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

In the Matter of the First Amended Accusation Against: Shahriar Sean Parsa, M.D. Physician's and Surgeon's Certificate No. A 101165 Respondent.	Case No.: 800-2021-074909

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 February 20, 2026.

IT IS SO ORDERED: January 22, 2026.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the First Amended Accusation Against:

SHAHRIAR SEAN PARSA, M.D.,

Physician's and Surgeon's Certificate No. A 101165

Respondent.

Agency Case No. 800-2021-074909

OAH No. 2024100598

PROPOSED DECISION

Administrative Law Judge Michael C. Starkey, State of California, Office of Administrative Hearings, heard this matter on March 18 through 20, and August 13, 2025, via videoconference.

Supervising Deputy Attorney General Greg W. Chambers represented complainant Reji Varghese, Executive Director, Medical Board of California, Department of Consumer Affairs.

Attorney Cyrus A. Tabari represented respondent Shahriar Sean Parsa, M.D., who was present.

The record was held open for briefing. Complainant's closing brief, hearing transcripts (Volumes I through IV), respondent's closing brief, and complainant's reply were received and marked for identification as Exhibits 59 through 63, QQQ, and 64, respectively. The record was closed on October 27, 2025.

FACTUAL FINDINGS

Jurisdictional Matters

1. On August 8, 2007, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 101165 to respondent Shahriar Sean Parsa, M.D. This certificate was in full force and effect at all relevant times and is scheduled to expire on November 30, 2026, unless renewed.

2. On January 31, 2024, acting in his official capacity as Executive Director of the Board, complainant Reji Varghese issued and served an accusation against respondent. Complainant alleged that cause exists to discipline respondent's certificate because he: was grossly negligent in his care of Patients 1 through 5 (names withheld for privacy); and was repeatedly negligent in his care of Patients 1, 2 and 5, in connection with the administration and/or prescription of opioid, ketamine,[1] sedative, corticosteroid, and antibiotic medications; and that this establishes cause to discipline his license. Complainant also seeks costs.

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[1] Ketamine or ketamine hydrochloride is a non-barbiturate, rapid-acting injectable anesthetic. It is a dangerous drug as defined in Code section 4022 and a Schedule III controlled substance as defined by Health and Safety Code section 11056.

3. Respondent timely filed a notice of defense and this proceeding followed.

4. On March 20, 2025, complainant filed the operative first amended accusation, which added a third cause for discipline: failure to maintain adequate and accurate medical records of Patients 1, 2, 3, and 5.

Background

5. From approximately 2013 through 2020, respondent worked part time at Los Gatos Urgent Care (LGUC), primarily on weekends. From March 2020, through June 2021, respondent maintained a solo practice, focused on primary care. From June 2021 through March 3, 2025, respondent worked as a primary care and urgent care physician and a supervisor for Optum Clinic (formerly known as Physician's Medical Group) in San Jose.

Expert Testimony

6. Kathryn Maxwell, M.D., testified for complainant. Dr. Maxwell has been licensed as a physician in California since 2004 and is board certified in family medicine. She has worked as a physician for a large medical group in the County of San Diego since 2005, primarily in urgent care, but she occasionally works as a primary care provider (PCP). Dr. Maxwell served as associate chair of this medical group's urgent care practice for one year. From 2013 through the present, Dr. Maxwell has served as a preceptor for various physician, nurse, and nurse practitioner programs. She has served as an expert reviewer for the Board since 2022.

7. Dean J. Nickles, M.D., testified for respondent. Dr. Nickles has practiced as a physician for 45 years. He is board certified in internal medicine. He was board

certified in critical care from 1987 to 1997. He worked as a physician in the United States Army for 11 years and for the last 25 years has practiced primarily as a PCP, currently in Emeryville. He teaches medical students and nurse practitioner students in clinical practice and served for several years on a quality committee for his medical group.

8. Paul Wender, M.D., testified for respondent. Dr. Wender has practiced as a physician for approximately 30 years. Dr. Wender is board certified in anesthesia and worked as an anesthesiologist through 2020. He served as an assistant clinical professor for four years in the early 2000's. In 2016, Dr. Wender founded a ketamine clinic, administering ketamine infusions for mood disorders and chronic pain conditions. This is now his exclusive work. Dr. Wender's testimony was offered solely regarding prescribing ketamine.

Patient 1

OPIOIDS

9. Patient 1, a 33-year-old female, a former smoker with chronic pain and severe opioid use disorder, was first seen by respondent at LGUC on November 4-5, 2017, for an abscess. Patient 1 was then seen again on June 2, 2018, for abdominal pain. In the year and a half that respondent treated Patient 1, there were numerous records from Farzaneh Tabrizi, M.D. (who owned and operated LGUC, treated its patients, and was respondent's employer) noting that Patient 1 was opioid dependent. Respondent's own November 18, 2018, record states that Patient 1 was in "chronic pain, opioid dependent." However, respondent administered intramuscular and intravenous opioid injections to Patient 1 more than 30 times in the urgent care setting, with no record of a pain contract or urine toxicology screens.

10. At hearing, respondent submitted a copy of an undated "Yelp" review, apparently from Patient 1, which states that respondent "was the only one who made the correct diagnosis and honestly saved my life" and that respondent is "one of the last breed of doctors who sees each patient as a person, not a dollar sign or way to bill insurance."

11. On May 26, 2019, respondent saw Patient 1 for the final time. Respondent administered promethazine and hydromorphone—an opioid—to Patient 1. In a Board interview on March 16, 2023, respondent stated that on May 26, 2019, Patient 1 "looked very bad. She looked grey, almost no weight, probably less than 100 pounds. Uh - - she - - she was - - she was not in good shape. She was in horrible shape, depressed . . ." A coroner's report, dated May 29, 2019, contradicted this description of Patient 1, noting, the "body is that of a normally developed, well nourished, adult white female, weighing 174 pounds, measuring 68 inches, and appearing consistent with the documented age of 33 years." At hearing, respondent had no explanation for this discrepancy. When asked why his patient care record did not reflect his description, he testified that "looking gray . . . does not mean anything clinically" and does not need to be documented. He testified that he did not believe Patient 1's condition was deteriorating and that the record shows she had a migraine, which can cause a patient to look gray. In his investigative interview, respondent reported that Patient 1 "became paranoid . . . She was freaking out. I don't know what the cause it - - what was the cause." Respondent's records of care for Patient 1 do not reflect these concerns either. Respondent did not recommend mental health treatment during his final visit with Patient 1.

12. Respondent administered an opioid to Patient 1 during her final visit, presumably for her chronic pain. Respondent never clearly coordinated Patient 1's care

with her PCP even though respondent testified that Dr. Tabrizi was one of Patient 1's PCP's. Respondent, who wrote "f/u w PCP" on the record for Patient 1's final visit, also testified at hearing that he was her PCP at the time of the last visit.

13. Patient 1 died the next day from mixed drug toxicity (heroin, buprenorphine, butalbital, clonazepam, promethazine, and amphetamine) while in hospital. An emergency room physician apparently prescribed some opioid medication to her that day. Also, a syringe containing a pink and white substance was found in her purse.

14. Dr. Maxwell opined that it was an extreme departure from the standard of care for respondent to treat Patient 1, a chronic pain patient, with opioids on a regular basis without a pain contract in place and without urine toxicology screens. Dr. Nickles testified that the prescribing of opioids was appropriate and within the standard of care, but did not explain whether he considered Patient 1's opioid dependence in forming that opinion.

CORTICOSTEROIDS

15. Respondent administered corticosteroids to Patient 1 on eight occasions. He reports that he administered them for asthma exacerbated by pneumonia, and also in an attempt to confirm a lupus diagnosis.

16. Dr. Maxwell opined that it was a simple departure from the standard of care for respondent to repeatedly treat Patient 1 with corticosteroids in the urgent care setting. Dr. Maxwell explained that corticosteroids are used to treat inflammation but have many adverse side effects and are rarely used long-term. She opined that a reasonably prudent urgent care provider would refer a patient to a specialist, such as a

rheumatologist, for treatment of a condition that might require repeated injection of corticosteroids.

17. Conversely, Dr. Nickles reports that he frequently gives patients corticosteroids, including for musculoskeletal pain, as respondent did here. He also testified it is appropriate to give corticosteroids to patients for whom lupus is suspected as there is no test for lupus, and if the patient responds to the steroid, that could confirm a lupus diagnosis.

ANTIBIOTICS

18. Respondent administered an injection of ceftriaxone (an antibiotic) to Patient 1 on two occasions, without prescribing a complimentary oral antibiotic after diagnoses of an abscess, sinusitis, and fever of unknown origin. Dr. Maxwell opined that these were simple departures from the standard of care because a follow-up course of oral antibiotics is necessary to prevent antibiotic-resistance. Dr. Nickles disagreed, opining that the records contain no evidence of a bacterial infection that would require the prescription of oral antibiotics on those two occasions. Dr. Nickles did not explain why—if there was no bacterial infection—respondent administered the injectable antibiotic.

KETAMINE

19. Respondent also prescribed ketamine to Patient 1 on May 6 and April 29, 2019. There appears to have been another prescription for ketamine that was picked up the day after Patient 1 died. Respondent did not prescribe a more traditional antidepressant medication to Patient 1.

20. Dr. Maxwell opined that it was not the standard of care to prescribe ketamine from urgent care centers from 2017 through 2019, and it would be an extreme departure from the standard of care to do so. Dr. Maxwell also opined that prescribing ketamine to Patient 1, who was opioid dependent, was a breach of the standard of care because ketamine is a drug with the potential for abuse. Dr. Maxwell opined that it would breach the standard of care for a PCP to prescribe ketamine during this period, reporting that ketamine "came into" the PCP literature in 2022, as a 19th option in an algorithm for the treatment of depression. Dr. Maxwell reports that she understands that the prescription of ketamine is gaining acceptance, but it was not within the standard of care for an urgent care physician or PCP before 2022. She opines that if a PCP's patient presents with mental health disorders, such as depression, the PCP usually provides an option of first-line medication or refers the patient to mental health providers. Dr. Maxwell initially opined that selective serotonin reuptake inhibitors (SSRIs) are the first-line medications to treat depression or anxiety, but later conceded that serotonin-norepinephrine reuptake inhibitors (SNRIs) like Wellbutrin are also acceptable.

21. Dr. Nickles testified that ketamine is not "a drug that I'm familiar with, nor have I used that drug in my career." Nevertheless, Dr. Nickles opined that it is a physician's choice regarding which drug to prescribe first for mental health problems and respondent's prescribing of ketamine comported with the standard of care.

22. Dr. Wender has never practiced as an urgent care physician or PCP. He is very knowledgeable about ketamine, based on his experience and training as an anesthesiologist, and his experience operating a ketamine clinic since 2016. Dr. Wender opines that ketamine is a safe treatment for mood disorders and especially effective for "treatment-resistant" depression. Dr. Wender opines that ketamine is

"pretty much" a "miracle drug." Dr. Wender persuasively opines that ketamine is not a respiratory depressant (as claimed by Dr. Maxwell) even at 10 times the dose used for psychiatric treatment and it actually acts briefly (for approximately 15 minutes) as a respiratory stimulant. He reports that ketamine is regarded as the safest anesthetic drug, originally used on the battlefield in Vietnam because it could be administered without monitoring. However, it is not used as an anesthetic in the United States because of excess salivation and a contraindication for severe hypertension. Dr. Wender opines that, assuming a patient does not have severe hypertension, ketamine nasal spray is safe for home administration.

23. Regarding the standard of care for an urgent care practitioner prescribing ketamine from 2017 to 2021, Dr. Wender opined "Well, I don't think there would have been a written standard. It would be basically the same standard of care anywhere. There were no written standards back then." Dr. Wender opines that the standard of care was not different for a PCP "because giving care is giving care. I mean, you don't give a lower standard necessarily just because you decide to do it somewhere else." Dr. Wender opines that it is within the standard of care to prescribe ketamine as a first treatment for a mood disorder. Dr. Wender opines that ketamine dosages for this purpose are much lower than for the use of ketamine as an anesthetic.

24. Respondent admitted he had taken no classes regarding the prescribing or administering of ketamine prior to 2018, but reported that he was familiar with ketamine based on his habit of constantly continuing his medical education, even in areas outside his formal training. Respondent also reports that he spoke to Patient 5's psychiatrist prior to prescribing ketamine to that patient, who was the first patient to whom he prescribed or administered ketamine.

Patient 2

25. On April 11, 2015, respondent first treated Patient 2, a then 35-year-old male who had an infected testosterone implant. Respondent directed Patient 2 to the hospital for the infection. Patient 2 continued to visit respondent at LGUC from April 11, 2015, through November 10, 2019, and then after respondent left LGUC. Following a motorcycle accident, Patient 2 visited respondent for severe knee pain including after surgery. Respondent also treated Patient 2 for undiagnosed abdominal pain, subsequent to evaluations by a general surgeon, an endocrinologist, and a pain specialist.

OPIATES

26. Between June 15, 2016, and January 29, 2021, respondent wrote Patient 2 a total of 32 opioid prescriptions – the majority of which were Oxycodone HCL 30 mg #40. There were no documented discussions regarding treatment goals or response to therapy, mitigation of risks, or effective monitoring of therapy.

27. Dr. Maxwell opined that the prescribing of opioids to Patient 2 in the urgent care and primary care settings constituted extreme departures from the standard of care, due to the failure of respondent to review the treatment goals, mitigate risks including by prescribing naloxone (brand name Narcan, an opioid antagonist used to treat opioid overdose), and monitor Patient 2's therapy such as through the use of toxicology screens or controlled substance agreement. Patient 2 later testified that the opioids were for his chronic pain after serious knee injuries and undiagnosed abdominal pain and respondent counseled him about the risks of opioids and referred him to a pain specialist (but he had already visited a pain clinic), and that he already had a prescription for Narcan. Patient 2 reports that respondent

diagnosed him with lupus and referred him to a rheumatologist, who confirmed the diagnosis. Respondent and Patient 2 also testified that Patient 2 (as well as Patients 3 and 4, who are Patient 2's brother and wife, respectively) have jobs that involve government contracts and security clearances and they asked respondent to record as little as possible in their patient records.

28. Dr. Nickles opined that respondent failed to adequately document the indications and goals of treatment (regarding opiates and other prescriptions and treatments), but Patient 2 was experiencing chronic pain and there is no reason to prescribe Narcan if the patient already has a prescription, so respondent's prescription of opiates to Patient 2 did not breach the standard of care. Dr. Nickles clarified that his criticism of respondent's medical recordkeeping applied to respondent's records for all five patients at issue.

KETAMINE

29. Respondent wrote Patient 2 prescriptions for ketamine for depression, chronic pain, and PTSD on eight occasions between April 11, 2019, and April 30, 2021. There were no documented referrals to mental health specialists and no prescriptions for other medications to treat depression or PTSD.

30. Dr. Maxwell testified that the prescribing of ketamine to Patient 2 was an extreme departure from the standard of care. Patient 2 later testified that he had previously tried other medications for depression, but once respondent prescribed him ketamine the "color came back in my life" and he also experienced relief from his chronic pain. He credits respondent for "turning my life around" and reports that the ketamine had a lasting effect and he has not felt the need to take it in years. Dr.

Nickles and Dr. Wender opined that respondent's prescription of ketamine did not breach the standard of care for the same reasons as previously discussed.

SEDATIVE

31. Respondent also prescribed zolpidem tartrate (brand name Ambien, a Schedule IV controlled substance and sedative widely used to treat insomnia) on 13 occasions, with no documented discussion of risk, referral to a mental health specialist, or Narcan prescription. During this time, other providers were prescribing opioid medications to Patient 2.

32. Dr. Maxwell opined that to treat insomnia an urgent care physician will typically prescribe a non-controlled substance sleep aid (like eszopiclone or trazadone, or antihistamines) first and should direct the patient to see a sleep specialist as zolpidem tartrate is not recommended for long term use, is addictive, and has serious risks and side effects. Dr. Maxwell opined that respondent's prescription of zolpidem tartrate to Patient 2 was a simple departure from the standard of care. Dr. Nickles opined that these prescriptions only reflect "poor documentation."

TESTOSTERONE

33. Respondent prescribed testosterone to Patient 2 on 17 occasions between 2017 and 2022, without any record of testing to establish a low level of this hormone or normal levels during treatment until January 2021 (showing a high level) and then again in August 2022. Dr. Maxwell opined this constituted a simple departure from the standard of care. Patient 2 later testified that he had been diagnosed with low testosterone prior to seeing respondent. Dr. Nickles opined that it was within the standard of care to continue testosterone therapy and the one test showing a high

level was not concerning because there is a poor correlation between testosterone levels and clinical improvement.

Patient 3

34. Respondent prescribed ketamine to Patient 3, an Arizona resident and the brother of Patient 2, on four occasions between April 16, 2019, and August 10, 2020. The records fail to note any discussion with Patient 3 regarding the use of ketamine. There were no documented discussions about risks, and no referral to a mental health specialist. At hearing, respondent testified that he spoke with Patient 3 initially for almost an hour and learned that he had back pain, sleep problems, a past history of ruptured muscle cells due to dehydration, and possibly PTSD. Patient 3 heard from Patient 2 that ketamine had been very helpful and wanted to try it and was also suffering from a high level of pain from a very recent elbow surgery.

35. Dr. Maxwell opined that the prescribing of ketamine to Patient 3 was an extreme departure from the standard of care in a primary care setting due to the failure to first consider first-line medications used to treat depression and management of PTSD. Drs. Nickles and Wender disagreed, as discussed above.

Patient 4

36. According to the medical records available, respondent met with Patient 4 (Patient 2's wife) only on a single occasion. In his subject interview, respondent thought he may have met with Patient 4 on two occasions. Respondent prescribed ketamine to Patient 4 in April of 2019, July 2019, April 2020, and September 2021. Respondent claims that Patient 4, an Arizona resident who travelled to California to be treated by him, provided him records that he returned to her. Respondent claims he did not record the rationale for his ketamine prescribing due to the sensitive nature

of Patient 4's job. Presumably, the rationale was for anxiety. There was no evidence respondent tried other treatments for Patient 4's mental health or pain; there was no referral to mental health providers; there was no recorded discussion of the risk of ketamine.

37. Dr. Maxwell opined that respondent's prescribing of ketamine to Patient 4 was an extreme departure from the standard of care. Dr. Nickles did not specifically opine as to respondent's care and treatment of Patient 4, but the rationale of his opinions regarding respondent's prescription of ketamine to the other four patients appears applicable.

Patient 5

KETAMINE

38. Respondent began treating Patient 5, a 59-year-old female, on August 30, 2016. Respondent prescribed ketamine nasal spray and ketamine lozenges to Patient 5 on 16 occasions between December 28, 2018, and September 2, 2021, for treatment-resistant depression. Patient 5 last saw respondent in clinic on March 8, 2020.

39. The medical records described anxiety and depression, but did not mention any discussion of risks, or prior treatments or recommendations from mental health professionals. On September 4, 2019, Dr. Tabrizi documented that Patient 5 experienced forgetfulness as an adverse effect of ketamine. Nevertheless, in Patient 5's next visit to LGUC on March 8, 2020, respondent again prescribed ketamine without addressing the issue. In respondent's investigative interview, he reported that he was unaware of this issue and "[i]f there was anything, [the] patient actually was -- started to remembering things, because the depression was -- started getting better."

40. Dr. Maxwell opined that respondent's prescription of ketamine to Patient 5 was an extreme departure from the standard of care, based on the same reasoning discussed earlier but also because the records showed that he continued to prescribe ketamine after Patient 5 reported it was causing her memory problems, without addressing that problem.

41. Dr. Nickles and Dr. Wender disagreed, on the same bases as previously discussed.

42. At hearing, respondent testified that Patient 5 asked for a refill of a prescription for ketamine previously prescribed her psychiatrist because she was low-income and unable to pay the psychiatrist's $800-per-visit fee. Respondent reports that Patient 5 had already tried numerous other medications and treatments for her depression, without much success. Respondent pointed to a record of his December 17, 2018, examination of Patient 5, which bears a handwritten note that indicates that Patient 5 was diagnosed with severe depression and had been evaluated "at Stanford" and prescribed ketamine. Respondent testified that Patient 5 responded to treatment and became a "different person," including starting a fitness regimen, reuniting with her son, and getting back to a "normal life" without "suffering." Respondent did not dispute Dr. Maxwell's characterization that he failed to address Patient 5's complaint to Dr. Tabrizi of "forgetfulness" as a side effect of the ketamine respondent prescribed and then prescribed her more of the drug.

SEDATIVES

43. Beginning in approximately June 2018, respondent prescribed several controlled substance sedatives to Patient 5, including alprazolam (brand name Xanax, a benzodiazepine used to treat anxiety), eszopiclone (brand name Lunesta, a sedative

used to treat insomnia), clonazepam (a sedative for anxiety). Pursuant to the records, respondent did not check the Controlled Substance Utilization Review and Evaluation System (CURES) regarding this patient until March 8, 2020, long after he prescribed clonazepam and alprazolam to her. Many other professionals had prescribed sedatives to Patient 5, including Dr. Tabrizi.

44. Dr. Maxwell admitted uncertainty whether CURES reports show when a medication was prescribed, or when the prescription is filled, or whether a prescription was a "refill" of one originally prescribed by another provider. Dr. Maxwell opined that respondent's prescription of controlled substance sedatives to Patient 5 prior to checking CURES was a simple departure from the standard of care. She also opined that his continued prescription of these drugs after checking CURES but with no one coordinating the prescription of these drugs between providers were also simple departures from the standard of care.

45. Dr. Nickles agreed that a failure to check CURES before prescribing these medications would be a simple departure from the standard of care, but opined that it is not required to document whether CURES was checked. Respondent testified that he checked CURES before prescribing medication for Patient 5 and every other patient: "[e]very single patient every single time." Respondent also pointed out that, regarding the clonazepam prescription, Dr. Maxwell admitted that it appears that Patient 5 called for a refill of this prescription, which had already been prescribed to her by another physician. Dr. Maxwell did not specifically opine that CURES needs to be checked when refilling a prescription.

The Complaint and Investigation

46. The Board received a complaint from the California Department of Public Health (CDPH)-Prescription Review Program that Patient 1 died from mixed drug toxicity and respondent was one of the last known doctors to have prescribed to her before she died. A Board medical consultant identified additional patients of respondent with concerning prescription patterns and the Board investigated.

47. During this investigation, respondent wrote a letter to the Board, dated September 27, 2021, responding to a Board letter inquiring about Patient 1 and four other patients, apparently focused on respondent's prescribing of ketamine. In his letter, respondent stated that he did not have access to the LGUC records, but then stated "[a]t no time did I prescribe ketamine to this patient [Patient 1], or any other narcotics." At hearing, respondent testified that he did not remember writing this letter but it is on his letterhead and appears to bear his signature. He testified that he does not know why it says he did not prescribe ketamine to Patient 1.

Respondent's Additional Evidence

48. Respondent completed medical school and a residency in internal medicine in Iran. In 2001, he emigrated to the United States. He worked as a visiting clinician for two years at the Mayo Clinic from 2002 to 2004; was a surgical resident in 2005 to 2006; edited research manuscripts at the University of Hawaii in 2006 and 2007; and served as a visiting scholar researcher for a surgical oncology melanoma project at Stanford University from 2007 to 2009. Respondent is not board certified in any medical discipline in the United States.

49. On March 18, 2025, respondent testified that he was "currently practicing" at Optum Clinic (See Factual Finding 5). On August 13, 2025, respondent

testified that he was terminated from his employment with Optum on March 3, 2025, and has since started own practice in San Jose. Respondent reports that this termination was not related to patient care or recordkeeping.

50. Respondent reports that he was very nervous during the hearing and English is not his first language so he sometimes had difficulty understanding the precise meanings and definitions of certain words.

51. On the website for his current practice, respondent states that he "excels in the area of rare and difficult cases to diagnose" and that he has "helped hundreds of patients find answers to lingering and complex medical issues."

52. Respondent submitted 59 letters, primarily from former or current patients, but also some from coworkers and colleagues. The authors, especially the patients, hold respondent in the highest regard, many reporting that he provided diagnoses or treatment that solved problems no other provider was able to solve.

53. Respondent first testified at hearing that he checks CURES for every patient, every time he prescribes medication. Later he testified that he checks CURES every four months and has always done this.

54. Respondent reports that Dr. Tabrizi, his employer at LGUC, multiple times told him his patient record may not exceed one page (handwritten on a pre-printed form) and that Dr. Tabrizi once tore up a record in front of a patient and threatened to fire him, and that is the primary reason he did not keep more detailed patient records. He reports that he did his best to ensure patient care while at LGUC, often working many unpaid additional hours. In 2024, pursuant to a stipulation without admissions, the Board placed Dr. Tabrizi on probation for a period of three years, after issuing an

accusation charging her with negligence in patient care and failure to maintain adequate and accurate medical records. Dr. Tabrizi did not testify in this proceeding.

55. In June 2025, respondent completed a 16-hour medical recordkeeping course offered by the University of California, Irvine School of Medicine.

56. Respondent reports that he now uses recordkeeping software that employs artificial intelligence to "listen" and summarize (with patient consent) to the conversation respondent has with each patient, and afterwards respondent reviews the summary and makes any necessary corrections.

57. Respondent reports that, since 2020, he no longer prescribes controlled substances to his patients, and instead he refers them to an emergency department for acute pain, or to a pain specialist for chronic pain. He reports that there was no event that triggered this change in his practice and that he rarely prescribed such drugs beforehand.

58. Regarding his ability to pay the cost award requested by complainant, respondent reports that it would be a hardship because he is "almost broke financially," citing alimony and attorney's fees from a divorce. He did not submit any financial records to support this testimony, but it was credible.

Ultimate Findings

59. Respondent generally appeared to be a sincere witness, but his false statement in the September 27, 2021, letter to the Board denying that he prescribed ketamine to Patient 1 (see Factual Finding 47); his grossly inaccurate description of Patient 1 as probably less than 100 pounds when he last saw her (see Factual Finding 11); his equivocation about these statements; and other inaccuracies in his testimony

(see Factual Finding 49), raised serious questions about his credibility, regardless of his intent. His testimony regarding his care of Patients 1 through 5 was not credible to the extent he makes claims that were not corroborated by the patient records or other evidence.

60. Dr. Maxwell's testimony regarding the applicable standards of care was generally persuasive. She appeared to be knowledgeable, unbiased, and willing to reconsider her opinions in light of new information. Dr. Nickles is very experienced and knowledgeable, but his opinions were generally not as well-explained and he appeared to be somewhat biased in favor of respondent. Dr. Wender is very knowledgeable regarding ketamine and his opinions regarding the drug itself were persuasive. However, his expertise is in anesthesia and ketamine clinics. He is not especially qualified to opine on the standard of care applicable to urgent care (or primary care) physicians, nor did he appear to be unbiased on the topic of prescribing ketamine, which he views as "pretty much" a "miracle drug."

KETAMINE

61. Dr. Maxwell's opinion was persuasive that the standard of care applicable to urgent care physicians in the relevant period (2017 through 2021) did not include prescribing ketamine as a first-line treatment for depression or other mood disorders. There is no evidence that Patient 1 had tried other treatments for depression or mood disorders prior to respondent's prescription of ketamine to her, and respondent knew or should have known that Patient 1 was opioid dependent, increasing the risk of prescribing ketamine (a drug that can be abused) to her. However, in considering all the evidence, it was only shown that this constituted a simple departure from the standard of care, rather than an extreme departure.

62. Similarly, respondent's prescription of ketamine to Patients 3 and 4 constituted simple departures from the standard of care because the evidence did not establish that any other treatment for a mood disorder was attempted prior. Conversely, the evidence established that Patients 2 and 5 had previously tried multiple other treatments for depression and therefore respondent's prescription of a ketamine nasal spray to these patients was not shown to be a departure from the standard of care, for failure to first try more common medications. However, respondent's prescription of ketamine to Patient 5, after she complained of forgetfulness as a side effect, without addressing this concern, was a simple departure from the standard of care.

OPIATES

63. Dr. Maxwell's opinion was persuasive that respondent's administration and prescription (once) of opioid medication to Patient 1 was an extreme departure from the standard of care because she was opiate dependent and there was no evidence of a pain contract, urine toxicology screens, or an explanation of the risks. Dr. Nickles's opinion to the contrary did not appear to consider Patient's 1 opioid dependence.

64. Conversely, the evidence did not show that respondent's prescription of opioid medication to Patient 2 departed from the standard of care because Patient 2 credibly testified that he had previously been prescribed opiates by a pain specialist and already had a prescription for Narcan.

SEDATIVES

65. Dr. Maxwell's opinion, that respondent's prescription of Ambien to Patient 2 was a simple departure from the standard of care because he did not begin

with a less dangerous sleep aid or refer Patient 2 to a sleep specialist, was more persuasive than Dr. Nickles's assertion that this was at worst a documentation error. No evidence contradicted the factual assumptions that support Dr. Maxwell's opinion.

66. Dr. Maxwell's opinion was persuasive that respondent's prescription of several controlled substance sedatives to Patient 5 constituted a simple departure from the standard of care prior to checking CURES, and afterwards, because no one was coordinating the prescription of these drugs between providers. Respondent's claim that he checked CURES before every prescription of a drug was not credible.

TESTOSTERONE

67. Dr. Maxwell's opinion, that respondent committed a simple departure from the standard of care by prescribing testosterone to Patient 2 without any record of testing to establish a low level of this hormone or normal levels during treatment until January 2021, was not persuasive in light of later evidence which showed that Patient 2 had previously been diagnosed with low testosterone by a specialist, and in light of Dr. Nickles's opinion that there is a poor correlation between testosterone levels and clinical improvement.

CORTICOSTEROIDS

68. Dr. Maxwell's opinion that respondent committed a simple departure from the standard of care by prescribing corticosteroids to Patient 1 on eight occasions was less persuasive than Dr. Nickles's opinion to the contrary, especially in light of respondent's explanation that the primary purpose was to confirm a lupus diagnosis, which Dr. Nickles endorsed as an accepted use.

ANTIBIOTICS

69. Respondent committed two simple departures from the standard of care when he administered antibiotic injections to Patient 1 without prescribing a complimentary oral antibiotic to prevent antibiotic resistance. Dr. Maxwell's opinion was more persuasive than Dr. Nickles's, who did not address the abscess and fever diagnoses or explain why one would administer the injection if there was no bacterial infection present.

RECORDKEEPING

70. The evidence overwhelmingly established that respondent failed to maintain adequate medical records for Patients 1, 2, 3, and 5. Even Dr. Nickles was critical of respondent in this regard.

Costs

71. In connection with the investigation and enforcement of this accusation, complainant requests an award of costs in the total amount of $45,701.50, comprising $17,644.50 in investigative services, $12,950 in expert witness fees, and $15,107 in attorney and paralegal services provided by the Department of Justice and billed to the Board. That request is supported by declarations that comply with the requirements of California Code of Regulations, title 1, section 1042. Respondent argues that these declarations fail to state each task with sufficient specificity and that a quarter-hour billing increment is unreasonable. These arguments are rejected and the costs are found to be reasonable.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant is required to prove cause for discipline of a professional license, permit, or registration by "clear and convincing proof to a reasonable certainty." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) To the extent respondent contends mitigation or rehabilitation, it is his burden to prove those contentions by a preponderance of the evidence. (Evid. Code, §§ 115, 500.)

First Cause for Discipline (Gross Negligence)

2. The Board may discipline the physician's and surgeon's certificate of a licensee who commits unprofessional conduct. (Bus. & Prof. Code, § 2234 [all further statutory references are to the Business and Professions Code unless stated otherwise].) Unprofessional conduct includes conduct that is grossly negligent. (§ 2234, subd. (b).) An extreme departure from the standard of care constitutes gross negligence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) Cause exists to discipline respondent's physician's and surgeon's certificate under section 2234, subdivision (b), in light of Factual Finding 63 (prescribing opioid medication to Patient 1, who was opioid-dependent, without a pain contract, urine toxicology screens, or an explanation of the risks).

Second Cause for Discipline (Repeated Acts of Negligence)

3. Unprofessional conduct includes conduct that is repeatedly negligent. (§ 2234, subd. (c).) Respondent successfully defended the allegations that he was negligent in his prescription of: ketamine to Patients 2 and 5; opioid medication to Patient 2; testosterone to Patient 2; and corticosteroids to Patient 1. (Factual Findings

62, 64, 67 & 68.) However, cause exists to discipline respondent's physician's and surgeon's certificate under section 2234, subdivision (c), based on findings that he committed simple departures from the standard of care in his prescription of ketamine to Patients 1, 3, 4, and 5; and sedatives to Patient 2 and 5; and by administering antibiotic injections to Patient 1 without prescribing a complimentary oral antibiotic. (Factual Findings 61, 62, 65, 66 & 69.)

Third Cause for Discipline (Inaccurate and Incomplete Recordkeeping)

4. Pursuant to section 2266, a licensee's failure to maintain adequate and accurate records also constitutes unprofessional conduct. Cause exists to discipline respondent's physician's and surgeon's certificate under section 2266 in light of Factual Finding 70.

Determination of Discipline

5. Cause for discipline having been established, the next issue is what discipline is appropriate. The Board's highest priority is protection of the public. (§ 2229.) However, "to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees." (Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines ("Guidelines") (12th ed. 2016), at p. 2; see Cal. Code Regs., tit. 16, § 1361.) The Board may consider a respondent's attitude toward his offense and his character, as evidenced by his behavior and demeanor at hearing. (*Yellen v. Board of Medical Quality Assurance* (1985) 174 Cal.App.3d 1040, 1059–1060.) The Guidelines provide for disciplinary orders that deviate from the recommended discipline, in appropriate circumstances where the departures and supporting facts are identified.

6. For the violations found in this case, the Guidelines recommend a maximum discipline of outright revocation and a minimum disciplinary order of revocation, stayed, with a five-year period of probation, including standard conditions plus: education course, prescribing practices course, a medical recordkeeping course, an ethics course, a clinical competence assessment program, monitoring of practice and/or billing, solo practice prohibition, and areas of prohibited practice. Complainant argues for the minimum discipline, with an education course, prescribing practices course, a medical recordkeeping course, an ethics course, and a clinical competence assessment program. Respondent argues that the appropriate discipline should be, at most, a public reprimand because respondent completed a recordkeeping course and implemented new recordkeeping procedures and therefore poses no threat to the public.

7. Respondent committed one extreme and numerous simple departures from the standard of care and pervasively failed to keep adequate records. No patient harm was alleged or proven. Respondent showed some mitigation for his documentation deficiencies in that Dr. Tabrizi appears to have limited the length of his patient records. Respondent also recently demonstrated rehabilitation by voluntarily taking a 16-hour recordkeeping course and implementing new documentation software and procedures. Based on the evidence, it appears that respondent devotes an extraordinary amount of time and effort into the care of his patients and that many of his patients regard him as a truly remarkable physician, singularly capable of diagnosing and treating many ailments. Respondent appears to share this opinion, which enhances concerns about him complying with the standard of care appropriate to his training and expertise. The minimum discipline recommended by the Guidelines is sufficient to protect the public. There is no cause to deviate except that, as

recommended by complainant, it is not necessary to impose conditions requiring a practice or billing monitor, solo practice prohibition, or areas of prohibited practice.

Costs

8. A licensee who is found to have committed a violation of the licensing act may be ordered to pay a sum not to exceed the reasonable costs of investigation and enforcement. (§ 125.3.) Cause exists to order respondent to pay the Board's costs in the amount of $45,701.50. (Factual Finding 71 and Legal Conclusions 2–4.)

9. Cost awards must not deter licensees with potentially meritorious claims from exercising their right to an administrative hearing. (*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) Cost awards must be reduced where a licensee has been successful at hearing in getting the charges dismissed or reduced; a licensee is unable to pay; or where the scope of the investigation was disproportionate to the alleged misconduct. (*Ibid.*) The agency must also consider whether the licensee has raised a colorable challenge to the proposed discipline, and a licensee's good faith belief in the merits of his or her position. (*Ibid.*). Respondent successfully defended several of many allegations against him (See Factual Findings 61, 62, 64, 67, and 68.) Further, while respondent did not submit documents to show a complete picture of his finances, his testimony showed that the requested award would impose a financial hardship. The cost award will be reduced from $45,701.50 to $15,000.

ORDER

Physician's and Surgeon's Certificate No. A 101165, issued to respondent Shahriar Sean Parsa, M.D., is revoked; however, revocation is stayed, and respondent is placed on probation for five years under the following terms and conditions:[2]

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its

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[2] Please note that, although the Guidelines recommend Optional Conditions 23 (Monitoring-Practice/Billing), 24 (Solo Practice Prohibition), and 26 (Prohibited Practice), these conditions are not imposed. (See Legal Conclusions 6 & 7.)

designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

3. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent

shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

4. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations, section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

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

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

5. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

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

Respondent shall pay all expenses associated with the clinical competence assessment program. At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

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

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

6. Notification

Within seven days of the effective date of this Decision, respondent shall provide a true copy of this decision and accusation to the Chief of Staff or the Chief

Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

7. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. Obey All Laws

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

9. Quarterly Declarations

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

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

10. General Probation Requirements

Compliance with Probation Unit: respondent shall comply with the Board's probation unit.

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

Place of Practice: respondent shall not engage in the practice of medicine in respondent's or a patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

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

11. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. Non-Practice While on Probation

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

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years. Periods of nonpractice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

13. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

14. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation, or petition to revoke probation, or an interim suspension order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion

in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. Cost Recovery

Respondent is hereby ordered to reimburse the Medical Board of California the amount of $15,000 for its enforcement costs, pursuant to Business and Professions Code section 125.3. Respondent shall complete this reimbursement within 90 days from the effective date of this decision, or pursuant to a payment plan authorized by the Board.

17. Probation Monitoring Costs

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

DATE: 11/26/2025

Michael C. Starkey

MICHAEL C. STARKEY
Administrative Law Judge
Office of Administrative Hearings