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

| | |
|---|---|
| **In the Matter of the Accusation Against:**<br><br>**Anwar Saeed, M.D.**<br><br>**Physician's & Surgeon's Certificate No. A 63552**<br><br>**Respondent.** | **Case No. 800-2019-056837** |

## DECISION

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

**This Decision shall become effective at 5:00 p.m. on March 18, 2022.**

**IT IS SO ORDERED: February 16, 2022.**

**MEDICAL BOARD OF CALIFORNIA**

Richard E. Thorp MD

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

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
MEGAN R. O'CARROLL
Deputy Attorney General
State Bar No. 215479
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7543
Facsimile: (916) 327-2247
*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**ANWAR SAEED, M.D.**<br>**Mercy Internal Medicine Dept.**<br>**7115 Greenback Lane**<br>**Citrus Heights, CA 95621**<br><br>**Physician's and Surgeon's Certificate No. A 63552**<br><br>Respondent. | Case No. 800-2019-056837<br><br>OAH No. 2021070071<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** |

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

## PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Megan R. O'Carroll, Deputy Attorney General.

///

2. Respondent Anwar Saeed, M.D. (Respondent) is represented in this proceeding by attorney Dominique A. Pollara, whose address is: Pollara Law Group, 100 Howe Avenue, Suite 165N, Sacramento, CA 95825.

3. On or about September 26, 1997, the Board issued Physician's and Surgeon's Certificate No. A 63552 to Anwar Saeed, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-056837, and will expire on August 31, 2023, unless renewed.

## JURISDICTION

4. Accusation No. 800-2019-056837 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 14, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-056837 is attached as exhibit A and incorporated herein by reference.

## ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-056837. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

///

## CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2019-056837, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2019-056837, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 63552 to disciplinary action.

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

## CONTINGENCY

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

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

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

**DISCIPLINARY ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 63552 issued to Respondent Anwar Saeed, M.D., shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code, section 2227, subdivision (a)(4). This public reprimand, which is issued in connection with Respondent's care and treatment of a patient as set forth in Accusation No. 800-2019-056837, is as follows:

"Between April 18, 2014 and April 21, 2014, you departed from the standard of recordkeeping and care for a patient complaining of back pain as more fully described Accusation No. 800-2019-056837."

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

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course. Failure to

provide proof of successful completion of the course to the Board or its designee within twelve (12) months of the effective date of this Decision, unless the Board or its designee agrees in writing to an extension of that time, shall constitute general unprofessional conduct and may serve as the grounds for further disciplinary action.

## ACCEPTANCE

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

DATED: 12/2/2021

ANWAR SAEED, M.D.
*Respondent*

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

DATED: 12/2/21

DOMINIQUE A. POLLARA
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: 12/3/2021

Respectfully submitted,

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



MEGAN R. O'CARROLL
Deputy Attorney General
*Attorneys for Complainant*

SA2021301468
35705276.docx

# Exhibit A

**Accusation No. 800-2019-056837**

MATTHEW RODRIQUEZ
Acting Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
MEGAN R. O'CARROLL
Deputy Attorney General
State Bar No. 215479
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7543
Facsimile: (916) 327-2247
*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**Anwar Saeed, M.D.**<br>**Mercy Internal Medicine Department**<br>**7115 Greenback Lane**<br>**Citrus Heights, CA 95621**<br><br>**Physician's and Surgeon's Certificate No. A 63552,**<br><br>Respondent. | Case No. 800-2019-056837<br><br>**ACCUSATION** |

## PARTIES

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

2. On or about September 26, 1997, the Medical Board issued Physician's and Surgeon's Certificate Number A 63552 to Anwar Saeed, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2021, unless renewed.

## JURISDICTION

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

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

5. Section 2234 of the Code, states:

> 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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that 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.

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

## FACTUAL ALLEGATIONS

7. Respondent is board-certified in Internal Medicine, and employed by Mercy Medical Group. Respondent became the Primary Care Physician for the Confidential Patient (C.P.)[1], on or about July 24, 2012. C.P. was a 53-year-old man when he first saw Respondent on or about July 24, 2012, to establish care. In the fall of 2013, C.P. began complaining of hip and back pain. C.P. saw other practitioners in Respondent's group, and exchanged messages with Respondent about his back pain. A Physician Assistant working with Respondent referred C.P. to an Orthopedic specialist during 2013.

8. On or about April 15, 2014, C.P. sought treatment complaining of severe back pain. Respondent was unavailable and so another physician in Respondent's practice group saw C.P. for an appointment on April 15, 2014. The physician who saw C.P. on April 15, 2014 diagnosed him with an acute flare-up of lower back pain. He prescribed pain medication, recommended applying ice, and following up in a week. On April 16, 2014, at approximately 8:00 a.m., C.P. called Respondent's office complaining of 10 out of 10 pain shooting from his right hip, down his thigh, into his kneecap, and was given an appointment with Respondent for later that morning. C.P. called Respondent's office to report that he was in extreme pain, and could not keep the appointment because he went to the Mercy San Juan Emergency Room. At the Emergency Room, C.P. was given pain medication and diagnosed with muscle spasms.

9. On April 17, 2014, at approximately 9:00 a.m. in the morning, C.P. called Respondent again to say that he could not move his leg at all when he woke up. C.P. was given an appointment to see Respondent later that day. When C.P. arrived for his appointment with Respondent, he reported that he was in extreme pain with weakness in his right leg and pain shooting down his legs. He stated he was unable to walk. Respondent reported that he was

[1] The patient's name is omitted to protect his privacy. It will be provided in discovery.

unable to complete a physical examination due to C.P.'s condition. Respondent documented that any attempt to stand caused C.P. extreme pain.

10. Respondent's chart note for the April 17, 2014 visit does not contain a documented section for physical examination or history of present illness. Respondent documented certain statements in the section labeled "assessment" that could possibly be portions of a physical examination, such as the inability to walk, but it is not clear whether this was Respondent's objective finding or C.P.'s reports of his condition. Respondent did not document a history of C.P.'s back condition, or any recent injury or trauma. Respondent diagnosed C.P. with acute severe backache and sciatica with weakness of the right lower extremity. He did not list any differential diagnoses. Nonetheless, he directed Respondent to report immediately to the Emergency Room for "further evaluation and emergent MRI and possible neurosurgical evaluation."

11. Later that afternoon, C.P. again called Respondent's office and left a phone message for him explaining that the Emergency Room would not give him pain medication, and if he tried to lay down he would be screaming in pain. Respondent acknowledged the message that evening, noting that he was not able to override the Emergency Room physician's medical decision-making. Records from the Mercy San Juan Emergency Room show that C.P. left the Emergency Room without completing an MRI that had been ordered, because he found the act of lying flat and still in the MRI to be too painful. Records further show that C.P. had a verbal dispute with Emergency Room staff about the type of pain medication he could receive before the MRI. Emergency Room staff provided him with oral Percocet, and C.P. had asked for something stronger. Emergency Room staff explained that they could not provide stronger, intravenous opioids in the Emergency room setting. Emergency Room security intervened in the dispute, and C.P. left without receiving further care or direction from the medical staff.

12. The following morning, on or about April 18, 2014, C.P. again called Respondent's office, this time reporting that the tops of both his legs were completely numb and that he could not move his right leg, although he could move his toes. C.P. further reported that the Emergency Room staff were rude to him, and would not give him an MRI. C.P. left another message for

Respondent on that day, explaining that he was unable to lay flat for an MRI without stronger, injectable pain medications. He asked Respondent to send him to a different hospital where he could receive injectable pain medication in preparation for an MRI.

13. Although C.P. reported that he had not received an MRI at the Emergency Room the previous day, and that his symptoms and numbness were as bad, or worse, than the previous day, Respondent did not obtain urgent medical care for C.P. after receiving his April 18, 2014 messages. Respondent did not review or obtain the Emergency Room records from C.P.'s visit the previous day. Respondent did not speak to C.P. personally on April 18, 2014, or direct him to come in for an appointment or go back to the Emergency Room. Instead, C.P. left a series of messages for Respondent through his staff, and Respondent relayed messages back to C.P. through his staff. Through the series of messages, Respondent agreed to schedule an MRI for Respondent as an outpatient and to allow him to receive a shot of pain medication in his office before the MRI. Telephone messages reflect that Respondent's staff organized insurance authorization for an outpatient MRI and called around to various facilities for availability to schedule it as soon as possible. Respondent's staff were able to schedule an outpatient MRI for C.P. on Monday, April 21, 2014.

14. Further telephone messages on April 21, 2014, show that C.P. requested an injectable pain medication before the MRI, and that Respondent agreed to allow his nurse to administer an anti-inflammatory medication by injection. C.P. sent additional messages to Respondent indicating that the anti-inflammatory medication did nothing for him, and that he sought something stronger in order to be able to lay flat for the MRI. Messages from Respondent on April 21, 2014 indicated that he agreed to allow his nurse to administer a shot of Dilaudid to C.P. an hour before the procedure. On or about April 21, 2014, C.P. received an injection of Dilaudid under Respondent's order, however, there is no documentation of the dose or the method of administration of the Dilaudid. Respondent stated that he believed the nurse administered a dose of between 2 and 4 milligrams of Dilaudid to C.P.

15. On or about April 21, 2014, after receiving the dose of Dilaudid, C.P. proceeded to his outpatient MRI appointment. At the MRI appointment, C.P. exhibited an altered level of

consciousness and was taken to the Emergency Room without completing an MRI. C.P. was hospitalized, and eventually received surgery for a protruding disc in his spinal cord. He suffered spinal cord compression that caused paraplegia.

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

16. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed gross negligence in his care and treatment of C.P. The circumstances are as follows:

17. Paragraphs 7 through 15, above, are incorporated herein as if fully set forth.

18. Respondent was grossly negligent for his acts and omissions, including, but not limited to, the following:

a. Failing to identify and take urgent action for C.P.'s continuing, untreated condition on April 18, 2014;

b. Ordering an injection of 2-4 milligrams of Dilaudid for C.P. and allowing him to leave the office, unmonitored, for an outpatient MRI.

19. Respondent's conduct, as set forth above, constitutes gross negligence in violation of section 2234, subdivision (b), of the Code, thus subjecting Respondent's license to discipline.

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

20. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care and treatment of C.P. The circumstances are as follows:

21. Paragraphs 7 through 15, above, are incorporated herein as if fully set forth.

22. Respondent was repeatedly negligent for his acts and omissions, including, but not limited to, the following:

a. Failing to identify and take urgent action for C.P.'s continuing, untreated condition on April 18, 2014;

b. Failing to adequately and accurately document the visit of April 17, 2014; and

c. Ordering an injection of 2-4 milligrams of Dilaudid for C.P. and allowing him to leave the office, unmonitored, for an outpatient MRI.

23. Respondent's conduct, as set forth above, constitutes repeated negligent acts in violation of subdivision 2234, subdivision, (c) of the Code, thus subjecting Respondent's license to discipline.

## THIRD CAUSE FOR DISCIPLINE

**(Inadequate or Inaccurate Recordkeeping)**

24. Respondent is subject to disciplinary action under section 2266, of the Code in that he failed to adequately and accurately maintain medical records for C.P. as set forth in Paragraphs 7 through 15, above, which are incorporated by reference herein as if fully set forth.

## PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 63552, issued to Anwar Saeed, M.D.;

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

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

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

DATED: APR 14 2021

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

SA2021301468
34986966.docx