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

In the Matter of the Accusation Against: Michael Yadegari, M.D. Physician's and Surgeon's Certificate No. A 100335 Respondent.	Case No.: 800-2019-057269

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 September 8, 2023.

IT IS SO ORDERED: August 9, 2023.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
LATRICE R. HEMPHILL
Deputy Attorney General
State Bar No. 285973
300 So. Spring Street, Suite 1702
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Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 800-2019-057269
MICHAEL YADEGARI, M.D. **2784 Casiano Road** **Los Angeles, CA 90077-1524**	OAH No. 2022100380
Physician's and Surgeon's Certificate No. A 100335,	**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**
Respondent.	

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

PARTIES

1. Reji Varghese (Complainant) is the Interim 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 Latrice R. Hemphill, Deputy Attorney General.

2. Respondent Michael Yadegari, M.D. (Respondent) is represented in this proceeding by attorneys Dennis Ames and Pogey Henderson, whose address is: La Follette, Johnson, De Haas, Fesler & Ames, 677 North Main Street, Suite 901, Santa Ana, CA 92705-6632.

3. On or about June 1, 2007, the Board issued Physician's and Surgeon's Certificate No. A 100335 to Michael Yadegari, 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. 800-2019-057269, and will expire on June 30, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-057269 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 June 30, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-057269 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. 800-2019-057269. 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. 800-2019-057269, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not admit to the charges in the Accusation. However, 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. 800-2019-057269, 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 100335 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 probationary terms 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. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2019-057269 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

16. 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.

17. 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 100335 issued to Respondent MICHAEL YADEGARI, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

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

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

2. 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.

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

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

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

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent.

Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

At the end of the evaluation, the program will submit a report to the Board or its designee,

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

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

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

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

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the

Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and until successful completion of the clinical competence assessment program and review of the submitted report by a Board designee, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

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

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

calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

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

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

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

9. 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.

10. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $9,690.00 (nine thousand six hundred ninety dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs.

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

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

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

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Travel or Residence Outside California

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

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

13. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards'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 (2) years.

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

15. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

17. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its

designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-057269 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Dennis Ames and Pogey Henderson. 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: 04/26/2023

MICHAEL YADEGARI, M.D.
Respondent

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I have read and fully discussed with Respondent Michael Yadegari, 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: 4/26/23

DENNIS AMES
POGEY HENDERSON
Attorneys for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

LATRICE R. HEMPHILL
Deputy Attorney General
Attorneys for Complainant

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I have read and fully discussed with Respondent Michael Yadegari, 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: _____

DENNIS AMES
POGEY HENDERSON
Attorneys for Respondent

ENDORSEMENT

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

DATED: 4/27/2023

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

LATRICE R. HEMPHILL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-057269

ROB BONTA
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Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 800-2019-057269
MICHAEL YADEGARI, M.D. **3130 S. Hill Street** **Los Angeles, CA 90007-3817** **Physician's and Surgeon's Certificate No. A 100335,** Respondent.	**A C C U S A T I O N**

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 June 1, 2007, the Medical Board issued Physician's and Surgeon's Certificate Number A 100335 to Michael Yadegari, 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 June 30, 2023, unless renewed.

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JURISDICTION

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

4. Section 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 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.

STATUTORY PROVISIONS

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 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.

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.

COST RECOVERY

8. Section 125.3 of the Code states:

(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 licensee 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.

STANDARD OF CARE

9. **General Anxiety Disorder (GAD)**-General Anxiety Disorder is a common disorder that has symptoms similar to panic disorder, obsessive-compulsive disorder, and other types of anxiety. It can lead to significant impairments in role functioning and reduced quality of life. It can be effectively treated with cognitive behavior therapy, medication or a combination of the two modalities. Primary care physicians are usually the first point of contact for patients with anxiety disorder. The physician must assess the severity and extent of the functional impairment caused by the anxiety disorder. This assessment is done with a detailed history and an objective screening questionnaire. A complete review of the patient's over-the-counter and prescribed medication history is important as certain medications can trigger anxiety side effects.

Laboratory evaluation testing, including thyroid hormone testing, should also be considered. Once medical causes of anxiety are excluded, the physician, along with the patient, must choose either behavioral therapy or medications or both.

If pharmacotherapy is chosen, initial treatment with a serotonergic antidepressant (SSRI) or a serotonin norepinephrine reuptake inhibitor (SNRI) is recommended as these medications are the best-studied treatments found to be efficacious for anxiety disorder. Because of their excellent safety profile, these medications are commonly initiated and monitored by primary care physicians. Because of variable responses to these medications, patients often need to try several medications over several months to find the one medication that works best for them.

Benzodiazepines have an important role in the management of generalized anxiety disorder, but concerns about the risks of drug dependency and tolerance limit their use. Other concerns include abuse, amnesia, and withdrawal symptoms. Benzodiazepines are used as a short-term adjunct therapy during the initial treatment with SSRI or SNRI medications.

10. **Concurrent use of Benzodiazepines and Opiates**-Benzodiazepines and opiate medications both cause central nervous system depression and can decrease respiratory drive. Concurrent use of these medications is likely to put patients at greater risk for potentially fatal overdose. In 2016 the FDA issued a black box warning against the combination of these two classes of medications to discourage physicians from prescribing this combination of medications. Physicians should strongly avoid prescribing both narcotics and benzodiazepines concurrently, as the risks outweigh the benefits. When confronted with patients concurrently using both medications, physicians should taper the patients off opiate medications first. If the patient wants to continue the opiate therapy, then the benzodiazepine should be tapered slowly and gradually. Other non-benzodiazepine medication approved for anxiety should be offered to the patient who is receiving the benzodiazepine for treatment of anxiety.

11. **Management of Insomnia**-The main modalities in the treatment of insomnia in adults are psychological/behavioral therapies, pharmacologic treatment, or a combination of both. There are many causes and triggers of insomnia. Confirmation of insomnia requires a detailed history and physical examination. The history should include a two-week sleep diary and

interview of the bed partner to help in assessing the severity of insomnia. A review of the patient's medication regimen should be done to highlight potential medications that can cause insomnia. Cognitive behavioral therapy is often the safest treatment for most patients, but is underutilized. Most physicians rely on pharmacotherapy for control of insomnia.

If pharmacotherapy is chosen, non-benzodiazepine medication should always be tried first due to the addiction potential and risks of long-term benzodiazepine therapy. If benzodiazepines are used, they should only be administered for a short term. Safer medications, such as melatonin or antihistamines should be tried first. Antidepressants, such as Trazodone and tricyclics may be used if the insomnia is associated with depression. FDA approved non-benzodiazepine sedative hypnotics known as "Z-drugs," could be tried if other safer alternatives do not work. These include Zolpidem, beginning with a low dose.

12. **Maintenance of Medical Records**-Every physician must maintain accurate and adequate medical records. A physician treating a patient with controlled substances, requires a medical history, results of a physical examination, laboratory results and radiologic testing. Vital signs should be recorded at every visit. The records should reflect all treatments provided at the consultation/visit, including all medications prescribed (including dosage and number of pills dispensed). Ongoing monitoring of progress or lack thereof, should be documented. A record of response to aberrant behavior from opiate use should be documented. Results of CURES Reports should be maintained in the patient's chart. Drug testing should also be documented. Routine laboratory testing should be documented, when warranted. Results of all ordered tests, including EKG, x-rays, should be documented in the chart.

13. **Evaluation and Non-Opiate Management of Chronic Pain**-The initial evaluation of chronic pain requires the physician to take a complete history and perform a physical examination followed by appropriate radiologic and laboratory testing to determine if the pain is caused by cancer or some other source. Appropriate subspecialty consultations are recommended if the diagnosis is elusive. Tissue biopsies and further specialized nerve testing may be appropriate in certain situations. Opiate pain medications are recommended for managing cancer pain for palliative and ethical concerns. For non-cancer chronic pain, opiate therapy is not the

first line of treatment due to the risks of addiction, drug overdose, and respiratory depression. Non-pharmacologic therapy and non-opiate therapy are often preferred. Weight loss, aerobic exercises, aquatic pool therapy, and cognitive therapy can often improve pain from osteoarthritis. Non-opiate medications, like non-steroidal anti-inflammatory (NSAID) drugs, acetaminophen, and anti-seizure medications can often significantly reduce pain and restore functionality. Surgical consultations for joint injections and total joint replacements are other treatment options. Patients do not need to sequentially fail all these therapies before narcotics may be tried if the benefits of narcotics outweigh the risks. Opiate therapy is most beneficial when combined with non-pharmacologic therapy and non-opiate medications.

14. **Initiation and Monitoring of Chronic Opiate Pain Medication**-If non-opiate medications and non-pharmacologic therapy did not adequately control the patient's pain, opiates may be considered if the benefits outweigh the risks. Opiates with the lowest potency and addiction potential should always be tried first for a defined period, usually one to three months. The patient's progress should be monitored for benefit and harm, including the patient's level of pain, function, quality of life, and adverse effects. If it is determined that opiate therapy will be continued beyond 90 days, the titration of pain medication dosage should be slow. Ideally, the morphine equivalent dose (MED) should not exceed 80-90 per day. Risks of drug overdose and death and other adverse effects increase significantly beyond this dosage.

The patient's risk of drug addiction and aberrancy should also be assessed prior to starting long term opiate therapy. Risk stratification is one of the most important tools a physician can do to mitigate potentially adverse consequences of opiate therapy. This involves performing a psychological evaluation which assesses the risks of addictive behaviors. This can be performed by using a questionnaire such as the Opioid Risk Tool, SOAPP-R, or PHQ-9. Patients with an above average risk of addiction can benefit from a referral to a psychiatrist. The patient can also be closely monitored with regular urine drug testing and checking CURES.

Patients on chronic opiate therapy need to be monitored on a regular basis, every one to three months. Periodic assessments allow the physician to determine if the medication is controlling the patient's pain and improving the patient's functional status. The physician can

discontinue or taper the patient off the medication if the harm outweighs the benefits. The assessment should focus on analgesia, activities of daily living, adverse side effects of the opiates, aberrant behaviors, and the patient's affect. The patient should also be monitored for compliance by checking CURES, urine drug testing, and pill counts. If drug abuse or diversion is confirmed, the physician should arrange an immediate face-to-face meeting with the patient to re-evaluate treatment, and in some cases, taper the opiate therapy, if appropriate. If the MED exceeds 80-90 per day, the patient should be educated on the use of naloxone therapy. Sleep apnea, chronic respiratory illnesses, and concurrent benzodiazepine use increase the toxicity risks in opiate dependent patients. Therefore, naloxone therapy is strongly recommended for these patients.

15. **Informed Consent and Patient Care Agreements**-When considering long-term use of opiates, the physician should discuss the risks and benefits of the treatment plan with the patient (or conservator). The patient consent addresses the risks and side effects of opiate medications. These include constipation, sexual dysfunction, osteoporosis, cognitive impairment, over-sedation, drug interactions, respiratory depression, impaired driving skills, opiate dependency, and addiction. A discussion emphasizing the medical evidence questioning the benefit of long-term opiate therapy should also be held. A patient consent and pain management agreement typically outlines the joint responsibilities of the physician and the patient, including replacement and early refills of lost medications. It also emphasizes the patient's responsibility to obtain the prescribed opiate medication from only one physician or practice and from only one pharmacy. It highlights the patient's agreement to periodic drug testing and prescription drug monitoring (CURES). The use of the combined patient consent form/pain care agreement has been shown to improve narcotic patient compliance with treatment goals and objectives and to reduce the risk of aberrant behavior.

16. **Testosterone Replacement Therapy**-Testosterone treatment is currently FDA approved as replacement therapy only for men with primary testicular failure due to genetic causes, trauma, toxic injury, infection, or orchiectomy. It is also approved for men with secondary central pituitary disorders due to tumor, trauma, or radiation. The benefits of testosterone replacement therapy are not well proven in off-label use for age-related low

testosterone, opioid related hypogonadism, low libido, aging-related low energy and vitality, lack of concentration, and depression. The health risks from long term testosterone treatment include potential increased risks of stroke, heart attack, blood clot, stimulation of prostate cancer cell and prostate glands, liver toxicity, abnormal blood lipids, and erythrocytosis. Testosterone replacement therapy can also worsen apneic episodes in obstructive sleep apnea patients. Due to the increase in associated risks with use, the FDA advised that an informed discussion between the patient and doctor be conducted prior to starting testosterone therapy. The FDA further recommended periodic blood testing to monitor for polycythemia and metabolic effects on blood cholesterol and liver function. In men at risk for prostate cancer, PSA testing is also advised. Despite the FDA warnings, contradictory results were found. Because of the conflicting data on cardiovascular risks and benefits, there are no current universal recommendations for screening men for low testosterone and clinical hypogonadism.

However, if a male patient has signs or symptoms of testosterone deficiency, testosterone levels should be confirmed on at least two occasions. All major expert guidelines strongly endorse a second repeat testosterone measurement for confirmation as 30% of men with an initial low level in the hypogonadal range have a normal testosterone concentration on repeat measurement. Additional confirmatory tests such as luteinizing hormone and follicle stimulating hormone should be obtained in the presence of a low testosterone level to help in determining primary or secondary causes.

Before starting therapy, a history and physical examination, including a testicular and prostate examination, should be performed at baseline to assess for risks of prostate cancer. Blood laboratory tests, including CBC, chemistry, lipid panel, liver function tests, and PSA, should be performed at baseline. Laboratory tests, including testosterone level, should be repeated every 6-12 months, or sooner if indicated. The expert consensus is that the testosterone level should be targeted to the mid to upper normal range of the reference value, but not above the upper limit of the normal range. The usual dose of testosterone is 50 mg to 400 mg via intramuscular injection every 2 to 4 weeks. Topical and gel preparations are also available. The

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dose should be adjusted to reach a therapeutic level and should be reduced if the serum testosterone level exceeds the normal reference range, to minimize the side effects.

FACTS

17. Respondent is board-certified in Internal Medicine and Gastroenterology. He serves as the medical director for twenty clinics owned by American Health Services, a non-profit organization. Respondent currently treats patients at Hill Street Medical Services in downtown Los Angeles, and at clinics located in Van Nuys and Santa Clarita. He previously worked at Downtown Medical and Mental Health Services, where many of the patients identified in this Accusation were treated. That location has since closed.

Patient 1[1]

18. Patient 1 established care with Respondent in 2014.[2] He was 49-years-old at the time and homeless. He suffered from chronic ulcerative colitis with rectal bleeding. He also complained of chronic low back pain from osteoarthritis and had a history of COPD. Patient 1 had an extensive psychiatric history, including anxiety, depression, post-traumatic stress disorder and suicidal thoughts, which required frequent hospitalizations. Patient 1's medication history included various opiates and muscle relaxants.

19. By July 2015, Respondent prescribed alprazolam, a benzodiazepine; olanzapine, an antipsychotic, Latuda, an antipsychotic; and trazodone, an antidepressant, for Respondent. By February 2016, Respondent increased the dose of alprazolam to 6 mg per day (up from 4 mg per day), due to increased anxiety. Patient 1 remained on this high dose of alprazolam for 18 months through late 2017.

20. Because of the patient's increasing anxiety and insomnia, zolpidem, a hypnotic, 10 mg was added to Patient 1's medication regimen in January 2016 and continued monthly for one year.

21. Patient 1 was referred to a cardiologist in 2015 for evaluation of chest pain and underwent surgery for the placement of coronary stents.

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[1] The patients are identified by number in this Accusation to address privacy concerns.

[2] Care rendered to the Patients prior to 2015 is described for historical purposes only.

22. Respondent saw Patient 1 on a monthly basis for refills of his psychiatric and cardiovascular medications. Despite several orders for blood testing, it appears that the patient was noncompliant. Only one blood test result from an emergency department visit is found in the patient's chart. Only one urine toxicology test was performed in September 2017.

Patient 2

23. Patient 2 established care with Respondent in 2014. He was 52-years-old at the time and homeless. He was HIV positive and had sought treatment for sexually transmitted diseases and a testicular infection. Patient 2 was seen by Respondent on a monthly basis for medication renewals and primary care issues. He had regular testing to monitor his T-cell count and received highly active antiretroviral therapy (HAART therapy) and prophylactic antibiotics for his AIDS syndrome.

24. Respondent also prescribed opiates for Patient 2, including Tylenol with codeine. Per CURES, Respondent prescribed Tylenol with codeine starting in January 2016, but he did not document this medication in the patient's chart until April 2016. The indication for the opiate is noted as chronic low back pain and painful ambulation. Respondent did not try a safer non-addictive pain medication prior to initiating opiate therapy for Patient 2. The patient was referred to a pain management specialist and physical therapy, but was noncompliant. No imaging evaluations of Patient 2's back and legs were obtained during the three years of opiate therapy. Physical examinations were often lacking in detail, often with just "abnormal" as a finding with no specific descriptions. No range of motion examinations are noted.

25. Patient 2 was referred to an Infectious Disease specialist for his chronic AIDS wasting syndrome with chronic diarrhea and diffuse Kaposi sarcoma.

26. Patient 2 also suffered from chronic anxiety and depression. He had a single psychotherapy session with the therapist in 2015, but none thereafter. Respondent regularly prescribed alprazolam for the patient's anxiety since 2014. However, a detailed comprehensive evaluation of the patient's anxiety disorder was never conducted over Respondent's four years of anxiety management. Patient 2 was at high risk for controlled substance dependency due to his history of sexual abuse, polysubstance abuse, and depression.

Patient 3

27. Patient 3 established care with Respondent in early 2014. She was 33-years-old at the time and homeless. She was HIV positive, had bipolar disorder and was obese. Patient 3 was a smoker, she had a history of polysubstance abuse, including cocaine and methamphetamines. She also suffered from post-traumatic stress disorder from a sexual assault when she was a minor.

28. Respondent noted that Patient 3 suffered from chronic low back pain due to osteoarthritis and required chronic opiate pain management. Prior to 2015, she was prescribed tramadol or hydrocodone for pain management. By 2015, Respondent prescribed to Patient 3 monthly prescriptions for 10 mg of hydrocodone. In early 2016, Respondent prescribed monthly scripts of daily hydrocodone, 4 mg of clonazepam, a benzodiazepine, and 10 mg of zolpidem, a hypnotic. In 2017, Respondent added ibuprofen and tramadol for additional pain management. In 2018, Patient 3 sustained an acute elbow fracture with an infection. She was continued on the same pain management regimen of hydrocodone, ibuprofen and tramadol.

29. In May 2018, Patient 3's anxiety worsened, and Respondent changed the patient's prescription from clonazepam to alprazolam. He also added an SSRI to treat her depression and control her anxiety. Respondent discontinued Patient 3's prescription for Zolpidem as it was not helping with her insomnia. During the second half of 2018, Respondent tried several different muscle relaxants for better back pain management, including cyclobenzaprine, Robaxin, and baclofen. He also tried naproxen, and gabapentin was added for pain management. By late 2019 Patient 3's back pain worsened, and therefore, Soma, a different muscle relaxant, was added to her medication regimen.

30. Patient 3 had a positive urine toxicology screen for cocaine and methamphetamine in December 2019. She was referred to a methadone maintenance clinic for opioid addiction management. Respondent stopped prescribing narcotics for Patient 3 at that time.

Patient 4

31. Patient 4 established care with Respondent in 2014. He was 56-years-old at the time and homeless. He was HIV positive and had chronic hepatitis C. He also complained about chronic low back pain and had a history of schizophrenia.

32. Respondent initially treated Patient 4's low back pain with tramadol. As his complaints of pain worsened, Respondent changed his medication to ibuprofen, baclofen and Tylenol with codeine. By the end of 2015, Respondent was prescribing these three medications for Patient 4 on a monthly basis.

33. Patient 4 developed chronic ear pain in early 2016. Over time, an ulcer formed over his ear. Patient 4 was referred to USC County Medical Center for a biopsy of the ear ulcer, the results of which were positive for squamous cell cancer. Patient 4 had his ear resected during the summer of 2016. He started radiation and chemotherapy, but was noncompliant. Due to chronic ear and back pain, Respondent changed Patient 4's pain management to 15 mg of hydrocodone daily, for the next fifteen months.

34. In early 2017, Patient 4 had a low serum testosterone level based on a routine laboratory screening (242 ng/dl). He was diagnosed with clinical hypogonadism as he had symptoms of impotence and fatigue. Respondent prescribed testosterone cream 200 mg, every two weeks, however, the patient's testosterone level was never rechecked. No genitourinary examination was conducted and a PSA level was not checked prior to starting testosterone therapy.

35. Patient 4's cancer progressed due to his noncompliance with treatment. He continued with Respondent for primary care. In 2018 he was diagnosed with essential hypertension and Respondent prescribed medication for hypertension control. Testosterone therapy continued into 2018 with no laboratory monitoring.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

36. Respondent Michael Yadegari, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he committed repeated negligent acts in his care of four patients. The circumstances are as follows:

37. The facts and allegations set forth in paragraphs 18 through 35, above, are incorporated herein.

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Patient 1

38. Respondent failed to perform a detailed assessment of Patient 1's anxiety disorder from 2015-2017. An anxiety questionnaire was not prepared. A detailed history of the patient's anxiety symptoms, including triggering and relieving factors, was not conducted or was not charted. There was no assessment of functional limitations caused by the patient's anxiety. There were no trials of non-addictive, safer anxiolytic medications which could have reduced the patient's benzodiazepine dependency. Closer monitoring with psychotherapists could have also reduced the patient's need for long-term benzodiazepine therapy. Long term benzodiazepine use should have been avoided to prevent drug dependency and addiction in this high risk patient. The patient became dependent on high dose alprazolam for over a year.

39. The failure to perform a comprehensive and detailed anxiety examination of Patient 1 is a simple departure from the standard of care.

40. The failure to implement a trial of safer and non-addictive anxiolytic medication for Patient 1 is a simple departure from the standard of care.

41. Patient 1 was receiving opiate prescriptions from pain management physicians. Respondent should have minimized his prescribing of benzodiazepine medication to Patient 1 to avoid the risk of accidental overdose. Patient 1 suffered from COPD, therefore, his risk of accidental respiratory failure was magnified. Patient 1 should have been prescribed naloxone to minimize the risk of concomitant opiate and benzodiazepine therapy.

42. Respondent's failure to taper Patient 1's benzodiazepine dose is a simple departure from the standard of care.

43. Respondent's failure to prescribe naloxone for Patient 1 is a simple departure from the standard of care.

44. Respondent failed to perform a detailed evaluation of Patient 1's insomnia prior to prescribing zolpidem for him. The patient was homeless and a comprehensive sleep evaluation was prohibited. Therefore, a safer, non-addictive sleep medication, such as an antihistamine and or melatonin should have been tried prior to choosing zolpidem. Zolpidem also can cause respiratory suppression when used with opiates and a benzodiazepine. Respondent started Patient

1 on a dose of zolpidem 10 mg. It is recommended that the starting dose of zolpidem be small,
2 such as 2.5 mg to 5 mg, to minimize side effects.

3 45. Respondent's failure to perform a detailed insomnia evaluation on Patient 1 is a
4 simple departure from the standard of care.

5 46. Respondent's failure to try a safer, non-addictive sleep medication for Patient 1 is a
6 simple departure from the standard of care.

7 47. Respondent's decision to start Patient 1 on a dose of 10 mg of zolpidem is a simple
8 departure from the standard of care.

9 **Patient 2**

10 48. Respondent prescribed alprazolam for Patient 2 starting in 2014. The medication was
11 filled monthly until 2018. Respondent failed to prepare a detailed and comprehensive evaluation
12 of the patient's anxiety disorder at any time during the four years of anxiolytic therapy. No
13 screening questionnaires were completed, no history of triggers or relieving factors of anxiety
14 were elicited and no functional limitations were queried. Respondent failed to try an SSRI or a
15 safer medication alternative, such as an antihistamine or tricyclics. Patient 2 suffered from
16 chronic depression which may have triggered his depression. A safe antidepressant medication
17 could have been prescribed to reduce Patient 2's anxiety and depression.

18 49. Respondent's failure to conduct a comprehensive anxiety evaluation on Patient 2 is a
19 simple departure from the standard of care.

20 50. Respondent's failure to start a trial of safer anxiolytic medication for Patient 2 is a
21 simple departure from the standard of care.

22 51. Respondent's failure to better manage Patient 2's depression and thus reduce the
23 patient's secondary anxiety is a simple departure from the standard of care.

24 52. Respondent prescribed long term opiate therapy to manage Patient 2's chronic low
25 back and leg pain. However, Respondent's evaluation of the patient's pain syndrome was
26 inadequate. The physical examination only noted muscle spasm and muscle tenderness, but no
27 range of motion, including flexion and extension was noted. Because of the patient's HIV
28 disease, imaging studies, such as x-ray or CT scan, should have been done at some point over the

four years of opioid treatment to assess for other potential infectious or neoplastic causes of the pain. The Respondent's non-opiate management of Patient 2's chronic pain syndrome could have been optimized. Non-addictive muscle relaxants, gabapentin or pregabalin, SSRI medication, and tricyclics therapy could have been added to minimize the patient's need for narcotic therapy.

53. Respondent's failure to perform a thorough evaluation of Patient 2's chronic low back and leg pain is a simple departure from the standard of care.

54. Respondent's failure to offer a trial of safer non-opiate medication to treat Patient 2's pain is a simple departure from the standard of care.

55. Respondent started Patient 2 on long term narcotic therapy in 2014 without proper risk stratification. Risk stratification should have been conducted at any point between 2015 and 2018, to guide decisions on long term narcotic therapy. Patient 2 was at high risk for dependency and addiction due to his history of post-traumatic stress disorder, depression, and history of sexual abuse. Because Patient 2 was at high risk for dependency and addiction, Respondent should have performed regular CURES queries and urine toxicology testing to ensure compliance and minimize aberrant behaviors, such as diversion. Respondent failed to perform an adequate functional assessment of the benefits of long term opiate therapy. He never documented analgesic efficacy, adverse side effects, activities of daily living, aberrant behaviors, or Patient 2's affect.

56. Respondent's failure to perform an opioid risk stratification on Patient 2 is a simple departure from the standard of care.

57. Respondent's failure to obtain routine urine toxicology testing and CURES review for Patient 2 is a simple departure from the standard of care.

58. Respondent's failure to perform a detailed functional assessment of the benefits of the narcotic therapy on Patient 2 is a simple departure from the standard of care.

59. Patient 2 was at increased risk of accidental overdose by taking both codeine and alprazolam on a regular basis. Respondent should have tried to taper Patient 2 off one or both medications. Patient 2 should have been counseled on the increased risk of taking the

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combination of an opiate and a benzodiazepine. Respondent should have prescribed naloxone for Patient 2 while he was taking the combination of an opiate and a benzodiazepine.

60. Respondent's prescribing of an opiate and benzodiazepine for Patient 2 absent an informed consent describing the risks and benefits of the combination of the medications is a simple departure from the standard of care.

61. Respondent's failure to prescribe naloxone for Patient 2 while he was taking the combination of an opiate and a benzodiazepine is a simple departure from the standard of care.

62. Because Patient 2 had an increased risk of opioid addiction, Respondent should have obtained a pain contract/agreement and a signed informed consent document with Patient 2 during the four years he prescribed opiate therapy.

63. Respondent's failure to have a pain contract/agreement and a signed informed consent document with Patient 2 is a simple departure from the standard of care.

Patient 3

64. Respondent prescribed benzodiazepine therapy (clonazepam or alprazolam) for Patient 3 between 2016 and 2018 to manage her anxiety disorder. Respondent never performed a thorough and comprehensive evaluation of the patient's anxiety illness. A screening questionnaire was not completed. Respondent failed to complete a detailed review of symptoms on Patient 3, which included triggering and relieving events. Respondent failed to complete and document an assessment of Patient 3's functional limitations. Patient 3 did not undergo thyroid hormone testing to assess for possible hyperthyroidism, which could cause general anxiety. Patient 3 was a known polysubstance abuser. Urine drug toxicology testing should have been conducted to assess her for drugs that cause anxiety, such as amphetamines or cocaine. Only one urine drug screen was conducted on her in 2019, which was positive for amphetamines and cocaine.

65. Respondent's failure to perform a detailed a comprehensive evaluation of Patient 3's anxiety disorder is a simple departure from the standard of care.

66. Respondent's prescribing of long term benzodiazepine therapy to Patient 3 is a simple departure from the standard of care.

67. Respondent failed to perform an appropriate evaluation of Patient 3's chronic low back pain. Between 2015 and 2019, Respondent failed to perform a detailed back examination on Patient 3, including evaluation of her range of motion, with assessment of back flexion and extension. A straight leg test was not conducted. No sensory examination was conducted to check for nerve impingement. No radiologic imaging was done. Respondent could have optimized his non-opiate management of Patient 3's pain, including increasing the dose of her gabapentin and encouraging weight loss.

68. Respondent's failure to conduct a thorough and detailed evaluation of Patient 3's back and back pain is a simple departure from the standard of care.

69. Respondent's failure to prescribe other classes of non-opiate pain medication to treat Patient 3's back pain is a simple departure from the standard of care.

70. Respondent's failure to offer other non-opiate management of Patient's 3 back pain is a simple departure from the standard of care.

71. Respondent failed to recognize that Patient 3 was at increased risk for opiate addiction because he did not perform a proper risk stratification. He did not conduct routine CURES queries on Patient 3 and did not perform routine urine toxicology testing to enforce compliance and prevent medication diversion. Respondent prescribed two short acting opiate medications for Patient 3, tramadol and hydrocodone. The combination was not recommended due to a lack of synergy and the increased toxicity risks and potential for addiction. Respondent failed to document the specific details of opiate monitoring of Patient 3, including the analgesic effects, the adverse side effects, activities of daily living, aberrancy and Patient 3's affect. There was no detailed review of symptoms performed or documented to determine if the long term use of the opiate medication was helping the patient.

72. Respondent's failure to perform a proper risk stratification on Patient 3, to determine her risk for opiate dependency and addiction, is a simple departure from the standard of care.

73. Respondent's failure to conduct routine CURES queries and urine toxicology testing on Patient 3 is a simple departure from the standard of care.

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74. Respondent's prescribing of two short acting opiate medications for Patient 3 is a simple departure from the standard of care, due to the increase in toxicity, with minimal benefits.

75. Respondent prescribed long term opiate therapy for Patient 3's back pain management. He also regularly prescribed either alprazolam or clonazepam for management of Patient 3's anxiety. Patient 3 was at increased risk of accidental overdose due to the combination of opiates and benzodiazepines. Respondent should have prescribed naloxone to minimize Patient 3's risk of accidental overdose.

76. Respondent's failure to prescribe naloxone for Patient 3 is a simple departure from the standard of care.

77. Respondent should have obtained a pain management contract/agreement with Patient 3 as she was at high risk for opioid addiction. A pain management contract/agreement would have enforced medication compliance and minimized medication aberrancy. Because Patient 3 was at high risk for accidental overdose from being prescribed the combination of opiates and benzodiazepines, Respondent should have documented a detailed informed consent discussion with her about the risks and benefits of this medication combination.

78. Respondent's failure to obtain a pain management contract/agreement with Patient 3 and to document an informed consent discussion with her regarding her medications is a simple departure from the standard of care.

79. Respondent prescribed zolpidem for Patient 3 on six occasions in 2016. However, there is no documentation in the patient's chart reflecting the indication for the medication or the dose. There was no thorough evaluation of insomnia, if this was the rationale for the prescription. Secondary causes of insomnia include methamphetamine use, depression, post-traumatic stress disorder, recurrent urinary tract infections, or homelessness. No secondary cause of insomnia was documented in Patient 3's chart. Nevertheless, safer, non-addictive sleeping medications should have been tried, including antihistamines, melatonin and tricyclics, before initiating zolpidem therapy. Zolpidem should be initiated at low doses and titrate upwards, if necessary. Respondent prescribed zolpidem to Patient 3 at a high dose of 10 mg. The combination of

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zolpidem, a central nervous system depressant, with opiates and benzodiazepines put Patient 3 at high risk for accidental drug overdose.

80. Respondent's failure to conduct a thorough insomnia evaluation for secondary causes on Patient 3 is a simple departure from the standard of care.

81. Respondent's failure to offer Patient 3 a trial of safer, non-addictive sleeping medications and to start zolpidem at a high dose is a simple departure from the standard of care.

Patient 4

82. Respondent failed to conduct a sufficient evaluation of Patient 4's chronic low back pain. Respondent should have tried other non-opiate medications including other NSAIDS, gabapentin, pregabalin, SSRI, and tricyclics.

83. Respondent's failure to conduct an appropriate evaluation of Patient 4's low back pain is a simple departure from the standard of care.

84. Respondent failed to perform a proper risk stratification of Patient 4's opiate pain management. He also failed to regularly monitor CURES and perform routine urine toxicology testing on Patient 4. Respondent failed to document the details of a functional assessment of long term narcotic therapy on Patient 4, including analgesia, adverse side effects, activities of daily living, aberrancy and Patient 4's affect.

85. Respondent's failure to perform a proper risk stratification on Patient 4 is a simple departure from the standard of care.

86. Respondent's failure to regularly monitor Patient 4's CURES reports and to perform routine urine toxicology testing is a simple departure from the standard of care.

87. Respondent's failure to document details of a functional assessment of Patient 4's opioid therapy is a simple departure from the standard of care.

88. Respondent should have obtained a pain management contract/agreement with Patient 4 as he was at high risk for opioid addiction. A pain management contract/agreement would have enforced medication compliance and minimized medication aberrancy. Because Patient 4 was at high risk for accidental overdose from taking long term opiate medications, Respondent should

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have documented a detailed informed consent discussion with him about the risks and benefits of the long term use of opiates and the potential for accidental overdose.

89. Respondent's failure to obtain a pain management contract/agreement and document an informed consent discussion with Patient 4 is a simple departure from the standard of care.

90. Respondent initiated testosterone therapy for Patient 4 based on a single low testosterone blood value of 242 ng/dl in February 2017. No repeat testing was conducted. Respondent did not perform a digital prostate examination on Patient 4 prior to starting hormonal therapy. Respondent did not document an informed consent discussion with Patient 4 regarding the risks and benefits of testosterone therapy. Respondent did not perform follow up testosterone testing six months after initiating hormonal therapy.

91. Respondent's decision to initiate testosterone therapy for Patient 4 based on a single low testosterone blood value is a simple departure from the standard of care.

92. Respondent's decision to initiate testosterone therapy for Patient 4 without performing a digital prostate examination and to have an informed consent discussion with the patient, or document an informed consent discussion, is a simple departure from the standard of care.

93. Respondent's failure to perform follow up testosterone testing six months after initiating hormonal therapy on Patient 4 is a simple departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

94. Respondent Michael Yadegari, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for Patients 1 through 4. The circumstances are as follows:

95. The facts and allegations set forth in paragraphs 18 through 35, above, are incorporated herein.

96. The facts and allegations set forth in the First Cause for Discipline, paragraphs 36 through 93, above, are incorporated herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 100335, issued to Michael Yadegari, M.D.;

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

3. Ordering Michael Yadegari, 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: JUN 30 2022

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

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