BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

KIMBERLY KIRCHMEYER, Executive Director, Medical Board of California, Petitioner, v. SOLEYMAN MIRAKHOR, M.D., Physician's and Surgeon's Certificate Number C 52017, Respondent.	Case No. 800-2015-0016740 OAH No. 2019040659

RULING AND ORDER ON PETITION FOR INTERIM SUSPENSION ORDER

Petitioner Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs (Department), State of California, petitioned for an Interim Suspension Order (ISO) suspending Physician's and Surgeon's Certificate Number C 52017 held by respondent Soleyman Mirakhor, M.D.

Howard W. Cohen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings, presided over the noticed ISO hearing on May 3, 2019, in Los Angeles, California. Claudia Ramirez, Deputy Attorney General, represented petitioner. Timothy Windham, Attorney at Law, represented respondent, who was present.

The ALJ read and considered the ISO petition and opposition, with points and authorities, declarations, and exhibits. The papers in support of the petition were marked collectively as exhibit 1 and admitted into evidence. The papers in opposition to the petition were marked collectively as exhibit A and admitted into evidence. The record was held open through May 8, 2018, to allow respondent to file an additional declaration and petitioner to file a reply. Respondent timely filed a declaration, which was marked as exhibit B. Petitioner filed a reply, objections, and a request for official notice, which were collectively marked as exhibit 2. Petitioner's objections to portions of exhibit B were sustained; all other objections were overruled, and the rest of exhibit B was admitted into evidence.

The record was closed and the matter submitted on May 8, 2019.

FACTUAL FINDINGS

1. The Board issued Physician and Surgeon's Certificate Number C 52017 to respondent on July 27, 2005. The certificate is scheduled to expire on January 31, 2021.

2. Petitioner seeks an ISO under Government Code section 11529 to suspend respondent's certificate to prevent him from practicing medicine pending a final decision on an Accusation to be filed in this matter. Petitioner filed all documents in this matter in her official capacity.

Respondent's Psychiatric Treatment of Four Patients

3. Petitioner alleges that, with respect to four patients respondent treated, respondent was grossly negligent, engaged in repeated negligent acts, demonstrated incompetence, engaged in repeated acts of excessive prescribing of controlled substances, prescribed dangerous drugs without an appropriate examination or medical indication, kept inadequate and inaccurate records, and engaged in unprofessional conduct.

4. Petitioner's allegations were based on and supported by the declaration of Alan A. Abrams, M.D. In opposition to the petition, respondent offered the declaration of Nathan Lavid, M.D., and the declaration of respondent himself.

PATIENT 1[1]

5. Petitioner alleged that respondent committed gross negligence in that, from February to August 2015, he: (a) prescribed Patient 1 a large number of central nervous system (CNS) psychotropic medications with serious drug-to-drug interactions without first obtaining her other treatment records; (b) failed to document somatic medications that Patient 1 was currently taking or how they would interact with the 26 medications he was prescribing; (c) did not obtain a Controlled Substance Utilization Review and Evaluation System (CURES) report on Patient 1 to see whether she was prescribed controlled substances, thereby failing to learn that Patient 1 was physically dependent on morphine and hydrocodone-acetaminophen; (d) prescribing amitriptyline, which causes mood swings and is inappropriately risky for a patient respondent diagnosed with Bipolar Disorder, Mixed; (e) excessively prescribed 15 multiple psychotropic medications in very high doses without being aware of other psychotropic medications Patient 1 was taking; (f) prescribed multiple CNS-impairing medications without any monitoring of CNS impairment or noting the possibility of CNS impairment; (g) failed to learn of other CNS depressants Patient 1 was taking before prescribing high doses of multiple CNS depressants; (h) failed to warn Patient 1 of the danger of his off-label prescription of a dangerous combination of medications; (i) failed to be aware of the dangers of the combinations of high dose medications he was prescribing to Patient 1; (j) started Patient 1 on an initial does of Lamictal of 100 mg per day, creating an unacceptable risk of fatal skin rashes; (k) rapidly escalated the amitriptyline dose,

[1] Patients' names have been omitted to protect patient privacy.

creating a risk of a manic switch; (*l*) used ultra-high doses of 300 mg per day of amitriptyline; (m) failed to warn Patient 1 of the risks of amitriptyline; (n) failed to maintain adequate and accurate records; (o) failed to maintain a current medication history; (p) reached unsupportable diagnoses without obtaining information from prior treatment providers; (q) failed to obtain Patient 1's informed consent for prescribed medications; and (r) failed to consider likely causes of, and accurately diagnose, Patient 1's visual disturbances.

6. Petitioner alleged that respondent engaged in repeated negligent acts in that, from February to November 2015, he failed to take an adequate history to support his diagnoses and failed to accurately diagnose Patient 1.

7. Petitioner alleged that respondent demonstrated incompetence from February to August 2015 by showing a lack of basic knowledge about psychopharmacology and drug-to-drug interactions when he prescribed multiple psychotropic medications in very high doses without awareness of other psychoactive medications Patient 1 was taking, prescribed multiple CNS-impairing medications without monitoring CNS impairment, started Patient 1 on an initial dose of 100 mg of Lamictal per day, failed to investigate all the medications Patient 1 was taking, failed to monitor Patient 1 for Serotonin syndrome, failed to accurately diagnose Patient 1's visual disturbance, and from August 2015 to November 2015 failed to investigate Patient 1's symptoms as possible medication side effects.

8. Petitioner alleged that respondent engaged in repeated acts of excessive prescribing of controlled substances to Patient 1, and that his acts constituted unprofessional conduct.

9. The evidence, including declarations of Dr. Adams, Dr. Lavid, and respondent, exhibits, and argument supports a conclusion that petitioner has demonstrated a reasonable probability of success in the underlying action with respect to Patient 1. For example:

a. Respondent declared that Patient 1 told him that she had been previously diagnosed and treated for bipolar disorder while living in Texas (ex. B, para. 7), but that information is not documented in the patient's medical record. (Petn., ex. G, pp. 161-162.) The patient's medical record contradicts respondent's declaration: "The patient is a young adult, white lady who herself has made her own diagnosis of being bipolar . . . ." (Petn., ex. G, p. 162.)

b. Respondent declared that Patient 1 met all the criteria for bipolar disorder (ex. B, para. 7), but Dr. Abrams opined that if respondent believed she suffered from Bipolar Disorder, Mixed, his use of amitriptyline was risky and without justification. According to Dr. Abrams, Amitriptyline is well documented to cause mood state switches from depressed states (depression, anxiety, irritability, violence, suicide) or mixed states (literally "up" and "down" at the same time) to manic states (euphoria, grandiosity, excessive involvement in risky activities).

c. Respondent declared that he increased the dosage of Celexa to 40 mg daily because the patient reported that she had been treating with Dr. Barr who was already treating her with Celexa (ex. B, para. 8), but the dosage of Celexa that Dr. Barr was prescribing is not documented in the patient's medical record. (Petn., ex. G, p. 0161.)

d. Dr. Abrams opined that respondent was simultaneously prescribing a relatively high dose of Celexa (60 mg daily), a very high dose of Wellbutrin (450 mg daily), a very high dose of Trileptal (300 mg twice a day), as well as Latuda (120 mg daily) and trazodone (200 mg daily), all of which would add to the CNS depression and psychomotor impairments. Respondent was prescribing many medications associated with Serotonin Syndrome (such as Celexa, amitriptyline, trazodone, Latuda, and Trileptal) to Patient 1, who was already taking medications associated with Serotonin Syndrome (such as hydrocodone and cyclobenzaprine).

e. On August 19, 2015, Patient 1 reported having visual disturbances, but respondent documented that she had no side effects to medication. Dr. Abrams opined that blurry vision and visual disturbances can be early signs of Serotonin Syndrome.

f. Respondent declared that, during her hospitalization, Patient 1 tested positive for amphetamine and Norco, and he surmised that she may have used amphetamines at a party and overdosed on medications and alcohol. (Ex. B, paras. 20, 22.) The medical record, however, notes a different likelihood, that the positive amphetamine test was due to Patient 1 having been taking prescription bupropion. Dr. Abrams opined that there is no need for surmise as to opioids and alcohol, because the positive result could be explained by her taking Norco, prescribed for her by another physician, and she did not test positive for alcohol.

g. Though obtaining a CURES report was not the standard of care at the time respondent saw Patient 1, he was required but failed to make sufficient efforts to ascertain what medications Patient 1 was consuming and to consider possible interactions with medications he wished to prescribe.

h. Respondent agrees with Dr. Abrams that visual hallucinations is a sign and symptom of Serotonin Syndrome, but declared that Patient 1 never exhibited those signs and symptoms. (Ex. B, para. 24.) Patient 1 did complain of visual hallucinations, but respondent did not explore whether those hallucinations might be the result of interaction between medications he had prescribed and medications, not noted in his records, that other treating physicians were prescribing for Patient 1.

i. Respondent declared that Patient 1 did not complain about medications he prescribed (ex. B, para. 25), but on June 3, 2015, she complained that amitriptyline had caused double vision, stuttering, irritability, sadness, depression, weakness, fatigue, and racing thoughts. Respondent himself noted that he was seeking the right dose of medications that would cause remission of Patient 1's symptoms.

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PATIENT 2

10. Petitioner alleged that respondent committed gross negligence in treating Patient 2 in that: (a) from November 2012 to May 2016, he prescribed daily doses of sedative-hypnotics Klonopin and Ambien without documenting evidence of a panic disorder or disclosure to Patient 2 of the risk of addiction to those medications; (b) he failed to document that Patient 2 was also taking hydrocodone prescribed by another physician, which Ambien can interact with and cause respiratory depression; (c) he switched from Lexapro to Celexa to Paxil without providing a rationale in the medical notes; (d) he initiated Paxil at 80 mg per day; (e) he prescribed multiple central nervous system impairing medications without monitoring CNS impairment or noting the possibility of CNS impairment; (f) he continued to prescribe a high dose of Ambien after the FDA issued warnings about the risks to women; (g) he prescribed a combination of medications that could result in CNS impairment without performing mental status examinations to justify the prescriptions; and (h) he prescribed multiple proserotonergic medications without monitoring for Serotonin syndrome.

11. Petitioner alleged that respondent engaged in repeated negligent acts in that, from December 2011 to May 2016, he inaccurately diagnosed Patient 2 with severe mental illness, and subsequently with Bipolar II Disorder, without reasonable supporting data or sufficient documentation.

12. Petitioner alleged that respondent demonstrated incompetence from November 2012 to May 2016, demonstrating a lack of knowledge about psychopharmacology when he prescribed chronic doses of sedative-hypnotics to Patient 2 without evidence to support a diagnosis of panic disorder, prescribed Ambien and Klonopin for four years of daily use, creating an addiction, initiated Paxil at 80 mg per day, prescribed multiple CNS-impairing medications without noting the possibility of or monitoring CNS impairment, and treated Patient 2 with multiple proserotonergic medications without any monitoring; failing to inform Patient 2 of the risk of addiction; failing to document medications; and failing to consider drug interactions.

13. Petitioner alleged that respondent engaged in repeated acts of excessive prescribing of controlled substances to Patient 2, and that his acts constituted unprofessional conduct.

14. The evidence, including declarations of Dr. Adams, Dr. Lavid, and respondent, exhibits, and argument supports a conclusion that petitioner has demonstrated a reasonable probability of success in the underlying action with respect to Patient 2. For example:

a. Respondent apparently believed Patient 2 was on Celexa when she was really on Lexapro. (Petn., ex. J, pp. 2334-2336.) On August 22, 2013, Respondent prescribed Paxil 80 mg suddenly to Patient 2, an older patient, rather than the accepted starting dose of 20 mg per day. (Petn., ex. J, p. 23 1 6.) His note states "[i]ncrease Paxil to 80 mg daily." (*Ibid.*) But he does not demonstrate that records show he had previously prescribed lower doses of Paxil.

b. Although respondent advised Patient 2 that she should not take Ambien or should decrease the dose from 10 mg to 5 mg, (ex. B, para. 36), he continued to prescribe Ambien 10 mg along with her other medications such as Klonopin 1.0 mg. (Petn., ex. J, p. 2313; Petn., ex. H.) Dr. Abrams opined that respondent continued to prescribe a high dose of Ambien even after FDA warnings were issued about the risks to women of consuming Ambien in doses greater than 5 mg.

c. Although respondent disputes that he diagnosed Patient 2 with Type II Bipolar Disorder on May 3, 2016 (ex. B, para. 38), the record shows that he electronically signed the document on May 3, 2016, that he is the "author" of the document, and that he issued prescriptions on that date to the patient. (Petn., ex. J, pp. 2301 to 2305.)

PATIENT 3

15. Petitioner alleged that respondent committed gross negligence in that: (a) he started Patient 3 on an initial dose of Lamictal of 100 mg per day on September 2, 2014, posing a risk of fatal skin rash and not documenting warning Patient 3 of the risk; (b) he started Patient 3 on lithium without first obtaining baseline chemistries or documenting disclosure of risks to Patient 3; (c) from August 2014 to August 2016, he prescribed multiple CNS-impairing medications without monitoring CNS impairment, and failed to address side effects of Klonopin; and (d) he treated Patient 3 with multiple proserotonergic medications without any monitoring or comment when Patient 3 began to show signs associated with Serotonin syndrome and without documenting those signs.

16. Petitioner alleged that respondent engaged in repeated negligent acts in that, from August 2014 to August 2016, he inaccurately diagnosed Patient 3.

17. Petitioner alleged that respondent demonstrated incompetence from August 2014 to August 2016, showing a lack of prescribing practices and pharmacology when he started Patient 3 on an initial dose of Lamictal of 100 mg per day, started Patient 3 on lithium without taking baseline chemistries, prescribed multiple CNS-impairing medications without noting the risk of or monitoring CNS impairment, and treated Patient 3 with multiple proserotonergic medications without monitoring or comment when Patient 3 showed signs associated with Serotonin Syndrome.

18. Petitioner alleged that respondent engaged in repeated acts of excessive prescribing of controlled substances to Patient 3, and that his acts constituted unprofessional conduct.

19. The evidence, including declarations of Dr. Adams, Dr. Lavid, and respondent, exhibits, and argument supports a conclusion that petitioner has demonstrated a reasonable probability of success in the underlying action with respect to Patient 3. For example:

a. Dr. Abrams opined that respondent diagnosed Patient 3 with "bipolarity" without any history taking of actual mood states lasting at least one week, and began an aggressive and dangerous course of treatment. Respondent omitted (ex. B, paras. 42

to 44) that he diagnosed Patient 3 with bipolarity; he did make such a diagnosis, however, in the Impression and Plan section of his records. (Petn., ex. K, p. 2397.)

b. Dr. Adams opined that Lamictal should be started at 25 mg per day and be increased slowly, not started at a dose of 100 mg per day, which respondent did. (Ex. B, para. 45.)

c. Respondent justified prescribing Lithium without baseline laboratory studies by noting that Patient 3 did not remain on Lithium. (Ex. B, para. 52.) Dr. Abrams opined that baseline studies must be conducted before initiating lithium therapy.

d. Patient 3 complained of muscle problems that, Dr. Abrams opined, may have been early signs of Serotonin Syndrome. On November 4, 2014, Patient 3 complained of muscle weakness and attributed it to Latuda; Patient 3 was also being prescribed Luvox. (Petn., ex. K, p. 2388.) A month later, on December 2, 2014, Patient 3 continued to complain of muscle weakness from Latuda. (Petn., ex. K, p. 2386.) Dr. Abrams opined that Luvox and Latuda are associated with Serotonin Syndrome. Respondent noticed extreme sweating, also a sign of Serotonin syndrome. (Petn., ex. K, p. 2368 [Aug. 19, 2015 visit].) Patient 3 also reported sweaty and wet hands. (Petn., ex. K, pp. 2360 [June 24, 2015 visit], 2374 [Dec. 8, 2015 visit].) Respondent agrees with Dr. Abrams' opinion that "serotonin syndrome is exhibited by . . . diaphoresis . . . ."[2] (Ex. B, para. 24.) Respondent did not make any notation that he considered these effects as possibly due to Serotonin Syndrome even though, Dr. Abrams opined, he was prescribing four medications (Seroquel, Luvox, Trileptal and BuSpar) that could combine to create Serotonin Syndrome. (Petn., ex. K, pp. 2374 to 2375.)

PATIENT 4

20. Petitioner alleged that respondent committed gross negligence in that: (a) from March 2014 to September 2016, he failed to obtain Patient 4's other treatment records and learn of other CNS depressants that Patient 4 was taking before prescribing a large number of CNS psychotropic medications, risking serious drug-to-drug interactions, and he failed to warn other prescribers about the dangers or minimize the risk; (b) he prescribed Viibryd 40 mg to a patient with minimal symptoms who was already on a high dose, 450 mg, of Wellbutrin, risky for a patient whom respondent believed suffered from Bipolar II Disorder; (c) he added benzodiazepines Ativan and Klonopin to the CNS depressants (Risperdal, baclofen, fentanyl, hydroxyzine, tramadol, and oxycodone) being taken simultaneously by Patient 4; (d) he failed to monitor CNS impairment; (e) and he failed to consider or document the risk of the combined use of benzodiazepines and opioids.

21. Petitioner alleged that respondent engaged in repeated negligent acts in that, from March 2014 to September 2016, he failed to take a minimally adequate history to support his diagnoses and failed to sufficiently document symptoms to support his diagnoses.

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[2] Diaphoresis means sweating, especially to an unusual degree as a symptom of disease or a side effect of a drug.

22. Petitioner alleged that respondent demonstrated incompetence from March 2014 to September 2016, demonstrating a lack of knowledge of prescribing practices and psychopharmacology when he prescribed multiple CNS-impairing medications without monitoring CNS impairment, failed to monitor for CNS depression, failed to monitor Patient 4's mental status, failed to reduce doses when Patient 4 was in remission, diagnosed panic disorder with no basis, and prescribed chronic doses of sedative-hypnotics when Patient 4 was suffering opioid addiction.

23. Petitioner alleged that respondent engaged in repeated acts of excessive prescribing of controlled substances to Patient 4, and that his acts constituted unprofessional conduct.

24. The evidence, including declarations of Dr. Adams, Dr. Lavid, and respondent, exhibits, and argument supports a conclusion that petitioner has demonstrated a reasonable probability of success in the underlying action with respect to Patient 4. For example:

a. Dr. Abrams opined that (a) respondent did not note sufficient symptoms to meet criteria for Panic Disorder (see ex. B, para. 55);

b. Though respondent acknowledges that the patient was receiving hydrocodone from other physicians (ex. B, para. 60), he does not appear to have known when treating Patient 4 that the patient was consuming hydrocodone or to have considered the possibility of an iatrogenic opioid use disorder, even though another provider had indicated an issue with substance abuse;

c. Respondent did not document any consideration of the possibility of chronic opioid use causing Patient 4 's mood problems or anxiety or his problematic relationships or homelessness; and

d. Respondent did not consider other medications that Patient 4 was currently taking or how they would interact with the medications that he was prescribing.

LEGAL CONCLUSIONS

1. The Board is the state agency charged with administering and enforcing the Medical Practice Act, Business and Professions Code section 2000 et seq., which governs the practice of licensed physicians and surgeons in the State of California. (Bus. & Prof. Code, § 2004.)

2. An administrative law judge may issue an interim order "suspending a license, imposing drug testing, continuing education, supervision of procedures, limitations on the authority to prescribe, furnish, administer, or dispense controlled substances, or other license restrictions." (Gov. Code, § 11529, subd. (a).)

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3. An administrative law judge may issue an ISO suspending a certificate:

> only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act . . . or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare.

(Gov. Code, § 11529, subd. (a).)

4. An administrative law judge "shall grant the interim order where, in the exercise of discretion, the administrative law judge concludes that: (1) [t]here is a reasonable probability that the petitioner will prevail in the underlying action [; and] (2) [t]he likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order." (Gov. Code, § 11529, subd. (e).)

5. Petitioner bears the burden of proof; the standard of proof is a preponderance of the evidence. (Gov. Code, § 11529, subd. (e).)

6. Respondent is subject to an interim order under Government Code section 11529 in that there is a reasonable probability that petitioner will prevail in the underlying action, and the likelihood of injury to the public in not issuing the Order below outweighs the likelihood of injury to the licensee in issuing the Order.

7. The evidence is sufficient to demonstrate that respondent's unrestricted practice will result in endangerment to the public health, safety, or welfare. (Factual Findings 1-24.) Respondent presented no evidence to demonstrate that some action less drastic than suspension, such as monitoring or supervision, would be sufficient to protect his patients, or how lesser action might be effectuated. Consequently, suspension is warranted.

ORDER

The petition for an interim suspension order is granted. Physician's and Surgeon's Certificate, number C 52017, issued to respondent Soleyman Mirakhor, M.D., is suspended.

Pending a final decision on an Accusation to be filed in this matter, respondent may not practice medicine or surgery or do any act for which licensure by the Board is required.

Respondent shall be required, upon receipt of the order of suspension, to immediately deliver to the Medical Board of California, or its agent, for safekeeping pending a final administrative order of the Board in this matter, all indicia of his licensure as a physician, as contemplated by Business and Professions Code section 119, including but not limited to his wall certificate and wallet card issued by the Medical Board of California, as well as all

prescription forms, all prescription drugs not legally prescribed to respondent by his treating physician and surgeon, all Drug Enforcement Administration Drug Order forms, and all Drug Enforcement Administration registrations and permits.

DATED: May 15, 2019

DocuSigned by:
Howard W. Cohen
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HOWARD W. COHEN
Administrative Law Judge
Office of Administrative Hearings