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

In the Matter of the First Amended Accusation Against: Sabri Elshenawy Malek, M.D. Physician's and Surgeon's Certificate No. A 89836 Respondent.	Case No.: 800-2019-054129

DECISION

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

This Decision shall become effective at 5:00 p.m. on July 27, 2022.

IT IS SO ORDERED: June 27, 2022.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

BEFORE THE

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DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the First Amended Accusation against:

SABRI ELSHENAWY MALEK, M.D.,

Physician's and Surgeon's Certificate No. A89836,

Respondent.

Agency Case No. 800-2019-054129

OAH No. 2021070022

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on March 7, 8, and 14 through 16, 2022, by video and teleconference.

Rebecca L. Smith, Deputy Attorney General, represented complainant William Prasifka, Executive Director, Medical Board of California (Board), Department of Consumer Affairs.

Raymond J. McMahon, Doyle Schafer McMahon, LLP, Attorneys at Law, represented respondent Sabri Elshenawy Malek, M.D.

A protective order sealing portions of the record issued separately.

At hearing, complainant moved to allow an amendment by interlineation to the First Amended Accusation to correct a date, changing "June 7, 2018" to "July 7, 2018" at page A26, line 21, page A28, lines 15, 18, and 22, and page A33, lines 5, 8, and 12. There was no objection. The motion was granted.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on March 16, 2022.

The record was reopened to allow complainant to file the version of the First Amended Accusation incorporating the interlineated amendments. Complainant timely filed the First Amended Accusation with interlineated amendments. The record was again closed and the matter was submitted for decision on April 4, 2022.

SUMMARY

Complainant seeks to discipline respondent's physician's and surgeon's certificate on grounds of gross negligence, repeated negligent acts, unprofessional conduct based on incompetence, and inadequate and inaccurate recordkeeping with respect to Patients 1 through 6.

Respondent asserts cause for discipline does not exist.

Based on the evidentiary record, respondent's certificate shall be revoked, the revocation shall be stayed, and respondent shall be placed on five years' probation.

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FACTUAL FINDINGS

Jurisdiction

1. The Board issued Physician's and Surgeon's Certificate No. A 89836 to respondent on January 12, 2005. The certificate is scheduled to expire on July 31, 2022.

2. Complainant brought the Accusation in his official capacity as Executive Director of the Board. Respondent filed a Notice of Defense. Complainant filed a First Amended Accusation (FAA) on January 12, 2022. This hearing ensued.

Respondent's Background

3. From March 2017 through 2019, respondent performed interventional pain management procedures at his clinic in Pasadena, the Interventional Anesthesia and Pain Management Clinic, Inc.

4. Respondent became a staff anesthesiologist at San Gabriel Valley Medical Center in Alhambra in February 2018 and, from April 2017 to January 2018, respondent practiced with the Century Anesthesia Medical Group in Los Angeles. Before 2017, respondent practiced at various locations as a staff anesthesiologist and pain management specialist.

5. Respondent received his medical degree from the J.H. Quillen College of Medicine, East Tennessee State University, in 2001. He completed a one-year internship in family medicine at The Medical Center in Columbus, Georgia, in 2002,

and a three-year anesthesiology residency at SUNY Downstate Medical Center in Brooklyn, New York, and the University of Medicine and Dentistry in Newark, New Jersey, in 2005. A servicemember with the U.S. Army, respondent completed a one-year fellowship in pain management at Walter Reed Army Medical Center in 2006 and served there as staff anesthesiologist and Director of Interventional Pain Management while on active duty in the U.S. Army from 2006 to 2010.

6. Respondent is a diplomate of the American Board of Anesthesiology, and is board-certified in interventional pain management by the World Institute of Pain.

Complainant's Allegations Regarding Respondent's Treatment of Patients 1 Through 6

7. Complainant alleges that, from 2017 to 2019, respondent engaged in:

(a) gross negligence with respect to Patient 1 (LC), Patient 2 (NP), Patient 3 (AV), Patient 4 (LB), Patient 5 (RF), and Patient 6 (ED), in that respondent failed to evaluate the patients' suitability for discharge following certain procedures and to document a post-operative examination confirming suitability for discharge; and, in addition, with respect to Patient 4, respondent failed to discuss the risks and benefits of and alternatives to ketamine infusions and failed to obtain the patient's written informed consent for those procedures (ex. 2, FAA, first cause for discipline);

(b) repeated negligent acts in care and treatment (ex. 2, FAA, second cause for discipline), including,

(i) with respect to Patients 1 through 6, failing to obtain informed consent before performing interventional pain management procedures, failing to document vital signs and medications, failing to evaluate for suitability for discharge

and to conduct a post-procedure examination, and failing to maintain accurate and adequate medical records

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(ii) with respect to Patient 2, failing to document a discussion of the risks and benefits of controlled substances and to obtain a signed opioid pain management agreement, and failing to refer the patient for imaging studies before initiating treatment;

(iii) with respect to Patient 4, failing to discuss the risks and benefits of and alternatives to 11 ketamine infusion treatments and to obtain the patient's written informed consent for those treatments, and documenting virtually identical medical record data for all dates of service;

(iv) with respect to Patient 5, performing intercostal nerve blocks without justification or medical indication; and

(iv) with respect to Patient 6, recommending a three-level right-sided lumbar transforaminal injection without medical indication or justification.

(c) incompetence in the care and treatment of Patients 1 through 6 (ex. 2, FAA, third cause for discipline) based on the allegations supporting the causes for discipline for gross negligence and repeated negligent acts; and

(d) inadequate record keeping for Patients 1 through 6 (ex. 2, FAA, fourth cause for discipline).

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Expert Witnesses

8. Complainant designated two expert witnesses, Standiford Helm, II, M.D., and Wei Wah Kwok, M.D.

9. Dr. Helm, who consulted for the Board during the investigation of respondent and testified as an expert witness at hearing, received his medical degree from the Tufts University in 1977. He completed an internship in internal medicine at Boston City Hospital in 1978 and a two-year residency in anesthesiology at UCLA in 1980. He is licensed in California and has been a diplomate of the American Board of Anesthesiology since October 1982, with a subspecialty certification in pain medicine that expires in 2023. He is also a diplomate of the American Board of Pain Medicine since 1993 and of the American Board of Interventional Pain Physicians since 2006. Dr. Helm is a qualified medical evaluator for the Board. He has provided pain management treatment to, by his estimate, tens of thousands of patients. He is on the medical staff at various medical centers in Orange County.

10. Dr. Kwok received his medical degree from the Tufts University School of Medicine in 2001. He completed two two-year residencies in anesthesiology, first at Northwestern Memorial Hospital, Northwestern University Feinberg School of Medicine, then at Beth Israel Deaconess Medical Center, Harvard Medical School, in 2005, and a one-year fellowship in pain medicine at UCLA Pain and Spine Care, UCLA David Geffen School of Medicine, in 2006. Dr. Kwok is a diplomate of the American Board of Anesthesiology, with a certification in the subspecialty of pain medicine. Dr. Kwok is licensed to practice in California. He became an expert reviewer for the Board in 2014. He practices as a staff anesthesiologist and interventional pain medicine physician, primarily in Fullerton and Irvine, seeing patients suffering chronic pain, and serves patients at Placentia-Linda Hospital and St. Jude Medical Center.

11. Respondent designated Richard Markus Paicias, M.D. as an expert witness. Dr. Paicias received his medical degree from the University of Arizona in 1983. He completed a rotating internship in 1984, and a residency in Anesthesia in 1986, both at Harbor-UCLA Medical Center in Torrance. He is a diplomate of the American Board of Anesthesiology (1989), with a subspecialty certification in pain management (1998-2008), the American Academy of Pain Management, and the American Academy of Pain Medicine (1998). He is the Medical Director and Primary Investigator for SC Spine and Sport, and is president of Southern California Spine and Sport Medical Associates, Inc. He serves as Executive Board Member of the American Society of Pain and Neuroscience Board of Directors Executive Committee. He is an editorial board member and reviewer for the Journal of Chronic Diseases and Management, and is a board member on the Pain Therapy Applied Research and Technology Advisory Board. He was an Assistant Professor at UCLA, Harbor-UCLA Medical Center Anesthesiology Department, and at the University of California, Irvine, in pain management, and served as the Medical Director of the Newport Coast Surgery Center. Dr. Paicias publishes regularly in academic journals and reviews for the Journal of Neuromodulation, which he called, "our bible in this field."

12. Drs. Helm, Kwok, and Paicias were qualified to testify as experts on the standard of care in this case. Any additional weight given to one expert's testimony over another's was based on the content of the experts' testimony and the bases for their opinions, as set forth below.

13. The expert witnesses agreed generally that the applicable standard of care was that level of skill and knowledge that a reasonable, prudent pain management physician would apply in similar circumstances. Lack of knowledge or incompetence is the absence of a qualification or fitness to perform a function.

GROSS NEGLIGENCE

Patients 1 through 6

14. During the relevant time period, respondent treated Patients 1 through 6 on multiple dates for various conditions. Respondent treated acute and chronic pain, prescribed pain medications, performed pain management procedures, used injections to reduce inflammation, performed procedures for facet joint pain, and performed ketamine infusions. If local anesthesia was insufficient for a procedure, respondent used Midazolam, a benzodiazepine and anxiolytic medication, to effect conscious sedation. Midazolam and ketamine infusions make patients drowsy.

15. Complainant alleged that respondent failed to evaluate all six patients' suitability for discharge following certain procedures and failed to document a post-operative examination confirming suitability for discharge.

16. The medical records do not reflect that each patient received a post-operative examination or was otherwise evaluated for suitability for discharge at the end of each visit.

17. The complaining nurse testified that patients were released from respondent's care without being evaluated and having someone to drive them; her testimony, however, is suspect and cannot be credited. (See Factual Findings 98-100, *infra*.)

18. Respondent testified that the patients signed character reference letters confirming that they were instructed not to drive and that they were told their procedure would not take place if they did not have a driver. Dr. Paicias testified that, in view of those letters and because no one could testify to knowing firsthand that the

patients did, in fact, drive themselves away after their visit to respondent, there is no support for an expert opinion that respondent departed from the standard of care. But the letters on which Dr. Paicias bases his opinion are suspect and were given little or no weight, and his opinion is, therefore, not persuasive.

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19. Respondent himself wrote the letters for his patients to sign. The letters recite that each patient was told before every injection "to arrange for a driver *and for me to be supervised* by a family member or friend for the next 24 hours after my procedure. I also know that if I fail to arrange for a driver, Dr. Malek would cancel/reschedule my treatment procedure until I made the proper arrangements. I always complied with his instructions." (Exs. L, M, N, FF, & GG, italics added.) Three of the letters included a line to identify the patient's "Wife/driver/care taker," and a signature line for that person. (Exs. L, M, & N.)

20. Five patients, Patients 3 (AV), 4 (LB), and 6 (ED), as well as two patients not involved in this case, Patients TW and WG, each signed a copy of the letter. With respect to Patients 3, 4, and 6, the "wife/driver/care taker" line was left blank, and the "wife/driver/care taker" signature line was left blank.

21. The fact that none of the letters identifies a driver or has a driver's signature erodes respondent's contention that he did, in fact, require his patients to have a driver. Compounding this problem, respondent heatedly insisted at hearing that his instruction to patients to arrange for a driver was mandatory, while his instruction to have supervision for 24 hours was a mere suggestion. But the plain language of the letter directly contradicts that testimony, mandating both a driver and

a caregiver. The contradiction further suggests that respondent did not, in fact, instruct the patients that they could not drive home.

22. Respondent introduced into evidence a photograph of a sign posted in his office and placed near the patient sign-in sheet, stating that every patient receiving treatment "is required to bring a driver. If patient was not able to bring a driver, the treatment will have to be rescheduled." (Ex. U.) The evidentiary record, though, did not establish that the signs were enforced when respondent treated Patients 1 through 6.

23. Finally, respondent acknowledged that he allowed patients who had no driver to leave his office one hour after the injection.

24. Dr. Helm and Dr. Kwok agreed that, in their expert opinions, if respondent allowed patients to drive themselves home after their visits, respondent's failure to evaluate the patients for suitability for discharge was an extreme departure from the standard of care. The treatments included conscious sedation or ketamine infusions, both of which render patients drowsy.

25. The evidentiary record lacks any evaluation of Patients 1 through 6 for suitability for discharge, and lacks a post-procedural examination in the case of Patient 4. That record, challenged only by non-credible evidence that those evaluations took place, is convincing evidence that no such evaluations occurred. The absence of even one identified driver on forms respondent himself drafted for the patients in this case supports a conclusion that patients were permitted to drive themselves, at least if they waited an hour, after respondent's procedures. Failure to evaluate the patients for suitability for discharge, and particularly for their ability to drive after the visit, created a significant risk of harm to the patients' and the public's safety.

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Informed Consent for Ketamine Treatment for Patient 4 (LB)

26. With respect to Patient 4, complainant alleged respondent failed to discuss the risks and benefits of and alternatives to ketamine infusions and failed to obtain the patient's written informed consent for 11 ketamine infusion therapy procedures. (For a discussion of informed consent with respect to the patients' interventional pain management procedures, see Factual Findings 34-41, 59-60, & 71-73, *infra*.)

27. Dr. Kwok reported and testified that the standard of care requires documentation in the medical records that the physician discussed the risks and benefits of the use of controlled substances, including ketamine, along with other treatment modalities. A written controlled medication consent is not required but recommended; a written surgical procedure consent is required. Dr. Kwok found there was a signed opioid pain medication agreement, but there was no signed surgical procedure consent or any documented discussion of informed consent for the procedures respondent performed.

28. Dr. Kwok noted respondent stated during his interview that he had the patient sign a written surgical or procedural consent on the patient's initial visit authorizing all procedures while under his care. But there was no such consent in the records Dr. Kwok reviewed, only a short paragraph titled "Consent To Treatment" embedded in a general clinic policy form. There was no language informing the patient of any risks, benefits, or alternatives to the procedure. Each surgical procedure had unique risks, benefits, and alternatives. These must be discussed with the patient and signed consent obtained from the patient prior to the procedure. Ketamine

infusions can be performed by multiple injections over weeks; if respondent had obtained a single consent for the whole series, that would have been acceptable.

29. Dr. Kwok concluded there was an extreme departure from the standard of care and repeated negligent acts based on a lack of knowledge for failing to obtain surgical or procedural consent. Given the absence of documentation, one cannot be certain informed consent was obtained.

30. Dr. Kwok found no departure from standard of care as it related to informed consent for the prescription of controlled substances.

31. Dr. Paicias agreed respondent failed to document his verbal informed consent discussions, so there is no way to know from the records what risks, benefits, and alternatives, if any, were discussed with Patient 4, whether Patient 4 had questions regarding the ketamine infusion procedures, or whether there was a discussion of potential outcomes. Dr. Paicias testified, however, that verbal consent for office-based procedures, including ketamine infusions, is consistent with the standard of care. Written consent is only required for procedures performed in a surgery center or hospital. Though informed consent should be documented in the records for the ketamine procedures, written informed consent is not required.

32. Respondent testified he spent about an hour talking to Patient 4 about the risks, benefits, and alternatives and obtained Patient 4's informed consent for the ketamine treatments. Respondent testified that he documented those informed consent discussions but his EMR software deleted the entries or rendered them inaccessible. He testified the EMR documentation of the ketamine procedures is a "complete fiasco" and it misrepresents his efforts. Respondent testified that because of the horrible template, he would document informed consent in a handwritten log not

included in the EMR. But the log does not mention informed consent; it records vitals and other information. As a result of courses he has attended since the Accusation was filed, respondent testified, he has added to his records a written consent form.

33. Dr. Kwok's opinion on the standard of care is more persuasive than Dr. Paicias's, in light of the evidence on this record. Respondent's testimony about the shortcomings of his EMR software is, however, credited.

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REPEATED NEGLIGENT ACTS

Patients 1 through 6

34. Complainant alleged that, with respect to Patients 1 through 6, respondent (a) failed to obtain informed consent before performing interventional pain management procedures, (b) failed to document patients' vital signs and medications administered, (c) failed to evaluate for suitability for discharge and to conduct a post-procedure examination, and (d) failed to maintain accurate and adequate medical records.

35. Some of the evidence concerning these allegations has already been addressed. (See Factual Findings 14-33, *ante*.)

(a) Informed Consent

36. Respondent's medical records for all the patients' visits repeat an EMR template phrase to the effect that written informed consent was obtained. (See, e.g., ex. 28, pp. A496-A497.) Respondent testified that the notation is an error, an artifact of

his EMR software. He acknowledged that no written informed consent was included in the patient charts and that he did not obtain written informed consents from the patients before each procedure. Respondent testified he obtained verbal informed consent before each procedure. He offered no credible corroborative evidence.

37. Dr. Kwok and Dr. Helm testified the standard of care required respondent to obtain a written informed consent signed by each patient before each procedure, not just verbal consent, and not just the general written consent form respondent obtained when he first saw each patient. In that general form, there is no discussion of the risks, benefits, and alternatives applicable to the procedures respondent eventually performed. (See ex. 28, p. A478). Dr. Kwok and Dr. Helm testified respondent's failure to do so was a simple departure from the standard of care.

38. Dr. Kwok testified written consent, unlike verbal consent, can detail benefits, risks, and alternatives for the patient to thoughtfully review before signing. For Patient 4, there was no documentation of either written or verbal informed consent, so one may assume informed consent was not obtained. Written signed consent confirms that the patient has received the pertinent information and given consent. Any procedures under conscious sedation require written informed consent.

39. Dr. Paicias agreed that the general consent form respondent used is just a broad consent to respondent's treating the patient and provides no information about any particular procedure, each of which has different risks, benefits, and alternatives. He attributed the notation in the charts, "Written informed consent obtained," to a flaw in respondent's EMR software and agrees respondent did not obtain written informed consent.

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40. But Dr. Paicias testified that verbal informed consent is as good as written informed consent and complies with the standard of care. He disagreed that written informed consent improves a patient's understanding of risks and benefits. He testified a signed consent is primarily designed to protect doctors in a litigious world.

41. The opinions of Drs. Helm and Kwok about the standard of care for informed consent are more persuasive than that of Dr. Paicias.

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(b) Documenting Vitals and Medications

42. Respondent testified that all his patients were monitored during their procedures, and that the procedures were so brief no documentation of the patients' vital signs was necessary or appropriate.

43. Complainant's experts testified that, for most or all of the patients, there was nothing in the chart indicating the patients' vital signs were monitored during any procedure. For example, Patient 1 received cervical facet medial branch blocks. The patient's vital signs were recorded before but not during the procedure. Dr. Helm agreed with respondent that many procedures lasted less than 15 minutes, and others were so brief that even if the patients were monitored every 15 minutes, at most only one set of vitals during the procedure could be taken. But Dr. Helm testified he could not determine whether monitoring took place because it was not documented, which Dr. Helm considered repeated simple negligence.

44. Dr. Paicias testified that, ketamine treatments aside, the standard of care did not require respondent to document patients' vital signs during their procedures. Injections take five minutes or less, so, after recording the baseline vitals before the procedure, there is no need to record more unless an untoward event occurs. The pulse oximeter and other equipment were running, even if nothing is recorded.

45. The opinion of Dr. Paicias is more persuasive than that of complainant's expert witnesses.

(c) Suitability for Discharge

46. Respondent told the Board investigator under oath with respect to discharge instructions to patients, that "It's all done verbally, though. It's all done every visit verbally. But you need it in writing? We'll – we'll get writing, no problem." Respondent's attorney interjected, "It doesn't exist in writing." (Ex. 13, p. A358.)

47. At hearing, respondent acknowledged that he did not retain in his records documentation of any post-procedure analysis of suitability for discharge or discharge instructions. He testified he did provide written discharge instructions to the patients but retained no copies. He did not produce a template of his customary post-procedure discharge instructions, and his testimony is not credible on this subject.

48. Dr. Paicias acknowledged that, at least with respect to certain patients, he saw no documentation that the patient was cleared for discharge after any procedure or that the patient was discharged with a driver.

49. The evidence supports a conclusion that the patients' medical records lack documentation of suitability for discharge or discharge instructions.

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(d) Medical Record Keeping

50. Dr. Helm and Dr. Kwok found the procedure notes in the patients' EMR charts lack adequate notation of the medications administered to the patients.

51. In addition to the procedure notes, the charts included, among other things, Healthcare Common Procedure Coding (HCPC) and a list of medications. Dr. Helm testified that the presence of an HCPC code for a medication, e.g., Midazolam, reasonably leads one to assume that Midazolam was used, yet the procedure notes do not show its use. He found that respondent's failure to document medications administered and the patients' condition during their procedures constituted an extreme departure.

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52. Dr. Paicias and respondent explained that the appearance of a medication HCPC code on the billing code sheet is standard information generated for the proposed procedure. It does not reflect what was actually administered. If the medication is not, in fact, administered, it is discarded.

53. Dr. Paicias's opinion was more persuasive than that of Dr. Helm. No conclusions about medications actually administered can be drawn from a medication's presence on the HCPC page. Nevertheless, respondent acknowledged that he could not identify from some of the procedure notes what medications were administered and in what quantity.

54. Dr. Kwok also found errors in respondent's charts for each patient, constituting simple departures from the standard of care. Respondent testified that the errors were for the most part due to a faulty EMR system. He testified convincingly

of his efforts to work with the software company to correct some of the errors. Dr. Paicias supported respondent's position and found no departure.

Patient 2

55. With respect to Patient 2, complainant alleged respondent failed to document a discussion of the risks and benefits of controlled substances and to obtain a signed opioid pain management agreement, and failed to refer the patient for imaging studies before initiating treatment.

56. Dr. Kwok testified the standard of care required a signed opioid pain management agreement and, in this patient's case, a cervical x-ray prior to the procedure, given a diagnosis of fibromyalgia and negative nerve injury test results. Respondent administered a cervical epidural steroid injection under conscious sedation.

57. Dr. Paicias testified that whether the standard of care requires imaging before a procedure is situation-dependent. For Patient 2, who experienced arm and neck pain, use of an epidural without imaging was appropriate. This patient had no cervical radiculopathy and was experiencing carpal tunnel pain, so no imaging of the cervical spine was necessary.

58. Dr. Paicias's testimony was more persuasive about the need for imaging prior to the procedure.

Patient 4

59. With respect to Patient 4, complainant alleged respondent failed to discuss the risks and benefits of and alternatives to 11 ketamine infusion treatments

and to obtain the patient's written informed consent for those treatments, and documented virtually identical medical record data for all dates of service.

60. This allegation is addressed above, as it relates to allegations of gross negligence. (See Factual Findings 26-33, *ante*.)

Patient 5

61. With respect to Patient 5, complainant alleged respondent performed intercostal nerve blocks without justification or medical indication.

62. Dr. Helm testified that the patient presented with back, arm, and hand pain and peripheral neuropathy, and that those symptoms do not clearly indicate why an intercostal nerve block would be the treatment of choice. In Dr. Helm's opinion, the lack of a rationale in the patient's notes is a simple departure from the standard of care.

63. Similarly, Dr. Kwok testified that respondent's treatment plan demonstrated a lack of knowledge, because it contained no documentation of medical necessity for intercostal nerve blocks. For example, pain along thoracic dermatomes would support the necessity for the procedure.

64. Dr. Paicias wrote in his report that the patient experienced what was historically called "hand/shoulder syndrome". Performing intercostal nerve blocks in the upper thoracic spine is commonly employed and is not a deviation from standard of care. The records also show respondent performed lumbar medial branch blocks with a diagnosis of lumbar facet arthropathy. Dr. Paicias contends there is no deviation from standard of care for this treatment.

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65. Dr. Paicias's opinion is more persuasive than the findings of Dr. Helm and Dr. Kwok.

Patient 6

66. With respect to Patient 6, complainant alleged respondent recommended a three-level right-sided lumbar transforaminal injection without medical indication or justification.

67. Dr. Helm testified the documentation did not justify the treatment responded provided. The patient suffered from severe osteoarthritis; she refused hip replacement and her orthopedic surgeon referred her to respondent for a hip injection. She had pain from her hip to her ankle. There were no signs of radiculopathy, just pain on the same side as her hip problem. Though a facet injection might be appropriate, there was no justification for an epidural injection. The notes were confused about where respondent intended to perform the injection and the reasons for doing so.

68. Dr. Kwok opined that respondent departed from the standard of care because his records did not set forth his reasoning and the indications for performing the procedure. Dr. Kwok found respondent did not adequately document a treatment plan and demonstrated a lack of knowledge, constituting a simple departure from the standard of care. After the patient's initial visit, respondent recommended a three-level transforaminal injection, with no basis for that in the medical chart and no imaging. And respondent did not address the hip joint pain for which the patient was referred. The standard of care requires that medical records set out the doctor's reasoning and indications for performing procedures.

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69. Dr. Paicias wrote in his report and testified that, despite the referring physician sending the patient to respondent to treat her hip pain, respondent's duty was to assess the patient and provide any necessary care. Back pain and hip pain overlap in their geography. A painful "hip area", is often the result of lumbar radiculopathy. A patient who complains of hip pain might have pain that originates in the hip, or might have back pain that is referred to the hip region. Respondent believed the patient's pain was caused by lumbar radiculopathy, a back problem, not an arthritic hip joint. It was not only appropriate but imperative that he treat what he felt was the underlying cause. Under those circumstances, it was appropriate to perform an epidural injection. The patient also had back surgery in the past, which supports a diagnosis of lumbar radiculopathy and the need for an epidural steroid injection. There was documentation in the patient's chart of symptoms consistent with radiculopathy.

70. Dr. Paicias's opinion was more persuasive on this issue than that of Dr. Helm and Dr. Kwok.

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INCOMPETENCE, LACK OF KNOWLEDGE

71. Complainant alleged respondent demonstrated incompetence and lack of knowledge in the care and treatment of Patients 1 through 6 based on the allegations supporting the causes for discipline for gross negligence and repeated negligent acts.

72. For all six patients, complainant alleged respondent failed to obtain informed consent prior to performing interventional pain management procedures, failed to document vital signs and medications administered, failed to evaluate for

suitability for discharge, and failed to maintain accurate and adequate medical records. Also, (a) for Patient 2, respondent failed to obtain a signed opioid pain management agreement and failed to refer the patient for imaging studies; (b) for Patient 4, respondent failed to obtain written informed consent before ketamine infusions; and (c) for Patient 6, respondent recommended a three-level right-sided lumbar transforaminal injection without medical indication or justification.

73. The evidence concerning those allegations, other than allegations concerning respondent's medical recordkeeping, has been addressed. (Factual Findings 14-70, *ante*. For medical recordkeeping, see Factual Findings 14-60, *ante*, and 74-85, *infra*.)

INADEQUATE RECORDKEEPING FOR PATIENTS 1 THROUGH 6

74. Complainant alleged respondent engaged in inadequate and inaccurate record keeping for Patients 1 through 6 (fourth cause for discipline).

75. Much of the evidence concerning those allegations has been addressed. (Factual Findings 14-60, *ante*.)

76. Patient 1's chart reflects the same procedure indication, detailed description, and disposition for every visit. Medications are infrequently described in the progress notes, only in the HCPC codes, and respondent does not know exactly what medications were given or in what quantities. The same incomplete physical examination findings are repeated over numerous visits.

77. Patient 2's chart shows the same vital signs on different visits. Physical examination entries for different dates are identical. Procedure notes are incomplete.

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78. Patient 3 was listed as a new workers' compensation patient on dates six months apart. The chart has the same procedure note for multiple visits.

79. Patient 4's chart contains unintelligible and inaccurate notes. They also state that, at each of the patient's 11 visits, the patient admitted using street drugs with a needle, but in fact she only used marijuana. There are conflicting notes about whether the patient was ever hospitalized for attempted suicide.

80. Patient 5's chart, similarly, listed the same indications, vitals, disposition, and other information over multiple visits. Medications were infrequently described in body of procedure notes. One note had physical exam findings for a different patient.

81. For all patients, respondent frequently failed to document the sedative medications administered and the quantity administered.

82. Dr. Helm opined these are extreme departures reflecting a lack of knowledge about medical recordkeeping.

83. Dr. Kwok testified that a treating physician must maintain adequate and accurate medical records. Even while making allowances for typical errors, medical records deficiencies prevent a reviewing physician from ascertaining respondent's competence.

84. Dr. Paicias testified that the medical records demonstrate that respondent is competent at diagnosing and treating patients. He also testified no doctor would have difficulties managing these six patients based on respondent's records. Respondent attributed the great majority of medical records errors and insufficiencies to faulty EMR software but agreed the records are respondent's responsibility.

85. The opinions of complainant's expert witnesses about respondent's recordkeeping are more persuasive than the opinion of Dr. Paicias.

Evidence of Mitigation and Rehabilitation

86. Respondent argued that the basis for the Board's investigation leading to the filing of the Accusation, a complaint made by a nurse whom respondent had temporarily employed, was motivated by racism.

87. The evidence shows that, when Majida Ibrahim, an investigator with the Division of Investigation, Health Quality Investigation Unit, interviewed the nurse, the nurse expressed prejudiced beliefs about respondent's religion. She "said she was hesitant in filing this complaint because she heard from others that Muslim physicians do not care about their patients. She also heard that Muslims can be violent and terrorist like." (Ex. 3, p. A63.)

88. The nurse's explicit prejudice calls into serious question her motive for filing a complaint with the Board. She damaged her credibility further in her testimony at this hearing, when she denied that she had expressed those sentiments to the investigator. Her denial is not credited.

89. Although at least one of the nurse's motives in bringing the complaint was her religious prejudice, Investigator Ibrahim proceeded to investigate the substance of her allegations. Investigator Ibrahim conducted interviews and a drug audit. He obtained respondent's medical records from respondent with some difficulty, and he interviewed respondent. During the investigation, Investigator Ibrahim found it necessary to suggest that respondent voluntarily submit to a mental examination because he had displayed "anger issues" in the course of the investigation.

90. As part of his investigation, Investigator Ibrahim sent the case file to Dr. Helm, acting as an expert consultant. Dr. Helm advised Investigator Ibrahim that respondent had engaged in multiple departures from the standard of care with respect to six patients.

91. Investigator Ibrahim completed an Investigation Report on June 10, 2020, and a supplemental report, conveying the results of his investigation. Complainant thereafter filed the Accusation.

92. At times during the hearing, respondent angrily suggested that the prosecution of this case was, like the nurse's complaint, motivated by prejudice, and that the charges against him were degrading, defamatory, and unfair. He testified the Deputy Attorney General is his "enemy" and is "trying to destroy" his career.

93. There is no basis on this record, however, for finding that either Investigator Ibrahim's conclusions with respect to respondent's treatment and care of the patients at issue here, Dr. Helm's opinions as a consultant to the investigation, complainant's decision to file an Accusation, the Deputy Attorney General's prosecution of the case, or the opinions of complainant's expert witnesses were animated by prejudice.

94. Respondent offered the testimony of two character witnesses and character reference letters from five patients.

95. The two character witnesses, Hussam Khatib and Salah Ali Eltantawi, testified they each have a business relationship with respondent and consider him a friend. They testified that respondent is ethical and generous and that he volunteers his time to the Muslim community in the San Gabriel area.

96. Respondent drafted identical or similar character reference letters for the patients in this case to sign. Those letters recite that the person signing the letter was respondent's patient, felt well cared for, was happy with respondent's treatment, believed respondent to have integrity and honor, and received "the best medical care I have ever had in my life." (See, e.g., exs. L, M, & N.) The fact that the letters were drafted by respondent, used hyperbolic language about the quality of care respondent provided, and in particular contained omissions pertinent to this matter (see Factual Findings 19-21, *ante*.) all lessen the letters' persuasive effect.

97. Respondent testified he has taken many steps to address the documentation issues raised in the First Amended Accusation. He voluntarily took three medical record keeping programs approved by the Board. As part of PACE and PBI courses, respondent submitted charts for review. Both programs gave him passing or superior grades. Respondent also completed many Continuing Medical Education (CME) courses. He took and completed a 55-hour American Society of Anesthesiology (ASA) CME course in anesthesiology, which respondent characterized as the "most extensive" such course "in the world." Respondent also recertified with the American Society of Anesthesiology in pain management last year. Respondent attended and completed CME courses sponsored by ASRA, which respondent characterized as the "most prominent authority in pain management." Respondent testified he has now completed four times the CME hours the Board requires, gratuitously adding that the Board is "a corrupt organization."

98. Respondent testified that he has modified his practices since the Accusation was filed. He has created a new written informed consent for every procedure. He has signed a contract with Athena, a medical records software

company, to replace the MRE software he has been using. The transition to the new software will, however, take another six months.

99. Respondent testified he now uploads information after every procedure. He has hired a full-time scribe to help him document patient visits, has begun using voice recognition software, and uses a Dictaphone to ensure there is redundancy. He recognizes the need to keep narcotic medical records for three years and has started to do so. He has hired a chaperone. He spends more time reviewing his charts and relies less on preprinted documentation. As a result of the Accusation filed against him, respondent has begun using an opioid risk tool as part of his patient intake form.

100. Respondent offered no documents, testimony, or declarations from anyone familiar with his medical practice to corroborate his testimony about modifications he has implemented.

101. Respondent testified he volunteers with a cancer survival group at Methodist Hospital, with Union Station in Pasadena to serve the homeless and mentally ill, and with the homeless team at Union Station on Skid Row in downtown Los Angeles as a pain consultant and for infusions. He is in the process of starting A Beautiful Mind, a nonprofit organization for ketamine infusions, because ketamine treatments are very expensive. He volunteers as an anesthesiologist with the Los Angeles County Disaster Response Team and with international relief organizations.

Costs

102. Complainant alleged costs of investigation in the amount of $1,777.50 and costs of prosecution in the amount of $27,930 plus expert costs of $4,523.50, for a total of $34,231.

103. Those costs are reasonable.

LEGAL CONCLUSIONS

Applicable Authority

104. The Board is responsible for enforcing the disciplinary provisions of the Medical Practice Act. (Bus. & Prof. Code, § 2004, subd. (a)). The Board's highest priority is to protect the public. (Bus. & Prof. Code, § 2229.) A certificated practitioner who violates the Medical Practice Act may have his or her certificate revoked or suspended or placed on probation, be publicly reprimanded, or have "other action taken in relation to discipline" as the Board deems proper. (Bus. & Prof. Code, § 2227.)

105. The Board may discipline a practitioner's certificate for unprofessional conduct, which includes, among other things, any violation of the Medical Practice Act, gross negligence, repeated negligent acts, incompetence, and failure to maintain adequate and accurate records of services provided to patients. (Bus. & Prof. Code, §§ 2234, subds. (a)-(c), 2261, 2266.)

106. The absence of any harm resulting from treatment does not determine whether a violation of the Medical Practice Act has occurred. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 578-579, *citing Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 949-950.)

107. "[A] physician is required to possess and exercise, in both diagnosis and treatment, that reasonable degree of knowledge and skill which is ordinarily possessed and exercised by other members of his profession in similar circumstances." (*Landeros v. Flood* (1976) 17 Cal. 3d 399, 408.) "The courts require only that physicians and

surgeons exercise in diagnosis and treatment that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Bardessono v. Michels* (1970) 3 Cal.3d 780, 788.)

108. The rigorous educational, training, and testing requirements for obtaining a physician's license justify imposing on complainant a burden of proof of clear and convincing evidence. (Evid. Code, § 115; *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856; *Imports Performance v. Department of Consumer Affairs, Bureau of Automotive Repair* (2011) 201 Cal.App.4th 911.)

Causes for Discipline

109. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (b), in that respondent committed gross negligence in the treatment and care of Patients 1 through 6, as set forth in Factual Findings 14 to 33.

110. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (c), in that respondent committed repeated negligent acts in the treatment and care of Patients 1 through 6, as set forth in Factual Findings 34 to 70.

111. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (d), in that respondent demonstrated incompetence, based upon his lack of knowledge, in his treatment and care of Patients 1 through 6, as set forth in Factual Findings 71 to 73.

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112. Cause exists to discipline respondent's certificate under Business and Professions Code section 2266, in that he failed to maintain adequate and accurate medical records for Patients 1 through 6, as set forth in Factual Findings 74 to 85.

Appropriate Discipline

113. "To the extent *not inconsistent with public protection*," disciplinary actions shall be calculated to aid in the rehabilitation of licensees. (Bus. & Prof. Code, § 2229, italics added.) To implement the mandates of section 2229, the Board has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines), 12th Edition, 2016." (Guidelines, p. 2.)

114. For gross negligence, repeated negligent acts, incompetence, and failure to maintain adequate records, under Business and Professions Code sections 2234, subdivisions (a) through (c), and 2266, respectively, the Guidelines recommend a minimum penalty of stayed revocation and five years' probation. The Guidelines may be departed from based on mitigating evidence and rehabilitation factors including early acceptance of responsibility and demonstrated willingness to undertake Board-ordered rehabilitation.

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115. It was established by clear and convincing evidence that respondent engaged in gross negligence, repeated negligent acts, incompetence, and failure to maintain adequate records. It was established by clear and convincing evidence that at least some of the care respondent provided to each of Patients 1 through 6 constituted repeated simple departures from the standard of care or demonstrated lack of knowledge. And respondent failed in numerous instances with respect to Patients 1 through 6 to maintain adequate records. (See Factual Findings 14 through

85.) These failures demonstrate that respondent repeatedly acted in violation of the Medical Practice Act and of statutory and regulatory provisions governing the professional practice of medicine.

116. Respondent also offered, at best, mixed testimony about taking responsibility for his failures. But as to the record keeping flaws, and some of the other deficiencies noted above, the record includes convincing evidence of respondent's attempts to work to correct software failures in his EMR system and to work with the EMR company in an effort to fix the system, all of which proved futile. This significantly mitigates the discipline recommended in the Guidelines. The coursework he has completed, too, will be accounted for in the Order that follows. Some mitigation is also credited based on respondent's testimony concerning changes to his practice, though not so much as might have been credited had respondent offered any corroboration.

117. The purpose of a disciplinary action such as this is to protect the public, not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) Accordingly, the Order that follows is both necessary and sufficient for the protection of the public.

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118. On this record, and in view of all the evidence, the safety of the public will be protected if respondent is placed on three years' probation with appropriate terms and conditions.

Costs of Investigation and Enforcement

119. Respondent may be ordered to pay the board "a sum not to exceed the reasonable costs of the investigation and enforcement of the case." (Bus. & Prof. Code,

§ 125.3.) The board incurred reasonable costs of investigation and enforcement in the amount of $34,231. (Factual Findings 102, 103.)

120. The California Supreme Court has established guidelines for determining whether costs should be assessed in light of the particular circumstances of each case. (*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32.) Some testimony concerning financial hardship was heard. Costs shall be paid according to a payment schedule approved by the Board.

ORDER

Physician's and Surgeon's Certificate No. A 89836, issued to respondent Sabri Elshenawy Malek, M.D., is revoked in consequence of the determination of the first, second, third, and fourth causes for discipline, separately and for all of them. The revocation is stayed, however, and respondent is placed on probation for three years on the following terms and conditions:

1. Notification

Within seven days of the effective date of this Decision, respondent shall provide a true copy of this Decision and First Amended 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 that 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 changes in hospitals, other facilities, or insurance carrier.

2. Supervision of Physician Assistants and Advanced Practice Nurses

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

3. 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.

4. 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.

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5. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and

telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

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

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

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

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

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6. 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.

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7. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

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

8. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, costs of investigation and enforcement, 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.

9. 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.

10. 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 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.

11. 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.

12. 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.

Courses taken after the acts that gave rise to the charges in the First Amended 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 courses would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

13. Medical Record Keeping Course

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

14. Costs of Investigation and Enforcement

Respondent shall pay the Board's costs of investigation and enforcement of this action in the amount of $34,231 according to a monthly payment plan approved by the Board.

DATE: 05/04/2022

Howard W. Cohen (May 4, 2022 11:34 PDT)

HOWARD W. COHEN

Administrative Law Judge

Office of Administrative Hearings

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

In the Matter of the First Amended Accusation Against: **SABRI ELSHENAWY MALEK, M.D.** **3814 Elma Road** **Pasadena, CA 91107** **Physician's and Surgeon's Certificate No. A 89836,** Respondent.	Case No. 800-2019-054129 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended 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 January 12, 2005, the Board issued Physician's and Surgeon's Certificate Number A 89836 to Sabri Elshenawy Malek, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2022, unless renewed.

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JURISDICTION

3. This First Amended Accusation is brought before the Board under the authority of the following provisions of the Business and Professions Code (Code) unless otherwise indicated

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. 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.

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(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.

6. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

(g) The failure by a certificate holder, in the absence of good cause, to attend

and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

7. 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.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

8. Code section 4021 states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

9. Code section 4022 provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

COST RECOVERY

10. Business and Professions Code section 125.3 states that:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FACTUAL ALLEGATIONS

Patient 1.[1]

11. Patient 1, a 60-year-old, first presented to Respondent at Interventional Anesthesia & Pain Management Clinic (the clinic) for a pain management consultation on June 2, 2018 with complaints of back and neck pain. Her medical history was noted to be significant for fibromyalgia and depression. Upon examination, Respondent noted that Patient 1 was in mild distress with a stiff and tender cervical spine and tenderness to palpation along the cervical and lumbar facet regions. She had decreased C-spine and L-spine range of motion, with trigger points

[1] For privacy purposes, the patients in this First Amended Accusation are referred to as Patients 1 through 6.

noted along the her head and neck muscles, a positive Faber test[2] with tenderness to palpation of the left sacroiliac joint, and tenderness to palpation over the right anterior acromioclavicular joint and rotator cuff.

12. Respondent noted a diagnosis of chronic back pain, myalgia, neck pain, cervical degenerative disc disease and osteoarthritis. An order for a urine drug screen with patient's name dated June 2, 2018 was present in Patient 1's medical records but no drug screen results were noted. There were no printed CURES Report[3] in Patient 1's medical records nor any documentation reflecting that Respondent reviewed her CURES Report. Patient 1 signed a Policy Statement[4] and a Pain Management Treatment Program/Chronic Pain Medication Agreement. Respondent noted that Patient 1 was taking hydrocodone[5] but there was no reference to its efficacy, dose or side effects. Respondent prescribed 90 tablets of prescribed Norco 10/325 mg,[6]

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[2] Faber test, also known as Patrick's test, is used to identify the presence of hip pathology by attempting to reproduce pain in the hip, lumbar spine or sacroiliac region.

[3] CURES is the Controlled Substance Utilization Review and Evaluation System which stores Schedule II, III and IV controlled substance prescription information reported as dispensed in California. Prescribers authorized to prescribe, order, administer, furnish, or dispense Schedule II, III, or IV controlled substances, and pharmacists, may access CURES data for patient care purposes.

[4] The Policy Statement sets forth "WE ARE NOT A NARCOTIC CLINIC, WE DO NOT PRESCRIBE NARCOTICS. WE ARE A PAIN MANAGEMENT CLINIC. WE TREAT PAIN!..Pain therapy may also include Medical Management (**especially opioids and other controlled substances regulated by the DEA, state, and federal laws**) which we do not offer or provide, besides in the form of advice ailments and as the providers in our practice see best for your care…" The Policy Statement further sets forth "Our clinic policy is to keep the patient for thirty minutes after the procedure is done because the patient receives a local anesthetic which paralyzes the movement to some extent and can result in lack of control. We ask the patient to wait for thirty minutes if they have a driver and an hour if they are driving themselves."

[5] Hydrocodone, a semisynthetic opioid, in combination with acetaminophen is a Schedule II Controlled Substance and a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Norco, a brand name for hydrocodone-acetaminophen, is a narcotic pain medication. It is a Schedule II Controlled Substance and a dangerous drug pursuant to Business and Professions Code section 4022.

90 tablets of Soma 350 mg,[7] 30 tablets of Pamelor 25 mg,[8] 60 tablets of Naprosyn 250 mg.[9] She was referred to physical therapy and prescribed multiple braces. Patient 1 was instructed to return to the clinic for right and left medial branch nerve blocks, right epidural steroid injection, and left sacroiliac joint injection.

13. Throughout Patient 1's care with Respondent, she was prescribed 90 tablets of Norco and 90 tablets of Soma on a monthly basis. Patient 1's medical records do not contain any drug screen results or CURES Reports.

14. Patient 1 underwent multiple interventional pain management procedures[10] while under Respondent's care.

15. On July 7, 2018, Patient 1 underwent left C5-7 medial branch nerve blocks and a left sacroiliac injection. Respondent documented that "written informed consent was obtained." Patient 1's medical records do not contain a consent for the July 7, 2018 procedure. Patient 1's pre-operative and post-operative diagnosis was noted to be cervical facet arthropathy and sacroiliac joint arthropathy. Anesthesia was noted to be conscious sedation[11] without any description of its administration. At the bottom of the note, under the heading HCPC Codes,[12] Respondent set forth: "Injection, midazolam hydrochloride,[13] per 1 mg (J2250)" and "Injection,

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[7] Soma, a brand name for carisoprodol, is a muscle relaxant. It is a Schedule IV Controlled Substance and a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Pamelor, a brand name for Nortriptyline HCI is used in the treatment of depression; vulvodynia; primary nocturnal enuresis and belongs to the drug class tricyclic antidepressants. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Naprosyn is a nonsteroidal anti-inflammatory drug used to treat pain or inflammation. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[10] Interventional pain management procedures refers, in general, to various percutaneous or minor surgical procedures targeting specific anatomical structures identified as possible sources of pain.

[11] Conscious sedation is a combination of a sedative and an anesthetic during a medical procedure.

[12] HCPC stands for the Healthcare Common Procedure Coding. It is a standardized code system necessary for medical providers to submit healthcare claims to Medicare and other health insurances.

[13] Midazolam hydrochloride, also known by the brand name Versed, is used for sedation. It is a Schedule IV Controlled Substance and a dangerous drug pursuant to Business and Professions Code section 4022.

Triamcinolone Acetonide,[14] not otherwise specified, 10 mg (J3301)." Respondent documented that vital signs were observed throughout the procedure and remained stable but no vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 1's medical records. There is no documentation reflecting medical clearance for Patient 1 to leave the clinic following the procedure.

16. On August 20, 2018, Patient 1 underwent left medial branch nerve blocks. The procedure note reflects that the procedure was performed at the left C1 level but the procedure of and billing data suggest that the procedure was done at the C5-7 levels. Respondent documented that "written informed consent was obtained." Patient 1's medical records do not contain a consent for the August 20, 2018 procedure. Patient 1's pre-operative and post-operative diagnoses were cervical and lumbar facet arthropathy. Anesthesia was noted to be conscious sedation. The conscious sedation was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Codes, Respondent set forth: "Injection Midazolam Hcl Per 1 Mg (J2250), "kenalog[15] 10 Mg (J3301)" and "Injection Ketorolac Tromethamine[16] Per 15 Mg (J1885)." Respondent documented that there was pulse oximetry, electrocardiogram and blood pressure monitoring; however, there was no documentation of pulse oximetry, electrocardiogram and blood pressure readings during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 1's medical records. There is no documentation reflecting medical clearance for Patient 1 to leave the clinic following the procedure.

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[14] Triamcinolone Acetonide is a corticosteroid used to reduce swelling, redness, itching, and allergic reactions.

[15] Kenalog contains Triamcinolone and is used to reduce swelling, redness, itching, and allergic reactions.

[16] Ketorolac Tromethamine is a nonsteroidal anti-inflammatory drug (NSAID) that is used to treat moderately severe pain and inflammation, usually after surgery.

17. On November 17, 2018, Patient 1 underwent a cervical epidural steroid injection. Respondent documented that "written informed consent was obtained." Patient 1's medical records do not contain a consent for the November 17, 2018 procedure. Patient 1's pre-operative and post-operative diagnosis was cervical spondylosis. Anesthesia was noted to be conscious sedation. The conscious sedation was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg and ketorolac. Respondent noted that supplemental oxygen was delivered as needed but did not document the patient's oxygen saturation level at any point during the procedure or document why supplemental oxygen was needed. Respondent documented that vital signs were observed throughout the procedure and remained stable but no vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 1's medical records. There is no documentation reflecting medical clearance for Patient 1 to leave the clinic following the procedure.

18. On January 3, 2019, Patient 1 underwent trigger point injections. Respondent documented that "written informed consent was obtained." Patient 1's medical records do not contain a consent for the January 3, 2019 procedure. Patient 1's pre-operative and post-operative diagnoses were noted to be muscle spasm, myalgia, myositis and neck disorder. Anesthesia was noted to be local. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent noted that the patient tolerated the procedure well with no complications and that she was discharged home after 15 minutes. There are no written discharge instructions in Patient 1's medical records. There is no documentation reflecting medical clearance for Patient 1 to leave the clinic following the procedure.

19. On February 2, 2019, Patient 1 underwent right C5-7 medial branch nerve blocks. Respondent documented that "written informed consent was obtained." Patient 1's medical records do not contain a consent for the February 2, 2019 procedure. Patient 1's pre-operative

and post-operative diagnosis was cervical facet arthropathy. Anesthesia was noted to be conscious sedation. The conscious sedation was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent noted that the procedure was done at the right C5, C6 and C7 levels and that a "similar procedure was repeated at C1-2."[17] Respondent noted that vital signs remained stable throughout the procedure but no vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 1's medical records. There is no documentation reflecting medical clearance for Patient 1 to leave the clinic following the procedure.

20. On March 1, 2019, Patient 1 underwent radiofrequency ablation of the right C4-7 medial branch nerves. Respondent documented that "written informed consent was obtained." Patient 1's medical records do not contain a consent for the March 1, 2019 procedure. Patient 1's pre-operative and post-operative diagnosis was cervical facet arthropathy. Anesthesia was noted to be conscious sedation. The conscious sedation was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg and ketorolac. Respondent noted that vital signs remained stable throughout the procedure but no vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well and that there were no apparent complications. There is no documentation in Patient 1's medical records reflecting medical clearance to leave the clinic following the procedure.

21. On May 3, 2019, Patient 1 underwent left C5-7 medial branch nerve blocks. Respondent documented that "written informed consent was obtained." Patient 1's medical records do not contain a consent for the May 3, 2019 procedure. Patient 1's pre-operative and post-operative diagnosis was cervical facet arthropathy. Anesthesia was noted to be local and conscious sedation. The conscious sedation was not described in the body of the procedure note.

[17] The procedure log and billing data suggest that the procedure was done at the right C5-7 levels.

At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg and ketorolac. Respondent noted that vital signs remained stable throughout the procedure but no vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 1's medical records. There is no documentation reflecting medical clearance for Patient 1 to leave the clinic following the procedure.

22. On June 8, 2019, Respondent noted that Patient 1 was discharged from his practice for drug seeking behavior and abusive behavior towards Respondent's staff.

Patient 2.

23. Respondent's medical records for Patient 2 contains both general clinic notes and worker's compensation reports and evaluations. Patient 2, a 56-year-old female, first presented to Respondent on May 30, 2018, for a worker's compensation evaluation related to cumulative trauma from April 19, 2017 through April 19, 2018. Patient 2 complained of back, neck, arm and foot pain. In Respondent's general clinic note, he documented that Patient 2's medical history was significant for asthma, high cholesterol, hypertension, diabetes and obesity.[18] In Respondent's correspondence worker's compensation note, he documented that she was diagnosed with fibromyalgia, lumbar and cervical facet arthropathy, polyarthritis of the bilateral upper extremities, and myofascial pain. The physical examination findings documented in Respondent's general clinic note reflects that Patient 2 had cervical spine tenderness to palpation. The physical examination findings in the worker's compensation note reflects multiple abnormalities including decreased cervical and lumbar spine range of motion, cervical and lumbar spine tenderness to palpation, decreased reflexes throughout, weakness in the upper and lower extremities, decreased sensation along the left C6 dermatone. No imaging studies were available

[18] A majority of Respondent's progress notes for Patient 2 reflect a weight of 250 pounds. Physical examination findings reflected not that she is not an obese person and other occasions, that she is an obese person.

for review. She was prescribed 60 tablets of Lyrica[19] 75 mg. She was referred to physical therapy and prescribed back brace. She was advised to return to clinic for lumbar medial branch nerve blocks and sacroiliac joint injection.

24. Patient 2's subsequent visits to Respondent led to additional diagnoses of cervical radiculopathy and peripheral neuropathy. She underwent an additional medication trial of Norco, Naprosyn and gabapentin.[20] There is no documentation in Patient 2's medical records of any discussion regarding the risks and benefits of using controlled substances nor does Patient 2's medical records contain a signed opioid pain medication agreement. There is no documentation of a referral for imaging studies.

25. Patient 2 underwent multiple interventional pain management procedures while under Respondent's care.

26. On June 27, 2018, Patient 2 underwent trigger point injections under local anesthesia. Her pre-operative and post-operative diagnoses were muscle spasm, myalgia, myositis and neck disorder. Respondent documented that "written informed consent was obtained." Patient 2's medical records do not contain a consent for the June 27, 2018 procedure. The local anesthesia used was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 2's medical records. There is no documentation reflecting medical clearance for Patient 2 to leave the clinic following the procedure.

27. On July 9, 2018, Patient 2 underwent a left sacroiliac joint injection under conscious sedation. Her pre-operative and post-operative diagnosis was sacroiliac joint arthropathy.

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[19] Lyrica, a brand name for pregabalin, is a prescription medication used to treat neuropathic pain. It is a Schedule V Controlled Substance and a dangerous drug pursuant to Business and Professions Code section 4022.

[20] Gabapentin, also known by the brand name Neurontin, is a prescription pain medication commonly used to treat nerve pain. It is a dangerous drug pursuant to Business and Professions Code section 4022.

Respondent documented that "written informed consent was obtained." Patient 2's medical records do not contain a consent for the July 9, 2018 procedure. The conscious sedation was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent noted that vital signs remained stable throughout the procedure but no vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 2's medical records. There is no documentation reflecting medical clearance for Patient 2 to leave the clinic following the procedure.

28. On August 8, 2018, Patient 2 underwent left C5-7 medial branch nerve blocks under conscious sedation. Her pre-operative and post-operative diagnoses was cervical facet arthropathy and syndrome. Respondent documented that "written informed consent was obtained." Patient 2's medical records do not contain a consent for the August 8, 2018 procedure. The conscious sedation was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent noted that vital signs remained stable throughout the procedure but no vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 2's medical records. There is no documentation reflecting medical clearance for Patient 2 to leave the clinic following the procedure.

29. On December 10, 2018, Patient 2 underwent right C5-6 and C6-7 cervical epidural steroid injections under conscious sedation. Her pre-operative diagnoses were cervical spondylosis and radiculopathy. Respondent documented that "written informed consent was obtained." Patient 2's medical records do not contain a consent for the December 10, 2018 procedure. The conscious sedation was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of

midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent documented that pulse oximetry, electrocardiogram and blood pressure monitoring was done; however, there is no documentation of pulse oximetry, electrocardiogram and blood pressure readings. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 2's medical records. There is no documentation reflecting medical clearance for Patient 2 to leave the clinic following the procedure.

30. On January 24, 2019, Patient 2 underwent trigger point injections under local anesthesia. Her pre-operative and post-operative diagnosis was spinal enthesopathy. Respondent documented that "written informed consent was obtained." Patient 2's medical records do not contain a consent for the January 24, 2019 procedure. The local anesthesia was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent noted that the patient tolerated the procedure well, there were no complications and she was discharged home after 15 minutes.

31. Patient 2 also underwent a ketamine infusion[21] on January 24, 2019 for fibromyalgia. Respondent noted that the patient tolerated the procedure well, she was taken to the recovery area where written discharge instructions for the procedure were given. There are no written discharge instructions in Patient 2's medical records. There is no documentation reflecting medical clearance for Patient 2 to leave the clinic following the procedure.

32. On March 1, 2019, Patient 2 underwent bilateral C1-2 cervical epidural steroid injections. Respondent documented that "written informed consent was obtained." Patient 2's medical records do not contain a consent for the March 1, 2019 procedure. Patient 2's pre-

[21] Ketamine infusion therapy involves the administration of a single infusion or a series of infusions for the management of psychiatric disorders and symptoms of depression. Ketamine is a noncompetitive N-methyl-D-aspartate (NMDA) receptor antagonist that has traditionally been used for the induction and maintenance of anesthesia. It is a Schedule III Controlled Substance and a dangerous drug pursuant to Business and Professions Code section 4022.

operative and post-operative diagnoses were cervical radiculopathy, cervical degenerative disc disease and cervical disc herniation. Anesthesia was noted to be monitored anesthesia care and conscious sedation. The conscious sedation was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg and ketorolac. Respondent noted that vital signs remained stable throughout the procedure but no vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 2's medical records. There is no documentation reflecting medical clearance for Patient 2 to leave the clinic following the procedure.

33. Respondent documented discharging Patient 2 from his practice on May 17, 2019 due to a lack of response to treatment.

Patient 3.

34. Patient 3, a 70-year-old male, presented to Respondent for an initial consultation on January 23, 2019 with a chief complaint of shoulder pain. Respondent noted that Patient 3 was being seen as a worker's compensation patient with a date of injury of September 14, 2015. Patient 3 reported tripping and falling while working in the maintenance department at the San Gabriel County Club. He had additional complaints of pain in the head, arm, wrist and fingers, though only his left shoulder was part of the worker's compensation claim. Respondent noted that Patient 3's medical history was significant for hyperlipidemia and two shoulder surgeries. Respondent noted that Patient 3's physical examination was remarkable for left sided facet tenderness to palpation, decreased C-spine range of motion with pain and spasm, diminished reflexes of the left upper extremity with left greater than right upper extremity motor weakness, hyperalgesia along the left C5-7 dermatomes and decreased range of motion of the left wrist. Respondent diagnosed Patient 3 with shoulder pain, possible facet arthritis, complex regional pain syndrome, chronic headache, and cervicalgia.

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35. Respondent prescribed 90 tablets of gabapentin 100 mg and 60 tablets of Celebrex[22] 100 mg. Patient 3 was referred to physical therapy, prescribed a cervical brace, and advised to return to the clinic for a left stellate ganglion block. Patient 3 signed a Policy Statement[23] and a Pain Management Treatment Program/Chronic Pain Medication Agreement.

36. On March 1, 2019, Patient 3 underwent a left C7 stellate ganglion block. Respondent documented that "informed consent was obtained." Patient 3's medical records do not contain a consent for the March 1, 2019 procedure. Patient 3's pre-operative and post-operative diagnosis was noted to be reflex sympathetic dystrophy (RSD) of the upper limb. Anesthesia was noted to be conscious sedation. The procedure note documented that a total of 2 mg of Versed was administered. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of Fentanyl Citrate[24] 0.1 mg, midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg and ketorolac. Respondent noted that there were no complications and that "the patient was kept in the clinic for an additional 30 mins for monitoring with no sequelae noted." No vital signs were noted and there was no documentation reflecting medical clearance for Patient 3 to leave the clinic following the procedure.

37. On March 14, 2019, Patient 3 underwent a left C7 stellate ganglion block. Respondent documented that "informed consent was obtained." Patient 3's medical records do not contain a consent for the March 14, 2019 procedure. Patient 3's pre-operative and post-operative diagnoses were noted to be RSD of the upper limb. Anesthesia was noted to be conscious sedation. The procedure note reflects that a total of 2 mg of Versed was administered. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of Fentanyl Citrate 0.1 mg, midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg and ketorolac. Respondent noted that there were no complications and that "the patient was kept in

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[22] Celebrex, a brand name for celecoxib, is a nonsteroidal anti-inflammatory drug (NSAID) used for pain relief. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[23] See footnote 4.

[24] Fentanyl Citrate is an opioid pain medication used during anesthesia for surgery. It is a Schedule II Controlled Substance and a dangerous drug pursuant to Business and Professions Code section 4022.

the clinic for an additional 30 mins for monitoring with no sequelae noted." No vital signs were noted and there was no documentation reflecting medical clearance for Patient 3 to leave the clinic following the procedure.

Patient 4.

38. Patient 4, a then 50-year-old female, presented to Respondent on February 28, 2019 for a consultation and evaluation for a ketamine infusion. She complained of anxiety and depression. Her medical history was significant for major depressive disorder, attempted suicide and anxiety. Respondent documented that Patient 4 had numerous treatments for her depression including electroconvulsive therapy, multiple anti-depressants, and transcranial magnetic stimulation. Upon physical examination, Respondent noted that Patient 4 was in moderate distress, depressed and had anxiety. Respondent diagnosed Patient 4 with depression and anxiety. Patient 4 signed a Policy Statement[25] and a Pain Management Treatment Program/Chronic Pain Medication Agreement.

39. Patient 4 underwent 11 ketamine infusions between February 28, 2019 to November 7, 2019.[26]

40. The first ketamine infusion therapy notes a pre-operative diagnosis of fibromyalgia. The remaining 10 ketamine infusion therapy procedure noted a pre-operative diagnosis of depression.

41. There is no consent specific to ketamine infusion therapy in Patient 4's medical records. Respondent failed to document any discussions with Patient 4 regarding the risks, benefits and alternatives to treatment. Patient 4's medical records do not document any discharge procedures for releasing Patient 4 from Respondent's care following each of the ketamine infusions.

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[25] See footnote 4.

[26] The ketamine infusions took place on February 28, 2019, March 1, 2019, March 3, 2019, March 6, 2019, March 8, 2019, March 13, 2019, March 27, 2019, June 12, 2019, August 27, 2019, October 1, 2019, and November 7, 2019.

Patient 5.

42. Patient 5, a then 50-year-old female, presented to Respondent on September 21, 2017 for an initial consultation. She complained of hand, shoulder and back pain. She was referred to Respondent by Dr. R.A. for possible complex regional pain syndrome following shoulder arthroscopic surgery for partial rotator cuff tear.

43. Patient 5's medical history was noted to be significant for scoliosis, arthritis and thyroid disorder. With respect to Patient 5's physical examination, Respondent noted that she had crepitus over the left wrist joint, tender to palpation over the left wrist, positive effusion over the left wrist, instability and decreased range of motion of the left wrist along with an anxious and sad mood. Respondent further noted that he suspected fracture from reviewing the MRI. Respondent documented the following diagnoses: complex regional pain syndrome type I, arthritis, lumbar and cervical facet joint pain, myofascial pain, hand and joint pain and chronic back pain. Respondent noted that the patient was participating in physical therapy. Patient 5 signed a Policy Statement[27] and a Pain Management Treatment Program/Chronic Pain Medication Agreement. Respondent obtained a CURES Report for the previous 12 months. Respondent prescribed 60 tablets of Norco 5/325 mg, 60 tablets of Tramadol[28] 50 mg, 90 tablets of Neurontin 100 mg, 30 tablets of Neurontin 300 mg, 30 tablets of Pamelor 25 mg, and topical lidocaine numbing cream. Injection therapy was not documented in Patient 5's initial visit plan.

44. Throughout the course of her care by Respondent, Patient 5 was prescribed 60 tablets of Norco 5/235 mg and 60 tablets of Tramadol 50 mg on multiple occasions.

45. Patient 5 underwent multiple interventional pain management procedures while under Respondent's care.

46. On October 12, 2017, Patient 5 underwent a left stellate ganglion block. Respondent documented that "informed consent was obtained." Patient 5's medical records do not contain a consent for the October 12, 2017 procedure. Patient 5's pre-operative and post-operative

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[27] See footnote 4.

[28] Tramadol is a synthetic pain medication used to treat moderate to moderately severe pain. It is a Schedule IV Controlled Substance and a dangerous drug pursuant to Business and Professions Code section 4022.

diagnoses were noted to be RSD of the upper limb. Anesthesia was noted to be conscious sedation. The procedure note documented that a total of 2 mg of Versed was administered. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent noted that there were no complications and that "the patient was kept in the clinic for an additional 30 mins for monitoring with no sequelae noted." No vital signs were noted and there was no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

47. On November 13, 2017, Patient 5 underwent an ultrasound guided right T1-4 intercostal nerve block.[29] Respondent noted a detailed and informed consent for the procedure was obtained in writing. Patient 5's medical records do not contain a consent for the November 13, 2017 procedure. Patient 5's pre-operative and post-operative diagnosis was noted to be intercostal neuralgia. The patient's medical records do not include documentation of a history of post-herpetic neuralgia, pain along the thoracic dermatomes or history of rib fractures or rib trauma. Sedation was not described in the body of the procedure note. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg, ondanstetron hydrochloride,[30] per 1 mg and ketorolac. No vital signs were documented during the procedure. It was noted that the patient was discharged home with suitable verbal and written instructions. There are no written discharge instructions in Patient 5's medical records. There is no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

48. On December 2, 2017, Patient 5 underwent a left stellate ganglion block. Respondent documented that "informed consent was obtained." Patient 5's medical records do not contain a consent for the December 2, 2017 procedure. Patient 5's pre-operative and post-operative

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[29] An intercostal nerve block is used for defining potential sources of pain in the chest and abdominal wall as well as relieving pain in the chest area. Intercostal nerves are located under each rib.

[30] Ondansetron hydrochloride, also known by the brand name Toradol, is an antiemetic medication used to prevent nausea and vomiting. It is a dangerous drug as defined in Business and Professions code section 4022.

diagnosis was RSD of the upper limb. Anesthesia was noted to be conscious sedation. The procedure note documented that a total of 2 mg of Versed was administered. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg, ketorolac and ondansetron hydrochloride. Respondent noted that there were no complications and that "the patient was kept in the clinic for an additional 30 mins for monitoring with no sequelae noted." No vital signs were noted and there was no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

49. On December 9, 2017, Patient 5 underwent a left sacroiliac joint injection. Respondent documented that "written informed consent was obtained." Patient 5's medical records do not contain a consent for the December 9, 2017 procedure. Patient 5's pre-operative and post-operative diagnosis was noted to be sacroiliitis. Anesthesia was noted to be conscious sedation. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg, ketorolac and ondansetron and dexamethasone sodium phosphate,[31] 1 mg. No vital signs were noted. As part of the procedure note, Respondent set forth that "the patient was taken to the recovery area where written discharge instructions for the procedure were given." There are no written discharge instructions in Patient 5's medical records. There is no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

50. On December 16, 2017, Patient 5 underwent a trigger point injection. Respondent documented that "written informed consent was obtained." Patient 5's medical records do not contain a consent for the December 16, 2017 procedure. Patient 5's pre-operative and post-operative diagnoses were noted to be muscle spasm, myalgia, myositis and backache. Anesthesia was noted to be local. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg, ketorolac and ondansetron and dexamethasone sodium phosphate, 1 mg. Respondent noted that the patient tolerated the procedure well, there were no complications and she was discharged

[31] Dexamethasone sodium phosphate is a corticosteroid.

home after 15 minutes. No vital signs were documented following the procedure and there is no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

51. On January 13, 2018, Patient 5 underwent trigger point injections. Respondent documented that "written informed consent was obtained." Patient 5's medical records do not contain a consent for the January 13, 2018 procedure. Patient 5's pre-operative and post-operative diagnoses were noted to be muscle spasm, myalgia, myositis, back ache and neck disorder. Anesthesia was noted to be local. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent noted that the patient tolerated the procedure well, there were no complications and she was discharged home after 15 minutes. No vital signs were documented following the procedure and there is no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

52. On April 19, 2018, Patient 5 underwent a left stellate ganglion block. Respondent documented that "informed consent was obtained." Patient 5's medical records do not contain a consent for the April 19, 2018 procedure. Patient 5's pre-operative and post-operative diagnosis was noted to be RSD of the upper limb. Anesthesia was noted to be conscious sedation. The procedure note reflects that a total of 2 mg of Versed was administered. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg, ketorolac and ondansetron hydrochloride. Respondent noted that there were no complications and that "the patient was kept in the clinic for an additional 30 mins for monitoring with no sequelae noted." No vital signs were documented following the procedure and there is no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

53. On June 9, 2018, Patient 5 underwent a left sacroiliac joint injection. Respondent documented that "written informed consent was obtained." Patient 5's medical records do not contain a consent for the June 9, 2018 procedure. Patient 5's pre-operative and post-operative diagnosis was sacroiliac joint arthroplasty. Anesthesia was noted to be conscious sedation. At

the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg, and intramuscular injection of Toradol. Respondent noted that vital signs remained stable throughout the procedure but no vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 5's medical records. There is no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

54. On July 14, 2018, Patient 5 underwent lumbar medial branch nerve blocks. Respondent documented that "written informed consent was obtained." Patient 5's medical records do not contain a consent for the July 14, 2018 procedure. Patient 5's pre-operative and post-operative diagnosis was lumbar facet arthropathy. Anesthesia was noted to be conscious sedation. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg and ketorolac. No vital signs were documented during the procedure. Respondent noted that the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 5's medical records. There is no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

55. On March 1, 2019, Patient 5 underwent a left stellate ganglion block. Respondent documented that "an informed consent was obtained." Patient 5's medical records do not contain a consent for the March 1, 2019 procedure. Patient 5's pre-operative and post-operative diagnosis was noted to be RSD in the upper limb. Anesthesia was noted to be conscious sedation. The procedure note reflects that a total of 2 mg of Versed was administered. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of Fentanyl Citrate 0.1 mg, midazolam hydrochloride, per 1 mg, triamcinolone acetonide, 10 mg, and ketorolac. Respondent noted that there were no complications and that "the patient was kept in the clinic for an additional 30 mins for monitoring with no sequelae noted." No vital signs were documented

following the procedure and there is no documentation reflecting medical clearance for Patient 5 to leave the clinic following the procedure.

Patient 6.

56. Patient 6, a then 74-year-old female, presented to Respondent on March 1, 2019 for an initial consultation with Respondent. She complained of bilateral leg, back and hip pain. She was referred to Respondent by K.K., PA-C of Orthopedic Center Medical Group for consideration of right hip intra-articular joint injection for severe right hip osteoarthritis.

57. Respondent noted that Patient 6's medical history was significant for high cholesterol. A review of Patient 6's medication list and record from the orthopedist reveals that her medical history also included hypertension, osteoporosis, gout and severe hip osteoarthritis. Respondent noted that Patient 6's physical examination was remarkable for abnormalities in the C-spine and L-spine with a positive Patrick's test. There is no documentation of an examination of hip range of motion or hip pain with motion. There is no documentation of imaging studies being reviewed. Respondent diagnosed Patient 6 with impaired ambulation, chronic back pain, peripheral neuropathy, hip contusion, knee pain, shoulder pain and neck pain. Respondent prescribed 60 tablets of Tramadol, 50 mg and 60 tablets of Naprosyn, 250 mg. Patient 6 signed a Policy Statement[32] and a Pain Management Treatment Program/Chronic Pain Medication Agreement. Respondent recommended physical therapy, a back brace, and electric scooter.

58. On May 2, 2019, Patient 6 returned to Respondent's clinic for a right lumbar transforaminal injection at L3-4, L4-5 and L5-S1. Respondent documented that written informed consent was obtained for the procedure; however, Patient 6's medical records do not contain a consent for the May 2, 2019 procedure. Patient 6's pre-operative and post-operative diagnoses were lumbar radiculopathy, lumbar degenerative disease, and failed back surgery syndrome. Anesthesia was noted to be conscious sedation. At the bottom of the note, under the heading HCPC Code, Respondent referenced injections of midazolam hydrochloride, per 1 mg and triamcinolone acetonide, 10 mg. Respondent noted that vital signs remained stable throughout the procedure but no vital signs were documented during the procedure. Respondent noted that

[32] See footnote 4.

the patient tolerated the procedure well with no complications and that she was given written discharge instructions for the procedure. There are no written discharge instructions in Patient 6's medical records. There is no documentation reflecting medical clearance for Patient 6 to leave the clinic following the procedure.

59. That same day, Respondent filled out a therapy continuation request from Humana Pharmacy prescribing 60 tablets of Tramadol, 50 mg.

STANDARD OF CARE

60. When prescribing controlled substances for chronic pain, the standard of care requires that the physician perform a history and physical examination; develop and document a treatment plan and objectives; assess the potential benefits and risks of the medications and discuss the potential risks and benefits with the patient; perform periodic reviews of the course of pain treatment and make modifications in treatment based on the patient's progress or lack of progress; consider obtaining additional evaluations and consultations; and, maintain accurate and complete records. The medical records must demonstrate a history and examination along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed and periodic review documentation.

61. When a physician performs an interventional pain management procedure, the standard of care requires a medical indication or justification for the procedure. The medical indication and justification for the procedure must be documented in the patient's medical records.

62. When performing an interventional pain management procedure, the standard of care requires that the physician discuss the risk, benefits and alternative methods of treatment with the patient and obtain the patient's written consent for the specific procedure. Each interventional pain management procedure has unique risks, benefits and alternatives that must be discussed with the patient.

63. When performing an interventional pain management procedure, the standard of care requires that the physician monitor the patient during the procedure and maintain documentation of vital signs and medications being administered during the procedure. The physician is required

to prepare a report of how the procedure was performed, including a contemporaneous account of the findings and subsequent treatment which allows the reader of the report to reconstruct the events that occurred during the procedure.

64. When performing an interventional pain management procedure with conscious sedation, the standard of care requires that the physician evaluate the patient's suitability for discharge following the procedure and document the post-operative examination confirming the patient's suitability for discharge.

65. The standard of care requires that the physician maintain accurate and complete medical records, demonstrating a history of exam along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed and periodic review documentation.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

66. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed gross negligence in his care and treatment of six patients. Complainant refers to and, by this reference, incorporates herein, paragraphs 11 through 59, 62, and 64, above, as though fully set forth herein. Respondent committed the following acts of gross negligence:

Patient 1.

67. Respondent failed to evaluate Patient 1's suitability for discharge and failed to document a post-operative examination confirming Patient 1's suitability for discharge following the interventional pain management procedures performed on June 7, 2018, August 20, 2018, November 17, 2018, January 3, 2019, February 2, 2019, March 1, 2019, and May 3, 2019.

Patient 2.

68. Respondent failed to evaluate Patient 2's suitability for discharge and failed to document a post-operative examination confirming Patient 2's suitability for discharge following the interventional pain management procedures performed on June 27, 2018, July 9, 2018, August 8, 2018, December 10, 2018, January 24, 2019, and March 1, 2019.

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Patient 3.

69. Respondent failed to evaluate Patient 3's suitability for discharge and failed to document a post-operative examination confirming Patient 3's suitability for discharge following the interventional pain management procedures performed on March 1, 2019 and March 14, 2019.

Patient 4.

70. Respondent failed to discuss the risk, benefits and alternative methods of treatment with the patient and obtain the patient's written consent before initiating Patient 4's 11 ketamine infusions during the timeframe of February 28, 2019 to November 7, 2019.

71. Respondent failed to evaluate Patient 4's suitability for discharge and failed to document a post-operative examination confirming Patient 4's suitability for discharge following Patient 4's 11 ketamine infusions performed between February 28, 2019 to November 7, 2019.

Patient 5.

72. Respondent failed to evaluate Patient 5's suitability for discharge and failed to document a post-operative examination confirming Patient 5's suitability for discharge following the interventional pain management procedures performed on October 12, 2017, November 13, 2017, December 2, 2017, December 9, 2017, December 16, 2017, January 13, 2018, April 19, 2018, June 9, 2018, July 14, 2018, and March 1, 2019.

Patient 6.

73. Respondent failed to evaluate Patient 6's suitability for discharge and failed to document a post-operative examination confirming Patient 6's suitability for discharge following the interventional pain management procedure performed May 2, 2019.

74. Respondent's acts and/or omissions as set forth in paragraphs 11 through 59, 62, 64, and, 66 through 73, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

75. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he committed repeated negligence acts with respect to his care and treatment of six patients. Complainant refers to and, by this reference, incorporates herein, paragraphs 11 through 74, above, as though fully set forth herein. The circumstances are as follows:

76. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a repeated negligent act.

77. Respondent committed the following repeated acts of negligence:

Patient 1.

78. On or about June 2, 2018, and thereafter, Respondent committed the following acts, individually and/or collectively, of negligence, in connection with his treatment and care of Patient 1, as follows:

79. Respondent failed to obtain Patient 1's informed consent prior to performing interventional pain management procedures on June 7, 2018, August 20, 2018, November 17, 2018, January 3, 2019, February 2, 2019, March 1, 2019, and May 3, 2019.

80. Respondent failed to document Patient 1's vital signs and medications administered during the interventional pain management procedures performed on June 7, 2018, August 20, 2018, November 17, 2018, January 3, 2019, February 2, 2019, March 1, 2019, and May 3, 2019.

81. Respondent failed to evaluate Patient 1's suitability for discharge and failed to document a post-operative examination confirming Patient 1's suitability for discharge following the interventional pain management procedures performed on June 7, 2018, August 20, 2018, November 17, 2018, January 3, 2019, February 2, 2019, March 1, 2019, and May 3, 2019.

82. Respondent failed to maintain accurate and complete medical records for Patient 1. On multiple occasions, Respondent documented the identical examination findings and indications for procedures, which appears to be copied and repeated from visit to visit. Procedure records failed to accurately and specifically describe the procedures being performed.

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Patient 2.

83. On or about May 30, 2018, and thereafter, Respondent committed the following acts, individually and/or collectively, of negligence, in connection with his treatment and care of Patient 2, as follows:

84. Respondent failed to document any discussion of the risks and benefits of the use of controlled substances and failed to obtain a signed opioid pain medication agreement.

85. Respondent's treatment plan and described objectives of treatment for Patient 2 included medication management and injection therapy. Respondent failed to refer Patient 2 for imaging studies (i.e., a cervical spine x-ray and/or cervical spine MRI) before initiating treatment.

86. Respondent failed to obtain Patient 2's informed consent prior to performing interventional pain management procedures on June 27, 2018, July 9, 2018, August 8, 2018, December 10, 2018, January 24, 2019, and March 1, 2019.

87. Respondent failed to document Patient 2's vital signs and medications administered during the interventional pain management procedures performed on June 27, 2018, July 9, 2018, August 8, 2018, December 10, 2018, January 24, 2019, and March 1, 2019.

88. Respondent failed to evaluate Patient 2's suitability for discharge and failed to document a post-operative examination confirming Patient 2's suitability for discharge following the interventional pain management procedures performed on June 27, 2018, July 9, 2018, August 8, 2018, December 10, 2018, January 24, 2019, and March 1, 2019.

89. Respondent failed to maintain accurate and complete medical records for Patient 2. On multiple occasions, Respondent documented the identical examination findings and indications for procedures. Procedure records failed to accurately and specifically describe the procedures being performed.

Patient 3.

90. On or about January 23, 2019 and thereafter, Respondent committed the following acts, individually and/or collectively, of negligence, in connection with his treatment and care of Patient 3, as follows:

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91. Respondent failed to obtain Patient 3's informed consent prior to performing interventional pain management procedures on March 1, 2019 and March 14, 2019.

92. Respondent failed to document Patient 3's vital signs and medications administered during the interventional pain management procedures performed on March 1, 2019 and March 14, 2019.

93. Respondent failed to evaluate Patient 3's suitability for discharge and failed to document a post-operative examination confirming Patient 3's suitability for discharge following the interventional pain management procedures performed on March 1, 2019 and March 14, 2019.

94. Respondent failed to maintain accurate and complete medical records for Patient 3. On multiple occasions, Respondent documented the identical examination findings and indications for procedures. Procedure records failed to accurately and specifically describe the procedures being performed.

Patient 4.

95. On or about February 28, 2019 and thereafter, Respondent committed the following acts, individually and/or collectively, of negligence, in connection with his treatment and care of Patient 4, as follows:

96. Respondent failed to discuss the risk, benefits and alternative methods of treatment with the patient and obtain the patient's written consent before initiating 11 ketamine infusions during the timeframe of February 28, 2019 to November 7, 2019.

97. Respondent failed to evaluate Patient 4's suitability for discharge and failed to document a post-operative examination confirming Patient 4's suitability for discharge following Patient 4's 11 ketamine infusions performed between February 28, 2019 to November 7, 2019.

98. Respondent failed to maintain accurate and complete medical records for Patient 4. On multiple occasions, Respondent documented the identical medical record data for all dates of service except for minor changes in the history of present illness and vital signs.

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Patient 5.

99. On or about September 21, 2017 and thereafter, Respondent committed the following acts, individually and/or collectively, of negligence, in connection with his treatment and care of Patient 5, as follows:

100. On November 13, 2017, Respondent performed intercostal nerve blocks without justification or medical indication.

101. Respondent failed to obtain Patient 5's informed consent prior to performing interventional pain management procedures on October 12, 2017, November 13, 2017, December 2, 2017, December 9, 2017, December 16, 2017, January 13, 2018, April 19, 2018, June 9, 2018, July 14, 2018, and March 1, 2019.

102. Respondent failed to document Patient 5's vital signs and medications administered during the interventional pain management procedures performed on October 12, 2017, November 13, 2017, December 2, 2017, December 9, 2017, December 16, 2017, January 13, 2018, April 19, 2018, June 9, 2018, July 14, 2018, and March 1, 2019.

103. Respondent failed to evaluate Patient 5's suitability for discharge and failed to document a post-operative examination confirming Patient 5's suitability for discharge following the interventional pain management procedures performed on October 12, 2017, November 13, 2017, December 2, 2017, December 9, 2017, December 16, 2017, January 13, 2018, April 19, 2018, June 9, 2018, July 14, 2018, and March 1, 2019.

104. Respondent failed to maintain accurate and complete medical records for Patient 5. On multiple occasions, Respondent documented the identical examination findings and indications for procedures. The procedure records failed to accurately and specifically describe the procedures being performed.

Patient 6.

105. On or about March 1, 2019 and thereafter, Respondent committed the following acts, individually and/or collectively, of negligence, in connection with his treatment and care of Patient 6, as follows:

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106. Patient 6 was referred to Respondent for consideration of right hip intra-articular joint injection. As part of his treatment plan and described objectives of treatment for Patient 6, Respondent recommended a 3 level right-sided lumbar transforaminal injection without medical indication or justification.

107. Respondent failed to obtain Patient 6's informed consent prior to performing interventional pain management procedure May 2, 2019.

108. Respondent failed to document Patient 6's vital signs and medications administered during the interventional pain management procedure performed on May 2, 2019.

109. Respondent failed to evaluate Patient 6's suitability for discharge and failed to document a post-operative examination confirming Patient 6's suitability for discharge following the interventional pain management procedures performed on May 2, 2019.

110. Respondent failed to maintain accurate and complete medical records for Patient 6. Respondent failed to document the patient's vital signs and amount of sedative medication given during the May 2, 2019 procedure.

111. Respondent's acts and/or omissions as set forth in paragraphs 11 through 110, above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Lack of Knowledge)

112. Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code, in that he was incompetent in the care and treatment of six patients. Complainant refers to and, by this reference, incorporates herein, paragraphs 11 through 111, above, as though fully set forth herein. The circumstances are as follows:

113. The allegations of the First and Second Causes for Discipline are incorporated herein by reference as if fully set forth.

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Patient 1.

114. On or about June 2, 2018, and thereafter, Respondent was incompetent in connection with his treatment and care of Patient 1, as follows:

115. Respondent failed to obtain Patient 1's informed consent prior to performing interventional pain management procedures on June 7, 2018, August 20, 2018, November 17, 2018, January 3, 2019, February 2, 2019, March 1, 2019, and May 3, 2019.

116. Respondent failed to document Patient 1's vital signs and medications administered during the interventional pain management procedures performed on June 7, 2018, August 20, 2018, November 17, 2018, January 3, 2019, February 2, 2019, March 1, 2019, and May 3, 2019.

117. Respondent failed to evaluate Patient 1's suitability for discharge and failed to document a post-operative examination confirming Patient 1's suitability for discharge following the interventional pain management procedures performed on June 7, 2018, August 20, 2018, November 17, 2018, January 3, 2019, February 2, 2019, March 1, 2019, and May 3, 2019.

118. Respondent failed to maintain accurate and complete medical records for Patient 1. On multiple occasions, Respondent documented the identical examination findings and indications for procedures, which appears to be copied and repeated from visit to visit. Procedure records failed to accurately and specifically describe the procedures being performed.

Patient 2.

119. On or about May 30, 2018, and thereafter, Respondent was incompetent in connection with his treatment and care of Patient 2, as follows:

120. Respondent failed to document any discussion of the risks and benefits of the use of controlled substances and failed to obtain a signed opioid pain medication agreement.

121. Respondent's treatment plan and described objectives of treatment for Patient 2 included medication management and injection therapy. Respondent failed to refer Patient 2 for imaging studies (i.e., a cervical spine x-ray and/or cervical spine MRI) before initiating treatment.

122. Respondent failed to obtain Patient 2's informed consent prior to performing interventional pain management procedures on June 27, 2018, July 9, 2018, August 8, 2018, December 10, 2018, January 24, 2019, and March 1, 2019.

123. Respondent failed to document Patient 2's vital signs and medications administered during the interventional pain management procedures performed on performed on June 27, 2018, July 9, 2018, August 8, 2018, December 10, 2018, January 24, 2019, and March 1, 2019.

124. Respondent failed to evaluate Patient 2's suitability for discharge and failed to document a post-operative examination confirming Patient 2's suitability for discharge following the interventional pain management procedures performed on June 27, 2018, July 9, 2018, August 8, 2018, December 10, 2018, January 24, 2019, and March 1, 2019.

125. Respondent failed to maintain accurate and complete medical records for Patient 2. On multiple occasions, Respondent documented the identical examination findings and indications for procedures. Procedure records failed to accurately and specifically describe the procedures being performed.

Patient 3.

126. On or about January 23, 2019 and thereafter, Respondent was incompetent in connection with his treatment and care of Patient 3, as follows:

127. Respondent failed to obtain Patient 3's informed consent prior to performing interventional pain management procedures on March 1, 2019 and March 14, 2019.

128. Respondent failed to document Patient 3's vital signs and medications administered during the interventional pain management procedures performed on March 1, 2019 and March 14, 2019.

129. Respondent failed to evaluate Patient 3's suitability for discharge and failed to document a post-operative examination confirming Patient 3's suitability for discharge following the interventional pain management procedures performed on March 1, 2019 and March 14, 2019.

130. Respondent failed to maintain accurate and complete medical records for Patient 3. On multiple occasions, Respondent documented the identical examination findings and indications for procedures. Procedure records failed to accurately and specifically describe the procedures being performed.

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Patient 4.

131. On or about February 28, 2019 and thereafter, Respondent was incompetent in connection with his treatment and care of Patient 4, as follows:

132. Respondent failed to discuss the risk, benefits and alternative methods of treatment with the patient and obtain the patient's written consent before initiating 11 ketamine infusions during the timeframe of February 28, 2019 to November 7, 2019.

133. Respondent failed to evaluate Patient 4's suitability for discharge and failed to document a post-operative examination confirming Patient 4's suitability for discharge following Patient 4's 11 ketamine infusions performed between February 28, 2019 to November 7, 2019.

134. Respondent failed to maintain accurate and complete medical records for Patient 4. On multiple occasions, Respondent documented the identical medical record data for all dates of service except for minor changes in the history of present illness and vital signs.

Patient 5.

135. On or about September 21, 2017 and thereafter Respondent was incompetent in connection with his treatment and care of Patient 5, as follows:

136. On November 13, 2017, Respondent performed intercostal nerve blocks without justification or medical indication.

137. Respondent failed to obtain Patient 5's informed consent prior to performing interventional pain management procedures on October 12, 2017, November 13, 2017, December 2, 2017, December 9, 2017, December 16, 2017, January 13, 2018, April 19, 2018, June 9, 2018, July 14, 2018, and March 1, 2019.

138. Respondent failed to document Patient 5's vital signs and medications administered during the interventional pain management procedures performed on October 12, 2017, November 13, 2017, December 2, 2017, December 9, 2017, December 16, 2017, January 13, 2018, April 19, 2018, June 9, 2018, July 14, 2018, and March 1, 2019.

139. Respondent failed to evaluate Patient 5's suitability for discharge and failed to document a post-operative examination confirming Patient 5's suitability for discharge following the interventional pain management procedures performed on October 12, 2017, November 13,

2017, December 2, 2017, December 9, 2017, December 16, 2017, January 13, 2018, April 19, 2018, June 9, 2018, July 14, 2018, and March 1, 2019.

140. Respondent failed to maintain accurate and complete medical records for Patient 5. On multiple occasions, Respondent documented the identical examination findings and indications for procedures. The procedure records failed to accurately and specifically describe the procedures being performed.

Patient 6.

141. On or about March 1, 2019 and thereafter, Respondent was incompetent in connection with his treatment and care of Patient 6, as follows:

142. Patient 6 was referred to Respondent for consideration of right hip intra-articular joint injection. As part of his treatment plan and described objectives of treatment for Patient 6, Respondent recommended a 3 level right-sided lumbar transforaminal injection without medical indication or justification.

143. Respondent failed to obtain Patient 6's informed consent prior to performing an interventional pain management procedure on May 2, 2019.

144. Respondent failed to document Patient 6's vital signs and medications administered during the interventional pain management procedure performed on May 2, 2019.

145. Respondent failed to evaluate Patient 6's suitability for discharge and failed to document a post-operative examination confirming Patient 6's suitability for discharge following the interventional pain management procedures performed on May 2, 2019.

146. Respondent failed to maintain accurate and complete medical records for Patient 6. Respondent failed to document the patient's vital signs and amount of sedative medication given during the May 2, 2019 procedure.

147. Respondent's acts and/or omissions as set forth in paragraphs 11 through 146, above, whether proven individually, jointly, or in any combination thereof, constitute incompetence pursuant to section 2234, subdivision (d), of the Code. Therefore, cause for discipline exists.

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FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

148. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to his care and treatment of Patients 1, 2, 3, 4, 5, and 6. Complainant refers to and, by this reference, incorporates herein, paragraphs 11 through 65, above, as though fully set forth herein.

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 89836, issued to Respondent Sabri Elshenawy Malek, M.D.;

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

3. Ordering Respondent Sabri Elshenawy Malek, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: JAN 11 2022

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

LA2020602387