XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
MEGAN R. O'CARROLL
Deputy Attorney General
State Bar No. 215479
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7543
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Mahmoud Khattab, M.D.** **9250 Big Horn Blvd., Ste. 100** **Elk Grove, CA 95758-1299** **Physician's and Surgeon's Certificate No. A 97693,** Respondent.	Case No. 800-2017-039667 **A C C U S A T I O N**

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 October 13, 2006, the Medical Board issued Physician's and Surgeon's Certificate Number A 97693 to Mahmoud Khattab, 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 February 28, 2022, unless renewed. On or about May 29, 2020, the Office of Administrative Hearings issued an Order approving a stipulation for an interim order of suspension of Physician's and Surgeon's License No. A 97693. On or about July 30, 2020, the

Office of Administrative Hearings issued a Decision for an interim order of suspension of Respondent's License until a final decision is adopted on this Accusation.

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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

> "The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
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> (b) Gross negligence.
>
> (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.
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> (d) Incompetence.
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> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
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> (g) The failure by a certificate holder, in the absence of good cause, to attend

and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2052 of the Code states:

(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter [Chapter 5, the Medical Practice Act], or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

(b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.

(c) The remedy provided in this section shall not preclude any other remedy provided by law.

7. Section 2216 of the Code states:

On or after July 1, 1996, no physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Section 1248.1. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

The definition of outpatient settings contained in subdivision (c) of Section 1248 [of the Health and Safety Code] shall apply to this section.

8. Section 2259.7 of the Code states:

The Medical Board of California shall adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician and surgeon outside a general acute care hospital, as defined in Section 1250 of the Health and Safety Code. In adopting those regulations, the Medical Board of California shall take into account the most current clinical and scientific information available. A violation of these extraction and postoperative care standards shall constitute unprofessional conduct.

9. California Code of Regulations, title 16, section 1356.6, states:

(a) A liposuction procedure that is performed under general anesthesia or

intravenous sedation or that results in the extraction of 5,000 or more cubic centimeters of total aspirate shall be performed in a general acute-care hospital or in a setting specified in Health and Safety Code Section 1248.1.

(b) The following standards apply to any liposuction procedure not required by subsection (a) to be performed in a general acute-care hospital or a setting specified in Health and Safety Code Section 1248.1:

(1) Intravenous Access and Emergency Plan. Intravenous access shall be available for procedures that result in the extraction of less than 2,000 cubic centimeters of total aspirate and shall be required for procedures that result in the extraction of 2,000 or more cubic centimeters of total aspirate. There shall be a written detailed plan for handling medical emergencies and all staff shall be informed of that plan. The physician shall ensure that trained personnel, together with adequate and appropriate equipment, oxygen, and medication, are onsite and available to handle the procedure being performed and any medical emergency that may arise in connection with that procedure. The physician shall either have admitting privileges at a local general acute-care hospital or have a written transfer agreement with such a hospital or with a licensed physician who has admitting privileges at such a hospital.

(2) Anesthesia. Anesthesia shall be provided by a qualified licensed practitioner. The physician who is performing the procedure shall not also administer or maintain the anesthesia or sedation unless a licensed person certified in advanced cardiac life support is present and is monitoring the patient.

(3) Monitoring. The following monitoring shall be available for volumes greater than 150 and less than 2,000 cubic centimeters of total aspirate and shall be required for volumes between 2,000 and 5,000 cubic centimeters of total aspirate:

(A) Pulse oximeter

(B) Blood pressure (by manual or automatic means)

(C) Fluid loss and replacement monitoring and recording

(D) Electrocardiogram

(4) Records. Records shall be maintained in the manner necessary to meet the standard of practice and shall include sufficient information to determine the quantities of drugs and fluids infused and the volume of fat, fluid and supranatant extracted and the nature and duration of any other surgical procedures performed during the same session as the liposuction procedure.

(5) Discharge and Postoperative-care Standards.

(A) A patient who undergoes any liposuction procedure, regardless of the amount of total aspirate extracted, shall not be discharged from professionally supervised care unless the patient meets the discharge criteria described in either the Aldrete Scale or the White Scale. Until the patient is discharged, at least one staff person who holds a current certification in advanced cardiac life support shall be present in the facility.

(B) The patient shall only be discharged to a responsible adult capable of understanding postoperative instructions.

10. Section 2261 of the Code states:

> Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

11. Section 2262 of the Code states:

> Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.
>
> In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section.

12. Section 2263 of the Code states: The willful, unauthorized violation of professional confidence constitutes unprofessional conduct.

13. Section 2264 of the Code states:

> The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

14. 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.

15. Section 2271 of the Code states: Any advertising in violation of Section 17500, relating to false or misleading advertising, constitutes unprofessional conduct.

16. Section 2272 of the Code states: Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct.

17. Section 2286 of the Code states:

> It shall constitute unprofessional conduct for any licensee to violate, to attempt to violate, directly or indirectly, to assist in or abet the violation of, or to conspire to violate any provision or term of Article 18 (commencing with Section 2400), of the Moscone-Knox Professional Corporation Act (Part 4 commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), or of any rules and regulations duly adopted under those laws.

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18. Section 2415 of the Code states:

(a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing, or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section.

(b) The division or the board shall issue a fictitious-name permit authorizing the holder thereof to use the name specified in the permit in connection with his, her, or its practice if the division or the board finds to its satisfaction that:

(1) The applicant or applicants or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons or doctors of podiatric medicine, as the case may be.

(2) The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants.

(3) The name under which the applicant or applicants propose to practice is not deceptive, misleading, or confusing.

(c) Each permit shall be accompanied by a notice that shall be displayed in a location readily visible to patients and staff. The notice shall be displayed at each place of business identified in the permit.

(d) This section shall not apply to licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with that medical school.

(e) Fictitious-name permits issued under this section shall be subject to Article 19 (commencing with Section 2421) pertaining to renewal of licenses.

(f) The division or the board may revoke or suspend any permit issued if it finds that the holder or holders of the permit are not in compliance with the provisions of this section or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a fictitious-name permit shall be conducted in accordance with Section 2230.

(g) A fictitious-name permit issued to any licensee in a sole practice is automatically revoked in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

(h) The division or the board may delegate to the executive director, or to another official of the board, its authority to review and approve applications for fictitious-name permits and to issue those permits.

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(i) The California Board of Podiatric Medicine shall administer and enforce this section as to doctors of podiatric medicine and shall adopt and administer regulations specifying appropriate podiatric medical name designations.

19. Section 125 of the Code states:

Any person, licensed under Division 1 (commencing with Section 100), Division 2 (commencing with Section 500), or Division 3 (commencing with Section 5000) is guilty of a misdemeanor and subject to the disciplinary provisions of this code applicable to them, who conspires with a person not so licensed to violate any provision of this code, or who, with intent to aid or assist that person in violating those provisions does either of the following:

(a) Allows their license to be used by that person.

(b) Acts as their agent or partner.

20. Section 651 states:

(a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.

(b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes a statement or claim that does any of the following:

(1) Contains a misrepresentation of fact.

(2) Is likely to mislead or deceive because of a failure to disclose material facts.

(3)(A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

(B) Use of any photograph or other image of a model without clearly stating in a prominent location in easily readable type the fact that the photograph or image is of a model is a violation of subdivision (a). For purposes of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure being advertised, of the licensee who is advertising for his or her services.

(C) Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size

what procedures were performed on that patient is a violation of subdivision (a). Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.

(4) Relates to fees, other than a standard consultation fee or a range of fees for specific types of services, without fully and specifically disclosing all variables and other material factors.

(5) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) Makes a claim either of professional superiority or of performing services in a superior manner, unless that claim is relevant to the service being performed and can be substantiated with objective scientific evidence.

(7) Makes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.

(8) Includes any statement, endorsement, or testimonial that is likely to mislead or deceive because of a failure to disclose material facts.

(c) Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(d) Any person so licensed shall not compensate or give anything of value to a representative of the press, radio, television, or other communication medium in anticipation of, or in return for, professional publicity unless the fact of compensation is made known in that publicity.

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

(f) Any person so licensed who violates this section is guilty of a misdemeanor. A bona fide mistake of fact shall be a defense to this subdivision, but only to this subdivision.

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.

(h) Advertising by any person so licensed may include the following:

(1) A statement of the name of the practitioner.

(2) A statement of addresses and telephone numbers of the offices maintained by the practitioner.

(3) A statement of office hours regularly maintained by the practitioner.

(4) A statement of languages, other than English, fluently spoken by the practitioner or a person in the practitioner's office.

(5)(A) A statement that the practitioner is certified by a private or public board or agency or a statement that the practitioner limits his or her practice to specific fields.

(B) A statement of certification by a practitioner licensed under Chapter 7 (commencing with Section 3000) shall only include a statement that he or she is certified or eligible for certification by a private or public board or parent association recognized by that practitioner's licensing board.

(C) A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician and surgeon's licensing board prior to January 1, 2019, or (iii) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section 1600) and the use of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for certifying medical doctors and other health care professionals that is based on the applicant's education, training, and experience. A multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2019, shall retain that approval.

For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician and surgeon's licensing board prior to January 1, 2019, or an

organization with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.

(D) A doctor of podiatric medicine licensed under Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs

that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Article (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

The California Board of Podiatric Medicine shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph, to be deposited in the State Treasury in the Podiatry Fund, pursuant to Section 2499. The fee shall not exceed the cost of administering this subparagraph.

(6) A statement that the practitioner provides services under a specified private or public insurance plan or health care plan.

(7) A statement of names of schools and postgraduate clinical training programs from which the practitioner has graduated, together with the degrees received.

(8) A statement of publications authored by the practitioner.

(9) A statement of teaching positions currently or formerly held by the practitioner, together with pertinent dates.

(10) A statement of his or her affiliations with hospitals or clinics.

(11) A statement of the charges or fees for services or commodities offered by the practitioner.

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(12) A statement that the practitioner regularly accepts installment payments of fees.

(13) Otherwise lawful images of a practitioner, his or her physical facilities, or of a commodity to be advertised.

(14) A statement of the manufacturer, designer, style, make, trade name, brand name, color, size, or type of commodities advertised.

(15) An advertisement of a registered dispensing optician may include statements in addition to those specified in paragraphs (1) to (14), inclusive, provided that any statement shall not violate subdivision (a), (b), (c), or (e) or any other section of this code.

(16) A statement, or statements, providing public health information encouraging preventative or corrective care.

(17) Any other item of factual information that is not false, fraudulent, misleading, or likely to deceive.

(i) Each of the healing arts boards and examining committees within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

(j) The Attorney General shall commence legal proceedings in the appropriate forum to enjoin advertisements disseminated or about to be disseminated in violation of this section and seek other appropriate relief to enforce this section. Notwithstanding any other provision of law, the costs of enforcing this section to the respective licensing boards or committees may be awarded against any licensee found to be in violation of any provision of this section. This shall not diminish the power of district attorneys, county counsels, or city attorneys pursuant to existing law to seek appropriate relief.

(k) A physician and surgeon or doctor licensed pursuant to Chapter 5 (commencing with Section 2000) by the Medical Board of California or a doctor of

podiatric medicine licensed pursuant to Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who knowingly and intentionally violates this section may be cited and assessed an administrative fine not to exceed ten thousand dollars ($10,000) per event. Section 125.9 shall govern the

issuance of this citation and fine except that the fine limitations prescribed in paragraph (3) of subdivision (b) of Section 125.9 shall not apply to a fine under this subdivision.

FACTUAL ALLEGATIONS

Practice Information

21. Respondent opened a private practice in Elk Grove, California in approximately 2011, practicing internal medicine. He is Board-certified in Internal Medicine. In approximately 2014, he began increasing the cosmetic aspects of his practice and began performing liposuctions in 2015. His practice is now exclusively cosmetic. Respondent advertises his practice as "Precision M.D. Cosmetic Surgery Center." This is the name posted on the outside of the building, it is the name printed on all the office documents and patient records, and it the name under which he advertises on his website, on television and online. But Respondent's practice is not an accredited surgery center, it is merely a medical office. Respondent holds a Fictitious Name Permit (FNP), allowing him to practice under the name of "Precision M.D." Between December 2019 and March of 2020, Respondent's FNP for "Precision M.D." was delinquent. Respondent has since renewed the permit.

22. Respondent is the only physician at Precision M.D., despite a very high volume of patients. Respondent estimates that on any business day his practice sees approximately 25-30 patients. He employs approximately 14 staff members, including three Medical Assistants, four receptionists, two estheticians, an office manager, two consultants, and an Executive Director. In addition to nonsurgical procedures like laser treatments and injections, he performs surgeries including liposuction, breast augmentations, and hair transplantations. Respondent estimates that he performs approximately 500 liposuction procedures each year.

23. Respondent performs these surgeries in a room in his medical office. He is not Board-certified in plastic surgery. He does not have hospital privileges at any hospital. As of March of 2020, Respondent's office did not have a crash cart and did not monitor patients' blood

pressures and cardiac rhythms during surgeries. When asked by the Board's Medical Consultant in March of 2020 whether he was "ACLS certified," Respondent did not know what ACLS means. As of March 3, 2020, Respondent did not have a transfer agreement with any hospital. As of March 3, 2020, Respondent did not have a locking device for controlled medications in his office, did not maintain a log of their use, and did not document waste of these substances to prevent diversion.

24. Before approximately October of 2017, Respondent did not have an automatic external defibrillator (AED), available during the surgeries, and did not prepare patients with an intravenous line during surgeries, or have opioid reversal medications available. Respondent began using intravenous opioids and benzodiazepines in surgeries in approximately November of 2017. He allows Medical Assistants to mix intravenous drugs and push them through the lines during surgeries. Respondent allows patients to leave the surgical table during procedures to use the restroom, and takes breaks himself during surgery to meet with other patients while the surgical patient is left on the table with only Medical Assistants in the room. He does not maintain a sterile surgical field, occasionally breaking during surgery to take a telephone call, and only uses hand sanitizer to clean his hands before resuming surgery. He leaves the surgical room immediately after the surgical procedure is done, allowing nurses and even Medical Assistants to evaluate whether a patient is safe to leave. He does not have a set of rules or criteria in place for the staff members to evaluate whether a patient may safely leave after a procedure. When asked by the Board's Medical Consultant in March of 2020 whether he was familiar with Aldrete's Scale or White's Scale, he responded that he was not, and believed that those principles were only applicable to general anesthesia.

Patient 1

25. Patient 1 sought a cosmetic procedure to reduce the size of her stomach. In September of 2017, she called Respondent's office, Precision M.D., and spoke with the Office Manager to inquire about cosmetic procedures. The Office Manager, Ms. L.A., has no medical licensure. Despite having no medical licensure, Ms. L.A. receives a commission of 2% on all patients she enters into Respondent's surgical calendar. Ms. L.A. exchanged emails and photos

with Patient 1, and advised her that she was a good candidate for Vaser liposuction.[1] Ms. L.A. invited Patient 1 to come into the office for a preoperative appointment, but told her it was not required. Patient 1 preferred not to drive to the office for a preoperative appointment, and declined. Thereafter, Patient 1 agreed to the procedure, and Respondent's Office charged her credit card $6,000.00. Her procedure was scheduled for October 11, 2017. Patient 1 forwarded laboratory results to the office by email before the appointment.

26. When Patient 1 arrived at Precision M.D. on October 11, 2017, she was given forms to sign. Surgical Tech A.A. took photographs of her, took her blood pressure, and she took a Xanax pill by mouth. Patient 1 told Surgical Tech A.A. that she was allergic to Norco, (hydrocodone and acetaminophen), and the Surgical Tech wrote that down. The Surgical Tech took Patient 1 to a different area of the office where Respondent performed procedures, and gave her paper garments to put on. Patient 1 found the surgical area to be dirty with debris and boxes everywhere and carpet on the floor. She was shown to a bathroom adjacent to the surgical area to change into the paper garments. Patient 1 and Surgical Tech A.A. waited in this area for Respondent for approximately 45 minutes while a workman was working on a machine. When Respondent came into the room, it was the first time Patient 1 had ever seen him, and he did not immediately address her. Instead, he interacted with the workman, and appeared angry and spoke on the telephone and signed the workman's paperwork.

27. The first time Respondent ever spoke to Patient 1 was after he had instructed Surgical Tech A.A. to have Patient 1 remove her paper garments and stand up by the wall. As she was naked against the wall, Respondent came over to mark her body with a pen and addressed her for the first time, asking "how are you?" He never asked her any medical questions, never spoke about any side effects of the procedure, and never listened to her heart or lungs. When Patient 1 later reviewed her medical records from Precision M.D., she saw that Respondent had signed a "consultation note," dated October 11, 2017, stating that he listened to her heart and lungs, and

[1] The Vaser liposuction process requires mixing a solution of saline, epinephrine, and a local anesthetic (tumescent solution), and injecting it under the skin. A titanium probe is then inserted under the skin to deliver ultrasound energy to loosen fat cells, before vacuuming out the liquid aspirate, which consists of a mixture of the infiltrated solution, blood, and fat. He also performs injections and laser skin treatments.

discussed the risks and benefits of Vaser liposuction, identifying potential complication such as bleeding, infections, and contour irregularities before obtaining her consent to the procedure. All of this was false.

28. Patient 1 had an oxygen monitor on her for the procedure, but no blood pressure monitor or EKG leads were attached to her. She had no intravenous line placed. As soon as the procedure began Patient 1 was in extreme pain. She felt like she was being tortured. Respondent did not wait for the tumescent (local anesthetic) solution to work before beginning the suctioning. During his March 2020 interview with the Board's Medical Consultant, Respondent was asked how long he allows for the tumescent solution to work, and he incorrectly responded that as soon as the fluid is in it is appropriate to begin the surgery. This is false, as the tumescent solution requires time to take effect without causing excessive pain to a patient. Patient 1 requested pain relief four times during the procedure. At one point, she heard Respondent tell the Surgical Tech to give her Norco. Patient 1 was terrified because she was allergic to Norco, but she then heard Surgical Tech A.A. tell Respondent that Patient 1 was allergic to Norco, and he directed Surgical Tech A.A. to give her Valium and extra strength Tylenol.

29. Respondent infiltrated 4,330 cubic centimeter (ccs) of tumescent solution, and aspirated 2,400 ccs of total aspirate. Respondent's use of medication during the procedure constituted conscious sedation. Respondent's operative note falsely states that Patient 1 had an I.V. placed, that her blood pressure and heart rhythms were monitored throughout the procedure, and that she tolerated the procedure well. After the procedure ended, Respondent immediately left the room and she never saw him again that day. The Surgical Tech remained with Patient 1, and was the one to determine when it was safe for Patient 1 to leave. Respondent has no written discharge criteria for these unlicensed staff members to follow to determine when it is safe for a patient to go home. After the surgery Patient 1's blood pressure was 82/52 at 4:20 p.m., and 95/58 at 4:50 p.m. when she was discharged. There are no further post operative vital signs, and no record of ACLS certified staff monitoring the patient after surgery. There were no written discharge protocols noted or established before discharge.

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30. A few days after the procedure, Patient 1 began to feel that she had an infection. At a post operative appointment with Respondent on or about October 17, 2017, she became overwhelmed with everything she had been through and told Respondent that she did not like him. Respondent raised his voice and broke into a verbal assault, telling her that she was the worst patient he had ever had, and the rudest woman he had ever met, and that he was not her slave.

31. After this verbal altercation at the appointment, Patient 1 called Respondent's office and asked that he refer her to a different physician. Respondent stated that she could see him for follow up care. Patient 1 instead sought care with her regular provider, and was admitted to the hospital for three days where she had abdominal abscesses drained, which were not found to be infected. Patient 1 did not have a good cosmetic result. Ms. L.A. had told Patient 1 that she would have a recovery period of about two days, but Patient 1 did not find this to be true, and was out of work for two weeks.

Patient 2

32. Patient 2 and her husband met with Office Manager L.A. at Precision M.D. on or about February 22, 2019. Ms. L.A. told Patient 2 that she would recommend a liposuction procedure over a coolsculpting procedure for Patient 2 because it would provide good results with minimal downtime of about 2 days. Respondent joined the consultation for about two minutes and agreed with the planned procedure. He reiterated that Patient 2 would have a two-day recovery period. He did not discuss any potential risks or complications from the procedure. Ms. L.A. continued to speak with Patient 2 and her husband about financing options.

33. Respondent falsely signed a consultation note, dated February 18, 2019 stating that he conducted an examination and warned Patient 2 of potential risks and side effects during the consultation, including vaser burns, scars, and infections. Respondent never performed a physical examination on Patient 2 before the surgery, or had a discussion with her about the risks and benefits of the procedures.

34. In the weeks after the February 18, 2019 consultation, Respondent's office continued to call Patient 2 to ask if she was going to go through with the procedure. Eventually Patient 2

decided that she would, and Ms. A contacted CareCredit company to get Patient 2's credit limit raised. Even the with limit raised it was not enough to cover the $12,000 cost, so Ms. L.A. assisted Patient 2's husband to open a CareCredit card. On or about May 22, 2019, Patient 2 and her husband's cards were charged a total of $12,000.00.

35. Patient 2 arrived at Precision M.D. for her procedure on or about May 31, 2019 at 8:00 a.m. She was provided with consent forms to sign on that morning, but did not have time to read them or ask questions before signing. Patient 2 changed into paper garments and two female staff members placed an intravenous line in her right hand. Patient 2 found the procedure excruciatingly painful and screamed out for Respondent to stop the procedure. Respondent paused briefly to infiltrate more local anesthetic, but began the procedure again almost immediately without waiting for the solution to take effect. Patient 2 again screamed out for Respondent to stop the procedure, but he did not. When the procedure was over, Patient 2 was unable to stand or use her right arm. Two female staff members assisted her into her clothes.

36. Respondent documented in his operating note that he infiltrated 4,444 cc of tumescent solution and extracted 6,000 cc of total aspirate. He documented 60 minutes of Vaser time. The operating note further states that Patient 2 had continuous EKG cardiac and blood pressure monitoring during the procedure, with results printed every 30 minutes. This is false. Patient 2 was not attached to an EKG or blood pressure monitor during the procedure. The operative note further states that Patient 2 tolerated the procedure well and was discharged home, ambulatory, in good condition. The handwritten notes by Respondent's staff indicate that Patient 2 was given two Norco 5/325 tablets, and two Valium 5 mg tablets to take by mouth before the procedure. She was given additional intravenous medications of Fentanyl and Ativan during the procedure in the amount of 300 mcg fentanyl and 2 mg of Ativan. Respondent lacks knowledge and understanding to use these drugs. The level of sedation of Patient 2 constituted conscious sedation. Only two blood pressures are recorded for Patient 2, at 9:00 a.m. and 2:33 p.m. There are no further post operative vital signs, and no record ACLS certified staff monitoring the patient after surgery. There were no written discharge protocols noted or established before discharge.

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37. Several days later Patient 2 and her husband returned to Precision M.D. for a follow up appointment with Respondent. Although she had been told that the recovery for the procedure was two days, Patient 2 was still unable to walk and had to come in a wheelchair. Patient 2's husband asked Respondent why he did not stop the procedure when Patient 2 asked him to, and Respondent said that he did not do that. Patient 2's husband stood up and began advancing toward Respondent and Respondent called for his staff to contact the police. When Patient 2's husband showed the police pictures of her abdomen, they did not arrest him.

38. Under the bandages the entire width of Patient 2's abdomen was burned with areas of black, charred skin, and areas where blood and pus were oozing. The skin was burned from the inside of the abdominal wall out. Photographs show a large area of disfigured, severely burned skin covering Patient 2's entire mid-section. Patient 2's husband was distraught by the pain and suffering he witnessed his wife experiencing.

39. . Respondent continued to see Patient 2 for follow up every week for approximately six weeks. He repeatedly told her that her skin was doing fine and would heal normally. Finally, at a follow up appointment on July 12, 2019, Respondent told Patient 2 that he wanted to remove "a chunk of dead skin" on the side of her abdomen. Patient 2 asked him if he would have to cut her skin, and he said he would not. Respondent did not explain that he was planning to surgically debride her wound, and did not obtain informed consent for any procedure. Patient 2 was brought to the surgical room and asked to lay on the table. Respondent did not explain the procedure he planned to do, and did not provide her with any consent forms to sign. Patient 2 asked whether the procedure would hurt, and she was told it would not. Patient 2 spoke up then and asked Respondent if he was going to inject her stomach. When Patient 2 saw that she was being draped with surgical sheets, she began to cry and refused to go through with the procedure. Respondent became angry and left the room.

40. Patient 2 went to her primary care physician who referred her to a proper wound clinic. Patient 2 required several months of treatment at the wound care clinic. She was diagnosed with a third degree burn and suffered extensive scarring.

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Patient 3

41. On or about June 12, 2019, Patient 3 went to Respondent's office for a consultation for cosmetic surgery on her thighs and underneath both arms. The Office Manager, Ms. L.A. examined her and said she was a candidate for liposuction on her arms. Ms. L.A. discussed treatments to Patient 3's thighs and neck, and brought Respondent in to discuss these treatments. Respondent told Patient 3 that the liposuction to her arms would be an "easy fix" and agreed with threading to her neck. He further recommended that Patient 3 have an additional liposuction procedure to her thighs, but Patient 3 refused. As soon as Patient 3 declined the more expensive procedure to her thighs, he left her to Ms. L.A. Ms. L.A. charged Patient 3's CareCredit card $8,400.00 that day, June 12, 2019, and scheduled the surgery for June 17, 2019. Patient 3 paid for liposuction to her arms, a thread lift for her neck, and J. Plasma for her thighs.[2]

42. Respondent signed a consultation note, dated June 12, 2019, claiming that on this date he discussed treatment options with Patient 3, and warned her about potential side effects such as burns, scars, asymmetry, lumps and infections. This note is totally false. Respondent never spoke with Patient 3 about any negative possibilities from the planned procedures. He only spoke of positive outcomes she could expect.

43. On June 17, 2019, a friend drove Patient 3 to Respondent's office. Before the procedure, she signed an electronic pad with both her signature and initials, but did not have time to review what she was signing. A staff member took photos of her thighs, arms, and neck, and then took her to the procedure room. She had an I.V. placed, and felt very relaxed, and then believes she became unconscious. The medical record states that Respondent infiltrated 4,142 cc of tumescent solution and suctioned 1,900 ccs. He administered anxiolytics, Valium, analgesics, and Norco to Patient 3 constituting conscious sedation. He started infiltration at 2:17 p.m., the Vaser at 2:21 p.m., and the suctioning at 2:39 p.m. There is no documentation of the procedures done to Patient 3's neck or thighs.

[2] A "thread neck lift" is a procedure to insert sutures into the neck to tighten the skin in that area. A "J. Plasma" procedure is process of inserting gaseous material under the skin in an effort to promote skin tightening in the area. J. Plasma is not approved by the FDA for skin tightening, and any use of it is considered off label. There is not even a template consent form with an electronic signature for use of J. Plasma in Patient 3's medical records.

44. Patient 3 recalled waking up several times during the procedure and feeling pain near her elbow. At one point during the procedure, she recalls hearing sounds of women chatting and laughing so she asked the women what they were doing and if they were on a break. They responded that they were on a break, and that Respondent was not in the room. She fell back to sleep and the next thing she recalled was being in her friend's car with no memory of how she got there or who dressed her in a compression suit. She did not receive any discharge instructions or paperwork. Respondent's use of medication during the procedure constituted conscious sedation. Patient 3's medical record showed inadequate post operative documentation of vital signs, and no record ACLS certified staff monitoring her after surgery. There were no written discharge protocols noted or established before discharge.

45. The next day, Patient 3 returned for a follow up appointment and told Respondent that she was in extreme pain. Respondent told her it was all normal and to keep wearing the bandages and compression suit for three more days. Patient 3 continued to call the office to report that she was in extreme pain, and was continually reassured, and told to drink pineapple juice to help with swelling. On or about June 21, 2019, she removed the compression suit and for the first time saw her underarms. She was alarmed to see chunks of blackened skin on the back of her arms.

46. On June 25, 2019, at another follow-up appointment, she again told Respondent how distressed she was and that she was experiencing terrible pain and her arm skin was peeling off. Respondent told her it was all normal, and to apply xerofoam (an antibiotic bandage) to her arms. After the June 25, 2019 appointment, Patient 3 felt constant pain and began to detect a foul odor coming from the back of her arms. She reported the odor to Respondent at another follow up appointment or about July 2, 2019, and he advised her to stop wearing the compression suit.

47. On July 9, 2019, Patient 3 had an appointment with Respondent when he finally removed the bandages to look at her arms. When he saw her arms his face turned white and he looked shocked. He started yelling orders to his staff and told them to prepare the surgery room immediately. Photographs of Patient 3's arms demonstrate that they were severely burned and disfigured. Patient 3 became very frightened at Respondent's reaction to seeing her arms and

began to cry. Respondent did not tell Patient 3 what was wrong, or what he was going to do, and never gave her any consent forms to sign for any kind of treatment or procedure. He just told her he was going to fix her arms.

48. As Patient 3 was lying down on the surgical table she saw that Respondent had multiple long needles and scissors prepared. Respondent took a needle and injected her arms. She believes it numbed her arms. Patient 3 closed her eyes and cried, as she could hear Respondent using scissors to cut away skin from her arms and stitch them back up. After the procedure Respondent told her that she did not need to worry about anything and that he would take of her himself and that she should not go see any other doctor. He told her to return every few days so he could change the bandages personally. He prescribed antibiotics and pain medication to her and told her she would be healed in two-to-three weeks.

49. During the rest of July 2019, and through September of 2019, Patient 3 returned and saw Respondent at least eleven times. At one of these appointments Respondent told Patient 3 that the reason her arms were burned was because the company that manufactured the metal probe he used during her surgery had made a defective product. He showed her a probe and claimed it was missing the tip that regulated the heat properly. He blamed the manufacturer for the poor results and the excessive pain Patient 3 had endured and said that he contacted the manufacturer to request all new probes. At the visits, Respondent repeatedly told her that he was giving her the best and most expensive skin care possible.

50. On July 28, 2019, Patient 3 was in such pain that she went to Mercy General Hospital Emergency Room. At the Emergency Room, the physicians gave her pain medicine and changed her antibiotics. The Emergency Room physician noted that she would likely need a referral to a wound care clinic. When Patient 3 returned to see Respondent the next day and told him that she had been to the Emergency Room he became livid. He told Patient 3 that he was giving her the best, most expensive care possible, and that she was not to go to any other doctors to treat her arms.

51. Patient 3 found Respondent's reaction to her Emergency Room visit suspicious and began to lose trust in him. As the weeks wore on and her arms did not heal in the time

Respondent had told her they would, she became angry at him. She stopped calling him "Dr. Khattab" and referred to him only as "Khattab." He took offense at that and told her that she needs to refer to him properly as "Dr. Khattab." At her last appointment with Respondent, the two had a heated argument. She told him he was a butcher, and he shouted at her to get out of his office. As she was attempting to leave through the door she came in, he prevented her and ushered her to the private door at the back. She exited at the back, but walked around to the front office and made a scene. She warned patients in the lobby not to see Respondent and that he butchered her. He yelled at everyone that she was "trash."

Patient 4

52. In November of 2017, Patient 4 met with Ms. L.A. for a consultation for liposuction. Ms. L.A. told Patient 4 that she was a candidate for Vaser liposuction and quoted her a price for the procedure. Patient 4 complained that the price was too high, so Ms. L.A. went and got Respondent. Respondent spent approximately a minute with Patient 4, and quoted her a price of $5,000.00 for a liposuction on her lower flanks and abdomen, but assured her that he would be able to blend her lower abdomen with the upper abdomen. Patient 4 opened a CareCredit card with Ms. L.A., and she was billed for the procedure that day, November 6, 2017. Ms. L.A. told Patient 4 that she would only require a few days to recover from the procedure. Patient 4 received prescriptions for Keflex and Norco.

53. Respondent signed a document in Patient 4's medical record, dated November 6, 2017, entitled "Consult Form." Respondent documented that he examined Patient 4's heart, lungs, and abdomen. He documented that her vital signs were normal. Neither Respondent, nor any other staff member at Precision M.D. ever listened to Patient 4's heart, or lungs, on November 6, 2017, and her vital signs were not taken. Respondent documented that he discussed all options for fat reduction with Patient 4, and informed her of the risks and benefits of the procedures. This is not true. Respondent never discussed other alternatives to liposuction with Patient 4, and did not mention any risks associated with the procedure. Respondent documented that he warned Patient 4 that her decision to do only the lower abdomen and flanks would increase the possibility of unevenness since she was not having the upper abdomen done. This is

the exact opposite of what Respondent told Patient 4. He told her that he would be able to "blend" the upper and lower abdomen.

54. On or about November 22, 2017, Patient 4 arrived at Respondent's Office for the procedure. Patient 4 was asked to initial and sign a large packet of forms. She did not have time to read the forms or ask questions about them. Instead, she signed an electronic tablet with her initials and an electronic signature. An employee took Patient 4's photographs, and led her to a surgical suite. The room was dirty and cluttered with boxes and debris and Patient 4 was concerned that the environment did not seem clean or safe.

55. Patient 4 was given narcotics and anxiolytics in amounts and doses that are not entirely clear from the records. The records show that Norco was given orally, and that Patient 4 received 5 mg of Valium at some point, although the route of administration is not documented. Respondent's use of medication during the procedure constituted conscious sedation. Patient 4 was also given intra-muscular Ceftriaxone in the right deltoid.

56. Surgical Tech A.A. signed the pre-surgical procedure checklist. Tech A.A. took a set of pre-procedure vitals and documented a weight of 149.7 pounds. The record shows that a staff member mixed up three one-liter bags of tumescent solution with 1,000 mg of lidocaine per liter and calculated the maximum dose of lidocaine. Three total bags were infused for a total volume of 3.33 Liters. Respondent did not sign this medication documentation. Staff members at Precision M.D. reported that the unlicensed staff, not Respondent, routinely mix up the tumescent solutions for liposuction procedures. Unlicensed staff members also routinely administer I.V. medications during the surgery.

57. There is a handwritten chart note, not signed by Respondent, documenting the procedure. It states that an I.V. was placed in the left arm, incisions were made to the abdomen at 1:37 p.m., the infiltration was begun at 1:39 p.m., and the total amount infiltrated was 3,333 cc. The Vaser was started at 1:45 p.m., lasted for 28 minutes, and suction began at 2:19 p.m., with 2,900 ml suctioned. The procedure ended at 2:55 p.m. The note states that 1 milliliter of atropine was administered at 3:15 p.m., but there is no explanation for this. The note states that Patient 4 tolerated the procedure well.

58. Patient 4 recounts that she experienced an enormous amount of pain during the procedure. She recalled feeling Respondent jerking the cannula aggressively. Patient 4 cried out in pain approximately six times during the procedure, asking Respondent to stop the procedure. He would not immediately stop. On some occasions he would eventually stop and seemed to be administering more pain medication, but she could not see because there was a drape between her head and her body. It is not clear what other local anesthesia was provided or the amounts or times of dosages.

59. Patient 4's medical record also contains a typed surgical report. It is signed by Tech A.A. on November 24, 2017 and by Respondent on November 28, 2017. It also states that Patient 4 had liposuction on November 22, 2017 with 2,900 milliliters of fat removed. While it contains some of the same information as the chart notes, it contains several additional statements that are false. It states that a Registered Nurse began the preoperative assessment. It refers to an anesthesia record, although there is no anesthesia record in Patient 4's medical record. It states that Patient 4 was monitored with continuous blood pressure readings and EKG monitoring and that these records were printed every thirty minutes. This is false. Patient 4 had no blood pressure monitoring during the procedure and at no time was she connected to an EKG monitor or leads. Staff present during the procedure confirmed that Respondent did not have intraoperative EKG or blood pressure monitoring available at his practice. Patients at Precision M.D. were only hooked up to an oxygen monitor on their finger. The operative report further states that Patient 4 was given nitrous oxide, but she does not recall breathing into any tube or receiving nitrous oxide. The template surgical report states that a "standard manual technique" was used in the liposuction. There is no more specific description, and there are no end points noted.

60. Surgical Tech A.A. reported that she and other staff prepared the operative notes using a template per Respondent's direction. The templates contained the language about preoperative procedures and continuous blood pressure and cardiac monitoring. The staff would attempt to obtain Respondent's electronic signature on these reports, but after several days if he had not signed them, they would affix his electronic signature. The staff completed all the charting for the practice and they had access to Respondent's electronic signature.

61. There are four blood pressure readings in Patient 4's chart, at 12:30 p.m., 3:18 p.m., 3:26 p.m. and 3:56 p.m. At 3:18 p.m. Patient 4's blood pressure had decreased to 64/37 with a heartrate of 50. At 3:26 p.m., her pulse was 51, and her blood pressure was 90/62 HR. Only one set of vitals were taken after that time, at 3:56 p.m. Patient 4 was discharged home with her friend to drive her after the procedure. There are no further post-operative vital signs, and no record ACLS certified staff monitoring the patient after surgery. There were no written discharge protocols noted or established before discharge.

62. Patient 4 had been under the impression she would be able to return to work the following week after the surgery, but she found she was in so much pain after the procedure that she was unable to return to work for approximately two weeks. She returned for follow up appointments with Respondent on or about November 24, 2017, December 6, 2017, and February 21, 2018. The February 21, 2018 note states, "one-hour touch up Vaser lipo" but there is no physician note that day.

63. Patient 4 reported that following her procedure, she complained to Respondent that she was experiencing lumpiness and unevenness in her abdomen. Respondent documented that this was the result of Patient 4's failure to wear her compression garment as directed. Patient 4 stated that she wore the compression garment for three weeks. After several months, Patient 4 noted she had a roll around her midsection that was not going away. Respondent told her she needed another procedure to remove the roll. He told Patient 4 it would cost $2,000.00. Patient 4 reluctantly agreed.

64. On March 1, 2018, Patient 4 returned to Precision M.D. for a procedure on her upper abdomen. Her CareCredit card was charged $2,000.00 on March 1, 2018. Again, she signed an electronic tablet on March 1, 2018, and her electronic signature was added to a large package of consents and waivers that she did not review, and many of which were not applicable to her procedure. Respondent did not document any history or physical. There was no clearance for surgery or discussion of the need for atropine at the last surgery. Patient 4 was provided Norco again, and two doses of Valium 5 mg. Patient 4 was given Ceftriaxone intramuscularly in the right deltoid.

65. Tech A.A. documented mixing up the bags of tumescent solution. She mixed four bags, although only two of the bags were documented to have been infused, for a total of 2,222 cc. As with the first surgery, there is a handwritten report without Respondent's signature, and typed surgical reports with Tech A.A. and Respondent's electronic signatures. The procedure started at 12:06 p.m. and ended at 1:05 p.m. Vital signs were taken at 10:30 a.m. and 1:13 p.m. A total of 1,100 ccs were noted to be suctioned. Patient 4 reported that this procedure was even more painful than the first, despite Respondent having assured her it would not be as painful as the first. She found the pain to be excruciating and requested more pain medication several times.

66. For this procedure, there are two typewritten surgical reports, both signed electronically by Tech A.A. and Respondent. Both falsely state that Patient 4 was continuously monitored with a blood pressure machine and an EKG throughout the procedure. Both refer to a non-existent anesthesia record and history and physical. One of the reports, however, falsely reports that Patient 4 had fat transfer to the buttocks of 775 milliliters per side. This note is electronically signed by Respondent on March 1, 2018, the day of the surgery.

67. Patient 4 suffered severe pain after the procedure, and found that she used up all the medication Respondent prescribed. He prescribed more medication for her. In the weeks after the second procedure, Patient 4 noticed her abdomen becoming more and more lumpy. Photographs of the area show folds and creases of skin covering the abdomen. Patient 4 raised the issue with Respondent who told her that different people heal differently. Respondent recommended Patient 4 undergo Venus Legacy treatments to temporarily improve the appearance of her stomach. Patient 4 paid an additional $2,000.00 for this treatment. During August or September of 2018, Respondent's office performed an additional procedure for skin tightening that involved a red light being pressed over her abdomen. This procedure was not painful. Respondent did not charge Patient 4 for this procedure.

68. Finally, Respondent recommended Patient 4 undergo a procedure that involved J-Plasma. This time, Patient 4 was unwilling to undergo any more treatments with Respondent. She sought treatment from Board-certified Plastic Surgeon who told her that he could not perform

surgery because Respondent removed too much fat. Patient 4 continues to experience nerve pain in her abdomen to this day.

Patient 5

69. During October and November of 2018, Patient 5 performed internet research looking for a physician who performed facial freckle removal. On or about November 29, 2018, Patient 5 had her first appointment at Respondent's Office for a consultation. At her initial consultation, Patient 5 only met with Ms. L.A., and did not meet with Respondent. L.A. examined Patient 5's face and diagnosed Patient 5 as having freckles and stated that she was a candidate for a PicoWay Resolve Treatment.[3] Ms. L.A. told Patient 5 that the PicoWay Resolve Treatment would remove her freckles. Patient 5 did not have freckles and instead had dermatosis papulose nigra, which is grouped, in the same family of non-malignant skin lesions called seborrheic keratoses.[4] Nonetheless, based on Ms. L.A.'s representations, Patient 5 agreed to have the PicoWay Resolve Treatment performed. Patient 5 agreed to pay Respondent's practice a total of $2,400.00 for three PicoWay Resolve Treatments. Ms. L.A. assisted Patient 5 to open a CareCredit to pay for the procedures and the required creams and medications that are used post-operatively. Patient 5 did not receive a complete treatment plan to coincide with the opening of her CareCredit account. Patient 5 electronically signed an electronic tablet and her signature and initials were applied to various consent forms, cancelation policies, waivers, and non-disclosure agreements. Respondent failed to examine Patient 5 on November 29, 2018, and failed to perform a consultation of her on that date. Patient 5 did not meet Respondent in any way on that date.

70. On or about December 21, 2018, Patient 5 arrived at Respondent's clinic for her first PicoWay Resolve Treatment. Nurse K.S. performed a PicoWay Resolve laser treatment for "freckles and moles" on Patient 5's face using the following settings: 2.5 J/cm, 6 mm x 6 mm.

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[3] PicoWay Resolve is a laser device used for benign pigmented lesions such as freckles and age spots. The technology uses an ultra-short laser pulse to breakdown the pigment into smaller particles.

[4] Management of dermatosis papulose nigra, if treated at all, is most commonly achieved for cosmetic reasons only; they are not medically necessary to remove. Because these lesions are relatively small and supervision, the most common treatment is light electrodesiccation using low power settings. Lasers are not a preferred first line of treatment. PicoWay Resolve has not been cleared by the FDA to treat dermatosis papulose nigra.

spot size, 3,272 pulses at 1064 nm wavelength; and .30 J/cm, 6 mm x 6 mm spot size, 2,152 pulses at 532 nm wavelength. Respondent failed to document a consultation note clearing Patient 5 for this laser treatment, did not meet Patient 5 on December 21, 2018, and failed to supervise Nurse K.S. in any way as she performed this laser procedure on Patient 5's face. A treatment record documented by Nurse K.S. stated that pictures of Patient 5's face were taken before the PicoWay Resolve cosmetic procedure was performed but there are no photos from December 21, 2018, documented in Patient 5's medical record. The procedure took approximately 15 minutes and following the procedure, Nurse K.S. told Patient 5 that healing could take up to five days.

71. In the beginning of 2019, Patient 5 attempted to call and cancel her scheduled second PicoWay Resolve Treatment. Despite previously signing a cancellation policy on November 29, 2018, that stated she risked a cancellation fee of $250.00, Respondent's staff told Patient 5 that she would lose the entire $800.00 for the PicoWay Resolve laser treatment because she was cancelling within seven days of the scheduled procedure. Patient 5 wanted to cancel her appointment because she felt the recovery time was too long and she was going to miss too much work. Out of concern that she would be forced to lose the full $800.00, rather than a portion of the amount, Patient 5 felt compelled to go forward with the second PicoWay Resolve procedure. Patient 5 specifically requested a consultation with the Respondent on the date scheduled for her second PicoWay Resolve procedure to ensure that she was receiving proper treatment.

72. On or about January 10, 2019, Patient 5 went to Respondent's office for a second PicoWay Resolve procedure. At this visit, for the first time, Respondent performed a consultation, he examined and felt Patient 5's face, and he diagnosed her with having moles. Based on Respondent's examination, Patient 5 was given the impression that she actually had moles and not freckles. Respondent misdiagnosed Patient 5 by failing to diagnose her with dermatosis papulose nigra. Respondent recommended that Patient 5 undergo a "TRL single spot" procedure rather than the PicoWay Resolve laser because the Respondent stated this was the best treatment option to remove moles.[5] Respondent told Patient 5 that she would feel some pain and

[5] The Contour TRL ("tunable resurfacing laser") is an ablative laser, which removes the top layer of skin by vaporizing the tissue. The length of recovery time will depend on the depth of the treatment.

that her face would be red for two to three days after having the TRL laser treatment. Respondent failed to articulate that Patient 5 could experience burning and scarring as a result of the procedure, nor did he offer her less invasive alternatives. Respondent failed to articulate the nature of the procedure and delineate the goals of Patient 5's treatment. Respondent failed to obtain Patient 5's written consent prior to carrying out the TRL treatment. Patient 5 verbally agreed to have Respondent perform the TRL treatment.

73. Prior to performing the TRL treatment, Respondent failed to recognize that the patient's skin color was a Fitzpatrick phototype 4, which placed Patient 5 at risk of excessive scarring and pigmentary complications following treatment with ablative lasers. Respondent did not explain to Patient 5 that her skin color placed her at a greater risk for complications. Photos were taken of Patient 5 prior to the procedure being carried out which clearly show her skin color and that she had evidence of dermatosis papulose nigra. There is no evidence of burning or scarring in the photos taken on January 10, 2019, before Respondent performed the laser procedure. Respondent did not perform a test spot with the TRL on patient 5, nor did he undergo the process of treating just one lesion to determine if Patient's 5's skin type was at risk for post inflammatory hyperpigmentation and scarring. Respondent falsely documented in Patient 5's medical chart that on or about January 10, 2019, that he or someone in his office asked her whether any of her lesions had changes in color, texture or depth. Respondent falsely documented in his medical chart that on or about January 10, 2019, he explained to Patient 5 that she has, "Asian skin type 4 and there is possibility of hypo and hyper pigmentation that can last for few months." Patient 5 reported that Respondent never mentioned her "Asian skin" until February 2019 and that the assessment paragraph contained in Respondent's January 10, 2019, progress note is false.[6]

74. On or about January 10, 2019, Respondent treated Patient 5 with a TRL single spot at the following settings: 2940 nm Erbium:YAK laser at a rate of 8.0, 25 micron depth, and 2 mm spot size. The TRL single spot procedure took approximately 15 minutes to go over Patient 5's

[6] Respondent mislabeled the January 10, 2019, progress note as occurring on January 11, 2019, and signed off on the chart on February 20, 2019.

entire face. Immediately, following the procedure, Patient 5 was shown a mirror and she felt that Respondent had "messed up." Following the TRL procedure, Patient 5 signed a written consent form for the TRL procedure.

75. Between January 10, 2019, and February 13, 2019, Patient 5 repeatedly returned to Respondent's office for follow-up after the TRL procedure. During that time, photos were taken of Patient 5's face. The photos showed extensive burning and scarring across Patient 5's face where Respondent had performed the TRL treatment. During that time, Respondent often failed to document follow-up treatment notes, such as January 15, 2019, and January 28, 2019, and he refused to perform a close up physical examination on January 18, 2019, and January 28, 2019. On February 13, 2019, at a follow-up appointment, Respondent mentioned for the first time to Patient 5 that she had "Asian skin" and that her skin color would heal differently and be darker for a longer period following TRL treatment. Patient 5 felt information on healing related to her skin tone and color would have factored into her decision to have the TRL procedure performed in the first place. Following the February 13, 2019, visit, Patient 5 lost all faith and trust in Respondent and chose seek a second opinion.

76. Between March 7, 2019, and through September 16, 2019, Patient 5 has had multiple follow-up procedures performed by a Board-Certified Dermatologist to correct the burning, redness, and scarring caused by Respondent's use of lasers on Patient 5's face.

Patient 6

77. On or about early 2018, Patient 6 sought out cosmetic medical services for treatment of her history of acne on her jawline and face. Patient 6 contacted Respondent's clinic for a "free" consultation and Respondent's office was told that she needed to provide a credit card number. Patient 6 later attempted to cancel this consultation, but she was informed that if she cancelled or no-showed to the consultation, her credit card would be charged $100.00. On or about March 1, 2018, Patient 6 went to Respondent's clinic for her consultation. At her initial consultation, Patient 6 only met with Ms. L.A. Patient 6 informed L.A. that she had a history of acne and had received facials and chemical peels in the past to treat her skin. L.A. informed

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Patient 6 that she was a candidate for the Halo™ procedure.[7] L.A. did not mention any other treatment options and stated that the Halo procedure had "promising results," and that Patient 6 would be happy with the outcome. Ms. L.A. documented on a consultation note that she recommended two Halo procedures at a total cost of $3600.00.

78. Patient 6 was hesitant about moving forward but Ms. L.A. strongly urged her to agree to the procedure, and assured her she would have wonderful results. Patient 6 was told that she would need to purchase topical treatments and two Halo procedures at a cost of $3,600.00[8]. Patient 6 placed a little more than half of the amount on her credit card and was asked to electronically sign documents. Respondent failed to examine Patient 6 on or about March 1, 2018, failed to perform a consultation with Patient 6, nor did Patient 6 meet Respondent in any way on that date. Respondent falsely documented a "consult form" for March 1, 2018, where he stated that he had performed a full consultation with Patient 6.

79. Immediately following her consultation with L.A., Patient 6 began to have second thoughts regarding her upcoming Halo procedure. On or about March 2, 2018, Patient 6 went to Respondent's clinic and requested that the office cancel her procedure and she explained that she needed to be out of the country to take care of her sick grandmother. The receptionist, after consulting with L.A., told Patent 6 that Respondent's clinic would not refund her credit card or cancel her procedure. Respondent's refusal to refund Patient 6's credit card was in violation of his Office's own cancelation agreement that Patient 6 had previously electronically signed and initialed on March 1, 2018, which specifically stated that Patient 6 was subject a $250.00 cancellation fee if the procedure was cancelled within seven business days of the planned procedure. Instead, Respondent's office staff offered to refund Patient 6's personal credit card if Patient 6 opened a third party medical credit company account through CareCredit to pay for the two Halo procedures and for the required creams and medications that were to be used post-

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[7] Halo Laser Treatment uses hybrid technology of a non-ablative laser, combined with an ablative laser to create controlled zones of coagulation to chosen depths unto the dermis that stimulate new collagen and fractionally vaporize micro laser channels into the epidermis; addressing time and texture of the skin.

[8] $2000.00 for the first procedure and a discounted rate of $1600.00 for the second procedure.

operatively. Patient 6 agreed to open a CareCredit account in exchange for having her personal credit card refunded. After refunding Patient 6's credit card, Respondent's office staff billed Patient 6's newly opened CareCredit account a total of $3,884.46.

80. On March 8, 2018, Patient 6 returned to Respondent's clinic for the Halo laser procedure. Patient 6 requested that the procedure be cancelled but was informed that she could not cancel the procedure without forfeiting the $2000.00 fee. Prior to the procedure, Patient 6 electronically signed on an electronic pad and was told that her signature would be cut and pasted onto the consent forms. Patient 6 was not provided an opportunity to read or review the consent forms before the procedure. Respondent's clinic staff took photos of Patient 6's face and uploaded the photos in to her medical chart. Respondent's staff then brought Patient 6 to a procedure room. Respondent did not perform a consultation, nor perform and examination prior to Patient 6's Halo procedure.

81. Nurse K.S. performed the Halo procedure on Patient 6. Respondent did not supervise Nurse K.S. as she performed the Halo procedure. The Halo procedure took approximately 10 to 15 minutes and Patient 6 felt nothing during procedure. There was no pain, no heat, or pressure. After the procedure, Patient 6 did not notice any change in the feeling or appearance of her skin. Patient 6 was unsure whether the Halo machine was actually operational during the procedure. According to Nurse K.S.'s procedure note she used the following settings while performing Patient 6's procedure: 1,470 nm laser at 450 microns and 50% coverage, and the 2,940 nm laser at 50 microns and 20% coverage and energy was delivered in the range of 91-494 Joules. After the procedure, Respondent's staff provided Patient 6 a copy of her consent forms as she was walking out of Respondent's clinic.

82. On or about March 15, 2018, Patient 6 went to Respondent's office for a follow-up appointment. Patient 6 met Respondent for the first time at the follow-up appointment. Patient 6 informed Respondent that she was not satisfied with the procedure and stated that she had new acne and pimples from the topical medications that she had purchased from Respondent's clinic. Respondent stated the medications she had received were too greasy for her skin and recommended that she purchase two additional skin care products from Respondent's clinic.

Respondent stated that it appeared based on his review of the before procedure photos that Patient 6 had experienced a big improvement from the Halo procedure. Patient 6 stated that she did not wish to go forward with a second Halo procedure because she was unhappy with the results and felt there was no difference. Respondent stated that Patient 6 needed multiple Halo procedures, at least three more, to get the results that she desired. Patient 6 was shocked and dismayed to hear this as Ms. L.A. had told her that she would receive the desired results after no more than two treatments. On or about March 28, 2018, Respondent's office cancelled Patient 6's second Halo procedure and refunded her $1,600.00. Respondent failed to document progress notes for March 15, 2018, and March 28, 2018, in Patient 6's chart. Patient 6 did not seek a second opinion regarding Respondent's Halo procedure or the treatment that she received.

Patient 7

83. In and around May 2018, Patient 7 began searching for a physician who performs cosmetic procedures to treat unwanted loose skin and fat on her underarms. After finding Respondent's website on the internet that advertised cosmetic procedures, Patient 7 called Respondent's clinic. After a couple of phone calls with Ms. L.A. regarding her concerns and desires in having the loose skin tightened up, Patient 7 scheduled a face to face consultation with L.A.

84. On May 9, 2018, Patient 7 attended a consultation with Ms. L.A. at Respondent's office. Respondent did not attend the consultation and did not examine Patient 7. During the consultation, L.A. informed Patient 7 that she was a candidate for liposuction under arms. L.A. informed Patient 7 that she had a girlfriend who had liposuction under arms and that her friend was able to return to work the following day. L.A. did not discuss any other treatment options with Patient 7, nor did L.A. mention any risks or complications associated with liposuction. L.A. did not advise Patient 7 that she needed to have a consultation with Respondent prior to proceeding with the liposuction procedure. At the end of the visit, L.A. convinced Patient 7 to open a third party medical credit company account through CareCredit to pay for the $4000.00 cost of the liposuction procedure.

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85. Following the consultation with L.A., Patient 7 requested that she meet with Respondent to receive assurance that the liposuction procedure was an appropriate treatment. On May 15, 2018, Patient 7 attended a consultation with Respondent at his office. Respondent told Patient 7 that she was a good candidate for liposuction. Respondent stated she would be "very happy" with the outcome and that he would "sculpt" her underarms as part of the procedure. Respondent did not discuss any other possible treatment options with Patient 7, and he did not suggest that she would need additional procedures and treatments to achieve the cosmetic results that she wished to receive. Respondent did not tell Patient 7 about any risks and complications related to having liposuction. Patient 7 was nervous about proceeding with the procedure and Respondent leaned over and gave her a hug and told her everything would be fine. Patient 7 decided to go forward with the procedure. Patient 7 was not provided any documents to review or sign prior to the date of her scheduled liposuction procedure on May 31, 2018.

86. Respondent documented a progress note for the May 15, 2018, consultation with Patient 7. Respondent falsely documented that he explained the risks and complications of liposuction to Patient 7. Respondent falsely documented that he explained alternative treatments to Patient 7. Respondent falsely documented that he explained to Patient 7 that she would need additional treatments beyond liposuction to achieve the cosmetic results that she was looking for by having the procedure performed. Respondent's progress note failed to document an adequate history and physical prior to Patient 7 being scheduled for liposuction. Respondent failed to document that he addressed Patient 7's history of depression, and failed to document a past surgical history. Respondent failed to document a history of the medications that Patient 7 was actually taking and Respondent failed to document a past surgical history. Respondent did not document a complete history and physical which included a cardiac and pulmonary examination. Respondent's May 15, 2018, consultation note while signed by Respondent, is not dated and was not completed within Respondent's electronic health record system and lacks an appropriate time stamp to indicate when it was actually drafted and signed.

87. On May 31, 2018, Patient 7 arrived at Respondent's office location for her liposuction procedure. Patient 7 had a friend drive her to the office and planned on having the

friend drive her home following the procedure. Respondent's office staff provided Patient 7 an electronic tablet and they told her to sign her name on the tablet. Patient 7 signed her name into the tablet. Patient 7 was not provided an opportunity to read and review any of the documents and she did not know how many documents her signature and initials would be affixed to. The first time Patient 7 saw all the forms her signature applied to was on July 25, 2018, when she requested a complete set of records. After Patient 7 provided the electronic signature, she was wheeled outside of the main office to the surgical suite around the corner from Respondent's main office.

88. Upon entering the surgical suite, Patient 7 observed that the suite was dirty and disorganized. She observed that there appeared to be a full garbage bag of medical waste in the corner from a previous procedure. Patient 7 was told to change into her surgical garments and was provided a Valium, hydrocodone and other medications prior to her procedure. Respondent's staff took photos of Patient 7's arms. Respondent failed to document Patient 7's BMI (body mass index) and patient weight prior to starting surgery.

89. According to a May 31, 2019 handwritten chart note, Respondent made his incision in the right arm at 9:41 a.m., began infiltrating the tumescent solution into Patient 7's right arm at 9:41 a.m., and began the Vaser procedure on Patient 7's right arm at 9:46 a.m. The tumescent fluid was prepared by a medical assistant. Respondent began suctioning Patient 7's right arm at 10:02 a.m. and collected 650 cc of fluid from the right arm. According to the handwritten note in Patient 7's chart, Respondent made an incision on Patient 7's left arm at 10:22 a.m., started infiltration at 10:23 a.m., and started the Vaser procedure at 10:19 a.m. Respondent began suctioning at 10:30 a.m. and collected 850 cc of fluid from the left arm. According to the medical records, only two vital signs were taken of Patient 7 during the procedure, one at 8:30 a.m., and one at the end of the procedure. There is no record of continuous intraoperative monitoring for Patient 7's vital signs every 15 minutes, including her heart rhythm, blood pressure, pulse, and oxygen saturation, despite having Patient 7 under conscious sedation and being highly dosed with lidocaine. Patient 7 did not have EKG pads or a blood pressuring device placed on her during the liposuction procedure. During the procedure, Patient 7 also received nitrous oxide and was not

properly monitored during the process. Respondent did not document the times when Patient 7 was placed on and off nitrous oxide, the flow rate, and the how the nitrous oxide was administered.

90. Patient 7 felt immediate pain upon Respondent beginning the Vaser liposuction procedure on her right arm. Patient 7 kept moving around and the Respondent kept scolding her to "stop moving." The Respondent did not inquire in to why the procedure was causing Patient 7 so much pain. Despite Respondent's documentation stating that his office would wait up to an hour to let the tumescent solution diminish the pain receptors in Patient 7's right arm, Respondent proceeded a mere five minutes after insertion of the fluid which likely had not had enough time to numb the area that was being liposuctioned. Respondent then proceeded to Vaser Patient 7's left arm. Patient 7 reported that her left arm hurt very badly as well, but not as badly as the right arm. Respondent failed to use and establish appropriate liposuction endpoints, including visual inspection, pinch test, and bloody aspirate, prior to concluding the liposuction procedure on Patient 7. Following the completion of the liposuction procedure, Respondent immediately left the room and left his assistants to get Patient 7 up, dressed, and discharged from his office. As she was being discharged, Patient 7 was told for the first time that she needed someone to stay with her that night and ensure that she was safe. Patient 7 was discharged by Respondent's medical assistants, not Respondent, and was not provided any instructions on how long she needed to wear the compression garments on her arms. There is no documentation that a series of post-operative vitals were taken, no documentation that Respondent evaluated Patient 7 at discharge and there is no record that the discharging staff who were observing Patient 7 were ACLS certified. Respondent prescribed an antibiotic, Keflex, 500 mg. two times a day for ten days, rather than the appropriate dosage of 500 mg. four times a day for one day. Respondent used ceftriazone for surgical prophylaxis despite no evidence that Patient 7 had allergies rather than the more appropriate cefazolin.

91. On June 1, 2018, Patient 7 saw Respondent for her one-day follow-up examination. In Respondent's noted he documented that she had liposuction on her arms but under comments stated that Patient 7 was in clinic for post 1 day liposuction on her abdomen. During the follow-

up examination, Patient 7 became "hot and sweaty," light-headed and almost fainted. Respondent failed to document that Patient 7 experienced heat related complications and almost fainted in the June 1, 2018, examination note. Respondent informed Patient 7 that she needed to wear her compression garments for two to three weeks, that the procedure went smoothly and that everything looked good.

92. On or about June 6, 2018, Patient 7 went to Respondent's clinic and had a follow-up appointment regarding a rash on her hands. Vital signs were documented. Respondent did not document a progress note. On or about June 19, 2018, Patient 7 went to Respondent's clinic and had a follow-up regarding appointment regarding bumps on the back of her triceps and to discuss massaging. Respondent did not document a progress note. During the visit on or about June 19, 2018, Respondent informed Patient 7 that she no longer needed to wear the compression garments. Patient 7 complained that her arms were not turning out as Respondent had promised. Respondent informed Patient 7 that she should have the Venus Legacy[9] treatment. This was the first time anyone from Respondent's clinic indicated to Patient 7 that she may need additional treatments and procedures beyond liposuction in order to get the results that she wanted.

93. On or about July 19, 2018, Patient 7 had a seven-week follow-up appointment regarding her liposuction procedure with Respondent. Respondent authored a treatment note. Patient 7 told Respondent that she was not happy with the results of the liposuction procedure and that she was frustrated with him and his office. Patient 7 told Respondent that she felt that he and his staff had not been truthful about the procedure and what she should expect following the procedure. Respondent stated that he did nothing wrong and that it's "just your arms." Respondent documented that Patient 7 had asked for injections to remove the lumps and wrinkles from her arms but that he had refused because the requested injections were not within the standard of care. Respondent documented that he recommended the Venus Legacy treatment but that Patient 7 stated she could not pay for additional procedures. According to Respondent,

[9] Venus Legacy™ is a non-invasive devise that uses multi-polar radio frequency and pulsed magnetic fields to create a therapeutic heat matrix over the skin. It creates a thermal reaction under the tissue that stimulates the body's natural healing response, increasing blood circulation and causing the skin to contract.

Patient 7 made numerous phone calls and sent numerous e-mails to the clinic complaining about his care however, there is no record that any of these communications were documented in Patient 7's medical chart.

Patient 8

94. Patient 8 was a 66-year old woman when she met with Respondent on January 5, 2019 to address her concerns about acne on her face. She inquired about the Halo treatment for the acne. She had received Botox and Juvederm from Respondent on previous occasions. Respondent told Patient 8 that she had melasma and that the Halo procedure had a good success rate for treatment of melasma. He did not warn her of any risks or side effects of the Halo treatment or discuss any other possibilities for treatment of her concerns. He inquired what the limit was on her CareCredit card, and when she told him it was $2,000.00, he immediately got on the phone and had the limit raised to $6,000.00. Respondent told Patient 8 that he recommended two treatments with the Halo machine, and that both procedures would cost $4,000.00 but that he would give her a $400.00 discount. He charged her CareCredit card for both procedures on that day and told her that she would not be able to receive a refund if she canceled the second procedure. He also charged her approximately $400.00 for various topical skincare products his office sells under a Precision MD label, including hydroquinone. Patient 8 asked if she could obtain the products online for a lower price, and he told her that she needed to purchase the ones he sold at his practice.

95. Patient 8 has Fitzpatrick Phototype 6 skin, which places her at higher risk for complications from the Halo laser treatment. Respondent did not inquire whether Patient 8 had any history of attempting other less invasive treatments for melasma before recommending the Halo treatment. He did not recommend that Patient 8 attempt topical lightening creams such as hydroquinone, tretinoin, or niacinamide before proceeding to the laser treatment. Although he recommended that she use hydroquinone cream, he did not allow it time to work before proceeding with the laser treatment. He did not recommend oral tranexamic acid, or chemical peeling before proceeding to the Halo laser, which is a more expensive procedure, and has increased risks for Patient 8's skin type.

96. An employee at Respondent's office brought Patient 8 an electronic tablet and asked her to sign and initial it. Her signature and initials were subsequently applied to large amount of paperwork, including waivers and releases and informed consents. Patient 8 did not have an opportunity to review these documents before signing or before the procedure. One of the documents Patient's 8 signature was applied to was an informed consent for use of nitrous oxide, which was not applicable to her treatment. A female staff member brought Patient 8 to a treatment room and performed the Halo procedure without Respondent present. Patient 8 did not know that Respondent would not be performing the procedure himself.

97. The treatment records show that Registered Nurse K.S. performed the procedure on Patient 8. She documented using settings recommended by Respondent, and treating the full face. The employee did not perform a patch skin test on Patient 8's skin before using the Halo laser on her face. Patient 8 was wearing a personal hat as part of her outfit that day, and the employee who performed the procedure did not ask her to remove it. Patient 8 found the Halo laser procedure was very painful. Patient 8 had not been warned that the procedure would be painful and she was shocked by how painful it was. The treatment records states that Nurse K.S. applied anti-inflammatory and anti-bacterial cream, provided post treatment instructions and made an appointment for a one-week follow up.

98. When Patient 8 returned home after the procedure, she noticed that the areas of her skin that had been treated were much darker than before the treatment. She also noticed that the areas where her hat had been covering her face were not treated, and were not darker. She had not been warned that the treatment could make her face darker, and was concerned that the procedure had not been done correctly.

99. At a follow up appointment on January 15, 2019, Respondent diagnosed Patient 8 with a fungal infection and prescribed anti-fungal treatment. He directed her to stop using certain topical products she purchased from his office and to return in a week. As of January 15, 2019, Patient 8 was still listed as having two Halo treatments scheduled. Respondent documented a February 19, 2019 follow up appointment in which he stated that Patient 8 was unhappy that her melasma was not gone. He wrote that he had successfully treated Patient 8's fungal infection and

that Patient 8 had not been compliant with the hdryoquinone treatment and was only having one Halo treatment. On March 12, 2019, Patient 8 was refunded $1,600.00 on her CareCredit Card, apparently for the second Halo treatment, which she canceled.

100. Respondent backdated and falsified a consultation note, dated January 5, 2019. He documented that on January 5, 2019, he recommended Patient 8 undergo two Halo treatments for treatment of melasma, and that she elected to only undergo one treatment. He falsely stated that he warned her of risks of treatment, such as worsening melasma, and laser burns, and that she understood and elected to proceed with the single Halo treatment.

101. Patient 8 found that the darkening of her skin has not improved. She has continued to seek treatment for her darkened skin with other providers and using other treatments.

Patient 9

102. Patient 9 is a Spanish-speaking woman who saw Respondent's cosmetic services advertised on a local Spanish-language television channel. She went to Precision M.D. on or about March 14, 2018, seeking injections to improve the appearance of wrinkles in her face at the outside edges of her eyes (frequently referred to as "crow's eyes"), and lines between the outside of her lips and the bottom of the chin (frequently referred to as "marionette lines"). Patient 9 spoke to a Spanish-speaking employee at Precision M.D., C.J. She explained to Ms. C.J. that she wanted Voluma injections in the two areas. C.J. told Patient 9 that Botox works well around the eyes. Patient 9 agreed to have Botox around the crow's feet and Voluma in the marionette lines.

103. Patient 9 was provided with a series of paperwork and consent forms in English. She signed and dated the forms. Another female employee took Patient 9 to pay for the procedures. Patient 9 paid $240.00 for the Botox treatment and $850.00 for the Voluma treatment. After paying for the procedures, a staff member took her to the treatment room and took photographs of her face. At no point prior to payment did any nurse or physician evaluate her or discuss her treatment options or recommendations with her.

104. Respondent then entered the room and walked over to Patient 9 without speaking to her or introducing himself. He silently began performing injections. He injected her around her eyes. He then injected directly into the middle of her chin. At this point Patient 9 spoke to

Respondent and asked him if he was going to inject the sides of her chin. He responded that he already had done so. Patient 9 knew this was false because she felt where he injected her chin and it was in the middle. He then abruptly left the room.

105. Respondent signed a consultation note, dated March 14, 2018, falsely stating that he spoke with Patient 9, and explained the risk and benefits of Voluma and Botox, and answered all her questions. At his interview with Board investigators, Respondent claimed that he did speak with Patient 9 and provide her with the information and advice. Respondent did not document the locations of the injection sites or the lot or serial number of the substances injected. Patient 9 subsequently called Precision M.D. to explain that she was unhappy with the results of her treatment on the chin because the area she wanted treated was not addressed. Patient 9 was told that she would be charged $100.00 for any follow up appointment or consultation, and therefore elected not to return.

Unlawful Electronic Signatures and Forms at Precision M.D.

106. Respondent instituted a policy at Precision M.D. where patients would not have an opportunity to review and sign documents in hard copies while signing. Instead, patients are provided with an electronic tablet on which to place their signature and initials. Respondent's staff would then apply the initials and signature to various packages of documents without the patient's specific knowledge and input. The patient does not have control over the specific documents and areas of documents to which their initials and signatures are applied. This does not constitute a knowing and intelligent acknowledgment or agreement to any of the terms the patients' signatures and initials are applied to.

107. Often, the employees who apply the patients' signatures and initials have no more understanding of the documents than the patients do. This leads to the employees applying signatures and initials to documents purporting that the patients acknowledged and consented to treatments that neither the patient nor Respondent even contemplated. For example, Patients 1, 2, 3, 4, and 7 all received Vaser liposuction procedures. But Precision M.D. applied all these patients' electronic signature to consent forms for both Vaser Liposuction and Smart Liposuction procedures. Respondent has not performed Smart Liposuction procedures for several years and

did not perform it on these patients. Similarly, Respondent's staff applied Patient 9's electronic signature and initials to a consent form for nitrous oxide. Because Patient 9 was not undergoing any type of surgical procedure, neither she nor Respondent had any intention of using this gas during her injections. Respondent even failed to correct a cut and pasted name of a different medical facility in his boiler-plate documents.[10] This demonstrates that the electronic signatures applied by these patients to various consent forms were not knowing or intelligent acknowledgments or waivers to any of the procedures. Moreover, with the exception of Patient 6,[11] all the patients alleged in this Accusation had their electronic signatures applied to consent forms on the very day of their procedures. These documents contain instructions to patients that they should have received before the procedure, such as information about stopping certain medications two weeks before the procedure.

108. Before any of the patients could even meet with Ms. L.A., Respondent required them to have their electronic signature applied to a packet of documents relating to cancellation polices, non-disclosure, arbitration, and privacy waivers. Many of the terms in these agreements are unconscionable contract provisions. For example, all nine patients had their electronic signature affixed to a form entitled "HIPPA Policy" in which the following provision occurs:

> I understand and acknowledge that in the event I designate (*sic*) or criticize Precision M.D. Cosmetic Surgery Center And/Or Dr. Mahmoud Khattab, online or in any public form, I hereby unconditionally authorize Precision M.D. Cosmetic Surgery Center And/Or Dr. Mahmoud Khattab to make specific reference in his response to my statements to the medical care Precision M.D. Cosmetic Surgery Center And/Or Dr. Mahmoud Khattab provided to me and I waive any HIPAA protections or any other protections or defenses that I would otherwise have for the privacy of my medical records.

Respondent uses this provision to silence and intimidate patients from speaking about the illegal and fraudulent activities at his practice. Respondent has gone so far as to sue patients in Superior Court for defamation due to the patients' negative online review. The Sacramento Superior Court has dismissed one of these lawsuits under Anti-SLAPP laws.

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[10] The Nitrous Oxide consent form refers to the business "Sculpted Contours Luxury Medical Aesthetics" instead of Precision M.D. This is business in Atlanta, Georgia.

[11] Patient 6 did not even sign a tablet for staff to electronically apply her signature on the date of her first treatment.

109. The nine patients alleged in this Accusation further had their signature applied to an agreement stating that they acknowledge that Respondent may use the photographs in their medical records for advertising purposes, and that the photographs belong to Precision M.D., and do not belong to the patient. The patients also had their electronic signature prematurely applied to a general release and to onerous cancellation policies that prohibited cancelation for even medical purposes, or imposed excessive fees.

CareCredit Card Issues:

110. Patients 2, 3, 4, 5, 6, 7, and 8 used CareCredit Cards for their treatment at Precision M.D. None of the patients received a written financial disclosure form setting forth the credit and debt obligations of the CareCredit account. None of the patients received a timely, truthful, and complete treatment plan setting forth the procedure that the CareCredit account was established to finance.

Advertising Violations

111. Respondent advertises himself online as "Board-certified and a member of the Academy of Cosmetic Surgery." The Academy of Cosmetic Surgery is not part of the American Board of Medical Specialties (ABMS). Respondent is Board-certified in Internal Medicine. Respondent uses the term "Board-certified" in his advertising without specify that his certification is from the American Board of Internal Medicine, thereby falsely giving the impression that he has ABMS certification in a medical field relating to the cosmetic services he advertises.

112. Respondent falsely advertises that prospective patients can obtain a free consultation, but he charges a $100.00 fee if the prospective patient attempts to cancel or reschedule the consultation. Respondent and his staff provide false and misleading information about cosmetic results and downtime from surgery in both written and verbal representations. Respondent seeks and encourages staff members to obtain positive reviews in online forums like Yelp and RealSelf, and provides payments to the staff for obtaining these reviews without notifying the public of this fact.

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Dishonest Statements

113. On December 5, 2019, an Investigator working on behalf of the Board sent Respondent a letter requesting that he participate in an interview regarding his care to the nine patient alleged in this Accusation. On December 16, 2019, the Investigator provided Respondent's counsel with possible dates for an interview between January 15, 2020 and January 23, 2020. Respondent's counsel replied that Respondent would be out of the country between January 15 through 26, 2020. On January 22, 2020, Board investigators observed Respondent at his office at Precision M.D. When the interview was rescheduled, in March 3, 2020, Respondent initially told Board investigators that he was in fact out of the country in mid-to-late January of 2020. At a follow up interview on March 12, 2020, Respondent admitted that he had not actually left the country, but contended that he had originally planned a trip, which he subsequently canceled.

114. During the interviews, Respondent falsely stated that he had only had two malpractice cases filed against him. At the first interview, Respondent claimed that he did in fact have a crash cart, in his surgical suite, that he uses an EKG and blood pressure monitor continuously during surgery, and that he had written discharge policies at his practice for determining when patients were may be safely releases from care. At his second interview, he admitted that these statements were false, but provided documentation of having corrected these violations. In both interviews, Respondent continued to maintain that the consultation notes in each of the patients' records are true and correct statements. Respondent falsely stated that he personally meets with every liposuction patient before the day of surgery and that he never meets a liposuction patient for the first time on the day of surgery. Respondent falsely stated that liposuction patients do not sign consent forms on the day of surgery.

115. Respondent falsely claims that he is the only person with access to his electronic signature. He initially claimed that he personally signed the template consent forms in each of the patients' medical records, but contradicted himself by stating that his electronic signature automatically populates when the patient signs. Respondent falsely claimed that he never leaves the practice while a patient is still being monitored by staff members after a procedure.

Liposuction Violations

116. Respondent failed to comply with safety precautions for the treatment of Patients 1, 2, 3, 4, and 7. He performed procedures on these patients in his medical office without having written discharge criteria, a transfer agreement with a nearby hospital, or hospital privileges. He allowed unlicensed staff to mix the tumescent solution, push intravenous medications, and monitor the patients during and after surgery and to discharge the patients without his input. He used conscious sedation with the patients. He failed to have endpoints for the use of the Vaser liposuction equipment, and failed to maintain it safely or understand its use. Respondent failed to use and establish appropriate liposuction endpoints on these patients, including visual inspection, pinch test, and bloody aspirate, prior to concluding the liposuction procedures.

117. Respondent performed these surgical procedures on Patients 1, 2, 3, 4, and 7, without sufficient knowledge and in a facility that was not safe and sanitary for the procedures. Respondent removed excess amounts of aspirate in all the patients than he was permitted to remove for the surgical environment and safety precautions he had in place. He removed 6,000 milliliters of aspirate from Patient 2, which is forbidden under any circumstances in an unaccredited surgical center. He failed to have the required safety measures in place for the amount of aspirate he suctioned from Patients 1, 3, 4, and 7, including measurement of fluid loss and replacement and monitoring. He used conscious sedation on all the liposuction patients, which is prohibited in a medical office.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

118. Respondent. is subject to disciplinary action under section 2234, subdivision (d), in that he was incompetent in his care and treatment of Patients 1, 2, 3, 4, and 7.

119. Paragraphs 21 through 117 are incorporated as if fully set forth here.

120. Respondent was incompetent in his care and treatment of Patients 1, 2, 3, 4, and 7 for his acts and omissions, including but not limited to, the following:

a. Failing to understand the action of the Vaser liposuction equipment and to maintain it safely and use it in a way that is not harmful to patients;

b. Failing to understand and use endpoints in Vaser liposuction procedures of one minute of Vaser per 100 cc of infiltration or lack of resistance and visual inspection, pinch test or bloody aspirate;

c. Mismanaging burn injuries in Patients 2 and 3, including dissuading the patients from obtaining specialized or emergency treatment for conditions he was not qualified to treat;

d. Misusing the tissue autorgraft products in Patient 3; and

e. Using hand sanitizer as a surgical scrub.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

121. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9.

122. Paragraphs 21 through 117 are incorporated as if fully set forth here.

123. Respondent was grossly negligent in his care and treatment of Patient 1, 2, 3, 4, 5, 6, 7, 8, and 9, for his acts and omissions, including but not limited to, the following:

a. Failing to understand the action of the Vaser liposuction equipment and to maintain it safely and use it in a way that is not harmful to for Patients 1, 2, 3, 5, and 7;

b. Failing to understand and use endpoints in Vaser liposuction procedures of one minute of Vaser per 100 cc of infiltration or lack of resistance and visual inspection, pinch test or bloody aspirate for Patients 1, 2, 3, 4, and 7;

c. Mismanaging burn injuries in Patients 2 and 3, including dissuading the patients from obtaining specialized or emergency treatment for conditions he was not qualified to treat;

d. Misusing the tissue autorgraft products in Patient 3;

e. Using hand sanitizer as a surgical scrub for Patients 1, 2, 3, 4, and 7;

f. Failing to obtain informed consent for Vaser liposuction for Patients 1, 2, 3, 4, and 7;

g. Using at or near the maximum amount of lidocaine in combination with other analgesics and anxiolytics for Patients 1, 2, 3, 4, and 7;

h. Performing surgery in an unsanitary and unsafe environment for Patients 1, 2, 3, 4, and 7;

i. Failing to document intra-surgical and post-surgical vital signs during use of conscious sedation at an unaccredited facility for Patients 1, 2, 3, 5, and 7;

j. Failing to maintain an anesthesia record for Patients 1, 2, 3, 4, and 7;

k. Failing to adequately document the surgical procedures for Patients 1, 2, 3, 4, and 7;

l. Failing to document waste of controlled substances for Patients 1, 2, 3, 4, and 7;

m. Allowing unlicensed staff to mix tumescent solution for Patients 1, 2, 3, 4, and 7;

n. Allowing unlicensed staff to push intravenous controlled substances and to furnish controlled substances for Patients 1, 2, 3, 4, and 7;

o. Failing to perform and document an adequate clearance for surgery within 30 days including a history and physical for Patients 1, 2, 3, 4, and 7;

p. Failing to have hospital privileges or a transfer agreement while performing liposuction in a medical office for Patients 1, 2, 3, 4, and 7;

q. Allowing unlicensed staff to consult with liposuction patients, provide surgical recommendations, and take payment without his presence or input for Patients 1, 2, 3, 4, and 7;

r. Failing to comply with liposuction statutes for monitoring and safety for Patients 1, 2, 3, 4, and 7;

s. Failing to obtain informed consent, either verbally or in writing, for wound debridement procedures in Patient 3 or for the proposed treatment of Patient 2;

t. Leaving Patient 3 alone with unlicensed staff in the middle of a liposuction procedure while he took a break;

u. Removing over 5 liters of aspirate from Patient 2;

v. Failing to obtain informed consent for use of J. Plasma in Patient 3, for a procedure that is not FDA approved;

w. Failing to document the lot or serial number of the allograft products used on Patient 3;

x. Failing to document any procedure notes of the neck or thigh treatments of Patient 3;

y. Failing to stop the procedure when Patient 2 unequivocally withdrew consent during the Vaser procedure;

z. Using nitrous oxide in an unsafe manner and failing to adequately document the use in Patient 7;

aa. Failing to document the reason for the use of atropine in Patient 4;

bb. Performing a second procedure on Patient 4 without having cleared her after requiring atropine in the prior procedure;

cc. Performing liposuction on Patient 4 despite her not being a proper candidate for the procedure;

dd. Falsely documenting consultation notes for all Patients;

ee. Allowing Nurse K.S. to perform a laser treatment on or about December 21, 2018, on Patient 5 without Respondent first examining the patient, nor did Respondent document a consultation note, before prescribing laser therapy for a skin condition that is treated by less invasive means;

ff. Misdiagnosing Patient 5's skin condition of dermatosis papulose nigra as "freckles and moles" and by performing laser treatment on Patient 5's face rather than a less invasive electrodesiccation procedure leading to excessive burning and scarring;

gg. Failing to fully articulate the risks of laser treatment on Patient 5's skin condition of dermatosis papulose nigra and failed to properly assess the goals of treatment for the patient before providing treatment prior to using the TRL procedure;

hh. Providing dermatological services to Patient 5 despite being only board certified in internal medicine and lacking the proper knowledge and skills to treat dermatosis papulose nigra with lasers;

ii. Allowing Nurse K.S. to perform a laser treatment on or about March 8, 2018, on Patient 6 without first consulting with Patient 6 and examining her before prescribing laser therapy for a skin condition that should have been treated by less invasive means;

jj. Performing a Halo laser treatment on Patient 8 before completing a trial of the required less invasive, less risky procedures for treatments of melasma;

kk. Failing to perform a test on Patient 8 despite her having Fitzpatrick phototype 6 skin;

ll. Failing to discuss the specific risks of the Halo laser procedure despite her skintype and concerns;

mm. Failing to have the required expertise to treat Patient 8's skin concern or to properly supervise the nurse who performed the Halo procedure on Patient 8;

nn. Placing his own financial interests over the best treatment options for Patient 8;

oo. Failing to document the location of injections and lot or serial number of products injected into Patient 9;

pp. Failing to consult with and listen to Patient 9's requests or to conduct a follow up without requiring additional payment;

qq. Failing to obtain a knowing and intelligent informed consent from any of the patients by applying their electronic signature to templated documents; and

rr. Applying the patients' signatures to unconscionable contracts.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

124. Respondent is subject to disciplinary action under section 2234, subsection (c), in that he committed repeated negligent acts in his care and treatment of Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9.

125. Paragraphs 21 through 117 are incorporated as if fully set forth here.

126. Respondent was repeatedly negligent in his care and treatment of Patient 1, 2, 3, 4, 5, 6, 7, 8, and 9, for his acts and omissions, including but not limited to, the following:

a. Failing to understand the action of the Vaser liposuction equipment and to maintain it safely and use it in a way that is not harmful to for Patients 1, 2, 3, 4, and 7;

b. Failing to understand and use endpoints in Vaser liposuction procedures of one minute of Vaser per 100 cc of infiltration or lack of resistance and visual inspection, pinch test or bloody aspirate for Patients 1, 2, 3, 4, and 7;

c. Mismanaging burn injuries in Patients 2 and 3, including dissuading the patients from obtaining specialized or emergency treatment for conditions he was not qualified to treat;

d. Misusing the tissue autorgraft products in Patient 3;

e. Using hand sanitizer as a surgical scrub for Patients 1, 2, 3, 4, and 7;

f. Failing to obtain informed consent for Vaser liposuction for Patients 1, 2, 3, 4, and 7;

g. Using at or near the maximum amount of lidocaine in combination with other analgesics and anxiolytics for Patients 1, 2, 3, 4, and 7;

h. Performing surgery in an unsanitary and unsafe environment for Patients 1, 2, 3, 4, and 7;

i. Failing to document intra-surgical and post-surgical vital signs during use of conscious sedation at an unaccredited facility for Patients 1, 2, 3, 4, and 7;

j. Failing to maintain an anesthesia record for Patients 1, 2, 3, 4, and 7;

k. Failing to adequately document the surgical procedures for Patients 1, 2, 3, 4, and 7;

l. Failing to document waste of controlled substances for Patients 1, 2, 3, 4, and 7;

m. Allowing unlicensed staff to mix tumescent solution for Patients 1, 2, 3, 4, and 7;

n. Allowing unlicensed staff to push intravenous controlled substances and to furnish controlled substances for Patients 1, 2, 3, 4, and 7;

o. Failing to perform and document an adequate clearance for surgery within 30 days including a history and physical for Patients 1, 2, 3, 4, and 7;

p. Failing to have hospital privileges or a transfer agreement while performing liposuction in a medical office for Patients 1, 2, 3, 4, and 7;

q. Allowing unlicensed staff to consult with liposuction patients, provide surgical recommendations, and take payment without his presence or input for Patients 1, 2, 3, 4, and 7;

r. Failing to comply with liposuction statutes for monitoring and safety for Patients 1, 2, 3, 4, and 7;

s. Failing to obtain informed consent, either verbally or in writing, for wound debridement procedures in Patient 3 or for the proposed treatment of Patient 2;

t. Leaving Patient 3 alone with unlicensed staff in the middle of a liposuction procedure while he took a break;

u. Removing over 5 liters of aspirate from Patient 2;

v. Failing to obtain informed consent for use of J. Plasma in Patient 3, for a procedure that is not FDA approved;

w. Failing to document the lot or serial number allograft products in Patient 3;

x. Failing to document any procedure notes of the neck or thigh treatments of Patient 3;

y. Failing to stop the procedure when Patient 2 unequivocally withdrew consent during the Vaser procedure;

z. Using nitrous oxide in an unsafe manner and failing to adequately document the use in Patient 7;

aa. Failing to document the reason for the use of atropine in Patient 4;

bb. Performing a second procedure on Patient 4 without having cleared her after requiring atropine in the prior procedure;

cc. Performing liposuction on Patient 4 despite her not being a proper candidate for the procedure;

dd. Falsely documenting consultation notes for all Patients;

ee. Allowing Nurse K.S. to perform a laser treatment on or about December 21, 2018, on Patient 5 without Respondent first examining the patient, nor did Respondent document a consultation note, before prescribing laser therapy for a skin condition that is treated by less invasive means;

ff. Misdiagnosing Patient 5's skin condition of dermatosis papulose nigra as "freckles and moles" and by performing laser treatment on Patient 5's face rather than a less invasive electrodesiccation procedure leading to excessive burning and scarring;

gg. Failing to fully articulate the risks of laser treatment on Patient 5's skin condition of dermatosis papulose nigra and failed to properly assess the goals of treatment for the patient before providing treatment prior to using the TRL procedure;

hh. Providing dermatological services to Patient 5 despite being only board certified in internal medicine and lacking the proper knowledge and skills to treat dermatosis papulose nigra with lasers;

ii. Allowing Nurse K.S. to perform a laser treatment on or about March 8, 2018, on Patient 6 without first consulting with Patient 6 and examining her before prescribing laser therapy for a skin condition that should have been treated by less invasive means;

jj. Performing a Halo laser treatment on Patient 8 before completing a trial of the required less invasive, less risky procedures for treatments of melasma;

kk. Failing to perform a test on Patient 8 despite her having Fitzpatrick phototype 6 skin;

ll. Failing to discuss the specific risks of the Halo laser procedure despite her skintype and concerns;

mm. Failing to have the required expertise to treat Patient 8's skin concern or to properly supervise the nurse who performed the Halo procedure on Patient 8;

nn. Placing his own financial interests over the best treatment options for Patient 8;

oo. Failing to document the location of injections and lot or serial number of products injected into Patient 9;

pp. Failing to consult with and listen to Patient 9's requests or to conduct a follow up without requiring additional payment;

qq. Failing to obtain a knowing and intelligent informed consent from any of the patients by applying their electronic signature to templated documents;

rr. Applying the patients' signatures to unconscionable contracts.

ss. Prescribing Keflex, 500 mg. two times a day for ten days to Patients 1, 2, 3, 4, and 7, rather than the appropriate dosage of 500 mg. four times a day for one day; and

tt. Prescribing ceftriazone for surgical prophylaxis to Patient 7 instead of the more appropriate cefazolin, without documenting a reason.

FOURTH CAUSE FOR DISCIPLINE

(Falsification of Medical Records)

127. Respondent is subject to disciplinary action under section 2261 and 2262 of the Code in that he falsified medical records with fraudulent intent and he documented consultations that did not occur.

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128. Paragraphs 21 through 117, above, are incorporated by reference as if fully set forth here.

129. Respondent's acts of documenting consultations and consents that did not occur with Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9, documenting surgical monitoring and conditions that did not occur, and altering medical records to prevent detection of illegal practices constitutes falsification of medical records, and fraud, thereby subjecting his license to discipline.

FIFTH CAUSE FOR DISCIPLINE

(Aiding and Abetting the Unlicensed Practice of Medicine)

130. Respondent is subject to disciplinary action under section 2052, and 2264, in that he permitted and participated in the unlicensed practice of medicine.

131. Paragraphs 21 through 117 are incorporated as if fully set forth here.

132. Respondent's acts of permitting and encouraging Ms. L.A. to conduct patient consultations, receive a commission, make treatment recommendations and accept payment for medical services at his practice, with limited or no in input from a physician constitutes aiding and abetting the unlicensed practice of medicine. Respondent's practice of allowing medical assistants and unlicensed staff to push intravenous medications, distribute controlled medications, and monitor and discharge patients after surgery constitutes aiding and abetting the unlicensed practice of medicine. Respondent has thereby subjected his license to discipline.

SIXTH CAUSE FOR DISCIPLINE

(Dishonest or Fraudulent Acts)

133. Respondent is subject to disciplinary action under section 2234, subdivision (e), in that he committed dishonest and fraudulent acts.

134. Paragraphs 21 through 117, above, are incorporated by reference as if fully set forth here.

135. Respondent committed dishonest and fraudulent acts related the practice of medicine for his acts and omissions, including but not limited to, the following:

a. Misrepresenting his credentials and services to patients;

b. Providing inadequate and inaccurate medical information to patients 1, 2, 3, 4, 5, 6, 7, 8, and 9;

c. Providing treatment recommendations based on his financial gain rather than sound medical advice;

d. Providing an incentive for Ms. L.A. to upsell patients on medical treatments;

e. Lying to Board investigators repeatedly;

f. Falsifying medical records;

g. Conducting false advertising;

h. Intimidating patients into not filing complaints or lawsuits about his treatment;

i. Applying Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9's electronic signature to forms they did not see or discuss, including unconscionable contract provisions; and

j. Dissuading Patients 2 and 3 from seeking outside or expert treatment for his medical errors.

SEVENTH CAUSE FOR DISCIPLINE

(Advertising Violations)

136. Respondent is subject to disciplinary action under sections 2271, 2272, 2415, and 651, in that he disseminated false and misleading advertising in connection with Precision M.D

137. Paragraphs 21 through 117, above, are incorporated by reference as if fully set forth here.

138. Respondent conducted false and misleading advertising in connection with Precision M.D. for his acts and omissions, including but not limited to, the following:

a. Advertising a free consultation to Patient 6, but attempting to charge her for wishing to cancel the fee consultation;

b. Representing himself on television and internet sites to be "Board-certified" without including the fact that he is Board certified in Internal Medicine, and placing a non-ABMS group next to the words "Board-certified";

c. Representing his practice name on the internet, building sign, and letterhead to be "Precision M.D. Cosmetic Surgery Center," when his FNP was for "Precision

M.D." and his facility is an unaccredited medical office, and even the FNP for "Precision M.D." was delinquent during the Fall of 2019;

d. Falsely representing to patients, and permitting and encouraging Ms. L.A. to represent to patients, that they would receive exaggerated cosmetic results and misrepresenting the risks and downtime from the procedures;

e. Encouraging patients to seek more expensive services than they requested;

f. Failing to provide consultations and treatment plans before charging patients for services on CareCredit financing;

g. Failing to provide timely, truthful, and complete treatment plan setting forth the procedure that the CareCredit account was established to finance for Patients 2, 3, 4, 5, 6, 7, and 8;

h. Failing to provide financial disclosures for all the terms of the CareCredit cards opened by Patients 2, 3, 4, 5, 6, 7, and 8; and

i. Imposing onerous cancelation clauses and unconscionable contract provisions in written agreements that Patients signatures and initials were applied to without them being able to observe and sign or initial the actual documents at the time the signature or initials were applied.

EIGHTH CAUSE FOR DISCIPLINE

(Violation of Liposuction and Practice Setting Statutes)

139. Respondent is subject to disciplinary action under sections 2216 and 2259.7 of the Code, and California Code of Regulations, title 16, section 1356.6, in that he violated the laws applicable to the provision of liposuction services to Patients 1, 2, 3, 4, and 7.

140. Paragraphs 21 through 117, above, are incorporated by reference as if fully set forth here.

141. Respondent violated statutes governing liposuction procedures and the use of conscious sedation for his acts and omissions, including but not limited to, the following:

a. Performing conscious sedation in a medical office;

b. Performing a liposuction procedure that removed more than 5 liters of aspirate from Patient 2 in a medical office;

c. Performing liposuction procedures of greater than 2,000 cc total aspirate, but less than 5,000 cc on Patients 1 and 4 without having continuous blood pressure and electrocardiogram and fluid loss and replacement monitoring;

d. Failing to have continuous blood pressure and electrocardiogram and fluid loss and replacement monitoring available for Patients 3 and 7;

e. Failing to have written discharge criteria and to ensure an ACLS certified staff member remained at all time with Patients 1, 2, 3, 4, and 7;

f. Failing to have intravenous access for Patients 1 or 4;

g. Failing to have a transfer agreement or hospital privileges and a written emergency plan in place during any of the liposuction procedures.

NINTH CAUSE FOR DISCIPLINE

(Inadequate or Inaccurate Medical Records)

142. Respondent. is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records relating to the provision of services to Patient 1, 2,3, 4, 5, 6, 7, 8, and 9.

143. Paragraphs 21 through 117, above, are incorporated here as if fully set forth.

144. As set forth in paragraphs 21 through 117, Respondent failed to adequately and accurately document the provision of care to Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9, thus subjecting his license to discipline.

TENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

145. Respondent Mahmoud Khattab, M.D. is subject to disciplinary action under section 2234, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. Paragraphs 21 through 117 are incorporated as if fully set forth here.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 97693, issued to Mahmoud Khattab, M.D.;

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

3. Revoking the FNP "Precision M.D.";

4. Ordering Mahmoud Khattab, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: AUG 14 2020

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

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