] Alprazolam (Xanax®), a benzodiazepine, is a centrally acting hypnotic-sedative. It is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug as defined in Business and Professions Code section 4022.

prescription by Respondent for Ativan 1 mg dispense 60 for a 15-day supply. Then, six days later, on June 22, 2015, she filled another Xanax prescription by another provider of 2 mg dispense 60 for a 30-day supply.

50. Respondent also prescribed P-6 multiple stimulants concurrently. For example, on May 1, 2015, P-6 filled a prescription by Respondent for Metadate ER[18] 20 mg dispense 90 for a 30-day supply, which equates to a daily dose of 60 mg. This was concurrent with a prescription for Adderall[19] 10 mg dispense 60 for a 30-day supply. In addition, Respondent concurrently prescribed P-6 very similar stimulant medications with the same active ingredient. For example, on May 20, 2015, P-6 filled a prescription of Concerta[20] 36 mg dispense 30 for a 30-day supply written by Respondent. Then, three days later, March 23, 2015, P-6 filled another prescription by Respondent for Metadate ER (methylphenidate) 20 mg, dispense 90 for a 30-day supply.

51. Respondent also prescribed the patient opiates like oxycodone for her pains.

52. In a letter by P-6 dated June 18, 2016, she reported emotional distress and not being able to focus or concentrate. This is not indicative of an individual who was responding to treatment. Rather, the letter suggests that P-6 had likely developed tolerance and withdrawal to the benzodiazepines and stimulants that she was prescribed.

53. Respondent's failure to maintain adequate records of his treatment of P-6 was an extreme departure from the standard of care. His progress notes are illegible, and the legible documents among his records do not provide a complete account of his treatment, including the basis for his assessment, the treatment offered, and the reasoning supporting his treatment.

54. Respondent's unsupported diagnosis of the patient with ADHD was a departure from the standard of care.

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[18] Methylphenidate (Metadate,® Concerta,® Ritalin®) is a stimulant used to treat ADHD and narcolepsy. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(6), and a dangerous drug as defined in Business and Professions Code section 4022.

[19] Adderall® is brand name for a drug containing a combination of amphetamine and dextroamphetamine, central nervous system stimulants that affect chemicals in the brain and nerves that contribute to hyperactivity and impulse control. It is used to treat narcolepsy and ADHD. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug as defined in Business and Professions Code section 4022.

[20] Concerta® is a brand name of methylphenidate, described above, at footnote 18.

55. Respondent's concurrent prescribing of multiple benzodiazepines and stimulants to P-6 and his early filling of her benzodiazepine prescriptions, despite signs that P-6 was addicted to and abusing her medications and despite her lack of response to treatment, was an extreme departure from the standard of care.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

56. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, because he engaged in the following acts of gross negligence in the care and treatment of patients, as alleged above:

A. Respondent failed to maintain adequate records of his treatment of P-2;

B. Respondent failed to maintain adequate records of his treatment of P-3;

C. Respondent failed to maintain adequate records of his treatment of P-4;

D. Respondent did not provide a basis for his diagnoses of P-5 with ADHD, anxiety, depression, PTSD, and excessive daytime sleepiness, and he failed to consider whether his prescribed medication regimen, numbering some 17 medications at one point, was causing the symptoms underlying these diagnoses;

E. Respondent failed to justify the risks of the medication regimen he prescribed to P-5, which included excessive amounts of addictive stimulants, given the patient's lack of response to the medication;

F. Respondent failed to maintain adequate records of his treatment of P-6; and

G. Respondent concurrently prescribed multiple benzodiazepines and stimulants to P-6 and filled her benzodiazepine prescriptions early, despite signs that P-6 was addicted to and abusing her medications and despite her lack of response to treatment.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

57. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, because he engaged in repeated negligent acts in the care and treatment of patients. These acts include those alleged in the First Cause for Discipline, as well as the following, as alleged above:

A. Respondent failed to maintain adequate records of his treatment of P-1;

B. Respondent diagnosed P-1 with "Pain Disorder," without documenting any evaluation of the patient's pain and without specifying whether its etiology was psychological, physical, or both;

C. Respondent continued prescribing Ambien to P-1 despite warning signs of her addiction to it, and he failed to document taking steps to address her potential addiction or to justify his continued prescribing;

D. Respondent failed to justify the risks of the medication regimen he continued to prescribe to P-2, despite the patient's lack of response to the medication, and he ceased prescribing an antidepressant medication for the patient's Major Depressive Disorder;

E. Respondent diagnosed P-3 with "Pain Disorder," without documenting any evaluation of the patient's pain and without specifying whether its etiology was psychological, physical, or both;

F. Respondent prescribed excessive amounts of Ambien to P-3 despite warning signs of his addiction to it, and he failed to document taking steps to address P-3's potential addiction and to justify his continued prescribing;

G. Respondent failed to maintain adequate records of his treatment of P-5; and

H. Respondent did not provide a basis for his diagnoses of P-6 with ADHD.

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THIRD CAUSE FOR DISCIPLINE

(Prescribing Without a Prior Examination and Medical Indication)

58. Respondent is subject to disciplinary action under section 2242 of the Code, because he prescribed, dispensed, or furnished dangerous drugs as defined in section 4022 of the Code without an appropriate prior examination and a medical indication, as alleged above.

FOURTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Records)

59. Respondent is subject to disciplinary action under section 2266 of the Code, because he failed to maintain adequate and accurate records of the medical services he provided to patients, as alleged above.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 37184, issued to Emil Soorani, M.D.;

2. Revoking, suspending, or denying approval of Emil Soorani, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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

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

DATED: 2/26/2020

Jennifer for Christine Lally
CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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