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

In the Matter of the Accusation Against: Ramiz Naim Elias, M.D. Physician's and Surgeon's Certificate No. A 99956 Respondent.	Case No.: 800-2017-029123

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 December 30, 2021.

IT IS SO ORDERED: November 30, 2021.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
JASON J. AHN
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **RAMIZ NAIM ELIAS, M.D.** **5600 Shasta Daisy Trl** **SAN DIEGO CA 92130-6972** **Physician's and Surgeon's Certificate No. A 99956** Respondent.	Case No. 800-2017-029123 OAH No. 2020020209 **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 Jason J. Ahn, Deputy Attorney General.

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2. Respondent Ramiz Naim Elias, M.D. (Respondent) is represented in this proceeding by attorney Robert W. Frank, whose address is: 110 West A Street, Suite 1200, San Diego, CA 92101.

3. On or about May 4, 2007, the Board issued Physician's and Surgeon's Certificate No. A 99956 to Ramiz Naim Elias, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-029123, and will expire on October 31, 2020, unless renewed.

JURISDICTION

4. On December 31, 2019 Accusation No. 800-2017-029123 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 December 31, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-029123 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2017-029123. Respondent has also carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation 800-2017-029123, a copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. A 99956 to disciplinary action.

10. Respondent agrees that if an accusation is ever filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2017-029123 shall be deemed true, correct, and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A 99956 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.

CONTINGENCY

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

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-029123 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

ADDITIONAL PROVISIONS

14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

15. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 99956 issued to Respondent Ramiz Naim Elias, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not prescribe any controlled substances for treatment of pain unless while providing medical care at hospitals, Emergency Rooms, Skilled Nursing Facilities (SNF), or assisted living facilities.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or

cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

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

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

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

hours of CME of which 40 hours were in satisfaction of this condition.

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

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

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

5. 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 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.

6. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

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

medicine. Respondent shall comply with the program's recommendations.

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

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

7. MONITORING - PRACTICE/BILLING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

10. 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.

11. 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.

12. 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 thirty (30) calendar days.

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

13. 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.

14. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of

probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

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

15. 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.

16. 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.

17. 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.

18. 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.

19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-029123 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert W. Frank. I fully 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 fully agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 09.22.2021

RAMIZ NAIM ELIAS, M.D.
Respondent

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I have read and fully discussed with Respondent Ramiz Naim Elias, 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: 9-22-21

ROBERT W. FRANK
Attorney for Respondent

ENDORSEMENT

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

DATED: September 22, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

Jason Ahn

JASON J. AHN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-029123

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO DEC. 31 2019
BY D. ESPERANZA ANALYST

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **RAMIZ NAIM ELIAS, M.D.** **7695 Cardinal Court, Ste. 370-375** **San Diego, CA 92123** **Physician's and Surgeon's Certificate** **No. A 99956,** Respondent.	Case No. 800-2017-029123 **A C C U S A T I O N**

PARTIES

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

2. On or about May 4, 2007, the Medical Board issued Physician's and Surgeon's Certificate No. A 99956 to Ramiz Naim Elias, 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 October 31, 2020, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states, 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:
>
> ...
>
> (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.

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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.

...

6. Section 2266 of the Code states:

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

7. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A 99956 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A,[1] B, C, and D, as more particularly alleged hereinafter:

Patient A

9. On or about January 8, 2016, Patient A first presented to Respondent. At the time of this visit, Patient A was a fifty-one (51) year-old female with a prior medical history including, but not limited to, diabetes mellitus, hypertension, obesity, left shoulder degenerative disease, left knee degenerative changes with spurs, left lateral meniscus tear, left knee mild ACL sprain, benign positional vertigo, and asthma. Respondent failed to obtain Patient A's prior medical

[1] References to "Patient A – D" are used to protect patient privacy.

records. Respondent failed to review Patient A's prior medical records. Respondent prescribed controlled substances to Patient A which Patient A was reportedly previously prescribed, including, but not limited to, oxycodone,[2] OxyContin,[3] and Soma.[4] Patient A did not sign a controlled substance agreement until March 14, 2017. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.[5]

10. On or about July 30, 2016, Patient A returned to Respondent for a refill of her medications. Respondent failed to conduct a physical examination and/or failed to document having conducted a physical examination of Patient A. Respondent refilled OxyContin, oxycodone, Soma, Lisinopril,[6] and Metformin.[7] Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.

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[2] Oxycodone HCL (OxyContin®) is a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, Oxycodone HCL is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. The Drug Enforcement Administration (DEA) has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

[3] OxyContin® is a brand name for Oxycodone HCL. See footnote 2 (above).

[4] Soma® (carisoprodol) 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. When properly prescribed and indicated, it is used for the short-term treatment of acute and painful musculoskeletal conditions. Soma® is commonly used by those who abuse opioids to potentiate the euphoric effect of opioids, to create a better "high." According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States. According to Diversion Drug Trends, published by the DEA on the trends in diversion of controlled and noncontrolled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

[5] CURES is the Controlled Substances Utilization Review and Evaluation System (CURES), a database of schedule II, III, and IV controlled substance prescriptions dispensed in California, serving the public health, regulatory oversight agencies, and law-enforcement.

[6] Lisinopril is used to treat high blood pressure and heart failure.

[7] Metformin can be used to treat type 2 diabetes.

11. On or about August 27, 2016, Patient A returned to Respondent for a refill of her medications. Respondent failed to conduct a physical examination and/or failed to document having conducted a physical examination of Patient A. Respondent refilled OxyContin, oxycodone, Soma, Lisinopril, and Metformin. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.

12. On or about September 23, 2016, Patient A returned to Respondent complaining of headaches and vertigo and requested a refill of her medications. Respondent refilled OxyContin, oxycodone, Soma, Lisinopril, and Metformin, without a reduction in dosage. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.

13. On or about November 17, 2016, Patient A presented to Respondent complaining of shoulder pain and vertigo. Respondent failed to taper off the controlled substances he prescribed to Patient A. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.

14. On or about January 13, 2017, Patient A presented to Respondent. Respondent refilled oxycodone, Soma, and Lisinopril. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.

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15. On or about February 14, 2017, Patient A returned to Respondent with complaints of asthma and vertigo and a request to refill her medications. Respondent refilled Symbicort (Budesonide/Formoterol),[8] Montelukast,[9] Albuterol,[10] OxyContin, oxycodone, Soma, Lisinopril, Metformin, and Amlodipine.[11] Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.

16. On or about March 14, 2017, Patient A returned to Respondent. Respondent's medical records for this visit indicate, among other things, that Patient A was informed that Respondent would soon stop issuing prescription refills of codeine, that Patient A needed an appointment with a pain management specialist, and that Patient A's prescription refills would continue until then, but should not be more than a few months. Respondent refilled Symbicort (Budesonide / Formoterol), Montelukast, Albuterol, OxyContin, oxycodone, Soma, Lisinopril, Metformin, and Amlodipine. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.

17. On or about April 13, 2017, Patient A presented to Respondent for a refill of her medications. Respondent refilled OxyContin and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.

18. On or about May 11, 2017, Patient A returned to Respondent requesting a refill of her medications. Respondent refilled Symbicort (Budesonide / Formoterol), Montelukast, Albuterol, OxyContin, oxycodone, Soma, Lisinopril, Metformin, and Amlodipine. Respondent failed to

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[8] Symbicort can be used to treat asthma and chronic obstructive pulmonary disease (COPD).

[9] Montelukast can be used to treat allergies and prevent asthma attacks.

[10] Albuterol can be used to treat or prevent wheezing and shortness of breath caused by breathing problems.

[11] Amlodipine can be used to treat high blood pressure and chest pain.

request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient A's CURES reports.

19. On or about September 12, 2017, Patient A presented to Respondent requesting a refill of her medications. Respondent's medical records for this visit indicate, among other things, that Patient A was informed that Respondent would no longer issue prescription refills of her narcotic medications.

20. During the course of his care and treatment of Patient A, from on or about January 8, 2016 through on or about September 12, 2017, Respondent reduced the dosage of opiates prescribed on or around January 3, 2017, which was approximately one year after Respondent first prescribed opiates to Patient A and two months prior to when Patient A signed a controlled substance agreement.

21. During the course of his care and treatment of Patient A, from on or about January 8, 2016 through on or about September 12, 2017, Respondent advised and/or referred Patient A to seek a pain management specialist on May 2, 2016, approximately four (4) months after Respondent first prescribed a controlled substance to Patient A and then again on or about August 16, 2017, approximately nineteen (19) months after the first visit.

22. During the course of his care and treatment of Patient A, from on or about January 8, 2016 through on or about September 12, 2017, Respondent suggested and/or referred Patient A to an orthopedic surgeon, S.A., M.D., on or about April 2, 2016, which was approximately three (3) months after Respondent first prescribed a controlled substance to Patient A, then again January 19, 2017, which was approximately nine (9) months after Respondent indicated the need for such a referral.

23. During the course of his care and treatment of Patient A, from on or about January 8, 2016 through on or about September 12, 2017, Respondent failed to offer and/or suggest and/or failed to document having offered and/or suggested a structured tapering of the opiates or drug-holidays or replacement opioids with minimal bridging during transition.

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24. On or about February 9, 2016, Respondent suggested and/or implemented treatment alternatives to opiates such as offering intra-articular steroid injection and ordering a knee splint. However, Respondent did not adequately suggest and/or utilize other pharmacologic and/or non-pharmacologic alternatives to opioid treatment.

25. During the course of his care and treatment of Patient A, from on or about January 8, 2016 through on or about September 12, 2017, Respondent failed to review Patient A's CURES reports. Respondent failed to use and/or failed to document having used urine toxicology screenings. Respondent failed to investigate and/or failed to document having investigated whether or not Patient A suffered from obstructive sleep apnea,[12] even though Patient A had a high Body Mass Index of 46-47 and a known history of asthma requiring maintenance inhaler, Symbicort, and was regularly consuming opiates as directed by Respondent.

26. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, the following:

(a) Paragraphs 9 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to prescribe opiates to Patient A in a safe manner.

Patient B

27. On or about May 14, 2015, Patient B first presented to Respondent. At the time of this visit, Patient B was a fifty-three (53) year-old female with a prior medical history including, but not limited to, tobacco dependence, glaucoma,[13] diabetes mellitus, hypertension, spinal fusion

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[12] Obstructive sleep apnea is a potentially serious sleep disorder. It causes breathing to repeatedly stop and start during sleep.

[13] Glaucoma is a group of eye conditions that can cause blindness.

L3-4,[14] COPD,[15] asthma, opiate dependence, insomnia, right carpal tunnel syndrome,[16] left frontal stroke, and multiple back surgeries. Respondent failed to obtain Patient B's prior medical records. Respondent failed to review Patient B's prior medical records. Respondent prescribed to Patient B OxyContin and oxycodone. Patient B did not sign a controlled substance agreement until January 29, 2016. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

28. On or about July 14, 2015, Respondent prescribed Promethazine HCL – Codeine Phosphate[17] to Patient B. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

29. On or about August 7, 2015, Respondent refilled OxyContin and oxycodone for Patient B. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

30. On or about September 11, 2015, Patient B returned to Respondent. Respondent refilled OxyContin and Neurontin.[18] Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

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[14] Spinal fusion is a surgical procedure used to correct problems with the small bones in the spine (vertebrae).

[15] Chronic Obstructive Pulmonary Disease (COPD) is a group of lung diseases that block airflow and make it difficult to breathe.

[16] Carpal tunnel syndrome is a common condition that causes pain, numbness, and tingling in the hand and arm.

[17] Promethazine HCL - Codeine Phosphate is a combination medicine and a Schedule V controlled substances pursuant to Health and Safety Code section 11058 and a dangerous drug pursuant to Business and Professions Code section 4022.

[18] Neurontin (Gabapentin) can be used with other medications to prevent and control seizures.

31. On or about October 6, 2015, Patient B presented to Respondent for a refill of her medications. Respondent refilled OxyContin, oxycodone, Victoza,[19] Metformin, Neurontin, and Soma. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

32. On or about November 5, 2015, Patient B returned to Respondent. Respondent refilled Soma 350 mg, OxyContin 80 mg, and oxycodone HCL 30 mg. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

33. On or about December 3, 2015, Patient B presented to Respondent. Respondent refilled OxyContin and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

34. On or about January 29, 2016, Patient B returned to Respondent for a refill of her medications. Respondent refilled OxyContin and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

35. On or about February 26, 2016, Patient B presented to Respondent. Respondent refilled OxyContin, oxycodone, and Victoza. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

36. On or about March 25, 2016, Patient B returned to Respondent for a refill of her medications. Respondent refilled Soma, OxyContin, and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

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[19] Victoza (Liraglutide) is an anti-diabetic medication which can be used to treat type 2 diabetes.

37. On or about April 22, 2016, Patient B presented to Respondent. Respondent refilled Soma, OxyContin, and added a prescription for temazepam.[20] Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

38. On or about May 19, 2016, Patient B returned to Respondent. Respondent refilled temazepam. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

39. On or about June 16, 2016, Patient B presented to Respondent. Respondent refilled Soma, oxycodone, and OxyContin. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

40. On or about July 14, 2016, Patient B returned to Respondent for a refill of her medications. Respondent refilled oxycodone, OxyContin, and Soma. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

41. On or about July 25, 2016, Patient B presented to Respondent stating that she needed to be admitted to the hospital for her back pain. Respondent's medical records for this visit indicate, among other things, a plan of care to schedule Patient B for an MRI[21] of the spine and then upon receipt of the results, to refer Patient B to a spinal surgeon for assessment.

42. On or about September 9, 2016, Patient B returned to Respondent for a refill of her medications. Respondent refilled Soma, oxycodone, and OxyContin. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

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[20] Temazepam 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. When properly prescribed and indicated, it is used for treatment of insomnia.

[21] Magnetic Resonance Imaging (MRI) scan is a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues in your body.

43. On or about February 14, 2017, Patient B presented to Respondent for a pre-operative assessment. Respondent cleared Patient B for a lumber fusion procedure.

44. On or about June 6, 2018, Patient B returned to Respondent for a refill of her medications. Respondent refilled OxyContin and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient B's CURES reports.

45. During the course of his care and treatment of Patient B, from on or about May 14, 2015 through on or about January 3, 2019, Respondent failed to review Patient B's CURES reports before October 2018.

46. During the course of his care and treatment of Patient B, from on or about May 14, 2015 through on or about January 3, 2019, Respondent failed to use urine toxicology screenings and/or failed to document having used urine toxicology screenings.

47. During the course of his care and treatment of Patient B, from on or about May 14, 2015 through on or about January 3, 2019, Respondent failed to offer and/or suggest and/or failed to document having offered and/or suggested a structured tapering of the opiates or drug-holidays or replacement opioids with minimal bridging during transition.

48. During the course of his care and treatment of Patient B, from on or about May 14, 2015 through on or about January 3, 2019, other than prescribing Soma, Respondent failed to adequately suggest and/or utilize, and/or failed to document having adequately suggested and/or utilized, pharmacologic and/or non-pharmacologic alternatives to opioid treatment.

49. On or about December 3, 2015, Respondent noted in the medical record, among other things, that Patient B was to follow up with a pain management specialist and was provided a list of specialists. Respondent's medical records also indicate, among other things, that Respondent discussed a referral to physical therapy. This was approximately four (4) months after Respondent issued the first prescription for a controlled substance to Patient B. Respondent made a referral to a pain management specialist on or about January 3, 2017 (C.F., M.D.), and again on or about July 3, 2018 (B.W., M.D.). Respondent advised Patient B and/or referred Patient B to an orthopedic surgeon on or about September 9, 2016 and to neurosurgery on or about January 30,

2017.

50. Respondent committed gross negligence in his care and treatment of Patient B, which included, but was not limited to, the following:

(a) Paragraphs 27 through 49, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to prescribe opiates to Patient B in a safe manner.

Patient C

51. On or about October 20, 2015, Patient C first presented to Respondent. At the time of this visit, Patient C was a sixty-two (62) year-old male with a prior medical history including, but not limited to, leukemia,[22] osteomyelitis[23] and diskitis[24] of C6 - C7, pancytopenia,[25] unstable angina,[26] PE,[27] anxiety, ADHD,[28] cervical spine fusion,[29] lumbar spine discectomy,[30] COPD, smoking, alcohol use, and marijuana use. Respondent failed to obtain Patient C's prior medical records. Respondent failed to review Patient C's prior medical records. Respondent refilled

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[22] Adult acute myeloid leukemia (AML) is a type of cancer in which the bone marrow makes abnormal myeloblasts (a type of white blood cell), red blood cells, or platelets.

[23] Osteomyelitis is an infection of the bone, a rare but serious condition.

[24] Discitis or diskitis is an infection in the intervertebral disc space that affects different age groups.

[25] Pancytopenia is a condition that occurs when a person has low counts for all three types of blood cells: red blood cells, white blood cells, and platelets.

[26] Angina is a type of chest pain caused by reduced blood flow to the heart.

[27] Pulmonary Embolism (PE) is a blockage in one of the pulmonary arteries in your lungs.

[28] ADHD stands for attention deficit hyperactivity disorder, a chronic condition including attention difficulty, hyperactivity, and impulsiveness.

[29] Spinal fusion is a surgical procedure used to correct problems with the small bones in the spine (vertebrae).

[30] Disectomy is the surgical removal of abnormal disc material that presses on a nerve root or the spinal cord.

Patient C's prescriptions for OxyContin, oxycodone, Soma, Adderall,[31] and Xanax.[32] Patient C did not sign a controlled substance agreement until November 20, 2015. Respondent's medical records for this visit indicate, among other things, that Patient C's opiate dependence was due to spine osteomyelitis and diskitis, and that Patient C was chronically on opiates. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports.

52. On or about December 18, 2015, Patient C returned to Respondent for a refill of his medications. Respondent refilled Patient C's prescriptions for OxyContin, oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports. Respondent's medical records for this visit indicate, among other things, that Patient C admitted illicit drug use.

53. On or about January 19, 2016, Patient C returned to Respondent for a refill of his medications. Respondent refilled Patient C's prescriptions for OxyContin, oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports. Respondent's medical records for this visit indicate Patient C admitted to illicit drug use.

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[31] Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

[32] Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that 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. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

54. On or about February 8, 2016, Respondent referred Patient C to a pain management specialist (X.Q., M.D.).

55. On or about February 19, 2016, Patient C presented to Respondent for a refill of his medications and with complaints of pain in his hips, back, and knees. Patient C also purportedly requested a different pain management specialist, as he was unable to secure an appointment with the current one within the next three months. Respondent refilled Patient C's prescriptions for OxyContin, oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports.

56. On or about April 22, 2016, Patient C returned to Respondent for a refill of his medications. Respondent refilled OxyContin, oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports.

57. On or about May 21, 2016, Patient C presented to Respondent for a refill of his medications and a new referral to psychiatry and pain management. Respondent refilled oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports.

58. On or about June 18, 2016, Patient C returned to Respondent for a refill of his medications. Respondent refilled oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports. Respondent's medical records for this visit indicate, among other things, that Patient C admitted to illicit drug use.

59. On or about July 16, 2016, Patient C presented to Respondent. Respondent refilled oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to

document having checked Patient C's CURES reports. Respondent's medical records for this visit indicate, among other things, that Patient C admitted to illicit drug use.

60. On or about August 16, 2016, Patient C presented to Respondent. Respondent refilled oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports. Respondent's medical records for this visit indicate, among other things, that Patient C admitted to illicit drug use.

61. On or about October 23, 2016, Patient C presented to Respondent. Respondent refilled oxycodone, Xanax, Soma, and Adderall. Respondent's medical records for this indicate, among other things, that Patient C looked pale and weak. Respondent failed to order any laboratories studies and/or failed to document having ordered any laboratory studies. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports. Respondent's medical records for this visit indicate, among other things, that Patient C admitted to illicit drug use.

62. On or about November 17, 2016, Patient C presented to Respondent. Respondent refilled oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports. Respondent's medical records for this visit indicate, among other things, that Patient C admitted to illicit drug use.

63. On or about December 17, 2016, Patient C returned to Respondent. Respondent refilled oxycodone, Xanax, Soma, and Adderall. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient C's CURES reports.

64. During the course of his care and treatment of Patient C, from on or about October 20, 2015 through on or about December 17, 2016, Respondent failed to review Patient C's CURES reports.

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65. During the course of his care and treatment of Patient C, from on or about October 20, 2015 through on or about December 17, 2016, Respondent failed to use urine toxicology screenings and/or failed to document having used urine toxicology screenings.

66. During the course of his care and treatment of Patient C, from on or about October 20, 2015 through on or about December 17, 2016, Respondent failed to offer and/or suggest, and/or failed to document having offered and/or suggested, a structured tapering of opiates or drug-holidays or replacement opioids with minimal bridging during transition.

67. Other than prescribing Soma, Respondent failed to adequately suggest and/or utilize, and/or failed to document having adequately suggested and/or utilized, pharmacologic and/or non-pharmacologic alternatives to opioid treatment.

68. On or about February 8, 2016, Respondent referred Patient C to a pain management specialist (X.Q., M.D.).

69. On or about April 23, 2016, Respondent abruptly stopped prescribing OxyContin to Patient C.

70. During the course of his care and treatment of Patient C, from on or about October 20, 2015 through on or about December 17, 2016, Respondent failed to clearly define the appropriate treatment for the specific conditions causing Patient C's pain such as leukemia, osteomyelitis, prior surgeries, or other conditions.

71. Respondent committed gross negligence in his care and treatment of Patient C, which included, but was not limited to, the following:

(a) Paragraphs 51 through 70, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to prescribe opiates to Patient C in a safe manner; and

(c) Respondent failed to use urine toxicology screenings.

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Patient D

72. On or about October 20, 2015, Patient D first presented to Respondent. At the time of this visit, Patient D was a fifty-five (55) year-old female with a prior medical history including, but not limited to, opiate dependence, lumbar degenerative disc disease with bilateral sciatica, wheelchair-bound, obesity (BMI of approximately 53), atrial fibrillation,[33] hypothyroidism,[34] metabolic syndrome,[35] hypertension, hyperlipidemia,[36] self-reported anxiety, and self-reported hepatitis C. Respondent referred and/or advised Patient D to seek treatment from a pain management specialist, a spine surgeon, a physical therapist, and a psychiatrist. Respondent failed to obtain Patient D's prior medical records. Respondent failed to review Patient D's prior medical records. Respondent's medical records for this visit indicate, among other things, that Patient D had chronic pain and opiate dependence. Respondent refilled Patient D's prescriptions for OxyContin, Xanax, Adderall, and Dilaudid.[37] Patient D did not sign a controlled substance agreement until November 20, 2015. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

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[33] Atrial fibrillation is an irregular, often rapid heart rate that commonly causes poor blood flow.

[34] Hypothyroidism is a condition in which the thyroid gland does not produce enough thyroid hormone.

[35] Metabolic syndrome is a cluster of conditions that increase the risk of heart disease, stroke, and diabetes.

[36] Hyperlipidemia is a condition in which there are high levels of fat particles (lipids) in the blood.

[37] Hydromorphone (Dilaudid®), an opioid analgesic, 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. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. The Drug Enforcement Administration (DEA) has identified hydromorphone, such as Dilaudid®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.) The Federal Drug Administration has issued black box warnings for Dilaudid® which warn about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warnings also caution about the risks associated with concomitant use of Dilaudid® with benzodiazepines or other central nervous system (CNS) depressants.

73. On or about February 19, 2016, Patient D presented to Respondent. Respondent refilled Patient D's prescriptions for OxyContin, Dilaudid, Xanax, and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

74. On or about March 19, 2016, Patient D returned to Respondent. Respondent's medical records for this visit state, among other things, "Discussed with the patient the need to see a pain specialist, she agree[s] on discontinuing hydromorphone due to high potency and replace by oxycodone starting 30 mg and will taper down every month the dose if pain is tolerable until she see[s] the pain M.D." Respondent refilled Patient D's prescriptions for OxyContin, Xanax, and Dilaudid. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

75. On or about April 22, 2016, Patient D presented to Respondent. Respondent refilled Patient D's prescriptions for Xanax, OxyContin, and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

76. On or about June 18, 2016, Patient D returned to Respondent. Respondent refilled Patient D's prescriptions for Xanax, OxyContin, and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

77. On or about July 16, 2016, Patient D presented to Respondent. Respondent refilled Patient D's prescriptions for Xanax, OxyContin, and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

78. On or about August 16, 2016, Patient D returned to Respondent. Respondent's medical records for this visit indicate, among other things, that Patient D appeared lethargic, her mouth was drooping, and she could barely hold her eyes open. Respondent refilled Patient D's

prescriptions for Xanax, OxyContin, and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

79. On or about November 17, 2016, Patient D presented to Respondent. Respondent refilled Patient D's prescriptions for Xanax, OxyContin, and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

80. On or about December 17, 2016, Patient D returned to Respondent. Respondent refilled Patient D's prescriptions for Xanax, OxyContin, and oxycodone. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

81. Respondent's medical records for Patient D include a notice signed by Patient D, which stated, "Attention!!! As of February 20th, 2017, Dr. Elias will no longer be writing prescriptions for any narcotics. All those in need of pain medications will be referred to a pain management specialist."

82. On or about February 21, 2017, Patient D returned to Respondent. Respondent refilled Patient D's prescriptions for oxycodone and Xanax. Respondent failed to request and/or failed to document having requested a urine toxicology screening. Respondent failed to check and/or failed to document having checked Patient D's CURES reports.

83. During the course of his care and treatment of Patient D, from on or about October 20, 2015 through on or about February 21, 2017, Respondent failed to review Patient D's CURES reports.

84. During the course of his care and treatment of Patient D, from on or about October 20, 2015 through on or about February 21, 2017, Respondent failed to use urine toxicology screenings and/or failed to document having used urine toxicology screenings.

85. During the course of his care and treatment of Patient D, from on or about October 20, 2015 through on or about February 21, 2017, Respondent failed to offer and/or suggest, and/or failed to document having offered and/or suggested, a structured tapering of opiates or

drug-holidays or replacement opioids with minimal bridging during transition.

86. During the course of his care and treatment of Patient D, from on or about October 20, 2015 through on or about February 21, 2017, Respondent failed to adequately suggest and/or utilize, and/or failed to document having adequately suggested and/or utilized, pharmacologic and/or non-pharmacologic alternatives to opioid treatment.

87. During the course of his care and treatment of Patient D, from on or about October 20, 2015 through on or about February 21, 2017, even though Patient D's BMI was abnormally high at 48 to 53, Respondent failed to investigate, and/or failed to document having investigated, the development and/or progression of obstructive sleep apnea.[38]

88. Respondent committed gross negligence in his care and treatment of Patient D, which included, but was not limited to, the following:

(a) Paragraphs 72 through 87, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to prescribe opiates to Patient D in a safe manner.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

89. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 99956 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, and D, as more particularly alleged hereinafter:

Patient A

90. Respondent committed repeated negligent acts in his care and treatment of Patient A, which included, but was not limited to, the following:

(a) Paragraphs 9 through 26, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to prescribe opiates in a safe manner;

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[38] Obstructive sleep apnea is a potentially serious sleep disorder. It causes breathing to repeatedly stop and start during sleep.

(c) Respondent failed to obtain and/or review Patient A's prior medical records;

(d) Respondent failed to properly use a controlled substance agreement; and

(e) Respondent failed to use urine toxicology screenings.

Patient B

91. Respondent committed repeated negligent acts in his care and treatment of Patient B, which included, but was not limited to, the following:

(a) Paragraphs 27 through 50, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to prescribe opiates in a safe manner;

(c) Respondent failed to obtain and/or review Patient B's prior medical records;

(d) Respondent failed to properly use a controlled substance agreement; and

(e) Respondent failed to use urine toxicology screenings.

Patient C

92. Respondent committed repeated negligent acts in his care and treatment of Patient C, which included, but was not limited to, the following:

(a) Paragraphs 51 through 71, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to prescribe opiates in a safe manner;

(c) Respondent failed to obtain and/or review Patient C's prior medical records; and

(d) Respondent failed to use urine toxicology screenings.

Patient D

93. Respondent committed repeated negligent acts in his care and treatment of Patient D, which included, but was not limited to, the following:

(a) Paragraphs 72 through 88, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to prescribe opiates in a safe manner;

(c) Respondent failed to obtain and/or review Patient D's prior medical records; and

(d) Respondent failed to use urine toxicology screenings.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and/or Accurate Records)

94. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 99956 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and/or accurate records regarding his care and treatment of Patients A, B, C, and D, as more particularly alleged in paragraphs 8 through 93, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

95. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 99956 to disciplinary action under sections 2227 and 2234 of the Code, in that he engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 8 through 94, above, which are hereby incorporated by reference as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

96. To determine the degree of discipline, if any, to be imposed on Respondent Ramiz Naim Elias, M.D., Complainant alleges that on or about August 1, 2017, the Medical Board of California issued a citation order against Respondent (Citation Order No. 8002014007284) for willful, unauthorized violation (s) of professional confidence, in violation of Section 2263 of the California Business and Professions Code. That citation and order is now final and is 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 No. A 99956, issued to Respondent Ramiz Naim Elias, M.D.;

2. Revoking, suspending or denying approval of Respondent Ramiz Naim Elias, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Ramiz Naim Elias, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent Ramiz Naim Elias, M.D., if placed on probation, to disclose the disciplinary order to patients pursuant to Business and Professions Code section 2228.1; and

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

DATED: December 31, 2019

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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