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

In the Matter of the Accusation Against:	)	
	)	
MOHAMMAD ALI SHAMIE, M.D.	)	**Case No. 17-2012-225391**
	)	
Physician's and Surgeon's Certificate No. A 39228	)	
	)	
Respondent.	)	
	)	

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on September 16, 2016.

IT IS SO ORDERED August 18, 2016.

MEDICAL BOARD OF CALIFORNIA

By: ____________________
Howard Krauss, M.D., Chair
Panel B

KAMALA D. HARRIS
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
RICHARD D. MARINO
Deputy Attorney General
State Bar No. 90471
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-8644
Facsimile: (213) 897-9395
Attorneys for Complainant

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

In the Matter of the Accusation Against: **MOHAMMAD SHAMIE, M.D. 2810 East Del Mar Blvd., Suite 3 Pasadena, CA 91107** **Physician's and Surgeon's Certificate No. A39228.** Respondent.	Case No. 17-2012-225391 OAH No. 2105080338 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement in this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as its final disposition of the Acucusation.

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Richard D. Marino, Deputy Attorney General.

2. Respondent MOHAMMAD SHAMIE, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, whose address is: 3699 Wilshire Boulevard, 10th Floor Los Angeles, CA 90010-2719.

3. On or about October 25, 1982, the Medical Board of California issued Physician's and Surgeon's Certificate No. A39228 to MOHAMMAD SHAMIE, 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. 17-2012-225391, and will expire on September 30, 2016, unless renewed.

JURISDICTION

4. Accusation No. 17-2012-225391 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 16, 2015. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 17-2012-225391 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. 17-2012-225391. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 17-2012-225391, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the factual allegations set forth in Paragraph 20, subparagraphs A through OO, inclusive, and the disciplinary charges set forth Paragraphs 21, 24, 25, and 26 in the Accusation, and that Respondent hereby gives up his right to contest those charges.

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

CONTINGENCY

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

13. 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.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A39228 issued to Respondent MOHAMMAD SHAMIE, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s) III, IV and V) of the Act.[1]

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

[1] Respondent currently prescribes Adderall, a Schedule II controlled substance, for several patients whose names and medical records, with their approval, have been provided to the Medical Board of California. For those and only those patients, Respondent will be permitted to prescribed Adderall or its generic equivalent during Respondent's probation.

document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

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

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

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

4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the

Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

6. 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.

7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

8. 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.

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

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

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10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

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(b).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

11. 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.

12. 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 in California 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 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; and General Probation Requirements.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. 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.

15. 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.

16. 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.

/

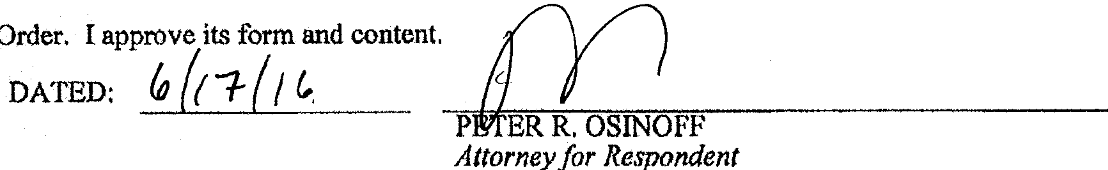
ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff. 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: June /17/2016

MOHAMMAD SHAMIE, M.D.
Respondent

I have read and fully discussed with Respondent MOHAMMAD SHAMIE, 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: 6/17/16

PETER R. OSINOFF
Attorney for Respondent

ENDORSEMENT

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

Dated: June 20, 2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

RICHARD D. MARINO
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 17-2012-225391

KAMALA D. HARRIS
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
RICHARD D. MARINO
Deputy Attorney General
State Bar No. 90471
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-8644
Facsimile: (213) 897-9395
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 14, 2015
BY: [illegible] ANALYST

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

In the Matter of the Accusation Against:	Case No. 17-2012-225391
Mohammad Shamie, M.D. **2810 East Del Mar Blvd., Suite 3** **Pasadena, CA 91107**	ACCUSATION
Physician's and Surgeon's Certificate No. A39228,	
Respondent.	

Complainant alleges:

PARTIES

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

2. On or about October 25, 1982, the Board issued Physician's and Surgeon's Certificate Number A39228 to Mohammad Shamie, 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 September 30, 2016, 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 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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section

2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated 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 provides:

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

7. Section 2238 of the Code provides:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

8. Section 2241 of the Code provides:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d) (1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

9. Section 2242 of the Code provides:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions

exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

10. Section 725 of the Code provides:

"a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist."

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) . . . ."

11. Health and Safety Code section 11152 provides:

"No person shall write, issue, fill, compound, or dispense a prescription that does not conform to this division."

12. Health and Safety Code section 11153, in pertinent part, provides

"(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

". . . ."

13. Health and Safety Code section 11190, in pertinent part, provides:

"(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

"(1) The name and address of the patient.

"(2) The date.

"(3) The character, including the name and strength, and quantity of controlled substances involved.

"(b) The prescriber's record shall show the pathology and purpose for which the

controlled substance was administered or prescribed.

"(c) (1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to Section 4170 of the Business and Professions Code, the prescriber shall record and maintain the following information:

"(A) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the patient.

"(B) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

"(C) NDC (National Drug Code) number of the controlled substance dispensed.

"(D) Quantity of the controlled substance dispensed.

"(E) ICD-9 (diagnosis code), if available.

"(F) Number of refills ordered.

"(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

"(H) Date of origin of the prescription.

"(2) (A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation.

"(B) The reporting requirement in this section shall not apply to the direct

administration of a controlled substance to the body of an ultimate user.

"(d) This section shall become operative on January 1, 2005.

"(e) The reporting requirement in this section for Schedule IV controlled substances shall not apply to any of the following:

"(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

"(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.

"(f) Notwithstanding paragraph (2) of subdivision (c), the reporting requirement of the information required by this section for a Schedule II or Schedule III controlled substance, in a format set by the Department of Justice pursuant to regulation, shall be on a monthly basis for all of the following:

"(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

"(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005."

CONTROLLED SUBSTANCE/DANGEROUS DRUGS

14. The following medications are controlled substances and dangerous drugs within the meaning of the Health and Safety Code and Business and Professions Code:

A. Hydrocodone - is a semi-synthetic opioid synthesized from codeine, one of the opioid alkaloids found in the opium poppy. It is a narcotic analgesic used orally as an antitussive/cough suppressant, but also commonly taken orally for relief of moderate to

severe pain.

B. Oxycodone – is used to help relieve moderate to severe pain. Oxycodone belongs to a class of drugs known as narcotic (opiate) analgesics. It works in the brain to change how the body feels and responds to pain.

C. Lunesta - is used to treat sleep problems or insomnia. Use of this medication is usually limited to short treatment periods of 1 to 2 weeks or less.

D. Seroquel - is an antipsychotic medicine. It works by changing the actions of chemicals in the brain. Seroquel is used to treat schizophrenia in adults and children who are at least 13 years old. Seroquel is used to treat bipolar disorder (manic depression) in adults and children who are at least 10 years old. It is also used together with antidepressant medications to treat major depressive disorder in adults. Extended-release quetiapine (Seroquel XR) is for use only in adults and should not be given to anyone younger than 18 years old.

E. Ativan - (lorazepam) is used for the management of anxiety disorders, the short-term relief of symptoms of anxiety or anxiety associated with depression. Lorazepam is effective for insomnia and panic attacks, and is used in combination with other medications to prevent nausea and vomiting resulting from chemotherapy. Lorazepam also is administered before anesthesia for sedation and used for prevention and treatment of alcohol withdrawal. It is also used for treating seizures (status epilepticus).

F. Prozac - is the brand name of fluoxetine, a prescription drug used to treat depression. This antidepressant is in a class of drugs known as selective serotonin reuptake inhibitors, or SSRIs. These medications work by increasing the amount of serotonin in the brain. In addition to depression, Prozac is used to treat obsessive-compulsive disorder (OCD), binge-eating and vomiting in people with moderate to severe

bulimia, and panic disorder. Fluoxetine capsules and tablets sold under the brand name Sarafem are used to treat premenstrual dysphoric disorder (PMDD), a condition in which a woman has symptoms of depression, irritability, and tension before menstruation.

G. Paxil - is the brand name for the antidepressant drug paroxetine. Though doctors prescribe Paxil to treat depression, it's also used to treat several anxiety disorders, including: Panic disorders, marked by sudden attacks of extreme fear and worry, social anxiety disorder, an intense fear of interacting with other people; Generalized anxiety disorder (GAD); Post-traumatic stress disorder (PTSD); and Obsessive-compulsive disorder (OCD). Paxil is also approved by Food and Drug Administration (FDA) to help women going through menopause manage hot flashes. Sometimes doctors prescribe Paxil off-label to treat conditions other than those for which it has been approved by the FDA. For example, doctors may prescribe Paxil to treat chronic headaches. For people with diabetes, the drug may help alleviate tingling in the hands and feet related to the condition. Paxil may also be used to treat men who experience premature ejaculation. In controlled-release form, Paxil CR, can relieve the physical and psychological symptoms some women experience before their menstrual cycle begins each month. Paxil belongs to a class of antidepressant medications called selective serotonin-reuptake inhibitors. SSRIs work by boosting levels of serotonin, a neurotransmitter that helps the brain send messages from one nerve cell to another.

J. Zoloft – (sertraline) is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors. Sertraline affects chemicals in the brain that may become unbalanced and cause depression, panic, anxiety, or obsessive-compulsive symptoms. Zoloft is used to treat depression, obsessive-compulsive disorder, panic disorder, anxiety disorders, post-traumatic stress disorder, and premenstrual dysphoric disorder.

I. Viibryd - is used to treat depression. It is an SSRI and partial serotonin receptor agonist. It works by helping to restore the balance of certain natural substances in the brain (neurotransmitters such as serotonin). This medication may improve mood, sleep, appetite, and energy level and may help restore interest in daily living.

J. Lexapro - (escitalopram) is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors. Escitalopram affects chemicals in the brain that may become unbalanced and cause depression or anxiety. Lexapro is used to treat anxiety in adults. Lexapro is also used to treat major depressive disorder in adults and adolescents who are at least 12 years old.

K. Suboxone - contains a combination of buprenorphine and naloxone. Buprenorphine is an opioid medication. An opioid is sometimes called a narcotic. Naloxone is an special narcotic drug that reverses the effects of other narcotic medicines. Suboxone is used to treat narcotic (opiate) addiction. It is not for use as a pain medication.

L. Clonazepam – This medication is used to prevent and control seizures. This medication is known as an anticonvulsant or antiepileptic drug. It is also used to treat panic attacks. Clonazepam works by calming the brain and nerves. It belongs to a class of drugs called benzodiazepines.

M. Acetaminophen with Codeine - This medication is used to relieve mild to moderate pain. This product is a combination of acetaminophen and the narcotic drug codeine. Codeine acts on certain centers in the brain to reduce pain. This medication may also be used to suppress a cough.

N. Diazepam – This medication is used to treat anxiety, acute alcohol withdrawal, and seizures. It is also used to relieve muscle spasms and to provide sedation before medical procedures. This medication belongs to a class of drugs called

benzodiazepines which act on the brain and nerves (central nervous system) to produce a calming effect. It works by enhancing the effects of a certain natural chemical in the body-- Gamma-Aminobutyric Acid (GABA).

O. Xanax (Alprazolam): a Schedule III controlled substance used to treat anxiety.

P. Lortab - This combination medication is used to relieve moderate to severe pain. It contains a narcotic pain reliever (hydrocodone) and a non-narcotic pain reliever (acetaminophen). Hydrocodone works in the brain to change how the body feels and responds to pain. Acetaminophen can also reduce a fever.

Q. Ambien – (zolpidem) is used to treat sleep problems (insomnia) in adults. Zolpidem belongs to a class of drugs called sedative-hypnotics. It acts on the brain to produce a calming effect. This medication is usually limited to short treatment periods of 1 to 2 weeks or less.

R. Pristiq – (desvenlafaxine) is used to treat depression. It may improve mood, feelings of well-being, and energy level. Desvenlafaxine is known as a serotonin-norepinephrine reuptake inhibitor (SNRI). Desvenlafaxine may also be used to relieve nerve pain, anxiety, and panic attacks. It may also be used to treat hot flashes that occur with menopause.

S. Venlafaxine XL150 - Effexor XR (venlafaxine hydrochloride extended-release) is an antidepressant used to treat patients with major depressive disorders such as panic and social disorders.

T. Ritalin - (methylphenidate) is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Ritalin is used to treat attention deficit disorder (ADD) and attention deficit hyperactivity

disorder (ADHD). It is also used in the treatment of a sleep disorder called narcolepsy (an uncontrollable desire to sleep). When given for attention deficit disorders, Ritalin should be an integral part of a total treatment program that may include counseling or other therapies.

U. Lamictal - (lamotrigine) is an anti-epileptic medication, also called an anticonvulsant. Lamictal is used either alone or in combination with other medications to treat epileptic seizures in adults and children. Lamotrigine is also used to delay mood episodes in adults with bipolar disorder (manic depression). The immediate-release form of Lamictal (regular tablet and orally disintegrating tablet) can be used in children as young as 2 years old when it is given as part of a combination of seizure medications. However, this form should not be used as a single medication in a child or teenager who is younger than 16 years old. The extended-release form of lamotrigine (Lamictal XR) is for use only in adults and children who are at least 13 years old.

V. Abilify - (aripiprazole) is an antipsychotic medication. It works by changing the actions of chemicals in the brain. Abilify is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression). It is also used together with other medications to treat major depressive disorder in adults. Abilify is also used to treat irritability and symptoms of aggression, mood swings, temper tantrums, and self-injury related to autistic disorder in children who are at least 6 years old.

W. Wellbutrin – (bupropion) is used to treat depression. It can improve mood and feelings of well-being. It may work by helping to restore the balance of certain natural chemicals (neurotransmitters) in the brain.

X. Provigil - (modafinil) is a medication that promotes wakefulness. It is

thought to work by altering the natural chemicals (neurotransmitters) in the brain. Provigil is used to treat excessive sleepiness caused by sleep apnea, narcolepsy, or shift work sleep disorder

Y. Aplenzin - This medication is used to treat depression. It may also be used to prevent seasonal affective disorder (SAD), a type of depression that occurs each year at the same time (for example, during winter). This medication can improve mood and feelings of well-being. It may work by restoring the balance of certain natural substances (dopamine, norepinephrine) in the brain.

Z. Chloral Hydrate – is used for treating sleep disorders. It may be used to prevent symptoms of alcohol withdrawal or to treat existing withdrawal symptoms. It may also be used to produce sedation or sleep before certain procedures, or to relieve anxiety due to certain procedures or substance withdrawal. It may also be used to treat other conditions as determined by a doctor. Chloral hydrate is a nonbarbiturate sedative and hypnotic. It works by depressing the central nervous system (brain). This causes drowsiness and helps to induce sleep. It is less likely to cause a slower breathing rate than barbiturate-type sedatives/hypnotics.

AA. Adderall – This combination medication is used to treat attention deficit hyperactivity disorder as part of a total treatment plan, including psychological, social, and other treatments. It may help to increase the ability to pay attention, concentrate, stay focused, and stop fidgeting. This product is a combination of stimulants (amphetamine and dextroamphetamine). It is thought to work by restoring the balance of certain natural substances (neurotransmitters) in the brain. This drug may also be used to treat a certain sleeping disorder (narcolepsy).

BB. Restoril – (temazepam) this medication is used to treat sleep problems

(insomnia). Temazepam belongs to a class of drugs called sedative-hypnotics. It acts on the brain to produce a calming effect.

CC. Methylin - (methylphenidate) is used for treating attention deficit disorders--for example, attention deficit hyperactivity disorder . It is also used to treat uncontrollable periods of daytime sleep (narcolepsy). Methylin is a central nervous system stimulant. Exactly how it works is not known.

DD. Vynanse - (lisdexamfetamine) is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Vyvanse is used to treat attention deficit hyperactivity disorder in adults and in children who are at least 6 years old. Vyvanse is also used to treat moderate to severe binge eating disorder in adults. This medicine is not to be used for obesity or weight loss.

EE. Nuvigil – (armodafinil) reduces extreme sleepiness due to narcolepsy and other sleep disorders, such as periods of stopped breathing during sleep (obstructive sleep apnea).

STANDARD OF CARE

15. The standard of care for a psychiatric practice is to maintain accurate and complete medical records for patients. The records must document an assessment, the basis for the assessment, treatment options offered, and response to treatment. The records must be legible if handwritten.

16. The standard of care requires psychiatrists to provide an appropriate prior exam that includes a mental status examination. The psychiatric evaluation may be augmented by testing, such as serology testing, to rule out any metabolic etiologies to the patient's complaints, or psychological testing to help quantify or detect the patient's symptoms.

17. When providing mental health treatment, the standard of care requires an

appropriate prior exam so that a proper assessment and a differential diagnosis can be determined. The type of treatment varies depending on the mental health diagnosis. The response to treatment typically requires prospective evaluation, and with this prospective evaluation, treatment can be changed depending on the response. In addition, the standard of care requires that the patient be informed of the risks as well as the benefits of the treatment.

18. The standard of care imposes a duty on psychiatrists to demonstrate professional honesty . The American Psychiatric Association's Principles of Medical Ethics, 2013 Edition establishes the Standard of Care for professional honesty in psychiatric practice. Section 2 states, "A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities."

19. When treating patients with ADHD, the Standard of Care requires continuous performance testing to quantify the ADHD symptoms.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent Mohammad Shamie, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he committed gross negligence during his care, treatment and management of Patients T.H., J.B., D.C., J.R. and M.S, as follows:

A. On or about July 19, 2012, the Medical Board of California received an anonymous consumer complaint alleging that Respondent, psychiatrist, was writing excessive prescriptions for controlled substances and other dangerous drugs. An investigation was opened and Respondent's Controlled Substance Utilization Review and Evaluation System (CURES) report was examined by a district medical consultant who concluded that Respondent's prescribing practices were problematic. Five patients, T.H., J.B., D.C., J.R. and M.S., whose names were listed on the CURES report were contacted

1 and their medical records reviewed.

2 **Patient T.H.**

3 B. On or about February 21, 2014, Patient T.H. advised the Medical Board of
4 California (MBC) that he no longer saw Respondent. He felt that Respondent was
5 indifferent. Patient T.H. stated that Respondent prescribed Suboxone. According to Patient
6 T.H., Respondent would get the prescription medications from the pharmacy, have the
7 insurance pay for the prescription, dispense a portion of the prescription, keep the rest, and
8 charge the patient for the portion given.

9 C. Respondent's medical records for Patient T.H. are handwritten and many,
10 illegible. Included in the records is a dictated psychiatric history and evaluation when the
11 patient was admitted to Las Encinas Hospital on January 8, 2006, along with a discharge
12 summary from that hospitalization. On admission, Patient T.H. was diagnosed with Major
13 Depression, Chronic, and Multiple Prescription Drug Addiction. Patient T.H. was
14 discharged after a hospitalization of eleven days with diagnoses of Bipolar Disorder, Not
15 Otherwise Specified, and Chemical Dependency on Opiates. Upon his discharge, Patient
16 T.H. was placed on a psychotropic medication regimen of Lexapro 10 mg, one tablet every
17 morning, Depakote ER 500 mg at bedtime, phenobarbital 30 mg, one tablet at bedtime for
18 five days, then one-half tablet at bedtime, quantity 10 dispensed. The records indicated that
19 Patient T.H. or his mother picked up pills of Suboxone on the following dates, among
20 others: January 24, 2006; January 25, 2006; January 27, 2006; and, February 6, 2006. The
21 Suboxone prescriptions reintroduced Patient T.H. to opiates after he just had undergone
22 withdrawal for same.

23 D. During the investigation, Respondent spoke with representatives of the Board.
24 He advised that Patient T.H. suffered from severe insomnia, and that is the reason for
25 writing prescriptions for both Lunesta and Ambien. The Suboxone prescription was written
26 immediately after the patient's hospitalization, at a time when the patient was on opiates.
27 The use of Suboxone introduced opiates again.

28 E. When asked why he would prescribe stimulant medication, such as Ritalin and

Adderall, to Patient T.H., when the patient suffered from severe insomnia, Respondent replied that he was writing low doses, that he was not worried about affecting Patient T.H.'s sleep, and that he was using the stimulants to treat depression and some symptoms of poor concentration and ADD-type symptoms, which he attributed as a secondary diagnosis. Respondent acknowledged that he did not do a formal evaluation for ADD (Attention Deficit Disorder), which is referred to in the current psychiatric nomenclature as ADHD (Attention Deficit-Hyperactivity Disorder). He relied on the clinical interview, where in the clinical interview, questions and answers are not documented well.

F. Respondent advised he had not seen Patient T.H. for several months. He did not know the patient was seeing another psychiatrist. As revealed in the CURES report, the last prescription written by Respondent for Patient T.H. was on September 13, 2013 for Suboxone 8 mg, dispense 60. A review of his CURES profile, starting from August 13, 2009 to October 15, 2013, revealed additional prescriptions for the following controlled substances: Lunesta , phenobarbital, Ambien and Adderall.

G. Respondent, as revealed in his dictated psychiatric evaluation and discharge summary, was able to have a face-to-face interview, to perform a mental status examination, and to evaluate Patient T. H. and generate an assessment. Respondent, however, did not document why he would change his assessment to Bipolar Disorder from Major Depressive Disorder. Later on, while he was treating Patient T.H., on an outpatient basis, Respondent diagnosed the Patient with depression and ADHD.

H. Respondent failed to perform a standard evaluation of ADHD. ADHD is a childhood disorder that can persist into adulthood. The standard of care evaluation not only relies on a clinical evaluation of symptoms, but an account of a history of having the illness as a child that has persisted. The standard typically includes psychological testing with either questionnaires or computerized performance testing. Moreover collateral information is typically obtained for a diagnosis of adult ADHD, especially in patients with addiction, as it can be dangerous to prescribe many medications used in the treatment of ADHD in those who suffer from addiction, as some of these medications are inherently

addictive themselves .

I. While Respondent did appear to make a proper assessment that Patient T.H. suffered from addiction, he did not formulate the effects of addiction on his clinical presentation and did not follow the standard for making a psychiatric assessment of comorbid conditions, such as ADHD.

Patient J.B.

J. Patient J.B. first became acquainted with Respondent when she was a patient at Las Encinas Hospital where she was suffering from severe depression with Severe Suicidal Tendencies. There are over 900 pages of medical records from Respondent for Patient J.B. The records include illegible handwritten notes interspersed with Workers' Compensation dictations and various copies of prescriptions.

K. Representatives of the Medical Board of California interviewed Respondent regarding his care, treatment and management of Patient J.B. Respondent reported that Patient J.B. was abusing pain medication. He also reported that he had diagnosed Patient J.B. with Attention Deficit Disorder (ADD) based, primarily, on her inability to concentrate and to do her daily work in her life.

L. During his interview, Respondent was asked whether Patient J.B.'s symptoms of inability to concentrate and focus might be due to other etiologies than ADD. Respondent reported that Patient J.B.'s inadequate response to antidepressant medication was another factor in his assessment of ADD and in prescribing the medication. Respondent further reported that he also diagnosed Patient J.B. with OCD, based on the patient's inability to handle papers, misplacing things, and collecting at home.

M. Respondent also reported that he also diagnosed Patient J.B. with PTSD, based on the patient having recurrent traumatic thoughts regarding the work-related injury that occurred while she was a teacher. While the notes are illegible, in his interview with

the Board, Respondent does not report that Patient J.B. is improving with any of the treatments he has offered, which include multiple medication changes.

N. Respondent prescribed Patient J.B. Suboxone for pain. Respondent's records did not support this treatment.

O. Between 2009 and 2013, Respondent wrote numerous prescriptions for Patient J.B., including Suboxone, Ambien and Adderall.

P. While Respondent's records are voluminous, over 900 pages, they are not an accurate documentation of the psychiatric evaluation and treatment offered. They are illegible. Even Respondent was unable to read them when asked to do so in the interview with the representatives from the Board.

Q. Respondent's records lack documentation for his assessment of OCD.

R. Regarding Respondent's diagnosis of ADD, he made that determination without any standardized assessment. ADD is a childhood disorder that can persist as an adult, and has many symptoms that are shared with other psychiatric conditions, such as addiction and depression, from which Patient J.B. suffered.

S. Respondent made additional diagnoses, including PTSD, based upon the patient's self-reporting and without obtaining any collateral information.

Patient D.C.

T. On February 2, 2014, representatives of the Board interviewed Patient D.C.'s father. He conveyed the following:

1) Patient D.C. has suffered from Clinical Depression for many years, and has gone to Respondent for treatment. He felt that Respondent had over-prescribed to Patient D.C. and was only interested in making money from his patients. Respondent had caused Patient D.C. to become addicted to Ritalin as

well as painkillers. According to the father, when D.C. was out of medication, Respondent would sell pills to D.C.

2) On one occasion, Patient D.C.'s father received a call from a homicide detective who wanted to know why a person, identified as P.R., would have possession of Patient D.C.'s prescriptions.

U. Respondent's records for Patient D.C. were reviewed. The first legible note showed that the patient presented to Respondent on July 7, 2009. Respondent advised that he had provided care to Patient D.C. when he was at Las Encinas Hospital prior to this date. Respondent advised that he had no documentation that Patient D.C. had been on Ritalin and admits that there is no documentation that the patient had been on Ritalin.

V. Although the July 7, 2009, visit was Respondent's first with Patient D.C., he did not document it.

W. Respondent had been advised that Patient D.C. had a history of addiction, and a "love of Vicodin and benzodiazepines, and a lot of other drugs, such as Oxycontin." On July 7, 2009, Respondent prescribed Xanax and Ativan as needed for anxiety. At the same time, he discontinued Pristiq, replacing it with Venlafaxine XL and Ritalin. He also discontinued his Abilify and Wellbutrin, replacing them with Risperdal.

X. Respondent reported to the Board that at his visit in August 2009, he started the patient on Provigil as well as Aplenzin. He does not provide any rationale why he used Aplenzin, which has the same active ingredient, bupropion, as Wellbutrin. He also conveyed to the Medical Board that he did not attribute the patient's anxiety to Provigil, and that he doesn't see Provigil causing anxiety in patients.

Y. Respondent restarted Patient D.C. on Ritalin in September 2009, at twice

the dose he had prescribed previously.

CC. Respondent also treated Patient D.C. with electroconvulsive therapy (ECT) but failed to document the treatment because it was performed at the hospital, not at Respondent's office.

Z. A review of CURES profiles for Patient D.C. shows six (6) pages of scheduled medications prescribed by Respondent, including Ambien (zolpidem), Ritalin (methylphenidate), Ativan (lorazepam), Lunesta (eszopiclone), Klonopin (clonazepam), chloral hydrate, Adderall (dextro-amphetamine salts), Restoril (temazepam), Methylin (methylphenidate), Suboxone (buprenorphin), Provigil (modafinil), Vyvanse (lisdexamfetamine), and Nuvigil (armodafinil). Respondent's records do not support the administration of these medications.

AA. Respondent did not provide an evaluation that would render an accurate psychiatric assessment for Patient D.C. Respondent provided psychotropic medications inherently abusable with his multiple prescriptions of benzodiazepines, alprazolam, lorazepam, Klonopin, and temazepam, as well as the hypnotics phenobarbital, zolpidem, zaleplon, as well as the stimulants he prescribed, Nuvigil and Provigil, Adderall, Vyvanse, and methylphenidate. While under his care, Respondent also started Patient D.C. on Suboxone for treatment of an opiate addiction.

BB. Patient D.C. required electroconvulsive therapy during his care with Respondent, which showed that he was not responding to the psychiatric treatment offered or the vast majority of the medications prescribed. However, Respondent did not document this information or that he considered referring the patient to a higher level of substance abuse care, such as residential treatment. Respondent did not refer the patient to any type of substance abuse treatment that could be concurrently received while he was

receiving outpatient psychiatric care, such as involvement in a twelve step program.

Patient J.R.

CC. Respondent provided his medical records for Patient J.R. Similar to the other patient records provided by Respondent, they are handwritten and illegible. During his interview with representatives from the Board, Respondent stated that Patient J.R. was referred to him through the Internet for Suboxone and that his initial evaluation was conducted on September 27, 2012.

DD. According to Respondent, Patient J.R. advised that he was using Norco for back pain and that this was his drug of choice. Respondent stated that this was an atypical type of referral to him. Respondent prescribed Suboxone for Patient J.R.

EE. In discussing Patient J.R. with representatives of the Board, Respondent stated that he starts a prescription of Suboxone at his office after having the prescriptions for the same filled at a pharmacy and delivered to his office. Respondent added that he administers the drug and charges the patient a fee for handling the medication.

FF. Respondent further stated that, while there is no such documentation in the medical record, Patient J.R. would call Respondent's office and ask for a prescription. Respondent stated that he would not write a prescription or dispense the medication without the patient presenting at his office.

GG. Patient J.R.'s last visit with Respondent was in August 2013 at which time Respondent wrote prescriptions for Suboxone. He informed the Board that he wrote the prescription for Valtrex as it was a refill for a prescription that was written by another physician.[1]

HH. A review of the CURES profile for Patient J.R. showed that the patient

[1] Respondent stated that the patient had a sore for which another physician had prescribed Valtrex.

filled prescriptions written by Respondent on a regular basis, the last being on September 12, 2013.

Patient M.S.

II. A review of Patient M.S.'s CURES profile showed that she received the following prescriptions from Respondent: Lunesta, Adderall XR, and Ativan. The last prescription written by Respondent was for Adderall and dispensed on October 14, 2013.

JJ. Respondent provided Patient M.S.'s records to the Board. Respondent's first record is dated July 11, 2007. The note was illegible but Respondent advised that it indicated that the patient had been on Ritalin at the time of evaluation, having been diagnosed with ADD as a child.

KK. According to Respondent, Patient M.S. was attending California State University, Northridge and was still showing poor attention, scattered thinking, problems with motivation, depression, and insomnia.

LL. After the Federal Drug Administration (FDA) recommended lowering the starting dose of Lunesta from 2 mg to 1 mg, Respondent continued the drug at the highest dose, stating that Patient M.S. did not have any side effects with this medication. Respondent, however, did not document this information.

MM. In his interview, Respondent did not state what antidepressant medication he has prescribed Patient M.S. However, his records show an approved refill for Effexor XR and a refill request for Pristiq.

NN. Respondent's last note for Patient M.S. is dated January 22, 2014. Like almost all of Respondent's records, it is extremely difficult to read.

OO. Respondent failed to conduct any psychological testing, review any collateral information concerning Patient M.S. and review any response by the patient to the medication he prescribed or, in the alternative, failed to document that he did so.

PP. The following acts and omissions, considered individually and collectively constitute extreme departures from the standard of care.

1) Failing to maintain legible patient records.

2) Failing to maintain adequate and accurate records pertaining to the provision of his services. More specifically, Respondent's records did not document an adequate assessment or the basis for Respondent's assessments, the treatment options offered to the patients and the patients' responses to treatment.

3) Failing to warn the patients of the risks as well as the benefits of treatment or, in the alternative, failing to document that he did so.

4) Failing to conduct an appropriate prior exam, evaluation and mental status examination in person.

5) Writing prescriptions to patients whom he knew or should have known were addicts.

6) Charging patients fees for medications when those medications were fully paid for by the patient's medical insurance carrier.

7) Failing to devolve a differential diagnosis for patients or, in the alternative, failing to document that he did so.

8) As to Patient T.H., specifically, Respondent prescribed Suboxone for maintenance treatment in a patient already off opiates, without having close face-to-face follow-up or any type of monitoring, such as urine drug screens, to ensure that the patient was taking the medication as directed, and not having an exacerbation of his addiction and abusing other opiates. Suboxone is inherently addictive as an opiate, and can trigger a patient's addiction if not properly monitored. Moreover, Respondent prescribed inherently addictive agents, such as phenobarbital, Ambien and benzodiazepines, as well as sedative hypnotics, Lunesta and Ambien, which are well understood in the psychiatric community to have addiction potential, and the addiction potential is acknowledged in medical literature, is dangerous, and not helpful for his treatment of addiction, and rather could exacerbate

Patient T.H.'s addiction.

9) As to Patient T.H., specifically, treating the patient for insomnia with sedative hypnotic medication without regard or consideration of the patient's addiction.

10) As to Patient J.B., specifically, making an assessment of OCD without substantiation or, in the alternative, failing to document the substantiation.

11) As to Patient J.B., specifically, making diagnoses and formulating assessments based on the patient's self-reporting and without obtaining any collateral or substantiating information.

12) As to Patient D.C., specifically, failing to consider alternative treatments when the patient failed to respond positively to electroconvulsive therapy.

13) As to Patient J.R., specifically, Respondent's failure to obtain collateral information supporting the patient's history and to insist that the patient submit to the urine drug screens Respondent ordered.[2]

14) As to Patient J.R., specifically, administering Suboxone at his office.

15) As to Patient M.S., specifically, failing to conduct any psychological testing, review any collateral information concerning Patient M.S. and review any response by the patient to his prescribed medication.

16) As to Patient M.S., specifically, failing to advise her that some of the symptoms she was experiencing may have been due the medications she was taking.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

21. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts during his care, treatment and management of Patients T.H., J.B., D.C., J.R. and M.S., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph

[2] Respondent advised that the patient always had an excuse for not having the urine drug testing performed; yet, Respondent continued to prescribed controlled substances to Patient J.R.

20, above, as though set forth in full.

B. The following acts and omissions are departures from the standard of care.

1) Failing to maintain legible patient records.

2) Failing to maintain adequate and accurate records pertaining to the provision of his services. More specifically, Respondent's records did not document an adequate assessment or the bases for Respondent's assessments, the treatment options offered to the patients and the patients' responses to treatment.

3) Failing to warn the patients of the risks as well as the benefits of treatment or, in the alternative, failing to document that he did so.

4) Failing to conduct an appropriate prior exam, evaluation and mental status examination in person.

5) Writing prescriptions to patients whom he knew or should have known were addicts.

6) Charging patients fees for medications when those medications were fully paid for by the patient's medical insurance carrier.

7) Failing to devolve a differential diagnosis for patients or, in the alternative, failing to document that he did so.

8) As to Patient T.H., specifically, Respondent prescribed Suboxone for maintenance treatment in a patient already off opiates, without having close face-to-face follow-up or any type of monitoring, such as urine drug screens, to ensure that the patient was taking the medication as directed, and not having an exacerbation of his addiction and abusing other opiates. Suboxone is inherently addictive as an opiate, and can trigger a patient's addiction if not properly monitored. Moreover, Respondent prescribed inherently addictive agents, such as phenobarbital, Ambien and benzodiazepines, as well as sedative hypnotics, Lunesta and Ambien, which are well understood in the psychiatric community to have addiction potential, and the addiction potential is acknowledged in medical literature, is dangerous, and not helpful for his treatment of addiction, and rather could exacerbate

Patient T.H.'s addiction.

9) As to Patient T.H., specifically, treating the patient for insomnia with sedative hypnotic medication without regard or consideration of the patient's addiction.

10) As to Patient J.B., specifically, making an assessment of OCD without substantiation or, in the alternative, failing to document the substantiation.

11) As to Patient J.B., specifically, making diagnoses and formulating assessments based on the patient's self-reporting and without obtaining any collateral or substantiating information.

12) As to Patient D.C., specifically, failing to consider alternative treatments when the patient failed to respond positively to electroconvulsive therapy.

13) As to Patient J.R., specifically, Respondent's failure to obtain collateral information supporting the patient's history and to insist that the patient submit to the urine drug screens Respondent ordered.[3]

14) As to Patient J.R., specifically, administering Suboxone at his office.

15) As to Patient M.S., specifically, failing to conduct any psychological testing, review any collateral information concerning Patient M.S. and review any response by the patient to his prescribed medication.

16) As to Patient M.S., specifically, failing to advise her that some of the symptoms she was experiencing may have been due the medications she was taking.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

22. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (d), for incompetence in that he failed to demonstrate the necessary skill and knowledge to discharge the duties and responsibilities of a physician and surgeon during his care, treatment and management of Patients T.H., J.B., D.C., J.R. and M.S., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 20,

[3] Respondent advised that the patient always had an excuse for not having the urine drug testing performed; yet, Respondent continued to prescribe controlled substances to Patient J.R.

above, as though set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Dishonest or Corrupt Acts)

23. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (e), for committing dishonest or corrupt acts during his care, treatment and management of Patients T.H., J.B., D.C., J.R. and M.S., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 20, above, as though set forth in full.

B. Respondent wrote and filled prescriptions for controlled substances and other dangerous drugs. Although the prescriptions were covered by the patients' medical insurance plans, Respondent charged the patients a fee for each prescription. Respondent dispensed only a portion of the written prescription and kept the rest for himself.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

24. Respondent is subject to disciplinary action under Business and Professions Code section 2266 in that he failed to maintain adequate and accurate medical records for Patients T.H., J.B., D.C., J.R. and M.S., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 20, above, as though set forth in full.

SIXTH CAUSE FOR DISCIPLINE

(Violation of Drug Statutes)

25. Respondent is subject to disciplinary action under Business and Professions Code section 2238 in that he violated the applicable drug statutes during his care, treatment and management of Patients T.H., J.B., D.C., J.R. and M.S., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 20, above, as though set forth in full.

SEVENTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

26. Respondent is subject to disciplinary action under Business and Professions Code section 725 in that he excessively prescribed to Patients T.H., J.B., D.C., J.R. and M.S., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 20, above, as though set forth in full.

EIGHTH CAUSE FOR DISCIPLINE

(Prescribing to Addicts)

27. Respondent is subject to disciplinary action under Business and Professions Code section 2241 in that he prescribed controlled substances and other dangerous drugs to patients he knew or should have known were addicts, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 20, above, as though set forth in full.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

28. Respondent is subject to disciplinary action for unprofessional conduct, generally, under Business and Professions Code section 2234, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 20, above, as though set forth in full.

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 A39228, issued to Mohammad Shamie, M.D.;

2. Revoking, suspending or denying approval of Mohammad Shamie, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

1 3. Ordering Mohammad Shamie, M.D., if placed on probation, to pay the Board the
2 costs of probation monitoring; and
3 4. Taking such other and further action as deemed necessary and proper.
4
5 DATED: July 16, 2015

for KIMBERLY KIRCHMEYER
6 Executive Director
Medical Board of California
7 Department of Consumer Affairs
State of California
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Complainant
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