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

In the Matter of the Accusation Against: Moise Tofic Zagha, M.D. Physician's and Surgeon's Certificate No. A 34602 Respondent.	Case No. 800-2021-076524

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 31, 2024.

IT IS SO ORDERED December 30, 2024.

MEDICAL BOARD OF CALIFORNIA

Jenna Jones for
Reji Varghese, Executive Director

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **MOISE TOFIC ZAGHA, M.D.** **16133 Ventura Blvd., Suite 300** **Encino, CA 91436-2428** **Physician's and Surgeon's Certificate No. A 34602,** Respondent.	Case No. 800-2021-076524 OAH No. 2024050139 **STIPULATED SURRENDER OF LICENSE AND ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Surrender and Disciplinary Order, which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

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2. MOISE TOFIC ZAGHA, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, Esq., whose address of record is 355 South Grand Avenue, Suite 1750 Los Angeles, CA 90071.

3. On or about October 15, 1979, the Board issued Physician's and Surgeon's Certificate No. A 34602 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-076524 and will expire on October 31, 2024, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-076524 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 5, 2024. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2021-076524 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2021-076524. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

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CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2021-076524, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

13. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. A 34602 without further notice to, or opportunity to be heard by, Respondent.

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his

consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

16. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

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17. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 34602, issued to Respondent MOISE TOFIC ZAGHA, M.D., is surrendered and accepted by the Board, effective December 31, 2024.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of December 31, 2024, the effective date of the Board's Decision and Order.

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2021-076524 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $62,715.00 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of

California, all of the charges and allegations contained in Accusation No. 800-2021-076524 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 10/15/2024

MOISE TOFIC ZAGHA, M.D.
Respondent

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

DATED: 10/16/2024

PETER R. OSINOFF, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 10/16/2024

Respectfully submitted,

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

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2021-076524

ROB BONTA
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **MOISE TOFIC ZAGHA, M.D.** **16133 Ventura Blvd., Suite 300** **Encino, CA 91436-2428** **Physician's and Surgeon's Certificate No. A 34602,** Respondent.	Case No. 800-2021-076524 **ACCUSATION**

Complainant alleges:

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 15, 1979, the Board issued Physician's and Surgeon's Certificate Number A 34602 to Moise Tofic Zagha, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2024, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

> The board shall have the responsibility for the following:
>
> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
>
> (b) The administration and hearing of disciplinary actions.
>
> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.
>
> (d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.
>
> (e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.
>
> (f) Approving undergraduate and graduate medical education programs.
>
> (g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).
>
> (h) Issuing licenses and certificates under the board's jurisdiction.
>
> (i) Administering the board's continuing medical education program.

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

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

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

STATUTORY PROVISIONS

6. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

(h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.

(i) Dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee.

7. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

8. Section 2241 of the Code states:

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

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

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

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

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

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

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

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

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

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9. Section 2266 of the Code states:

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

10. Section 725 of the Code states:

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

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

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

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

11. Section 741 of the Code states:

(a) Notwithstanding any other law, when prescribing an opioid or benzodiazepine medication to a patient, a prescriber shall do the following:

(1) Offer the patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression when one or more of the following conditions are present:

(A) The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

(B) An opioid medication is prescribed within a year from the date a prescription for benzodiazepine has been dispensed to the patient.

(C) The patient presents with an increased risk for opioid overdose, including a patient with a history of opioid overdose, a patient with a history of opioid use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

(2) Consistent with the existing standard of care, provide education to the patient on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression.

(3) Consistent with the existing standard of care, provide education on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression to one or more persons designated by the patient, or, for a patient who is a minor, to the minor's parent or guardian.

(b) A prescriber is not required to provide the education specified in paragraphs (2) or (3) of subdivision (a) if the patient receiving the prescription declines the education or has received the education within the past 24 months.

(c) This section does not apply to a prescriber under any of the following circumstances:

(1) When prescribing to an inmate or a youth under the jurisdiction of the Department of Corrections and Rehabilitation or the Division of Juvenile Justice within the Department of Corrections and Rehabilitation.

(2) When ordering medications to be administered to a patient while the patient is in either an inpatient or outpatient setting.

(3) When prescribing medications to a patient who is terminally ill, as defined in subdivision (c) of Section 11159.2 of the Health and Safety Code.

COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Three Patients)

13 Respondent Moise Tofic Zagha, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of Patients 1, 2, and 3.[1] The circumstances are as follows:

Patient 1

14. Patient 1 (or "patient"), was a 31-year-old male, who treated with Respondent from approximately June 2020 through December 2022, when Respondent terminated the doctor-patient relationship due to continued drug-seeking behavior by Patient 1. The patient had multiple ailments/conditions including Attention Deficit Disorder (ADD), insomnia, generalized anxiety disorder, and alopecia (hair loss). The patient also stated that he was in a car accident in 2011, but per his health questionnaire in June 2020, the patient had no weakness in his muscles or joints, no difficulty walking, and no pain in the calves or buttock.

15. Respondent treated Patient 1 with long-term controlled substances, despite the patient exhibiting, early on, many "red flags" or warning signs of addiction, substance use disorder, and diversion (e.g., use of multiple providers or "doctor shopping" and use of multiple pharmacies). For example, during the time period Respondent treated Patient 1, Respondent and multiple other providers (at least five other doctors/providers) prescribed to the patient a combination of controlled substances, including the following: benzodiazepines such as alprazolam (Xanax), clonazepam, diazepam (Valium); opioids, such as suboxone, a medication typically used to treat patients with opioid use disorder and also used to treat pain; and sedatives/hypnotics, such as zolpidem (Ambien) and suvorexant (Belsomra), both of which are sleep aids.

16. Opioids were more frequently prescribed by others but with Respondent's knowledge. Often, benzodiazepines and sedatives/hypnotics were concurrently prescribed with an opioid (e.g., suboxone). Occasionally, more than one benzodiazepine or sedatives/hypnotics were prescribed concurrently. These medications when used concurrently potentiate the individual medications' negative effects, such as sedation, motor impairment, cognitive

[1] The patients are identified by numbers to protect their privacy.

impairment, and respiratory depression, which can lead to death. Respondent and multiple other providers were prescribing opioids, benzodiazepines, and sedatives/hypnotics for chronic use that when used concurrently are synergistic for negative health outcomes.

17. Although Respondent was prescribing both opioids/narcotics and benzodiazepines to Patient 1, there was no documentation that Respondent provided the patient with any education regarding accidental overdose, and there was no documentation that Respondent provided the patient with a naloxone (Narcan) antidote therapy prescription, which is an opioid reversal medication.[2]

18. Despite this combination of drugs, which were prescribed to the patient by Respondent as well as multiple other providers, Respondent failed to engage in, and/or document, an assessment of Patient 1's treatment and progress. Respondent's notes were scant, incomplete, lacking clarity, and at times illegible. There was no evidence that Respondent evaluated the patient's progress toward any treatment objectives. There was no documentation that Respondent utilized a 1-10 pain scale to assess the level of pain. Also, Respondent failed to consistently evaluate other treatment goals, such as the patient's activity level (functional goals), side effects, aberrant behaviors (opioid relapse, doctor-shopping), and the patient's affect (changes to mood, depression, or anxiety). There was no documentation that Respondent had placed the patient on a controlled substances contract. Respondent also failed to assess the patient's treatment for ADD with Adderall, an amphetamine used to treat ADD, or to inquire about side effects or concerns from long-term use of amphetamines. Moreover, Respondent failed to include a complete physical exam on any date commensurate with the patient's diagnosis and treatment.

19. Respondent initially prescribed the patient Adderall at 90 mg per day. This is an excessive dose, as Adderall doses should not exceed 40 to 60 mg per day.

20. Respondent failed to engage in and/or document discussions with the patient regarding compliance with the treatment plan, potential risks of long-term opioid use, chronic

[2] The standard of care for a provider in California, after January 1, 2019, is that when prescribing opioids concurrently with a benzodiazepine, the provider must offer a prescription for naloxone and educate the patient regarding overdose prevention and the use of naloxone. The patient was prescribed an opioid and benzodiazepine after January 1, 2019, but the medical record failed to show any evidence that naloxone was offered to the patient.

benzodiazepine use, combined opioid and benzodiazepines use, as well as the use of sedatives/hypnotics with any of these medications. Moreover, other than one urine toxicology screen, which was inadequate for monitoring Suboxone and zolpidem, there were no additional urine drug screens performed on Patient 1, and no completed pill counts.

21. Overall, Respondent committed the acts and/or omissions, described above, in his care and treatment of Patient 1, which represent extreme departures from the standard of care.

22. The above acts or omissions constitute gross negligence under the Code, and therefore subject Respondent's medical license to discipline.

Patient 2

23. Patient 2 (or "patient"), an 83-year-old female, was treated by Respondent from approximately March 2020 through February 2023, for various ailments including rheumatoid arthritis, chronic pain, insomnia, and anxiety. During this time-period, Respondent (and other providers) concurrently prescribed to the patient a combination of controlled substances including benzodiazepines, such as alprazolam (Xanax) and temazepam (a sedative to treat insomnia), and opioids, such as tramadol, a pain medication. Often, more than one benzodiazepine was prescribed concurrently. These medications when used concurrently potentiate the individual medications' negative effects, such as over-sedation, motor impairment, cognitive impairment, and respiratory depression, which can lead to death. Respondent and multiple other providers were prescribing opioids and benzodiazepines to an elderly patient for chronic use that when used concurrently are synergistic for negative health outcomes.

24. Specifically, Respondent prescribed benzodiazepines to Patient 2 for approximately one year for generalized anxiety disorder (GAD), but Respondent failed to appropriately assess and create a treatment protocol for a patient with GAD. For example, there was no documentation that after Respondent made the diagnosis of GAD, he began treatment for the patient's anxiety with cognitive behavioral therapy and/or prescribing the patient with SSRIs (Selective Serotonin Reuptake Inhibitor, e.g., Zoloft), as benzodiazepines do not improve long-term outcomes, and should only be used for a short term. Instead of prescribing less dangerous drugs/SSRIs, the patient was treated with long-term benzodiazepines, which placed her at risk.

25. Although Respondent was prescribing both opioids/narcotics and benzodiazepines to Patient 2, there was no documentation that Respondent provided the patient with any education regarding accidental overdose, and there was no documentation that Respondent provided the patient with naloxone.[3] Also, despite this combination of drugs which were prescribed to the patient by Respondent as well as multiple other providers, there was no documentation that Respondent had placed the patient on a controlled substances contract.

26. Moreover, Respondent's notes were scant, incomplete, lacking clarity, and at times illegible. For example, the medical records failed to clearly demonstrate any discussion between Respondent and the patient regarding potential risks of long-term opioid use, long-term benzodiazepine use, and combined opioid and multiple benzodiazepine use. There was also no evidence that Respondent evaluated the patient's progress toward any treatment objectives. The medical records indicate that Respondent only utilized a 1-10 pain scale on one occasion to assess the level of pain. Also, Respondent failed to consistently evaluate other treatment goals such as the patient's activity level (functional goals), side effects (such as the patient's three falls), aberrant behaviors, and the patient's affect (changes to mood, depression or anxiety). Furthermore, there were no urine drug screens completed on Patient 2, and no completed pill counts.

27. Overall, Respondent committed the acts and/or omissions, described above, in his care and treatment of Patient 2 which represent extreme departures from the standard of care.

28. The above acts or omissions constitute gross negligence under the Code, and therefore subject Respondent's medical license to discipline.

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[3] As stated above, the standard of care for a provider in California, after January 1, 2019, is when prescribing opioids concurrently with a benzodiazepine, the provider must offer a prescription for naloxone and educate the patient regarding overdose prevention and the use of naloxone.

Patient 3

29. Patient 3 (or "patient"), an 83-year-old male, was treated by Respondent from approximately March 2015 through May 2022, for various conditions including chronic low back pain, degenerative joint disease (DJD) in the left shoulder, anxiety, anorexia, and post-traumatic stress disorder (PTSD). During this time-period, Respondent concurrently prescribed to the patient a combination of controlled substances, including hydrocodone (a.k.a. Norco, an opioid pain medication) and diazepam (Valium). These medications when used concurrently potentiate the individual medications' negative effects, such as motor impairment, cognitive impairment, and respiratory depression, which can lead to death. Respondent was prescribing two medications to Patient 3, that when used concurrently are synergistic for negative health outcomes.

30. Specifically, Respondent treated the patient for muscle-skeletal pain with chronic high-dose hydrocodone, despite weak evidence or support for the use of said opioids. Also, Respondent treated the patient for anxiety and PTSD with long-term use of diazepam, when appropriate treatment of anxiety in this case should have begun with cognitive behavioral therapy and the prescribing of SSRIs. Moreover, Respondent failed to appropriately assess the patient for PTSD prior to initiating therapy and failed to utilize an evidence-based approach in formulating therapy.

31. As with Patients 1 and 2, Respondent's notes regarding Patient 3 were scant, incomplete, lacking clarity, and at times illegible. Respondent's notes were devoid of detail and critical information necessary for the patient's safety and failed to adequately provide other health professionals with important aspects of patient care. For example, there was no evidence that Respondent evaluated the patient's progress toward any treatment objectives, and the pain levels described were vague and frequently failed to specifically describe the anatomical location of pain, quality of pain, timing of pain, palliation, and provocation of pain. Respondent also failed to consistently evaluate other treatment goals such as the patient's activity level (functional goals), side effects, aberrant behaviors (signs of drug or alcohol use, unsanctioned dose escalation, and early refill requests), and the patient's affect (changes to mood, depression or

anxiety). Moreover, Respondent failed to specify measurable goals and objectives used to evaluate the treatment progress. Chart notes failed to show discernible improvement in pain and associated symptoms during the treatment period. Respondent also failed to include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy became necessary. Although Respondent did inform the patient regarding the risks associated with his pain medication, there was no evidence to demonstrate that Respondent clearly elucidated the long-term risks or side effects of benzodiazepines or the combined use of opioids and benzodiazepines.

32. Overall, Respondent committed the acts and/or omissions, described above, in his care and treatment of Patient 3, which represent extreme departures from the standard of care.

33. The above acts or omissions constitute gross negligence under the Code, and therefore subject Respondent's medical license to discipline.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Three Patients)

34. Respondent Moise Tofic Zagha, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code for the commission of acts or omissions involving negligence in the care and treatment of Patients 1, 2, and 3.

35. The facts and allegations set forth in the First Cause for Discipline are incorporated by reference as if fully set forth.

36. Each of the alleged acts of gross negligence set forth in the First Cause for Discipline, above, is also a negligent act.

37. The above acts or omissions constitute repeated negligent acts under the Code, and therefore subject Respondent's medical license to discipline.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing – Three Patients)

38. Respondent Moise Tofic Zagha, M.D. is subject to disciplinary action under sections 725 and 2238 of the Code, in that Respondent excessively prescribed dangerous drugs to Patients 1, 2, and 3, above.

39. The facts and allegations set forth in the First Cause for Discipline are incorporated by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing to an Addict – Patient 1)

40. Respondent Moise Tofic Zagha, M.D. is subject to disciplinary action under sections 2238 and 2241 of the Code, in that Respondent prescribed controlled substances to Patient 1 who had signs of addiction/dependence.

41. Paragraphs 14 through 20, inclusive, are incorporated herein by reference as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records – Three Patients)

42. By reason of the facts and allegations set forth in the First Cause for Discipline, above, Respondent Moise Tofic Zagha, M.D. is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1 and 2, above.

SIXTH CAUSE FOR DISCIPLINE

(Offer of Opioid Reversal Drug - Three Patients)

43. Respondent is subject to disciplinary action under sections 741 and 2238 of the Code, in that Respondent failed to timely offer Patients 1, 2, and 3, above, a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression. The circumstances are as follows:

44. The allegations of the First Cause for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

45. To determine the degree of discipline, if any, to be imposed on Respondent Moise Tofic Zagha, M.D., Complainant alleges that on or about April 7, 2016, in a prior disciplinary action titled *In the Matter of the Accusation Against Moise Tofic Zagha, M.D.* before the Medical

Board of California, in Case Number 06-2012-228084, Respondent's license was revoked. The revocation was stayed subject to three years' probation with terms and conditions for gross negligence, incompetence, excessive treatment or prescribing, violation of drug statute, prescribing without appropriate examination, failure to maintain adequate/accurate medical records, and unprofessional conduct in Respondent's care and treatment of one patient. That decision is now final and is incorporated by reference as if fully set forth herein.

44. To determine the degree of discipline, if any, to be imposed on Respondent Moise Tofic Zagha, M.D., Complainant alleges that on or about January 3, 2020, in a prior disciplinary action titled *In the Matter of the Accusation Against Moise Tofic Zagha, M.D.* before the Medical Board of California, in Case Number 800-2015-014414, Respondent's license was revoked. The revocation was stayed subject to thirty-five months' probation with terms and conditions for gross negligence, repeated negligent acts, prescribing without appropriate prior examination and/or medical indication, repeated acts of excessive prescribing, violation of drug statute, failure to maintain adequate and accurate medical records, incompetence, and unprofessional conduct in Respondent's care and treatment of one patient. That decision is now final and is incorporated by reference as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 34602, issued to Respondent Moise Tofic Zagha, M.D.;

2. Revoking, suspending or denying approval of Respondent Moise Tofic Zagha, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Moise Tofic Zagha, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: MAR 0 5 2024

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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