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

In the Matter of the First Amended Accusation Against: Kamyar Cohanshohet, M.D. Physician's & Surgeon's Certificate No A 86830 Petitioner.	Case No.: 800-2022-089200

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Benjamin Fenton, Esq. and Henry Fenton, Esq, attorneys for Kamyar Cohanshohet, for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on November 12, 2024.

IT IS SO ORDERED: NOV 13 2024

Michelle A. Bholat, MD

Michelle A. Bholat, M.D., Interim Chair
Panel A

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

In the Matter of the First Amended Accusation Against: **Kamyar Cohanshohet, M.D.** **Physician's & Surgeon's Certificate No. A 86830** **Respondent.**	**Case No. 800-2022-089200** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Benjamin Fenton, Esq. and Henry Fenton, Esq., on behalf of Respondent, Kamyar Cohanshohet, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of November 1, 2024, at 5:00 p.m.

Execution is stayed until November 12, 2024, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: October 31, 2024

JENNA JONES FOR
Reji Varghese
Executive Director
Medical Board of California

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

In the Matter of the First Amended Accusation Against: Kamyar Cohanshohet, M.D. Physician's and Surgeon's Certificate No. A 86830 Respondent.	Case No. 800-2022-089200

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 1, 2024.

IT IS SO ORDERED October 2, 2024.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

Michelle A. Bholat, M.D., Interim Chair
Panel A

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

In the Matter of the First Amended Accusation Against:

KAMYAR COHANSHOHET, M.D.

Physician's and Surgeon's Certificate No. A 86830,

Respondent.

Agency Case No. 800-2022-089200

OAH No. 2023070255

PROPOSED DECISION

Julie Cabos Owen, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on July 29, 30, and 31, and August 1, 2024. Reji Varghese (Complainant) was represented by Marsha E. Barr-Fernandez, Deputy Attorney General. Kamyar Cohanshohet, M.D. (Respondent) was represented by Benjamin Fenton and Henry Fenton, Attorneys at Law.

Prior to presentation of the evidence, Respondent made a "Motion in Limine to Exclude any Evidence Related to or Derived from any and all Cell Phone Returns and Text Messages (1) Obtained in Violation of Cal. C.C.P. § 1985.3 and (2) Outside the Scope of the Investigational Subpoena Duces Tecum" (Motion). Respondent's Motion

was heard by videoconference on May 10, 2024. For the reasons stated in the May 20, 2024 Ruling on Respondent's Motion, and as summarized in the Legal Conclusions, below, the ALJ denied Respondent's Motion.

Testimony and documents were received in evidence. The record closed and the matter was submitted for decision on August 1, 2024.

FACTUAL FINDINGS

Jurisdictional Matters

1. On April 21, 2004, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate Number A 86830 (license) to Respondent. That license is scheduled to expire on September 30, 2025.

2. On January 3, 2024, Complainant filed the First Amended Accusation while acting in his official capacity as the Executive Director of the Board. Respondent had filed a Notice of Defense to the original Accusation, and this hearing was scheduled.

Respondent's Provision of Controlled Substances to Patients

BACKGROUND INFORMATION

3. Respondent practices internal medicine. He is no longer certified by the American Board of Internal Medicine; his board certification expired four to nine years ago. Respondent does not have any current hospital privileges. He runs a solo private practice named Beverly Hills Pain Clinic. Respondent treats chronic pain patients, but he is not a pain management specialist.

4. Respondent is not licensed to practice medicine in any state other than California.

5. As set forth more fully below, Respondent provided controlled substances to Patient A, Patient B, Patient C, and Patient D. (For privacy protection, Patient names are not used.) The controlled substances Respondent provided to these patients included: (1) alprazolam - a benzodiazepine and central nervous system depressant used to treat anxiety disorders (brand names including Xanax), listed as a Schedule IV controlled substance (Health & Saf. Code, § 11057, subd. (d)(1)); (2) clonazepam - a benzodiazepine-based sedative used to control seizures and panic disorder (brand name Klonopin), listed as a Schedule IV controlled substance (Health & Saf. Code, § 11057, subd. (d)(7)); (3) hydrocodone - a semisynthetic opioid analgesic (brand names including Norco and Vicodin when mixed with varying percentages of acetaminophen), listed as a Schedule II controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(I)); (4) hydromorphone - an opioid pain medication (brand names including Dilaudid), listed as a Schedule II controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(J)); (5) methadone - a synthetic, long-acting opioid used to treat opioid dependence, listed as a Schedule II controlled substance (Health & Saf. Code, § 11055, subd. (c)); (6) oxycodone - an opioid analgesic used for pain (brand names including OxyContin and Roxicodone; brand name Percocet when combined with acetaminophen), listed as a Schedule II controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(M)); (7) zaleplon - a sedative used for short-term treatment of insomnia (brand name Sonata), listed as a Schedule IV controlled substance and narcotic (Health & Saf. Code, § 11057, subd. (d)(31)); and (8) zolpidem - a sedative primarily used to treat insomnia (brand names including Ambien and Intermezzo), listed as a Schedule IV controlled substance and narcotic (Health & Saf. Code, § 11057,

subd. (d)(32)). These controlled substances are also considered dangerous drugs. (Bus. & Prof. Code, § 4022.)

6. During the relevant time periods, Respondent's prescriptions for controlled substances should have been filled by pharmacies and reported to the Controlled Substance Utilization Review and Evaluation System (CURES). CURES allows healthcare prescribers, pharmacists, law enforcement, and regulatory boards to view patients' and providers' controlled substance prescription histories.

7. The facts set forth below (regarding Respondent's obtaining and providing controlled substances to his patients) were established by the credible testimony of Board Investigators Liana Akopova and Evan McNally, along with CURES reports, text messages, and other documentary evidence. (Complainant obtained the text messages by investigational subpoena to another law enforcement agency that secured them via search warrant. The texts were the subject of Respondent's pre-trial Motion that was denied.)

8. Respondent testified at the administrative hearing in an evasive and occasionally scornful manner. His speech was rapid, agitated, and often unintelligible. Respondent refused to admit any wrongdoing, and he provided rambling and sometimes sarcastic or outrageous responses on cross examination. Many of Respondent's assertions and denials were contradicted by the evidence. Consequently, Respondent's testimony lacked credibility and was unreliable to establish any factual findings.

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PATIENT A

9. On numerous occasions between December 2021 and June 2022, Respondent provided controlled substances to Patient A, a 70-year-old male who lived in Massachusetts and in Florida.

10. Respondent has never been licensed to practice medicine in Massachusetts or Florida.

11. Between December 2021 and June 2022, Respondent communicated with Patient A by using a non-face-to-face platform, i.e., unsecured text messages. Respondent kept no medical records for Patient A.

12. In his text communications with Patient A, Respondent did not document: discussions about Patient A's medical history; any physical examination of Patient A; any of Patient A's diagnoses or the indications for providing Patient A the controlled substances; any treatment plan; discussions about the risks, benefits, and potential side effects of, or alternatives to, the controlled substances; discussions about whether Patient A was experiencing any side effects or improvements from the medications; warnings to Patient A about potential negative or lethal drug interactions; or any recommendation that Patient A seek treatment from a local healthcare provider.

13. Respondent did not write prescriptions under Patient A's name, nor did Respondent report the controlled substances he provided to Patient A in the CURES database. Instead, Respondent acquired the controlled substances he provided to Patient A by filling prescriptions under the names of other individuals, including Patient A's wife and three fictious patients: Sam Danielson, Rebecca Millar, and Janet Parker.

14. Respondent's prescriptions for the three fictitious patients were always filled at Old Pasadena Pharmacy.

15. At the hearing, Respondent testified that Patient A's name did not appear in CURES reports as a patient for whom Respondent wrote prescriptions because Patient A is famous and "uses an alias with medications." Respondent insisted, incorrectly, that it is lawful to prescribe medications using a patient alias. Additionally, the alias Respondent purported to use for Patient A, "Alonzo," did not appear in any CURES reports. When shown the absence of the "Alonzo" alias in the CURES reports, Respondent stated, "That is too bad."

16. The evidence (including text exchanges and corresponding CURES reports) of Respondent's numerous fictitious prescriptions and provision of controlled substances to Patient A is extensive and will not be detailed below. However, examples of Respondent's modus operandi are cited below.

17. Respondent and his assistant, Claire, typically followed the same process when filling fictitious prescriptions to provide to Patient A. Patient A would text Respondent requesting "a prescription." (E.g., Exhibit 40, p. A278 [12/15/21 Patient A text at 8:19:16 p.m., "Hi Dr K, can you possibly send a prescription tomorrow?"].) Patient A specified or confirmed where Respondent should send the prescription, typically to either Brookline, Massachusetts or Captiva, Florida. (E.g., Exhibit 40, p. A279 [12/15/21 texts at 8:19:26 p.m. and 8:19:34 p.m., confirming that Respondent should send the prescription to Brookline].) Respondent would text Claire and ask if she could "go see Raul" (E.g., Exhibit 40, p. A541 [12/16/21 text at 7:57:37 a.m., "Can you go see Raul? Send Sonata and Oxy to Brookline."].) Claire would respond that she needed to check to see "who is up." (E.g., Exhibit 40, p. A542 [12/16/21 text at 8:24:10 a.m.].) Claire apparently had to confirm which fictious patient was due for a refill of a

particular controlled substance. Sometimes, there was "no one up" to receive a refill. (E.g., Exhibit 40, p. A542 [12/16/21 texts from Claire to Respondent at 9:50:54 a.m. and 9:51:12 a.m., "No one is up for sonata. Until end of the month/early January."].) Respondent occasionally had some of the requested medication in his possession. (E.g., Exhibit 40, p. A543 [12/16/21 text from Respondent to Claire at 10:55:46 a.m., "I have a Sonata. Let[']s get the rest."].) The same day, a prescription for the requested controlled substance was filled under one of three fictious patients' names at Old Pasadena Pharmacy. (E.g., Exhibit 93, p. A2470 [filling prescription for Rebecca Millar for oxycodone 150 tablets].) Thereafter, Claire would provide Respondent with the tracking number for the shipment, and Respondent would text Patient A the tracking number. (E.g., Exhibit 40, p. A551 [12/16/21 Claire text to Respondent at 3:44:21p.m., "Tracking #775525285102"], and p. A280 [12/16/21 Respondent text to Patient A at 5:20:01 p.m., "Tracking #775525285102."].) Patient A would typically confirm receipt of the controlled substances. (Exhibit 40, p. A281 [12/17/21 Patient A text to Respondent at 1:38:40, "Got here right at 8:30 this morning."].)

18. During the Board investigation, Investigator McNally confirmed the three purported patients (Sam Danielson, Rebecca Millar, and Janet Parker) were fictitious. A search of government databases revealed no records for any individuals with the three patients' names and dates of birth, and their listed addresses did not exist. Additionally, text messages between Respondent and Claire indicate their intent to input false phone numbers for three patients into an electronic health system to facilitate electronic prescriptions. Specifically, on January 7, 2022, at 12:58:08 p.m., Claire texted Respondent, "For the patients at Raul's[,] because only e-scripts are accepted, to send I need to input the patients info to [the electronic health records system.]"(Exhibit 40, p. A640.) A few minutes later, at 1:05:51 p.m., Claire texted Respondent, "The 3 Raul patients also need phone numbers added in the system to

send e-scripts. What do I enter?" (Exhibit 40, p. A641.) At 1:24:27 p.m., Respondent texted Claire, "Get 3 Google Voice #s for Raul. If you can't get 3, then as many as you can. Use [Respondent's phone number] as one of them if needed." (Exhibit 40, p. A641.)

19. The prescriptions Respondent filled for Patient A under the three fictious patients' names included oxycodone, zaleplon (brand name Sonata), and clonazepam (brand name Klonopin).

20. Respondent shipped the controlled substances to Patient A at non-pharmacy locations (i.e., residences) in Massachusetts and Florida.

21. In addition to sending controlled substances to Patient A at non-pharmacy locations in Massachusetts and Florida, Respondent also delivered controlled substances to Patient A at a hotel in California.

22. On April 14, 2022, Patient A texted Respondent, "I have to come out to Santa Monica for a couple of days. I need some of the pain meds. Can you send some down to me at my hotel? The room is in my wife's name. [Patient A's wife's name]/guest Room number [###] Le Meridien Hotel 530 Pico Blvd. Santa Monica, CA 90405 Thanks!" (Exhibit 40, p. A330.) Respondent asked when Patient A was coming, and Patient A informed him he would arrive the next day. (Exhibit 40, p. A331.) Respondent texted Claire, "Can you go see Raul and also renew [Patient B]?" (Exhibit 40, p. A1076.) Claire asked Respondent, "Do we need a label?" and Respondent texted back, "No. I have to drop it off to him in St. Monica." (Exhibit 40, p. A1077.) The same day, prescriptions for oxycodone, zaleplon (Sonata), and hydromorphone (Dilaudid) were filled under one of three fictious patients' names at Old Pasadena Pharmacy. (E.g., Exhibit 93, pp. A2372-A2373 [filling prescriptions for Sam Danielson].) Later the

same day, Respondent texted Patient A, "I have it in hand so please just tell me when you want me drop it off." (Exhibit 40, p. A331.) Patient A informed Respondent that Patient A's wife was already at the hotel and Respondent could drop off the medications that day or the next. (Exhibit 40, p. A332.) Respondent asked Patient A, "Will she know what the package contains, or does it need to be "cloaked" (I can't think of the right word)?" (Exhibit 40, p. A322.) Patient A assured Respondent that Patient A's wife was aware of the delivery, and Respondent agreed to deliver it the next day. (Exhibit 40, pp. A332-A333.)

23. On April 15, 2022, Respondent delivered oxycodone and zaleplon (Sonata) to the hotel in Santa Monica. He did not deliver the hydromorphone (Dilaudid). Respondent texted Patient A, "I left it at the front desk [for] you it's under your wife's name. It's in a Starbucks bag." (Exhibit 40, p. A334.) The same day, Patient A texted Respondent to thank him for the prescription and to ask about delaying payment for the zaleplon (Sonata), noting, "[I]f you look at the text chain I only asked for the pain meds [i.e., oxycodone]. Can you delay billing on the sonata for a week or two? It would help. Again, thanks for dropping the package off[.]" (Exhibit 40, p. A335.)

24. In addition to using the three fictious patients, Respondent wrote at least two prescriptions for Patient A under Patient A's wife's name.

25. On May 9, 2022, Respondent was unable to immediately acquire zaleplon (Sonata) for Patient A. Respondent texted Patient A, explained his dilemma, and offered to call in the prescription to a pharmacy in Massachusetts under Patient A's wife's name. Respondent's May 9, 2022 text noted his previous use of Patient A's wife's name to issue a prescription to Patient A. Specifically, Respondent texted Patient A:

> I have bad news. We are unable to get any Sonata until later this week ... most likely Thursday. Looking back, it appears as if I haven't been sending them more frequently these past few weeks forcing us to wait until more becomes available. I will make every effort to expedite the process. If you are in dire straits, I think we once called in a script under your wife's name and I would not be opposed to doing so again if you so wish[.]

(Exhibit 40, p. A346, 9/5/2022 text at 1:55:47 p.m.)

26. Patient A accepted Respondent's offer, and he provided Respondent with his wife's information and the pharmacy phone number. (Exhibit 40, pp. A346-A347.) Respondent provided Claire with the information to call in the prescription for zaleplon to the pharmacy in Massachusetts, and he informed Claire the patient information was for Patient A's wife. Claire confirmed she sent the prescription. (Exhibit 40, pp. A1127-A1128.) Respondent texted Patient A, informing him, "The Sonata order is in. I wrote for #30 to minimize any scrutiny by the Pharmacist, but I did include a refill. Please let me know once you pick them up." (Exhibit 40, p. A347.) Later that day, Patient A texted Respondent to thank him and confirm that he had picked up the zaleplon (Sonata) prescription called in under Patient A's wife's name. (Exhibit 40, p. A349.)

RESPONDENT'S POSSESSION OF DILAUDID TABLETS

27. Respondent prescribed 150 hydromorphone (Dilaudid) tablets, twice per month, to each of the three fictious patients. Typically, when Respondent obtained Patient A's controlled substances, he also filled prescriptions for hydromorphone

(Dilaudid) tablets under one of the fictitious patients' names. Respondent did not provide the hydromorphone to Patient A, but retained it in his possession, custody, or control.

28. To gain possession of the Dilaudid, Respondent texted Claire on numerous occasions to ask if she could "Uber" or deliver the "pills" to Respondent's home. (E.g., Respondent texted Claire: on 1/2/22, "Can you Uber those pills?" (Exhibit 40, p. A606); on 1/9/22, "Can you Uber those pills?" (Exhibit 40, p. A642); on 1/11/22, "Can you drop off those pills please, I'm home." (Exhibit 40, p. A648); on 1/31/22, "uber to raul and get those pills to me right away." (Exhibit 40, p. A721); on 2/22/22, "Please UBER the pills at 11 tonight." (Exhibit 40, p. A847); on 5/12/22, "do you have any pills with you that you can uber?" (Exhibit 40, p. A1140); and on 5/24/22, "can you uber the pills?" (Exhibit 40, p. A1175). Text exchanges between Respondent and Claire confirmed she took an Uber to his home to deliver "pills." (E.g., Exhibit 40, pp. A1176 - A1179.)

29. Sometimes, rather than asking Claire to deliver the pills to his home, Respondent instructed her to "leave the pills in the drawer" at his medical office, and she would confirm she did so. For example, on December 22, 2021, Respondent texted Claire, "Where will you put the meds from Raul?" (Exhibit 40, p. A570.) Claire responded, "I can drop them at yours or the office tomorrow?" (Exhibit 40, p. A571.) Respondent instructed her, "Bring to office tomorrow." (Exhibit 40, p. A571.) On December 23, 2021, Claire texted Respondent, "Pills are in your drawer." (Exhibit 40, p. A573.) (See also Exhibit 40, p. A1011-A1012 [4/1/22 text from Respondent, "Go home. I'll call you later. Leave the pills in the drawer," and Claire's response, "Leaving pills in drawer."].)

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30. Text exchanges between Respondent and Claire indicated the "pills" to which they referred included Dilaudid prescribed for fictitious patients through "Raul." For example, on February 14, 2022, Respondent texted Claire, "Did you get the pills from Raul?" (Exhibit 40, p. A816.) Claire responded, "Sonata isn't up until next week. They can fill the oxy but only partial of the dilaudid - until they get the new shipment in tomorrow." (Exhibit 40, p. A 8A17.) Respondent asked Claire, "Can you drop off what you have?" (Exhibit 40, p. A8A17.) Additionally, at least one text message between Respondent and Patient B indicated Respondent had a supply of Dilaudid at his disposal. (E.g., Exhibit 40, p. A496 [6/12/22 text from Respondent to Patient B, "If you want a handful of Dilaudid, I'll trade you for some rock."].)

PATIENT B

31. On numerous occasions between December 10, 2021, and November 21, 2022, Respondent provided controlled substances to Patient B, a 43-year-old male. The controlled substances Respondent provided included hydrocodone with acetaminophen (brand name Norco) and sildenafil (brand name Viagra).

32. Between December 10, 2021, and November 21, 2022, Respondent communicated with Patient B using a non-face-to-face platform, i.e., unsecured text messages. Respondent kept no medical records for Patient B.

33. In his text communications with Patient B, Respondent did not document: discussions about Patient B's medical history; any physical examination of Patient B; any of Patient B's diagnoses or indications for providing Patient B the controlled substances; any treatment plan; discussions about the risks, benefits, and potential side effects of, or alternatives to, the controlled substances; discussions about whether

Patient B was experiencing any side effects or improvements from the medications; or warnings to Patient B about potential negative or lethal drug interactions.

34. On numerous occasions between December 10, 2021, and November 21, 2022, Patient B texted Respondent requests for prescriptions of a specified number (typically 45 but later increased to 60) of "norcos" or sildenafil (Viagra). Patient B's requests were closely preceded or closely followed by text discussions about Patient B acquiring, delivering, and receiving payment for illicit substances that Patient B provided to Respondent, indicating Respondent prescribed the controlled substances to Patient B partially in exchange for Patient B delivering illicit substances to Respondent.

35. The evidence (including text exchanges and corresponding CURES reports) of all Respondent's discussions with and prescriptions for Patient B is extensive and will not be detailed below. However, examples of typical exchanges are cited below.

36. On December 20, 2021, at 5:50 p.m., Patient B texted Respondent, "Good afternoon. Can u call for another 45 norcos. I only have a couple left." (Exhibit 40, p. A389.) On December 21, 2021, at 11:56 a.m., Respondent answered, "Can you get Coke? [slang for cocaine] It's has to be quality." (*Id.* at p. A390.) The same day, at 2:03 p.m., Patient B responded, "How much u want?" At 2:04 p.m., Respondent stated, "8 ball. [slang for one-eighth ounce of a psychoactive drug]. It can't be disgusting. Please." (*Ibid.*) At 2:05:09 p.m., Patient B texted Respondent, "Can u send script to Walgreens for 45 norcos please[?]" (Id. at p. A391.) At 2:05:41 p.m., Respondent answered, "Yes." (*Ibid.*) At 2:06:10 p.m., Patient B responded, "I am gonna make some calls for the c." (*Ibid.*) At 2:07 p.m., Respondent texted, "I'll buy more if that helps with quality." (*Id.* at p. A392.) At 2:57 p.m., Patient B texted, "I am waiting on a call back, Can

u send the script now please." (*Id.* at p. A392.) At 3:05 p.m., Respondent texted, "Your Norco is ordered. #45 to Walgreens." (*Id.* at p. A393.) On December 22, 2021, Patient B. texted Respondent, "Its 300 for the ball. U want it[?] I'm going to get it now. You can venmo me the money." (*Id.* at p. A393.) Respondent responded, "Did you get it? I'll give you cash." (*Id.* at p. A394.)

37. In several text exchanges, Respondent complained about the quality of the substances Patient B provided; this indicated that Respondent personally ingested the illicit substances. (E.g., Exhibit 40 p. A404 [1/17/22 text from Respondent, "Last batch was really bad. I threw it away." Patient B response, "I have someone else I can get it from."]; pp. A407-A408 [1/26/22 text from Respondent, "Roll through. The stuff was a little better . . . still shit though." Patient B. response, "I haven't found anything good yet."]; pp. 418-421 [2/15/22 Patient B text to Respondent, "Can u call in script for 45 norcos please" and Respondent responded "I already did it. I hook you up and then you screw me over? That last batch was shit!"].) More detailed examples are set forth below.

38. On February 7, 2022, Patient B texted Respondent, "Hello Dr k. Do u need anything?" (Exhibit 40, p. A413.) Respondent answered, "I'm not gonna smoke any more garbage. I'll pay more, but not for kaka (*Id.* at p. A414) Patient B responded, "I have a quarter of some better stuff but it's 150 for the quarter." (*Id.* at pp. A414-A415.) Respondent answered, "Bring a half of it. If it is kaka, I'm done." (*Id.* at p. A415.) Patient B texted, "I will bring u what I have. Its 200 worth. Everyone says its better. I am [on my way] now." (*Ibid.*)

39. On March 1, 2022, respondent texted Patient B "What happened to the Coke I asked for?" Nobody you know has some decent cocaine? I can just go to the doorman at the W Hotel and get some faster than asking you." (Exhibit 40, p. A422.)

Patient B responded, "I can get some now its 320 for the ball. But I need the money to get it. Its better then decent. Its fire from what my friend says. He won't do anything if its not almost pure." (*Id.* at p. A423.) Respondent answered, "How about $160 for a half?" then "Never mind. I have $320." (*Id.* at p. A424.)

40. On May 23, 2022, Respondent texted Patient B "do you think you can get your hands on some prime time grade A shit? I'll pay double of you can. Maybe even triple. I'm serious. $600." (Exhibit 40, pp. A480-A482.) Patient B agreed. Respondent texted, "I just sent you $600. This stuff better be good." (*Id.* at p. A485.) After a discussion about Patient B's estimated time of arrival, he texted, "Did u send script to walgreens for me[?]" (*Id.* at p. A488.)

41. In one text exchange, Respondent also complained about the amount of the illicit substance Patient B had previously provided, further indicating his personal ingestion of the substance. On March 5, 2022, Respondent texted Patient B, "Can you get more? (Exhibit 40, p. A432.) When Patient B asked how much, Respondent answered, "I don't know. Last time I was supposed to get a ball and it was not even close. . . . I'll bring a scale to your car and if it's short, I pay nothing. Deal? . . . the last ball was almost half off." (*Id.* at p. A433-A434.) Patient B insisted it was weighed correctly, explaining, "It weighs more then [*sic*] the clear that[']s why it looks smaller." (*Id.* at p. A433.) Respondent later texted, "I don't mean to cause a big stink. Tell you what, just bring it but do me a favor and go to WALLGREENS [*sic*] and get some insulin syringes. I don't have a car." (*Id.* at p. A435.) A couple hours later Respondent texted, "Do you know when you might be arriving?" (Id. at p. A436), and Patient B texted, "Can u call in a script of 45 norcos tomorrow please[?]" (Id. at p. A437). Respondent agreed. The next day, Respondent texted Patient B, "Please don't forget to get insulin syringes (short). Wallgreeens [*sic*] St. Monica and Beverly Glen will sell them 'no questions

asked.'" (*Id.* at p. A439.) Patient B responded, "Can u call in my script for my norcos please[?]" (*Id.* at p. A440.)

42. On one instance (June 12, 2022), when Respondent was unable to have Claire call in Patient B's prescription on a Sunday, he texted Patient B, "I asked my girl to do it, but it's Sunday so I don't know if she will do it today cuz she is not technically working right now. I don't know how to do it myself. I'll keep you posted. If you want a handful of Dilaudid, I'll trade you for some rock." (Exhibit 40, p. A496.) ("Rock" is slang for crack cocaine.)

43. At hearing, Respondent's testimony about his interactions with Patient B lacked any credibility. Respondent denied prescribing Norco for Patient B in exchange for delivery of illicit drugs, but admitted he asked Patient B to obtain drugs for him. Respondent denied obtaining the illicit drugs for self-consumption, insisting the acquisitions did "not mean [Respondent] was taking them." He asserted he obtained them "when a friend wanted some or maybe [he was] invited to a bachelor party." Additionally, when asked on cross examination about the content of his texts with Patient B, Respondent gave sarcastic and sometimes outrageous answers. For example, when asked what he meant by "ball" or "8 ball" (these are references to the weight of the drug), Respondent answered flippantly, "[It] could be a basketball or football or ball of cocaine or meth." When asked what he meant when he complained about the "last batch" being "really bad" (Exhibit 40, p. A404), Respondent stated he meant "coffee." When asked what he meant in his May 23, 2022 text asking Patient B to get "some prime time grade A shit," Respondent again answered "coffee." When asked if Patient B was his "coffee provider," Respondent sarcastically answered, "Yes."

44. Respondent confirmed he allowed patients to tell him how many tablets of medication to prescribe (e.g., Patient B asking for 45 and then 60 Norcos) because

"they are the ones taking [the medication], and as a courtesy, I allow them to tell me how many they need." Respondent insisted it was within the standard of care to allow a patient to dictate the amount of the controlled substance he or she is prescribed.

PATIENT C

45. On numerous occasions between December 8, 2021, and November 21, 2022, Respondent provided controlled substances to Patient C, a 62-year-old male. The controlled substances Respondent provided included methadone and alprazolam (brand name Xanax).

46. Approximately once per month between December 8, 2021, and November 21, 2022, Patient C filled prescriptions Respondent issued for methadone, 165 tablets, at a 10-milligram dosage (17 total prescriptions with a total of 28,050 milligrams of methadone over the 11-month interval). Approximately once per month, Patient C filled prescriptions (13 total) Respondent issued for alprazolam at a two-milligram dosage, initially 60 tablets each time, and increasing to 90 tablets on May 31, 2022.

47. Between December 8, 2021, and November 21, 2022, Respondent communicated with Patient C using a non-face-to-face platform, i.e., unsecured text messages. Patient C typically texted Respondent to request refills on his methadone and alprazolam prescriptions.

48. The evidence (including text exchanges and corresponding CURES reports) of Respondent's discussions with and prescriptions for Patient C is extensive and will not be detailed below. However, selected exchanges are cited below.

49. On April 6, 2022, Respondent texted Patient C:

> I'm terribly sorry, but I can't prescribe Provigil. We will run into the same problem as we did with Xanax. Please note that memory loss, difficulty with concentration and fatigue are all side effects of Methadone. Please try to reduce your daily dose to see if your symptoms get better. Please feel free to call if you have further questions or concerns.

(Exhibit 40, p. A2559.)

50. On April 12, 2022, Patient C responded, "Thanks a-lot, if you notice i have decreased methadone quiet [*sic*] a bit over the past 2 years. I will keep working in decreasing even more." (Exhibit 40, p. A2559.) A couple minutes later, Patient C texted Respondent requesting an increase in his methadone prescription. Specifically, Patient C texted, "Dear Dr K, i want to increase the reserve on methadone a little more. If you see for almost a year i have filled once per month. Just give me another Rx. I am ok on Xanax. I want to have extra methadone on hand in case there is a shortage in the market." (Exhibit 40, p. A2559.) On April 14, 2022, Respondent issued Patient C's prescription for methadone.

51. On April 29, 2022, in response a text from Patient C, Respondent answered, "Which medication do you need refilled? Can you give me a daily schedule of your med intake please . . . times and dosage for both medications." (Exhibit 40, p. A2564.) In his response, Patient C asked Respondent for Xanax and methadone. Patient C informed Respondent that his wife was concerned about him taking methadone for such a long time even with a decrease. (Exhibit 40, p. A2565.)

52. On May 20, 2022, at 11:58 a.m., Respondent texted Patient C, "How many Methadone are you taking per day?" (Exhibit 40, p. A2572.) A few minutes later,

Respondent texted Patient C about discovering Patient C had gone to another doctor for a Xanax (alprazolam) prescription. Respondent stated:

> You are fully aware that the Medical Board is just looking for an excuse to revoke my license. You are also aware that they expect me to treat my patients like children and make sure they are getting their meds from only 1 Physician. They want me to check CURES and make sure of this policy of only 1 physician prescribing controlled substances. Moreover, it is highly advisable that patients not take Opiates and Benzos concurrently, but I have prescribed this to you without fail without any attempt to wean you off. It should not have been too much to expect that you would have [a] little respect for me and what I do by not going to [the other doctor] for more Xanax.

(Exhibit 94, p. A2573.)

53..... The same day (May 20, 2022), Patient C texted Respondent regarding Board investigators seeking a signed consent for Respondent's release of Patient C's medical records. Patient C texted Respondent, "Do you want me to text you the letter? I have to respond in 2-3 days i think." (Exhibit 94, p. A2576.) When Respondent asked, "What letter?," Patient C responded, "Two people showed up at my door and left a packet. .....Apparently, it is for some questions, I don't want to answer something wrong. I wanted your permission before texting it to you. It is 3-4 pages." (Exhibit 94, p. A2577) Patient C texted Respondent screen shot pictures of a Medical Board investigator's business card and a consent for Respondent's release of Patient C's medical records. Respondent texted back, "That makes sense. They are investigating

me because of what happened with [the other doctor]. I told you that I get [in] trouble when you get your pills from another doctor. Ignore the letter and stop getting Xanax from [the other doctor]." (Exhibit 94, p. A2581.) Patient C later texted Respondent, "I will never do anything to hurt you. However i have on my own cut the pain medication to last 30 days instead of 15 days as it is on the label. I will ignore the letter." (Exhibit 94, p. A2582.)

54. Respondent later texted Patient C, "[S]ince [the other doctor] obviously has no problem prescribing Xanax, please just ask him for it moving forward, As I have indicated, I am not supposed to be prescribing it to begin with. I have only done so because it was my understanding that you were unable to secure another Physician to do it. As far as the papers go, do whatever you think is best." (Exhibit 94, p. A2584.)

55. Patient C never provided a signed consent for Respondent's release of his medical records to the Board.

56. In his text communications with Patient C, Respondent did not document: discussions about Patient C's medical history; any physical examination of Patient C; any of Patient C's diagnoses or indications for providing Patient C the controlled substances; any treatment plan; discussions about the risks and benefits of, or alternatives to, all of the controlled substances provided; or continuing discussions about whether Patient C was experiencing any side effects or improvements from the medications.

57. Despite Respondent's May 20, 2022, text to Patient C that he was "not supposed to be prescribing" alprazolam (Xanex) to Patient C, Respondent continued to prescribe alprazolam to Patient C. Respondent increased the quantity prescribed from 60 to 90 pills per prescription on May 31, 2022.

PATIENT D

58. Patient D was a 35-year-old male at the time of his first documented interaction with Respondent on May 2, 2011. At that time, Patient D reported a history of chronic low back pain, degenerative disc disease of lumbar spine, and bilateral knee surgeries. Patient D reportedly also had anxiety, sleep apnea, and a sinus condition for which he was to have reconstructive surgery. On that date, among other things, Respondent prescribed Norco to Patient D.

59. From May 2, 2011, until August 28, 2018, Respondent continuously prescribed Patient D controlled substances, including a variety of opioids: Norco, Percocet, oxycodone, oxycontin, and hydromorphone (Dilaudid). (Specifics regarding the opioid prescriptions are detailed below.) Prescriptions or refills generally occurred every 10 to 15 days. Respondent also regularly prescribed Patient D sedatives: zolpidem (Ambien) (November 2011 through January 2015), and zaleplon (Sonata) (several times between May 2016 and April 2018). In 2016 and 2018, Respondent also prescribed Patient D benzodiazepines a few times: clonazepam (brand name Klonopin) and alprazolam (Xanax).

60. Over the years, Respondent made several changes and increases to Patient D's prescribed pain medications, but he did not significantly decrease the dosage or number of tablets prescribed. In 2011, Respondent initially prescribed Norco, 60 tablets, increasing to 75 tablets and then 90 tablets in 2011, then increasing to 180 tablets in 2012. On March 5, 2012, Respondent began prescribing Percocet, initially 90 tablets, then increasing to 180 tablets on March 22, 2012. In April 2012, Respondent prescribed both 180 Norco tablets and 180 Percocet tablets. In June 2012, Respondent discontinued the Norco and Percocet, and he prescribed 180 tablets of 20 milligram oxycodone; he increased the dosage to 30 milligrams in October 2012, with

the same number of tablets. On March 12, 2013, Respondent issued Patient D a prescription for 150 tablets of 30 milligram oxycodone, and he added a prescription for 30 tablets of 40 milligram OxyContin. On April 9, 2013, Respondent continued the prescription for OxyContin (40 milligram, 30 tablets), and he increased the prescription for 30 milligram oxycodone to 180 tablets. This continued for eight months until December 2013, when Respondent eventually increased the oxycodone dosage to 40 milligrams and the number of tablets to 215 tablets, and he replaced the OxyContin with 45 tablets of four milligram Dilaudid. In January 2014, Respondent reduced the oxycodone dosage to 30 milligrams (still 180 tablets), and he decreased the number of Dilaudid tablets to 30 (still four milligram dosage). By February 2014, Patient D listed he was taking an average of 12 oxycodone tablets (30 milligrams each) and two Dilaudid tablets (four milligrams each) per day. In 2014 and 2015, Respondent made slight changes to the tablet numbers (in March 2014, he decreased oxycodone to 170 tablets; in April 2014, he decreased oxycodone to 150 tablets, but increased Dilaudid to 60 tablets; then for a few months, he increased oxycodone to 170 tablets and decreased Dilaudid to 30 tablets; in June 2014, he increased oxycodone to 180 tablets and Dilaudid to 60 tablets; in December 2014, he increased oxycodone to 225 tablets and Dilaudid to 90 tablets; in January 2015, he returned the oxycodone to 180 tablets and the Dilaudid to 60 tablets), but the prescription pattern was generally 180 tablets of 30 milligram oxycodone and 60 tablets of four milligram Dilaudid. At some point between January 2015 and March 2017, Respondent increased the Dilaudid dosage to eight milligrams, and he continued prescribing 15-day supplies of 180 tablets of eight milligram Dilaudid and 180 tablets of 30 milligram oxycodone through August 2018. On many occasions, Respondent prescribed the oxycodone and Dilaudid simultaneously or within days apart.

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61. In October 2021, Respondent produced to the Board the medical records he had maintained for Patient D. (Exhibit 61.) On the first page of the produced records is a September 27, 2018 letter (cover letter) from Respondent stating, "This patient medical summary is in lieu of providing the whole medical chart, as it is my right under California law. Included are [Patient D's] initial paperwork and consent forms along with this summary." (Exhibit 61, p. A2000.) Respondent provided no justification for his failure to produce Patient D's entire medical chart, nor did he cite any law or regulation allowing him withhold portions of Patient D's medical records.

62. In his cover letter, Respondent acknowledges, "There is an ongoing investigation into possible aberrant behavior." (Exhibit 61, p. A2000.) Respondent seeks justify his prescriptions to Patient D, stating, "I am writing on behalf of my patient, [Patient D] to document the medical necessity of: OXYCODONE 30mg tablets & DILAUDID 8mg tablets." (*Ibid.*)

63. In his single-page cover letter, Respondent provided a summary of Patient D's purported history, diagnoses, and treatment. Respondent indicated he prescribed oxycodone and Dilaudid "for the treatment of Chronic Pain Syndrome (689.4). Stemming from, Degenerative Disc Disease of l-Spine (M51.36), Cervicalgia (M54.2), Lumbago (M54.5), Lumbar Radiculitis (M54.16), Temporomandibular Joint Disorders (M26.60) and Chronic Lower Back Pain (G89.29)." (Exhibit 61, p. A2000.) Respondent also noted Patient D had a "[s]leep study performed, results consistent with intermittent apnea." (*Ibid.*) However, Respondent did not document any physical examination, and it is unclear how he arrived at the listed diagnoses. Respondent included a summary of Patient D's "past treatments" (e.g., "ROLF Therapy," NSAIDs, "Acupuncture, Chiropractor, Physical Therapy," and epidural injections) without any indication of when and from whom he learned this information. (Exhibit 61, p. A2000.)

Respondent also asserted Patient D had made multiple functional improvements to support Respondent's treatment.

64. Patient D's medical records contain a 2011 initial patient intake form with Patient D's chief complaints and some medical history; two letters from Respondent to justify increasing Patient D's prescribed pain medication after insurance denials; photocopies of handwritten prescriptions; and a CURES report. The records also contain a billing statement for 72 "Comprehensive Office Visits" between 2015 and 2018 (Exhibit 61, A2025-A2029). Respondent's medical records for Patient D contain no office visit notes to document what occurred at the purported visits.

65. Given the absence of office progress notes, Respondent did not make or maintain documentation of: Patient D's chief complaints at each "office visit;" Patient D's subjective comments regarding any symptoms; physical examinations performed by Respondent; data relied upon by Respondent in making his assessment at each office visit; assessments and diagnoses of Patient D's conditions; or Respondent's recommended treatment plans to address Patient D's conditions.

66. Due to the absence of progress notes, Respondent did not document: the clinical indication for any controlled substances he prescribed to Patient D; discussions with Patient D regarding the risks or benefits of taking the controlled substances; discussions regarding the potential side effects of the medications or whether Patient D was experiencing any side effects; conversations wherein Respondent warned Patient D about potential negative and/or lethal drug interactions, including the dangers of combining opioids and benzodiazepines; whether Patient D was experiencing improvement in the conditions for which the controlled substances were being prescribed; or discussions about any non-opioid treatment options to supplant the controlled substances. Patient D's chart also lacks documentation that

Respondent requested or ordered laboratory tests or random toxicology screens to assist in determining possible diversion (for non-self-use) or exposure to illicit drugs that may adversely interact with the prescribed medications.

67. Respondent's cover letter summary is an apparent attempt to compensate for Respondent's failure to maintain any office progress notes in Patient D's medical records.

Respondent's Violations of Standard of Care

68. Complainant offered the uncontroverted testimony of Sammy Wong, M.D., to establish the standard of care in this case. Dr. Wong is licensed to practice medicine in California, and he has been a medical expert reviewer for the Board for about 15 years. He has been board certified in internal medicine since 1990.

69. Dr. Wong provided expert reports setting forth his opinions about Respondent's care and treatment of Patient A, Patient B, Patient C, and Patient D. (Exhibits 42, 43, 44, and 67.) Dr. Wong testified credibly and in general conformity with his reports. His opinions were persuasive and are adopted to establish the Factual Findings set forth below.

PATIENT A

70. Regarding the use of non-face-to-face platforms to communicate with patients, the standard of care requires physicians to sufficiently document encounters with patients to safely treat patients' conditions. The contents of non-face-to-face encounters should be incorporated into the patients' medical records. Physicians who communicate with their patients virtually should obtain and document the same information from the patient as with the traditional office visits, including side effects,

improvement with medication, and other concerns. The physician should also document and inform the patient of the indications for the medication, potential side effects, and alternative options. The physician should also document referrals to other providers.

71. Respondent prescribed oxycodone to Patient A for much longer than three months (at least from December 2021 through April 2022), implying the oxycodone was used for chronic pain. Respondent failed to document the various aspects of Patient A's pain and his response to the oxycodone, potential side effects, and pharmacologic and non-pharmacologic alternatives. Respondent failed to document the details of Patient A's insomnia and his response to the Sonata, potential side effects, and pharmacologic and non-pharmacologic alternatives. Respondent failed to document the various aspects of Patient A's anxiety and his response to the Klonopin, potential side effects, and pharmacologic and non-pharmacologic alternatives. Respondent failed to document any warning given to Patient A regarding potential complications of consuming oxycodone and Klonopin simultaneously. Respondent failed to document any recommendation that Patient A seek a physician where the patient resided for continued management of the patient's conditions.

72. Respondent committed an extreme departure from the standard of care by failing to sufficiently document encounters with Patient A to safely treat the patient's conditions.

73. The standard of care requires physicians licensed by the Board to prescribe controlled substances only for patients residing within the State of California. Additionally, the function of dispensing of regulated controlled substances is typically that of a state-licensed pharmacist. Physicians typically prescribe, but do not dispense controlled substances.

74. Respondent dispensed (obtained and shipped) controlled substances to Patient A to locations outside California. Respondent failed to recommend to Patient A that he seek and establish care with a local physician in his state of residence.

75. Respondent committed an extreme departure from the standard of care in dispensing controlled substances across state lines.

76. The standard of care requires a physician to prescribe medications for the correct individual who should also be a patient of the physician. The standard of care also requires the physician to prescribe medication for the appropriate indication and after performing a legitimate history and examination on a person.

77. Respondent had no doctor-patient relationship with, and had not performed a legitimate history and examination on, Patient A's wife when he prescribed medications at least two times under her name which were intended for Patient A.

78. Respondent committed an extreme departure from the standard of care when he prescribed medications for an individual with whom he had no doctor-patient relationship and without the appropriate history, examination, and indication.

PATIENT B

79. As noted in Factual Finding 70, when communicating with patients via non-face-to-face platforms, the standard of care requires physicians to sufficiently document encounters with patients to safely treat patients' conditions.

80. Respondent prescribed hydrocodone with acetaminophen (Norco) to Patient B for much longer than three months, implying the Norco was used for chronic

pain. Respondent failed to document the various aspects of Patient B's pain, his response to the Norco, any side effects, and alternatives to the Norco.

81. Respondent committed an extreme departure from the standard of care by failing to sufficiently document encounters with Patient B to safely treat the patient's conditions.

82. The standard of care requires physicians to treat patients objectively without expectation of personal benefit.

83. Respondent prescribed Norco (hydrocodone with acetaminophen) to Patient B to obtain personal benefit, i.e., illicit drugs, including cocaine, for Respondent's personal use. Respondent also offered to provide Patient B a "handful of Dilaudid" in exchange for delivery of crack cocaine. Dilaudid (hydromorphone) is four times more potent than morphine and hydrocodone. It is not within the standard of care to prescribe a "handful" of medication; a physician should prescribe a specific number of pills. Respondent should have pivoted his relationship with Patient B to that of a professional relationship.

84. Respondent committed an extreme departure from the standard of care when he failed to treat Patient B objectively without expectation of personal benefit.

PATIENT C

85. As noted in Factual Finding 70, when communicating with patients via non-face-to-face platforms, the standard of care requires physicians to sufficiently document encounters with patients to safely treat patients' conditions.

86. Respondent failed to document the various aspects of Patient C's pain and his response to the methadone, and pharmacologic and non-pharmacologic

alternatives. Respondent failed to document the details of Patient C's anxiety and his response to the alprazolam, potential side effects, and pharmacologic and non-pharmacologic alternatives. Respondent failed to document any warning given to Patient C regarding potential complications of consuming methadone and alprazolam simultaneously.

87. Respondent committed an extreme departure from the standard of care by failing to sufficiently document encounters with Patient C to safely treat the patient's conditions.

88. The standard of care requires physicians to prescribe doses of controlled substances in a safe manner.

89. Respondent prescribed Patient C a total of 28,050 milligrams of methadone over an 11-month interval (December 14, 2021, through November 14, 2022). The total morphine milligram equivalent (MME) prescribed for that 11-month interval was 84,150 milligrams. The morphine equivalent daily dose (MEDD) averaged 226 milligrams per day. Dosage increases beyond 50 MEDD are progressively more likely to yield diminishing returns (i.e., benefits for pain and function) and increasing risks to patients. There was no reduction of the MEDD over the 11-month interval. Respondent should have, but failed to, collaborate with Patient C to negotiate a structured tapering of the methadone or to consider alternative pharmacologic and non-pharmacologic modalities.

90. Respondent also prescribed Patient C a total of 1,980 milligrams of alprazolam (Xanax) over the 11-month interval. The daily amount of alprazolam over this interval averaged 5.32 milligrams per day. There was no reduction in the alprazolam doses over this interval. Despite Respondent's May 20 2022 text that he

was "not supposed" to prescribe the Xanax, Respondent continued to prescribe Xanax seven more times, and increased the number of tablets from 60 to 90.

91. Respondent committed an extreme departure from the standard of care by failing to prescribe controlled substances and doses in a safe manner.

PATIENT D

92. As noted above, the standard of care requires physicians to prescribe doses of controlled substances in a safe manner.

93. Over seven years, Respondent prescribed opioids - Norco, Percocet, oxycodone, and hydromorphone (Dilaudid) - to Patient D. Respondent also continuously prescribed zolpidem (Ambien). In May 2011, the first year Respondent prescribed opioids to Patient D, the initial MEDD was around 30, but doubled in January 2012. Thereafter, the MEDD progressively escalated. By the end of 2012, Respondent prescribed Patient D over 13 times the initial MEDD. From 2015 through 2018, the average MEDD and hovered around 1,100 milligrams. Dosage increases beyond 50 MEDD are progressively more likely to yield diminishing returns (i.e., benefits for pain and function) and increasing risks to patients.

94. Additionally, for an extended time, Respondent prescribed two short-acting opioids, oxycodone and hydromorphone (Dilaudid), simultaneously or within days apart. Although long-acting oxycontin was initially prescribed in March 2013, it was discontinued after eight months and replaced by the short-acting Dilaudid (in December 2013). This pattern of prescribing two short-acting opioids continued for the following five years, until September 2018. Some physicians prescribe two short-acting opioids temporarily to provide for a transition from one less effective short-acting opioid to another more effective short-acting opioid or from one that has

intolerable side effects to another that has tolerable side effects, if any. Respondent failed to document his reasoning for prescribing two short-acting opioids (oxycodone and Dilaudid) simultaneously for almost five years.

95. Respondent noted Patient D had "intermittent (sleep) apnea," but he prescribed Patient D a combination of opioids, sedatives (zolpidem/Ambien and zaleplon/Sonata), and benzodiazepines (clonazepam and alprazolam). Physicians should use careful monitoring and cautious dose titration if opioids are prescribed for patients with mild sleep-disordered breathing. Physicians should avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing to minimize risks for opioid overdose. Respondent did not conduct physical examinations of Patient D for monitoring purposes.

96. Physicians should consider offering naloxone to patients, re-evaluating patients more frequently, and referring patients to pain and/or behavioral health specialists when factors that increase risk for harm are present (e.g., history of overdose, history of substance use disorder, higher dosages of opioids greater than 50 MEDD, concurrent use of benzodiazepines with opioids). Naloxone was not considered or prescribed to Patient D despite the very high dose of opioids.

97. Respondent should have, but did not collaborate with Patient D to de-escalate the MEDD, structure a taper of the opioids, or to reintroduce alternative pharmacologic and non-pharmacologic modalities. No trial of drug holidays (i.e., opiate-free intervals) was considered or done.

98. Given the foregoing, Respondent committed an extreme departure from the standard of care in failing to prescribe controlled substances and doses in a safe manner.

99. The standard of care requires that physicians order random toxicology screens to uncover evidence of patients' diversion of controlled substances or exposure to illicit drugs that may have adverse drug-to-drug interactions.

100. Respondent continuously prescribed Patient D controlled substances for over seven years. Although there was no known risk of Patient D's future opioid use disorder or diversion in 2011, the risk for Patient D developing Opioid Use Disorder increased as Respondent prescribed substantially escalating doses of opioids continuously over seven years. Additionally, at times, Respondent wrote opiate prescriptions within days of each other increasing the possibility that Patient D was obtaining "early refills" for diversion to others. There were no progress notes in Patient D's medical chart to indicate Respondent ordered toxicology screens when the MEDD escalated or when Respondent issued opiate prescriptions within days of each other.

101. Respondent committed an extreme departure from the standard of care by failing to order random toxicology screens for Patient D to address possible diversion of controlled substances or exposure to illicit drugs.

102. The standard of care requires physicians to continuously evaluate and document the need to use opiates in the management of non-malignant pain. While the standard of care does not require physicians address all elements at every visit or encounter, one or more elements used in the safe prescribing of opiates should be incorporated with each visit or encounter that involves the on-going prescribing of a controlled substance. These include assessing: whether the pain affects the patient's activities and response to the opiates as it relates to performance of activities; level of analgesia response to the opiates; presence, or absence of adverse effects of the opiates; whether there is aberrant behavior (i.e., potential for diversion); and the patient's affect while on the opiates.

103. Respondent had numerous opportunities throughout the seven years of continuous care to evaluate and document Patient D's ongoing need for opiates and to adjust the prescription or consider alternatives (pharmacologic and non-pharmacologic). Although in his 2018 cover letter Respondent mentioned that Patient D failed to respond favorably to conventional therapeutic modalities such as yoga, acupuncture, and non-opioid medications, Respondent did not indicate how and when these modalities failed and whether repeat attempts were made at a later time. Although in his 2018 cover letter Respondent asserted Patient D's condition had improved, he failed to document in Patient D's medical records specifically when and how these improvements occurred.

104. Respondent committed an extreme departure from the standard of care by failing to continuously evaluate and document Patient D's need for opiates in the management of his non-malignant pain.

105. The standard of care requires physicians to document and maintain adequate and accurate medical records. For a physician treating a patient with opioids for chronic, non-cancer pain, an adequate medical record includes, but is not limited to, the documentation of: the patient's medical history; results of the physical examination and all laboratory tests ordered by the physician; patient consent; pain management agreement; results of the risk assessment, including results of any screening instruments used; description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity); instructions to the patient, including discussions of risks and benefits with the patient and any significant others; results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and functional improvement; notes on evaluations by, and consultations with, specialists; any other information used to

support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors (these may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers); authorization for release of information to other treatment providers as appropriate and/or legally required; and results of CURES data searches. The medical record should include all prescription orders for opioid analgesics and other controlled substances, whether written, phoned, or electronic. In addition, written instructions for the use of all medications should be given to the patient and documented in the record. Records should be up-to-date and maintained in an accessible manner to be readily available for review.

106. Patient D's medical records contained only three letters authored by Respondent (2018 cover letter and two letters following insurance provider denials) that summarized the care of Patient D. No physical examinations were documented, and there was no documented monitoring of patient progress in terms of pain management and functional improvement. This included the lack of progress notes to document what transpired at purported office visits.

107. Respondent committed an extreme departure from the standard of care in failing to document and maintain adequate and accurate medical records.

Respondent's Mental Illness Affecting Safe Practice of Medicine

ARRESTS AND INVESTIGATIONS

108. On June 14, 2022, the Board initiated an investigation of Respondent based on information received from the Los Angeles Police Department (LAPD).

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109. The LAPD notified the Board that on April 18, 2022, it received a 911 call about a male, later determined to be Respondent, displaying an assault-style rifle in a public location. Respondent went to a public park with what appeared to be an assault-style rifle, set it up on a bipod next to the tennis courts, and looked through and adjusted the scope on the rifle. Respondent also had a large dog with him. Based on photographs provided by witnesses, the LAPD believed the rifle was an airsoft weapon powerful enough to penetrate and cause serious bodily injury. The LAPD provided a copy of its Investigation Report and eyewitness photographs to the Board.

110. On June 27, 2022, Board Investigator Akopova ran a criminal history check on Respondent. She discovered that the Beverly Hills Police Department (BHPD) arrested Respondent for burglary theft on June 22, 2022. Investigator Akopova requested a certified copy of the BHPD police report.

111. On June 27, 2022, a BHPD officer informed the Board that, while at Respondent's home prior to his June 22, 2022 arrest, they observed the residence was dirty and filled with dog urine and feces. They also observed a methamphetamine pipe and methamphetamine in an amount consistent with personal use.

112. On June 28, 2022, Investigator Akopova received the BHPD report and case file. The report and case file included a detailed description of a commercial burglary at the La Cienega Tennis Pro Shop and photographs and surveillance video footage placing Respondent and his vehicle at the La Cienega Tennis Pro Shop location during the time of the burglary.

113. On June 28, 2022, based on the information received from the LAPD and BHPD, Investigator Akopova and other Board Investigators conducted field investigations at Respondent's residence and office addresses. They sought to

interview Respondent and obtain a voluntary agreement for mental and physical examinations and drug testing. Two BHPD officers who were present at the time of Respondent's June 22, 2022 arrest accompanied the Board investigators. The BHPD officers warned the Board investigators of the condition of Respondent's residence, stating it had a bad odor, dog urine and feces, and rotten food and trash throughout the residence.

114. When the Board investigators approached the front door of Respondent's residence located in a multi-unit apartment complex, they noted food, drinks, trash, and other items near his front door. The external covered patio adjoining Respondent's apartment contained trash and additional stored items, including tennis racquets.

115. After knocking on Respondent's door several times without a response, the Board investigators heard a male voice call out from the inside of the residence, "Who are you?" The man's speech was muffled and difficult to understand. Investigator Akopova informed him they were investigators with the Division of Investigation (DOI) and requested an interview. The Board investigators observed movement of the blinds at the patio window, and a man who resembled file photos of Respondent peeked through the blinds. Investigator Akopova displayed her DOI-issued identification, but the man backed away and made no response. The Board investigators kept knocking but nobody opened the door. Before leaving, Investigator Akopova left a confidential envelope at the front door of Respondent's residence; the envelope contained a cover letter, an authorization for voluntary mental and physical examinations, a blank release for medical records, and a DOI-issued business card.

116. After leaving Respondent's residence, the Board investigators proceeded to Respondent's medical office address. They attempted to enter the office but

encountered a locked door. Multiple knocks on the door received no response. They looked through the mail slot on the door and saw that the lights were out with no apparent occupants. They spoke with individuals at neighboring offices, but no one was familiar with Respondent's practice.

117. After leaving Respondent's medical office, Investigator Akopova and her supervisor went to the BHPD to speak with the detective in charge of the investigation of Respondent. The BHPD detective informed them his supplemental reports had not been completed, but he provided the Board investigators with some preliminary information.

118. The BHPD detective stated he was present on the day BHPD officers arrested Respondent for commercial burglary. When BHPD first detained Respondent, Respondent was confused, disheveled, with rash like wounds on his ankles, and appeared as though he had not showered for days. Respondent said he had to use the restroom and minutes later urinated on himself. The BHPD detective stated it was difficult for BHPD officers to enter Respondent's residence because it was full of garbage, boxes, dog urine and feces, and old food items. He described the residence as having a strong odor. Officers discovered inside the residence multiple burglary tools, as well as multiple weapons later determined to be airsoft weapons. The BHPD detective's partner observed a methamphetamine pipe and methamphetamine in amounts consistent with personal use. The BHPD detective further told Investigator Akopova that, while Respondent was in custody, Respondent attempted to take his own life by wrapping his t-shirt around his neck. The BHPD removed Respondent's clothing to prevent him from attempting suicide again.

119. The BHPD detective could not provide photos and videos from the June 22, 2022 arrest date because his report was not yet complete. However, he allowed

Investigator Akopova to view and screenshot photos and clips of videos in the possession of the BHPD that were available on their computer. Investigator Akopova captured the photos and videos with her DOI-issued cell phone.

120. Thereafter, Investigator McNally reached out to the BHPD to obtain evidence the BHPD had secured via search warrant. This included Respondent's cell phone returns with text messages. As instructed by BHPD, Investigator McNally issued an investigational subpoena, and on September 27, 2023, he obtained the cell phone returns (via portable hard drive download). Investigator McNally also obtained BHPD body camera footage.

121. In October 2022, the Board issued an Order Compelling Mental and Physical Examinations of Respondent (Compel Order). The Compel order required Respondent to undergo physical and mental examinations, as well as drug testing, including urine, blood, and hair testing.

122. On October 26, 2022, Investigator Akopova called Respondent's office phone number and left a message for him. On October 27, 2022, she received a return call from a female named Claire, who identified herself as Respondent's office manager. Investigator Akopova informed Claire she needed to contact Respondent, and she asked whether Respondent was still practicing medicine. Claire responded, "Yes."

123. On October 27, 2022, Respondent emailed Investigator Akopova and informed her he would comply with the Compel Order.

124. Investigator Akopova arranged for Respondent to undergo a physical examination, a mental evaluation, and biological drug testing on November 21, 22, and 23, respectively.

NOVEMBER 2022 MENTAL EVALUATION

125. On November 22, 2022, Respondent underwent a mental evaluation by Board-appointed psychiatrist, Alex Sahba, M.D, to determine whether Respondent suffered from any mental illness that could interfere with his ability to safely practice medicine. Following the evaluation, Dr. Sahba provided his expert report setting forth his opinions. That report was admitted into evidence at the hearing.

126. At hearing, Complainant offered the expert testimony of Dr. Sahba to establish Respondent's mental illness and its impact on his ability to practice medicine safely. Dr. Sahba testified credibly and in general conformity with his report.

127. Prior to meeting Respondent, Dr. Sahba reviewed the LAPD and BHPD reports, photographs, and video recordings. Dr. Sahba noted the information regarding: Respondent's displaying an assault style rifle in a public location; Respondent's residence filled with trash and feces; the methamphetamine and pipe found in his residence; his arrest for burglary; his unkempt appearance at the time of his arrest; and his attempt to take his own life by wrapping his t-shirt around his neck. Dr. Sahba also reviewed the available CURES report.

128. During the evaluation, Respondent reported that, "during childhood, [he] was disciplined through verbal means. He was never hit or spanked. He was never physically or sexually abused." (Exhibit 7, p. A87.) This account differed from the account Respondent gave to one of his current treatment providers (discussed below). At hearing, Respondent testified "maybe" Dr. Sahba fabricated the information about Respondent having an abuse-free childhood. Respondent denied withholding information or lying to Dr. Sahba, instead asserting he was "honest," but "at a bare minimum."

129. During the evaluation, Respondent denied any attempts to commit suicide or harm himself. This was contrary to the reports that he tried to strangle himself with his t-shirt while in police custody. When Dr. Sahba asked Respondent about his suicide attempt while in custody, Respondent stated, "I didn't mean it," and declined to comment further. (Exhibit 7, p. A96.)

130. During the evaluation, Respondent denied having drug or alcohol abuse problems. He denied ever using any hallucinogenic, heroin, cocaine, or methamphetamine. Respondent informed Dr. Sahba, "I do not do drugs." (Exhibit 7, p. A88; testimony of Dr. Sahba.) This is contrary to the evidence presented at hearing, including Respondent's texts with Patient B and Respondent's admissions to his treatment providers of prior illicit drug use. When Dr. Sahba asked Respondent about the methamphetamine and pipe observed at his residence, Respondent stated, "Maybe the police planted it there. Don't you think the police do these things?" (Exhibit 7, p. A95; testimony of Dr. Sahba.)

131. Dr. Sahba asked Respondent about the April 2022 incident when he took an assault style airsoft rifle to a public park and looked through the scope. Respondent explained "he has a 'BB gun,' which needs to be calibrated. He . . . was at the park to calibrate the gun. When asked what he [does] to calibrate the gun, [Respondent replied] 'You have to shoot the gun.'" (Exhibit 7, p. A96.) Respondent left after seeing a lot of people nearby and realizing it was a "bad idea." (*Ibid.*) Dr. Sahba noted Respondent knew that he would have to shoot the gun to calibrate it and there would be people nearby at the public park. "Hence, his decision to bring his gun to the park is indicative of impaired judgment." (*Ibid.*)

132. Dr. Sahba opined Respondent "is probably minimizing his history of substance usage," and "was probably under the influence of an illicit substance, most

likely methamphetamine, during and around the time of the April 2022 incident at the park." (Exhibit 7, p. A96.)

133. Dr. Sahba also asked Respondent about his burglary arrest and the multiple photographs placing Respondent and a vehicle registered to him at the location (La Cienega Tennis Pro Shop). Respondent stated, "I don't know anything about it." (Exhibit 7, p. A96.) When asked about the tennis racquets found in his house and in his car, Respondent stated, "I collect tennis racquets." (*Ibid.*) Respondent declined to comment further. Dr. Sahba noted Respondent's answers were "evasive and dismissive." (*Ibid.*)

134. After completing the evaluation, Dr. Sahba Dr. Sahba opined:

> Based upon the face-to-face interview, [Respondent's] answers to this examiner's questions, the test results, and the records, [Respondent] most likely meets [the] criteria for Stimulant Use Disorder, Amphetamine-type substance in accordance with the [American Psychiatric Association's] Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). There appears to be a pattern of stimulant use, probably methamphetamine, leading to clinically significant impairment or distress.

(Exhibit 7, p. A95.)

135. At the hearing, Dr. Sahba explained he used the qualifier, "most likely," regarding Respondent's diagnosed mental illness because Respondent "would not admit to things that would put his license in danger"; a definitive diagnosis would

require a full and truthful history. Consequently, Dr. Sahba provided the "most likely" diagnosis based on the available evidence, including police reports and evaluation.

136. Dr. Sahba opined that Respondent's likely diagnosis of Stimulant Use Disorder (also referred to as substance use disorder) impairs his judgment and poses a present danger or threat. Consequently, Respondent is unable to practice medicine safely at this time.

137. Dr. Sahba recommended, "at the very minimum," that Respondent be monitored and drug tested as frequently as the Board deems necessary, and that he be re-examined by a psychiatrist within six months of the November 22, 2022 evaluation. (*Id.* at pp. A96-A97.)

AUGUST 2023 BURGLARY ARREST

138. On August 3, 2023, LAPD officers arrested Respondent for commercial burglary. The arrest arose from the following circumstances.

139. An LAPD detective was investigating a series of five burglaries (committed between April 2023, and July 2023), targeting a store specializing in the sale and repair of tennis racquets (Westwood Sporting Goods or WSG). The detective reviewed WSG's video surveillance recordings of the suspect on multiple occasions attempting to break the door locks and gain entry to WSG. On a couple of occasions, the suspect was dressed as a law enforcement officer and a firefighter. The story and video surveillance footage were released to the news media, and Respondent was identified as the suspect by a member of the public.

140. On August 3, 2023, officers with the LAPD executed a search warrant at Respondent's residence. During the execution of the search warrant, distinct items of

clothing and tools that were used to commit the burglaries were discovered, and Respondent was arrested.

NOVEMBER 2023 MENTAL EVALUATION ADDENDUM

141. On November 16, 2023, Dr. Sahba was provided with additional materials obtained after his November 22, 2022 review and evaluation. The additional materials consisted of the text messages between Respondent and Patient A, Patient B, and Patient C, and the LAPD report of Respondent's August 2023 arrest. After reviewing the additional materials, Dr. Sahba provided a December 6, 2023 addendum setting forth his opinions. The addendum was admitted into evidence at the hearing, and Dr. Sahba testified credibly and in conformity with his addendum.

142. Dr. Sahba concluded that the additional materials supported and strengthened his previous opinions and diagnosis of substance use disorder. He felt comfortable deleting the qualifier "most likely," and definitively diagnosing Respondent with substance use disorder.

143. Dr. Sahba opined that two added diagnoses, Kleptomania and Antisocial Personality Disorder/Trait (APD), should be strongly considered as well.

144. Dr. Sahba noted that people with APD are impulsive, lack remorse, disregard the rights of others, will break social and general rules, and will commit repeated acts that are grounds for arrest, including theft. Respondent had a history of burglary arrests and disregard for others.

145. Respondent's ability to safely practice medicine is impacted by his substance use disorder, which is severe given his living conditions, arrests, and impaired judgment. With such impaired judgment, Respondent should not be treating

patients. Based on the additional information obtained after the initial November 2022 evaluation, Respondent is not safe to practice medicine at this time, even with monitoring and restrictions.

Respondent's Current Treatment

146. At the hearing, Respondent testified he last used drugs nine years ago. He insisted he has not used cocaine, crack, methamphetamine, or any other illicit substance for the past nine years. These assertions are contrary to the evidence (including his texts with Patient B) and are not credible.

147. Respondent's therapist, Gale Rapallo, LMFT, testified about Respondent's ongoing therapy. Rapallo has been treating Respondent since March 2024. She has diagnosed Respondent only with Attention Deficit Hyperactivity Disorder (ADHD) and depressive disorder. According to Rapallo, Respondent is working on a recovery process "free from impulsive behavior and addiction," "making a connection between impulsivity and negative consequences," and "enhancing personal skills and building relationships." She believes Respondent has been attending Alcoholics Anonymous (AA), and he is compliant with his medication regimen, managed by Nurse Practitioner Jane Mathews.

148. On cross examination, Rapallo was often hesitant to answer questions and responded in an evasive manner, unwilling to provide specifics. She did not know (or would not admit knowing) Respondent's full background including his numerous arrests, interactions with Patient B, and the allegations in the Accusation. Rapallo recalls Respondent reporting he last used methamphetamine or cocaine about "a year or so ago," but she "did not know exactly." She believes he has not recently used illicit substances, but she has "not asked [him] directly in the last month or two." She

"[doesn't] ask generally, [but] just rel[ies] on what [she] see[s]." Rapallo has not diagnosed Respondent with substance use disorder. She is not addressing that specifically in treatment, "but it is in the back of [her] mind." Rapallo did not present as a credible witness, and her observations were given little weight.

149. Respondent has been receiving treatment from Nurse Practitioner Jane Mathews since May 2024. NP Mathews has worked in an "independent practice for the last six years but [has] a supervising psychiatrist." (Testimony of Mathews.) She did not identify her supervising psychiatrist.

150. Respondent reported to NP Mathews that he was physically abused as a child. This is contrary to what is documented in Dr. Sahba's November 2022 report, which NP Mathews reviewed. She does not know why Respondent did not report the abuse to Dr. Sahba.

151. Respondent has been taking medication since June 2024, and NP Mathews provides medication support services. In addition to ADHD and depressive disorder, NP Mathews diagnosed Respondent with obsessive compulsive disorder.

152. NP Mathews prescribes Respondent Anafranil and Abilify. The medications "stop the ruminating in his mind" that was "telling him" to do "ridiculous stuff like theft at a tennis shop." (Testimony of Mathews.)

153. NP Mathews is aware of only one of Respondent's arrests for burglary, but not the second arrest. She understands Respondent is in "a lot of trouble with" the Board. NP Mathews knows Respondent was previously diagnosed with substance use disorder. She noted Respondent "gave [her] a fairly cursory history of the problems he had in his life." Respondent shared he had a substance use issue about eight or nine years ago but received treatment and felt it had been cured. Respondent did not share

with her that he relapsed and used illicit substances as recently as two years ago. She testified Respondent "is staying away from it is all I can tell you." However, Respondent does not undergo any toxicology screening.

154. NP Mathews did not know Respondent's full background including his substance use (past and recent), numerous arrests, and the allegations in the Accusation. Nevertheless, she sought to answer questions in a forthright manner, and her testimony was credited for the purpose of identifying what type of medications Respondent is currently taking.

155. Respondent testified that he would be open to any probationary terms imposed by the Board, including in-patient treatment.

Costs

156. Complainant submitted the Declarations of Supervising Investigator Emilia Shenian and Jeremy Paris as evidence of the costs of investigation in this matter. Their declarations established that the Board was billed a total of $81,777.25 for investigation services ($41,995.25 for 253.75 hours of investigator services provided by Matthew Pinkus, Michael Legaspi, Even McNally, Marc Gonzalez, Walter Carpio, Liana Akopova, and Veronika Pedrosian; and $39,782.00 for 238.00 hours of investigator services provided by the above-listed investigators and Kassandra Murphy).

157. Complainant submitted the June 17, 2024 Declaration of Amy Cleveland, Associate Government Program Analyst, as evidence of the expert costs in this matter. Her declaration established that the Board was billed a total of $17,585.00 for expert services (Dr. Sahba - $5,925.00; Lawrence Dardick, M.D. - $1,160.00; Dr. Wong - $9,100.00; Robert Schulman, M.D. - $1400.00). On July 25, 2024, Dr. Wong submitted an updated total of charges for $25,600 (adding $16,500 to his prior total).

158. Complainant submitted the Declarations of Deputy Attorney General Marsha E. Barr-Fernandez (DAG) as evidence of the costs of prosecution in this matter. The DAG's declarations indicate the Department of Justice, Office of the Attorney General, billed the Board $104,387.25 in prosecution costs through July 29, 2024.

159. The costs of investigation and prosecution in this matter totaled $220,249.50.

160. Respondent presented no evidence regarding ability to pay costs.

LEGAL CONCLUSIONS

Motion in Limine

1. Respondent made a pre-trial "Motion in Limine to Exclude any Evidence Related to or Derived from any and all Cell Phone Returns and Text Messages (1) Obtained in Violation of Cal. C.C.P. § 1985.3 and (2) Outside the Scope of the Investigational Subpoena Duces Tecum" (Motion). In her May 20, 2024 Ruling on Respondent's Motion in Limine to Exclude any Evidence from Cell Phone Returns and Text Messages (Ruling), the ALJ denied Respondent's Motion for reasons set forth in the Ruling, which is incorporated by reference and summarized below.

2. In this case, Board investigators failed to serve Respondent with notice of the investigational subpoena to BHPD seeking his personal records that were obtained by search warrant (i.e., cell phone records) as required by *Sehlmeyer v. Dept. of General Services* (1993) 17 Cal. App. 4th 1072 (*Sehlmeyer*). Given this deficiency, "reasonable steps" were not taken to notify him as envisioned in *Sehlmeyer*. Nevertheless, Respondent eventually received notice that his cell phone records had

been obtained from the BHPD. He was able to file his Motion, assert his privacy rights, and object to the use of subpoenaed records in the administrative proceeding. Since the purpose for the notification requirement is to "afford the third party a fair opportunity to assert [his] interests by objecting to disclosure" (*Sehlmeyer*, 17 Cal. App.4th at pp. 1080–1081), and Respondent voiced his objections in the Motion, exclusion of the evidence based on lack of notice is not warranted at this time. Instead, Respondent's objections were addressed as if made at time of the subpoena and a balancing of interests was conducted as required by *Sehlmeyer* and noted in *Saunders v. Superior Court* (2017) 12 Cal.App.5th Supp.1, 219 Cal.Rptr.3d 5 (analyzing the right to privacy in text messages).

3. In the case at hand, Respondent's privacy rights must be balanced against the Board's public protection mandate and ability to investigate any illegal and unprofessional conduct of its licensed physicians. While the intrusion into Respondent's privacy interest in his text messages is significant, this privacy interest is weighed against a similarly compelling governmental interest in investigating whether Respondent engaged in illegal conduct, possibly involving weapons or the abuse of illegal substances, or suffers from a mental illness affecting Respondent's ability to practice medicine safely. In this analysis, the Board's public protection interest outweighs Respondent's interest in the confidentiality of his text messages. Thus, the balance weighs in favor of disclosure of the records. However, given the privacy concerns involved, as noted in *Sehlmeyer*, steps should be taken to protect privacy of Respondent and any additional individuals named or involved in the text messages. Consequently, exhibits containing Respondent's text messages obtained from the BHPD were subject to a July 29, 2024 protective order placing those exhibits under seal.

Relevant Law

STANDARD OF PROOF

4. The standard of proof which must be met to establish the charging allegations is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit, and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

UNPROFESSIONAL CONDUCT, GROSS NEGLIGENCE, REPEATED NEGLIGENCE

5. The Board has the authority to revoke or suspend a physician's license for engaging in unprofessional conduct. (Bus. & Prof. Code, §§ 2004, 2234.)

6. Unprofessional conduct includes "violating or attempting to violate, directly or indirectly, assisting in or aiding and abetting the violation of, or conspiring to violate any provision of this chapter" (Bus. & Prof. Code, § 2234, subd. (a)); gross negligence (Bus. & Prof. Code, § 2234, subd. (b)); and repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)).

7. Gross negligence is defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197.) "Negligence and gross negligence are relative terms. 'The amount of care demanded by the standard of reasonable conduct must be in proportion to the apparent risk. As the danger

becomes greater, the actor is required to exercise caution commensurate with it.' (Prosser, Law of Torts (4th ed. 1971), at p. 180.)." (*Id.* at p. 198.)

8. "In order to be subject to discipline for unprofessional conduct, [a physician] must have demonstrated an unfitness to practice medicine by conduct which breaches the rules or ethical code of his profession or conduct which is unbecoming to a member in good standing of that profession. [Citations.]" (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 578.)

MAINTAINING ADEQUATE AND ACCURATE RECORDS

9. Business and Professions Code section 2266 provides, "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

SELF-ADMINISTRATION OF DRUGS IN DANGEROUS MANNER

10. Business and Professions Code section 2239 provides, in pertinent part:

> (a) The use or prescribing for or administering to himself or herself, of any controlled substance, or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of

any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct[.]

PRESCRIPTIONS

11. Business and Professions Code Section 2241.5, provides in pertinent part:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under their treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain[.] [¶]

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence. [¶]

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis. [¶]

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

12. Business and Professions Code section 2242, subdivision (a), provides: "Prescribing, dispensing, or furnishing dangerous drugs . . . without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

13. Business and Professions Code section 2261 provides: "Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine . . . which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

14. Business and Professions Code section 2238 provides: "A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

15. Health and Safety Code section 11153, subdivision (a), provides: "A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of their professional practice[.]"

16. Health and Safety Code section 11154, subdivision (a), provides: "Except in the regular practice of his or her profession, no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person . . . which is not under his or her treatment for a pathology or condition[.]"

17. Health and Safety Code section 11157 provides, "No person shall issue a prescription that is false or fictitious in any respect."

18. Health and Safety Code section 11173, subdivision (b), provides, "No person shall make a false statement in any prescription, order, report, or record, required by this division."

19. Health and Safety Code section 11174 provides, "No person shall, in connection with the prescribing, furnishing, administering, or dispensing of a controlled substance, give a false name or false address."

20. Health and Safety Code sections 11175 and 11180 prohibits a person from obtaining or possessing a controlled substance obtained by a prescription that does not comply with the requirements of the Health and Safety Code.

21. Business and Professions Code section 725, subdivision (a), provides, in pertinent part: "Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, . . . as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon[.]"

MENTAL ILLNESS IMPAIRING ABILITY TO SAFELY PRACTICE MEDICINE

22. Business and Professions Code section 822 provides:

> If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.

(b) Suspending the licentiate's right to practice.

(c) Placing the licentiate on probation.

(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

Causes for Discipline

FIRST CAUSE FOR DISCIPLINE (MENTAL ILLNESS AFFECTING SAFE PRACTICE OF MEDICINE)

23. Clear and convincing evidence established Respondent suffers from a substance use disorder which impacts his ability to safely practice medicine. Given his resulting impaired judgment, Respondent is unsafe to practice medicine at this time.

24. Cause exists to revoke or suspend Respondent's license, pursuant to Business and Professions Code section 822, on the grounds that Respondent is unable to practice medicine safely due to mental illness. (Factual Findings 3 through 145.)

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SECOND CAUSE FOR DISCIPLINE (USE OF DRUGS IN DANGEROUS MANNER)

25. Complainant alleges that Respondent's license is subject to disciplinary action under Business and Professions Code section 2239, "in that he used dangerous drugs, to the extent, or in such a manner as to be dangerous and injurious to Respondent, or to any other person or to the public." This allegation was not established by clear and convincing evidence. Although Respondent used dangerous drugs, the clear and convincing evidence did not establish that he was under the influence of any drug or controlled substance when he brought his assault style airsoft rifle to a public park or on any other occasion that was dangerous to Respondent or the public.

26. Cause does not exist to revoke or suspend Respondent's license, pursuant to Business and Professions Code section 2239, in that Complainant did not establish Respondent used dangerous drugs, to the extent, or in such a manner as to be dangerous and injurious to Respondent or to any other person or to the public. (Factual Findings 3 through 145.)

THIRD CAUSE FOR DISCIPLINE (GROSS NEGLIGENCE)

27. Clear and convincing evidence established Respondent committed extreme departures from the standard of care, i.e., gross negligence, when he: provided controlled substances to Patient A who did not reside in California; failed to adequately counsel Patient A to seek care with a local physician; failed to adequately document the medical indication for providing the controlled substances to Patient A; issued a prescription for a controlled substance for Patient A under Patient A's wife's name; failed to decline Patient B's offers of illicit substances in exchange for prescriptions; failed to disengage from the personal relationship with Patient B and

pivot the relationship to a professional doctor-patient relationship; failed to prescribe Patient C controlled substances and doses in a safe manner; failed to collaborate with Patient C about tapering of opioids or re-introducing alternative pharmacologic and non-pharmacologic modalities; continued to provide alprazolam to Patient C after May 20, 2022, instead increasing dosage; failed to prescribe and dose controlled substances in a safe manner to Patient D, instead escalating Patient D's MEDD average; failed to collaborate with Patient D about tapering of opioids or re-introducing alternative pharmacologic and non-pharmacologic modalities; failed to adequately make or keep office notes or other documentation reflecting each of the billed comprehensive office visits with Patient D, including documentation of Respondent's examinations, assessments, and treatment plans.

28. Cause exists to revoke or suspend Respondent's license, pursuant to Business and Professions Code sections 2234, subdivision (b), for his gross negligence in the treatment of Patient A, Patient B, Patient C, and Patient D. (Factual Findings 3 through 107.)

FOURTH CAUSE FOR DISCIPLINE (REPEATED NEGLIGENT ACTS)

29. Cause exists to revoke or suspend Respondent's license, pursuant to Business and Professions Code section 2234, subdivision (c), for his repeated negligent acts in the treatment of Patient A, Patient B, Patient C, and Patient D. (Factual Findings 3 through 107; Legal Conclusion 27.)

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FIFTH CAUSE FOR DISCIPLINE (FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS)

30. Clear and convincing evidence established Respondent failed to maintain adequate records and accurate records for Patient A, Patient B, Patient C, and Patient D.

31. Cause exists to revoke or suspend Respondent's license, pursuant to Business and Professions Code section 2266 in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A, Patient B, Patient C, and Patient D. (Factual Findings 3 through 107.)

SIXTH CAUSE FOR DISCIPLINE (ISSUING FALSE/FICTITIOUS PRESCRIPTIONS)

32. Clear and convincing evidence established Respondent acquired the controlled substances he provided to Patient A by filling prescriptions under the names of other individuals, including Patient A's wife and three fictious patients (Sam Danielson, Rebecca Millar, and Janet Parker). These prescriptions constituted false and fictitious and non-conforming prescriptions in violation of Business and Professions Code sections 2241.5, subdivisions (c)(6) and (c)(7), and 2261, and Health and Safety Code sections 11152 (prescriptions must conform with Health & Safety Code requirements), 11153, subdivision (a), 11154, 11157, 11171, 11173, 11174, 11175, 11180, and 11190 (prescriber duty to keep record of controlled substances).

33. Cause exists to revoke or suspend Respondent's license, pursuant to Business and Professions Code sections 2241.5, subdivisions (c)(6) and (c)(7), and 2261, and Health and Safety Code sections 11152, 11153, subdivision (a), 11154, 11157, 11171, 11173, 11174, 11175, 11180, and 11190, in that Respondent issued false and fictitious prescriptions. (Factual Findings 3 through 107.)

SEVENTH CAUSE FOR DISCIPLINE (VIOLATION OF PRESCRIBING STATUTES)

34. Cause exists to revoke or suspend Respondent's license, pursuant to Business and Professions Code sections 2234, 2238, 2241.5, subdivision (c), and 2242 of the Code, and Health and Safety Code, sections 11152 and 11165 (requiring adherence to CURES requirements), in that Respondent failed to comply with statutes and regulations for prescribing and dispensing controlled substances. (Factual Findings 3 through 107.)

EIGHTH CAUSE FOR DISCIPLINE (EXCESSIVE PRESCRIBING)

35. Cause exists to revoke or suspend Respondent's license, pursuant to Business and Professions Code section 725 in that he engaged in repeated acts of excessive prescribing, furnishing, or dispensing of drugs to Patient C and Patient D. (Factual Findings 3 through 107.)

NINETH CAUSE FOR DISCIPLINE (GENERAL UNPROFESSIONAL CONDUCT)

36. As demonstrated by his violations set forth above, Respondent committed unprofessional conduct as defined by the Business and Professions Code and thus engaged in conduct which breached the rules of the medical profession.

37. Cause exists to revoke or suspend Respondent's license, pursuant to Business and Professions Code section 2234, subdivision (a), in that Respondent engaged in unprofessional conduct. (Factual Findings 3 through 107.)

Analysis re: Appropriate Discipline

38. Respondent committed gross negligence, repeated negligent acts, and various statutory violations regarding the prescribing of controlled substances to four

patients. He also issued false and fictious prescriptions in his efforts to provide controlled substances to an out-of-state resident, Patient A. Furthermore, Respondent suffers from a mental illness that renders him unsafe to practice medicine. The remaining question is the nature of the discipline to be imposed against Respondent's license for his violations.

39. To determine the appropriate level of discipline, the Board considers factors set forth in statutes and regulations. Typically, the Board will consider factors to determine rehabilitation, including the nature and severity of the offenses, total criminal record (if relevant), time elapsed since the offenses, compliance with terms of parole, probation, or restitution, and any evidence of rehabilitation submitted by the licensee. (Cal. Code Regs., tit. 16, § 1360.1; Bus. & Prof. Code, § 2229.) The Board will also look to the "Manual of Model Disciplinary Orders and Disciplinary Guidelines," 12th Edition/2016 (Guidelines) to determine the appropriate discipline. (Cal. Code Regs., tit. 16, § 1361.) Disciplinary actions can include license revocation, suspension, probation, or public reprimand. (Bus. & Prof. Code, § 2227.)

40. Although Respondent has been practicing medicine for decades without discipline, and his current violations are egregious and involve his issuance of fictitious prescriptions and the provision of dangerous drugs and controlled substances, sometimes in excessive amounts, to patients without considering the danger involved. He engaged in an unprofessional quid-pro-quo approach to providing Norco and Viagra prescriptions (and offering a "handful of Dilaudid") to Patient B in exchange for Patient B's delivery of illicit substances for Respondent's self-consumption. Respondent's gross negligence, repeated negligence, and other prescribing violations, including his fictitious prescriptions, apparently stemmed from his blatant disregard

for the laws or the standard of care governing the practice of medicine. This approach to the practice of medicine created a significant risk of great harm to patients.

41. Additionally, Respondent suffers from a substance use disorder, and he has exhibited extremely impaired judgment, for example in his taking an assault type airsoft rifle to a public park and looking through the scope. He also attempted suicide when in police custody. As Dr. Sahba noted, Respondent's substance use disorder is severe, given his living conditions, arrests, and impaired judgment, and with such impaired judgment, Respondent should not be treating patients, even with restrictions in place.

42. Respondent also demonstrated a lack of candor with the Board. He admittedly was not fully candid with Dr. Sahba during the November 2022 evaluation. Additionally, at hearing, Respondent refused to fully acknowledge his violations, and he was sarcastic and disingenuous during cross examination. This bodes poorly for Respondent's cooperation with the Board should probation be ordered.

43. Given the foregoing, revocation of Respondent's license is warranted to protect the public health and safety.

Costs

44. Pursuant to Business and Professions Code section 125.3, Complainant is entitled to recover the reasonable costs of enforcement of this matter. Complainant has incurred reasonable costs in the amount of $$220,249.50, as set forth in Factual Findings 156 through 159.

45. To ensure that cost awards do not deter licentiates with potentially meritorious claims or defenses from exercising their right to a hearing, the Board must

use its discretion to reduce or eliminate costs by considering the following factors: the licentiate's ability to obtain dismissal or reduction of the charges; the licentiate's subjective good faith belief in the merits of his or her position; whether the licentiate raised a colorable challenge to the proposed discipline; the licentiate's financial ability to pay; and whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Zuckerman v. State Board of Chiropractic Examiners* (*Zuckerman*) (2002) 29 Cal.4th 32, 45.)

46. Considering all of the *Zuckerman* factors, there is no basis for reducing the award of Complainant's reasonable costs. In this case, Complainant established eight of the nine causes for discipline against Respondent, and Respondent has provided no evidence of inability to pay. Consequently, Respondent shall be required to pay the costs of enforcement of this matter in the amount of $220,249.50.

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ORDER

1. Physician's and Surgeon's Certificate Number A 86830, issued to Respondent, Kamyar Cohanshohet, M.D., is revoked.

2. If Respondent later applies for a new physician's and surgeon's certificate or reinstatement of his revoked physician's and surgeon's certificate, Respondent shall reimburse the Board $220,249.50, for its investigative and prosecutorial costs in this case, before reinstatement or issuance of any physician's and surgeon's certificate or as the Board in its discretion may otherwise order.

DATE: 09/03/2024

Julie Cabos-Owen

JULIE CABOS OWEN
Administrative Law Judge
Office of Administrative Hearings