

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

In the Matter of the Accusation
Against:

Michael Yadegari, M.D.

Physician's and Surgeon's
Certificate No. A 100335

Respondent.

Case No.: 800-2019-057269

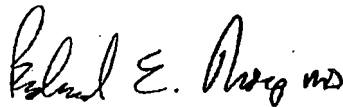
DECISION

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

This Decision shall become effective at 5:00 p.m. on September 8, 2023.

IT IS SO ORDERED: August 9, 2023.

MEDICAL BOARD OF CALIFORNIA



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

1 ROB BONTA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 LATRICE R. HEMPHILL
Deputy Attorney General
4 State Bar No. 285973
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
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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 **MICHAEL YADEGARI, M.D.**
14 **2784 Casiano Road**
Los Angeles, CA 90077-1524

15 **Physician's and Surgeon's**
16 **Certificate No. A 100335,**

17 Respondent.

Case No. 800-2019-057269

OAH No. 2022100380

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

18
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. Reji Varghese (Complainant) is the Interim Executive Director of the Medical Board
23 of California (Board). He brought this action solely in his official capacity and is represented in
24 this matter by Rob Bonta, Attorney General of the State of California, by Latrice R. Hemphill,
25 Deputy Attorney General.

26 2. Respondent Michael Yadegari, M.D. (Respondent) is represented in this proceeding
27 by attorneys Dennis Ames and Poge Henderson, whose address is: La Follette, Johnson, De
28 Haas, Fesler & Ames, 677 North Main Street, Suite 901, Santa Ana, CA 92705-6632.

1 15. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to
2 be an integrated writing representing the complete, final and exclusive embodiment of the
3 agreement of the parties in this above entitled matter.

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

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

10 **DISCIPLINARY ORDER**

11 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 100335 issued
12 to Respondent MICHAEL YADEGARI, M.D. is revoked. However, the revocation is stayed and
13 Respondent is placed on probation for four (4) years on the following terms and conditions:

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

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

26 2. **EDUCATION COURSE.** Within 60 calendar days of the effective date of this
27 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
28 for its prior approval educational program(s) or course(s), which shall not be less than 40 hours

1 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
2 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
3 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
4 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
5 completion of each course, the Board or its designee may administer an examination to test
6 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
7 hours of CME of which 40 hours were in satisfaction of this condition.

8 3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective
9 date of this Decision, Respondent shall enroll in a course in prescribing practices approved in
10 advance by the Board or its designee. Respondent shall provide the approved course provider
11 with any information and documents that the approved course provider may deem pertinent.
12 Respondent shall participate in and successfully complete the classroom component of the course
13 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
14 complete any other component of the course within one (1) year of enrollment. The prescribing
15 practices course shall be at Respondent's expense and shall be in addition to the Continuing
16 Medical Education (CME) requirements for renewal of licensure.

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

22 Respondent shall submit a certification of successful completion to the Board or its
23 designee not later than 15 calendar days after successfully completing the course, or not later than
24 15 calendar days after the effective date of the Decision, whichever is later.

25 4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
26 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
27 advance by the Board or its designee. Respondent shall provide the approved course provider
28 with any information and documents that the approved course provider may deem pertinent.

1 Respondent shall participate in and successfully complete the classroom component of the course
2 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
3 complete any other component of the course within one (1) year of enrollment. The medical
4 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
5 Medical Education (CME) requirements for renewal of licensure.

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

11 Respondent shall submit a certification of successful completion to the Board or its
12 designee not later than 15 calendar days after successfully completing the course, or not later than
13 15 calendar days after the effective date of the Decision, whichever is later.

14 5. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days
15 of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment
16 program approved in advance by the Board or its designee. Respondent shall successfully
17 complete the program not later than six (6) months after Respondent's initial enrollment unless
18 the Board or its designee agrees in writing to an extension of that time.

19 The program shall consist of a comprehensive assessment of Respondent's physical and
20 mental health and the six general domains of clinical competence as defined by the Accreditation
21 Council on Graduate Medical Education and American Board of Medical Specialties pertaining to
22 Respondent's current or intended area of practice. The program shall take into account data
23 obtained from the pre-assessment, self-report forms and interview, and the Decision, Accusation,
24 and any other information that the Board or its designee deems relevant. The program shall
25 require Respondent's on-site participation for a minimum of three (3) and no more than five (5)
26 days as determined by the program for the assessment and clinical education evaluation.
27 Respondent shall pay all expenses associated with the clinical competence assessment program.

28 At the end of the evaluation, the program will submit a report to the Board or its designee,

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

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

9 If Respondent fails to enroll, participate in, or successfully complete the clinical
10 competence assessment program within the designated time period, Respondent shall receive a
11 notification from the Board or its designee to cease the practice of medicine within three (3)
12 calendar days after being so notified. The Respondent shall not resume the practice of medicine
13 until enrollment or participation in the outstanding portions of the clinical competence assessment
14 program have been completed. If the Respondent did not successfully complete the clinical
15 competence assessment program, the Respondent shall not resume the practice of medicine until a
16 final decision has been rendered on the accusation and/or a petition to revoke probation. The
17 cessation of practice shall not apply to the reduction of the probationary time period.

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

27 The Board or its designee shall provide the approved monitor with copies of the Decision
28 and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the

1 Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement
2 that the monitor has read the Decision and Accusation, fully understands the role of a monitor,
3 and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the
4 proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed
5 statement for approval by the Board or its designee.

6 Within 60 calendar days of the effective date of this Decision, and until successful
7 completion of the clinical competence assessment program and review of the submitted report by
8 a Board designee, Respondent's practice shall be monitored by the approved monitor.
9 Respondent shall make all records available for immediate inspection and copying on the
10 premises by the monitor at all times during business hours and shall retain the records for the
11 entire term of probation.

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

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

23 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
24 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
25 name and qualifications of a replacement monitor who will be assuming that responsibility within
26 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
27 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
28 notification from the Board or its designee to cease the practice of medicine within three (3)

1 calendar days after being so notified. Respondent shall cease the practice of medicine until a
2 replacement monitor is approved and assumes monitoring responsibility.

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

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

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

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

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

23 10. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
24 ordered to reimburse the Board its costs of investigation and enforcement, including, but not
25 limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena
26 enforcement, as applicable, in the amount of \$9,690.00 (nine thousand six hundred ninety
27 dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs
28 shall be considered a violation of probation.

1 Payment must be made in full within 30 calendar days of the effective date of the Order, or
2 by a payment plan approved by the Medical Board of California. Any and all requests for a
3 payment plan shall be submitted in writing by respondent to the Board. Failure to comply with
4 the payment plan shall be considered a violation of probation.

5 The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to
6 repay investigation and enforcement costs.

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

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

12 12. GENERAL PROBATION REQUIREMENTS.

13 Compliance with Probation Unit

14 Respondent shall comply with the Board's probation unit.

15 Address Changes

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

21 Place of Practice

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

25 License Renewal

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

28 ///

1 Travel or Residence Outside California

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

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

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

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

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

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

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

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

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

9 15. COMPLETION OF PROBATION. Respondent shall comply with all financial
10 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
11 completion of probation. This term does not include cost recovery, which is due within 30
12 calendar days of the effective date of the Order, or by a payment plan approved by the Medical
13 Board and timely satisfied. Upon successful completion of probation, Respondent’s certificate
14 shall be fully restored.

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

22 17. LICENSE SURRENDER. Following the effective date of this Decision, if
23 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy
24 the terms and conditions of probation, Respondent may request to surrender his or her license.
25 The Board reserves the right to evaluate Respondent’s request and to exercise its discretion in
26 determining whether or not to grant the request, or to take any other action deemed appropriate
27 and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
28 shall within 15 calendar days deliver Respondent’s wallet and wall certificate to the Board or its

1 designee and Respondent shall no longer practice medicine. Respondent will no longer be subject
2 to the terms and conditions of probation. If Respondent re-applies for a medical license, the
3 application shall be treated as a petition for reinstatement of a revoked certificate.

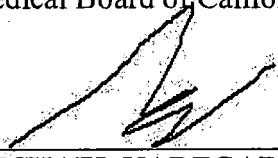
4 18. PROBATION MONITORING COSTS. Respondent shall pay the costs associated
5 with probation monitoring each and every year of probation, as designated by the Board, which
6 may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of
7 California and delivered to the Board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

9 19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
10 a new license or certification, or petition for reinstatement of a license, by any other health care
11 licensing action agency in the State of California, all of the charges and allegations contained in
12 Accusation No. 800-2019-057269 shall be deemed to be true, correct, and admitted by
13 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
14 restrict license.

15 ACCEPTANCE

16 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
17 discussed it with my attorneys, Dennis Ames and Pogey Henderson. I understand the stipulation
18 and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated
19 Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be
20 bound by the Decision and Order of the Medical Board of California.


21
22 DATED: 04/26/2023


23 MICHAEL YADEGARI, M.D.
24 Respondent

25 ///
26 ///
27 ///
28 ///

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

4
5 DATED: 4/26/23


6 DENNIS AMES
7 POGY HENDERSON
8 *Attorneys for Respondent*

9 **ENDORSEMENT**

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

12
13 DATED: _____

Respectfully submitted,

14 ROB BONTA
15 Attorney General of California
16 JUDITH T. ALVARADO
17 Supervising Deputy Attorney General

18 LATRICE R. HEMPHILL
19 Deputy Attorney General
20 *Attorneys for Complainant*

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

4
5 DATED: _____

DENNIS AMES
POGEY HENDERSON
Attorneys for Respondent

6
7
8
9 **ENDORSEMENT**

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

12 DATED: 4/27/2023

Respectfully submitted,

13
14 ROB BONTA
Attorney General of California
15 JUDITH T. ALVARADO
Supervising Deputy Attorney General

16 

17 LATRICE R. HEMPHILL
18 Deputy Attorney General
Attorneys for Complainant

19
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21
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Exhibit A

Accusation No. 800-2019-057269

1 ROB BONTA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 State Bar No. 155307
300 South Spring Street, Suite 1702
4 Los Angeles, California 90013
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5 Facsimile: (916) 731-2117
Attorneys for Complainant

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

11 In the Matter of the Accusation Against:

Case No. 800-2019-057269

12 **MICHAEL YADEGARI, M.D.**
13 **3130 S. Hill Street**
Los Angeles, CA 90007-3817

A C C U S A T I O N

14 **Physician's and Surgeon's Certificate**
15 **No. A 100335,**

16 Respondent.

17
18 **PARTIES**

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

22 2. On or about June 1, 2007, the Medical Board issued Physician's and Surgeon's
23 Certificate Number A 100335 to Michael Yadegari, M.D. (Respondent). The Physician's and
24 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
25 herein and will expire on June 30, 2023, unless renewed.

26 ///

27 ///

28 ///

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

23 **STATUTORY PROVISIONS**

24 6. Section 2234 of the Code, states:

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

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

1 (b) Gross negligence.

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

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

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

14 (d) Incompetence.

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

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

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

22 7. Section 2266 of the Code states:

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

26 COST RECOVERY

27 8. Section 125.3 of the Code states:

28 (a) Except as otherwise provided by law, in any order issued in resolution of a
disciplinary proceeding before any board within the department or before the
Osteopathic Medical Board, upon request of the entity bringing the proceeding, the
administrative law judge may direct a licensee found to have committed a violation or
violations of the licensing act to pay a sum not to exceed the reasonable costs of the
investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the
order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where
actual costs are not available, signed by the entity bringing the proceeding or its
designated representative shall be prima facie evidence of reasonable costs of
investigation and prosecution of the case. The costs shall include the amount of
investigative and enforcement costs up to the date of the hearing, including, but not
limited to, charges imposed by the Attorney General.

1 (d) The administrative law judge shall make a proposed finding of the amount
2 of reasonable costs of investigation and prosecution of the case when requested
3 pursuant to subdivision (a). The finding of the administrative law judge with regard
4 to costs shall not be reviewable by the board to increase the cost award. The board
5 may reduce or eliminate the cost award, or remand to the administrative law judge if
6 the proposed decision fails to make a finding on costs requested pursuant to
7 subdivision (a).

8 (e) If an order for recovery of costs is made and timely payment is not made as
9 directed in the board's decision, the board may enforce the order for repayment in any
10 appropriate court. This right of enforcement shall be in addition to any other rights
11 the board may have as to any licensee to pay costs.

12 (f) In any action for recovery of costs, proof of the board's decision shall be
13 conclusive proof of the validity of the order of payment and the terms for payment.

14 (g) (1) Except as provided in paragraph (2), the board shall not renew or
15 reinstate the license of any licensee who has failed to pay all of the costs ordered
16 under this section.

17 (2) Notwithstanding paragraph (1), the board may, in its discretion,
18 conditionally renew or reinstate for a maximum of one year the license of any
19 licensee who demonstrates financial hardship and who enters into a formal agreement
20 with the board to reimburse the board within that one-year period for the unpaid
21 costs.

22 (h) All costs recovered under this section shall be considered a reimbursement
23 for costs incurred and shall be deposited in the fund of the board recovering the costs
24 to be available upon appropriation by the Legislature.

25 (i) Nothing in this section shall preclude a board from including the recovery of
26 the costs of investigation and enforcement of a case in any stipulated settlement.

27 (j) This section does not apply to any board if a specific statutory provision in
28 that board's licensing act provides for recovery of costs in an administrative
disciplinary proceeding.

STANDARD OF CARE

20 9. **General Anxiety Disorder (GAD)**-General Anxiety Disorder is a common disorder
21 that has symptoms similar to panic disorder, obsessive-compulsive disorder, and other types of
22 anxiety. It can lead to significant impairments in role functioning and reduced quality of life. It
23 can be effectively treated with cognitive behavior therapy, medication or a combination of the
24 two modalities. Primary care physicians are usually the first point of contact for patients with
25 anxiety disorder. The physician must assess the severity and extent of the functional impairment
26 caused by the anxiety disorder. This assessment is done with a detailed history and an objective
27 screening questionnaire. A complete review of the patient's over-the-counter and prescribed
28 medication history is important as certain medications can trigger anxiety side effects.

1 Laboratory evaluation testing, including thyroid hormone testing, should also be considered.

2 Once medical causes of anxiety are excluded, the physician, along with the patient, must choose
3 either behavioral therapy or medications or both.

4 If pharmacotherapy is chosen, initial treatment with a serotonergic antidepressant (SSRI) or
5 a serotonin norepinephrine reuptake inhibitor (SNRI) is recommended as these medications are
6 the best-studied treatments found to be efficacious for anxiety disorder. Because of their
7 excellent safety profile, these medications are commonly initiated and monitored by primary care
8 physicians. Because of variable responses to these medications, patients often need to try several
9 medications over several months to find the one medication that works best for them.

10 Benzodiazepines have an important role in the management of generalized anxiety disorder,
11 but concerns about the risks of drug dependency and tolerance limit their use. Other concerns
12 include abuse, amnesia, and withdrawal symptoms. Benzodiazepines are used as a short-term
13 adjunct therapy during the initial treatment with SSRI or SNRI medications.

14 **10. Concurrent use of Benzodiazepines and Opiates-**Benzodiazepines and opiate
15 medications both cause central nervous system depression and can decrease respiratory drive.
16 Concurrent use of these medications is likely to put patients at greater risk for potentially fatal
17 overdose. In 2016 the FDA issued a black box warning against the combination of these two
18 classes of medications to discourage physicians from prescribing this combination of
19 medications. Physicians should strongly avoid prescribing both narcotics and benzodiazepines
20 concurrently, as the risks outweigh the benefits. When confronted with patients concurrently
21 using both medications, physicians should taper the patients off opiate medications first. If the
22 patient wants to continue the opiate therapy, then the benzodiazepine should be tapered slowly
23 and gradually. Other non-benzodiazepine medication approved for anxiety should be offered to
24 the patient who is receiving the benzodiazepine for treatment of anxiety.

25 **11. Management of Insomnia-**The main modalities in the treatment of insomnia in
26 adults are psychological/behavioral therapies, pharmacologic treatment, or a combination of both.
27 There are many causes and triggers of insomnia. Confirmation of insomnia requires a detailed
28 history and physical examination. The history should include a two-week sleep diary and

1 interview of the bed partner to help in assessing the severity of insomnia. A review of the
2 patient's medication regimen should be done to highlight potential medications that can cause
3 insomnia. Cognitive behavioral therapy is often the safest treatment for most patients, but is
4 underutilized. Most physicians rely on pharmacotherapy for control of insomnia.

5 If pharmacotherapy is chosen, non-benzodiazepine medication should always be tried first
6 due to the addiction potential and risks of long-term benzodiazepine therapy. If benzodiazepines
7 are used, they should only be administered for a short term. Safer medications, such as melatonin
8 or antihistamines should be tried first. Antidepressants, such as Trazodone and tricyclics may be
9 used if the insomnia is associated with depression. FDA approved non-benzodiazepine sedative
10 hypnotics known as "Z-drugs," could be tried if other safer alternatives do not work. These
11 include Zolpidem, beginning with a low dose.

12 **12. Maintenance of Medical Records-**Every physician must maintain accurate and
13 adequate medical records. A physician treating a patient with controlled substances, requires a
14 medical history, results of a physical examination, laboratory results and radiologic testing. Vital
15 signs should be recorded at every visit. The records should reflect all treatments provided at the
16 consultation/visit, including all medications prescribed (including dosage and number of pills
17 dispensed). Ongoing monitoring of progress or lack thereof, should be documented. A record of
18 response to aberrant behavior from opiate use should be documented. Results of CURES Reports
19 should be maintained in the patient's chart. Drug testing should also be documented. Routine
20 laboratory testing should be documented, when warranted. Results of all ordered tests, including
21 EKG, x-rays, should be documented in the chart.

22 **13. Evaluation and Non-Opiate Management of Chronic Pain-**The initial evaluation
23 of chronic pain requires the physician to take a complete history and perform a physical
24 examination followed by appropriate radiologic and laboratory testing to determine if the pain is
25 caused by cancer or some other source. Appropriate subspecialty consultations are recommended
26 if the diagnosis is elusive. Tissue biopsies and further specialized nerve testing may be
27 appropriate in certain situations. Opiate pain medications are recommended for managing cancer
28 pain for palliative and ethical concerns. For non-cancer chronic pain, opiate therapy is not the

1 first line of treatment due to the risks of addiction, drug overdose, and respiratory depression.
2 Non-pharmacologic therapy and non-opiate therapy are often preferred. Weight loss, aerobic
3 exercises, aquatic pool therapy, and cognitive therapy can often improve pain from osteoarthritis.
4 Non-opiate medications, like non-steroidal anti-inflammatory (NSAID) drugs, acetaminophen,
5 and anti-seizure medications can often significantly reduce pain and restore functionality.
6 Surgical consultations for joint injections and total joint replacements are other treatment options.
7 Patients do not need to sequentially fail all these therapies before narcotics may be tried if the
8 benefits of narcotics outweigh the risks. Opiate therapy is most beneficial when combined with
9 non-pharmacologic therapy and non-opiate medications.

10 **14. Initiation and Monitoring of Chronic Opiate Pain Medication-**If non-opiate
11 medications and non-pharmacologic therapy did not adequately control the patient's pain, opiates
12 may be considered if the benefits outweigh the risks. Opiates with the lowest potency and
13 addiction potential should always be tried first for a defined period, usually one to three months.
14 The patient's progress should be monitored for benefit and harm, including the patient's level of
15 pain, function, quality of life, and adverse effects. If it is determined that opiate therapy will be
16 continued beyond 90 days, the titration of pain medication dosage should be slow. Ideally, the
17 morphine equivalent dose (MED) should not exceed 80-90 per day. Risks of drug overdose and
18 death and other adverse effects increase significantly beyond this dosage.

19 The patient's risk of drug addiction and aberrancy should also be assessed prior to starting
20 long term opiate therapy. Risk stratification is one of the most important tools a physician can do
21 to mitigate potentially adverse consequences of opiate therapy. This involves performing a
22 psychological evaluation which assesses the risks of addictive behaviors. This can be performed
23 by using a questionnaire such as the Opioid Risk Tool, SOAPP-R, or PHQ-9. Patients with an
24 above average risk of addiction can benefit from a referral to a psychiatrist. The patient can also
25 be closely monitored with regular urine drug testing and checking CURES.

26 Patients on chronic opiate therapy need to be monitored on a regular basis, every one to
27 three months. Periodic assessments allow the physician to determine if the medication is
28 controlling the patient's pain and improving the patient's functional status. The physician can

1 discontinue or taper the patient off the medication if the harm outweighs the benefits. The
2 assessment should focus on analgesia, activities of daily living, adverse side effects of the opiates,
3 aberrant behaviors, and the patient's affect. The patient should also be monitored for compliance
4 by checking CURES, urine drug testing, and pill counts. If drug abuse or diversion is confirmed,
5 the physician should arrange an immediate face-to-face meeting with the patient to re-evaluate
6 treatment, and in some cases, taper the opiate therapy, if appropriate. If the MED exceeds 80-90
7 per day, the patient should be educated on the use of naloxone therapy. Sleep apnea, chronic
8 respiratory illnesses, and concurrent benzodiazepine use increase the toxicity risks in opiate
9 dependent patients. Therefore, naloxone therapy is strongly recommended for these patients.

10 **15. Informed Consent and Patient Care Agreements-**When considering long-term use
11 of opiates, the physician should discuss the risks and benefits of the treatment plan with the
12 patient (or conservator). The patient consent addresses the risks and side effects of opiate
13 medications. These include constipation, sexual dysfunction, osteoporosis, cognitive impairment,
14 over-sedation, drug interactions, respiratory depression, impaired driving skills, opiate
15 dependency, and addiction. A discussion emphasizing the medical evidence questioning the
16 benefit of long-term opiate therapy should also be held. A patient consent and pain management
17 agreement typically outlines the joint responsibilities of the physician and the patient, including
18 replacement and early refills of lost medications. It also emphasizes the patient's responsibility to
19 obtain the prescribed opiate medication from only one physician or practice and from only one
20 pharmacy. It highlights the patient's agreement to periodic drug testing and prescription drug
21 monitoring (CURES). The use of the combined patient consent form/pain care agreement has
22 been shown to improve narcotic patient compliance with treatment goals and objectives and to
23 reduce the risk of aberrant behavior.

24 **16. Testosterone Replacement Therapy-**Testosterone treatment is currently FDA
25 approved as replacement therapy only for men with primary testicular failure due to genetic
26 causes, trauma, toxic injury, infection, or orchiectomy. It is also approved for men with
27 secondary central pituitary disorders due to tumor, trauma, or radiation. The benefits of
28 testosterone replacement therapy are not well proven in off-label use for age-related low

1 testosterone, opioid related hypogonadism, low libido, aging-related low energy and vitality, lack
2 of concentration, and depression. The health risks from long term testosterone treatment include
3 potential increased risks of stroke, heart attack, blood clot, stimulation of prostate cancer cell and
4 prostate glands, liver toxicity, abnormal blood lipids, and erythrocytosis. Testosterone
5 replacement therapy can also worsen apneic episodes in obstructive sleep apnea patients. Due to
6 the increase in associated risks with use, the FDA advised that an informed discussion between
7 the patient and doctor be conducted prior to starting testosterone therapy. The FDA further
8 recommended periodic blood testing to monitor for polycythemia and metabolic effects on blood
9 cholesterol and liver function. In men at risk for prostate cancer, PSA testing is also advised.
10 Despite the FDA warnings, contradictory results were found. Because of the conflicting data on
11 cardiovascular risks and benefits, there are no current universal recommendations for screening
12 men for low testosterone and clinical hypogonadism.

13 However, if a male patient has signs or symptoms of testosterone deficiency, testosterone
14 levels should be confirmed on at least two occasions. All major expert guidelines strongly
15 endorse a second repeat testosterone measurement for confirmation as 30% of men with an initial
16 low level in the hypogonadal range have a normal testosterone concentration on repeat
17 measurement. Additional confirmatory tests such as luteinizing hormone and follicle stimulating
18 hormone should be obtained in the presence of a low testosterone level to help in determining
19 primary or secondary causes.

20 Before starting therapy, a history and physical examination, including a testicular and
21 prostate examination, should be performed at baseline to assess for risks of prostate cancer.
22 Blood laboratory tests, including CBC, chemistry, lipid panel, liver function tests, and PSA,
23 should be performed at baseline. Laboratory tests, including testosterone level, should be
24 repeated every 6-12 months, or sooner if indicated. The expert consensus is that the testosterone
25 level should be targeted to the mid to upper normal range of the reference value, but not above the
26 upper limit of the normal range. The usual dose of testosterone is 50 mg to 400 mg via
27 intramuscular injection every 2 to 4 weeks. Topical and gel preparations are also available. The

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1 dose should be adjusted to reach a therapeutic level and should be reduced if the serum
2 testosterone level exceeds the normal reference range, to minimize the side effects.

3 FACTS

4 17. Respondent is board-certified in Internal Medicine and Gastroenterology. He serves
5 as the medical director for twenty clinics owned by American Health Services, a non-profit
6 organization. Respondent currently treats patients at Hill Street Medical Services in downtown
7 Los Angeles, and at clinics located in Van Nuys and Santa Clarita. He previously worked at
8 Downtown Medical and Mental Health Services, where many of the patients identified in this
9 Accusation were treated. That location has since closed.

10 Patient 1¹

11 18. Patient 1 established care with Respondent in 2014.² He was 49-years-old at the time
12 and homeless. He suffered from chronic ulcerative colitis with rectal bleeding. He also
13 complained of chronic low back pain from osteoarthritis and had a history of COPD. Patient 1
14 had an extensive psychiatric history, including anxiety, depression, post-traumatic stress disorder
15 and suicidal thoughts, which required frequent hospitalizations. Patient 1's medication history
16 included various opiates and muscle relaxants.

17 19. By July 2015, Respondent prescribed alprazolam, a benzodiazepine; olanzapine, an
18 antipsychotic, Latuda, an antipsychotic; and trazodone, an antidepressant, for Respondent. By
19 February 2016, Respondent increased the dose of alprazolam to 6 mg per day (up from 4 mg per
20 day), due to increased anxiety. Patient 1 remained on this high dose of alprazolam for 18 months
21 through late 2017.

22 20. Because of the patient's increasing anxiety and insomnia, zolpidem, a hypnotic, 10
23 mg was added to Patient 1's medication regimen in January 2016 and continued monthly for one
24 year.

25 21. Patient 1 was referred to a cardiologist in 2015 for evaluation of chest pain and
26 underwent surgery for the placement of coronary stents.

27 ¹ The patients are identified by number in this Accusation to address privacy concerns.

28 ² Care rendered to the Patients prior to 2015 is described for historical purposes only.

1 22. Respondent saw Patient 1 on a monthly basis for refills of his psychiatric and
2 cardiovascular medications. Despite several orders for blood testing, it appears that the patient
3 was noncompliant. Only one blood test result from an emergency department visit is found in the
4 patient's chart. Only one urine toxicology test was performed in September 2017.

5 **Patient 2**

6 23. Patient 2 established care with Respondent in 2014. He was 52-years-old at the time
7 and homeless. He was HIV positive and had sought treatment for sexually transmitted diseases
8 and a testicular infection. Patient 2 was seen by Respondent on a monthly basis for medication
9 renewals and primary care issues. He had regular testing to monitor his T-cell count and received
10 highly active antiretroviral therapy (HAART therapy) and prophylactic antibiotics for his AIDS
11 syndrome.

12 24. Respondent also prescribed opiates for Patient 2, including Tylenol with codeine. Per
13 CURES, Respondent prescribed Tylenol with codeine starting in January 2016, but he did not
14 document this medication in the patient's chart until April 2016. The indication for the opiate is
15 noted as chronic low back pain and painful ambulation. Respondent did not try a safer non-
16 addictive pain medication prior to initiating opiate therapy for Patient 2. The patient was referred
17 to a pain management specialist and physical therapy, but was noncompliant. No imaging
18 evaluations of Patient 2's back and legs were obtained during the three years of opiate therapy.
19 Physical examinations were often lacking in detail, often with just "abnormal" as a finding with
20 no specific descriptions. No range of motion examinations are noted.

21 25. Patient 2 was referred to an Infectious Disease specialist for his chronic AIDS
22 wasting syndrome with chronic diarrhea and diffuse Kaposi sarcoma.

23 26. Patient 2 also suffered from chronic anxiety and depression. He had a single
24 psychotherapy session with the therapist in 2015, but none thereafter. Respondent regularly
25 prescribed alprazolam for the patient's anxiety since 2014. However, a detailed comprehensive
26 evaluation of the patient's anxiety disorder was never conducted over Respondent's four years of
27 anxiety management. Patient 2 was at high risk for controlled substance dependency due to his
28 history of sexual abuse, polysubstance abuse, and depression.

1 **Patient 3**

2 27. Patient 3 established care with Respondent in early 2014. She was 33-years-old at the
3 time and homeless. She was HIV positive, had bipolar disorder and was obese. Patient 3 was a
4 smoker, she had a history of polysubstance abuse, including cocaine and methamphetamines. She
5 also suffered from post-traumatic stress disorder from a sexual assault when she was a minor.

6 28. Respondent noted that Patient 3 suffered from chronic low back pain due to
7 osteoarthritis and required chronic opiate pain management. Prior to 2015, she was prescribed
8 tramadol or hydrocodone for pain management. By 2015, Respondent prescribed to Patient 3
9 monthly prescriptions for 10 mg of hydrocodone. In early 2016, Respondent prescribed monthly
10 scripts of daily hydrocodone, 4 mg of clonazepam, a benzodiazepine, and 10 mg of zolpidem, a
11 hypnotic. In 2017, Respondent added ibuprofen and tramadol for additional pain management.
12 In 2018, Patient 3 sustained an acute elbow fracture with an infection. She was continued on the
13 same pain management regimen of hydrocodone, ibuprofen and tramadol.

14 29. In May 2018, Patient 3's anxiety worsened, and Respondent changed the patient's
15 prescription from clonazepam to alprazolam. He also added an SSRI to treat her depression and
16 control her anxiety. Respondent discontinued Patient 3's prescription for Zolpidem as it was not
17 helping with her insomnia. During the second half of 2018, Respondent tried several different
18 muscle relaxants for better back pain management, including cyclobenzaprine, Robaxin, and
19 baclofen. He also tried naproxen, and gabapentin was added for pain management. By late 2019
20 Patient 3's back pain worsened, and therefore, Soma, a different muscle relaxant, was added to
21 her medication regimen.

22 30. Patient 3 had a positive urine toxicology screen for cocaine and methamphetamine in
23 December 2019. She was referred to a methadone maintenance clinic for opioid addiction
24 management. Respondent stopped prescribing narcotics for Patient 3 at that time.

25 **Patient 4**

26 31. Patient 4 established care with Respondent in 2014. He was 56-years-old at the time
27 and homeless. He was HIV positive and had chronic hepatitis C. He also complained about
28 chronic low back pain and had a history of schizophrenia.

1 32. Respondent initially treated Patient 4's low back pain with tramadol. As his
2 complaints of pain worsened, Respondent changed his medication to ibuprofen, baclofen and
3 Tylenol with codeine. By the end of 2015, Respondent was prescribing these three medications
4 for Patient 4 on a monthly basis.

5 33. Patient 4 developed chronic ear pain in early 2016. Over time, an ulcer formed over
6 his ear. Patient 4 was referred to USC County Medical Center for a biopsy of the ear ulcer, the
7 results of which were positive for squamous cell cancer. Patient 4 had his ear resected during the
8 summer of 2016. He started radiation and chemotherapy, but was noncompliant. Due to chronic
9 ear and back pain, Respondent changed Patient 4's pain management to 15 mg of hydrocodone
10 daily, for the next fifteen months.

11 34. In early 2017, Patient 4 had a low serum testosterone level based on a routine
12 laboratory screening (242 ng/dl). He was diagnosed with clinical hypogonadism as he had
13 symptoms of impotence and fatigue. Respondent prescribed testosterone cream 200 mg, every
14 two weeks, however, the patient's testosterone level was never rechecked. No genitourinary
15 examination was conducted and a PSA level was not checked prior to starting testosterone
16 therapy.

17 35. Patient 4's cancer progressed due to his noncompliance with treatment. He continued
18 with Respondent for primary care. In 2018 he was diagnosed with essential hypertension and
19 Respondent prescribed medication for hypertension control. Testosterone therapy continued into
20 2018 with no laboratory monitoring.

21 **FIRST CAUSE FOR DISCIPLINE**

22 **(Repeated Negligent Acts)**

23 36. Respondent Michael Yadegari, M.D. is subject to disciplinary action under section
24 2234, subdivision (c) of the Code in that he committed repeated negligent acts in his care of four
25 patients. The circumstances are as follows:

26 37. The facts and allegations set forth in paragraphs 18 through 35, above, are
27 incorporated herein.

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1 **Patient 1**

2 38. Respondent failed to perform a detailed assessment of Patient 1's anxiety disorder
3 from 2015-2017. An anxiety questionnaire was not prepared. A detailed history of the patient's
4 anxiety symptoms, including triggering and relieving factors, was not conducted or was not
5 charted. There was no assessment of functional limitations caused by the patient's anxiety.
6 There were no trials of non-addictive, safer anxiolytic medications which could have reduced the
7 patient's benzodiazepine dependency. Closer monitoring with psychotherapists could have also
8 reduced the patient's need for long-term benzodiazepine therapy. Long term benzodiazepine use
9 should have been avoided to prevent drug dependency and addiction in this high risk patient. The
10 patient became dependent on high dose alprazolam for over a year.

11 39. The failure to perform a comprehensive and detailed anxiety examination of Patient 1
12 is a simple departure from the standard of care.

13 40. The failure to implement a trial of safer and non-addictive anxiolytic medication for
14 Patient 1 is a simple departure from the standard of care.

15 41. Patient 1 was receiving opiate prescriptions from pain management physicians.
16 Respondent should have minimized his prescribing of benzodiazepine medication to Patient 1 to
17 avoid the risk of accidental overdose. Patient 1 suffered from COPD, therefore, his risk of
18 accidental respiratory failure was magnified. Patient 1 should have been prescribed naloxone to
19 minimize the risk of concomitant opiate and benzodiazepine therapy.

20 42. Respondent's failure to taper Patient 1's benzodiazepine dose is a simple departure
21 from the standard of care.

22 43. Respondent's failure to prescribe naloxone for Patient 1 is a simple departure from
23 the standard of care.

24 44. Respondent failed to perform a detailed evaluation of Patient 1's insomnia prior to
25 prescribing zolpidem for him. The patient was homeless and a comprehensive sleep evaluation
26 was prohibited. Therefore, a safer, non-addictive sleep medication, such as an antihistamine and
27 or melatonin should have been tried prior to choosing zolpidem. Zolpidem also can cause
28 respiratory suppression when used with opiates and a benzodiazepine. Respondent started Patient

1 on a dose of zolpidem 10 mg. It is recommended that the starting dose of zolpidem be small, such as 2.5 mg to 5 mg, to minimize side effects.

45. Respondent's failure to perform a detailed insomnia evaluation on Patient 1 is a simple departure from the standard of care.

46. Respondent's failure to try a safer, non-addictive sleep medication for Patient 1 is a simple departure from the standard of care.

47. Respondent's decision to start Patient 1 on a dose of 10 mg of zolpidem is a simple departure from the standard of care.

Patient 2

48. Respondent prescribed alprazolam for Patient 2 starting in 2014. The medication was filled monthly until 2018. Respondent failed to prepare a detailed and comprehensive evaluation of the patient's anxiety disorder at any time during the four years of anxiolytic therapy. No screening questionnaires were completed, no history of triggers or relieving factors of anxiety were elicited and no functional limitations were queried. Respondent failed to try an SSRI or a safer medication alternative, such as an antihistamine or tricyclics. Patient 2 suffered from chronic depression which may have triggered his depression. A safe antidepressant medication could have been prescribed to reduce Patient 2's anxiety and depression.

49. Respondent's failure to conduct a comprehensive anxiety evaluation on Patient 2 is a simple departure from the standard of care.

50. Respondent's failure to start a trial of safer anxiolytic medication for Patient 2 is a simple departure from the standard of care.

51. Respondent's failure to better manage Patient 2's depression and thus reduce the patient's secondary anxiety is a simple departure from the standard of care.

52. Respondent prescribed long term opiate therapy to manage Patient 2's chronic low back and leg pain. However, Respondent's evaluation of the patient's pain syndrome was inadequate. The physical examination only noted muscle spasm and muscle tenderness, but no range of motion, including flexion and extension was noted. Because of the patient's HIV disease, imaging studies, such as x-ray or CT scan, should have been done at some point over the

1 four years of opioid treatment to assess for other potential infectious or neoplastic causes of the
2 pain. The Respondent's non-opiate management of Patient 2's chronic pain syndrome could have
3 been optimized. Non-addictive muscle relaxants, gabapentin or pregabalin, SSRI medication, and
4 tricyclics therapy could have been added to minimize the patient's need for narcotic therapy.

5 53. Respondent's failure to perform a thorough evaluation of Patient 2's chronic low back
6 and leg pain is a simple departure from the standard of care.

7 54. Respondent's failure to offer a trial of safer non-opiate medication to treat Patient 2's
8 pain is a simple departure from the standard of care.

9 55. Respondent started Patient 2 on long term narcotic therapy in 2014 without proper
10 risk stratification. Risk stratification should have been conducted at any point between 2015 and
11 2018, to guide decisions on long term narcotic therapy. Patient 2 was at high risk for dependency
12 and addiction due to his history of post-traumatic stress disorder, depression, and history of
13 sexual abuse. Because Patient 2 was at high risk for dependency and addiction, Respondent
14 should have performed regular CURES queries and urine toxicology testing to ensure compliance
15 and minimize aberrant behaviors, such as diversion. Respondent failed to perform an adequate
16 functional assessment of the benefits of long term opiate therapy. He never documented
17 analgesic efficacy, adverse side effects, activities of daily living, aberrant behaviors, or Patient 2's
18 affect.

19 56. Respondent's failure to perform an opioid risk stratification on Patient 2 is a simple
20 departure from the standard of care.

21 57. Respondent's failure to obtain routine urine toxicology testing and CURES review for
22 Patient 2 is a simple departure from the standard of care.

23 58. Respondent's failure to perform a detailed functional assessment of the benefits of the
24 narcotic therapy on Patient 2 is a simple departure from the standard of care.

25 59. Patient 2 was at increased risk of accidental overdose by taking both codeine and
26 alprazolam on a regular basis. Respondent should have tried to taper Patient 2 off one or both
27 medications. Patient 2 should have been counseled on the increased risk of taking the

28 ///

1 combination of an opiate and a benzodiazepine. Respondent should have prescribed naloxone for
2 Patient 2 while he was taking the combination of an opiate and a benzodiazepine.

3 60. Respondent's prescribing of an opiate and benzodiazepine for Patient 2 absent an
4 informed consent describing the risks and benefits of the combination of the medications is a
5 simple departure from the standard of care.

6 61. Respondent's failure to prescribe naloxone for Patient 2 while he was taking the
7 combination of an opiate and a benzodiazepine is a simple departure from the standard of care.

8 62. Because Patient 2 had an increased risk of opioid addiction, Respondent should have
9 obtained a pain contract/agreement and a signed informed consent document with Patient 2
10 during the four years he prescribed opiate therapy.

11 63. Respondent's failure to have a pain contract/agreement and a signed informed
12 consent document with Patient 2 is a simple departure from the standard of care.

13 **Patient 3**

14 64. Respondent prescribed benzodiazepine therapy (clonazepam or alprazolam) for
15 Patient 3 between 2016 and 2018 to manage her anxiety disorder. Respondent never performed a
16 thorough and comprehensive evaluation of the patient's anxiety illness. A screening
17 questionnaire was not completed. Respondent failed to complete a detailed review of symptoms
18 on Patient 3, which included triggering and relieving events. Respondent failed to complete and
19 document an assessment of Patient 3's functional limitations. Patient 3 did not undergo thyroid
20 hormone testing to assess for possible hyperthyroidism, which could cause general anxiety.
21 Patient 3 was a known polysubstance abuser. Urine drug toxicology testing should have been
22 conducted to assess her for drugs that cause anxiety, such as amphetamines or cocaine. Only one
23 urine drug screen was conducted on her in 2019, which was positive for amphetamines and
24 cocaine.

25 65. Respondent's failure to perform a detailed a comprehensive evaluation of Patient 3's
26 anxiety disorder is a simple departure from the standard of care.

27 66. Respondent's prescribing of long term benzodiazepine therapy to Patient 3 is a simple
28 departure from the standard of care.

1 67. Respondent failed to perform an appropriate evaluation of Patient 3's chronic low
2 back pain. Between 2015 and 2019, Respondent failed to perform a detailed back examination on
3 Patient 3, including evaluation of her range of motion, with assessment of back flexion and
4 extension. A straight leg test was not conducted. No sensory examination was conducted to
5 check for nerve impingement. No radiologic imaging was done. Respondent could have
6 optimized his non-opiate management of Patient 3's pain, including increasing the dose of her
7 gabapentin and encouraging weight loss.

8 68. Respondent's failure to conduct a thorough and detailed evaluation of Patient 3's
9 back and back pain is a simple departure from the standard of care.

10 69. Respondent's failure to prescribe other classes of non-opiate pain medication to treat
11 Patient 3's back pain is a simple departure from the standard of care.

12 70. Respondent's failure to offer other non-opiate management of Patient's 3 back pain is
13 a simple departure from the standard of care.

14 71. Respondent failed to recognize that Patient 3 was at increased risk for opiate
15 addiction because he did not perform a proper risk stratification. He did not conduct routine
16 CURES queries on Patient 3 and did not perform routine urine toxicology testing to enforce
17 compliance and prevent medication diversion. Respondent prescribed two short acting opiate
18 medications for Patient 3, tramadol and hydrocodone. The combination was not recommended
19 due to a lack of synergy and the increased toxicity risks and potential for addiction. Respondent
20 failed to document the specific details of opiate monitoring of Patient 3, including the analgesic
21 effects, the adverse side effects, activities of daily living, aberrancy and Patient 3's affect. There
22 was no detailed review of symptoms performed or documented to determine if the long term use
23 of the opiate medication was helping the patient.

24 72. Respondent's failure to perform a proper risk stratification on Patient 3, to determine
25 her risk for opiate dependency and addiction, is a simple departure from the standard of care.

26 73. Respondent's failure to conduct routine CURES queries and urine toxicology testing
27 on Patient 3 is a simple departure from the standard of care.

28 ///

1 74. Respondent's prescribing of two short acting opiate medications for Patient 3 is a
2 simple departure from the standard of care, due to the increase in toxicity, with minimal benefits.

3 75. Respondent prescribed long term opiate therapy for Patient 3's back pain
4 management. He also regularly prescribed either alprazolam or clonazepam for management of
5 Patient 3's anxiety. Patient 3 was at increased risk of accidental overdose due to the combination
6 of opiates and benzodiazepines. Respondent should have prescribed naloxone to minimize
7 Patient 3's risk of accidental overdose.

8 76. Respondent's failure to prescribe naloxone for Patient 3 is a simple departure from
9 the standard of care.

10 77. Respondent should have obtained a pain management contract/agreement with Patient
11 3 as she was at high risk for opioid addiction. A pain management contract/agreement would
12 have enforced medication compliance and minimized medication aberrancy. Because Patient 3
13 was at high risk for accidental overdose from being prescribed the combination of opiates and
14 benzodiazepines, Respondent should have documented a detailed informed consent discussion
15 with her about the risks and benefits of this medication combination.

16 78. Respondent's failure to obtain a pain management contract/agreement with Patient 3
17 and to document an informed consent discussion with her regarding her medications is a simple
18 departure from the standard of care.

19 79. Respondent prescribed zolpidem for Patient 3 on six occasions in 2016. However,
20 there is no documentation in the patient's chart reflecting the indication for the medication or the
21 dose. There was no thorough evaluation of insomnia, if this was the rationale for the prescription.
22 Secondary causes of insomnia include methamphetamine use, depression, post-traumatic stress
23 disorder, recurrent urinary tract infections, or homelessness. No secondary cause of insomnia
24 was documented in Patient 3's chart. Nevertheless, safer, non-addictive sleeping medications
25 should have been tried, including antihistamines, melatonin and tricyclics, before initiating
26 zolpidem therapy. Zolpidem should be initiated at low doses and titrate upwards, if necessary.
27 Respondent prescribed zolpidem to Patient 3 at a high dose of 10 mg. The combination of

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1 zolpidem, a central nervous system depressant, with opiates and benzodiazepines put Patient 3 at
2 high risk for accidental drug overdose.

3 80. Respondent's failure to conduct a thorough insomnia evaluation for secondary causes
4 on Patient 3 is a simple departure from the standard of care.

5 81. Respondent's failure to offer Patient 3 a trial of safer, non-addictive sleeping
6 medications and to start zolpidem at a high dose is a simple departure from the standard of care.

7 **Patient 4**

8 82. Respondent failed to conduct a sufficient evaluation of Patient 4's chronic low back
9 pain. Respondent should have tried other non-opiate medications including other NSAIDS,
10 gabapentin, pregabalin, SSRI, and tricyclics.

11 83. Respondent's failure to conduct an appropriate evaluation of Patient 4's low back
12 pain is a simple departure from the standard of care.

13 84. Respondent failed to perform a proper risk stratification of Patient 4's opiate pain
14 management. He also failed to regularly monitor CURES and perform routine urine toxicology
15 testing on Patient 4. Respondent failed to document the details of a functional assessment of long
16 term narcotic therapy on Patient 4, including analgesia, adverse side effects, activities of daily
17 living, aberrancy and Patient 4's affect.

18 85. Respondent's failure to perform a proper risk stratification on Patient 4 is a simple
19 departure from the standard of care.

20 86. Respondent's failure to regularly monitor Patient 4's CURES reports and to perform
21 routine urine toxicology testing is a simple departure from the standard of care.

22 87. Respondent's failure to document details of a functional assessment of Patient 4's
23 opioid therapy is a simple departure from the standard of care.

24 88. Respondent should have obtained a pain management contract/agreement with Patient
25 4 as he was at high risk for opioid addiction. A pain management contract/agreement would have
26 enforced medication compliance and minimized medication aberrancy. Because Patient 4 was at
27 high risk for accidental overdose from taking long term opiate medications, Respondent should

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1 have documented a detailed informed consent discussion with him about the risks and benefits of
2 the long term use of opiates and the potential for accidental overdose.

3 89. Respondent's failure to obtain a pain management contract/agreement and document
4 an informed consent discussion with Patient 4 is a simple departure from the standard of care.

5 90. Respondent initiated testosterone therapy for Patient 4 based on a single low
6 testosterone blood value of 242 ng/dl in February 2017. No repeat testing was conducted.

7 Respondent did not perform a digital prostate examination on Patient 4 prior to starting hormonal
8 therapy. Respondent did not document an informed consent discussion with Patient 4 regarding
9 the risks and benefits of testosterone therapy. Respondent did not perform follow up testosterone
10 testing six months after initiating hormonal therapy.

11 91. Respondent's decision to initiate testosterone therapy for Patient 4 based on a single
12 low testosterone blood value is a simple departure from the standard of care.

13 92. Respondent's decision to initiate testosterone therapy for Patient 4 without
14 performing a digital prostate examination and to have an informed consent discussion with the
15 patient, or document an informed consent discussion, is a simple departure from the standard of
16 care.

17 93. Respondent's failure to perform follow up testosterone testing six months after
18 initiating hormonal therapy on Patient 4 is a simple departure from the standard of care.

19 **SECOND CAUSE FOR DISCIPLINE**

20 **(Failure to Maintain Adequate and Accurate Medical Records)**

21 94. Respondent Michael Yadegari, M.D. is subject to disciplinary action under section
22 2266 of the Code in that he failed to maintain adequate and accurate medical records for Patients
23 1 through 4. The circumstances are as follows:

24 95. The facts and allegations set forth in paragraphs 18 through 35, above, are
25 incorporated herein.

26 96. The facts and allegations set forth in the First Cause for Discipline, paragraphs 36
27 through 93, above, are incorporated herein.

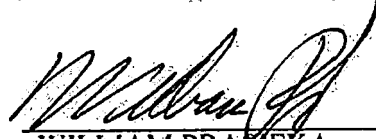
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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 100335, issued to Michael Yadegari, M.D.;
2. Revoking, suspending or denying approval of Michael Yadegari, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Michael Yadegari, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and,
4. Taking such other and further action as deemed necessary and proper.

DATED: JUN 30 2022



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

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