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

In the Matter of the Accusation Against: Azizulah Kamali, M.D. Physician's & Surgeon's Certificate No A 40135 Respondent.	Case No. 800-2018-042334

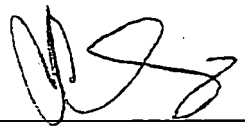
DECISION

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

This Decision shall become effective at 5:00 p.m. on November 19, 2021.

IT IS SO ORDERED October 21, 2021.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D. Chair
Panel A

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **AZIZULAH KAMALI, M.D.** 1947 N. California St., Ste. A Stockton, CA 95204-6029 Physician's and Surgeon's Certificate No. A 40135, Respondent.	Case No. 800-2018-042334 OAH No. 2021020014 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka ("Complainant") is the Executive Director of the Medical Board of California ("Board"). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by John S. Gatschet, Deputy Attorney General.

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2. Respondent Azizulah Kamali, M.D. ("Respondent") is represented in this proceeding by attorney Ian A. Scharg, Esq., whose address is:

Schuering Zimmerman & Doyle, LLP
400 University Avenue
Sacramento, CA 95825-6502

3. On or about July 18, 1983, the Board issued Physician's and Surgeon's Certificate No. A 40135 to Azizulah Kamali, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-042334, and will expire on April 30, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-042334 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 21, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-042334 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-042334. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-042334, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a *prima facie* basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

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

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

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED THAT the Physician's and Surgeon's Certificate No. 40135 issued to Respondent Azizulah Kamali, M.D., shall be and is hereby publically reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2018-042334, is as follows:

"Between November 1, 2016, and April 16, 2018, while treating Patients 1 and 2, you failed to properly document their pain management care as you prescribed controlled substances to them as more fully described in Accusation No. 800-2018-042334."

B. PRESCRIBING PRACTICES COURSE

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall successfully complete all coursework and provide proof of completion of the Prescribing Practices Course to the Board within one year of the effective date of the Decision and Order. This condition shall be monitored by the Probation Department.

C. MEDICAL RECORD KEEPING COURSE

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

Respondent shall successfully complete all coursework and provide proof of completion of the Medical Record Keeping Course to the Board within one year of the effective date of the Decision and Order. This condition shall be monitored by the Probation Department.

D. FAILURE TO COMPLY

If Respondent fails to enroll, participate in, or successfully complete the educational program(s) or course(s), described in conditions B and C, within the designated time period, Respondent shall receive and comply with a notification from the Board or its designee to cease

the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the educational program(s) or course(s) has been completed as required by the express language of the Decision and Order. In addition, failure to successfully complete the education program(s) or course(s) outlined above shall also constitute unprofessional conduct and is grounds for further immediate disciplinary action.

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ACCEPTANCE

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

DATED: 8/9/21

AZIZULAH KAMALI, M.D.
Respondent

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

DATED: 8/9/21

IAN A. SCHARG, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 8-9-21

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-042334

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **Azizulah Kamali, M.D.** 1947 N. California St., Ste. A Stockton, CA 95204-6029 Physician's and Surgeon's Certificate No. A 40135, Respondent.	Case No. 800-2018-042334 **ACCUSATION**

PARTIES

1. William Prasifka ("Complainant") brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about July 18, 1983, the Medical Board issued Physician's and Surgeon's Certificate Number A 40135 to Azizulah Kamali, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2021, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code provides, in pertinent part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
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> ...
>
> (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.
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> (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.
>
> ...

PERTINENT DRUG DEFINITIONS

6. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled

substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

7. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting formulation known as Oxycontin-ER. This formulation allows for extended release of the medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

8. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12.[1] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

9. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short acting semi-synthetic opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055 subdivision (b).

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[1] Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

FACTUAL ALLEGATIONS

Patient 1[2]

10. Between February 14, 2011, and July 8, 2013, Patient 1, established primary medical care with Respondent. Respondent had previously treated Patient 1 while he was working as a hospitalist and Patient 1 was hospitalized. During that time, Respondent treated Patient 1 on a regular basis for diabetes, hypertension, and chronic pain. Patient 1 stopped coming to see Respondent following the visit on July 8, 2013.

11. On October 5, 2017, Patient 1 returned to Respondent's office for treatment for a new diagnosis of bullous pemphigoid. Patient 1 had prior poor compliance with taking medications, was taking excessive analgesics, and he was drinking heavily when he returned to Respondent's care. Respondent prescribed 60 tablets of 60 mg OxyContin for pain, which was then refilled monthly. While Respondent documented a history and physical examination prior to restarting Patient 1's chronic pain therapy, Respondent failed to entertain non-opioid therapies, failed to document discussing the risks and benefits of opioid therapy, and failed to establish monitoring for misuse despite Patient 1's history of alcohol abuse. On or about February 2, 2018, Respondent received notification that Patient 1, who had been living in an assisted living facility, had been hospitalized in a behavioral health unit and the medical staff were requesting a referral to a psychiatrist. The medical staff noted that Patient 1 was, "no longer able to self-medicate properly."

12. On or about February 2, 2018, Respondent saw Patient 1 in his clinic. Respondent documented that Patient 1 would not receive OxyContin or methadone any further. Respondent prescribed Patient 1, 120 tablets of 10/325 mg Norco for pain to be taken QID. On or about Ferbuary 5, 2018, Respondent increased the frequency of the prescription for 10/325 mg tablets of Norco to be taken every four hours. On or about February 26, 2018, Respondent changed Patient 1's prescription to 60 tablets of 10/325 mg Percocet for pain after Patient 1 was released after a hospitalization for pancreatitis. On or about April 9, 2018, Respondent added 90 tablets of

[2] In order to promote confidentiality and protect privacy, all witness identifying information has been removed. All witnesses will be fully identified in discovery.

5/325 mg Percocet to be taken for breakthrough pain to Patient 1's 60 tablet of 10/325 mg prescription. On or about April 16, 2018, Respondent increased Patient 1's prescription for 10/325 mg Percocet to 90 tablets. Patient 1 stopped seeking treatment from Respondent following the April 16, 2018, visit.

13. Between October 5, 2017, and April 16, 2018, Respondent failed to develop and/or document developing a treatment plan with pain management objectives for Patient 1. Respondent failed to revisit and/or document that he revisited the treatment plan and he failed to make modifications despite Respondent repeatedly changing Patient 1's chronic pain medications. Between October 5, 2017, and April 16, 2018, Respondent failed to provide and/or document that he provided Patient 1 with informed consent regarding the potential risks and benefits of long term opioid therapy, the risk of drug interactions, the risk of respiratory depression, and the limited evidence as to the benefit of long-term opioid therapy. Between October 5, 2017, and April 16, 2018, Respondent failed to counsel and/or document that he counseled the patient and his caregivers on the signs of opiate overdose and opiate risks.

14. Between October 5, 2017, and April 16, 2018, Respondent failed to perform and/or document that he performed on-going patient assessments on how Patient 1 was progressing towards his chronic pain treatment objectives while on opioid therapy and whether there was any evidence of risks, such as overdose or diversion. Between October 5, 2017, and April 16, 2018, Respondent failed to monitor and/or document that he monitored Patient 1's compliance with opioid pain therapy through either reviewing Patient 1's CURES prescriptions, having Patient 1 provide urine drug screening, or by doing pill counting.

Patient 2

15. On November 1, 2016, Patient 2 established care with Respondent. Patient 2 had a chief complaint of chronic pain syndrome caused by chronic back pain due to L5-S1 radiculopathy. Respondent documented that Patient 2 was taking methadone and that he had enough medication to last until January 2017. Respondent performed a history and physical. Respondent documented that Patient 2 would return to his clinic in January 2017.

16. On or about December 20, 2016, Patient 2 returned to Respondent's clinic. Respondent documented that Patient 2 was present for a check-up and that he was still suffering from chronic pain caused by his L5-S1 vertebra and he had central disc herniation. The Respondent prescribed a monthly prescription of 90 tablets of 10 mg. methadone, which was a continuation of Patient 2's previous prescription. The Respondent did not document why Patient 2 needed a prescription in December 2016, despite previously documenting that Patient 2 would need a prescription in January 2017. On or about December 13, 2016, the Respondent obtained a urine drug screen from Patient 2 and the result of the urine drug screen indicated that Patient 2 was taking methadone as prescribed. Between January 12, 2017, and December 15, 2017, Respondent saw Patient 2 in clinic on a semi-regular basis. Visits were often monthly, but sometimes two to three months elapsed between encounters.

17. Between December 20, 2016, and December 15, 2017, Respondent failed to formulate and/or document that he formulated a treatment plan. In response to a series of typed questions presented to Respondent on or about April 1, 2020, by the Medical Board, Respondent stated he did not develop a treatment plan while treating Patient 2. Between December 20, 2016, and December 15, 2017, Respondent failed to obtain and/or document that he obtained informed consent from Patient 2 related to the benefits and potential risks of long-term opioid therapy, including the risks of over-sedation, respiratory depression, risk of misuse and overdose.

18. Between December 20, 2016, and December 15, 2017, Respondent failed to obtain and/or document that he obtained a pain management agreement with Patient 2. In response to a series of typed questions presented to Respondent on or about April 1, 2020, by the Medical Board, Respondent stated he did not obtain a pain management agreement with Patient 2. Between December 20, 2016, and December 15, 2017, Respondent failed to counsel Patient 2 and his caregivers on the risk of overdose and provide instruction on the safe administration of naloxone. Between December 20, 2016, and December 15, 2017, Respondent failed to perform and/or document that he performed an on-going patient assessment of Patient 2's progress on chronic pain management including noting evidence of Patient 2's progress towards treatment objectives and/or noting the absence of adverse events such as overdose or diversion. Finally,

between December 20, 2016, and December 15, 2017, Respondent failed to adequately document and/or monitor Patient 2's compliance with his pain management regimen. While Respondent did order one urine drug screen in late 2016, Respondent failed to order additional drug screens, check with the CURES prescribing database, or conduct pill counts in order to monitor Patient 2's compliance with his pain management regiment.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

19. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts during the care and treatment of Patients 1 and 2. The circumstances are as follows:

20. Complainant realleges paragraphs 10 through 18, and those paragraphs are incorporated by reference as if fully set forth herein.

21. Respondent committed the following negligent acts during the care and treatment of Patients 1 and 2:

a) By failing to appropriately perform and/or document performing a risk stratification for Patient 1 prior to prescribing controlled substances;

b) By failing to develop and/or document developing a treatment plan with pain management objectives, goals, and "exit strategy" for Patient 1;

c) By failing to obtain and/or document obtaining informed consent from Patient 1 for long-term opioid therapy;

d) By failing to discuss and/or document discussing overdose risk and response with Patient 1 and Patient 1's caregivers during long-term opioid therapy;

e) By failing to assess and/or document assessing Patient 1's response to long-term opioid therapy on an on-going basis;

f) By failing to properly perform and/or document performing compliance monitoring of Patient 1's progress on long-term opioid therapy;

g) By failing to develop and/or document developing a treatment plan with pain management objectives, goals, and "exit strategy" for Patient 2;

h) By failing to obtain and/or document obtaining informed consent from Patient 2 for long-term opioid therapy;

i) By failing to enter into a pain management agreement and/or document entering into a pain management agreement with Patient 2 prior to prescribing long-term opioid therapy;

j) By failing to discuss and/or document discussing overdose risk and response with Patient 2 and Patient 2's caregivers during long-term opioid therapy;

k) By failing to assess and/or document assessing Patient 2's response to long-term opioid therapy on an on-going basis; and,

l) By failing to properly perform and/or document performing compliance monitoring of Patient 2's progress on long-term opioid therapy.

SECOND CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

22. Respondent's license is subject to disciplinary action under section 2234 in that he committed general unprofessional conduct during the care and treatment of Patients 1 and 2. The circumstances are as follows:

23. Complainant realleges paragraphs 10 through 18, and those paragraphs are incorporated by reference as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 40135, issued to Azizulah Kamali, M.D.;

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

3. Ordering Azizulah Kamali, 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: OCT 21 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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