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

In the Matter of the Accusation Against: Ali Ahmad, M.D. Physician's and Surgeon's Certificate No. C 127870 Respondent.	Case No.: 800-2017-035109

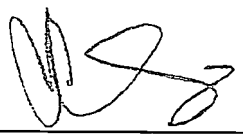
DECISION

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 18, 2022.

IT IS SO ORDERED: February 16, 2022.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the Accusation against:

ALI AHMAD, M.D.,

Physician's and Surgeon's Certificate No. C 127870,

Respondent.

Agency Case No. 800-2017-035109

OAH No. 2021020715

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on September 27 through 30, 2021, by video and teleconference.

Claudia Morehead, Deputy Attorney General, represented complainant William Prasifka, Executive Director, Medical Board of California (Board), Department of Consumer Affairs.

Anthony F. Witteman and Adam G. Wentland, Attorneys at Law, represented respondent Ali Ahmad, M.D.

A protective order sealing portions of the record issued separately.

At hearing, complainant moved to allow an amendment to the Accusation to correct a misspelling, changing "Lipoderm" to "Lipoden" wherever that term appears. The motion was granted.

Oral and documentary evidence was received. The record was held open for closing briefing and submission of redacted exhibits and a corrected request for a protective order. All closing briefs were timely filed. Complainant's closing brief was marked for identification as exhibit 30. Respondent's closing brief was marked for identification as exhibit U. Complainant's reply closing brief was marked for identification as exhibit 31.

The record was closed and the matter was submitted for decision on December 8, 2021.

SUMMARY

Complainant seeks to discipline respondent's physician's and surgeon's certificate on grounds of excessive prescribing of controlled substances, repeated negligent acts, and unprofessional conduct with respect to Patients 1 and 2, and incompetence and inadequate recordkeeping with respect to Patient 1.

Respondent asserts cause for discipline does not exist.

Based on the evidentiary record, respondent's certificate shall be revoked, the revocation shall be stayed, and respondent shall be placed on five years' probation.

FACTUAL FINDINGS

Jurisdiction

1. The Board issued Physician's and Surgeon's Certificate No. C 127870 to respondent on November 19, 2013. The certificate was scheduled to expire on November 30, 2021. The evidence did not establish whether respondent renewed his license. Any lapse of a license by operation of law does not deprive the Board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license. (Bus. & Prof. Code, § 118.)

2. Complainant brought the Accusation against respondent in his official capacity as Executive Director of the Board. Respondent filed a Notice of Defense. This hearing ensued.

Complainant's Allegations Regarding Respondent's Treatment of Patients 1 and 2

3. Respondent is a family medicine physician in private practice at his clinic in San Pedro since July 2015; he previously operated a clinic in Long Beach, which closed in 2016.

4. Complainant alleges, with respect to two patients, Patient 1 and Patient 2, that respondent engaged in:

(a) excessive prescribing of controlled substances, specifically, administering weekly injections of Toradol to both patients, exceeding the

recommended period of use, and prescribing excessive quantities of promethazine with codeine to Patient 2 for an excessive period of time (first cause for discipline);

(b) repeated negligent acts in care and treatment (second cause for discipline), including,

(i) with respect to Patient 1, prescribing opioids before the first recorded visit, failing to monitor and document the patient's response to opioids, failing to prescribe non-steroidal anti-inflammatory drugs (NSAIDs) instead of chronic opioids, continuing to prescribe opioids without obtaining imaging studies, treating anxiety and depression with regular human chorionic gonadotropin (hCG) injections, administering vitamin B12 replacement therapy without indication, prescribing ceftriaxone (Rocephin), azithromycin, and Tussionex (a cough medication containing hydrocodone) without documenting a proper examination or diagnosis, prescribing Norco, which contains hydrocodone, and Tussionex concurrently, and administering weekly Toradol injections, and,

(ii) with respect to Patient 2, administering weekly Toradol injections without monitoring for side effects, administering vitamin B12 replacement therapy without indication, administering testosterone replacement therapy without indication, evaluation, or monitoring, administering regular injections of Lipoden and hCG without indication, and prescribing promethazine with codeine in excessive quantities and for an excessive period of time;

(c) incompetence in the care and treatment of Patient 1 (third cause for discipline), specifically, by demonstrating a lack of knowledge in his diagnosis and treatment of the patient's menstrual irregularities and vitamins B12 and D deficiencies;

(d) inadequate record keeping by failing to properly record medications prescribed to treat Patient 1's anxiety and by prescribing ceftriaxone, azithromycin, and Tussionex but failing to document a proper examination and diagnosis of, and duplicating opioid treatment for, Patient 1 (fourth cause for discipline); and

(e) unprofessional conduct with respect to the care and treatment of Patients 1 and 2.

5. At hearing, complainant acknowledged that the evidence did not substantiate certain allegations of departures from the standard of care.

a. Complainant conceded that two repeated acts of negligence alleged in the second cause for discipline, at paragraph 42, subparagraphs (g) and (h), concerning the concurrent prescribing of Tussionex and Norco to Patient 1, require modification to conform to the evidence. Complainant acknowledged that, due to the relatively negligible amount of hydrocodone in Tussionex, prescribing 10 Norco (which contains hydrocodone) and Tussionex is not, itself, a departure from the standard of care.

b. Complainant acknowledged that the departure alleged in paragraph 42, subparagraph (a) concerning respondent's prior treatment of Patient 1 and part of the departure alleged in paragraph 42, subparagraph (d), concerning a failure to obtain prior imaging studies of Patient 1 are unsubstantiated. Complainant acknowledged that the evidence showed respondent treated Patient No. 1 at another clinic before seeing her at his newly opened San Pedro clinic, and he did not, as alleged, write prescriptions for her months before he ever saw her. Complainant did not modify its allegations regarding departures during the time period documented in the medical records for Patient 1 (October 3, 2015, to January 5, 2017).

Expert Witnesses

6. Complainant designated Bernard L. Katz, M.D. as an expert witness. Dr. Katz received his medical degree from the Baylor College of Medicine in 1987. He completed a four-year residency in family medicine at Santa Monica Hospital in 1990 and was Chief Resident there from 1989 to 1990. He also obtained a Master of Business Administration degree from the UCLA Anderson School of Business in 1999. Dr. Katz was board-certified in family medicine in 1990, 1997, 2004, and 2014, and in geriatrics in 2005 and 2018 by the American Board of Family Practice. He became a Medical Review Officer in 2018, has served as an expert reviewer for the Board since 2010, and received a Hospice Medical Director certification in 2021. He serves on the Primary Care Committee at UCLA Health and as Chair of the Quality Management Committee at UCLA Medical Group. He also served on the Pharmacy and Therapeutics Committee at Providence Saint John's Health Center from 2014 to 2018. He has been an Assistant Professor of Family Medicine at the David Geffen School of Medicine at UCLA since 2011. Dr. Katz is licensed to practice in California. He practiced family medicine with Santa Monica Bay Physicians in Pacific Palisades from 1990 to 2010 and has practiced family medicine as a member and as the Medical Director of the UCLA Health Community Physician Network since 2011. He has also been the Medical Director of Luxe Hospice in Pacific Palisades since 2018 and of the CVS MinuteClinic of California since 2009.

7. Respondent designated Bernard R. Wilcosky, M.D. as an expert witness. Dr. Wilcosky received his medical degree from Duke University in 1981. He completed a rotating internship in 1982, a residency in Anesthesia and Operative Service in 1984, and a fellowship in Cardiothoracic Anesthesia in 1985, all at Letterman Army Medical Center in San Francisco. He is a diplomate of the National Board of Medical Examiners

(1982), the American Board of Anesthesiology (1985), with a certificate of added qualifications in pain management (1993, recertified in 2004), the American Academy of Pain Medicine (1993). He was certified by the American Academy of Pain Management (1993) and received an Advanced Prescriber Certificate (2015). He was on the teaching staff in the Anesthesia Residency and was the Director of the Pain Management Clinic from 1985 to 1989 at Letterman Army Medical Center. He was the Associate Medical Director of Pain Treatment Services from 1988 to 2001, and the Medical Director of Patient Treatment Services from 2001 to 2006, at Sequoia Hospital in Redwood City. Dr. Wilcosky is licensed to practice in California and has practiced as a pain medicine consultant since 2016. Prior to that, he was a staff anesthesiologist at Sequoia Hospital in Redwood City from 1988 to 2016, at Marshal Hale Memorial Hospital from 1986 to 1989, and at Shriners Hospital for Crippled Children from 1987 to 1998, and he held various committee appointments and clinical positions at Letterman Army Medical Center from 1985 to 1989.

8. Dr. Katz and Dr. Wilcosky testified as to the applicable standard of care in treating Patients 1 and 2, the subject of complainant's allegations.

9. Dr. Katz testified that the applicable standard of care in Los Angeles County and in California from March 2015 through December 2018 was that level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question. A simple departure from the standard of care occurs when a doctor fails to use that knowledge to prudently treat a patient's condition. Lack of knowledge is the absence of a qualification of fitness to perform a function.

10. According to Dr. Katz, the standard of care for prescribing controlled substances for pain during the relevant time period required the doctor to evaluate the patient's complaint of pain; prescribe effective treatments with the least potential for harm, ranging from analgesics and NSAID's to narcotics; use other modalities, e.g., physical therapy and laser treatments; regularly reevaluate the patient for the effectiveness of the treatment applied and for side effects; and determine whether an additional referral is needed. Dr. Katz recognized the potential adverse consequences of stopping a patient's opioids if the patient is dependent on them, stating that attempts should be made to taper the medications "if appropriate." Dr. Katz's discussion of the standard of care as applied to other charges against respondent's practices appears below.

11. Dr. Wilcosky testified that the standard of care will probably vary geographically within California, depending on health care accessibility and insurance. The patient population a doctor encounters will have occupational exposures present in some areas of California but not others, leading to differing health considerations for a clinician to address. Respondent's patients were relatively underserved in the area of referral physicians, such as pain management specialists, thereby shifting some of the responsibility for managing pain onto the primary care physician. Respondent practiced in an industrial harbor area, with concomitant hazardous environmental and occupational exposures that may differ from exposures in other areas in the state, so the standard of care may vary.

12. With respect to opioid management, which Dr. Wilcosky testified was "the gist" of his involvement in this case, respondent met the standard of care and exercised the skill that would be exercised by most other doctors in his position. Respondent had to tailor his treatment to what was available to his patients, especially

if no pain management specialists were available for referrals. Respondent's patients with chronic pain had longstanding opioid prescriptions. Centers for Disease Control and Prevention (CDC) guidelines for opioid prescribing do not establish the standard of care, but respondent attempted to contribute to his patients' sense of well-being by applying alternative medicine techniques, with medications that may not be universally accepted but have some support in the literature. Patients 1 and 2 were already taking opioids. The use of vitamins, safer when a doctor administers them than when a patient obtains them at a drugstore, as well as Myers' cocktail infusions and hCG, is a reasonable "therapeutic trial" to try to improve a patient's sense of wellbeing, lessen anxiety, and perhaps reduce dependence on opioids. The potential benefits of this "therapeutic trial" greatly outweighed the risks. If the patient does not make progress toward treatment goals, the therapeutic trial may be discontinued.

13. Dr. Katz's testimony regarding the general standard of care is given greater weight than that of Dr. Wilcosky's. Dr. Wilcosky's suggestion that the standard of care governing the practice of primary care medicine for San Pedro's harbor workers differs from the standard of care for the patients Dr. Katz serves reflects questionable judgment. Though the relative prevalence of certain health conditions varies depending on the location, employment, and socioeconomic status of different patient populations, every patient in California is entitled to receive the same level of care whether they see a doctor in San Pedro, Santa Monica, or Pacific Palisades. As for the standard of care with respect to treating chronic pain, Dr. Katz is persuasive regarding assessment, treatment modalities, reevaluation, and referral. Dr. Wilcosky is persuasive that at least some of the "therapeutic trials," though not supported by peer-reviewed studies and with possibly no greater medical value than placebos, presented potential benefits that appeared to outweigh their risks.

PATIENT 1

14. Respondent treated Patient 1 at his San Pedro clinic from October 3, 2015, to January 13, 2017, for various conditions including a history of chronic back pain, knee pain, shoulder pain, ankle pain, insomnia, and anxiety. Respondent had previously treated Patient 1 at the Long Beach clinic, continuing to refill and prescribe narcotics for her, a medication regime that had started years before while she was treated by another physician.

15. Dr. Katz opined, in his expert report dated December 7, 2019, as modified in his supplemental report dated July 18, 2021, and in his testimony at hearing, that respondent engaged in the following simple departures from the standard of care in treating Patient 1: overprescribing Toradol injections and failing to prescribe oral analgesics, including NSAID's; continuing to prescribe narcotic medication without evaluations and, if appropriate, tapering, and despite telling the patient an MRI would be required prior to additional narcotics refills; prescribing selective serotonin reuptake inhibitors (SSRI) but keeping conflicting records about which SSRI was administered, and prescribing hCG, a hormone, to treat Patient 1's anxiety, without explanation; treating Patient 1 with vitamin B12 with no clear medical indication; and prescribing ceftriaxone, azithromycin, and Tussionex without documentation of examination and diagnosis.

16. Dr. Katz concluded that medical records revealed respondent's lack of knowledge in his diagnosis and treatment of Patient 1's menstrual irregularities; in diagnosing her with a vitamin B12 deficiency and treating her with regular vitamin B12 injections and an intravenous infusion of "Myers' cocktail" (a combination of vitamins and minerals); and in diagnosing and treating her for vitamin D deficiency.

17. Dr. Katz opined that respondent did not depart from the standard of care in prescribing benzodiazepines to Patient 1, in performing a history and physical examination of her, in monitoring her response to prescription medications, in documenting her medical record, or in arriving at appropriate diagnoses.

Excessive Prescribing of Toradol (First and Second Causes for Discipline)

18. With respect to Toradol, Dr. Katz testified that respondent's repeatedly administering Toradol injections, and his failure to explore the use of oral analgesics and oral NSAIDs, was a simple departure from the standard of care. Toradol is to be used, he testified, for short-term treatment of acute pain, not to exceed five days, but respondent administered it on many of Patient 1's frequent visits. Complainant established that administering Toradol injections to both patients beyond the five-day limit was excessive. Respondent concedes that Patient 1 received at least 30 Toradol injections and Patient 2 received at least 31 injections, which shows that respondent exceeded the five-day limit called for under the standard of care and supported by the Toradol FDA package insert.

19. Dr. Wilcosky, in his expert report and his testimony, opined that respondent did not depart from the standard of care in treating Patient 1's pain with too many Toradol injections rather than prescribing oral analgesics. He wrote that injecting intramuscular Toradol on an episodic basis for acute pain or acute exacerbations of chronic pain is commonly employed, within the standard of care, and unlikely to result in harm. He wrote that Dr. Katz's opinion that injections of Toradol should not be used more than five days does not apply except when it is being used around the clock.

20. The FDA insert for Toradol, which respondent introduced into evidence, does not substantiate Dr. Wilcosky's opinion. It advises that Toradol by injection may be used as a single or multiple dose on a regular or 'prn' schedule for the management of moderately severe, acute pain that requires analgesia at the opioid level, usually in a postoperative setting. . . . Patients should be switched to alternative analgesics as soon as possible, but ketorolac tromethamine therapy is not to exceed 5 days." (Ex. P5, p. B96.) The insert provides instructions for single administration use, which may be followed by oral Toradol (but not for more than five days), as well as for multiple-dose injection treatments with a maximum daily dose. (*Id.* at pp. B87, B96.)

Repeated Negligent Prescription of Opioids (Second Cause for Discipline)

21. With respect to respondent's continued prescribing of narcotics to Patient 1, Dr. Katz found that respondent regularly refilled Patient 1's narcotics prescriptions without monitoring and documenting her response to treatment, without reevaluating the effectiveness of her treatment, without prescribing NSAID's instead of chronic opioids, without obtaining imaging studies, and without attempting to taper her narcotics dosage.

22. Dr. Katz opined that failing to attempt to taper the dose of or wean the patient off narcotics, "if appropriate," is a failure to meet the standard of care. Dr. Katz stated that "[t]he standard of care requires that a physician prescribe narcotic pain medication to alleviate the patient's pain and suffering . . . . The lowest dose possible is to be prescribed to control the patient's pain, and alternative methods of alleviating the patient's pain should be explored. If a patient's treatment regimen is stable, then the patient should be seen regularly to reevaluate the effectiveness of the treatment and attempts should be made to taper the medications if appropriate." (Ex. 25, p.

A1073.) Respondent failed to monitor Patient 1's response to treatment. Dr. Katz opined that "[t]here was documentation of general symptoms at each visit, but no specific documentation of response to treatment," such as a description of their functional activities and status of their functional activities. (Ex. 25, A1072.)

23. Respondent also noted on October 3, 2015, that Patient 1 needed an MRI, and told her on November 15 that the MRI would be required prior to his authorizing additional Norco refills. Nevertheless, respondent continued to prescribe Norco refills through the end of the year, over the course of six more visits, despite Patient 1's failure to obtain an MRI. Respondent did not note in the medical records the reason for ignoring his own imposed precondition of an MRI for further Norco refills.

24. Dr. Wilcosky opined that respondent did not depart from the standard of care in treating Patient 1's pain with narcotics. Respondent was familiar with Patient 1's narcotics prescription history, having treated her at the Long Beach Clinic prior to seeing her at his San Pedro Clinic in October 2015. Dr. Wilcosky opined that Patient 1's "description of her pain and her physical examination provided a reasonable basis to continue an apparently successful treatment regimen prescribed by another doctor." (Ex. P, p. B48.) Dr. Wilcosky criticized CDC guidelines requiring a dose reduction or discontinuation of opioids, while approving a modification to those guidelines that "urge an examination of the clinical circumstances before adjusting well established dosing regimens." (*Ibid.*) Dr. Wilcosky excused respondent's continued opioid prescriptions despite the absence of an MRI because of customary delays that were "a function of insurance approval, capacity of radiographic facilities, and patient logistics." (*Ibid.*) He wrote that "[c]ontrary to the opinion of [Dr. Katz], treatment of pain is not predicated on the presence of a correlative imaging study." (*Ibid.*)

25. Dr. Katz's opinion on the issue of Patient 1's narcotics treatment is more persuasive than Dr. Wilcosky's. The medical records for Patient 1 (as well as for Patient 2; see Factual Findings 43, 45-47) do not reflect that respondent diagnosed her with, or treated her for a condition that caused, intractable pain. Respondent testified that he allegedly reduced Patient 1's and Patient 2's MME. But he did not document Patient 1's response to his treatment with continued opioid prescriptions and Toradol injections, or establish or document that he was able to decrease the morphine micro-equivalents (MME) of medication she was prescribed. Having assumed responsibility for treating his patients' pain, respondent was responsible for addressing their opioid dependency, attempting to reduce that dependency, and documenting whether or not a reduction in dependency was possible. Though Patient 1 testified her MME decreased under respondent's care, her documented condition remained the same throughout her course of treatment and respondent continued to administer Toradol injections to her for pain.

26. Dr. Katz also did not opine that pain treatment is predicated on imaging studies, but that respondent, having instructed Patient 1 he would not prescribe additional Norco until she obtained an MRI, should have at least documented the reasons for his change of mind. The reasons for a delay in Patient 1's obtaining an MRI are not relevant to this finding.

Treating Anxiety and Depression with SSRI and Regular hCG Injections

27. Dr. Katz concluded that respondent's prescribing SSRI and hCG to treat Patient 1's anxiety and improve her sense of well-being lacked a documented basis conforming to the standard of care. He found that respondent prescribed SSRI's but

kept conflicting records about them, and prescribed hCG, a hormone, to treat Patient 1's anxiety, without medical indication or explanation.

28. Dr. Wilcosky testified there is no applicable standard of care for the use of hCG. In support of using SSRI and hCG as alternatives to narcotics, he wrote "[t]here is anecdotal evidence" that reducing anxiety might lessen the patient's experience of pain, because anxiety can be a pain amplifier. Dr. Wilcosky testified the benefits currently appear to outweigh the risks but, "[a]s with many off label treatments, strict protocols have not been established and will await further study." (Ex. P, p. B49.)

29. Dr. Katz is more persuasive about a standard of care for the use of hCG and documentation of Patient 1's SSRI's. Dr. Wilcosky's opinion that respondent appropriately used hCG to treat her anxiety and depression to the extent that they act as pain amplifiers remains unsupported by the medical records as well as the medical literature. The patient was already receiving Xanax, Toradol injections, narcotics, and SSRIs. Prescribing hCG to improve a patient's energy levels and sense of well-being is not a medical indication for hCG or within the standard of care.

Vitamin B12 Injections

30. Dr. Katz found that respondent departed from the standard of care by treating Patient 1 with vitamin B12 injections with no clear indication, and with intravenous infusions of Myers' cocktail. According to the medical records, Patient 1 did not have a vitamin B12 deficiency warranting injections of vitamin B12, and any alleged benefit that Patient 1 claimed to have received was, according to Dr. Katz, a placebo effect. The medical records do not reflect that Patient 1 showed signs of immunosuppression, Dr. Katz testified, and the data does not, in any case, support the contention that vitamin B12 reinforces a healthy immunity system.

31. The standard of care required respondent to identify the cause of Patient 1's fatigue, malaise, and insomnia and treat her underlying symptoms. Prescribing vitamin B12 injections to improve a patient's sense of well-being is not medically indicated. No double-blind randomized studies show any benefit of the Myers' cocktail. The standard of care to treat fatigue, malaise, anxiety, and insomnia is to review prescribed substances the patient is taking, the patient's sleep patterns and habits, and see whether any should be altered to treat the underlying symptoms. Patient 1 was taking a high-dose tranquilizer, the benzodiazepine Xanax, three times per day, and a narcotic. So the patient's experience of sleepiness and malaise was not surprising. Respondent should have tried to taper those medications, not try the unproven Myers' cocktail injections, which have no benefits but do have risks, such as infection and bleeding, and for which the patient must pay. The standard of care for a family physician is to practice evidence-based medicine.

32. Dr. Wilcosky disagreed, testifying that the use of vitamin B12 injections and intravenous infusions of Myers' cocktail even where there is no deficiency is "relatively widespread." As with many alternative therapies, randomized controlled studies have not been done, and doctors may rely on anecdotal evidence of improvements in patients' sense of well-being.

33. While Dr. Katz is more persuasive about the existence of a standard of care requiring application of evidence-based medicine and for the use of vitamin B12 injections absent medical indication and the use of Myers' cocktail infusions, the likelihood of harm to patients resulting from respondent's use of these substances appears to have been minimal.

Documenting Examination and Diagnosis Warranting Treatment with Ceftriaxone, Azithromycin, and Tussionex

34. Dr. Katz found that respondent administered and prescribed a ceftriaxone (Rocephin) injection and azithromycin (Zithromax Z-Pak) to Patient 1 without documenting a proper examination or diagnosis of an alleged bacterial infection to support the need for that treatment. There was no documented physical examination of the head and neck or respiratory system, and no documentation of fever. There was no documentation in the medical record that respondent prescribed Tussionex to prevent Patient 1 from suffering opioid withdrawal, which she could not take in pill form because of a swollen throat. Opioid medications such as hydrocodone, morphine, and Dilaudid are available in liquid form. Although Dr. Katz opined respondent departed from the standard of care based on the documentation in the medical records, complainant alleged that respondent's failures to document his decisions to administer ceftriaxone and azithromycin reflected poor record-keeping.

35. Dr. Wilcosky did not opine on these issues. Respondent testified that Patient 1 complained about a three-day cough, yellow sputum, difficulty swallowing, fever, body aches, and fatigue and malaise, as well as chronic pain. Respondent examined the patient's back and administered an antibiotic, cephtriaxone, by intramuscular injection because Patient 1 was having difficulty swallowing. He gave Patient 1 a Z-pack for her cough, but told her not to take it without consulting further with respondent. Respondent did not want to abruptly discontinue the patient's narcotics; because of her sore throat, she could not take her Norco pills, and Tussionex contains a narcotic, so it was a safe substitute.

36. Given the absence in the medical records of support for respondent's treatment, and the availability of liquid opioid medications, Dr. Katz's opinion is persuasive.

Incompetence in Diagnosing and Treating Patient 1's Menstrual Irregularities and Vitamins B12 and D Deficiencies

37. Dr. Katz found, concerning respondent's diagnosis and treatment for Patient 1's menstrual irregularities, vitamin B12 deficiency, and vitamin D deficiency, that none of respondent's explanations, provided through his testimony and that of Patient 1, are documented in the medical record. Respondent prescribed progesterone, vitamins B12 and D, and Myer's cocktail, as documented in the medical record, without documenting his medical rationale, thereby constituting a departure from the standard of care.

38. Dr. Wilcosky wrote that use of vitamin B12 injections and Myers' cocktail to improve a patient's sense of well-being and try to reduce opioid dependency in absence of a vitamin evidence of deficiency is widespread. Respondent administered vitamin B12 not for a B12 deficiency, but as a therapeutic trial to see whether there could be some benefit. The same rationale applies to Myers' cocktail. The potential for risk is low.

39. Again, Dr. Katz is more persuasive about the existence of a standard of care requiring the application of evidence-based medicine, but the likelihood of harm to patients resulting from respondent's treatment appears to have been minimal.

Inadequate Recordkeeping for Treating Anxiety and for Prescribing Ceftriaxone, Azithromycin, and Tussionex

40. Dr. Katz found that respondent failed to properly record the medications he prescribed to treat Patient 1's anxiety and failed to document a proper examination and diagnosis to support his prescription of ceftriaxone, azithromycin, and Tussionex (see Factual Findings 34-36, *ante*).

41. Dr. Katz's opinion is persuasive.

PATIENT 2

42. Respondent treated Patient 2 at his San Pedro clinic from February 2016 to September 2018 for various conditions including fatigue and back and shoulder pain, for which Patient 2 took oxycodone, Soma, and promethazine as prescribed by a previous physician.

43. Dr. Katz opined that respondent engaged in the following simple departures from the standard of care in treating Patient 2: overprescribing Toradol, 60 mg, to treat pain without monitoring for potential side effects, and prescribing Phenergan with codeine in the quantities and for the length of time prescribed; treating with vitamin B12 injections with no clear indication; treating with testosterone replacement without indication, adequate evaluation or monitoring; using Lipoden without support for the proposition that its contents aid in weight loss or speed up metabolism, and without any record the patient was informed of risks and benefits; and using hCG without sufficient documentation of physical examination and laboratory studies to make a diagnosis of testosterone deficiency.

44. Dr. Katz opined that respondent did not depart from the standard of care in treating Patient 2's pain; in performing a history and physical examination; in documenting the patient's response to prescription medication; and in documenting treatment of Patient 2.

45. Dr. Wilcosky's opinions, or respondent's testimony, with respect to each alleged departure are addressed below.

Toradol and Promethazine (Phenergan)

46. Dr. Katz found a simple departure from the standard of care in respondent's prescription of Toradol without monitoring for side effects, and of Phenergan with codeine in the quantity and for the length of time that the prescriptions were issued. Dr. Katz's opinion regarding Toradol for Patient 2 is based on the same concerns as for Patient 1. (See Factual Findings 15, 18-20.) His opinion regarding Phenergan centers on its codeine content, given that Patient 2 was already on chronic narcotic analgesics and Oxycodone. Respondent's claim that he was treating Patient 2 for chronic bronchitis, which was exacerbated by working as a longshoreman in the harbor at night, is unsupported by documentation in the medical records for a significant portion of the time period covered by the prescriptions.

47. Dr. Wilcosky concluded that respondent did not depart from the standard of care in prescribing Toradol injections for Patient 2's pain and failing to monitor for potential side effects, for the same reasons that applied to Patient 1. (See Factual Findings 15, 18-20.) Dr. Wilcosky determined that respondent appropriately tailored a pain management regimen to Patient 2's needs, and his prescriptions and diagnostic and monitoring efforts, were within the standard of care. He also wrote that

there is a shortage of pain specialists, shifting the burden of pain care to primary care providers. He lauded respondent's multimodal approach to pain management.

48. As with Patient 1, Dr. Katz's opinion as to the overuse of Toradol and Phenergan without sufficient supporting documentation is persuasive.

Vitamin B12

49. Dr. Katz found that respondent never checked Patient 2's vitamin B12 levels and never found or documented a deficiency. He opined that vitamin B12 injections without clear indication is a simple departure from the standard of care.

50. Dr. Wilcosky testified that respondent was not administering vitamin B12 to correct a deficiency, but as a therapeutic trial to see whether there could be some benefit. Dr. Katz's view is more traditional, but vitamin B12 deficiency is rare. Most injectable vitamin B12 is given to enhance a patient's sense of well-being. Dr. Wilcosky pointed to some preliminary studies discussing a possible anti-depressive effect of vitamin B12 injections and encouraging further research.

51. Dr. Katz's position as to the current standard of care is persuasive, though further research may eventually reveal some anti-depressive benefit to vitamin B12 injections. Though there was a simple departure, the risks generally inherent with injections may be fairly minor.

Testosterone

52. Dr. Katz found that respondent administered testosterone without proper medical indication, evaluation, or monitoring. Respondent did not document a physical examination of Patient 2's testes or prostate. Because testosterone therapy is contraindicated in the presence of prostate cancer, the standard of care requires

documenting a normal prostate exam prior to testosterone therapy. According to Dr. Katz, respondent administered a single testosterone lab test during the afternoon, when testosterone levels are generally low, rather than in the morning, as is customary. Testing for testosterone replacement therapy does not vary based on the physical location of a patient or the patient's work schedule. Respondent testified a second test was done in the morning, and the testosterone was also low. But by that time, respondent had already begun administering testosterone replacement therapy, which suppresses the body's ability to make endogenous testosterone. Respondent did not monitor the patient's response to the therapy.

53. Respondent testified that people on chronic opioids, such as Patient 2, may have a suppressed endocrine system and low testosterone. Patient 2 presented with decreased libido, erectile dysfunction, decreased concentration, and anxiety. Although some physicians believe a morning testosterone test yields more accurate results than an afternoon test, port workers work an inconsistent schedule and have trouble being available for a morning test. The lab was important, but also important was respondent's clinical impressions of what Patient 2 was experiencing. Respondent ordered testosterone to help the patient feel better, and also ordered a second lab, the results of which were again low. Patient 2 told respondent he gradually felt better with the treatment, with improving libido and erectile dysfunction, ability to concentrate, and a sense of wellbeing. Dr. Wilcosky's report did not address this issue.

54. Dr. Katz's opinion regarding the standard of care, and respondent's simple departure by his failure to evaluate, monitor, or document his testosterone treatment of Patient 2 is persuasive.

Lipoden and hCG

55. Respondent testified that Lipoden injections, containing amino acids and vitamins, are used to help increase a patient's metabolism and energy levels, possibly leading the patient to exercise more and lose weight. Patient 2 wanted to lose weight, so respondent administered Lipoden and hCG injections to give him energy.

56. Dr. Katz found a simple departure from the standard of care in respondent's use of Lipoden and hCG. Patient 2's laboratory studies did not demonstrate a growth hormone deficiency, which might have justified the use of hCG. The patient was overweight, but there was no documented discussion of diet and other modalities for weight management, and no documented medical justification of a need for the Lipoden injections. Dr. Wilcosky did not address this issue in his report.

57. Dr. Katz's opinion is persuasive.

Other Evidence

58. Respondent offered eight character-reference letters.

59. Dr. Zakaria Ahmad, respondent's younger brother, a licensed physician in California and professional colleague of respondent's for the past three years, wrote in an August 12, 2021, letter that respondent is skilled, knowledgeable, and compassionate, caring toward employees and patients, and driven to provide the best possible health care.

60. Jessica Mokdad, respondent's office manager, wrote in an August 17, 2021, letter that she has worked for him for six years, that he is hard-working, dedicated, honest, compassionate, and gentle, and cares about his patients.

61. Respondent informed both Dr. Zakaria Ahmad and Ms. Mokdad of this proceeding. He felt too awkward to tell the other character references, who include Patient 1; another office manager, Jessica Guerrero; Lynsey Ly, the clinic's accountant; Mark Newman, D.C., a chiropractor from whom respondent rented office space; Osman Dandan, a physician assistant who worked at the San Pedro clinic for a few months; and Rostam Khoshsar, M.D., an anesthesiologist and pain management specialist to whom respondent used to refer patients. They wrote of respondent's moral character, dedication, integrity, concern with patient safety, professionalism, knowledge, and intelligence.

62. Respondent completed a Professional Boundaries, Inc. (PBI) medical record keeping course through the University of California, Irvine, in July 2021, and a PBI prescribing course focused on opioids, pain management, and addiction in August 2021.

LEGAL CONCLUSIONS

Applicable Authority

1. The Board is responsible for enforcing the disciplinary provisions of the Medical Practice Act. (Bus. & Prof. Code, § 2004, subd. (a)). The Board's highest priority is to protect the public. (Bus. & Prof. Code, § 2229.) A certificated practitioner who violates the Medical Practice Act may have his or her certificate revoked or suspended or placed on probation, be publicly reprimanded, or have "other action taken in relation to discipline" as the Board deems proper. (Bus. & Prof. Code, § 2227.)

2. The Board may discipline a practitioner's certificate for unprofessional conduct, which includes, among other things, any violation of the Medical Practice Act,

gross negligence, repeated negligent acts, incompetence, and failure to maintain adequate and accurate records of services provided to patients. (Bus. & Prof. Code, §§ 2234, subds. (a)-(c), 2261, 2266.) It is a violation of the Medical Practice Act to excessively prescribe controlled substances or to prescribe them without an appropriate prior examination and a medical indication. (Bus. & Prof. Code, §§ 725, 2241.5, subds. (c) & (d), 2242; see Health & Saf. Code, § 11153.)

3. The absence of any harm resulting from treatment does not negate whether a violation of the Medical Practice Act has occurred. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 578-579, *citing Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 949-950.)

4. "[A] physician is required to possess and exercise, in both diagnosis and treatment, that reasonable degree of knowledge and skill which is ordinarily possessed and exercised by other members of his profession in similar circumstances." (*Landeros v. Flood* (1976) 17 Cal. 3d 399, 408.) "The courts require only that physicians and surgeons exercise in diagnosis and treatment that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Bardessono v. Michels* (1970) 3 Cal.3d 780, 788.)

5. The rigorous educational, training, and testing requirements for obtaining a physician's license justify imposing on complainant a burden of proof of clear and convincing evidence. (Evid. Code, § 115; see *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856; *Imports Performance v. Department of Consumer Affairs, Bureau of Automotive Repair* (2011) 201 Cal.App.4th 911.)

Causes for Discipline

6. Cause exists to discipline respondent's certificate under Business and Professions Code sections 725, subdivision (a), in that respondent prescribed excessive amounts of controlled substances to Patients 1 and 2, as set forth in Factual Findings 14, 15, 18 through 26, and 42 through 47.

7. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (c), in that respondent committed repeated negligent acts in the treatment of Patients 1 and 2, as set forth in Factual Findings 14 through 36 and 42 through 56.

8. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (d), in that respondent demonstrated incompetence, based upon his lack of knowledge, in treating Patient 1, as set forth in Factual Findings 37 through 39.

9. Cause exists to discipline respondent's certificate under Business and Professions Code section 2266, in that he failed to maintain adequate and accurate medical records for Patient 1, as set forth in Factual Findings 40 and 41.

10. Cause exists to suspend or revoke respondent's license under Business and Professions Code section 2234, in that respondent engaged in unprofessional conduct in his care and treatment of Patients 1 and 2, as forth in Factual Findings 14 through 56.

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Appropriate Discipline

11. In addition to prioritizing public protection, Business and Professions Code section 2229 specifies that, "*to the extent not inconsistent with public protection*, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. (Italics added.) To implement the mandates of section 2229, the Board has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines), 12th Edition, 2016." (Guidelines, p. 2.)

12. For excessive prescribing, repeated negligent acts, incompetence, failure to maintain adequate records, and general unprofessional conduct, under Business and Professions Code sections 725, 2234, subdivisions (c) and (d), 2266, and 2234, respectively, the Guidelines recommend a minimum penalty of stayed revocation and five years' probation. The Guidelines may be departed from based on mitigating evidence and rehabilitation factors including early acceptance of responsibility and demonstrated willingness to undertake Board-ordered rehabilitation.

13. It was established by clear and convincing evidence that respondent engaged in excessive prescribing, repeated negligent acts, incompetence, failure to maintain adequate records, and general unprofessional conduct. It was established by clear and convincing evidence that some of the care respondent provided to each of Patients 1 and 2 constituted repeated simple departures from the standard of care. And respondent failed in numerous instances with respect to Patient 1 to maintain adequate records. (See Factual Findings 14 through 57.) These failures demonstrate that respondent repeatedly acted in violation of the Medical Practice Act and of statutory and regulatory provisions governing the professional practice of medicine.

14. The purpose of a disciplinary action such as this is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) Accordingly, the Order that follows is both necessary and sufficient for the protection of the public.

15. On this record, and in view of all the evidence, the safety of the public will be protected if respondent is placed on five years' probation with appropriate terms and conditions.

ORDER

Physician's and Surgeon's Certificate No. C 127870, issued to respondent Ali Ahmad, M.D., is revoked in consequence of the determination of the first, second, third, fourth, and fifth causes for discipline, separately and for all of them. The revocation is stayed, however, and respondent is placed on probation for five years on the following terms and conditions:

1. Notification

Within seven days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier that 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 changes in hospitals, other facilities, or insurance carrier.

2. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

3. 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.

4. 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.

5. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in

writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

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

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

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

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

6. 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.

7. 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 Board'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 years.

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

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions

of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

8. 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.

9. 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.

10. 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 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.

11. 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.

12. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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13. 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.

14. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any

information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the 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.

15. Clinical Competence Assessment

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as

defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

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

DATE: 01/05/2022

Howard W. Cohen (Jan 5, 2022 15:38 PST)

HOWARD W. COHEN
Administrative Law Judge
Office of Administrative Hearings