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

In the Matter of the Accusation Against Sadegh Salmassi, M.D. Physician's and Surgeon's License No. A39604 Respondent	Case No. 800-2017-035440

DECISION

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

This Decision shall become effective at 5:00 p.m. on February 18, 2021.

IT IS SO ORDERED: January 19, 2021.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation against:

SADEGH SALMASSI, M.D., Respondent

Agency Case No. 800-2017-035440

OAH No. 2019070812

PROPOSED DECISION

Erin R. Koch-Goodman, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on November 16, 17, and 18, 2020, from Sacramento, California.

Sarah J. Jacobs, Deputy Attorney General, appeared on behalf of William Prasifka (complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

Dennis R. Thelen, Attorney at Law, LeBeau and Thelen LLP, appeared on behalf of Sadegh Salmassi, M.D. (respondent), who was present at hearing.

Oral and documentary evidence was received, the record closed and the matter submitted for decision on November 18, 2020.

FACTUAL FINDINGS

Jurisdictional Matters

1. On February 28, 1983, the Board issued respondent Physician's and Surgeon's Certificate (license) No. A 39604. Respondent's license is in full force and effect until August 31, 2022, unless renewed or revoked. Respondent owns and operates a private family practice in Delano. Delano is an agricultural city of approximately 53,000 people, located in the Central Valley approximately 32 miles from Bakersfield.

2. On January 11, 2019, former Executive Officer Kimberly Kirchmeyer, in her official capacity, made and served an Accusation against respondent. The Accusation alleges respondent committed gross negligence, repeated negligent acts, excessive prescribing of controlled substances, and did not maintain adequate and accurate medical records during his care and treatment of Patient A. More specifically, complainant alleges, between August 17, 2012 and August 27, 2013, respondent saw Patient A for 19 office visits, and excessively prescribed opioids, methadone, and central nervous system (CNS) depressants; administered Demerol, an acute pain drug, for chronic pain and failed to take vital signs before the Demerol injection on February 21, 2013. In addition, at each appointment, respondent failed to: obtain an adequate pain history using a pain scale; conduct an assessment, plan, and treatment objectives; acquire informed consent regarding risks, benefits, and alternatives to opioids; secure a pain management agreement; monitor opioid use with urine tests; make a pain management referral or document why a referral was not made; and conduct a periodic treatment review (semi-annual or annual). On two occasions, respondent also failed to: evaluate a breast lump, a breast mass, and hoarseness, and make appropriate

referrals, or document why referrals were not made; as well as diagnose hypertension as the reason to prescribe Lisinopril. Finally, respondent did not adequately document his care and treatment of Patient A, and repeatedly failed to document his thought-process or medical decision-making.

3. On or about January 24, 2019, respondent timely filed a Notice of Defense. This hearing followed.

Patient A

4. Patient A was a 45-year-old woman, measuring 68 inches and weighing 244 pounds, and described as a chronic pain patient. According to her medical record, Patient A was diagnosed with: fibromyalgia (widespread musculoskeletal pain), lumbalgia (low back pain), radiculitis of lumbosacral spine (cervical lumbar spine pain), and interstitial cystitis (bladder pain syndrome), as well as hypercoagulability syndrome (increased blood clotting), hypothyroidism (underactive thyroid), obesity (overweight), and Post-Traumatic Stress Disorder (PTSD) (mental health condition following trauma). At all times relevant, respondent was Patient A's primary care provider (PCP) and treating physician. Between August 17, 2012, and August 27, 2013, Patient A saw respondent 19 times. On August 28, 2013, Patient A died.

5. At each appointment, respondent documented each appointment with an Office Visit Note (Note) in an electronic medical record (EMR). The EMR Note included standard areas of inquiry: chief complaints (CC), history of present illness (HPI), and review of systems (ROS); past, family, social, and medication history; examination; diagnoses; and prescription. For CC, HPI, and ROS, respondent generally wrote a one-sentence description. For example, on August 17, 2012, respondent wrote: CC – "[Patient A] is here for pain all over body, refills on medication and swollen body";

HPI – "The above named patient is here because of the above complaint and to seek treatment and evaluation"; ROS – "Unchanged since last visit 01/17/12, except refer to present illness." On November 5, 2012, respondent wrote: CC – "[Patient A] is here for swollen body"; HPI – "The above named patient is here because of the above complaint and to seek treatment and evaluation"; ROS – "Unchanged since last visit 02/15/12, except refer to present illness." On April 16, 2013, respondent wrote: CC – "[Patient A] is here for refills on medication"; HPI – "The above named patient is here because of the above complaint, including treatment refills"; ROS – "Unchanged since last visit 01/11/13, except refer to present illness."

6. For past, family, and social history, all Notes list the same exact information, including: "drinks alcohol occasionally." For examination, respondent almost uniformly noted: "No change in her physical exam since her prior visit."

7. For chronic pain, respondent treated Patient A with a combination drug therapy, prescribing opioids (i.e., narcotic analgesics); CNS depressants, including benzodiazepines, sedatives, tranquilizers, and hypnotics; antidepressants; and muscle relaxants. Collectively, the medications cause sedation, respiratory depression, coma, and death, and carry risks of addiction and overdose. Taken together, the effects of the medications synergize. When combined with alcohol, the effects can be even greater. With few exceptions, respondent did not document his medical decision-making for his care or treatment of Patient A, including his medication choices or changes in medication, strength, or dose. Nonetheless, respondent changed Patient A's combination drug therapy on an almost monthly basis.

8. For other ailments, respondent treated Patient A with condition specific medications. He prescribed Coumadin (blood thinner) and Plavix (anticoagulant) to treat her hypercoagulability syndrome; Levoxyl and Synthroid for hypothyroidism;

Phentermine (Schedule IV[1]) for weight loss; and Cymbalta to treat depression and PTSD. According to the medical record, respondent also prescribed Patient A: Protonix, a medication for gastroesophageal reflux disease (GERD), and Lisinopril and Spironolactone, medications for hypertension or high blood pressure. However, there is no documented diagnosis of GERD or hypertension in the EMR for Patient A. Here too, with few exceptions, respondent did not document his medical decision-making for his diagnosis, care, or treatment of Patient A.

CHRONIC PAIN TREATMENT

9. Over the course of a year, from August 17, 2012, through August 27, 2013, respondent prescribed Patient A a combination of opioids including Demerol (Schedule II), Dilaudid/Hydromorphone (Schedule II), Methadone (Schedule II), OxyContin/Oxycodone (Schedule II), and Ultram/Tramadol (narcotic-like analgesic); CNS depressants including Ambien/Zolpidem (Schedule IV, sedative), Klonopin/Clonazepam (Schedule IV, benzodiazepine, sedative), Lunesta (Schedule IV, sedative),[2] and Xanax/Alprazolam (Schedule IV, benzodiazepine, sedative); antidepressants, including Cymbalta, Elavil/Amitriptyline and Topamax; and muscle relaxants, Norflex/Orphenadrine (sedative), and Flexeril/Cyclobenzaprine. More

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[1] Drugs are scheduled based upon the drug's acceptable medical use and the drug's abuse or dependency potential. Applicable here: Schedule II drugs have a high potential for abuse, with use potentially leading to severe psychological or physical dependence; and Schedule IV drugs have a low potential for abuse and low risk of dependency.

[2] The copay was $50 and respondent changed the prescription to Ambien.

specifically, in August 2012, Patient A received an in-office injection of Demerol[3] 100 milligram (mg.). Her daily prescription opioids at that time included: Dilaudid 4 mg. 4x/day (64 MME),[4] OxyContin Extended Release (ER) 40 mg. 4x/day (240 MME), and Ultram,[5] 100 mg. 3x/day (30 MME), for a total of 334 daily morphine milligram equivalents (MME).[6] She was also taking CNS depressants, Ambien 12.5 mg. 1x/day, Klonopin 1 mg. 2x/day, and Xanax 0.25 mg. 3x/day; antidepressants Cymbalta 30 mg. 2x/day and Elavil 100 mg. 1x/night; and the muscle relaxant Norflex ER 100 mg. 1x/night.[7]

10. In September, respondent continued the Ultram (30 MME); and replaced the Demerol, Dilaudid, and OxyContin (304 MME) with Methadone 10 mg. 4x/day (320 MME), thereby increasing Patient A's daily MME from 334 to 350. He reduced the CNS depressants, changing the strength of Ambien from 12.5 mg. to 10 mg. 1x/day, but

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[3] The Demerol injection was given on one day, and therefore, cannot be used to calculate the patient's daily average opioid regime.

[4] MME stands for morphine milligram equivalent. The EMR notes a prescription for 4 mg. 4x/day (64 MME), but with 180 tablets. A prescription for 180 tablets would actually equate to 8 mg. 3x/day or 12 mg. 2x/day (96 MME).

[5] Tramadol became a Schedule IV drug on August 18, 2014.

[6] MME or MED, morphine equivalent dosing, determines a patient's cumulative intake of drugs in the opioid class over a 24-hour period.

[7] For Schedule II through IV controlled substances, the CURES report provided fill dates.

maintained Klonopin and Xanax. He increased the antidepressant Cymbalta from 2x/day to 3x/day and continued the Norflex. In October, respondent maintained all medications. In November, respondent again gave Patient A an in-office Demerol 100 mg. injection; continued the Ultram (30 MME); and replaced the Methadone 10 mg. 4x/day (320 MME) with OxyContin 40 mg. 3x/day (180 MME),[8] thereby decreasing Patient A's daily MME from 350 to 210. The remaining CNS depressants, antidepressants, and muscle relaxer were continued. In December, respondent continued the opioids Oxycodone and Ultram (210 MME); decreased the CNS depressant Ambien from 10 mg. 1x/day to 12.5 mg. half tablet 1x/day and continued Klonopin and Xanax; continued Cymbalta and Elavil; and muscle relaxant Norflex.

11. In January 2013, respondent continued the opioids OxyContin and Ultram (210 MME); continued the CNS depressants Ambien and Klonopin, but discontinued Xanax. He also continued the antidepressants Cymbalta and Elavil and added Topamax 50 mg. 2x/day and continued the muscle relaxant Norflex. In February, respondent again gave Patient A an in-office Demerol 100 mg. injection and continued the opioids OxyContin and Ultram (210 MME). He increased the CNS depressant Ambien from 12.5 mg. half tablet 1x/day to 10 mg. 1x/day and continued the Klonopin. He also continued the antidepressants Cymbalta, Elavil, and Topamax; and muscle relaxer Norflex.

12. In March, respondent continued all medications. In April, respondent decreased the OxyContin from 40 mg. 3x/day (180 MME) to 20 mg. 3x/day (90 MME)

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[8] In early November 2012, respondent prescribed OxyContin 40 mg. 2x/day (120 MME), making her total daily MME 150, but increased the dose to 3x/day at the end of November.

and continued the Ultram (30 MME), thereby decreasing Patient A's daily MME from 210 to 120. He continued the CNS depressants Ambien and Klonopin, antidepressants Cymbalta and Elavil, decreased Topamax from 50 mg. 2x/day to 25 mg. 2x/day, and continued the muscle relaxer Norflex.

13. In May, respondent increased the OxyContin from 20 mg. 3x/day (90 MME) to 40 mg. 3x/day (180 MME) and continued Ultram (30 MME), thereby increasing Patient A from 120 to 210 MME He also increased the CNS depressant Ambien from 10 mg. 1x/day to 12.5 mg. 1x/day, continued Klonopin and the antidepressants Cymbalta, Elavil and Topamax. Finally, he continued the muscle relaxer Norflex and added Flexeril 10 mg. 1x/night. On May 16, 2013, a CVS pharmacist called respondent's practice, questioning the doubling of Patient A's OxyContin prescription; the prescription was confirmed and filled. In June, respondent continued all medications. In July, respondent discontinued Flexeril, but maintained all other medication.

14. Finally, in August 2013, respondent continued the Ultram (30 MME) and OxyContin ER, 20 mg. 3x/day (90 MME),[9] filled August 15; and on August 27, respondent added Methadone 40 mg. 3x/day (1,440 MME). As of August 27, Patient A had a 1,560 daily MME. Respondent also continued Ambien and increased Klonopin from 1 mg. 2x/day to 3x/day (1 AM/2 PM); continued antidepressants Cymbalta, Elavil, and Topamax; and doubled the dose of the muscle relaxant Norflex 100 mg. 2x/day.

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[9] On August 9, 2013, Brian Horan D.O. also prescribed Patient A Oxycodone/Acetaminophen 325 mg./5 mg. (Percocet) 20 mg. 3x/day, 25 tablets for approximately eight days (22.5 MME).

TREATMENT OF OTHER AILMENTS

15. On September 20, 2012, respondent documented a CC of "lump on breast" but did not complete or record a breast health history, a breast examination, diagnostic imaging, a specialist referral, or document why a referral was unnecessary. On March 12, 2013, respondent documented a CC of "mass on right breast" but again did not complete or record a breast health history, a breast examination, diagnostic imaging, a specialist referral, or document why a referral was unnecessary. On August 15, 2013 and August 27, 2013, respondent documented a CC of "hoarse voice" but did not complete or record an ear, nose, and throat (ENT) history; an ENT examination; an otolaryngologist referral or document why a referral was unnecessary.

Medical Evidence

BOARD GUIDELINES

16. In 1994, the Board adopted a policy statement entitled, "Prescribing Controlled Substances for Pain." The statement outlined the Board's approach to improving appropriate prescribing for effective pain management, while preventing drug diversion and abuse.

17. In 2002, as a result of Assembly Bill (AB) 487, a task force was established to review the 1994 policy statement and to assist the Division of Medical Quality to "develop standards to assure the competent review in cases concerning the management, including, but not limited to, the under treatment, under medication, and over medication of a patient's pain." The task force developed Guidelines for Prescribing Controlled Substances (Guidelines) to all patients with pain. In 2003, the Board adopted the Guidelines. The Guidelines encourage the use and consideration of six categories: (1) medical history and physical examination; (2) treatment plan and

objectives, (3) informed consent; (4) periodic review; (5) consultation; and (6) medical records. In 2007, the Board reissued the Guidelines, espousing the use and consideration of the same six categories, and noting a change in the law allowing the prescribing of opioids to addicts for care and treatment of a medical condition other than detoxification.

BOARD EXPERT – WILLIAM K. MORA, M.D., FAMILY MEDICINE

18. Dr. Mora completed his Bachelor of Arts in 1978 at the University of California (UC), San Diego, before spending two years volunteering with the Peace Corps in Columbia, South America. In 1981, he returned to the United States for medical school, and in 1985, he earned his Medical Degree from UC, Davis. Dr. Mora then completed a three-year residency in family practice and a one-year fellowship in emergency medicine at Valley Medical Center of Fresno (a UC, San Francisco affiliate). In 1986, he became licensed to practice medicine in California. He is a Diplomate of the National Board of Medical Examiners, American Board of Family Medicine, American Board of Holistic Medicine, and American Board of Medical Acupuncture; and was Board Certified with Added Qualification in Sports Medicine from 1999-2009. He has been an Expert Reviewer for the Board since 1996. He has reviewed 25 to 30 cases, with five to ten cases involving pain management.

19. Dr. Mora has practiced family medicine for 34 years. Currently, Dr. Mora is a family medicine physician with Health Associates Medical Group in Sacramento. He has worked in private practice, hospital emergency departments, urgent care facilities, and family medicine clinics, and has practiced field medicine in South America and Africa.

20. The Board retained Dr. Mora to conduct a review of documents and provide an opinion as to whether respondent acted within the medical standard of care for a family practice doctor when he treated Patient A. Dr. Mora reviewed multiple documents provided by the Board, including: the Board Investigative Report; respondent's Summary of Care for Patient A; medical records and CURES report (from January 4, 2010 through August 27, 2013); coroner's report and death certificate; and respondent's Board interview recording. On or about December 19, 2018, Dr. Mora issued a Report, finding respondent made five simple departures and four extreme departures from the standard of care when treating Patient A. More specifically, Dr. Mora found respondent's care and treatment of Patient A departed from the standard of care, because he: excessively prescribed opioids (extreme departure), Methadone (extreme departure), and CNS depressants (extreme departure), as well as administered Demerol injections for chronic pain (simple departure for administering Demerol for chronic pain; and extreme departure for not taking vital signs before the Demerol injection on February 21, 2013); failed to evaluate and document an examination and findings regarding breast lumps on September 20, 2012, and breast masses on March 12, 2013 (collectively, a simple departure) and hoarseness on August 15, 2013 and August 27, 2013 (collectively, a simple departure); treated, but failed to diagnose or document hypertension (simple departure); and generally, failed to document his medical decision-making (simple departure).

Standard of Care

21. Dr. Mora defined the standard of care as "the level of skill, knowledge, and ability a physician, in the same field, with the same experience, would provide a patient." He described a simple departure as the lack of ordinary care, and an extreme departure as a significant lack of ordinary care.

22. As a family physician, and in consultation with the 2007 Guidelines, Dr. Mora identified the standard of care for a family practice physician prescribing opioids, including Methadone, to require the consideration and documentation of: (1) a history and physical examination, including a review of systems, chronic illnesses, and a history of the presenting illness(es) for each visit; (2) consideration of safer alternative modalities; (3) a risk/benefit discussion with the patient; (4) verbal or written informed consent; (5) review of CURES reports; screen for opioid use/dependence disorder; (6) urine testing for ongoing controlled substance prescriptions[10]; (7) monitoring/treatment of chronic conditions; (8) ordering/monitoring of preventative screening measures; and documenting all of the above in the patient chart. For documentation, Dr. Mora described the standard of care for a family practice physician to require sufficient explanation and/or a detailed description of the rationale for diagnosis and the medical decision-making behind specific treatment or medication prescribed or lack thereof.

23. In addition, when a family physician substitutes one opioid for another or prescribes Methadone to replace an opioid medication, an equivalent dose calculation should be made and documented (i.e., an MME or equivalent). Also, a family physician prescribing a combination of medications (i.e., opioids, CNS depressants including benzodiazepines, antidepressants, and muscle relaxants) must educate the patient about side effects and risks, including the cumulative effects and possible interactions between drugs, the risk of drinking alcohol while taking the medications, as well as the

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[10] At hearing, Dr. Mora conceded that family physicians did not check CURES or require urine testing for opioid patients in 2012 or 2013; the Guidelines added the additional screening methods in 2014.

risks of overdose and addiction. Finally, a family physician treating a chronic pain patient should use drugs shown to relieve long-term pain, and not drugs for sudden episodes of acute/short-term pain, like Demerol.

Treatment for Chronic Pain

24. Considering the facts, Dr. Mora found, at each appointment, respondent failed to complete or record: (1) a pain history using a 1 to 10 pain scale; (2) treatment objectives and an assessment of the same, including pain reduction/increase, adverse effects of medication, physical ability to complete activities of daily living (ADLs), or emotional status; (3) a risk, benefit, and alternatives discussion; (4) informed consent; (5) a pain management agreement; (6) urine tests to monitor opioid use; (7) a pain management referral or documentation why a referral was unnecessary; (8) periodic treatment review (semi-annual or annual); and (9) his thought-process or medical decision-making for the care and treatment provided to Patient A, including his rationale for prescribing a certain drug or making changes to dose or type of drug. In fact, none of the above was included in any record for Patient A. Collectively, Dr. Mora found respondent made an extreme departure from the standard of care at each appointment. In addition, Dr. Mora noted numerous changes in medication over the 12-month treatment period and found no explanation for the same in the EMR (e.g., in September 2012, Cymbalta 30 mg. was changed from 2x/day to 3x/day; in December 2012, OxyContin ER 40 mg. 2x/day to 3x/day; in March 2013, OxyContin ER 40 mg. 3x/day was changed to 20 mg. 3x/day; and in August 2013, Klonopin from 1 mg. 2x/day to 3x/day (1 AM/2 PM)).

25. Further, Dr. Mora found respondent did not appropriately prescribe or adjust Patient A's chronic pain medications. For total opioid or analgesic intake, in September 2012, respondent substituted Methadone 40 mg. 4x/days for 320 MME for

OxyContin 40 mg. 3x/day for 180 MME, a substantial drop without explanation. In July 2013, respondent had Patient A on OxyContin and Ultram for 210 MME and on August 27, 2013, respondent added Methadone 40 mg. 3x/day for 1,440 MME, for a total of 1,650 MME, a substantial increase without explanation. In addition, Methadone prescribed in amounts greater than 100 mg. risks QT prolongation (heart takes longer than usual to recover after each beat), and a baseline EKG prior to prescribing Methadone is proper, but was not ordered by respondent. Finally, Patient A was also prescribed Elavil, another drug with the risk of QT prolongation. Based upon the above, Dr. Mora considers respondent's prescribing practices regarding Methadone to be an extreme departure.

26. Furthermore, the combination of opioids and CNS depressants, including benzodiazepines, antidepressants, and muscle relaxants, exponentially increases the effects of sedation and respiratory depression. As such, a family physician using a combination drug therapy must closely monitor the patient; as well as educate the patient of the cumulative effects of the drugs, the potential drug interactions, the effects when alcohol is consumed, and the risk of overdose and addiction. Ultimately, if a family physician is unable to adequately control chronic pain, a referral should be ordered to a pain specialist, even if the specialist is farther away. Dr. Mora considers respondent's chronic pain drug therapy, combining multiple drugs with side effects of sedation, respiratory depression, coma, and death, as well as addiction and overdose, to be an extreme departure.

27. Finally, on August 17, 2012, November 1, 2012, and February 21, 2013, respondent provided Patient A with in-office Demerol injections. Demerol is a strong medication used to treat acute pain following injury, not long-term or chronic pain. Dr. Mora found respondent's use of Demerol improper. Notwithstanding the above, when

Demerol is given, patients should be closely monitored, including the taking of vital signs before an intermuscular injection is administered. On August 17, 2012, November 1, 2012, or February 21, 2013, Patient A did not present with an acute injury or exacerbation of the same; instead, she presented with her continued chronic pain. Respondent's prescription of Demerol was improper and constitutes a simple departure. On February 21, 2013, respondent committed an extreme departure when he failed to take Patient A's vital signs before administering the Demerol.

Treatment for Other Ailments

28. Dr. Mora identified the standard of care for a family practice physician evaluating complaints of a breast lump, a breast mass, or hoarseness, to require the consideration and documentation of a history and specific physical examination, diagnostic imaging, and referral to a specialist. Respondent did not take or document: a history or breast examination, order diagnostic imaging, or refer Patient A to a specialist for her complaints on September 20, 2012 or March 12, 2013, which Dr. Mora found to be a simple departure. Similarly, Dr. Mora found respondent did not take or document a history or ENT examination, or otherwise refer Patient A to a specialist for her complaints of hoarseness, lasting more than two weeks, on August 15, 2013 and August 27, 2013. Dr. Mora found these failures to also be a simple departure.

29. Finally, Dr. Mora identified the standard of care for a family practice physician prescribing a condition-specific medication to require the diagnosis and documentation of the underlying condition. Respondent prescribed Lisinopril to Patient A but did not diagnosis hypertension in the EMR or document his reasons for prescribing the same. Dr. Mora found this to be a simple departure.

RESPONDENT'S EXPERT – RICHARD A. JOHNSON, M.D.

30. Dr. Johnson completed his Bachelor of Science in physics in 1973 at the University of Washington, before earning his Medical Degree from Washington University School of Medicine, St. Louis, Missouri in 1977. Dr. Johnson then completed a three-year residency in family medicine at UC, Los Angeles (LA) Medical Center. In 1978, he became licensed to practice medicine in California. He is Board Certified with the American Board of Family Practice. In 1980, he joined the family medicine faculty at UCLA, and for 20 years, served as a director for clinical services and the residency program. He has been a family physician, in an office-based practice, for more than 40 years. Currently, Dr. Johnson currently practices family medicine with the Pacific Palisades Medical Group, and simultaneously provides clinical direction to rotating UCLA medical students and residents. He has held administrative and committee positions, presented and led workshops at medical conferences, and published in peer-reviewed journals in the area of family medicine.

31. Respondent retained Dr. Johnson to conduct a review of documents and provide an opinion as to whether respondent's care and treatment of Patient A was within the medical standard of care for a family practice doctor. Dr. Johnson reviewed multiple documents provided by respondent, including: the Accusation; respondent's Summary of Care for Patient A; medical records and CURES report (January 4, 2010 through August 27, 2013); coroner's report and death certificate; and respondent's Board interview recording/transcript. On September 30, 2019, Dr. Johnson issued a Report, finding respondent did not depart from the standard of care at any time during his treatment of Patient A. Dr. Johnson testified at hearing consistent with his Report.

Standard of Care

32. According to Dr. Johnson, "[t]he standard of care is defined by the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians of the same specialty would carry out under the same or similar circumstances." However, he noted: "it is obvious that no two physicians will necessarily treat a patient in the same fashion." So, "the standard of care allows for the range of clinical practices and judgments that would represent a spectrum of care that could be observed within a large group of reasonable, prudent and careful physicians for any given similar patient encounter." Dr. Johnson did not delineate a simple or extreme departure from the standard of care. Instead, he defined simple and gross negligence for the purposes of his opinions. "Simple negligence occurs if in a given episode of care, a physician's care and treatment substantially deviates from the care that could be observed within a large group of reasonable, prudent and careful physicians managing a similar episode." In comparison, "[g]ross negligence is care below that standard of care that is characterized as the lack of even scant care."

33. After reviewing the EMR, Dr. Johnson was able to understand the care and treatment respondent provided to Patient A; and found the same to be a part of the "spectrum of care" found within a large group of family practice physicians. Dr. Johnson was also not critical of respondent's documentation, explaining there is "no standard of care that defines medical record documentation content because clearly reasonable, careful physicians use a wide spectrum of content, recording and authoring schemes."

Treatment for Chronic Pain

34. Dr. Johnson defines the standard of care, in 2012 and 2013, for family practitioners prescribing opioids, to include:

> Monitor the patient at some interval (usually not longer than 6 months); Ensure that the patient has some physiologic basis for having pain; Determine if the patient is satisfactorily able to perform their activities of daily living and make appropriate medication changes to improve quality of life; Be alert and reasonably consider that a patient is not harmfully misusing or abusing the chronic opiate medication management strategy.

35. For Dr. Johnson, the Guidelines are not the standard of care, nor are they intended to mandate the standard of care. They are more complex and detailed than the current standard of care, and not the current reality of practice for reasonably careful family physicians. In addition, in 2012 and 2013, practitioners did not calculate equivalent doses (i.e., MME), obtain informed consent, use a pain management contract, and/or routinely refer a patient to a pain management consultant.

36. Considering the facts, Dr. Johnson found respondent appropriately treated Patient A's chronic pain with a combination drug therapy, adjusting medications as needed. He found no issue with respondent replacing OxyContin with Methadone, including in August 2013. He also found respondent prescribed all CNS depressants as directed by the manufacturer. In addition, Dr. Johnson found respondent appropriately administered Demerol to Patient A, on three occasions, to

treat Patient A's acute pain at those appointments. Also, because Patient A was stable, the taking of vital signs before the injection was unnecessary.

37. In sum, Dr. Johnson found respondent's combination drug therapy for Patient A to be a clear attempt to decrease Patient A's pain. Respondent did so with the least toxic regime, while also minimizing bad side effects or outcomes. Respondent's care and treatment allowed Patient A to have a functional life. Notwithstanding the above, when Patient A reported pain beyond respondent's ability to manage, on two occasions, he sent Patient A to the hospital for immediate admission to control and monitor her pain.

Treatment for Other Ailments

38. Dr. Johnson noted no positive findings in the EMR on September 20, 2012 (breast lump), March 12, 2013 (breast mass), or August 15, 2013 and August 27, 2013 (hoarseness). Without positive findings noted, there was no requirement to send Patient A for imaging or make a referral for either condition. Moreover, given Patient A's complex health conditions, respondent's decision to observe prospectively and not aggressively pursue testing and diagnosis of the hoarseness, which has a low underlying risk of malignancy, was within the standard of care. Finally, the EMR shows repeated blood pressure readings indicative of hypertension. Lisinopril is used to treat hypertension and was managing the condition adequately. Dr. Johnson found respondent was acting within the standard of care when treating Patient A for hypertension.

RESPONDENT

39. Respondent completed his pre-medical education in 1966, before earning his Medical Degree from Pahlavi University in Shiraz, Iran in 1973. Respondent

then completed a one-year rotating internship at Pahlavi University affiliated hospitals. In 1974 and 1975, he practiced as an emergency room physician at the Red Lion and Sun Hospital of Rezayeh and the Clinic of Social Affairs of Iran, Rezayeh.

40. In 1975, respondent moved to the United States to complete a three-year residency in anatomical and clinical pathology at the University of Illinois in Chicago. In 1979, he worked as an emergency room physician at the Louise Burg Hospital in Chicago. In 1980, he joined the faculty at the University of Missouri, Kansas City (UMKC) as an assistant professor in pathology. He became Board Certified with the American Board of Pathology in 1981 and became licensed to practice medicine in California in 1983.

41. In 1984, respondent moved to California and joined the Delano Regional Medical Center (DRMC) as the Director of the medical clinic and laboratory; the same year, respondent opened a private practice family medicine office in Delano. From 1985 to 1987 and 2006 to 2007, respondent served as the chairman of the Department of Family Medicine at DRMC, and in 1989, served as the chief of staff. He has also served on several administrative committees and currently sits on the Delano Regional Medical Group Board as the Director and Treasurer. In 1999, he became Board Certified with the American Board of General Practice.

Patient A

42. Respondent recalls Patient A. He first met her at DRMC, where she was a licensed vocational nurse (LVN). Thereafter, Patient A contacted respondent at his private practice and selected him as her PCP. Respondent provided care and treatment of Patient A for approximately 10 years. In 2007, she was in a car accident and began experiencing chronic pain, and respondent began treating her for the same. Later,

Patient A left DRMC and began working inside the state prison in Delano. At the prison, an inmate attacked and tried to rape her. She left the prison on worker's compensation for PTSD, and respondent began treating her for PTSD as well.

43. Respondent used a combination therapy to treat Patient A's chronic pain. He typically prescribed a one-month supply of controlled substances and saw Patient A in the office at least once a month. He remembers telling Patient A not to drink alcohol while taking the pain prescriptions, but because she was a trained medical professional, respondent was not concerned about her compliance with prescriptions. In addition, she never showed signs of drug seeking behaviors or instances of overdose. Ultimately, respondent believed Patient A's pain was well-managed using the combination drug therapy. Notwithstanding, on two occasions, respondent admitted Patient A to the hospital because he could not adequately control her pain.

44. When necessary, respondent referred Patient A to specialists including urology, obstetrics and gynecology. But between 2003 and 2013, there were no pain management specialists in Delano; there were two in Bakersfield, over 30 miles away. Nonetheless, respondent felt capable of providing pain management to Patient A. However, he was unfamiliar with Methadone. Therefore, when he changed Patient A from OxyContin to Methadone, he contacted the Methadone Clinic in Delano for the proper dosing. At hearing, respondent admitted not specifically telling the Board in his interview that he used the Methadone Clinic for guidance in his Methadone dosing for Patient A.

45. Respondent documented his care and treatment of Patient A in the EMR. At each appointment, he created a Note. Without exception, respondent always conducted an examination of Patient A based upon her CCs. He only documented changes (i.e., if no breast lump or mass found, nothing was documented).

46. Ultimately, respondent learned of Patient A's death when the coroner called his office. Respondent was shocked as he had seen Patient A the previous day. He subsequently learned that Patient A had been drinking alcohol the night before and had a combination of prescription drugs in her system when she died.

Discussion

47. Drs. Mora and Johnson are both highly qualified members of the medical community, but their opinions in this matter are at odds on every issue. In resolving the conflicts in their testimony, their opinions must be weighed against each other consistent with the record. In doing so, consideration has been given to their qualifications and believability, the reasons for their opinions, and the factual basis of their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) With due consideration to these factors, Dr. Mora's testimony is found to be more persuasive and credible than Dr. Johnson's, in all respects.

48. Dr. Mora provided specific and detailed testimony. He clearly defined the standard of care, and deviations therefrom. When questioned, he agreed, in 2012 and 2013, physicians were not yet regularly using MME dosing, CURES reports, or urine testing. Nonetheless, Dr. Mora's MME discussion was concrete and helpful to compare opioid doses and medications (i.e., Methadone 40 mg. 4x/days for 320 MME for OxyContin 40 mg. 3x/day for 180 MME (September 2012); adding Methadone 40 mg. 3x/day for 1,440 MME, to OxyContin and Ultram for 210 MME (August 2013) for a total of 1,650 MME). In comparison, Dr. Johnson's testimony was general and vague. He provided no specific requirements for the standard of care. Instead, Dr. Johnson

described the standard of care as a "range of clinical practices" and opined that respondent was within the range.

49. Dr. Mora explained the need for greater documentation. Dr. Johnson denied any documentation standard of care existed, "because clearly reasonable, careful physicians use a wide spectrum of content recording and authoring schemes." However, simply because something can be done two different ways, does not make both acceptable examples of the standard of care. Again, Dr. Johnson's testimony lacked substance and support.

50. Dr. Mora borrowed from the Guidelines to define the standard of care, including the six categories to model best practices when prescribing opioids. Dr. Johnson dismissed the Guidelines as onerous, complex, and not practical for practitioners to follow; and instead, provided a generic list of items a physician should consider at any patient appointment (e.g., monitor the patient, ensure an objective finding for treatment, use medication to help the patient, and make sure the medication is well tolerated and not abused). While the Guidelines are not the standard of care, they offer direction to practitioners on prescribing opioids, with examples and sample materials. In fact, the Board has spent considerable time and money developing the Guidelines to assist California practitioners who prescribe controlled substances.

51. In 1990, the Intractable Pain Treatment Act established laws to assist physicians in the course of treatment for a person diagnosed with intractable pain. In 1994, the Board issued a policy statement on Prescribing Controlled Substances for Intractable Pain, to improve appropriate prescribing for effective pain management, while preventing drug diversion and abuse. In 2003, the Board adopted Guidelines for Prescribing Controlled Substances for Pain, intending to improve effective pain

management; by avoiding under treatment, over treatment, or other inappropriate treatment of a patient's pain; and by clarifying the principles of professional practice that are endorsed by the Board so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain. The Guidelines listed six categories for use and consideration: History/Physical Examination; Treatment Plan and Objectives; Informed Consent; Periodic Review; Consultation; and Records. The Guidelines were reissued in 2007, listing the same six categories, but noting a change in law allowing the prescribing of opioids to addicts for care and treatment of a medical condition other than detoxification.

52. Notwithstanding the Guidelines, the opioid epidemic has been in the national news for more than 15 years. Doctors are the access point to opioids and they must remain steadfast in the screening/monitoring of patients for treatment of pain and opioid abuse. In 2012 and 2013, respondent should have been aware of the changing tide in prescribing opioids; and the new standards for monitoring chronic pain patients, even for a family practitioner. By 2013, the Guidelines had been out for at least 10 years. Respondent should have been adding protocols to his practice to better monitor chronic pain patients and protect himself. In fact, respondent was not ignorant of the newly developing practices for pain patients: he prescribed only a 30-day supply of opioids at a time and saw Patient A on a monthly basis. At the same time, respondent needed to acknowledge his limitations. He was not a pain management specialist and he was prescribing Patient A more than 12 medications at a time, many causing sedation and carrying risks of decreased respiration, coma, and death. While there was no pain management specialist in Delano, there were two in Bakersfield, a short 32-mile drive away.

53. In sum, Dr. Mora offered findings supported by reasonable explanations and thorough analysis; Dr. Johnson did not. Moreover, Dr. Mora applied the correct definition of simple departure, a lack of ordinary care; Dr. Johnson did not. In fact, Dr. Johnson defined simple negligence as a "substantial deviation" from the standard of care. As such, Dr. Johnson's findings cannot be relied upon to evaluate respondent's care and treatment of Patient A.

LEGAL CONCLUSIONS

Standard of Proof

1. To revoke or suspend respondent's medical license, complainant must establish the allegations and violations alleged in the Accusation by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The requirement to produce clear and convincing evidence is a heavy burden, far in excess of the preponderance of evidence standard that is sufficient in most civil litigation. 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. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

2. Business and Professions Code section 2234 requires the Board to "take action against any licensee who is charged with unprofessional conduct." "Unprofessional conduct includes but is not limited to: (b) gross negligence, and (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." (Bus. & Prof. Code, § 2234, subd. (c).) Unprofessional conduct also includes "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, subd. (a).)

3. In addition, Business and Professions Code section 2266 states: "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Cause for Discipline

4. Cause exists for disciplinary action under Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in gross negligence in his care and treatment of Patients A.

5. Cause exists for disciplinary action under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in repeatedly negligent acts in his care and treatment of Patients A.

6. Cause exists for disciplinary action under Business and Professions Code section 725, subdivision (a), by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in excessive prescribing in his care and treatment of Patient A.

7. Cause exists for disciplinary action under Business and Professions Code section 2266, by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent failed to maintain adequate and accurate records for the prescribing of controlled substances to Patient A.

8. Considering the Factual Findings and Legal Conclusions as a whole, respondent's actions constitute cause for discipline. However, with monitoring and guidance, respondent can provide medical care to patients without harm to the public.

ORDER

Physician's and Surgeon's Certificate No. A 39604 issued to respondent Sadegh Salmassi, M.D. is REVOKED. However, the revocation is STAYED, and respondent is placed on probation for three years upon 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 the following: 1) the name and address of 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 Courses

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 months after respondent's initial enrollment. Respondent

shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but before 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 if 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 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the 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. Practice Monitoring

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 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 five 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 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.

6. Notification

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

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

7. Supervision of Physician Assistants and Advanced Practice Nurses

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

8. Obey All Laws

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

9. Quarterly Declarations

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

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

10. General Probation Requirements

- **Compliance with Probation Unit**

  Respondent shall comply with the Board's probation unit.

- **Address Changes**

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

- **Place of Practice**

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

- **License Renewal**

Respondent shall maintain a current and renewed California physician's and surgeon's license.

- **Travel or Residence Outside California**

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

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

11. Interview with the Board or its Designee

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

12. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions

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

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

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of 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; and Quarterly Declarations.

13. Completion of Probation

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

14. Violation of Probation

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

15. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms

and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. Probation Monitoring Costs

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

DATE: December 18, 2020

ERIN R. KOCH-GOODMAN
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
DEMOND L. PHILSON
Deputy Attorney General
State Bar No. 220220
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7548
Facsimile: (916) 327-2247
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Jan. 11 2019
BY Sara Fasano ANALYST

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

In the Matter of the Accusation Against: **Sadegh Salmassi, M.D.** **1205 Garces Highway** **P. O. Box 26** **Delano, CA 93216-0026** **Physician's and Surgeon's Certificate No. A 39604,** Respondent.	Case No. 800-2017-035440 **A C C U S A T I O N**

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 February 28, 1983, the Medical Board issued Physician's and Surgeon's Certificate Number A 39604 to Sadegh Salmassi, 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 August 31, 2020, unless renewed.

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 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:

"(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."

5. 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."

6. Section 725 of the Code states:

"(a) 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 is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (b), of the Code, in that respondent committed gross negligence in his care and treatment of patient A[1]. Departures from the standard of care in Respondent's treatment of patient A were identified as follows:

Patient A

8. Patient A is a female born in 1968 with a history of interstitial cystitis, pelvic pain, lumbalgia, and post-traumatic stress disorder. As early as 2010, Respondent began treating and prescribing Patient A controlled substances. Respondent saw her approximately once a month in 2012 and 2013. Respondent prescribed her multiple controlled substances including methadone[2], OxyContin (oxycodone)[3], Dilaudid (hydromorphone)[4], Norflex (orphenadrine)[5], Klonopin (clonazepam)[6] and Ambien (zolpidem)[7]. Respondent was aware patient A used alcohol occasionally.

9. On August 17, 2012, Respondent saw patient A for complaints of body pain and swelling, and refills on medication. Patient A's History of Present Illness (HPI) noted that patient A was in the office because of the above complaint and to seek treatment and evaluation.

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[1] The patients are referred to by letters in order to preserve their privacy. Their identity will be disclosed in the discovery provided to the respondent.

[2] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Oxycodone, brand name OxyContin, 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.

[4] Hydromorphone, brand name Dilaudid, 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] Orphenadrine is a muscle relaxer. Orphenadrine is used together with rest and physical therapy to treat skeletal muscle conditions such as pain or injury.

[6] Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Zolpidem, brand name Ambien, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

Respondent indicated in patient A's Review of Systems (ROS) section that her status was unchanged since her last visit on January 17, 2012, except for her present illness. Respondent noted patient A's occasional alcohol use. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change in patient A's physical exam since her prior visit, except that she was having substernal chest pain radiating to her right arm and also left flank pain radiating to her pelvis with some burning sensation in urination and generalized body ache that was tender to touch. Respondent diagnosed patient A with renal colic, chest pain, fibromyalgia[8], hypercoagulability syndrome[9], lumbalgia[10], hypothyroidism[11], post-traumatic stress syndrome (PTSD), and obesity. Respondent prescribed Cymbalta[12] 30 mg # 90, Klonopin 1 mg #60, Ultram[13] 50 mg #180, Demerol[14] 100 mg (administered in the office), Dilaudid 4 mg #180, Oxycodone ER 40 mg #120, and Norflex[15] 100 mg #30. Patient A was to otherwise continue the previously prescribed medications and follow up in a month.

10. On September 20, 2012, Respondent saw patient A for refills on medication, a lump on her breast, hot flashes and a referral for lap band. Patient A's HPI noted that patient A was in the office because of the above complaint and to seek treatment and evaluation. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change in patient A's physical exam since her prior visit. Respondent diagnosed patient A with fibromyalgia, lumbalgia, hypothyroidism, PTSD, and obesity. Respondent prescribed Ambien 10 mg #30 and Methadone 10 mg #240. Respondent planned to order basic metabolic panel

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[8] Fibromyalgia is a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues.

[9] Hypercoagulable states are usually genetic (inherited) or acquired conditions. The genetic form of this disorder means a person is born with the tendency to form blood clots.

[10] Lumbalgia is a general term used to describe pain in the lower back.

[11] Hypothyroidism is an underactive thyroid gland. Hypothyroidism means that the thyroid gland can't make enough thyroid hormone to keep the body running normally. People are hypothyroid if they have too little thyroid hormone in the blood.

[12] Cymbalta is an antidepressant that's used to treat mood and anxiety disorders, including panic disorder.

[13] Ultram is a narcotic-like pain reliever used to treat moderate to severe pain.

[14] Demerol is a prescription opioid for treating moderate to severe pain.

[15] Orphenadrine (Norflex) belongs to the group of medications called skeletal muscle relaxants. It is used to treat acute muscle spasms.

(BMP)[16], physical therapy, international normalised ratio (INR)[17] and Hypothyroid panel[18], and have patient A follow up in a month.

11. On October 17, 2012, Respondent saw patient A for refills on medication and lab reports. Patient A's HPI noted that patient A was in the office for lab results done on October 15, 2012. Patient A had been hospitalized at Kaweah Delta Hospital for five days because of chest pain, eye problems, and high CK-MB[19]. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change in patient A's physical exam since her prior visit, with the exception of a raspy voice and a tender nodule at her right thigh. Respondent diagnosed patient A with fibromyalgia, lumbalgia, hypothyroidism, PTSD, and obesity. Respondent prescribed Methadone 10 mg #240 and Synthroid[20] 0.2 mg #30. Patient A was to continue the previously prescribed medications. On October 24, 2012, Respondent added an addendum prescribing Phenergan with codeine[21] for cough and ordered a repeat hypothyroid panel in four weeks.

12. On November 1, 2012, Respondent saw patient A for complaints of body pain and swelling. Patient A's HPI noted that she was doing fine until the previous week when she started to feel swollen, gained weight, and her body was red and shiny, and felt heavy in her chest. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change in patient A's physical exam since her prior visit, except she looked swollen all over her body and her lungs revealed high pitch wheezing. Patient A's chest x-rays revealed no heart enlargement but there was chest congestion. Respondent diagnosed patient A with asthma, bronchitis, edema, fibromyalgia, lumbalgia, hypothyroidism, PTSD, and

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[16] The basic metabolic panel (bmp) is a panel of blood tests that serves as an initial broad medical screening tool.

[17] The international normalised ratio (INR) is a laboratory measurement of how long it takes blood to form a clot. It is used to determine the effects of oral anticoagulants on the clotting system.

[18] This panel helps screen for hypothyroidism, or low thyroid function.

[19] The CPK-MB test is a cardiac marker used to assist diagnoses of an acute myocardial infarction. It measures the blood level of CK-MB (creatine kinase-muscle/brain), the bound combination of two variants (isoenzymes CKM and CKB) of the enzyme phosphocreatine kinase.

[20] Synthroid is a medication used in the treatment of thyroid gland pathology.

[21] This combination medication is used to treat symptoms caused by the common cold, flu, allergies, or other breathing illnesses (e.g., sinusitis, bronchitis).

obesity. Respondent prescribed Lasix[22] 80 mg #30, Demerol 100 mg, and Spironolactone[23] 50 mg #30. Patient A was to continue the previously prescribed medications. Respondent ordered a complete blood count CBC[24], BMP, and a hypothyroid panel. Patient A was to follow up in ten days. On the same day, Respondent added an addendum prescribing Ambien 12.5 mg #30.

13. On November 5, 2012, Respondent saw patient A for complaints of a swollen body. Patient A's HPI noted that she was in the office for the above complaint and to seek treatment and evaluation. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change in patient A's physical exam since her prior visit. Respondent diagnosed patient A with edema, fibromyalgia, lumbalgia, hypothyroidism, PTSD, and obesity. Respondent prescribed OxyContin 40 mg #60. Patient A was to continue the previously prescribed medications and follow up as needed.

14. On November 12, 2012, Respondent saw patient A for the results of her lab reports that were taken on November 9, 2012. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change in patient A's physical exam since her prior visit. Respondent diagnosed patient A with fibromyalgia, lumbalgia, hypothyroidism, PTSD, and obesity. Respondent prescribed refills for Cymbalta and Coumadin[25]. Patient A was to follow up in one month.

15. On November 12, 2012, Respondent saw patient A for refills on her medications. Patient A's HPI noted that she was taking Coumadin, that her blood test showed high INR, and she had shortness of breath going up one flight of stairs. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change in patient A's physical exam since her prior visit. Respondent diagnosed patient A with fibromyalgia, hypercoagulability syndrome, antiphospholipid syndrome[26], Coumadin toxicity, lumbalgia,

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[22] Furosemide belongs to the class of medications called diuretics. It is used to treat edema (fluid retention) that occurs with congestive heart failure and disorders of the liver, kidney, and lung.

[23] Spironolactone is used to treat high blood pressure and heart failure.

[24] A complete blood count (CBC) measures the concentration of white blood cells.

[25] Coumadin is a potent blood thinner used for stroke prevention.

[26] A disorder in which the immune system mistakenly attacks normal proteins in the blood. Antiphospholipid syndrome can cause blood clots to form within the arteries, veins, and

hypothyroidism, PTSD, and obesity. Respondent prescribed refills for Cymbalta 30 mg # 90, Klonopin 1 mg #60, Ambien 10 mg #30, Elavil[27] 100 mg #30, Ultram 50 mg #180, Norflex 100 mg #30, and OxyContin 40 mg #90. Respondent held the Coumadin prescription. Respondent ordered physical therapy and a follow up in a month.

16. On January 11, 2013, Respondent saw patient A for refills on her medications, sleeplessness, and headaches. Patient A's HPI noted that she had been having severe body ache, generalized body weakness, and was seen in the emergency room at the county hospital of Fresno. Patient A wanted further evaluation and treatment. Respondent indicated in patient A's ROS that she gained weight, had heartburn, floaters, depression, and pain in her jaw, shoulder, elbow, wrist, hand, hip, knee, ankle, foot and chest. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed she was very lethargic, shaky, weak, and overweight. Patient A had tenderness all over her body.
Respondent diagnosed patient A with fibromyalgia, lumbalgia, sleep apnea, migraine headaches, PTSD, hypothyroidism, and obesity. Respondent prescribed Klonopin 1 mg #60, Topamax[28] 50 mg #60, Phentermine[29] 15 mg #30, OxyContin 40 mg #90, and Lunesta[30] 2 mg #30. Respondent was referred for Overnight Pulse Oximetry[31]. Patient A was to follow up in a month. On January 21, 2013, Respondent changed Patient A's Lunesta prescription to Ambien 10 mg #30, and advised her to stop taking Coumadin.

17. On February 11, 2013, Respondent saw patient A for urinary tract infection and refills on her medications. Patient A's HPI noted that she was in the office for the above complaint and to seek treatment and evaluation. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013, except for her present illness.

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organs.

[27] Elavil is used to treat mental/mood problems such as depression.

[28] Topamax is the brand name of topiramate, an anticonvulsant drug used to prevent seizures and reduce the frequency of migraines.

[29] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant and an appetite suppressant.

[30] Lunesta is a sedative and is used to treat insomnia.

[31] Overnight pulse oximetry is a test to monitor and record the level of oxygen in your blood as you sleep through the night.

Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change since her last visit, except she has flanks and hypogastric tenderness. Respondent diagnosed patient A with fibromyalgia, hypercoagulability syndrome, Cystitis[32], PTSD, hypothyroidism, and obesity. Respondent prescribed Cipro[33] 500 mg and OxyContin 40 mg #90.

18. On February 21, 2013, Respondent saw patient A for a Demerol injection. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013. Patient A's vital signs were not taken. The physical examination showed no change since her last visit. Respondent diagnosed patient A with fibromyalgia and lumbalgia. Respondent gave patient A a Demerol injection. Patient A was to follow up as needed and planned.

19. On March 12, 2013, Respondent saw patient A for refills on her medications, a mass on her right breast, and hair loss. Patient A's HPI noted that she was in the office for the above complaint and to seek treatment and refill. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013, except for her present illness. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change since her last visit. Respondent diagnosed patient A with fibromyalgia, hypercoagulability syndrome, lumbalgia, PTSD, hypothyroidism, and obesity. Respondent prescribed Klonopin 1 mg #60, Ambien 10 mg #30, Coumadin 5 mg #45, and OxyContin 20 mg #90.

20. On April 16, 2013, Respondent saw patient A for refills on her medications. Patient A's HPI noted that she was in the office for the above complaint and to seek treatment and refill. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013, except for her present illness. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change since her last visit. Respondent diagnosed patient A with fibromyalgia, hypercoagulability syndrome, lumbalgia,

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[32] Cystitis is the medical term for inflammation of the bladder.
[33] Cipro is used to treat a variety of bacterial infections.

PTSD, hypothyroidism, and obesity. Respondent prescribed Cymbalta 30 mg #90, Klonopin 1 mg #60, Ambien 10 mg #30, Topamax 25 mg #60, Ultram 50 mg #180, Phentermine 15 mg #30, and OxyContin 20 mg #90. Patient A was to continue the same previous medications and follow up in a month.

21. On April 23, 2013, Respondent saw patient A for chest and pelvic pain. Patient A's HPI noted that she had been known to have hypercoagulability syndrome and fibromyalgia. It noted Patient A started with severe low back pain and pelvic pain the day before and went to the emergency room but she was not seen on time and she left. Patient A woke up that morning with severe chest pain and continuous pain all over her body including her pelvis and back. It stated patient A was in the office for further evaluation and treatment. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013, except for her present illness. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed patient A was tender all over her body and had severe pain in her pelvis and lower back area and left side of the chest. Respondent noted patient A could stand up straight when she is walking. Respondent diagnosed patient A with angina pectoris[34], pelvic pain, hypercoagulability syndrome, fibromyalgia, lumbalgia, hypothyroidism, and obesity. Respondent prescribed Demerol 50 mg/5 mL syrup. Respondent referred patient A to the emergency room for direct admit.

22. On May 1, 2013, Respondent saw patient A for a hospital follow up. Patient A's HPI noted that she had been on painkillers for fibromyalgia and on phentermine for weight control. Patient A had been admitted to the hospital but then discharged because they thought that patient A had been an abuser of methamphetamine, which had been a noted byproduct of phentermine. Patient A passed out while taking a shower the previous day and she was taken to the hospital and was evaluated for a head injury. Patient A was in the office for further evaluation. Patient A was in severe pain in her pelvis and lower back. Patient A could not stand straight or walk due to the severe pain. Respondent indicated in patient A's ROS that her status was unchanged since her

[34] Angina pectoris is a condition marked by severe pain in the chest, often also spreading to the shoulders, arms, and neck, caused by an inadequate blood supply to the heart.

last visit on January 11, 2013, except for her present illness. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed patient A was tender all over her back and had pain radiating to her pelvic area, hip joints and legs. Respondent's diagnoses included lumbalgia, radiculitis[35], and fibromyalgia. Respondent referred patient A to the hospital for direct admit, pain control, and evaluation of source of her pain. Patient A was to follow up after discharge

23. On May 16, 2013, Respondent saw patient A for refills on her medications. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013, except for her present illness. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change since her last visit. Respondent diagnosed patient A with fibromyalgia, lumbalgia, radiculitis, hypercoagulability syndrome, PTSD, hypothyroidism, and obesity. Respondent prescribed Cymbalta 30 mg #90, Klonopin 1 mg #60, Ambien 12.5 mg, Elavil 100 mg #30, Topamax 25 mg #60, Ultram 50 mg #180, OxyContin 20 mg #90, and Flexeril[36] 10 mg# 30. Patient A was to continue the same previous medications. On the same day, Respondent added an addendum noting a statement from a pharmacist where patient A filled her prescription. The pharmacist indicated he would look up patient A's prescription history and depending on the past medication she had taken and based on her diagnosis, he would decide if he would fill her prescription for OxyContin.

24. On June 17, 2013, Respondent saw patient A for refills on her medications and pain in her right foot. Patient A's HPI noted that she was in the office because of the above complaint and to seek treatment and evaluation. It also noted that patient A fell and twisted her right foot two weeks ago. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013, except for her present illness. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change since her last visit, except she had a tender discolored right foot. Patient A's x-rays showed spurs in both of her feet. Respondent diagnosed patient A with fibromyalgia, lumbalgia, radiculitis,

[35] Radiculitis or radicular pain is transferred pain that "radiates" along the path of a nerve.

[36] Flexeril (cyclobenzaprine) is a muscle relaxant used to treat skeletal muscle conditions such as pain or injury.

contusion foot, hypercoagulability syndrome, PTSD, hypothyroidism, and obesity. Respondent prescribed Klonopin 1 mg #60, Ambien 12.5 mg, and OxyContin 20 mg #180.

25. On July 15, 2013, Respondent saw patient A for red eyes, a hair problem, and refills on her medications. Patient A's HPI noted that she was in the office because of the above complaint and to seek treatment and evaluation. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013, except for her present illness. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change since her last visit, except she had bilateral congested bulbar[37] and palpebral conjunctivitis[38]. Respondent diagnosed patient A with conjunctivitis, fibromyalgia, lumbalgia, radiculitis, hypercoagulability syndrome, PTSD, hypothyroidism, and obesity. Respondent prescribed Klonopin 1 mg #60, Ambien 12.5 mg, Norflex 100 mg #60, OxyContin 20 mg #180, Tobradex ophthalmic ointment and Maxitrol ophthalmic suspension. Patient A was to continue the same previous medications.

26. On August 15, 2013, Respondent saw patient A for refills on her medications, a hoarse voice, and referral to a specialist. Patient A's HPI noted that she was in the office because of the above complaint and to seek treatment refill. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013, except for her present illness. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change since her last visit. Respondent diagnosed patient A with fibromyalgia, lumbalgia, radiculitis, contusion foot, hypercoagulability syndrome, PTSD, hypothyroidism, and obesity. Respondent prescribed Cymbalta 30 mg #60, Klonopin 1 mg #90, Ambien 12.5 mg, Coumadin 5 mg #45, Warfarin 7.5 mg #46, and OxyContin 20 mg #180. Patient A was to continue the same previous medications, check labs in four weeks, and follow up in one month.

27. On August 27, 2013, Respondent saw patient A for a hoarse voice, trouble swallowing, tiredness, chest pain, and weight loss consultation. Patient A's HPI noted that she

[37] Nasal congestion.
[38] Palpebral conjunctivitis is an allergic reaction of the eye.

was in the office because of the above complaint and to seek treatment and evaluation. Respondent indicated in patient A's ROS that her status was unchanged since her last visit on January 11, 2013, except for her present illness. Patient A's vital signs were taken and a physical examination was conducted. The physical examination showed no change since her last visit. Respondent diagnosed patient A with Hyperglycemia/Pre-diabetes, fibromyalgia, lumbalgia, radiculitis, hypercoagulability syndrome, PTSD, hypothyroidism, and obesity. Respondent prescribed Methadone 40 mg #90. Patient A was to continue the same previous medications and follow up as needed or as planned.

28. On August 27, 2013, patient A filled her very last prescription at a pharmacy for methadone tablets #360.

29. On August 28, 2013, Patient A died. The Fresno County Coroner investigated the death of patient A on August 28, 2013. The investigation report indicated that the manner of her death was by "accident". The cause of her death was determined to be "acute intoxication due to combined effects of tricyclic antidepressants, methadone, and zolpidem".

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30. Respondent committed gross negligence in his care and treatment of patient A, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by excessively prescribing opioids; and

(b) Respondent departed from the standard of care by excessively prescribing methadone; and

(c) Respondent departed from the standard of care by excessively prescribing multiple central nervous system depressants; and

(d) Respondent departed from the standard of care by failing to take vital signs before giving the patient a Demerol injection on February 21, 2013.

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31. Respondent's conduct, as described above, constitutes gross negligence in the practice of medicine in violation of section 2234(b) of the Code and thereby provides cause to discipline Respondent's license.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

32. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (c), of the Code, in that respondent committed repeated acts of negligence in his care and treatment of patient A.

33. Paragraphs 9 through 32 as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

34. Respondent committed acts of repeated negligence in his care and treatment of patient A, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by failing to obtain an adequate pain history and not using a pain scale; and

(b) Respondent departed from the standard of care by failing to adequately conduct an assessment, plan, and treatment objectives with the patient; and

(c) Respondent departed from the standard of care by not obtaining informed consent regarding the risks, benefits and alternatives to opioids from the patient; and

(d) Respondent departed from the standard of care by failing to enter into a pain management agreement with the patient; and

(e) Respondent departed from the standard of care by failing to monitor the patient's proper usage of the opioids he prescribed, including but not limited to, urine tests; and

(f) Respondent departed from the standard of care by failing to refer the patient to a pain management specialist or not documenting that no pain specialist was available in the area; and

(g) Respondent departed from the standard of care by failing to perform a periodic review (e.g. semi-annual or annual treatment plan review) of the patient's progress; and

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(h) Respondent departed from the standard of care by failing to maintain adequate medical records; and

(i) Respondent departed from the standard of care by administering Demerol intramuscularly for chronic pain; and

(j) Respondent departed from the standard of care by failing to evaluate the complaint of a breast lump and mass; and

(k) Respondent departed from the standard of care by failing to evaluate the patient's chief complaint of hoarseness and not referring her to an otolaryngologist; and

(l) Respondent departed from the standard of care by failing to document the diagnosis of hypertension or another reason for prescribing Lisinopril in the medical records; and

(m) Respondent departed from the standard of care by failing to explain his thought process and medical decision-making in the patient's medical records.

35. Respondent's conduct, as described above, constitutes repeated acts of negligence in the practice of medicine in violation of section 2234(c) of the Code and thereby provides cause to discipline Respondent's license.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing)

36. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent excessively overprescribed in his care and treatment of patient A, as more particularly alleged in paragraphs 9 through 36 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

37. Respondent is subject to disciplinary action under section 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records regarding his care and treatment of patient A as more particularly alleged in paragraphs 9 through 36 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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DISCIPLINE CONSIDERATIONS

38. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about December 7, 2007, in a prior disciplinary action entitled In the Matter of the Accusation Against Sadegh Salmassi, M.D. before the Medical Board of California, in Case Number 08-2005-171093. Respondent was given a Public Reprimand.

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 39604, issued to Sadegh Salmassi, M.D.;

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

3. Ordering Sadegh Salmassi, 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:
January 11, 2019

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

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