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

In the Matter of the Accusation Against:	)	
Sultan Ahmad Sultan, M.D.	)	**Case No. 800-2014-010065**
Physician's and Surgeon's Certificate No. A 48095	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on August 30, 2019.

IT IS SO ORDERED: August 1, 2019.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SULTAN AHMAD SULTAN, M.D.** **CARE Medical Clinic Inc.** **6500 Coyle Ave, #4** **Carmichael, CA 95608** **Physician's and Surgeon's Certificate No. A 48095** Respondent.	Case No. 800-2014-010065 OAH No. 2018090609 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Steven D. Muni, Supervising Deputy Attorney General.

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2. Respondent Sultan Ahmad Sultan, M.D. (Respondent) is represented in this proceeding by attorney Heather Hoganson, whose address is: Simas Law Group, North Pointe Business Center, 3835 North Freeway Boulevard, Suite 228, Sacramento, CA 95834.

3. On or about April 2, 1990, the Board issued Physician's and Surgeon's Certificate No. A 48095 to Sultan Ahmad Sultan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-010065, and will expire on April 30, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2014-010065 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 27, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-010065 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-010065. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2014-010065, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him, before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2014-010065 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

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

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

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 48095 issued to Respondent Sultan Ahmad Sultan, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. 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.

3. 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 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 (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) 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 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. 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 (6) months after Respondent's initial enrollment. Respondent shall successfully

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complete any other component of the course within one (1) 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.

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 (6) 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 (3) and no more than five (5) 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.

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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.

A clinical competence assessment 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 course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. 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 (3) calendar days after being so notified. The 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 the Respondent did not successfully complete the clinical competence assessment program, the 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. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to

compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within

15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the 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.

8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. 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.

10. 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.

11. 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(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or 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 thirty (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.

12. 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.

13. 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 Boards'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 (2) years.

Periods of non-practice 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; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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14. 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.

15. 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.

16. 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.

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.

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ACCEPTANCE

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

DATED: 06/20/2019

S. A. Sultan
SULTAN AHMAD SULTAN, M.D.
Respondent

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

DATED: 6/20/19

Heather Hoganson
HEATHER HOGANSON
Attorney for Respondent

ENDORSEMENT

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

DATED: June 20, 2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

Steven D. Muni
STEVEN D. MUNI
Supervising Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2014-010065

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Aug. 27 20 18
BY [illegible] ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2014-010065
SULTAN AHMAD SULTAN, M.D. CARE Medical Clinic Inc. 6500 Coyle Ave, #4 Carmichael, CA 95608 **Physician's and Surgeon's Certificate No. A 48095,** Respondent.	**ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about April 2, 1990, the Medical Board issued Physician's and Surgeon's Certificate Number A 48095 to Sultan Ahmad Sultan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2020, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

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

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

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

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

5. Section 2234 of the Code states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2266 of the Code states:

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

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent is subject to disciplinary action under section 2234, subdivision (b) in that he engaged in act(s) amounting to gross negligence in his care and treatment of Patients 1, 2, 3, 4, and 5.[1]. The circumstances are as follows:

8. At all times relevant to the charges brought herein, the standard of care required that a history and physical examination be performed prior to prescribing controlled substances for pain, including an assessment of the pain, physical and psychological function, substance abuse history, history of prior treatment, assessment of underlying or coexisting diseases or conditions, and documentation of the presence of a recognized medical indication for the use of a controlled substance.

9. At all times relevant to the charges brought herein, the standard of care required a treatment plan and objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychological function, and the plan should indicate if any further diagnostic evaluations or other treatments are planned.

10. At all times relevant to the charges brought herein, the standard of care required that the physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver, or guardian.

11. At all times relevant to the charges brought herein, the standard of care required that the physician and surgeon periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of the treatment depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and should consider other therapeutic modalities.

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[1] To protect their identities, the patients involved are identified as Patient 1, Patient 2, Patient 3, Patient 4 and Patient 5.

12. At all times relevant to the charges brought herein, the standard of care required that the patient be referred as necessary for additional evaluation and treatment to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist. Physicians should give special attention to those pain patients who are at risk of misusing their medications including those whose living arrangements pose a risk for medication misuse or diversion.

13. At all times relevant to the charges brought herein, the standard of care required that the physician and surgeon keep accurate and complete records documenting the history and physical examination, other evaluations and consultations, the treatment plan, objectives, informed consent, treatments and medications, the rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

Circumstances Related to Patient 1.

14. Between February 2011 and April 2013, Respondent treated Patient 1 for back and sacroiliac pain.[2] Throughout this period, Respondent prescribed Norco, a preparation of the opiate hydrocodone and acetaminophen, to Patient 1 on a monthly basis.[3] In March 2012, Respondent's chart included a note from another medical professional which indicated that Patient 1 had a history of methamphetamine abuse. On or about March 28, 2012, Patient 1 presented to Respondent with a complaint of right shoulder pain. Respondent noted reduced right shoulder range of motion, and ordered an x-ray of the shoulder. Patient 1 never completed the x-ray, and Respondent failed to follow up, but continued to prescribe Norco to Patient 1. On or about June 6, 2012, Respondent noted that no further Norco prescriptions would be issued until previously ordered labs and x-rays were conducted; however, Respondent continued to prescribe Norco to Patient 1 notwithstanding this note. On or about October 24, 2012, Respondent's chart included a

[2] Conduct occurring prior to September 14, 2011, is for informational purposed only, and is not alleged as a basis for disciplinary action.

[3] Norco (hydrocodone 10 mg / acetaminophen 325 mg) is a Schedule III controlled substance from the opiates class pursuant to Health and Safety Code section 11056, subdivision (e), and Tile 21 of the Code of Federal Regulations, section 1308.13, subdivision (e)(1)(iv), and is a dangerous drug pursuant to Business and Professions Code section 4022.

letter from Child Protective Services indicated that Patient 1 was in drug treatment and should not be taking opiates. Patient 1 presented to Respondent on or about November 7, 2012, and Respondent noted that he would discontinue Patient 1's Norco prescription. However, Respondent continued to prescribe Norco to Patient 1 notwithstanding this note. In an investigative interview, Respondent stated that he referred the patient to a pain management specialist on or about February 5, 2013. There is no legible indication of this in Respondent's records. There is no indication that the patient followed through on this referral, but Respondent nevertheless continued to prescribe Norco to Patient 1. Respondent ultimately discharged Patient 1 from his care in or about April 2013.

15. In his physical examination notes, Respondent failed to document details of physical function. Respondent failed to document consideration of the patient's substance abuse history in formulating his treatment plan. Respondent failed to document the patient's prior pain treatment history. Respondent failed to establish a recognized medical indication for the prescription of controlled substances through imaging or other diagnostic studies. These failures collectively and individually violate the standard of care and represent gross negligence.

16. Respondent failed to document any objectives by which his treatment of Patient 1 could be evaluated. Respondent failed to document any rationale for the quantity of Norco he prescribed to Patient 1. Respondent failed to document any consideration of non-opiate treatment of Patient 1's pain. These failures collectively and individually violate the standard of care and represent gross negligence.

17. Respondent failed to perform any systematic or structured review of the course of Patient 1's pain treatment. Patient 1 was seen regularly for follow-up visits, but the only criteria governing the quantity of Norco prescribed was patient demand. Respondent failed to document any evaluation of function or quality of life, or pain severity levels. Respondent twice failed to follow through on his own stated intention to cease prescribing Norco to Patient 1. These failures to perform periodic review and assessment of Patient 1's treatment collectively and individually violate the standard of care and represent gross negligence.

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18. Respondent continued to prescribe controlled substances to Patient 1 notwithstanding the patient's noncompliance with Respondent's referral to a pain management specialist. Doing so violates the standard of care and represents gross negligence.

19. Respondent failed to keep adequate legible medical records documenting his treatment of Patient 1. This violates the standards of care and represents gross negligence.

Circumstances Related to Patient 2.

20. Between February 2007 and May 2012, Respondent treated Patient 2 for back pain. Throughout this period, Respondent prescribed hydrocodone[4] on a regular basis to Patient 2. Respondent's chart includes a March 2007 spine x-ray, which the radiologist interpreted as normal. Respondent's chart does not include any other radiological or other diagnostic study of Patient 2. Respondent's own periodic physical examination of Patient 2 mentions only "tenderness at L5/S1." On or about October 31, 2011, Respondent noted that no further refills of controlled substances were to be authorized until Patient 2 completed lab studies that Respondent had previously ordered. These lab studies were not completed until January 2012, but Respondent authorized refills of Norco for Patient 2 on six separate occasions in November and December 2011. Beginning in June, 2011, Respondent also prescribed the muscle relaxant Soma (carisoprodol) to Patient 2.[5] Respondent prescribed both hydrocodone and Soma to Patient 2 on a continuous basis until the patient transitioned to a different provider in May 2012.

21. Respondent failed to document Patient 2's physical and psychological functioning. Respondent's chart included records of an Emergency Department visit on July 22, 2007, in which the emergency physician indicated a high suspicion of drug-seeking behavior. Respondent failed to document any consideration of this suspicion. Respondent failed to document any consideration of the patient's past treatment for pain. Respondent failed to establish a recognized

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[4] Hydrocodone/APAP is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Carisoprodol is a muscle relaxant with a known potentiating effect on narcotics. In December, 2011, the Federal Drug Administration listed carisoprodol as a Schedule IV controlled substance. (76 Fed.Reg. 77330 (Dec. 12, 2011).)

medical indication for the prescription of controlled substances through imaging or other diagnostic studies. A patient with chronic low back pain requiring long-term opiate therapy and muscle relaxants should have advanced imaging studies done to evaluate for structural spine pathology. Respondent failed to obtain any imaging studies of Patient 2's spine, beyond a 2007 x-ray that was read as normal. These failures collectively and individually represent gross negligence.

22. Respondent failed to document any objectives by which his treatment of Patient 2 could be evaluated. Respondent failed to document any rationale for the quantity of hydrocodone he prescribed to Patient 2. Respondent failed to document any consideration of non-opiate treatment of Patient 2's pain. Respondent failed to document a rationale for the combination of hydrocodone with Soma, both of which were authorized by Respondent for unusually frequent refills, far in excess of what would be usual for chronic pain management. Soma potentiates the euphoric effect of opiates, heightening the potential for abuse. These failures collectively and individually represent gross negligence.

23. Respondent failed to perform any systematic or structured review of the course of Patient 2's pain treatment. Patient 2 was seen regularly for follow-up visits, but Respondent failed to state any reason for the patient's frequent refills of controlled substances. Respondent failed to document any evaluation of function or quality of life, or pain severity levels. Respondent failed to follow through on his own note of October 31, 2011, in which he stated his intention to discontinue prescribing controlled substances to this patient until the patient completed previously ordered lab studies. Respondent failed to document a rationale for prescribing Soma to this patient, or a rationale for the excessive quantity of Soma he prescribed. These failures to perform periodic review and assessment of Patient 2's treatment collectively and individually represent gross negligence.

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24. Respondent failed to refer Patient 2 to either a Pain Management, Spine Surgery, or Physical Medicine specialist. Respondent failed to coordinate care with other medical providers treating Patient 2. These failures collectively and individually represent gross negligence.

25. Respondent failed to keep adequate legible medical records documenting his treatment of Patient 2. This represents gross negligence.

Circumstances Related to Patient 3.

26. Between March 2011 and September 2012, Respondent treated Patient 3 for symptoms of diffuse axial pain, headaches, and pain in various joints. On or about July 26, 2011, the patient reported having lost her Norco. Respondent replaced her prescription, and began also prescribing Fiorinal, a preparation of aspirin, caffeine, and the barbiturate butalbital.[6] Over the following year, the patient received multiple early refills of Soma and Norco from both Respondent and another medical provider. The patient was ultimately discharged from Respondent's practice in September 2012 based on suspected abuse of controlled substances.

27. Respondent failed to document any objectives by which his treatment of Patient 3 could be evaluated. Respondent failed to document any rationale for escalating the patient's dosage of Norco and Soma, or for the combination of Norco and Soma. Respondent failed to consider non-opiate pharmacological pain management therapies. These failures collectively and individually represent gross negligence.

28. Respondent failed to document any discussion of the risks and benefits of chronic opiate therapy with Patient 3, or any discussion of the additional risk posed by the combination of Soma and hydrocodone. These failures to obtain informed consent from Patient 3, collectively and individually, represent gross negligence.

29. Respondent failed to perform any systematic or structured review of the course of Patient 3's pain treatment. Patient 3 was seen regularly for follow-up visits, but Respondent failed to state any reason for the patient's frequent refills of controlled substances. Respondent

[6] Fiornial is a trade name of a combination of the barbiturate butalbital with aspirin and caffeine and is a controlled by the Federal Drug Enforcement Administration and is classified under Schedule III.

failed to document any evaluation of function or quality of life, or pain severity levels. Respondent failed to document a rationale for prescribing Soma to this patient, particularly in light of the risk of abuse inherent in prescribing Soma with opiates. These failures to perform periodic review and assessment of Patient 3's treatment collectively and individually represent gross negligence.

30. Respondent failed to make any referral to a Pain Management, Physical Medicine, or other musculoskeletal specialist for Patient 3. Respondent failed to coordinate care with the other medical providers who prescribed to Patient 3. These failures collectively and individually represent gross negligence.

31. Respondent failed to keep adequate legible medical records documenting his treatment of Patient 3. This represents gross negligence.

Circumstances Related to Patient 4.

32. Between August 2007 and June 2014, Respondent treated Patient 4 for fibromyalgia, lumbago, and headaches. From the initial date of treatment, the patient reported a history of opium addiction. Respondent prescribed methadone to Patient 4 on a continuous basis until the patient was ultimately dismissed from Respondent's practice in 2014.[7]

33. Respondent documented a history and several physical examinations of Patient 4's back and joints, but Respondent's documentation of his physical examination was incomplete and illegible. Respondent documented few details of physical function, and no mention of psychological function. Respondent failed to document any pain severity measurement. Respondent failed to document any imaging studies to support a medical indication for opioid therapy. A diagnosis of fibromyalgia is not a valid medical indication for high dose opioid therapy. Respondent failed to adequately monitor Patient 4's dosing and refills in light of the

[7] Methadone is a Schedule II controlled substance from the opiates class pursuant to and Health and Safety Code section 11055, subdivision (c), and Title 21 of the Code of Federal Regulations, section 1308.12, subdivision (c)(15), and is a dangerous drug pursuant to Business and Professions Code section 4022.

patient's history of opium addiction. These failures collectively and individually represent gross negligence.

34. Respondent failed to document any objectives by which his treatment of Patient 4 could be evaluated. Respondent failed to document whether the methadone he prescribed was primarily for addiction treatment or pain management. Respondent failed to document any consideration of non-opioid treatment of Patient 4's pain, such as physical therapy, massage, or non-opioid pharmacologic pain management therapies. These failures collectively and individually represent gross negligence.

35. Respondent failed to perform any systematic or structured review of the course of Patient 4's pain treatment. Patient 4 was seen frequently for follow-up, but Respondent failed to document any reason for the frequent refills of methadone. These failures collectively and individually represent gross negligence.

36. Respondent failed to keep adequate legible medical records documenting his treatment of Patient 4. This represents gross negligence.

Circumstances Related to Patient 5.

37. Between August 2007 and August 2014, Respondent treated Patient 5 for fibromyalgia, lumbago, and abdominal pain. The patient reported from his initial visit a history of opioid addiction. Respondent prescribed methadone to Patient 5 on a continuous basis until the patient was ultimately dismissed from Respondent's practice in 2014.

38. Over the course of Respondent's treatment and care of Patient 5, the patient reported various musculoskeletal pain symptoms. Respondent's physical examinations of Patient 5 document limited musculoskeletal examination. Respondent documented few details of physical function. Respondent failed to document whether the patient's reported psychological issues, including post-traumatic stress disorder and anxiety, were improving with pain therapy. Respondent failed to document any pain severity measurement. Respondent failed to document any imaging studies to support an indication for opioid therapy. Imaging studies would be required to establish the presence of a musculoskeletal pathology sufficient to support an

indication for opioid pain therapy. These failures collectively and individually represent gross negligence.

39. Respondent failed to document any objectives by which his treatment of Patient 5 could be evaluated. Respondent failed to document whether the methadone he prescribed was primarily for addiction treatment or pain management. Respondent failed to document any consideration of non-opioid treatment of Patient 5's pain, such as physical therapy, massage, or non-opioid pharmacologic pain management therapies (other than Tylenol.) These failures collectively and individually represent gross negligence.

40. Respondent failed to perform any systematic or structured review of the course of Patient 5's pain treatment. Patient 5 was seen frequently for follow-up, but Respondent failed to document any reason for the frequent refills of methadone, other than treatment of withdrawal symptoms. These failures collectively and individually represent gross negligence.

41. Respondent failed to keep adequate legible medical records documenting his treatment of Patient 5. This represents gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

42. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he engaged in repeated acts amounting to negligence. The circumstances are set forth in paragraphs 8 through 42, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

43. Respondent failed to document details of physical and psychological functioning, and objective pain severity measurements in his care of Patient 3. These failures collectively and individually constitute negligence.

44. Respondent made a good faith effort to refer Patient 4 to a pain management specialist and to a methadone clinic. However, when the patient failed to follow through, Respondent continued to prescribe methadone for eight months, until the patient was finally discharged in June 2014. Respondent's delay in discharging this noncompliant patient constitutes negligence.

45. Respondent made a good faith effort to refer Patient 5 to a methadone clinic in 2011, 2013, and 2014. However, when the patient failed to follow through, Respondent continued to prescribe methadone, until the patient transferred to another medical provider for treatment in August 2014. Respondent's delay in discharging this noncompliant patient constitutes negligence.

THIRD CAUSE FOR DISCIPLINE

(Recordkeeping)

46. Respondent is subject to disciplinary action under section 2266 in that he failed to adequately document his medical care. The circumstances are set forth in paragraphs 8 through 46, which are incorporated here by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 48095, issued to Sultan Ahmad Sultan, M.D.;

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

3. Ordering Sultan Ahmad Sultan, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: August 27, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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