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

In the Matter of the Accusation Against: **Emil Soorani, M.D.** **P.O. Box 1107** **Topanga, CA 90290** **Physician's and Surgeon's Certificate No. A 37184,** Respondent.	Case No. 800-2015-011341 **A C C U S A T I O N**

PARTIES

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

2. On July 27, 1981, the Board issued Physician's and Surgeon's Certificate Number A 37184 to Emil Soorani, M.D. (Respondent). The certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, 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 provides that the Board shall have the responsibility for the enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

5. Section 2227 authorizes the Board to take action against a licensee who has been found guilty under the Medical Practice Act by revoking his or her license, suspending the license for a period not to exceed one year, placing the license on probation and requiring payment of costs of probation monitoring, or taking such other action as the Board deems proper.

6. At all times relevant to this matter, Respondent was licensed and practicing medicine in California.

STATUTORY PROVISIONS

7. Section 2234 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:
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> (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.
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> (b) Gross negligence.
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> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
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> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
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> (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.
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> (d) Incompetence.
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> . . .

8. Section 2238 states: "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."

9. Section 2242 states, in pertinent part, that "[p]rescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

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

FACTUAL ALLEGATIONS

11. From 2012 to 2017, Respondent practiced psychiatry in Santa Monica and Los Angeles, California. Respondent also provided treatment for physical and chronic pain.

Patient P-1

12. Respondent treated P-1[1] from approximately September 14, 2007, through May 16, 2017. Respondent's records of his treatment of P-1 consist of handwritten progress notes, which are illegible apart from the dates of the notes. Among the records are two typed letters by Respondent dated October 31, 2014, and April 17, 2015, summarizing his care of the patient. According to his letters, Respondent had been treating P-1 "for psychopharmacologic management purposes," since September 14, 2007, and had diagnosed her with "Pain Disorder" and depression. Respondent's treatment included prescribing the patient methadone[2] for pain. The letters do not mention that Respondent had also prescribed the patient Ambien[3] and clonazepam.[4] According to Respondent's letters, as of April 17, 2015, the patient's depression and panic were

[1] The patients are designated in this document as P-1 through P-6 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

[2] Methadone is a narcotic used to treat moderate to severe pain. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c), and a dangerous drug as defined in Business and Professions Code section 4022.

[3] Zolpidem (Ambien®) is a hypnotic and sedative used to treat insomnia. It is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(32), and a dangerous drug as defined in Business and Professions Code section 4022.

[4] Clonazepam is a benzodiazepine and sedative used to treat anxiety and panic disorder. It

in remission, and she no longer needed an antidepressant. At that time, she remained on a medication for anxiety and stress. Respondent also noted that the patient had been sober from alcohol for a long time, suggesting a history of alcohol abuse.

13. A legible note in the patient's records, dated August 29, 2013, indicates that Respondent was notified that another provider was prescribing the patient Ambien, and that the patient had sought an early refill of her medication. A few months later, Respondent began prescribing the patient Ambien while she was also receiving it from the other provider. The patient filled prescriptions for Ambien by the other provider on December 11, 2013 and January 27, 2014. She also filled Ambien prescriptions from Respondent on January 3, 2014, February 5, 2014, and March 5, 2014.

14. Respondent resumed prescribing the patient Ambien, in February 2016, and by May 2016 the patient was again obtaining early refills of her medication. The patient's early refills of her medications and her seeking simultaneous prescriptions from more than one provider indicated that she was taking more medication than directed, a sign that she may have developed tolerance to and withdrawal from the medication and that she had become addicted to it. Ambien is addictive, particularly to an individual who is predisposed to addiction, as this patient appears to have been, given her history of alcohol abuse. In addition, Ambien is a sedative that can synergistically interact with the many opiates that Respondent was also prescribing this patient, resulting in a potentially dangerous combined sedative effect on the patient.

15. Respondent's failure to maintain adequate records of his treatment of P-1 was a departure from the standard of care. His progress notes are illegible, and his summary-of-care letters do not provide an accurate and complete account of his treatment.

16. Respondent's diagnosis of the patient with "Pain Disorder," without documenting any evaluation of the patient's pain and without specifying whether its etiology was psychological, physical, or both, was a departure from the standard of care.

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is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in Business and Professions Code section 4022.

17. Respondent's continued prescribing of Ambien to this patient despite warning signs of her addiction to it, and his failure to document taking steps to address her potential addiction or to justify his continued prescribing was a departure from the standard of care.

Patient P-2

18. Respondent treated P-2 from approximately January 8, 2005, through at least September 2, 2016. Respondent's records of his treatment of P-2 consist of handwritten progress notes, which are illegible apart from the dates of the notes. Among the records are two typed letters by Respondent dated September 14, 2012, and July 10, 2014, summarizing his care of the patient. According to his letters, Respondent had been treating P-2 for Major Depressive Disorder, not otherwise specified, and Anxiety Disorder, not otherwise specified. Both letters conclude that the patient remained totally disabled from all occupational functioning. The July 10, 2014, letter states that his disability was in part physical due to "severe injury to right arm with permanent nerve damage."

19. The July 10, 2014, letter notes some improvement in the patient's Major Depressive Disorder. The letter does not document any pharmacological treatment for the patient's Major Depressive Disorder, such as an antidepressant medication. The letter notes that Respondent prescribed the patient Ambien, but Respondent did not document any basis for this medication, such as the patient's diagnosis with a sleep disorder.

20. The treatment that Respondent documented in his summary-of-care letters conflicts with Controlled Substance Utilization Review and Evaluation System (CURES)[5] reports of his prescribing. Respondent's July 10, 2014, letter states that Respondent prescribed the patient two 10 mg tablets of dextroamphetamine[6] in the morning and one to two tablets in the evening, "for focus." CURES reports, however, show that Respondent prescribed the patient a higher daily dose of dextroamphetamine, and that the dose and timing of the prescriptions fluctuated.

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[5] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California, serving regulatory oversight agencies, law enforcement, public health, and health care providers.

[6] Dextroamphetamine (Dexedrine®) is a stimulant used to treat ADHD and narcolepsy. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug as defined in Business and Professions Code section 4022.

Respondent did not document an explanation for these fluctuations. There were also times when P-2 filled his prescription for dextroamphetamine early. Respondent did not document his acknowledgment or an explanation of this. In addition, although Respondent states in his letters that he prescribed the patient 1 mg of Klonopin[7] as needed for anxiety, CURES reports show that in fact he prescribed the patient a 4 mg daily dose of Klonopin, a much higher dose, at a level that causes tolerance and withdrawal.

21. Respondent treated the patient with an aggressive and risky combination of psychiatric medications, including Abilify, an antipsychotic medication; dextroamphetamine for attention deficit hyperactivity disorder (ADHD); Klonopin for anxiety; Ambien for unknown reasons; and Synthroid, which is used to augment the antidepressant effects of antidepressant medications. Such a large number of psychiatric medications taken concurrently poses the risk of detrimental interactions between the drugs. In addition, three of the medications are addictive: dextroamphetamine, Klonopin, and Ambien. Respondent did not justify the risks of these medications, given the patient's lack of improvement from being totally disabled from all occupational functioning. In addition, while Respondent diagnosed the patient with Major Depressive Disorder, according to his July 10, 2014, summary-of-care letter, Respondent did not treat him with an antidepressant medication.

22. Respondent's failure to maintain adequate records of his treatment of P-2 was an extreme departure from the standard of care. His progress notes are illegible, and his summary-of-care letters do not provide an accurate and complete account of his treatment.

23. Respondent's failure to justify the risks of the medication regimen he prescribed to P-2, given the patient's lack of response to the medication, and his cessation of prescribing an antidepressant medication for the patient's Major Depressive Disorder was a departure from the standard of care.

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[7] Klonopin® is a brand name of clonazepam, described above, at footnote 4.

Patient P-3

24. Respondent treated P-3 from approximately February 2, 2012, through January 2, 2016. Respondent's records of his treatment of P-3 consist of handwritten progress notes, which are illegible apart from the dates of the notes. Also among the records are some typewritten documents and psychological tests, which are legible.

25. The February 2, 2012, initial evaluation form completed by Respondent includes check marks next to "Pain Disorder," and "296.22," which is a DSM-IV-TR code for Major Depressive Disorder, Single Episode, Moderate. While legible portions of the records, including the patient's complaints and the findings of a mental status examination by Respondent, support the presumed diagnosis of Major Depressive Disorder, there is no basis to support the presumed diagnosis of "Pain Disorder."

26. CURES reports show that Respondent prescribed the patient Ambien and Klonopin for years, over the course of his treatment of the patient. Respondent continued to prescribe these medications to the patient through April 2016, months after the date of the last record of his treatment of the patient, on January 2, 2016.

27. Respondent prescribed the patient excessive amounts of Ambien, by simultaneously prescribing him two different formulations of the medication (immediate release and controlled release), each at the highest daily dose. The patient in turn was regularly obtaining early refills of these prescriptions. The patient's early refills indicated that he was taking more medication than directed, a sign that he may have developed tolerance to and withdrawal from the medication and that he had become addicted to it.

28. Respondent's failure to maintain adequate records of his treatment of P-3 was an extreme departure from the standard of care. His progress notes are illegible, the records do not provide an accurate and complete account of his treatment, and there are no records supporting the final months of his prescribing of controlled substances to this patient.

29. Respondent's diagnosis of the patient with "Pain Disorder," without documenting any evaluation of the patient's pain and without specifying whether its etiology was psychological, physical, or both, was a departure from the standard of care.

30. Respondent's prescribing of excessive amounts of Ambien to this patient despite warning signs of his addiction to it, and his failure to document taking steps to address his potential addiction and to justify his continued prescribing was a departure from the standard of care.

Patient P-4

31. Respondent treated P-4 from approximately April 19, 2013, through July 21, 2016. Respondent's records of his treatment of P-4 consist of handwritten progress notes, most of which are illegible apart from the dates of the notes. There appear to be different authors of records throughout the chart, based on varying legibility of the handwritten records. Also, among the records are some typewritten documents, which are legible, including a letter from Respondent dated January 3, 2014, summarizing care of the patient. According to his letter, Respondent had been treating P-4 for "pain management purposes, secondary to a diagnosis of Severe Chronic Pain."

32. According to pharmacy records obtained by the Board, Respondent prescribed the patient a number of psychiatric medications over the course of his treatment. He also prescribed the patient opiates, such as fentanyl[8] and oxycodone.[9]

33. Respondent's failure to maintain adequate records of his treatment of P-4 was an extreme departure from the standard of care. His progress notes are illegible, the records do not provide an accurate and complete account of his treatment, and it is impossible to determine for which psychiatric conditions Respondent treated the patient.

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[8] Fentanyl is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug as defined in Business and Professions Code section 4022.

[9] Oxycodone is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as defined in Business and Professions Code section 4022.

Patient P-5

34. Respondent treated P-5 from approximately May 8, 2012, through March 18, 2016. Respondent's records of his treatment of P-5 consist of handwritten progress notes, most of which are illegible apart from the dates of the notes, and copies of prescriptions. Also, among the records are some typewritten documents, including several letters from Respondent summarizing care of the patient.

35. During his initial evaluation, the patient completed a Beck Depression Inventory and a Beck Anxiety Inventory, scoring zero on each, which is within normal limits. P-5 also completed an Adult ADHD Self-Report Scale. The patient scored 22 on this—scores of 11 points or higher indicate symptoms that may be consistent with adult ADHD. The patient noted no psychiatric complaints in his initial evaluation paperwork.

36. Respondent diagnosed P-5 with ADHD based on his first visit, when he was 39 years old. The only basis for this diagnosis appears to be the Adult ADHD Self-Report Scale, which is an insufficient basis to diagnose ADHD. There is no documentation that the patient was suffering from active ADHD, that he had had a clinical course indicative of the condition, or that he had been previously diagnosed with ADHD. This is not indicative of an individual who suffers from ADHD in adulthood, as the condition first emerges in childhood (and in most patients resolves by adulthood).

37. In August 2013, the patient injured his knee in a skiing accident, after which Respondent treated him for pain, including by prescribing him opiates like oxycodone and fentanyl.

38. In December 2012, six months after the patient's first visit, pharmacy records obtained by the Board show that Respondent began prescribing P-5 a high dose of Klonopin, which Respondent later confirmed was used to treat the patient's anxiety. But just a few months earlier, at his initial evaluation, the patient had no complaints of anxiety, and he had a negative inventory for anxiety. Respondent did not explain the origin of the patient's apparent

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new anxiety. One explanation that Respondent should have considered was that the high doses of stimulants that Respondent had begun prescribing the patient after his first visit were causing the patient to exhibit symptoms consistent with anxiety.

39. Respondent also diagnosed the patient with excessive daytime sleepiness, but Respondent's records do not document any consideration that the patient was simply sedated from the high-dose opiates and Klonopin that Respondent prescribed him. Nor did Respondent explain the origin of his diagnoses of the patient with depression or PTSD.

40. During the course of his treatment of P-5, Respondent prescribed him excessive amounts of addictive stimulants. For example, Respondent prescribed P-5 Vyvanse[10] at the FDA maximum dose of 70 mg daily, concurrently with a high dose of Dexedrine[11] 10 mg two tablets three times a day, for a daily dose of 60 mg. While prescribing this aggressive treatment for ADHD, Respondent was giving the patient an additional stimulant—Nuvigil[12] 250 mg in the morning. When combined with the two other stimulant medications, Nuvigil can have a synergistic effect that could cause increased anxiety and insomnia, and even lead to psychosis in some patients. Moreover, this was coupled with the stimulating antidepressant Wellbutrin[13] at a high dose of 450 mg in the morning. This exceeds the typical dose, but it is not uncommon by itself. However, in the context of the three other stimulant medications, this amount of Wellbutrin was extremely aggressive, could have been dangerous, and almost surely provoked anxiety in the patient.

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[10] Lisdexamfetamine (Vyvanse®) is a stimulant used to treat ADHD. It is a Schedule II controlled substance as defined by section 1308.12, subdivision (d)(5), of Title 21 of the Code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

[11] Dexedrine® is a brand name of dextroamphetamine, described above, at footnote 6.

[12] Armodafinil (Nuvigil®) is a stimulant used to treat narcolepsy. It is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (f), and a dangerous drug as defined in Business and Professions Code section 4022.

[13] Bupropion (Wellbutrin®) is an antidepressant used to treat depression. It is a dangerous drug as defined in Code section 4022.

41. According to Respondent's summary-of-care letters, by 2016, he was prescribing the patient some 17 medications. The patient's condition does not appear to have improved as a result of Respondent's treatment, as Respondent continued to report through 2016 that the patient remained totally disabled and was unable to work fulltime.

42. After his last visit with Respondent, on or about May 18, 2016, P-5 sought treatment from a pain management physician and then entered a rehabilitation facility, where he was weaned off of opiate medications.

43. Respondent's failure to maintain adequate records of his treatment of P-5 was a departure from the standard of care. His progress notes are illegible, and his summary-of-care letters do not provide a complete account of his treatment, including the basis for his assessment and the reasoning supporting his treatment.

44. Respondent's unsupported diagnoses of the patient with ADHD, anxiety, depression, PTSD and excessive daytime sleepiness and his failure to consider whether his prescribed medication regimen, numbering some 17 medications at one point, was causing the symptoms underlying these diagnoses was an extreme departure from the standard of care.

45. Respondent's failure to justify the risks of the medication regimen he prescribed to P-5, which included excessive amounts of addictive stimulants, given the patient's lack of response to the medication, was an extreme departure from the standard of care.

Patient P-6

46. Respondent treated P-6 from approximately November 1, 2012, when she was 40 years old, through March 23, 2016. Respondent's records of his treatment of P-6 consist of handwritten progress notes, most of which are illegible apart from the dates of the notes, and copies of prescriptions and correspondence with health insurance companies.

47. A March 25, 2014, disability insurance form and related letter from Respondent indicates that Respondent diagnosed the patient with Bipolar Disorder, Severe, Depressed with Psychotic Features; ADHD; and Pain Disorder of neck, feet, and wrist. The letter continues, "Patient continues to exhibit morbid depression, impulse behavior and delusional thinking. She is currently on several psychotropic medications and sees me regularly."

48. There is no legible documentation of any test results, history, or current symptomatology to support the patient's diagnosis with ADHD. Also, P-6 completed a patient questionnaire at the start of her treatment, in which she reported no prior history of being diagnosed with ADHD. This is not indicative of an individual who suffers from ADHD in adulthood, as the condition first emerges in childhood (and in most patients resolves by adulthood). The patient also indicated in the questionnaire that she used methamphetamine[14] off and on. Respondent did not document whether the patient was actively using methamphetamine during the time she was receiving care from him or whether he had considered the impact of the patient's history of methamphetamine in reaching his diagnosis of ADHD.

49. Respondent prescribed P-6 multiple benzodiazepines[15] concurrently, the prescriptions for which she filled early. The benzodiazepines prescribed by Respondent also overlapped with those prescribed by other providers. For example, on May 21, 2015, P-6 filled a prescription written by Respondent for Ativan[16] 1 mg, dispense 60 for a 15-day supply, which corresponds to 4 mg daily, a high dose. Just eight days later, on May 29, 2015, P-6 filled a prescription by another provider for the benzodiazepine Xanax[17] 2 mg dispense 60 for a 30-day supply, which is 4 mg daily and a high dose. Then, four days later, on June 2, 2015, P-6 filled a prescription by Respondent for Ativan 1 mg dispense 60 for a 15-day supply. Ten days later, on June 12, 2015, P-6 filled a prescription by Respondent for the benzodiazepine Klonopin 1 mg dispense 60 for a 15-day supply, which is 4 mg daily and is again a high dose. Then, on June 16, 2015, P-6 filled a

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[14] Methamphetamine is a powerful, highly addictive stimulant that affects the central nervous system. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(2), and a dangerous drug as defined in Business and Professions Code section 4022.

[15] Benzodiazepines are a controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug as defined in Business and Professions Code section 4022.

[16] Lorazepam (Ativan®), a benzodiazepine, is a centrally acting hypnotic-sedative. It is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug as defined in Business and Professions Code section 4022.

[17] Alprazolam (Xanax®), a benzodiazepine, is a centrally acting hypnotic-sedative. It is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug as defined in Business and Professions Code section 4022.

prescription by Respondent for Ativan 1 mg dispense 60 for a 15-day supply. Then, six days later, on June 22, 2015, she filled another Xanax prescription by another provider of 2 mg dispense 60 for a 30-day supply.

50. Respondent also prescribed P-6 multiple stimulants concurrently. For example, on May 1, 2015, P-6 filled a prescription by Respondent for Metadate ER[18] 20 mg dispense 90 for a 30-day supply, which equates to a daily dose of 60 mg. This was concurrent with a prescription for Adderall[19] 10 mg dispense 60 for a 30-day supply. In addition, Respondent concurrently prescribed P-6 very similar stimulant medications with the same active ingredient. For example, on May 20, 2015, P-6 filled a prescription of Concerta[20] 36 mg dispense 30 for a 30-day supply written by Respondent. Then, three days later, March 23, 2015, P-6 filled another prescription by Respondent for Metadate ER (methylphenidate) 20 mg, dispense 90 for a 30-day supply.

51. Respondent also prescribed the patient opiates like oxycodone for her pains.

52. In a letter by P-6 dated June 18, 2016, she reported emotional distress and not being able to focus or concentrate. This is not indicative of an individual who was responding to treatment. Rather, the letter suggests that P-6 had likely developed tolerance and withdrawal to the benzodiazepines and stimulants that she was prescribed.

53. Respondent's failure to maintain adequate records of his treatment of P-6 was an extreme departure from the standard of care. His progress notes are illegible, and the legible documents among his records do not provide a complete account of his treatment, including the basis for his assessment, the treatment offered, and the reasoning supporting his treatment.

54. Respondent's unsupported diagnosis of the patient with ADHD was a departure from the standard of care.

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[18] Methylphenidate (Metadate,® Concerta,® Ritalin®) is a stimulant used to treat ADHD and narcolepsy. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(6), and a dangerous drug as defined in Business and Professions Code section 4022.

[19] Adderall® is brand name for a drug containing a combination of amphetamine and dextroamphetamine, central nervous system stimulants that affect chemicals in the brain and nerves that contribute to hyperactivity and impulse control. It is used to treat narcolepsy and ADHD. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug as defined in Business and Professions Code section 4022.

[20] Concerta® is a brand name of methylphenidate, described above, at footnote 18.

55. Respondent's concurrent prescribing of multiple benzodiazepines and stimulants to P-6 and his early filling of her benzodiazepine prescriptions, despite signs that P-6 was addicted to and abusing her medications and despite her lack of response to treatment, was an extreme departure from the standard of care.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

56. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, because he engaged in the following acts of gross negligence in the care and treatment of patients, as alleged above:

A. Respondent failed to maintain adequate records of his treatment of P-2;

B. Respondent failed to maintain adequate records of his treatment of P-3;

C. Respondent failed to maintain adequate records of his treatment of P-4;

D. Respondent did not provide a basis for his diagnoses of P-5 with ADHD, anxiety, depression, PTSD, and excessive daytime sleepiness, and he failed to consider whether his prescribed medication regimen, numbering some 17 medications at one point, was causing the symptoms underlying these diagnoses;

E. Respondent failed to justify the risks of the medication regimen he prescribed to P-5, which included excessive amounts of addictive stimulants, given the patient's lack of response to the medication;

F. Respondent failed to maintain adequate records of his treatment of P-6; and

G. Respondent concurrently prescribed multiple benzodiazepines and stimulants to P-6 and filled her benzodiazepine prescriptions early, despite signs that P-6 was addicted to and abusing her medications and despite her lack of response to treatment.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

57. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, because he engaged in repeated negligent acts in the care and treatment of patients. These acts include those alleged in the First Cause for Discipline, as well as the following, as alleged above:

A. Respondent failed to maintain adequate records of his treatment of P-1;

B. Respondent diagnosed P-1 with "Pain Disorder," without documenting any evaluation of the patient's pain and without specifying whether its etiology was psychological, physical, or both;

C. Respondent continued prescribing Ambien to P-1 despite warning signs of her addiction to it, and he failed to document taking steps to address her potential addiction or to justify his continued prescribing;

D. Respondent failed to justify the risks of the medication regimen he continued to prescribe to P-2, despite the patient's lack of response to the medication, and he ceased prescribing an antidepressant medication for the patient's Major Depressive Disorder;

E. Respondent diagnosed P-3 with "Pain Disorder," without documenting any evaluation of the patient's pain and without specifying whether its etiology was psychological, physical, or both;

F. Respondent prescribed excessive amounts of Ambien to P-3 despite warning signs of his addiction to it, and he failed to document taking steps to address P-3's potential addiction and to justify his continued prescribing;

G. Respondent failed to maintain adequate records of his treatment of P-5; and

H. Respondent did not provide a basis for his diagnoses of P-6 with ADHD.

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THIRD CAUSE FOR DISCIPLINE

(Prescribing Without a Prior Examination and Medical Indication)

58. Respondent is subject to disciplinary action under section 2242 of the Code, because he prescribed, dispensed, or furnished dangerous drugs as defined in section 4022 of the Code without an appropriate prior examination and a medical indication, as alleged above.

FOURTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Records)

59. Respondent is subject to disciplinary action under section 2266 of the Code, because he failed to maintain adequate and accurate records of the medical services he provided to patients, as alleged above.

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 37184, issued to Emil Soorani, M.D.;

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

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

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

DATED: 2/26/2020

Jenne Jones for Christine Lally
CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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