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

In the Matter of the Accusation Against: Nadine Helmy Yassa, M.D. Physician's & Surgeon's Certificate No A 48720 Petitioner.	Case No.: 800-2022-091721

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Marvin Firestone, attorney for Nadine Helmy Yassa, M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on January 23, 2026.

IT IS SO ORDERED: January 23, 2026

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 Accusation Against: **Nadine Helmy Yassa, M.D.** **Physician's & Surgeon's Certificate No. A 48720** **Respondent.**	**Case No. 800-2022-091721** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Michael Firestone. Esq. on behalf of Respondent, Nadine Helmy Yassa M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of December 10, 2025, at 5 p.m.

Execution is stayed until January 12, 2026, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Respondent to file a Petition for Reconsideration.

DATED: December 5, 2025

Sharlene Smith For
Reji Varghese
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against: Nadine Helmy Yassa, M.D. Physician's and Surgeon's Certificate No. A 48720 Respondent.	Case No. 800-2022-091721

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 10, 2025.

IT IS SO ORDERED November 10, 2025.

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 Accusation Against:

NADINE HELMY YASSA, M.D., Respondent

Agency Case No. 800-2022-091721

OAH Case No. 2025020080

PROPOSED DECISION

Wim van Rooyen, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter from August 4 through 8, 2025, by videoconference from Sacramento, California.

Jannsen Tan, Deputy Attorney General, represented Reji Varghese (complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs, State of California.

Marvin Firestone, Attorney at Law, represented Nadine Helmy Yassa, M.D. (respondent), who was present.

At the start of the hearing, the undersigned heard oral argument from both parties concerning complainant's motion to quash subpoena and for issuance of a protective order concerning respondent's attempt to have Mr. Tan testify about

complainant's cost recovery request. For the reasons stated on the record, complainant's motion was granted. Evidence was then received, the record closed, and the matter submitted for decision on August 8, 2025.

On September 2, 2025, the undersigned briefly reopened the record to allow the parties to submit additional briefs concerning complainant's cost recovery request. Complainant and respondent timely submitted their briefs, which were marked as Exhibits 33 and O, respectively.

On September 19, 2025, Exhibits 33 and O were admitted as argument, the record was closed, and the matter was resubmitted for decision.

FACTUAL FINDINGS

Jurisdiction

1. On October 9, 1990, the Board issued respondent Physician's and Surgeon's Certificate No. A 48720 (license). The license will expire on July 31, 2026, unless renewed.

2. On December 6, 2024, complainant, in his official capacity, signed and later filed an Accusation in Case No. 800-2022-091721 (Accusation) against respondent, a board-certified neurologist with a solo private practice in Roseville, California. The Accusation asserts cause to discipline respondent's license for gross negligence, repeated negligent acts, clearly excessive treatment, dishonesty, inadequate recordkeeping, and general unprofessional conduct. The Accusation is based on the neurology care and treatment respondent provided to Patients A and B

in 2022 through 2024.[1] The Accusation further alleges, as a consideration for the degree of discipline to be imposed, if any, that the Board had previously disciplined respondent on multiple occasions. Complainant requests revocation of respondent's license and recovery of the Board's reasonable investigation and enforcement costs.

3. Respondent timely filed a Notice of Defense to the Accusation. Consequently, the matter was set for hearing pursuant to Government Code section 11500 et seq.

Patient A's Neurology Care and Treatment

4. The record in this case includes Patient A's complaint submitted to the Board, Patient A's medical records, a subsequent treatment summary for Patient A that respondent submitted to the Board, and a recording and transcript of respondent's April 8, 2024 interview by Board investigators. Additionally, both Patient A and respondent testified at hearing regarding the neurology care and treatment respondent provided to Patient A. After considering the record as a whole, clear and convincing evidence supports the following factual findings concerning Patient A's neurology care and treatment. Any remaining allegations involving Patient A were not established by clear and convincing evidence.

5. On April 16, 2022, Patient A, a 64-year-old woman, presented to the Sutter Roseville Medical Center Emergency Department (ED) with right side facial weakness reported as Bell's palsy. A brain magnetic resonance imaging (MRI) study

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[1] The Accusation and this decision refers to the patients as Patients A and B to protect their privacy and confidentiality.

showed focal white matter lesions suggestive of a demyelinating disease such as multiple sclerosis (MS),[2] with less likely possibilities including Lyme disease or progressive multifocal leukoencephalopathy. A consulting neurologist ordered a lumbar puncture, prescribed prednisone 60 mg a day for five days[3] for Bell's palsy, and instructed Patient A to see an outpatient neurologist to follow up on test results and any further management. Results from the lumbar puncture showed the presence of oligoclonal bands in Patient A's cerebrospinal fluid, which was further suggestive of MS.

6. On August 8, 2022, Patient A presented to respondent's office for an outpatient neurology consult. Patient A credibly testified that respondent was flustered and impatient, and told Patient A that Patient A had two electronic medical records (EMR) files in the Sutter Health system. Respondent stated: "I don't have time to go back and forth between two files . . . this is taking too much time . . . you need to contact Sutter Health and have them combine your files." Patient A attempted to give respondent a two-page document summarizing her medical history but respondent

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[2] MS is a nervous system disease that affects the brain and spinal cord. It damages the myelin sheath, which surrounds and protects nerve cells, resulting in lesions visible on MRI. This damage slows down or blocks messages between the brain and the body resulting in various neurological symptoms, including sensory disturbances, muscle weakness, balance and coordination issues, visual deficits, and cognitive deficits.

[3] Prednisone is a prescription corticosteroid medicine used to suppress the immune system and decrease inflammation in several medical conditions, including MS.

refused to accept it, stating: "I shouldn't have to rely on your documents . . . you need to contact Sutter Health to get this straightened out." When Patient A tried to orally give respondent health background information, respondent stated: "You need to answer only the questions I'm asking you . . . I don't want additional information."

7. In Patient A's chart, respondent described Patient A's history of hypothyroidism, fibromyalgia, transient ischemic attacks reportedly affiliated with stress, Factor V Leiden mutation,[4] obstructive sleep apnea, restless leg syndrome, degenerative joint disease of the lumbar spine, carpal tunnel syndrome, anxiety, and a recent diagnosis of MS based on an abnormal brain MRI and spinal tap with oligoclonal bands. She further noted that Patient A had memory problems and "pain all over."

8. In fact, Patient A credibly testified that she was not experiencing any confusion, memory problems, pain, or other active symptoms at the time of the consult. On the mental status examination, respondent herself found Patient A alert, cooperative, and fully oriented. Respondent also performed a neurological examination, which was normal except for slightly decreased hearing bilaterally.

9. In the assessment section of Patient A's chart, respondent stated that "Patient has a split chart in Epic, secondary to 2 different names which makes the information harder to obtain." Respondent then quoted verbatim the findings from Patient A's brain MRI, followed by the verbiage: "64n [*sic*] year old female with an abnormal MRI." Thereafter, respondent listed a primary encounter diagnosis of

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[4] Factor V Leiden mutation is a genetic disorder that increases the risk of blood clots.

relapsing-remitting MS and other diagnoses of seizure-like activity, paresthesias, and right-sided Bell's palsy. She described her plan as "prednisone 1 gm po every day x 5 warned" and "Chrt needs to be combined." Respondent also ordered electroencephalogram (EEG) and electromyography (EMG) tests for Patient A.

10. Patient A credibly testified that respondent did not discuss her diagnoses, assessment, or treatment plan with Patient A; did not explain to Patient A why she ordered the EEG and EMG tests or prescribed prednisone; and did not provide Patient A with an opportunity to ask questions. Patient A felt that she was rushed out of the appointment as quickly as possible and dismissed.

11. Patient A lost all confidence in respondent and decided not to see respondent again. On September 14, 2022, she filed a complaint with the Board about her neurology care and treatment by respondent.

Patient B's Neurology Care and Treatment

12. The record in this case includes complaints submitted to the Board from Patient B and Patient B's relative, Patient B's medical records, a video recording of Patient B's seizure activity, a subsequent treatment summary for Patient B that respondent submitted to the Board, and a recording and transcript of respondent's April 8, 2024 interview by Board investigators. Additionally, both Patient B and respondent testified at hearing regarding the neurology care and treatment respondent provided to Patient B. After considering the record as a whole, clear and convincing evidence supports the following factual findings concerning Patient B's neurology care and treatment. Any remaining allegations involving Patient B were not established by clear and convincing evidence.

13. Patient B was a 56-year-old woman when she first presented to respondent on May 17, 2023, for an evaluation of brain fog following a COVID-19 diagnosis. Patient B completed an intake form that listed numerous symptoms, including seizures, difficulty getting in and out of a chair, walking problems, difficulty concentrating, memory problems, weight loss, difficulty breathing, chest pain, constipation, diarrhea, skin wrinkling and bruising, her hands "clubbing up" or curling up, anxiety, and depression. Patient B left blank the portion of the intake form requesting a list of all her medications. Patient B credibly testified that she did so because she could not remember her medications, and respondent's receptionist told Patient B that respondent already had Patient B's medications on file from the referring physician's paperwork.

14. Respondent performed a neurological examination of Patient B. She noted that Patient B was tearful and documented that Patient B had abnormal movements, facial grimaces, slightly decreased hearing bilaterally, decreased sensation on the left, and an astasia abasia gait (an abnormal gait without any underlying neurological abnormalities). Respondent's impression was that Patient B's symptoms likely had an emotional overlay. Respondent noted that she needed Patient B's older medical records to better evaluate her complaints. Respondent also ordered a brain MRI, EEG, and nerve conduction studies (NCS) and EMG of the upper extremities.

15. June 2023 NCS and EMG studies revealed bilateral carpal tunnel syndrome and neuropathy. A June 2023 brain MRI showed moderate disproportionate asymmetric right hippocampal volume loss. At subsequent telehealth visits, Patient B reported continued seizure-like activity and/or violent jerks. After one such instance, Patient B was taken to the ED where she was given lorazepam and told that they did not have a specialist to evaluate her. Patient B's chart indicates that 20-minute EEG,

24-hour ambulatory EEG, and 72-hour ambulatory EEG studies were generally within normal limits.

16. On January 22, 2024, Patient B and a friend attended an in-person appointment with respondent. Patient B credibly testified that the waiting room was full, and respondent was running approximately two hours late. When Patient B was finally seen, respondent asked her about an upcoming surgery to remove a mass in her throat. When Patient B's friend suggested that respondent had the wrong patient, respondent said "oops" and found Patient B's chart.

17. Respondent then proceeded to discuss the possibility of Alzheimer's disease given the brain MRI findings, which respondent believed could explain Patient B's cognitive complaints. Respondent also opined that Patient B's seizures were likely "non-physiological" given the normal EEG studies. According to Patient B's chart, respondent diagnosed Patient B with COVID-19, cervical radiculopathy, carpal tunnel syndrome, and hippocampal sclerosis. Respondent then prescribed a trial of Lexapro 10 mg, a selective serotonin reuptake inhibitor (SSRI) used to treat depression and anxiety. Unbeknownst to respondent, Patient B was already taking Effexor, a serotonin-norepinephrine reuptake inhibitor (SNRI) also used to treat depression and anxiety. Respondent told the Board investigator that respondent asked Patient B if she was taking any medications at the January 2024 visit, but Patient B was tearful and never responded.

18. Patient B was angry and hurt after the January 2024 visit. She felt that respondent was cold and impersonal, did not know who Patient B was despite multiple visits, and just wanted to "rush [Patient B] through the system." On March 25, 2024, Patient B filed a complaint with the Board about her neurology care and treatment by respondent.

Expert Witness Opinions

19. Complainant presented the testimony of retained expert James Nelson, M.D. Respondent presented the testimony of retained experts Abhi Kapuria, M.D., and Marc Eugene Lenaerts, M.D. Each expert witness's opinions are discussed below.

JAMES NELSON, M.D.

20. Dr. Nelson obtained his medical degree in 1994 in Illinois. He became licensed with the Board in 2013 upon moving to California and continues to hold an active Board license. He is board certified in general neurology with a special qualification in child neurology. From 2015 to 2023, Dr. Nelson served as an assistant professor at the University of California, San Diego, where he had a child neurology practice consisting of inpatients and outpatients. Since 2024, he has maintained a child neurology practice affiliated with the Riverside Medical Clinic. Dr. Nelson has no record of Board discipline and has served as a Board expert consultant since 2020.

Although Dr. Nelson in his practice primarily treats neurology patients up to 30 years old, he remains board certified in general neurology. He has cared for many patients with MS, which largely presents and is treated similarly in children and adults.

21. As part of his evaluation of the case, Dr. Nelson reviewed the complaints filed by Patient A, Patient B, and Patient B's relative; Patient A and B's medical records; Patient A's two-page document summarizing her medical history; a video recording of Patient B's seizure activity; respondent's treatment summaries for Patients A and B submitted to the Board; respondent's curriculum vitae; and the audio recording and transcript of respondent's April 8, 2024 interview by Board investigators. Dr. Nelson prepared expert reports concerning respondent's neurology care and treatment of Patients A and B, dated June 27, 2024, and June 16, 2024, respectively. He generally

testified consistently with those reports at hearing. Before his hearing testimony, he also reviewed the expert reports of Drs. Kapuria and Lenaerts.

22. Dr. Nelson defined the applicable standard of care as that level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent neurologists in the same or similar circumstances. He defined negligence as a simple departure from the standard of care, i.e., the failure to use that level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful neurologists would use in the same or similar circumstances. He defined gross negligence as an extreme departure from the standard of care or the want of even scant care.

Patient A

23. Dr. Nelson opined there were two extreme departures from the standard of care concerning respondent's neurology care and treatment provided to Patient A. Each is discussed separately below.

24. First, respondent lacked an appropriate plan to diagnose and treat Patient A's abnormal MRI condition suggestive of MS. The standard of care requires a thoughtful assessment and plan for further testing and care, which should be discussed with the patient and well documented in the chart. By contrast, respondent's assessment and plan were seriously deficient in several respects:

- Respondent's assessment was very limited, consisting only of a notation concerning Patient A's split chart and a verbatim copy of the brain MRI findings, followed by the verbiage: "64n [*sic*] year old female with an abnormal MRI." Thereafter, respondent listed a primary encounter diagnosis of relapsing-remitting MS and other diagnoses of seizure-like activity,

paresthesias, and right-sided Bell's palsy, without any explanation of how she made those diagnoses. Although it can be proper to quote brain MRI findings as part of the neurologist's assessment, respondent's assessment contained no independent analysis or medical decision making.

- Given that MS typically manifests before the age of 50 and Patient A was older than 50 at the time of her consult with respondent, Patient A's presentation would be considered atypical and warranting further evaluation of other medical causes. The standard of care would require consideration of testing for myelin oligodendrocyte glycoprotein antibody, Lyme disease, lupus, immunosuppression, and metabolic issues. Respondent's chart did not suggest that she considered any of these issues.

- Respondent ordered EEG and EMG studies without any specific medical reasoning. Dr. Nelson surmised that respondent may have ordered the EEG to further investigate her apparent diagnosis of seizure-like activity and the EMG to further investigate her apparent diagnosis of paresthesia, but no such reasoning was reflected in Patient A's chart.

- Respondent's treatment plan was limited to an administrative notation to combine Patient A's chart and a prednisone prescription. The standard of care requires consideration of longer-term disease-modifying therapies (DMTs) and potential referral to an MS specialist if the diagnosis or treatment plan is not clear.

- The standard of care requires a thorough discussion with the patient about the MS diagnosis, alternative diagnoses, the plans for further testing, and potential treatment including DMTs. By contrast, Patient A indicated that

none of this was explained to her, and she did not have an opportunity to ask questions.

Dr. Nelson added that respondent's lack of a thorough, well-documented assessment and treatment plan for Patient A would make it virtually impossible for another provider to review Patient A's chart and understand respondent's medical rationale, thereby seriously impairing continuity of care.

25. Second, respondent inappropriately prescribed a short course of high dose prednisone to Patient A.

Dr. Nelson explained that relapsing-remitting MS, the form of MS respondent diagnosed in Patient A, is the most common form of MS. It is characterized by periods of relapses, attacks, flares, or exacerbations (new or increasing neurological symptoms over a few days or weeks) and remission (partial or complete recovery from neurological symptoms). DMTs are used for long-term management of MS by reducing the number and severity of relapses experienced over the course of the disease. By contrast, corticosteroids such as prednisone are used to treat acute MS relapses only. Because corticosteroids suppress the immune system and reduce inflammation, they decrease the duration and severity of symptoms during an MS relapse. Corticosteroids do not prevent MS relapses and have no impact on the long-term course or progression of MS.

The standard of care requires using a short course of a high-dose corticosteroid such as prednisone only when treating an MS relapse with active symptoms causing significant functional impairment. That is because corticosteroids are not effective to treat the general progression of MS and have significant side effects, including indigestion, insomnia, mood swings, heart palpitations, effects on bone health, etc. In

this case, respondent inappropriately ordered a high dose of prednisone (1 gram or 1000 mg a day for five days) for Patient A without any medical rationale indicated in Patient A's chart, even though Patient A had a normal neurological examination and no active symptoms at the time of her consult with respondent.

In support of his opinion, Dr. Nelson cited to a medical article attached to Dr. Kapuria's report: "Management of acute exacerbations in multiple sclerosis" by Daniel Ontaneda and Alex D. Rae-Grant (Ontaneda Article). The Ontaneda Article states, in part:

> Good level I and II evidence supports the use of steroids for decreasing the duration of symptoms during MS exacerbations.....In general, steroids should be reserved for patients having functional deficits due to an acute exacerbation to reduce the total use of steroids during their clinical course.

Another article attached to Dr. Kapuria's report, "High-dose oral methylprednisolone for the treatment of multiple sclerosis relapses: cost-minimisation analysis and patient satisfaction" by Horta-Hernandez et al. (Horta-Hernandez Article) also states that while DMTs decrease the risk of accumulation of new focal lesions in MS, high-dose steroids are used to accelerate remission and limit the residual neurological deficits of an MS attack.

Patient B

26. Dr. Nelson opined there were two simple departures from the standard of care concerning respondent's neurology care and treatment provided to Patient B. Each is discussed separately below.

27. First, respondent prescribed Lexapro for Patient B without properly assessing and diagnosing her with depression or anxiety.

Dr. Nelson explained that neurologists frequently encounter patients who have overlapping neurological and psychiatric issues. Neurologists are competent to prescribe psychiatric medications. The standard of care requires the neurologist to obtain a history of the patient's psychiatric complaints or symptoms and diagnose the patient with a psychiatric condition using the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders V (DSM V) before prescribing a psychiatric medication. The neurologist's analysis should be well documented in the patient's chart. A prescription cannot be based on an implied diagnosis derived from a patient's reported symptoms alone.

A neurologist is not required to formally screen for or diagnose anxiety or depression during a neurological evaluation. If psychiatric issues are suspected, the neurologist may refer the patient to a primary care provider or psychiatrist for further evaluation. But if the neurologist chooses to treat a psychiatric condition and prescribe a psychiatric medication, they become responsible for making and adequately supporting the diagnosis.

In this case, respondent chose to prescribe Patient B Lexapro, a psychiatric SSRI medication used to treat depression and anxiety. Although Patient B's chart contained some references to symptoms of depression and anxiety, respondent did not diagnose Patient B with depression or anxiety. She also did not analyze the DSM V criteria for depression or anxiety. Thus, respondent's assessment was incomplete and insufficient to support a prescription for Lexapro, and fell below the standard of care.

28. Second, respondent failed to obtain a sufficient medication history for Patient B before prescribing Lexapro.

The standard of care requires a neurologist to make a reasonable attempt to obtain a patient's medication history before prescribing medication. This is because the neurologist must avoid duplication of medications and consider potential interactive effects. In the case of prescribing an SSRI when a patient is already taking an SNRI, there is a potential risk of serotonin syndrome, a condition where the medications together cause too high levels of serotonin in the body leading to symptoms such as agitation, insomnia, confusion, rapid heart rate, muscle rigidity, sweating, and other potentially life-threatening symptoms.

In this case, Patient B left blank the portion of her intake form requesting a list of all her medications. At the January 2024 visit, Patient B was tearful and did not respond when respondent asked her if she was taking any medications at the time. Under circumstances where a patient is unable to adequately communicate a medication history, a reasonable and prudent neurologist would have: (i) made reasonable attempts to obtain the information by alternative means, such as by contacting the primary care provider or referring provider, calling the pharmacy, or speaking with the patient's family members with the patient's consent; and (ii) documented such efforts in the chart before prescribing medication. Respondent's failure to do so fell below the standard of care.

ABHI KAPURIA, M.D.

29. Dr. Kapuria obtained his medical degree in 2016. He completed a residency in neurology in 2020 and a fellowship in clinical neurophysiology in 2021. He is currently board certified in general neurology and clinical neurophysiology.

From January 2021 through July 2024, he worked for Telespecialists LLC in various capacities, including as an attending neurologist providing virtual care, director of physician development, and director of graduate medical education. From April 2023 through July 2024, he also served as an adjunct professor at the University of North Carolina for its medical scribes program. Since October 2024, Dr. Kapuria has worked as a neurohospitalist at Northwestern Medicine – Palos Community Hospital in Illinois. In that role, he specializes in managing acute neurological disorders in hospitalized patients, including stroke, seizure, and neuromuscular emergencies. However, he has also treated several MS patients. Additionally, Dr. Kapuria is the founder of Neurology Legal Consulting Inc. He has done "several dozen" cases of expert witness work since 2024.

Dr. Kapuria holds medical licenses in several states, but does not have an active California medical license. He has never served as a Board expert consultant.

30. As part of his evaluation of the case, Dr. Kapuria reviewed Patient A and B's medical records; a video recording of Patient B's seizure activity; the transcript of respondent's April 8, 2024 interview by Board investigators; respondent's curriculum vitae; and the Accusation. Dr. Kapuria prepared expert reports concerning respondent's neurology care and treatment of Patients A and B, both dated April 28, 2025. He generally testified consistently with those reports at hearing. He clarified that he had also reviewed the complaints of Patients A and B before his hearing testimony.

31. Dr. Kapuria defined the applicable standard of care as validated, evidence-based decision making based on applicable guidelines. He defined negligence as a smaller degree of departure from the standard of care. He defined gross negligence as a greater degree of departure from the standard of care, which

has a larger impact on the patient. He was unsure whether gross negligence required intentional conduct on the part of the physician.

Patient A

32. Dr. Kapuria confirmed that the standard of care for MS patients is generally the same for children and adults. He opined that there were no departures from the applicable standard of care concerning respondent's neurology care and treatment provided to Patient A. He disagreed with Dr. Nelson's findings of two extreme departures from the standard of care.

33. As to the first alleged extreme departure, Dr. Kapuria testified that respondent's chart reflected an appropriate assessment and plan to diagnose and treat Patient A's abnormal MRI condition suggestive of MS.

Dr. Kapuria noted that respondent obtained a detailed history and performed a thorough neurological examination. In terms of respondent's assessment, it was standard neurological practice to quote MRI findings in the chart, and she then properly recorded her own final diagnostic impressions. In terms of respondent's treatment plan, she appropriately prescribed medication (discussed further below) and ordered EEG and EMG studies, which would be the correct diagnostic tools to evaluate respondent's other diagnoses of seizure-like activity and paresthesia.

Overall, Dr. Kapuria found respondent's chart for Patient A "very extensive," making it "easy to follow her train of thought." He found respondent's recordkeeping for Patient A accurate, adequate, and compliant with the standard of care. Furthermore, it was Dr. Kapuria's understanding that respondent's treatment plan was not yet complete because she planned to imminently follow up with Patient A at a second appointment to confirm her diagnoses and discuss long-term treatment

options. However, Dr. Kapuria conceded there was no record of a planned second appointment in Patient A's chart.[5]

Dr. Kapuria also emphasized that just because Patient A's chart did not contain an exhaustive dialogue of respondent's discussions with Patient A did not mean that respondent actually failed to discuss her assessment, diagnoses, and treatment plan with Patient A. He observed that respondent noted in Patient A's chart that Patient A had memory problems. However, Dr. Kapuria agreed that if respondent actually failed to discuss her assessment, diagnoses, and treatment plan with Patient A, and/or refused to receive medical background information from Patient A, and/or refused to answer Patient A's questions, that would violate the standard of care.

34. As to the second alleged extreme departure, Dr. Kapuria testified that respondent appropriately prescribed a short course of high dose prednisone to Patient A. He agreed that Patient A had no neurological deficits and was not experiencing an MS relapse, attack, or acute exacerbation at the time of her consult with respondent. However, Dr. Kapuria opined that prednisone could also be prescribed to reduce the risk of another MS relapse in the short term while waiting to start a patient on a DMT.

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[5] At hearing, a screenshot of respondent's appointment book purportedly showing a second appointment for Patient A was excluded because it was produced long after the applicable discovery deadline. Even if it were admitted, it would have been entitled to little weight. Patient A's chart, under a section called "What's Next," reflected the upcoming appointments for Patient A's ordered EEG and EMG. Conspicuously absent was any second appointment with respondent for additional consultation. Thus, failure to admit the screenshot of respondent's appointment book was inconsequential to the decision.

In support of this opinion, Dr. Kapuria cited the Ontaneda Article, discussed above. He explained that the lower dose of prednisone prescribed in the ED in April 2022 for treatment of Patient A's Bell's palsy was too low to be effective for MS treatment. Thus, respondent properly prescribed a higher dose of prednisone in August 2022 to reduce the risk of another MS relapse until Patient A could be started on a DMT.

Patient B

35. Dr. Kapuria opined that there were no departures from the applicable standard of care concerning respondent's neurology care and treatment provided to Patient B. He disagreed with Dr. Nelson's findings of two simple departures from the standard of care.

36. As to the first simple departure, Dr. Kapuria testified that respondent properly prescribed Lexapro for Patient B without formally assessing and diagnosing her with depression or anxiety. Dr. Kapuria explained that there is "no clinical guideline that mandates formal depression or anxiety screening during every neurological evaluation." In his view, respondent appropriately prescribed Lexapro in response to Patient B's presentation of psychiatric symptoms, reflecting "sound clinical judgment in coordinating care while the patient awaits further psychiatric evaluation." However, Dr. Kapuria conceded that there was no record in Patient B's chart that respondent had recommended further psychiatric evaluation. Regardless, he found respondent's recordkeeping for Patient B accurate, adequate, and compliant with the standard of care.

37. As to the second simple departure, Dr. Kapuria testified that respondent did not fail to obtain a sufficient medication history for Patient B before prescribing Lexapro. He noted that Patient B had a responsibility to accurately inform respondent

about the medications she was taking. In this case, Patient B left blank the portion of the intake form requesting a list of all her medications. Additionally, there is no indication in the chart that Patient B ever informed respondent that she was already taking Effexor. Dr. Kapuria reasoned that when a patient is "alert, oriented, and able to provide a detailed medical history":

> it is not customary, nor required, to verify basic medication information through external sources such as family members, pharmacies, or primary care physicians unless there is reason to believe the information provided is incomplete, inconsistent, or unreliable. There is no indication in the record that such concerns were present during this encounter.

In any event, Dr. Kapuria believed that the low dosage of Lexapro respondent prescribed would not have likely caused serotonin syndrome in combination with the Effexor Patient B had already been taking.

MARC EUGENE LENAERTS, M.D.

38. Dr. Lenaerts obtained his medical degree in Belgium in 1989. He completed a neurology residency in Belgium in 1994 and another neurology residency in Oklahoma in 2000. He is currently board certified in general neurology in the United States, Belgium, and Luxembourg, with a subspecialty certification in headache medicine.

39. Since July 2016, Dr. Lenaerts has been a clinical professor in the Department of Neurology and the Department of Anesthesiology/Pain Management at the University of California, Davis in Sacramento, California. As a clinical professor,

he sees patients, conducts and publishes research, and teaches fellows, residents, and medical students. He specializes in headache neurology, but remains board certified in general neurology and has treated several patients with MS. Dr. Lenaerts also serves as the director of outpatient neurology at the University of California, Davis Medical Center.

40. Dr. Lenaerts has held an active Board license since 2008. He has no record of Board discipline. The record does not contain any evidence that he previously served as a Board expert consultant.

41. Dr. Lenaerts candidly disclosed that he has known respondent professionally for 10 to 15 years. He is familiar with her qualifications and practice, but they are not personal friends. He believes he can be objective in assessing her care and treatment. Dr. Lenaerts is aware that respondent has a disciplinary history with the Board but does not know the details of those prior cases. He acknowledged that a prior record of discipline generally gives him pause and warrants caution, but he strove to independently evaluate the care and treatment respondent provided in this case to Patients A and B.

42. As part of his evaluation of the case, Dr. Lenaerts reviewed Patient A and B's medical records; a video recording of Patient B's seizure activity; respondent's curriculum vitae; the transcript of respondent's April 8, 2024 interview by Board investigators; Dr. Nelson's curriculum vitae and expert reports; and the Accusation. Dr. Lenaerts prepared an expert report concerning respondent's neurology care and treatment of Patients A and B, dated April 28, 2025, and a supplemental declaration dated July 25, 2025. He generally testified consistently with his report at hearing.

43. Dr. Lenaerts defined the applicable standard of care as the latest, updated knowledge in medicine based on guidelines from applicable medical and specialist societies, applying the highest standards of safety. He defined negligence as a simple departure from the standard of care, which involves no harm or adverse consequences to the patient. He defined gross negligence as an extreme departure from the standard of care, which involves improper treatment, a delay in treatment, a lapse in treatment, or a total lack of treatment documentation that causes patient harm or a high risk of patient harm.

Patient A

44. Dr. Lenaerts opined that there were no departures from the applicable standard of care concerning respondent's neurology care and treatment provided to Patient A. He disagreed with Dr. Nelson's findings of two extreme departures from the standard of care.

45. As to the first extreme departure, Dr. Lenaerts testified that respondent's chart reflected an appropriate assessment and plan to diagnose and treat Patient A's abnormal MRI condition suggestive of MS. Although respondent's assessment and treatment plan could have been more detailed, it was sufficient given that she: (i) had issues with Patient A's split chart; and (ii) planned to have a "very soon follow up appointment" with Patient A to further review medical records, discuss additional testing, and make decisions about long-term treatment. Additionally, Dr. Lenaerts believed that respondent was justified in ordering EEG and EMG studies to investigate her other diagnoses of seizure-like activity and paresthesia attributable to radiculopathy.

Dr. Lenaerts agreed that if respondent actually failed to discuss her assessment, diagnoses, and treatment plan with Patient A, and/or refused to answer Patient A's questions and/or refused to receive medical background information from Patient A, that would violate the standard of care. He explained that "generally, the more data we have, the better we can take care of the patient." However, Dr. Lenaerts did not believe that Patient A's two-page document summarizing her medical history would have changed respondent's diagnostic approach.

46. As to the second extreme departure, Dr. Lenaerts testified that respondent appropriately prescribed a short course of high dose prednisone to Patient A. He agreed that it was within the standard of care to prescribe a short course of high dose steroids to treat an MS relapse. However, unlike Drs. Nelson and Kapuria, Dr. Lenaerts concluded that Patient A was likely still experiencing an MS relapse at the time of her August 2022 consult with respondent. He reached that conclusion because: (i) the April 2022 Bell's palsy episode occurred only a couple of months before the August 2022 consult; and (ii) he believed Patient A was still experiencing active symptoms such as pain and memory issues at the time of the August 2022 consult.

Additionally, Dr. Lenaerts, like Dr. Kapuria, opined that a short course of high dose prednisone could also be prescribed to delay another MS relapse for a limited period of time. He was unable to cite any medical article in the record for that proposition.

Finally, Dr. Lenaerts testified that it would also have been clinically sound to prescribe a short course of high dose prednisone due to the small likelihood that Patient A had cerebral vasculitis, which he described as a severe condition with neurological deficits and MRI findings similar to MS.

Patient B

47. Dr. Lenaerts opined that there were no departures from the applicable standard of care concerning respondent's neurology care and treatment provided to Patient B. He disagreed with Dr. Nelson's findings of two simple departures from the standard of care.

48. As to the first simple departure, Dr. Lenaerts testified that respondent properly prescribed Lexapro for Patient B without formally assessing and diagnosing her with depression or anxiety. According to Dr. Lenaerts, the diagnosis of depression was implicit based on Patient B's psychiatric symptoms. No formal assessment or diagnosis was necessary. Additionally, Dr. Lenaerts indicated his belief that respondent had referred Patient B to behavioral health services for further assessment. He emphasized that behavioral health services were often very impacted, and it was compassionate for respondent to initiate SSRI therapy for Patient B while waiting to access such services.

49. As to the second simple departure, Dr. Lenaerts testified that respondent did not fail to obtain a sufficient medication history for Patient B before prescribing Lexapro. He observed that Patient B left blank the portion of the intake form requesting a list of all her medications, which gave respondent "carte blanche to prescribe something." According to Dr. Lenaerts, respondent was not required to make inquiries from alternative sources because Patient B was competent to provide her medication information. Finally, Dr. Lenaerts noted that Lexapro is a safe, routinely-prescribed SSRI. The dose respondent prescribed Patient B was very low, conservative, and unlikely to cause a dangerous interaction with the Effexor she was already taking.

Respondent's Prior Board Discipline

50. Effective March 12, 2021, the Board issued a Decision adopting a Stipulated Settlement and Disciplinary Order that publicly reprimanded respondent's license under Business and Professions Code section 2227, subdivision (a)(4) (2021 Public Reprimand). The 2021 Public Reprimand provided that respondent failed to adequately and accurately document the history, treatment plan, tests, and rationale for treatment of three patients.

51. Effective July 23, 2021, the Board issued its Decision After Superior Court Remand (2021 Decision). The 2021 Decision followed a hearing before an Administrative Law Judge in 2016 and 2017, a 2018 Board decision adopting the Administrative Law Judge's proposed decision, and review by the Superior Court and Court of Appeal.

The 2021 Decision found cause to discipline respondent's license for gross negligence, repeated acts of negligence, excessive use of diagnostic procedures, failure to maintain adequate and accurate records, and failure to timely provide a complete, certified copy of a patient's medical records. The 2021 Decision included findings that respondent had diagnosed a patient with epilepsy and breakthrough seizures without an adequate medical basis, improperly diagnosed a patient with MS, ordered multiple repeat EEGs without medical indication, and lacked knowledge of or failed to consider the interactions between medications prescribed concomitantly.

The 2021 Decision revoked respondent's license, stayed the revocation, and placed respondent's license on probation for four and a half years, reduced from an original probation term of five years. Probation conditions included participating in a clinical competence assessment program; completing education, medical

recordkeeping, and professionalism (ethics) courses; having a practice monitor; and a solo practice prohibition.

52. Effective December 29, 2022, the Board issued a Decision adopting a Stipulated Settlement and Disciplinary Order that publicly reprimanded respondent's license under Business and Professions Code section 2227, subdivision (a)(4) (2022 Public Reprimand). The 2022 Public Reprimand provided that respondent failed to adequately document respondent's justification for stopping a patient's Adderall prescription and required respondent to complete a professionalism (ethics) course.

Respondent's Additional Evidence

53. Respondent was born in Egypt. She obtained her medical degree in 1980, subsequently moved to the United States, obtained her California license in 1990, and completed a residency in adult neurology in 1994. She also completed elective training in electrophysiology and a fellowship in child neurology in 1995. Respondent is board certified in adult neurology, child neurology, and sleep medicine.

54. Respondent currently has a solo private practice and also serves as an Assistant Professor at California Northstate University College of Medicine. She is an active member of the Coptic Orthodox Church and takes yearly medical missionary trips to underdeveloped and underserved countries. She is also an opera singer, speaks four languages, and edited a published book in 2023.

55. Respondent denied any professional misconduct involving Patients A and B. She believes she offered them competent neurology care and treatment, especially given the complexity of their cases and the limited availability of their medical records.

56. With regards to respondent's prior Board discipline, she timely complied with all probation requirements imposed by the 2021 Decision. She successfully completed the required coursework, including the clinical competence assessment program. Additionally, she "did five times more than the required amount of continuing medical education hours." She also passed 120 mock examinations to regain and sustain her board certifications. Respondent does not accept responsibility for the 2021 and 2022 Public Reprimands. She feels she was "extremely transparent" with the Board but chose to resolve the underlying accusations through stipulated settlements because she was financially and emotionally exhausted.

57. Respondent testified that she has never harmed a patient and has never been the subject of a malpractice lawsuit for money damages. Nevertheless, the Board's disciplinary actions have "tarnished all my hard work and accomplishments all over the world." Respondent explained that "all my siblings in Canada and Australia can read it online," which she found very unfair.

58. Respondent's testimony was generally respectful, but also curt, guarded, and at times evasive. Her tone and demeanor while testifying was generally dismissive of the patients' concerns and betrayed an underlying arrogance.

59. Respondent offered letters of support by James Benjamin Martel, M.D., and Roderick G.S. Sanden, M.D.

Dr. Martel is a board-certified ophthalmologist practicing in Rancho Cordova, California. He also serves as a clinical professor of ophthalmology and associate dean of graduate medical education at California Northstate University College of Medicine. Dr. Martel and respondent have known each other for over 35 years, they have patients in common, they refer patients to each other, and he regularly reviews her

treatment records as part of those referrals. Dr. Martel authored a July 23, 2025 letter of support praising respondent's excellent reputation in the medical community, profound expertise in diagnosing and treating complex neurological conditions, leadership and mentoring of young physicians, and empathetic and compassionate approach to patient care. His letter concludes:

> In summary, I wholeheartedly recommend Dr. Nadine Yassa for any role or recognition that acknowledges her outstanding contributions to medicine. Her expertise, compassion, and dedication make her a true leader in neurology and a vital part of our community.

Dr. Sanden is a neurosurgeon practicing in Carmichael, California. He also serves as an assistant clinical instructor at the University of California, Davis School of Medicine, Division of Neurosurgery. He has known respondent for over 30 years, is both a personal friend and a colleague who refers patients to respondent, and regularly reviews her treatment records as part of those referrals. Dr. Sanden authored a July 21, 2025 letter of support lauding respondent's exceptional qualifications, competence, ethics, compassionate patient care, and involvement in humanitarian medical missions. He also referenced her board certifications and "evaluation period" under the oversight of the "PACE program,"[6] which he believed documented that respondent received "the highest standards of medical professional training."

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[6] The Physician Assessment and Clinical Education (PACE) program offered by the University of California, San Diego School of Medicine is a program often

Costs

60. Complainant seeks a total of $10,549.25 in investigation costs. The investigation costs are supported by two Declarations of Investigative Activity by Michel Veverka dated April 17, 2024, with attached investigator logs. Those documents describe the general tasks performed, the time spent on each task, the billing rates, and the method of calculating the costs.

Stacie Barrera, the Board investigator assigned to this case, also testified at hearing. She explained that she bills her time spent on every case in 15-minute increments. She uses standard mathematical rounding up or down when billing. For example, if she actually spent 22 minutes on a particular task, she would round down and only bill for 15 minutes. However, if she actually spent 23 minutes on a particular task, she would round up and bill for 30 minutes. Additionally, if Ms. Barrera only spent seven or less minutes on a task, she would not bill for that task at all.

61. Complainant seeks a total of $3,750 in expert reviewer costs. The expert reviewer costs are supported by a Certification of Costs by Scott Steele dated June 4, 2025, with attached statements of services. Those documents describe the general tasks performed, the time spent on each task, the billing rates, and the method of calculating the costs.

62. Complainant seeks a total of $29,593.25 in prosecution costs. The prosecution costs are supported by a Certification of Prosecution Costs: Declaration of Jannsen Tan dated July 17, 2025, which attaches the Office of the Attorney General's

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completed by licensees on Board probation to satisfy the requirement of participating in a clinical competence assessment program.

billing records for this matter. Those documents describe the general tasks performed, the time spent on each task, the billing rates, and the method of calculating the costs. Collectively, they document $25,033.25 in billed prosecution costs. The Certification also estimates billing an additional $4,560 in prosecution costs after July 17, 2025, in preparation for the hearing.

LEGAL CONCLUSIONS

1. "Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount." (Bus. & Prof. Code, § 2001.1.)

Burden and Standard of Proof

2. Complainant bears the burden of proving by clear and convincing evidence that cause exists to discipline respondent's license. (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) "Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind." (*In re David C.* (1984) 152 Cal.App.3d 1189, 1208.)

3. If, and only if, complainant establishes cause for discipline, respondent must establish rehabilitation. Rehabilitation is akin to an affirmative defense. Consequently, respondent bears the burden of proving rehabilitation. (*Whetstone v. Bd. of Dental Examiners* (1927) 87 Cal.App. 156, 164.) The standard of proof for

rehabilitation is a preponderance of the evidence (Evid. Code, § 115), which means "more likely than not." (*Sandoval v. Bank of America* (2002) 94 Cal.App.4th 1378, 1388.)

Cause for Discipline

EVALUATION OF MEDICAL EXPERT OPINIONS

4. Respondent's overarching argument is that complainant cannot meet his burden of proving cause for discipline by clear and convincing evidence when three medical experts reviewed the case and reached "strikingly different conclusions." In respondent's view, the case "illustrates a fundamental truth about medical practice: reasonable physicians can and do disagree about complex clinical decisions." However, that argument necessarily assumes that all the medical expert opinions in the record are equally competent and well supported. Thus, before turning to an analysis of the specific pled causes for discipline, it is first necessary to evaluate the appropriate weight to be given to each medical expert opinion.

5. "It is well-settled that the trier of fact may accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke, Davis & Co.* (1973) 9 Cal.3d 51, 67 [citations omitted].) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at 67-68, quoting from *Nevarov v. Caldwell* (1958) 161 Cal.App.2d 762, 777.) Moreover, the trier of fact may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The testimony of "one credible witness may constitute substantial evidence." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

6. As an initial matter, it should be noted that Drs. Nelson, Kapuria, and Lenaerts are all appropriately qualified to render expert opinions in this matter. To be sure, Dr. Nelson primarily treats neurology patients up to 30 years old; Dr. Kapuria only completed his neurology residency in 2020 and does not hold a medical license in California; and Dr. Lenaerts, although exceptionally qualified, specializes in headache neurology. But they are all board certified in general neurology and have treated patients with MS.

7. Nevertheless, after careful evaluation of the entire record, Dr. Nelson's opinion is plainly entitled to greater weight for several reasons.

First, Dr. Nelson is the only expert witness who correctly identified the standard of care and provided the correct definitions of negligence and gross negligence. (See *Medical Board of California Expert Reviewer Guidelines*, Revised November 2023, pp. 30-37.) By contrast, Drs. Kapuria and Lenaerts used vague definitions that at times improperly incorporated a requirement of patient impact or harm.

Second, Dr. Nelson's testimony was most consistent with Patient A and B's medical records. By contrast, the opinions of Drs. Kapuria and Lenaerts contained a significant amount of post hoc rationalization of respondent's assessments and treatment plans, which was unsupported by the patients' actual charts. Both Drs. Kapuria and Lenaerts also relied heavily on unfounded assumptions about a planned follow-up appointment for Patient A and a behavioral health services referral for Patient B. (See *Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923 ["Like a house built on sand, the expert's opinion is no better than the facts on which it is based."].)

Third, Dr. Nelson's testimony was most consistent with the credible hearing testimony of Patients A and B. By contrast, Drs. Kapuria and Lenaerts either failed to consider or heavily discounted the patients' accounts.

Fourth, Dr. Lenaerts's long-term professional relationship with respondent casts some doubt on the objectivity of his expert opinion. There is nothing in the record to suggest that Dr. Lenaerts is anything but a well-qualified and ethical physician. Indeed, he candidly disclosed his professional relationship with respondent and sincerely testified that he endeavored to objectively evaluate the record. But despite an expert witness's best efforts, it is difficult to maintain complete neutrality when the expert has personal knowledge about a party outside of the present litigation. That may potentially explain Dr. Lenaerts's valiant attempts to provide post hoc rationalizations for respondent's assessments and treatment plans.

APPLICABLE LAW

8. The Board may discipline a licensee for unprofessional conduct. (Bus. & Prof. Code, §§ 2227, 2234.) Unprofessional conduct includes gross negligence (Bus. & Prof. Code, § 2234, subd. (b)); repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)); commission of any act involving dishonesty that is substantially related to the qualifications, functions, or duties of a physician and surgeon (Bus. & Prof. Code, § 2234, subd. (e)); failure to maintain adequate and accurate records relating to the provision of services to patients for at least seven years after the last date of service to a patient (Bus. & Prof. Code, § 2266); and repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees (Bus. & Prof. Code, § 725).

FIRST CAUSE FOR DISCIPLINE – GROSS NEGLIGENCE

9. Dr. Nelson clearly and convincingly opined that respondent's lack of an appropriate plan to diagnose and treat Patient A's abnormal MRI condition suggestive of MS was an extreme departure from the standard of care. Although respondent took an adequate history and completed a thorough neurological examination, Dr. Nelson identified numerous serious deficiencies in her limited assessment, diagnoses, and treatment plan, which she also failed to discuss with Patient A. Dr. Kapuria and Dr. Lenaerts's contrary opinions are inconsistent with respondent's own treatment records, contain a significant amount of post hoc rationalization, rely heavily on an unfounded assumption about a planned follow-up appointment for Patient A, and improperly discount Patient A's account.

10. Dr. Nelson also clearly and convincingly opined that respondent's prescription of high dose prednisone to Patient A was an extreme departure from the standard of care. He persuasively explained that, due to side effects, a high dose of corticosteroids should only be prescribed to treat an MS relapse when the patient has active symptoms causing functional limitations. His opinion was consistent with both the Ontaneda Article and the Horta-Hernandez Article cited by respondent's own expert. Based on Patient A's credible testimony and respondent's own normal neurological and mental status examination, Patient A did not have any active symptoms of MS causing functional limitations at the time of her consult with respondent. Thus, respondent's decision to prescribe Patient A a high dose of prednisone, unsupported by any medical reasoning in her chart, was grossly negligent.

The contrary opinions of Drs. Kapuria and Lenaerts are unpersuasive. Dr. Lenaerts's conclusion that Patient A was likely still experiencing an MS relapse at the time of her August 2022 consult with respondent is inconsistent with Patient A's

credible testimony, respondent's own neurological and mental status examination, and the opinions of Drs. Nelson and Kapuria. Additionally, Drs. Kapuria and Lenaerts's opinions that a high dose of corticosteroids could be prescribed to reduce the risk of another MS relapse are inconsistent with Dr. Nelson's well-reasoned explanation of the MS disease mechanism as well as the Ontaneda and Horta-Hernandez Articles. Indeed, neither Dr. Kapuria nor Dr. Lenaerts identified any medical article or treatise in the record that supports their opinions. Finally, Dr. Lenaerts's post hoc rationalization that respondent may have prescribed the prednisone to treat cerebral vasculitis is entirely unsupported by the record. Respondent's chart never mentioned that she even considered cerebral vasculitis as part of her differential diagnoses.

11. In sum, complainant established two extreme departures from the standard of care concerning respondent's neurological care and treatment of Patient A by clear and convincing evidence. Thus, cause exists to discipline respondent for gross negligence under Business and Professions Code sections 2227 and 2234, subdivision (b).

SECOND CAUSE FOR DISCIPLINE – REPEATED NEGLIGENT ACTS

12. Dr. Nelson clearly and convincingly opined that respondent's prescription of Lexapro for Patient B without properly assessing and diagnosing her with depression or anxiety was a simple departure from the standard of care. He persuasively explained that if a neurologist chooses to treat a psychiatric condition and prescribe a psychiatric medication, they become responsible for making and adequately supporting the diagnosis through a proper, documented assessment of the DSM V criteria. Respondent's failure to do so was negligent.

The contrary opinions of Drs. Kapuria and Lenaerts are unpersuasive. Dr. Kapuria stressed that a neurological evaluation is not required to include a formal depression or anxiety screening. That may be the case, but ignores the point that if a neurologist chooses to offer a psychiatric medication, the prescription must be supported by a documented diagnosis. Additionally, Dr. Lenaerts's suggestion that a diagnosis of depression should be implied from Patient B's symptoms strains credulity and violates even minimal standards of medical recordkeeping. Finally, Drs. Kapuria and Lenaerts heavily relied on an assumption that respondent had referred Patient B for behavioral health services or psychiatric care, but there is no evidence of such a referral in Patient B's chart.

13. Dr. Nelson also clearly and convincingly opined that respondent's failure to obtain a sufficient medication history for Patient B before prescribing Lexapro was a simple departure from the standard of care. He persuasively explained that when Patient B was tearful and failed to respond to respondent's question about medications at the January 2024 visit, respondent had an obligation to make further inquiries. The contrary opinions by Drs. Kapuria and Lenaerts erroneously assume that Patient B was able to effectively communicate her medication history to respondent at the January 2024 visit. Finally, even if the dose of Lexapro prescribed was ultimately harmless, it does not negate respondent's breach of the standard of care to obtain a complete medication history.

14. In sum, complainant established multiple separate and distinct departures from the standard of care by clear and convincing evidence. Thus, cause exists to discipline respondent for repeated negligent acts under Business and Professions Code sections 2227 and 2234, subdivision (c).

THIRD CAUSE FOR DISCIPLINE – CLEARLY EXCESSIVE TREATMENT

15. Complainant failed to establish by clear and convincing evidence that respondent engaged in repeated acts of clearly excessive prescribing. Based on Dr. Nelson's credible opinion, respondent's prescription of a high dose of prednisone to Patient A was clearly excessive. But no expert specifically opined that respondent's prescription of Lexapro to Patient B was clearly excessive. Dr. Nelson persuasively found that the prescription was unsupported by a proper documented assessment and diagnosis, and that respondent failed to obtain an adequate medication history before issuing the prescription. However, the dosage prescribed was very low and may have been appropriate, assuming a proper documented assessment and diagnosis of depression or anxiety and a supportive medication history.

16. Complainant also failed to establish by clear and convincing evidence that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. Although she failed to document her rationale for some of the tests she ordered, no expert opined that the ordered testing was clearly excessive.

17. In sum, the record does not contain clear and convincing evidence of repeated acts of clearly excessive prescribing or clearly excessive use of diagnostic procedures. Thus, cause does not exist to discipline respondent under Business and Professions Code sections 2227 and 725.

FOURTH CAUSE FOR DISCIPLINE - DISHONESTY

18. Complainant did not establish that respondent committed any act involving dishonesty that is substantially related to the qualifications, functions, or duties of a physician and surgeon. The Accusation's allegations in that regard were not established by clear and convincing evidence. Thus, cause does not exist to discipline

respondent for dishonesty under Business and Professions Code sections 2227 and 2234, subdivision (e).

FIFTH CAUSE FOR DISCIPLINE – INADEQUATE RECORDKEEPING

19. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records for Patients A and B. Dr. Nelson persuasively identified numerous recordkeeping deficiencies in Patients A and B's charts. The contrary opinions of Drs. Kapuria and Lenaerts are unpersuasive and contradict the obvious deficiencies in respondent's own treatment records. Thus, cause exists to discipline respondent for inadequate recordkeeping under Business and Professions Code sections 2227 and 2266.

SIXTH CAUSE FOR DISCIPLINE – GENERAL UNPROFESSIONAL CONDUCT

20. As discussed above, complainant established multiple departures from the standard of care by clear and convincing evidence. Such departures are unbecoming a member in good standing of the medical profession and demonstrate an unfitness to practice medicine. Thus, cause exists to discipline respondent for general unprofessional conduct under Business and Professions Code sections 2227 and 2234.

Appropriate Discipline

21. The existence of cause for discipline does not end the required analysis. It is also necessary to determine the appropriate degree of discipline.

22. Respondent's misconduct in this case was serious. It involved two patients and multiple departures from the standard of care, including two extreme departures. However, the purpose of a civil administrative licensing proceeding is not

to punish but to protect the public. (See *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Thus, the undersigned would ordinarily be inclined to consider whether a probation period with appropriate probation conditions could be imposed to monitor respondent and protect the public in lieu of license revocation.

23. Nevertheless, careful consideration of the record as a whole compels the conclusion that revocation is necessary to protect the public interest for two reasons.

First, respondent has an extensive disciplinary history with the Board, involving two public reprimands and a stayed license revocation with imposition of probation. Those prior cases involved very similar issues to the issues involved in this case, such as improper diagnoses of patients, unsupported treatment plans, failure to consider medication interactions, and poor recordkeeping. As part of respondent's prior Board probation, she was required to participate in a clinical competency program and complete education, medical recordkeeping, and professionalism (ethics) courses. Notwithstanding those remedial courses, respondent's misconduct persisted once she returned to unsupervised practice.

Second, respondent denied any misconduct in this case and also failed to accept responsibility for the misconduct underlying her two prior public reprimands. (See *Seide v. Com. of Bar Examiners of the State Bar of Cal.* (1989) 49 Cal.3d 933, 940 ["Fully acknowledging the wrongfulness of [one's] actions is an essential step towards rehabilitation"].) Although clearly intelligent and well-qualified, her testimony was unapologetic and arrogant. She blamed the patients, limited availability of medical records, and even the Board for her misfortunes. She displayed limited to no insight into her own misconduct. In sum, respondent does not appear to be a good candidate for further Board probation.

24. To be sure, respondent's letters of support laud her competence, professionalism, compassion for patients, and involvement in humanitarian medical missions. But those attributes are hard to square with the evidence in this case, respondent's extensive disciplinary history, and respondent's dismissive attitude towards Patients A and B. Additionally, Dr. Sanden is a personal friend, and both Drs. Martel and Sanden displayed limited to no knowledge of respondent's disciplinary history. (See *Seide, supra*, 49 Cal.3d at 940 ["If the character witnesses were not aware of the extent and seriousness of petitioner's criminal activities, their evaluations of his character carry less weight."].)

25. When the record as a whole is considered, license revocation is the appropriate discipline. Revocation is necessary to protect public health, safety, and welfare.

Costs

26. If cause for discipline is established, the Board may recover its reasonable investigation and enforcement costs for the case. (Bus. & Prof. Code, § 125.3.) In support of any cost recovery request, the Board must provide declarations and supporting documents that contain specific and sufficient facts to support findings regarding the actual costs incurred and the reasonableness of the costs, including a description of the general tasks performed, the time spent on each task, and the method of calculating the costs. (Cal. Code Regs., tit. 1, § 1042, subd. (b).) "When the agency presents an estimate of actual costs incurred, its Declaration shall explain the reason actual cost information is not available." (*Id.* subd. (b)(3).)

27. Here, complainant provided documentation of its actual investigation costs, including expert reviewer costs, and actual enforcement costs that complies with

California Code of Regulations, title 1, section 1042, subdivision (b). Contrary to respondent's arguments, the documentation provides specific and sufficient facts to support findings regarding the actual costs incurred and the reasonableness of the costs. They include a description of the general tasks performed, the time spent on each task, and the method of calculating the costs. Requiring a more detailed description of activities performed may unduly invade the attorney-client or other applicable privileges and protections. Furthermore, respondent's contention that costs are required to be billed in six-minute increments as opposed to 15-minute increments lacks merit. Neither Business and Professions Code section 125.3 nor California Code of Regulations, title 1, section 1042 imposes such a requirement.

28. An independent review of complainant's actual investigation costs ($10,549.25), expert reviewer costs ($3,750), and enforcement costs ($25,033.25), for a total amount of $39,332.50, reveals that the requested costs are reasonable given the complexity and issues in the case. However, the additional $4,560 in anticipated prosecution costs sought for the period between Mr. Tan's July 17, 2025 Certification and the hearing are unsupported. Complainant does not explain the reason that the actual cost information was not available at the time of the hearing. (Cal. Code Regs., tit. 1, § 1042, subd. (b)(3).) Thus, those costs will not be awarded.

29. Even when costs sought are reasonable, the California Supreme Court has set forth additional guidelines to determine whether the costs should be assessed or reduced in the particular circumstances of each case. (*Zuckerman v. State Bd. of Chiropractic Examiners* (2002) 29 Cal.4th 32.) These factors include whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of her position, whether the licensee has raised a colorable challenge to the proposed discipline, the licensee's

financial ability to pay, and whether the scope of the investigation was appropriate to the alleged misconduct.

30. Here, the scope of the investigation was appropriate. Respondent was successful in getting some of the alleged charges and causes for discipline dismissed. However, she raised no colorable challenge to the proposed discipline of revocation and presented no specific evidence of financial inability to pay. Considering all the relevant *Zuckerman* factors, a modest cost recovery reduction to $30,000 is warranted.

ORDER

1. The Physician's and Surgeon's Certificate No. A 48720 issued to respondent Nadine Helmy Yassa, M.D., is REVOKED.

2. Respondent Nadine Helmy Yassa, M.D., shall pay the Board $30,000 in investigation and enforcement costs for this matter.

DATE: October 8, 2025

Wim vanRooyen

WIM VAN ROOYEN
Administrative Law Judge
Office of Administrative Hearings