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

In the Matter of the Accusation Against:	Case No. 800-2019-062318
HOZAIR MOHAMMED SYED, M.D. **751 South Weir Canyon Road, #157662** **Anaheim, CA 92808** **Physician's and Surgeon's Certificate No. A 111058** Respondent.	**ACCUSATION**

PARTIES

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

2. On or about February 5, 2010, the Medical Board issued Physician's and Surgeon's Certificate No. A 111058 to Hozair Mohammed Syed, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2023, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2228.1 of the Code states, in pertinent part:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board and the Podiatric Medical Board of California shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

. . .

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information internet web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

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6. Section 2234 of the Code, states, in pertinent 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:

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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.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

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

8. Health and Safety Code Section 11165.4[1] states, in pertinent part:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the patient activity report or information from the patient activity report obtained from the CURES database to review a patient's controlled substance history for the past 12 months before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every six months thereafter if the prescriber renews the prescription and the substance remains part of the treatment of the patient.

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COST RECOVERY

9. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the

[1] This section became operative October 2, 2018.

investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the [ALJ] if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

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FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

10. Respondent has subjected his Physician's and Surgeon's Certificate No. A 111058 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, and C, and D,[2] as more particularly alleged hereinafter:

PATIENT A

11. On or about November 30, 2018, Patient A, a then thirty-one-year-old male, presented to Respondent for the first time for psychiatric treatment with complaints of panic attacks and mood swings. Patient A had been previously diagnosed with bipolar disorder approximately nine years earlier and prescribed medications since that time. At the conclusion of this visit, Respondent diagnosed Patient A with bipolar II disorder, and prescribed Lamictal,[3] Celexa,[4] trazadone,[5] and Xanax.[6] Respondent did not review CURES[7] on or before this visit.

12. Between on or about November 30, 2018, and on or about November 21, 2019, Patient A presented to Respondent for approximately twenty (20) clinical visits. For each of these visits, Respondent's handwritten notes in Patient A's chart are short and difficult to read. Throughout that time, Respondent regularly prescribed Patient A various medications, including,

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[2] To protect the privacy of the patients involved, the patients' names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

[3] Lamictal (brand name for Lamotrigine) is an anticonvulsant medication used to treat seizures and bipolar disorder. It is a dangerous drug pursuant to section 4022 of the Code.

[4] Celexa (brand name for citalopram) is a selective serotonin reuptake inhibitor used to treat depression. It is a dangerous drug pursuant to section 4022 of the Code.

[5] Trazadone is an antidepressant sedative medication, and a dangerous drug pursuant to section 4022 of the Code.

[6] Xanax (brand name for alprazolam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to section 4022 of the Code. It is a benzodiazepine medication used to treat anxiety.

[7] CURES (Controlled Substances Utilization Review and Evaluation System) is a database maintained by the Department of Justice of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement.

but not limited to, Xanax and Klonopin,[8] but he did not review CURES and was unaware that Patient A was being prescribed these same medications on a regular basis by other prescribers.

13. On or about February 1, 2019, Patient A presented to Respondent for a follow-up. At this visit, Patient A informed Respondent that he had an electroencephalogram (EEG) performed and was diagnosed with epilepsy.[9] Respondent did not further discuss and/or document any further discussion with Patient A regarding this diagnosis, he did not request a copy of the EEG report at any time, and did not speak with Patient A's neurologist at any time to verify the diagnosis.

14. On or about November 22, 2019, Respondent received a letter in the mail from Patient A's mother. In this letter, Patient A's mother informed Respondent that Patient A abuses benzodiazepines, is being prescribed these medications by multiple physicians, is abusive and violent when taking benzodiazepines, and was hospitalized a few months earlier for an overdose. Patient A's mother requested Respondent stop prescribing benzodiazepines to Patient A, and to try to get him into an inpatient facility as soon as possible for detoxification from these dangerous drugs.

15. On or about November 29, 2019, Respondent reviewed Patient A's CURES report for the first time.

16. On or about December 5, 2019, Patient A presented to Respondent for a follow-up and final visit. At this visit, Respondent confronted Patient A about receiving benzodiazepines from other physicians. Respondent informed Patient A that he would not prescribe any more benzodiazepines until Patient A discontinued receiving them from other physicians. At the conclusion of this visit, Respondent discontinued Xanax and prescribed Patient A trazadone, Lamictal and Celexa. Respondent did not refer Patient A to a dual diagnosis program and/or to a detoxification or rehabilitation facility at that time or any time thereafter.

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[8] Klonopin (brand name for Clonazepam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to section 4022 of the Code. It is a benzodiazepine medication used to treat anxiety.

[9] Epilepsy is a disorder of the brain characterized by repeated seizures.

PATIENT B

17. On or about February 20, 2017,[10] Patient B, a then twenty-nine-year-old male, presented to Respondent for the first time for psychiatric treatment. Patient B had a history of opiate addiction for eight years, and complained of depressive symptoms including low energy, low motivation, anxiety, and insomnia. Patient B reported taking Suboxone[11] for one year, but confessed to Respondent that he continued to smoke and inject heroin. Respondent did not refer Patient B to an addiction specialist or a higher level of care at that time, and did not prescribe a trial of non-controlled medications for depressive symptoms. At the conclusion of this visit, Respondent prescribed Patient B cyclobenzaprine,[12] Klonopin, and Suboxone.

18. On or about March 13, 2017, Patient B presented to Respondent for a follow-up. At this visit, Respondent informed Patient B that he is not an addiction specialist and recommended Patient B an addiction specialist for his care, but did not refer him to a dual diagnosis program or addiction specialist on that visit or any visit thereafter. At the conclusion of this visit, Respondent diagnosed Patient B with opioid dependence and prescribed Klonopin and Suboxone.

19. On or about October 3, 2017, Patient B presented to Respondent for a follow-up. At this visit, Patient B informed Respondent that he had previously been diagnosed with attention deficit hyperactivity disorder and complained of low concentration and focus. At the conclusion of this visit, Respondent prescribed Patient B Adderall.[13]

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[10] Patient B's certified complete record does not contain any treatment notes that predate June 5, 2017. Information regarding Respondent's treatment of Patient B prior to June 5, 2017, came from Respondent's statements at his subject interview on or about October 28, 2021.

[11] Suboxone (brand name for buprenorphine and naloxone) is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to section 4022 of the Code. It is a narcotic medication used to treat narcotic dependence.

[12] Cyclobenzaprine (brand name Flexeril) is a muscle relaxant, and dangerous drug pursuant to section 4022 of the Code.

[13] Adderall (brand name for dextroamphetamine and amphetamine) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an amphetamine salts medication used for attention deficit hyperactivity disorder and narcolepsy.

20. On or about January 2, 2018, Patient B presented to Respondent for a follow-up. At this visit, Patient B informed Respondent that he was ok and had no complaints. According to his records, at the conclusion of this visit, Respondent continued Patient B on his "same medications."

21. On or about January 4, 2018, Respondent prescribed Patient B Xanax for an unknown purpose. Patient B did not have a documented visit with Respondent on January 4, 2018, and Respondent's treatment records prior to that date do not reflect a plan to prescribe this medication.

22. Between on or about March 13, 2017, and on or about October 2, 2018, Patient B presented to Respondent for approximately twenty (20) clinical visits. For each of these visits, Respondent's handwritten notes in Patient B's chart are short and difficult to read. Throughout that time, Respondent regularly prescribed Patient B various medications, including, but not limited to, Xanax, Klonopin, and Adderall, but did not order any urine or serum drug toxicologies on Patient B at any time.

PATIENT C

23. On or about May 12, 2016, Respondent began providing psychiatric treatment to Patient C, a then twenty-nine-year-old male with a history of anxiety, social phobia, depression, insomnia, panic attacks, and agoraphobia. Respondent diagnosed Patient C with major depressive disorder and panic disorder, planned to rule out bipolar II disorder, and began prescribing controlled medications.

24. Between on or about July 10, 2017, and on or about March 10, 2020, Patient C presented to Respondent for approximately thirty-four (34) clinical visits. For each of these visits, Respondent's handwritten notes in Patient C's chart are short and difficult to read.

25. On or about July 10, 2017, Patient C presented to Respondent for a follow-up. At this visit, Patient C informed Respondent that he was experiencing flashbacks of his father throwing is head into a toilet approximately five to six times, and of being sexually assaulted for three years by his brother's friend. Respondent did not further discuss and/or document any further discussion with Patient C regarding the physical or sexual abuse, did not inquire whether the

abuse had been previously reported, did not inquire whether Patient C's abusers continued to surround themselves with underage youth, and did not contact law enforcement or a county child welfare agency to ask for recommendations regarding filing a report.

26. On or about October 26, 2018, Patient C presented to Respondent for a follow-up. At this visit, Patient C informed Respondent that he still recalls his physical and sexual abuse of childhood, specifically, that he was molested by his brother's friend and physically abused by his parents. Respondent did not further discuss and/or document any further discussion with Patient C regarding the physical or sexual abuse, did not inquire whether the abuse had been previously reported, did not inquire whether Patient C's abusers continued to surround themselves with underage youth, and did not contact law enforcement or a county child welfare agency to ask for recommendations regarding filing a report.

27. On or about October 28, 2021, Respondent participated in an interview with Board investigators. When asked about his reporting requirements after Patient C reported his sexual and physical abuse, Respondent stated that the abuse was long ago and there was nothing new to report.

PATIENT D

28. On or about February 6, 2017,[14] Patient D, a then fifty-four-year-old male, presented to Respondent for psychiatric treatment. Patient D had a history of generalized anxiety disorder, panic disorder with agoraphobia, and 15 years' sobriety from alcohol addiction without relapse. Patient D reported being previously prescribed Xanax 2mg four times daily and Valium[15] 10mg as needed. Respondent did not refer Patient D to an addiction specialist or a higher level of care at that visit or any visit thereafter, and did not prescribe Patient D non-controlled medications for

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[14] Patient D's certified complete medical record does not contain any treatment notes that predate August 2, 2017. Information regarding Respondent's treatment of Patient D prior to August 2, 2017, came from Respondent's statements at his subject interview on or about October 28, 2021.

[15] Valium (brand name for diazepam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to section 4022 of the Code. It is an anxiolytic and sedative medication used to treat anxiety, muscle spasms, and seizures.

his anxiety. At the conclusion of the visit, Respondent determined Patient D to be stable, and maintained him on the same doses of Xanax and Valium.

29. On or about July 11, 2017, Respondent began prescribing Patient D lorazepam[16] 1mg two times daily and Xanax 2mg four times daily.

30. On or about October 9, 2018, Patient D presented to Respondent for a follow-up. At this visit, Respondent discontinued lorazepam and prescribed Patient D Xanax 2mg three times daily and Valium 5mg daily.

31. Between on or about August 2, 2017, and on or about October 18, 2019, Patient D presented to Respondent for approximately twenty (20) clinical visits. For each of these visits, Respondent's handwritten notes in Patient D's chart are short and difficult to read. Throughout that time, Respondent regularly prescribed Patient D various medications, including, but not limited to, Xanax, Ativan, and Valium, but did not refer and/or document a referral for non-medication treatment options for anxiety.

32. Respondent committed repeated negligent acts in his care and treatment of Patients A, B, C, and D, that included, but was not limited to, the following:

A. Prescribing multiple benzodiazepines to Patient A for treatment of bipolar disorder and without ever checking CURES;

B. Failing to obtain collateral medical information for Patient A regarding his reported epilepsy diagnosis;

C. Abruptly refusing to prescribe Patient A benzodiazepines without referring Patient A to a dual diagnosis program and/or a detoxification or rehabilitation facility;

D. Prescribing benzodiazepines to Patient B, a patient with a substance abuse disorder, without first prescribing alternative non-controlled medications;

E. Failing to refer Patient B to a dual diagnosis program or addiction specialist at any time;

[16] Lorazepam (brand name Ativan) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to section 4022 of the Code. It is a sedative medication used to treat anxiety and seizure disorders.

F. Failing to perform any urine or serum drug toxicologies on Patient B at any time;

G. Failing to discuss and/or document a discussion with Patient C regarding whether his abuse had been previously reported and whether Patient C's abusers continued to surround themselves with underage youth, and failing to contact law enforcement or a county child welfare agency to ask for recommendations regarding filing a report;

H. Failing to refer Patient D to an addiction specialist or detoxification facility for substance use disorder treatment at any time;

I. Failing to utilize first line agents for Patient D's anxiety disorder; and

J. Failing to refer Patient D for non-medication treatment options for his anxiety disorder.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

33. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 111058 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patients A, B, C, and D, as more particularly alleged in paragraphs 10 through 32(J), above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

34. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 111058 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he was incompetent in his care and treatment of Patient C, as more particularly alleged in paragraphs 23 through 27, and 32(G), above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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DISCIPLINARY CONSIDERATIONS

35. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about February 21, 2014, the Board issued a Decision and Order that became effective on or about March 21, 2014, in an action entitled, *In the Matter of the Accusation Against Hozair M. Syed, M.D.,* Medical Board of California Case No. 09-2010-211439. In that matter, and as a result of Respondent's sexual misconduct, gross and repeated negligent acts, record keeping violations, and general unprofessional conduct with a single patient in or around 2010, Respondent's Physician's and Surgeon's Certificate No. A 111058 was placed on probation for seven years, subject to various terms and conditions of probation. Pursuant to a Petition for Early Termination of Probation, Respondent's probation was terminated on or about March 15, 2019.

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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. A 111058, issued to Respondent, Hozair Mohammed Syed, M.D.;

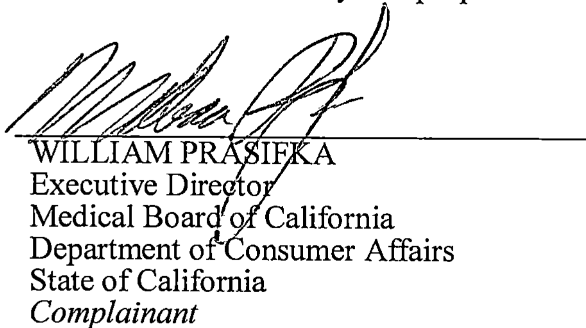
2. Revoking, suspending or denying approval of Respondent, Hozair Mohammed Syed, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, Hozair Mohammed Syed, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent, Hozair Mohammed Syed, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: SEP 06 2022



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

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