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

In the Matter of the Accusation Against: Samer Kabbani, M.D. Physician's & Surgeon's Certificate No. A 74135 Respondent.	Case No. 800-2020-073091

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 December 1, 2025.

IT IS SO ORDERED: October 28, 2025.

MEDICAL BOARD OF CALIFORNIA

MD.

Veling Tsai, M.D., Vice Chair
Panel A

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

In the Matter of the Accusation Against:

SAMER KABBANI, M.D.,

Physician's and Surgeon's Certificate No. A 74135

Respondent.

Agency Case No. 800-2020-073091

OAH No. 2025030890

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on September 15 through 17, 2025, by videoconference.

Deputy Attorney General Maryam Ahmad appeared representing complainant Reji Varghese, Executive Director of the Medical Board of California.

Attorneys Nicholas Jurkowitz and Nishka Khanna appeared representing respondent Samer Kabbani, M.D., who also was present.

The matter was submitted for decision on September 17, 2025.

FACTUAL FINDINGS

1. The Medical Board of California issued Physician's and Surgeon's Certificate Number A 74135 to respondent Samer Kabbani, M.D., on March 22, 2001. This certificate has expired without renewal.

2. Acting in his official capacity as the Executive Director of the Board, complainant Reji Varghese signed an accusation against respondent on November 13, 2023. Respondent returned a timely notice of defense.

3. Complainant alleges that respondent committed unprofessional conduct, and specifically sexual misconduct, when he invited a woman who previously had not been his patient to his office and touched her breasts under the pretense of examining her heart. Respondent admits that he and the woman met briefly at his office, but denies having purported to examine her heart or having touched her in any way.

Education and Professional Experience

4. Respondent graduated from medical school in Syria. In 1997, he completed a one-year postgraduate internship in Michigan, and in 1999 he completed an internal medicine residency in Missouri.

5. Between 1999 and 2003, respondent completed cardiology fellowships in California. He obtained the license described in Finding 1 during this period.

6. In 2003, respondent returned to Syria, and practiced there as a cardiologist until late 2005. Since late 2005, he has been in private practice in the United States as a cardiologist, in Michigan, Ohio, Florida, and California.

7. Between August 2016 and August 2022, respondent was a cardiologist in Eureka. He treated patients both in outpatient and inpatient settings.

8. Respondent returned to Florida in September 2022, and has been in private practice there since then. He also travels regularly to the United Arab Emirates to treat cardiology patients. Finally, respondent has practiced occasionally in Syria since 2022, and intends soon to begin training cardiologists there. He has no intention of returning to practice in California.

9. Cardiologist Ronald H. Main, M.D., testified that he and respondent worked together in Eureka between February 2021 and June 2021. Dr. Main found respondent warm and personable, and a strong cardiologist. He observed only scrupulously professional behavior by respondent while they worked together.

10. Medical office manager and medical assistant Lourdes Vazquez worked with respondent in Florida between 2013 and 2017, and in Eureka between 2017 and 2019. She believes respondent to be trustworthy and honest, and respectful toward patients and colleagues.

11. Physician assistant Patricia Carter works in Eureka, and shared patients with respondent for several years. She also has been respondent's patient. Carter considers respondent an excellent cardiologist who is responsive, professional, and courteous.

12. Medical assistant Samantha Spiering worked occasionally with respondent between 2018 and 2021, and served as respondent's primary medical assistant in 2021 and 2022. She testified that he always took patients' modesty seriously, asking permission to touch them and removing clothing or examination

gowns as little as possible. Respondent was friendly and collaborative with colleagues, and Spiering considers him trustworthy.

13. Medical assistant Sheri Webster was respondent's primary medical assistant between 2018 and 2021. They had, according to Webster's testimony, a professional working relationship that became friendly as well; respondent was especially supportive to Webster and her family when Webster's husband was terminally ill. With patients, Webster observed that respondent was gentle, honest, and respectful.

14. Respondent presented notes and cards from other colleagues praising his friendliness and professionalism.

15. Respondent also presented numerous cards and notes that he has saved over the years from patients, thanking him and wishing him well. Many of these patients expressed gratitude both for respondent's medical skill and for his compassion and patience.

Meeting With Caregiver on September 27, 2020

16. Starting in approximately 2018, respondent provided cardiology care to an elderly woman. He continued to treat this patient until her death in October 2020.

17. During the period when the elderly woman referenced in Finding 16 was respondent's patient, Caregiver was the patient's In-Home Supportive Services (IHSS) care provider. Caregiver performed non-medical tasks for the patient, such as cooking, cleaning, and running errands. In addition, Caregiver attended medical appointments with the patient, and helped the patient monitor her own health and communicate

with medical providers. Caregiver has no medical or nursing training and did not perform tasks for the patient that required such training.

18. In July 2020, at a routine office visit with the patient, respondent revised the patient's medication regimen. Caregiver was with the patient during this office visit. Respondent asked the patient to telephone or text-message him if she had any questions about the new medication or her response to it. The patient said that she did not know how to use text messaging, and asked respondent and Caregiver to arrange this communication. They agreed, and Caregiver gave respondent her telephone number. Respondent sent Caregiver a text message so that Caregiver would have his contact information as well.

19. The patient had a device to monitor her blood pressure at home. To use this device, a person needed to place a cuff around the wrist and push a button to start the measurement cycle. The machine then inflated the cuff to block blood flow temporarily, deflated it, and reported on a small screen the blood pressure its sensors had measured. Caregiver assisted the patient regularly in checking and recording the patient's blood pressure. On occasion, however, the device did not register the patient's blood pressure.

20. In late September 2020, Caregiver accompanied the patient to a follow-up appointment with respondent. Respondent had ordered some laboratory blood testing before the appointment, and at the appointment he discussed with the patient and Caregiver that the tests showed the patient's kidney function to be poor. He recommended that the patient increase her water intake. He also asked Caregiver to send him a text message every day reporting the patient's blood pressure, heart rate, oxygen saturation, and water consumption.

21. Caregiver sent her first text message to respondent in the early evening on Friday, September 25, 2020, with the patient's blood pressure, heart rate, and oxygen saturation readings. Respondent replied by asking how much water the patient had consumed during the day. Caregiver answered that question the next morning.

22. In the early evening on Saturday, September 26, 2020, Caregiver again sent respondent a text message about the patient. She reported the patient's morning blood pressure, heart rate, and oxygen saturation, and stated that in the evening the "machine wouldn't take her pressure." Respondent asked again about the patient's water intake, and Caregiver answered. Respondent replied, "Great job. Thanks."

23. The next morning (Sunday, September 27, 2020), respondent sent Caregiver a text message while Caregiver was on her way to the patient's home. He told Caregiver, "I'm in office this morning [until] early afternoon if you want [to] bring the blood pressure machine to check it [and] make sure it's accurate." Caregiver replied by saying that she would bring the patient's blood pressure device to respondent, although she did not say when she would do so.

24. Caregiver found respondent's invitation to his office on a Sunday somewhat odd. Nevertheless, she wanted to be sure that she gave the patient the best possible care, and she believed that respondent's invitation reflected a similar motive on his part. Caregiver conferred with the patient, and the patient agreed that Caregiver should take the blood pressure device to respondent's office that day.

25. Caregiver arrived at respondent's office shortly before noon. She telephoned respondent when she arrived, and he came to the building's door to let her in. To both of their knowledge, Caregiver and respondent were the only people in respondent's office suite.

CAREGIVER'S DESCRIPTION

26. Caregiver and respondent walked together from the building door to respondent's personal office. Caregiver sat on a couch near the office door. Respondent sat next to her, so close that their shoulders and legs touched.

27. Caregiver showed respondent the patient's electric blood pressure measurement device. Respondent explained to Caregiver that he suspected that this device was not sensitive enough to detect the patient's blood pressure when the blood pressure was especially low. Respondent offered Caregiver a manual blood pressure cuff and stethoscope, and said that he would show her how to use them.

28. To measure a person's blood pressure using a manual cuff and stethoscope, one places the cuff around the person's upper arm, and places the diaphragm of the stethoscope against the inner elbow of the same arm. Blood pressure measurement with a manual cuff and stethoscope does not involve placing any part of the stethoscope against the patient's chest wall.

29. Respondent demonstrated use of the manual cuff and stethoscope to Caregiver, on himself, although the evidence is unclear as to whether he demonstrated the technique correctly. Caregiver testified credibly that she never understood how to use the manual cuff and stethoscope.

30. Respondent then placed the chest piece of the stethoscope on Caregiver's left breast, by reaching inside her shirt with the chest piece in his hand. While holding the stethoscope on or near Caregiver's breast, respondent told her that he heard a heart murmur, and proposed that she immediately should have an electrocardiogram (ECG) to investigate it.

31. Caregiver found this information distressing, and surprising, because no medical provider ever before had suggested to her that she had a heart murmur. She agreed to the ECG. Caregiver had never undergone an ECG and did not know its diagnostic purpose.

32. Caregiver went with respondent to an examination room. Respondent asked her to expose her chest for the ECG, but did not offer her a gown or drape, and did not leave the room. Caregiver lay down on a table and pulled her shirt up near her clavicle, leaving her chest and breasts exposed.[1]

33. Respondent wiped the skin on Caregiver's breasts with a tissue from a packet, as if to clean the skin. He then applied a few electrodes to her body, connected by wires to the ECG device. He placed one or more electrodes on the upper portion of one breast, but did not place electrodes on Caregiver's sternum, or on her chest wall below her breasts. Respondent did not place a complete set of ECG electrodes on

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[1] Caregiver testified that she did not believe that she wore a brassiere that day. People who interviewed Caregiver immediately after the event, and also in late 2021, reported that she had described removing a brassiere. The evidence does not establish whether this conflict results from Caregiver's poor memory or from these interviewers' poor reporting. Regardless, conflict about this detail does not diminish Caregiver's credibility regarding her description of respondent's behavior.

The interviewer who spoke with Caregiver in late 2021 also summarized her as having said that she pulled the neckline of her shirt down to expose her chest, rather than pulling the waistband up. Caregiver testified credibly that this description of her statement is inaccurate.

Caregiver, and did not place them in appropriate locations for an effective diagnostic ECG.

34. Respondent started or purported to start the ECG device. He stared at Caregiver's torso, and said something to her that she did not hear well. When she asked him to repeat himself, respondent complimented Caregiver's figure.

35. Caregiver stood up and hurriedly disconnected herself from the electrodes. She struggled briefly to pull her shirt back over her torso, and respondent offered to help her. She declined, grabbed a piece of paper that she believed incorrectly[2] to be a printout of the ECG data the machine had collected from her, and left the examination room.

36. Caregiver went back to respondent's personal office to retrieve the blood pressure measurement device she had brought, the cuff and stethoscope respondent had offered her, and her purse. Respondent followed her, and stood in his office doorway. As Caregiver moved to leave the office, respondent leaned toward her as if to hug her and to kiss her lips. She turned her head, and his lips touched her cheek instead. Caregiver pushed past respondent to exit the office, left the building, and returned to the patient's home.

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[2] The parties presented considerable evidence about this document. Clear and convincing evidence established that it was not from an ECG performed on Caregiver on September 27, 2020, but did not establish whose (if anyone's) ECG printout it was or why it was in the examination room when respondent and Caregiver were there.

RESPONDENT'S DESCRIPTION

37. According to respondent, once he and Caregiver reached his office, he sat in his desk chair behind his desk, not next to her on the couch.

38. Respondent testified that Caregiver asked whether they should go to an examination room for the blood pressure device demonstration, but he told her that they would not because she was not a patient.

39. According to respondent, he first demonstrated on himself how to use the manual blood pressure cuff and stethoscope, and then allowed Caregiver to measure his blood pressure with these tools. He testified further that Caregiver seemed to understand his instructions and was able to measure his blood pressure. Respondent denies that he ever proposed to demonstrate on Caregiver how to take a person's blood pressure. The only physical contact respondent admits between himself and Caregiver is incidental contact that occurred while she practiced measuring his blood pressure.

40. Respondent testified that after Caregiver had satisfied both of them that she knew how to use the manual blood pressure cuff and stethoscope, they had a short and cordial discussion about her interest in attending nursing school. He then directed her to the building's rear exit (because its door would lock automatically behind her) and excused himself to the restroom. He did not watch Caregiver leave, but when respondent left the restroom he again was alone in the office suite.

REPORT TO MEDICAL GROUP

41. When Caregiver returned to the patient's home, she did not tell the patient what had happened when she was at respondent's office. The patient was able

to measure her blood pressure that evening, and Caregiver sent respondent a text message reporting the information.

42. Caregiver also provided IHSS care to the patient's son, who lived in the same apartment building as the patient. Later in the afternoon on September 27, 2020, Caregiver went to the son's apartment, and he perceived that Caregiver was in distress. After some prompting, she told him what had happened in respondent's office, in substantially the manner summarized in Findings 23 through 36 although with less detail.

43. The patient's son was very angry when he heard Caregiver's report, but thought he should "sleep on it" before taking any action. The next morning, he decided to relay Caregiver's report to respondent's medical group. He did not tell Caregiver that he intended to do so, or ask her permission; he testified credibly that he felt "obligated" to report respondent's sexually inappropriate behavior whether or not Caregiver wished to report it.

44. The patient's son called the medical group on Monday, September 28, 2020, and told the staff member with whom he spoke that respondent had put his hands down Caregiver's shirt and tried to kiss her, under the guise of teaching Caregiver to use a stethoscope. The staff member telephoned Caregiver later that day, and Caregiver confirmed the patient's son's report. The staff member passed the information to other physicians in respondent's medical group.

45. The medical group arranged an investigation, which included interviews with Caregiver and respondent. The investigator concluded that Caregiver's report was more credible than respondent's denials. On this basis, the medical group took disciplinary action against respondent, and reported the matter to the Medical Board.

CREDIBILITY ANALYSIS

46. Caregiver denies any interest in pursuing a medical or nursing career. She has moved to a different city, and currently works as a tour guide as well as in a warehouse.

47. Soon after this incident, the patient entered hospice care and died. For this reason, Caregiver had no further reason to communicate with respondent about the patient. Caregiver has had no contact with respondent since September 27, 2020.

48. The witnesses whose testimony is summarized in Findings 9 through 13 believe that Caregiver's allegations against respondent are untrue, because such behavior would be profoundly out of character for respondent. In light of the matters stated in Findings 41 through 47, however, and considering both Caregiver's and respondent's demeanor and motives, Caregiver's testimony about respondent's actions toward her on September 27, 2020, is credible. Where respondent's testimony differs from Caregiver's, as described in Findings 37 through 40, it is not credible. The matters stated in Findings 23 through 36 accurately describe respondent's actions toward Caregiver on September 27, 2020.

Standards of Care

49. Cardiologist John S. MacGregor offered testimony regarding standards of care for outpatient cardiologists. His undisputed testimony is persuasive.

50. By listening or purporting to listen to Caregiver's heart; by telling her that he heard an unusual and worrisome heart sound; and by offering Caregiver a diagnostic ECG, respondent formed a physician-patient relationship with Caregiver.

51. Taking a person's blood pressure does not involve placing a stethoscope on the person's breast or chest. A heart murmur is not a medical emergency warranting immediate diagnostic procedures without a prior review of the patient's medical records. An ECG is not an appropriate diagnostic procedure for a heart murmur.

52. Many cardiology procedures require the patient to give the cardiologist access to the patient's bare chest or torso. The standard of care is to offer the patient a gown or drape; to leave the room while the patient replaces clothing with the gown or drape; and to expose only as much of the body as is absolutely necessary to accomplish the medical procedure. In addition, the standard of care requires the physician to refrain from attention to or comment on a patient's breasts or appearance.

53. Dr. MacGregor testified credibly and persuasively that if respondent behaved toward Caregiver on September 27, 2020, in substantially the manner she described, respondent departed from the standard of care. Moreover, these departures are extreme.

Costs

54. Between January 1, 2022, and August 1, 2025, the Board had incurred $47,404.25 in costs for legal services provided to complainant by the California Department of Justice in this matter. In addition, complainant's counsel estimated that the Board would incur an additional $21,636.00 in legal fees between August 1, 2025, and the hearing date.

55. Complainant's claim for reimbursement of these costs is supported by a declaration that complies with California Code of Regulations, title 1, section 1042,

subdivisions (b)(2) and (b)(3), with respect to the amounts actually incurred and estimated. These costs are unreasonable, however, because they reflect considerable repetition and duplication of effort, especially given the small number of witnesses and issues in this matter. A reasonable amount for legal services from the Department of Justice for this matter is $40,000.

LEGAL CONCLUSIONS

1. The Board may take disciplinary action against respondent only if clear and convincing evidence establishes cause for such action. The factual findings above rest on clear and convincing evidence.

First Cause for Discipline (Sexual Misconduct)

2. Any act of "sexual abuse [or] misconduct" with a "patient, client, or customer" is unprofessional conduct for a health care provider that warrants disciplinary action. (Bus. & Prof. Code, § 726, subd. (a).)

3. Respondent's actions toward Caregiver on September 27, 2020, as summarized in Findings 23 through 36 and particularly in Findings 30, 32, 33, 34, and 36, constitute sexual misconduct that is cause for discipline against respondent.

Second Cause for Discipline (Gross Negligence)

4. Gross negligence by a physician in treating a patient is unprofessional conduct and is cause for discipline. (Bus. & Prof. Code, § 2234, subd. (b).)

5. In light of the matters stated in Findings 50 through 53, the matters stated in Findings 23 through 36 constitute cause for discipline against respondent.

Third Cause for Discipline (Generally Unprofessional Conduct)

6. Even absent gross negligence, other unprofessional conduct by a physician is cause for discipline. (Bus. & Prof. Code, § 2234.)

7. As summarized in Findings 23 through 36 and 53, respondent used deception, rooted in his reputation as a compassionate and competent cardiologist, to persuade Caregiver to allow him to touch and see her breasts. This unprofessional conduct is cause for discipline.

Disciplinary Considerations

8. The Medical Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Ed., 2016) call for at least seven years' probation for a physician who has committed sexual misconduct as defined by Business and Professions Code section 726. In this case, however, respondent has no plans to practice in California in the future, and denies that any sexual misconduct even occurred. Revocation of his California physician's and surgeon's certificate is appropriate to protect public welfare.

Costs

9. A physician who has committed a violation of the laws governing medical practice in California may be required to pay the Board the reasonable costs of the investigation and enforcement of the case, but only as incurred on and after January 1, 2022. (Bus. & Prof. Code, § 125.3.) The matters stated in Findings 54 and 55 establish that these costs for this matter total $40,000.

10. In *Zuckerman v. State Bd. of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth the standards by which a licensing board or

bureau must exercise its discretion to reduce or eliminate cost awards to ensure that the board or bureau does not deter licensees with potentially meritorious claims from exercising their administrative hearing rights. The court held that a licensing board requesting reimbursement for costs relating to a hearing must consider the licensee's "subjective good faith belief" in the merits of his position and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Id.*, at p. 45.) The board also must consider whether the licensee will be "financially able to make later payments." (*Ibid.*) Last, the board may not assess full costs of investigation and enforcement when it has conducted a "disproportionately large investigation." (*Ibid.*) None of these factors warrants reduction in respondent's cost reimbursement obligation.

ORDER

1. Physician's and Surgeon's Certificate Number A 74135, held by respondent Samer Kabbani, M.D., is revoked.

2. Respondent Kabbani must pay $40,000 to the Medical Board of California, within 30 days after the effective date of this decision, to reimburse the Board for its enforcement costs in this matter.

DATE: 10/08/2025

Juliet E. Cox

JULIET E. COX
Administrative Law Judge
Office of Administrative Hearings