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

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| In the Matter of the Accusation Against:<br><br>**NADER OSKOOILAR, M.D.**<br>**1601 Dove Street, Suite 290**<br>**Newport Beach, California 92660**<br><br>**Physician's and Surgeon's Certificate No. A48369,**<br><br>Respondent. | Case No. 800-2016-022486<br><br>**A C C U S A T I O N** |

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, and not otherwise.

2. On or about June 18, 1990, the Medical Board issued Physician's and Surgeon's Certificate No. A48369 to Nader Oskooilar, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on August 31, 2019, unless renewed.

## JURISDICTION

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

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

5. Section 2234 of the Code states, in relevant part:

"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.

"..."

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

7. Section 2238 of the Code states, in relevant part:

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

8. Section 2242 of the Code states:

"(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."

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9. Section 2266 of the Code states:

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

10. Section 725 of the Code states:

"(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) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

11. Section 4022 of the Code states:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

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"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

12. Section 11165 of the Health and Safety Code states, in relevant part:

"(a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

"..."

13. Section 11165.1 of the Health and Safety Code states, in relevant part:

"(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the department. Upon approval, the department shall release to that practitioner the electronic history of

controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

"..."

14. Section 11165.4 of the Health and Safety Code states:

"(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

"(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

"(B) For purposes of this paragraph, 'first time' means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

"(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

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"(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

"(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

"(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

"(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

"(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

"(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

"(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

"(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

"(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

"(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

"(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

"(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

"(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

"(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

"(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

"(5)(A) If all of the following circumstances are satisfied:

"(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

"(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

"(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

"(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

"(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

"(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

"(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

"(d)(1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

"(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

"(e) This section is not operative until six months after the Department of Justice certifies[1] that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

"(f) All applicable state and federal privacy laws govern the duties required by this section.

"(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application."

[1] Certified April 2, 2018. *See* https://oag.ca.gov/cures.

## FIRST CAUSE FOR DISCIPLINE

**(Gross Negligence)**

15. Respondent has subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patients A, B, and C,[2] as more particularly alleged hereinafter:

16. **Patient A**

(a) Between in or around 2016 through in or around 2018, Patient A saw Respondent, a psychiatrist, for psychiatric care related to her diagnosis of chronic generalized anxiety disorder. During this timeframe, Respondent also had Chronic Obstructive Pulmonary Disorder (COPD) and carried and utilized external oxygen to assist her breathing.

(b) Between in or around 2016 through in or around 2018, Respondent issued approximately thirty-two (32) prescriptions to Patient A for controlled substances, but the majority of the prescriptions are missing from this patient's medical record.

(c) Between in or around 2016 through in or around 2018, despite routinely prescribing controlled substances to Patient A, Respondent never performed and/or documented performing a mental status exam; never documented any discussion regarding suicidal ideation; and never obtained documentation of informed consent regarding the risks of prolonged use of sedatives to this patient.

(d) On January 15, 2019, Respondent was interviewed at the Health Quality Investigation Unit's San Diego Office regarding the care and treatment he had provided to Patient A. During the subject interview, Respondent admitted that he could not read his own notes at times. All of Respondent's charted notes for this patient are handwritten and mostly illegible, and do not record the duration or time of day of the interviews with the patient.

[2] Letters A, B, and C are used for the purposes of maintaining patient confidentiality.

(e) Patient A's medical records do not contain any CURES printouts. At the time Respondent prescribed controlled substances to Patient A, he was not informed of the drugs that this patient was also being prescribed from other physicians. Significantly, during his subject interview on January 15, 2019, Respondent stated that he did not use CURES to review patient history because he "couldn't get on line."

(f) Between in or around 2016 through in or around 2018, Respondent issued an excessive amount of sedatives to Patient A including, clonazepam and alprazolam. Respondent did not document any discussion with Patient A about the prescriptions from other physicians for controlled substances that she was filling, including additional sedatives from her primary care doctor. Furthermore, Respondent did not attempt to taper the amount of sedatives that he had been prescribing to Patient A for a prolonged period of time.

(g) Respondent maintained Patient A on the long-term use of multiple different sedatives despite the risks to this particular patient due to her age[3] and her COPD. Significantly, Respondent did not document in the medical record his rationale for his prescription regimen of the long-term use of sedatives for a patient over sixty-five (65) years old and suffering from a pulmonary condition.[4]

(h) Between in or around 2016 through in or around 2018, Respondent only prescribed sedatives to Patient A for treatment of her anxiety disorder. However, Respondent never attempted to prescribe this patient other drugs to treat the disorder, including "anti-depressants" such as selective serotonin reuptake inhibitors (SSRI). Respondent never documented his rationale for exclusively prescribing long-term use sedatives, and not attempting to trial the use of SSRI medication for this patient.

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[3] Patient A was born in 1950.

[4] *See* "Beers Criteria for Potentially Inappropriate Medication Use in Older Adults."; https://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf

(i) On or about August 18, 2017, Respondent issued multiple prescriptions for sedatives to Patient A. Patient A had recently filled prescriptions for other controlled substances from another physician including, oxycodone. Patient A's medical record does not contain any CURES print-outs, and Respondent did not document any discussion with this patient regarding the serious risks of concurrent use of sedatives and opioids.

(j) Respondent was aware that Patient A was taking thyroid medication and that she had been diagnosed with COPD. However, Respondent did not document in this patient's medical record any information or discussion with patient about whether her ongoing medical conditions were influencing her psychiatric diagnosis.

(k) Despite prescribing addictive controlled substances to Patient A for prolonged use, Respondent did not appropriately monitor this patient's drug compliance including; he never ordered a random drug toxicology screen of this patient to verify she was taking the drugs as prescribed; documentation of prescriptions in this patient's medical record is mostly missing, or illegible to the extent that prescriptions cannot be tracked; and no CURES print-outs were ever done for this patient.

17. Respondent committed gross negligence in his care and treatment of Patient A including, but not limited to, the following:

(a) Respondent's clinical notes for Patient A are either missing, illegible, disorganized, and/or missing time annotations;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered sedatives to Patient A;

(c) Respondent failed to obtain CURES reports for a review of Patient A's then current drug prescription profile;

(d) Respondent maintained Patient A on the long-term use of sedatives despite her age (> 65 years old) and COPD, and without documenting a rationale for said prescription regimen;

(e) Respondent failed to attempt to utilize SSRI medication to replace the prolonged use of sedatives by Patient A;

(f) Respondent prescribed the long-term use of sedatives to Patient A despite her COPD;

(g) Respondent prescribed the long-term use of sedatives to Patient A without performing and/or documenting a mental status exam; and/or documenting any discussion regarding suicidal ideation; and/or failing to obtain documentation of informed consent regarding the risks of prolonged use of sedatives;

(h) On or about August 18, 2017, Respondent issued multiple prescriptions for sedatives to Patient A without documenting any discussion regarding the serious risks of concurrent use of sedatives and opioids;

(i) Respondent failed to discuss and/or document discussion with Patient A about whether her ongoing medical conditions were influencing her psychiatric diagnosis; and

(j) Respondent failed to appropriately monitor and/or verify whether Patient A was taking his prescriptions for controlled substances as prescribed.

18. **Patient B**

(a) Between in or around 2014 through in or around 2018, Patient B saw Respondent for psychiatric care related to multiple diagnoses including, generalized anxiety disorder.

(b) Between in or around 2014 through in or around 2018, Respondent issued approximately seventy-seven (77) prescriptions to Patient B for controlled substances, but the majority of the prescriptions are missing from this patient's medical record.

(c) Between in or around 2014 through in or around 2018, despite routinely prescribing controlled substances to Patient B, Respondent never performed and/or documented performing a mental status exam; never documented any discussion

regarding suicidal ideation; and never obtained documentation of informed consent regarding the risks of prolonged use of sedatives to this patient.

(d) On January 15, 2019, Respondent was interviewed at the Health Quality Investigation Unit's San Diego Office regarding the care and treatment he had provided to Patient B. During the subject interview, Respondent admitted that he could not read his own notes at times. All of Respondent's charted notes for this patient are handwritten and mostly illegible, and do not record the duration or time of day of the interviews with the patient.

(e) Patient B's medical records do not contain any CURES printouts. At the time Respondent prescribed controlled substances to Patient B, he was not informed of the drugs that this patient was also being prescribed from other physicians. Significantly, during his subject interview on January 15, 2019, Respondent stated that he did not use CURES to review patient history because he "couldn't get on line."

(f) Between in or around 2014 through in or around 2018, Respondent issued an excessive amount of sedatives to Patient B including, alprazolam. Respondent also routinely prescribed the controlled drug Vyvanse, which is a stimulant used to treat Attention-deficit/hyperactivity disorder (ADHD). Significantly, Respondent never documented his rationale for prescribing the medication combination of a sedative (alprazolam) and a stimulant (Vyvanse) for Patient B's treatment. In addition, Respondent did not document any discussion with Patient B about the prescriptions from other physicians for controlled substances that he was filling, including multiple prescriptions for oxycodone and hydrocodone. Finally, Respondent did not attempt to taper the amount of sedatives that he had been prescribing to Patient B for several years.

(g) Between in or around 2014 through in or around 2018, Respondent only prescribed sedatives to Patient B for treatment of his anxiety disorder. However, Respondent never attempted to prescribe this patient other drugs to treat the

disorder, including SSRI medication. Respondent never documented his rationale for exclusively prescribing long-term use sedatives, and not attempting to trial the use of SSRI medication for this patient.

(h) Despite prescribing addictive controlled substances to Patient B for prolonged use, Respondent did not appropriately monitor this patient's drug compliance including, he never ordered a random drug toxicology screen of this patient to verify he was taking the drugs as prescribed; documentation of prescriptions in this patient's medical record is mostly missing, or illegible to the extent that prescriptions cannot be tracked; and no CURES print-outs were ever done for this patient.

19. Respondent committed gross negligence in his care and treatment of Patient B including, but not limited to, the following:

(a) Respondent's clinical notes for Patient B are either missing, illegible, disorganized, and/or missing time annotations;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered sedatives to Patient B;

(c) Respondent failed to obtain CURES reports for a review of Patient B's then current drug prescription profile;

(d) Respondent failed to attempt to utilize SSRI medication to replace the prolonged use of sedatives by Patient B;

(e) Respondent prescribed the long-term use of sedatives to Patient B without performing and/or documenting a mental status exam; and/or documenting any discussion regarding suicidal ideation; and/or failing to obtain documentation of informed consent regarding the risks of prolonged use of sedatives; and

(f) Respondent failed to appropriately monitor and/or verify whether Patient B was taking his prescriptions for controlled substances as prescribed.

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20. **Patient C**

(a) Between in or around 2017 through in or around 2018, Patient C saw Respondent for psychiatric care related to her diagnosis of anxiety disorder and panic disorder.

(b) Between in or around 2017 through in or around 2018, Respondent issued approximately forty-five (45) prescriptions to Patient C for controlled substances, but the majority of the prescriptions are missing from this patient's medical record.

(c) Between in or around 2017 through in or around 2018, despite routinely prescribing controlled substances to Patient C, Respondent never performed and/or documented performing a mental status exam; never documented any discussion regarding suicidal ideation; and never obtained documentation of informed consent regarding the risks of prolonged use of sedatives to this patient.

(d) On January 15, 2019, Respondent was interviewed at the Health Quality Investigation Unit's San Diego Office regarding the care and treatment he had provided to Patient C. During the subject interview, Respondent admitted that he could not read his own notes at times. All of Respondent's charted notes for this patient are handwritten and mostly illegible, and do not record the duration or time of day of the interviews with the patient.

(e) Patient C's medical records do not contain any CURES printouts. At the time Respondent prescribed controlled substances to Patient C, he was not informed of the drugs that this patient was also being prescribed from other physicians. Significantly, during his subject interview on January 15, 2019, Respondent stated that he did not use CURES to review patient history because he "couldn't get on line."

(f) Between in or around 2017 through in or around 2018, Respondent issued an excessive amount of sedatives to Patient C including, diazepam, lorazepam, alprazolam, zolpidem tartrate, and intermezzo. Respondent did not

document any discussion with Patient C about the prescriptions from other physicians for controlled substances that she was filling, including multiple prescriptions for hydrocodone, oxycodone, and carisoprodol. Furthermore, Respondent did not attempt to taper the amount of sedatives that he had been prescribing to Patient C for a prolonged period of time.

(g) Between in or around 2017 through in or around 2018, Respondent only prescribed sedatives to Patient C for treatment of her anxiety disorder and panic disorder. However, Respondent never attempted to prescribe this patient other drugs to treat the disorder, including SSRI medication. Respondent never documented his rationale for exclusively prescribing long-term use sedatives, and not attempting to trial the use of SSRI medication for this patient.

(h) Despite prescribing addictive controlled substances to Patient C for prolonged use, Respondent did not appropriately monitor this patient's drug compliance including, he never ordered a random drug toxicology screen of this patient to verify she was taking the drugs as prescribed; documentation of prescriptions in this patient's medical record is mostly missing, or illegible to the extent that prescriptions cannot be tracked; and no CURES print-outs were ever done for this patient.

21. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to, the following:

(a) Respondent's clinical notes for Patient C are either missing, illegible, disorganized, and/or missing time annotations;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered sedatives to Patient C;

(c) Respondent failed to obtain CURES reports for a review of Patient C's then current drug prescription profile;

(d) Respondent failed to attempt to utilize SSRI medication to replace the prolonged use of sedatives by Patient C;

(e) Respondent prescribed the long-term use of sedatives to Patient C without performing and/or documenting a mental status exam; and/or documenting any discussion regarding suicidal ideation; and/or failing to obtain documentation of informed consent regarding the risks of prolonged use of sedatives; and

(f) Respondent failed to appropriately monitor and/or verify whether Patient C was taking his prescriptions for controlled substances as prescribed.

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

22. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

23. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

24. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

25. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**THIRD CAUSE FOR DISCIPLINE**

**(Prescribing Dangerous Drugs Without an Appropriate Prior Examination and/or Medical Indication)**

26. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in sections 2242 and 4022, of the Code, in that Respondent prescribed, dispensed, or furnished dangerous drugs

without an appropriate prior examination and/or medical indication to Patients A, B, and C, as more particularly alleged hereinafter:

27. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

28. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

29. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**FOURTH CAUSE FOR DISCIPLINE**

**(Repeated Acts of Clearly Excessive Prescribing)**

30. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in section 725, of the Code, in that Respondent has committed repeated acts of clearly excessive prescribing drugs or treatment to Patients A, B, and C, as determined by the standard of the community of physicians and surgeons, as more particularly alleged hereinafter:

31. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

32. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

33. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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## FIFTH CAUSE FOR DISCIPLINE

**(Violation of Statute Regulating Drugs)**

34. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under section 2238, as defined in section 2238, of the Code, and, section 11165.4, of the Health and Safety Code, in that Respondent prescribed, ordered, administered, or furnished controlled substances to Patients A, B, and C, without first consulting the CURES database to review their controlled substance history before prescribing them a Schedule II, Schedule III, or Schedule IV controlled substance, as more particularly alleged hereinafter:

35. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

36. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

37. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

## SIXTH CAUSE FOR DISCIPLINE

**(Failure to Maintain Adequate and Accurate Medical Records)**

38. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

39. **Patient A**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

40. **Patient B**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

41. **Patient C**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Unprofessional Conduct)**

42. Respondent has further subjected his Physician's and Surgeon's Certificate No. A48369 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 15 through 41, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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## PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A48369, issued to Respondent Nader Oskooilar, M.D.;

2. Revoking, suspending or denying approval of Respondent Nader Oskooilar, M.D.'s, authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Nader Oskooilar, M.D., to pay the Medical Board the costs of probation monitoring, if placed on probation; and

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

DATED: April 18, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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