

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

**In the Matter of the Accusation
Against:**

George Ahad, M.D.

**Physician's & Surgeon's
Certificate No. A 111064**

Respondent.

Case No. 800-2017-031906

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 23, 2021.

IT IS SO ORDERED March 24, 2021.

MEDICAL BOARD OF CALIFORNIA



**Ronald H. Lewis, M.D., Chair
Panel A**

1 XAVIER BECERRA
Attorney General of California
2 ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
3 CHRISTINE A. RHEE
Deputy Attorney General
4 State Bar No. 295656
600 West Broadway, Suite 1800
5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
Telephone: (619) 738-9455
7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

9 **BEFORE THE**
10 **MEDICAL BOARD OF CALIFORNIA**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
12 **STATE OF CALIFORNIA**

13 In the Matter of the Accusation Against:

14 **GEORGE AHAD, M.D.**
15 **947 S. Anaheim Blvd.**
16 **Suite 240**
17 **Anaheim, CA 92805-5584**

18 **Physician's and Surgeon's Certificate No.**
19 **A111064,**

20 Respondent.

Case No. 800-2017-031906

OAH No. 2020090634

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

21 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
22 entitled proceedings that the following matters are true:

PARTIES

23 1. Christine J. Lally (Complainant) was the Interim Executive Director of the Medical
24 Board of California (Board) when Accusation No. 800-2017-031906 was filed.¹ She brought this
25 action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney
26 General of the State of California, by Christine A. Rhee, Deputy Attorney General.

27 ¹ On June 15, 2020, William Prasifka became the Executive Director of the Medical
28 Board.

1 2. Respondent George Ahad, M.D. (Respondent) is represented in this proceeding by
2 attorney Anthony F. Witteman, Esq., whose address is: 535 Anton Boulevard, 9th Floor
3 Costa Mesa, CA 92626-7109.

4 3. On or about February 10, 2010, the Board issued Physician's and Surgeon's
5 Certificate No. A111064 to George Ahad, M.D. (Respondent). Physician's and Surgeon's
6 Certificate No. A111064 was in full force and effect at all times relevant to the charges brought in
7 Accusation No. 800-2017-031906, and will expire on July 31, 2021, unless renewed.

8 **JURISDICTION**

9 4. Accusation No. 800-2017-031906 was filed before the Board, and is currently
10 pending against Respondent. The Accusation and all other statutorily required documents were
11 properly served on Respondent on April 6, 2020. Respondent timely filed his Notice of Defense
12 contesting the Accusation.

13 5. A true and correct copy of Accusation No. 800-2017-031906 is attached as Exhibit A
14 and incorporated herein by reference.

15 **ADVISEMENT AND WAIVERS**

16 6. Respondent has carefully read, fully discussed with counsel, and understands the
17 charges and allegations in Accusation No. 800-2017-031906. Respondent has also carefully read,
18 fully discussed with his counsel, and understands the effects of this Stipulated Settlement and
19 Disciplinary Order.

20 7. Respondent is fully aware of his legal rights in this matter, including the right to a
21 hearing on the charges and allegations in the Accusation; the right to confront and cross-examine
22 the witnesses against him; the right to present evidence and to testify on his own behalf; the right
23 to the issuance of subpoenas to compel the attendance of witnesses and the production of
24 documents; the right to reconsideration and court review of an adverse decision; and all other
25 rights accorded by the California Administrative Procedure Act and other applicable laws.

26 8. Having had the benefit of counsel, Respondent voluntarily, knowingly, and
27 intelligently waives and gives up each and every right set forth above.

28 ///

1
2
3
4
5
6
7
8
9
0
1
2
3
4
5
6
7
8
9
0
2
2
2
2
2
2
2
2
2

2
3
4
5
6

7
8
9
0

1
2
3

14

15
16
17
18
19
20
21
22
23
24

25

26
27
28

14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Respondent George Ahad, M.D.'s Physician's and Surgeon's Certificate No. A111064, shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2017-031906, is as follows:

Respondent failed to promptly treat probable malignancy and maintain adequate records in his care and treatment of Patient A and Patient B, as more fully described in Accusation No. 800-2017-031906.

1. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

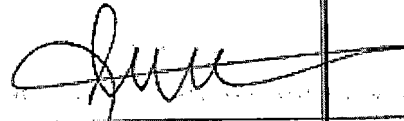
1 Respondent shall submit a certification of successful completion to the Board or its
2 designee not later than 15 calendar days after successfully completing the course, or not later than
3 15 calendar days after the effective date of the Decision, whichever is later.

4 Any failure to fully comply with this term and condition of the Disciplinary Order shall
5 constitute unprofessional conduct and will subject Respondent's Physician's and Surgeon's
6 Certificate to further disciplinary action.

7 ACCEPTANCE

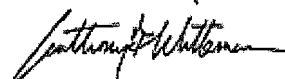
8 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
9 discussed it with my attorney, Anthony F. Witteman Esq. I understand the stipulation and the
10 effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated
11 Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be
12 bound by the Decision and Order of the Medical Board of California.

13
14 DATED: 2/16/2021


15 GEORGE AHAD, M.D.
Respondent

16 I have read and fully discussed with Respondent George Ahad, M.D., the terms and
17 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
18 I approve its form and content.

19
20 DATED: 2/17/2021


21 ANTHONY F. WITTEMAN, ESQ.
Attorney for Respondent

22 ///

23 ///

24 ///

25 ///

26 ///

27 ///

28 ///

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: February 17, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General



CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

SD2020700556
82721401.docx

Exhibit A

Accusation No. 800-2017-031906

1 XAVIER BECERRA
Attorney General of California
2 ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
3 CHRISTINE A. RHEE
Deputy Attorney General
4 State Bar No. 295656
600 West Broadway, Suite 1800
5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
Telephone: (619) 738-9455
7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

9
10 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

12
13 In the Matter of the Accusation Against:

Case No. 800-2017-031906

14 **GEORGE AHAD, M.D.**
15 **947 S. Anaheim Blvd., Suite 240**
Anaheim, CA 92805-5584

A C C U S A T I O N

16 **Physician's and Surgeon's Certificate**
17 **No. A111064,**

18 Respondent.

19
20 **PARTIES**

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

24 2. On or about February 10, 2010, the Medical Board issued Physician's and Surgeon's
25 Certificate No. A111064 to George Ahad, M.D. (Respondent). Physician's and Surgeon's
26 Certificate No. A111064 was in full force and effect at all times relevant to the charges brought
27 herein and will expire on July 31, 2021, unless renewed.

28 ///

JURISDICTION

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

4. Section 2227 of the Code states, in pertinent part:

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

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

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

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

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

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

...

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

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

...

(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.

...

6. 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."

///

FIRST CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. A111064 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in the care and treatment of Patients A and B,¹ as more particularly alleged hereinafter:

Patient A

8. On or about September 4, 2014 and December 16, 2015, Patient A saw a nurse practitioner at Respondent's practice for annual gynecological exams. Patient A was postmenopausal and had a surgical history including a sling procedure and a hysterectomy. Patient A's chart documented that her medical problems included hyperlipidemia, hypertension, metrorrhagia, and cystocele (a bladder hernia).

9. On or about April 18, 2016, a CT scan ordered by E.R. M.D., Patient A's primary care physician (PCP) showed a complex multilocular cystic mass in the right adnexa² approximately 6.6 x 5.2 x 6.6 centimeters (cm) in size. Patient A was also diagnosed with mild to moderate right hydronephrosis.³ A pelvic ultrasound on or about May 9, 2016 confirmed the complex multilocular cystic lesion in the right adnexa measuring 6.4 x 6.1 x 5.8 cm.

10. On or about May 16, 2016, Patient A, then seventy-two-years old, went to her PCP complaining of blood in her urine and right flank pain.

11. On or about May 19, 2016, Patient A returned to Respondent's office for the right adnexal cyst. Respondent conducted a physical exam and his assessment was for a right complex ovarian cyst and pelvic pain. Respondent ordered lab tests to measure tumor markers and noted that the plan was for a laparoscopic (or possibly open) bilateral salpingo-oophorectomy with frozen section should the tests be negative. Respondent also wrote that the surgical procedure

///

¹ Names of the patients have been omitted to protect the patients' privacy.

² The adnexa is the area adjoining the uterus that contains the ovary, fallopian tube, and associated vessels, ligaments, and connective tissue.

³ Hydronephrosis is kidney swelling.

1 would be done at University of California, Irvine (UCI) in case he needed a gynecologic
2 oncologist on standby.

3 12. On or about May 21, 2016, the lab report showed that the tumor markers were within
4 normal limits.

5 13. On or about May 27, 2016, Patient A underwent more imaging that was ordered by
6 her urologist. In this study, the radiologist noted a 5.8 cm heterogeneous lesion within the right
7 adnexa.

8 14. On or about June 13, 2016, Patient A's urologist reviewed the CT scan results from
9 May 27, 2016. The urologist noted that Patient A was to be scheduled for a right cystectomy⁴ and
10 a bilateral salpingo-oophorectomy.

11 15. On or about June 24, 2016, Patient A returned to Respondent's office to discuss
12 possible surgery. There are no notes summarizing what Patient A and Respondent discussed.
13 There are no notes showing that Respondent reviewed the lab results with Patient A.
14 Respondent's assessment was a symptomatic ovarian cyst, and his plan was for a pre-operative
15 appointment. He noted that his office would get dates for surgery.

16 16. On or about July 1, 2016, UCI confirmed that Patient A's surgery with Respondent
17 was scheduled for July 20, 2016.

18 17. On or about July 15, 2016, Patient A's PCP notified Respondent's office that the
19 surgery had to be cancelled. Patient A had been diagnosed with acute deep vein thrombosis
20 (DVT). On or about the same day, Patient A's PCP sent copies of a venous Doppler report
21 confirming Patient A's diagnosis. Patient A's surgery scheduled for July 20, 2016 was cancelled
22 until her DVT resolved.

23 18. On or about October 12, 2016, Patient A called Respondent's office and said she had
24 a pre-operative appointment to obtain clearance for surgery with her urologist. She also wanted
25 to reschedule her surgery with Respondent.

26 ///

27 ///

28 ⁴ A cystectomy is the partial or complete removal of the bladder or cyst.

1 19. On or about October 12, 2016, Patient A had a follow up visit with a hematologist.
2 The note for this visit included lab results for tumor markers from October 5, 2016. The
3 hematologist noted that the CA 125 tumor marker had increased from 17 on May 21, 2016 to 62.
4 The note also documented that Patient A had a ureteral stent placement scheduled for October 21,
5 2016 with her urologist.

6 20. On or about November 7, 2016, Patient A returned to Respondent's office for her pre-
7 operative visit with Respondent. No physical exam was documented in this note. Respondent
8 wrote that "[Patient A] is aware of all the details," and that she was to return to the office two
9 weeks post-surgery.

10 21. On or about November 9, 2016, Respondent performed a laparoscopic bilateral
11 salpingo-oophorectomy on Patient A at UCI. Respondent surgically removed the mass, bilateral
12 ovaries, and tubes. The intraoperative consultation with pathology reported to Respondent via
13 phone showed at least borderline epithelial tumor.

14 22. On or about November 9, 2016, the amended pathology report confirmed that Patient
15 A had endometrioid adenocarcinoma, grade 1.

16 23. On or about November 18, 2016, Patient A returned to Respondent's office for the
17 post-operative visit. He informed her of cancer diagnosis and ordered a PET (Positron-emission
18 tomography) scan and a referral to a gynecologic oncologist.

19 24. Respondent committed repeated negligent acts in his care and treatment of Patient A
20 which includes, but is not limited to, the following:

21 a. Respondent failed to promptly treat the probable malignancy;

22 b. Respondent failed to promptly facilitate proper surgical intervention with an
23 oncologist, which was indicated as early as the May 19, 2016 visit; and

24 c. Respondent failed to adequately document the proposed course of treatment,
25 alternatives, risks, or informed consent.

26 Patient B

27 25. On or about April 2, 2015, Patient B, then a fifty-two-year-old woman, saw
28 Respondent for an annual exam. Patient B was postmenopausal and had a history of fibroids and

1 an oophorectomy in 2011. During this visit, Patient B complained of pelvic pain of
2 approximately four to five months in duration. Respondent did a physical exam and noted an
3 enlarged uterus. He diagnosed Patient B with a benign fibroid and ordered a pelvic ultrasound.

4 26. On or about August 28, 2015, Patient B underwent the pelvic ultrasound.
5 Respondent's medical records for Patient B do not document any insurance issues as a cause for
6 delay. The ultrasound confirmed that the uterus was enlarged and noted approximately six
7 fibroids. The radiologist noted that the "[f]ibroid uterus increased in size and number compared
8 to prior study."

9 27. On or about September 3, 2015, Patient B returned to Respondent's office for the
10 ultrasound results. Respondent noted that Patient B had a history of endometriosis and multiple
11 related surgeries. He also documented that Patient B had severe right flank pain. His plan was
12 for Patient B to obtain medical clearance for a diagnostic dilation and curettage (D&C) to rule out
13 possible uterine cancer. Other possible documented procedures included a laparoscopic total
14 abdominal hysterectomy or lysis of adhesions. He noted that the risks, benefits, and alternatives
15 were explained to Patient B and he ordered her on one month's bed rest.

16 28. Approximately five months after this visit, on or about February 5, 2016, Patient B
17 returned to Respondent's office for her pre-operative visit. Patient B's diagnostic D&C was
18 scheduled for February 10, 2016. Respondent noted that surgery and urology were on standby.

19 29. On or about February 10, 2016, Respondent performed a diagnostic D&C on Patient
20 B at AHMC Anaheim Regional Medical Center. In his operative report, Respondent documented
21 that the procedure to be performed was an "examination under anesthesia and diagnosis of
22 cholelithiasis,"⁵ not a diagnostic D&C. He also wrote that he could not identify the cervix or see
23 normal cervical tissue. He documented that he examined and felt a posterior fixed mass.
24 Respondent did an endocervical and endometrial curettage, but wrote that he was not sure
25 whether enough tissue had been taken for pathology.

26 30. On or about February 15, 2016, Patient B returned to Respondent's office to follow
27 up on the D&C results. Respondent documented that he did not have the pathology results and

28 ⁵ Cholelithiasis is the formation of gallstones.

1 recommended that Patient B get a colonoscopy and follow up with her PCP. He also ordered a
2 CT scan of the pelvis and abdomen. Respondent's plan was to do surgery on the suspicious mass
3 at UCI and call a gynecologic oncologist if positive for cancer.

4 31. On or about February 18, 2016, the CT scan of Patient B's abdomen and pelvis
5 showed a complex mass measuring 10.1 x 13.2 cm.

6 32. On or about February 25, 2016, Patient B returned to Respondent's office for the CT
7 scan results. He noted that he did not know the source of the mass but that it was suspicious for
8 cancer. Respondent recommended surgery at UCI.

9 33. On or about April 12, 2016, at Respondent's recommendation, Patient B went to
10 UCI's emergency department complaining of abdominal pain. Respondent told Board
11 investigators that he was having issues scheduling Patient B's surgery because of her health
12 insurance. Patient B was admitted at UCI on or about the same date. She underwent surgery on
13 or about April 18, 2016 for an exploratory laparotomy and other related procedures done by R.B.,
14 M.D. Pathology confirmed that Patient B had stage IV ovarian cancer.

15 34. Respondent told Board investigators that the delays in Patient B's treatment were due
16 to difficulties with her health insurance. Respondent's medical records for Patient B, however, do
17 not document any insurance issues or communications with Patient B's insurance. Records from
18 UCI show that Respondent made a request for service with Patient B's insurance on or about
19 February 25, 2016, which was approved on or about February 29, 2016.

20 35. Respondent committed repeated negligent acts in his care and treatment of Patient B
21 which includes, but is not limited to, the following:

22 a. Respondent failed to promptly treat the probable malignancy in this case;

23 b. Respondent failed to promptly facilitate proper surgical intervention with an
24 oncologist; and

25 c. Respondent failed to adequately document the risks and alternatives to
26 treatment, informed consent, important details regarding the attempted referrals to
27 oncology, and reasons for the delay in treatment.

28 ///

