

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

In the Matter of the Accusation Against:

Inna Lamport, M.D.

Physician's and Surgeon's  
Certificate No. A 50462

Respondent.

Case No. 800-2018-046831

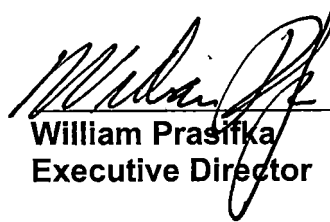
DECISION

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

This Decision shall become effective at 5:00 p.m. on March 3, 2022.

IT IS SO ORDERED February 24, 2022.

MEDICAL BOARD OF CALIFORNIA



\_\_\_\_\_  
William Prasifka  
Executive Director

1 ROB BONTA  
Attorney General of California  
2 JUDITH T. ALVARADO  
Supervising Deputy Attorney General  
3 TAN N. TRAN  
Deputy Attorney General  
4 State Bar No. 197775  
300 South Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
Telephone: (213) 269-6535  
6 Facsimile: (916) 731-2117  
*Attorneys for Complainant*  
7

8 **BEFORE THE**  
9 **MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 **INNA LAMPORT, M.D.**  
14 **1211 Brunswick Avenue**  
15 **South Pasadena, CA 91030**

16 **Physician's and Surgeon's Certificate**  
17 **No. A 50462,**

18 Respondent.

Case No. 800-2018-046831

OAH No. 2021100189

**STIPULATED SURRENDER OF  
LICENSE AND ORDER**

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

21 **PARTIES**

22 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of  
23 California (Board). He brought this action solely in his official capacity and is represented in this  
24 matter by Rob Bonta, Attorney General of the State of California, by Tan N. Tran, Deputy  
25 Attorney General.

26 2. Inna Lamport, M.D. (Respondent) is represented in this proceeding by attorney  
27 Raymond J. McMahon, Esq., Doyle Schafer McMahon, LLP, 5440 Trabuco Road, Irvine,  
28 California 92620.

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1 against Respondent. This stipulation constitutes a record of the discipline and shall become a part  
2 of Respondent's license history with the Board.

3 2. Respondent shall lose all rights and privileges as a physician and surgeon in  
4 California as of the effective date of the Board's Decision and Order.

5 3. Respondent shall cause to be delivered to the Board her pocket license and, if one was  
6 issued, her wall certificate on or before the effective date of the Decision and Order.

7 4. If Respondent ever files an application for licensure or a petition for reinstatement in  
8 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must  
9 comply with all the laws, regulations and procedures for reinstatement of a revoked or  
10 surrendered license in effect at the time the petition is filed, and all of the charges and allegations  
11 contained in Accusation No. 800-2018-046831 shall be deemed to be true, correct and admitted  
12 by Respondent when the Board determines whether to grant or deny the petition.

13 5. If Respondent should ever apply or reapply for a new license or certification, or  
14 petition for reinstatement of a license, by any other health care licensing agency in the State of  
15 California, all of the charges and allegations contained in Accusation No. 800-2018-046831 shall  
16 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of  
17 Issues or any other proceeding seeking to deny or restrict licensure.

18 ACCEPTANCE

19 I have carefully read the above Stipulated Surrender of License and Order and have fully  
20 discussed it with my attorney, Raymond J. McMahon, Esq. I understand the stipulation and the  
21 effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated  
22 Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound  
23 by the Decision and Order of the Medical Board of California.

24  
25 DATED: \_\_\_\_\_

12/27/21

  
\_\_\_\_\_  
INNA LAMPOR, M.D.  
Respondent

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I have read and fully discussed with Respondent Inna Lamport, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: December 27, 2021

RAYMOND J. MCMAHON, ESQ.  
*Attorney for Respondent*

**ENDORSEMENT**

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 2/23/22

Respectfully submitted,  
ROB BONTA  
Attorney General of California  
JUDITH T. ALVARADO  
Supervising Deputy Attorney General

TAN N. TRAN  
Deputy Attorney General  
*Attorneys for Complainant*

**Exhibit A**

**Accusation No. 800-2018-046831**

1 ROB BONTA  
Attorney General of California  
2 JUDITH T. ALVARADO  
Supervising Deputy Attorney General  
3 TAN N. TRAN  
Deputy Attorney General  
4 State Bar No. 197775  
California Department of Justice  
5 300 So. Spring Street, Suite 1702  
Los Angeles, CA 90013  
6 Telephone: (213) 269-6535  
Facsimile: (916) 731-2117  
7 *Attorneys for Complainant*

8  
9 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2018-046831

13 **Inna Lamport, M.D.**  
14 **1211 Brunswick Avenue**  
**South Pasadena, CA 91030**

**ACCUSATION**

15 **Physician's and Surgeon's Certificate**  
16 **No. A50462,**

17 Respondent.

18  
19 **PARTIES**

20 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity  
21 as the Executive Director of the Medical Board of California, Department of Consumer Affairs  
22 (Board).

23 2. On or about February 25, 1992, the Medical Board issued Physician's and Surgeon's  
24 Certificate Number A50462 to Inna Lamport, M.D. (Respondent). The Physician's and Surgeon's  
25 Certificate was in full force and effect at all times relevant to the charges brought herein and will  
26 expire on December 31, 2021, unless renewed.

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1 JURISDICTION

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

5 4. Section 2004 of the Code states:

6 The board shall have the responsibility for the following:

7 (a) The enforcement of the disciplinary and criminal provisions of the Medical  
8 Practice Act.

9 (b) The administration and hearing of disciplinary actions.

10 (c) Carrying out disciplinary actions appropriate to findings made by a panel or  
an administrative law judge.

11 (d) Suspending, revoking, or otherwise limiting certificates after the conclusion  
12 of disciplinary actions.

13 (e) Reviewing the quality of medical practice carried out by physician and  
surgeon certificate holders under the jurisdiction of the board.

14 (f) Approving undergraduate and graduate medical education programs.

15 (g) Approving clinical clerkship and special programs and hospitals for the  
16 programs in subdivision (f).

17 (h) Issuing licenses and certificates under the board's jurisdiction.

18 (i) Administering the board's continuing medical education program.

19 5. Section 2227 of the Code states:

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

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

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

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

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

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

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

### 8 STATUTORY PROVISIONS

9 6. Section 2234 of the Code, states:

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

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

15 (b) Gross negligence.

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

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

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

28 (d) Incompetence.

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

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

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

7. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription  
drugs, including prescription controlled substances, to an addict under his or her  
treatment for a purpose other than maintenance on, or detoxification from,

1 prescription drugs or controlled substances.

2 (b) A physician and surgeon may prescribe, dispense, or administer prescription  
3 drugs or prescription controlled substances to an addict for purposes of maintenance  
4 on, or detoxification from, prescription drugs or controlled substances only as set  
5 forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and  
6 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a  
7 physician and surgeon to prescribe, dispense, or administer dangerous drugs or  
8 controlled substances to a person he or she knows or reasonably believes is using or  
9 will use the drugs or substances for a nonmedical purpose.

10 (c) Notwithstanding subdivision (a), prescription drugs or controlled substances  
11 may also be administered or applied by a physician and surgeon, or by a registered  
12 nurse acting under his or her instruction and supervision, under the following  
13 circumstances:

14 (1) Emergency treatment of a patient whose addiction is complicated by the  
15 presence of incurable disease, acute accident, illness, or injury, or the infirmities  
16 attendant upon age.

17 (2) Treatment of addicts in state-licensed institutions where the patient is kept  
18 under restraint and control, or in city or county jails or state prisons.

19 (3) Treatment of addicts as provided for by Section 11217.5 of the Health and  
20 Safety Code.

21 (d)(1) For purposes of this section and Section 2241.5, addict means a person  
22 whose actions are characterized by craving in combination with one or more of the  
23 following:

24 (A) Impaired control over drug use.

25 (B) Compulsive use.

26 (C) Continued use despite harm.

27 (2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is  
28 primarily due to the inadequate control of pain is not an addict within the meaning of  
this section or Section 2241.5.

8. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section  
4022 without an appropriate prior examination and a medical indication, constitutes  
unprofessional conduct. An appropriate prior examination does not require a  
synchronous interaction between the patient and the licensee and can be achieved  
through the use of telehealth, including, but not limited to, a self-screening tool or a  
questionnaire, provided that the licensee complies with the appropriate standard of  
care.

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

(1) The licensee was a designated physician and surgeon or podiatrist serving in

1 the absence of the patient's physician and surgeon or podiatrist, as the case may be,  
2 and if the drugs were prescribed, dispensed, or furnished only as necessary to  
maintain the patient until the return of the patient's practitioner, but in any case no  
longer than 72 hours.

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

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

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

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

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

13 9. Section 2266 of the Code states:

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

16 10. Section 725 of the Code states:

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

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

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

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

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts - 3 Patients)**

3 11. Respondent, Inna Lamport, M.D., is subject to disciplinary action under section 2234,  
4 subdivision (c), of the Code for the commission of acts or omissions involving repeated negligent  
5 acts in the care and treatment of Patients 1, 2, and 3.<sup>1</sup> The circumstances are as follows:

6 **Patient 1**

7 12. Patient 1 (or "patient") is a 53-year-old female, who treated with Respondent from  
8 approximately January 2015 through March 2021,<sup>2</sup> mainly to continue Suboxone (a prescription  
9 medication used to treat dependence on opioid drugs, it is also a dangerous drug pursuant to  
10 section 4022 of the Code) for Patient 1's dependence on opiate prescriptions.<sup>3</sup> Patient 1 was also  
11 in recovery for alcohol dependence. Per CURES (Controlled Substance Utilization Review and  
12 Evaluation System, a drug monitoring database for Schedule II through V controlled substances  
13 dispensed in California), Patient 1 was being prescribed various opioids and benzodiazepines  
14 such as Alprazolam (Xanax) from various doctors before she began treating with Respondent.<sup>4</sup>

15 13. During her treatment of Patient 1, Respondent did not have a contract or consent  
16 agreement with the patient for the use of Suboxone. Respondent did not document that she had  
17 performed a physical examination on Patient 1, nor did Respondent document that a physical  
18 examination was performed on Patient 1 by another physician. Respondent did not obtain records  
19 from the detox center(s) or physician office(s) who had treated Patient 1. Respondent informed  
20 the Board that she did not check CURES for patients she treated in 2015 or 2016,<sup>5</sup> nor did  
21 Respondent perform drug tests or other drug screenings on Patient 1.

22 <sup>1</sup> The patients are identified by numbers to protect their privacy.

23 <sup>2</sup> These are approximate dates based on the medical records which were available to the  
24 Board. Patient 1 may have treated with Respondent before or after these dates.

25 <sup>3</sup> This case was initiated by a complaint filed by Patient 1, who alleged that Respondent  
26 dismissed Patient 1 from further care, and left her [Patient 1] addicted to Suboxone. Patient 1  
27 also alleged, among other things, that Respondent mainly treated her [Patient 1] at Respondent's  
28 home, and not in a medical office.

26 <sup>4</sup> The CURES reports shows that Patient 1 had an opioid use disorder and may have been  
27 "doctor shopping." When Patient 1 started on Suboxone, she appeared to stop the opioid  
28 prescriptions, but continued taking a high dose of benzodiazepines.

27 <sup>5</sup> Respondent did document that she checked CURES for Patient 1 on some of the visits,  
28 but it did not appear that Respondent checked CURES on a regular basis (e.g. every four months).

1 14. Overall, Respondent's care and treatment of Patient 1, as outlined above, represents  
2 multiple acts of negligence for prescribing controlled medications to Patient 1, who had signs of  
3 addiction.

4 Patient 2

5 15. Patient 2 (or "patient") is a 38-year-old male, who treated with Respondent from  
6 approximately May 2018 until June 2018.<sup>6</sup> Patient 2 had a history of homelessness, overdose,  
7 and reported that he had used heroin and cocaine previous to his first visit with Respondent. Per  
8 CURES, during her treatment of Patient 2, Respondent prescribed to Patient 2 mostly  
9 prescriptions for Suboxone, with one prescription for Lorazepam (a sedative used to treat  
10 anxiety).<sup>7</sup>

11 16. During her treatment of Patient 2, Respondent also did not have a contract or consent  
12 agreement with the patient for the use of Suboxone. Respondent did not adequately document  
13 that she had performed a physical examination on Patient 2, nor did Respondent document that a  
14 physical examination was performed on Patient 2 by another physician. Similar to the  
15 aforementioned patient, Respondent also did not obtain records from the detox center(s) or  
16 physician office(s) who may have previously treated Patient 2. Respondent did not perform drug  
17 tests or other drug screenings on Patient 2.

18 17. Overall, Respondent's care and treatment of Patient 2, as outlined above, represents  
19 multiple acts of negligence.

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23 For example, on December 30, 2018, it appears that Respondent may have checked CURES (for  
24 the first time on this patient), and was alerted to Patient 1's use of Xanax since 2014, and the  
dangerous combination of opioid and benzodiazepines.

25 <sup>6</sup> Again, these are approximate dates based on the medical records which were available to  
the Board. Patient 2 may have treated with Respondent before or after these dates.

26 <sup>7</sup> Lorazepam is a Schedule IV Controlled Substance and a dangerous drug pursuant to  
27 section 4022 of the Code, which if combined with other medications, can slow breathing and  
possibly lead to death. Of note, the recovery center where Respondent had treated Patient 2 was  
28 closed on or about June 19, 2018, but it appeared that Respondent continued to prescribe to  
Patient 2 multiple times after the center was closed.

1 **Patient 3**

2 18. Patient 3 (or "patient") is a 40-year-old female, who treated with Respondent from  
3 approximately September 2011 through February 2020,<sup>8</sup> mainly to continue Suboxone. During  
4 this time period, Respondent prescribed to Patient 3 multiple controlled medications such as  
5 Hydrocodone (an opiate), Gabapentin (commonly used to treat nerve pain and migraine  
6 headaches), Pamelor (Antidepressant and nerve pain medication), and Vistaril (anti-anxiety  
7 medication),<sup>9</sup> but the majority of the prescriptions were for Suboxone.

8 19. Similar to the above patients, Respondent did not have a contract or consent  
9 agreement with Patient 3 for the use of Suboxone. Moreover, Respondent did not adequately  
10 document Patient 3's vital signs, nor did Respondent obtain records from the detox center(s) or  
11 physician office(s), which may have treated Patient 3. Respondent informed the Board that she  
12 did not check CURES for patients she treated in 2015 or 2016,<sup>10</sup> nor did Respondent perform  
13 drug tests or other drug screenings on Patient 3.

14 20. Overall, Respondent's care and treatment of Patient 3, as outlined above, represents  
15 multiple acts of negligence.

16 **SECOND CAUSE FOR DISCIPLINE**

17 **(Excessive Prescribing - 3 Patients)**

18 21. By reason of the facts and allegations set forth in the First Cause for Discipline,  
19 above, Respondent is subject to disciplinary action under section 725 of the Code, in that  
20 Respondent excessively prescribed dangerous drugs to Patients 1, 2, and 3 above.

21 **THIRD CAUSE FOR DISCIPLINE**

22 **(Prescribing to an Addict - Patient 1)**

23 22. Respondent is subject to disciplinary action under section 2241 of the Code in that  
24 Respondent prescribed controlled substances to Patient 1, who had signs of addiction.

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26 <sup>8</sup> Again, these are approximate dates based on the medical records which were available to  
27 the Board. Patient 3 may have treated with Respondent before or after these dates.

28 <sup>9</sup> These four medications are dangerous drugs pursuant to section 4022 of the Code.

<sup>10</sup> Respondent did document that she checked CURES for Patient 3 on some of the visits,  
but it did not appear that Respondent checked CURES on a regular basis (e.g. every four months).





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

DATED: JUN 30 2021



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WILLIAM PRASIEKA  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

LA2021602155