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

In the Matter of the Accusation Against: Ehsan Sadri, M.D. Physician's and Surgeon's Certificate No. A 87053 Respondent.	Case No. 800-2022-090822

DECISION

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

This Decision shall become effective at 5:00 p.m. on October 17, 2025.

IT IS SO ORDERED September 19, 2025.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
CHRISTINE A. RHEE
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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: **EHSAN SADRI, M.D.** **361 Hospital Road, Suite 324** **Newport Beach, CA 92663-3524** **Physician's and Surgeon's Certificate No. A 87053,** Respondent.	Case No. 800-2022-090822 OAH No. 2025010671 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

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 Christine A. Rhee, Deputy Attorney General.

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2. Respondent Ehsan Sadri, M.D. (Respondent), is represented in this proceeding by attorney Gregory D. Werre, Esq., whose address is: 1230 Rosecrans Avenue, Suite 450, Manhattan Beach, CA 90266.

3. On or about May 5, 2004, the Board issued Physician's and Surgeon's Certificate No. A 87053 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2022-090822, and will expire on May 31, 2026, unless renewed.

JURISDICTION

4. Accusation No. 800-2022-090822 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 October 22, 2024. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A true and correct copy of Accusation No. 800-2022-090822 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2022-090822. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. 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.

8. Having had the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent admits that he failed to maintain adequate and accurate records in his care and treatment of Patient A, as alleged in the third cause for discipline in Accusation No. 800-2022-090822, and agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. A 87053 to disciplinary action.

10. Respondent further agrees that if an accusation or petition to revoke probation is filed against him in the future before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2022-090822 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

ADDITIONAL PROVISIONS

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 87053 issued to Respondent Ehsan Sadri, M.D., shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2022-090822, is as follows:

> As more fully described in Accusation No. 800-2022-090822, you failed to maintain adequate or accurate medical records in your care and treatment of Patient A, which occurred from February to September 2019.

1. INVESTIGATION/ENFORCEMENT COST RECOVERY. Within 60 calendar days of the effective date of this Decision, Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, legal and expert review, in the amount of $26,143.10 (twenty-six thousand, one hundred and forty-three dollars and ten cents). Costs shall be payable to the Medical Board of California.

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

Any failure to fully comply with this term and condition of the Disciplinary Order shall constitute unprofessional conduct and will subject Respondent's Physician's and Surgeon's Certificate No. A 87053 to further disciplinary action.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Gregory D. Werre, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement

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and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11 July 2025

EHSAN SADRI, M.D.
Respondent

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

DATED: 07/14/25

GREGORY D. WERRE, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

EHSAN SADRI, M.D.
Respondent

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

DATED: _____

GREGORY D. WERRE, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: July 14, 2025

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2022-090822

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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: **EHSAN SADRI, M.D.** **361 Hospital Rd., Ste. 324** **Newport Beach, CA 92663-3524** **Physician's and Surgeon's Certificate No. A 87053,** Respondent.	Case No. 800-2022-090822 **ACCUSATION**

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 May 5, 2004, the Board issued Physician's and Surgeon's Certificate No. A 87053 to Ehsan Sadri, 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 May 31, 2026, 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 2227 of the Code states, in pertinent part:

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

5. Section 2234 of the Code states, in pertinent part:

> 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:
>
> ...
>
> (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.

...

6. Section 2266 of the Code states that 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.

COST RECOVERY

7. 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.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A 87053 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patient A,[1] as more particularly alleged hereafter:

9. On or about May 8, 2015,[2] Respondent performed LASIK or LASEK[3] surgery on Patient A's right eye. From approximately May 2015 through December 2016, Respondent continued to treat Patient A for post-operative care, dry eye syndrome, and blepharospasm.

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[1] The patient's name has been omitted to protect her privacy. Respondent is aware of Patient A's identity.

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[3] LASIK, or laser-assisted in situ keratomileusis, is a procedure in which a flap is created to access the stromal tissue and a laser is used to reshape the stroma. The flap is then replaced and typically reseals itself without further medical intervention within a day or two. In contrast, LASEK, or laser-assisted subepithelial kerectomy, is a procedure in which the top layer of the cornea is removed and a laser is used to reshape the stroma underneath, thereby correcting the patient's vision. In a LASEK procedure, the outer layer of the cornea will regenerate in a few (continued...)

10. On or about February 6, 2019, Patient A, then a 45-year-old female, saw Respondent for a blepharospasm evaluation. Respondent assessed Patient A with dermatochalasis and blepharospasm and discussed available treatment options, including surgery and Botox.

11. On or about February 7, 2019, Patient A called Respondent's office to schedule an appointment for her blepharospasm. Patient A also expressed interest in getting LASIK for her left eye.

12. On or about February 13, 2019, Patient A saw Respondent for a LASIK evaluation for her left eye. Patient A also wanted to undergo a blepharoplasty for her right upper lid. Respondent conducted a physical exam and assessed that Patient A had astigmatism. Respondent documented that he did not recommend LASIK for Patient A's left eye because she had an early cataract, which was not ready for treatment at that time. Instead, Respondent recommended a refractive lens exchange (RLE)[4] for Patient A's left eye. According to the records, Patient A agreed to schedule an upper blepharoplasty.

13. On or about February 26, 2019, Patient A underwent corneal topography and ocular biometry for the planned RLE. The corneal topograph showed a significant amount of regular astigmatism, which would require a toric IOL.

14. On or about February 26, 2019, Patient A signed a consent form for the RLE. The consent form indicated that Patient A agreed to a "TMF" IOL, which is a Tecnis Multifocal Lens. Patient A signed a separate form indicating that she understood that Respondent recommended a multifocal IOL and that Patient A agreed to accept this premium lens, which would not be fully covered by insurance.

15. On or about March 12, 2019, Patient A's paperwork indicated that she paid for ORA System™ Technology (ORA), which is an intraoperative measurement which helps minimize the final refractive error. Despite paying extra for ORA, the records show that it was not used during Patient A's cataract surgery.

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days. Throughout the medical records, Patient A's May 2015 procedure was interchangeably referred to as LASIK and LASEK.

[4] A refractive lens exchange is a surgical procedure in which the patient's natural lens is replaced with an intraocular lens (IOL).

16. On or about March 12, 2019, Respondent performed the RLE on Patient A's left eye. According to Respondent's operative report, Respondent used a multifocal toric IOL, Tecnis Symfony model ZXT300, with a 22.5D spherical equivalent power.[5] The operative report included an addendum which inaccurately stated that Patient A had LASIK surgery in her left eye and that Patient A was informed that she had high astigmatism and that any refractory procedure prior to cataract surgery may result in the need for further LASIK surgery enhancements. Nothing in the medical records indicates when this addendum was added to the operative report, or that Patient A's medical history included undergoing LASIK in her left eye.

17. The medical records for Patient A also do not include the biometry data for the IOL implanted in Patient A's left eye or the Toric Lens Calculation, which memorializes the type of IOL used, the spherical equivalent power of the IOL and the proper axis for the IOL implantation, given Patient A's data.

18. On or about March 13, 2019, Respondent saw Patient A for a one-day follow-up appointment. Patient A reported that her vision was blurry, affecting her distance vision in the left eye. She also reported that her left eye felt scratchy. Patient A was using her prescription post-operative eye drops as prescribed. Respondent noted that Patient A was healing well and advised her to return to the clinic if she had any decrease in vision.

19. On or about March 28, 2019, Respondent saw Patient A for a two-week follow-up appointment. Patient A reported that her vision had gotten worse. Despite Patient A's reporting, Respondent documented that Patient A was healing well. Respondent noted that he explained neuroadaptation[6] to Patient A. Respondent also noted that he discussed the possibility of LASEK for Patient A's left eye. Respondent's plan included a diagnostic refraction[7] to be done by an optometrist.

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[5] The rest of Patient A's medical records inaccurately document that Respondent implanted the Tecnis Multifocal lens, model ZKB00, which is a non-toric IOL.

[6] Visual neuroadaptation refers to the process by which the brain adapts to changes induced in the quality of the retinal image by light dispersion after IOL implantation.

[7] Diagnostic refraction, or a vision test, is an eye exam that measures a person's prescription for eyeglasses or contact lenses.

20. On or about April 9, 2019, Patient A called Respondent's office and left a message stating that her vision had gotten far worse and that it had gotten to the point where she was bumping into walls and did not feel comfortable driving. A staff member called Patient A back and Patient A agreed to follow up with Respondent regarding her worsening vision at her next appointment on or about April 17, 2019.

21. On or about April 17, 2019, Respondent saw Patient A for a follow-up appointment. The note for this visit does not reference Patient A's complaints of worsening vision from April 9, 2019. Instead, the note documents that Patient A presented to the office for a Botox evaluation for both eyes. She was assessed with blepharospasm and received Botox injections for migraines.

22. On or about July 24, 2019, Respondent saw Patient A for a follow-up appointment. Patient A complained of blurry vision in her left eye and had difficulty reading up close. Despite Patient A's complaints, Respondent documented that Patient A was healing well. Respondent noted that the diagnostic refraction had not yet been done. He assessed Patient A with residual astigmatism in the left eye and recommended LASEK.

23. On or about August 6, 2019, Patient A underwent corneal topography for both eyes.

24. On or about August 15, 2019, Patient A saw S.L., an optometrist, for a diagnostic refraction of both eyes. Patient A complained of blurry vision in her left eye affecting her vision both near and far. S.L. documented that Patient A completed the pre-operative refraction for the LASEK procedure for her left eye. There was no documentation in the records indicating whether the IOL was correctly positioned in Patient A's left eye or whether it had migrated.

25. On or about August 19, 2019, Respondent performed the LASEK on Patient A's left eye.

26. Between on or about August 20, 2019 and September 6, 2019, Patient A returned to Respondent's office for multiple post-operative visits. She continued to report that her vision was blurry in her left eye.

27. Respondent committed gross negligence in his care and treatment of Patient A which includes, but is not limited to, the following: (1) his failure to timely identify and address Patient A's post-operative vision problems following the RLE, namely that the IOL was not in the correct

orientation either because it was not originally placed in the correct orientation and/or the IOL migrated post-operatively; and (2) his failure to maintain adequate and accurate records.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

28. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 87053 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged hereafter:

29. Paragraphs 9 through 27, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

30. Respondent has committed negligence in his care and treatment of Patient A which includes, but is not limited to, using the incorrect spherical equivalent power for the IOL.

THIRD CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Medical Records)

31. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 87053 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate medical records in his care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 30, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

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 No. A 87053, issued to Respondent Ehsan Sadri, M.D.;

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

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3. Ordering Respondent Ehsan Sadri, 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: OCT 22 2024

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

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