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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: Mark Anthony Knight, M.D. Physician's & Surgeon's Certificate No. A 78828 Respondent.	Case No. 800-2019-056493

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 30, 2021.

IT IS SO ORDERED: April 2, 2021.

MEDICAL BOARD OF CALIFORNIA

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

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation/Petition to Revoke Probation Against: **MARK ANTHONY KNIGHT, M.D.** **15039 Goldenwest Street** **Huntington Beach, CA 92647-2710** **Physician's and Surgeon's Certificate No. A 78828** Respondent.	Case No. 800-2019-056493 OAH No. 2019100458 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

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2. Respondent Mark Anthony Knight, M.D. (Respondent) is represented in this proceeding by attorney John D. Harwell, Esq., whose address is 225 27th Street, Manhattan Beach, CA 90266.

3. On or about April 24, 2002, the Board issued Physician's and Surgeon's Certificate No. A 78828 to Mark Anthony Knight, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation/Petition to Revoke Probation No. 800-2019-056493, and will expire on October 31, 2022, unless renewed.

JURISDICTION

4. On or about August 1, 2019, Accusation/Petition to Revoke Probation No. 800-2019-056493 was filed before the Board. The Accusation/Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on August 1, 2019. Respondent timely filed his Notice of Defense contesting the Accusation/Petition to Revoke Probation. A First Amended Accusation/Petition to Revoke Probation was filed before the Board on October 28, 2020, and is currently pending against Respondent. A true and correct copy of First Amended Accusation/Petition to Revoke Probation No. 800-2019-056493 is attached hereto as Exhibit A and incorporated herein by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation/Petition to Revoke Probation No. 800-2019-056493. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in First Amended Accusation/Petition to Revoke Probation No. 800-2019-056493, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the First Amended Accusation/Petition to Revoke Probation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the First Amended Accusation/Petition to Revoke Probation No. 800-2019-056493, and that Respondent hereby gives up his right to contest those charges.

10. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

11. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation/Petition to Revoke Probation No. 800-2019-056493 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. 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 Physician's and Surgeon's Certificate No. A 78828 issued to Respondent Mark Anthony Knight, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions, which shall supersede all other terms and conditions of probation previously ordered in Medical Board of California Case No. 800-2014-002269.

1. **EDUCATION COURSE**. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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

3. **CLINICAL COMPETENCE ASSESSMENT PROGRAM**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more

than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations. Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

4. **MONITORING - PRACTICE**. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

5. **SOLO PRACTICE PROHIBITION**. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

6. **PROHIBITED PRACTICE**. During probation, Respondent is prohibited from performing any surgery including any procedures under anesthesia or conscious sedation unless and until the Clinical Competence Assessment Program submits a report to the Board or its designee which unequivocally states that Respondent has demonstrated the ability to practice safely and independently. After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from performing any surgery including any procedures under anesthesia or conscious sedation. Any new patients must be provided this notification at the time of their initial appointment. The prohibited practice notification will no longer be required if the Clinical Competence Assessment Program submits a report to the Board or its designee which unequivocally states that Respondent has demonstrated

the ability to practice safely and independently.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

7. **NOTIFICATION**. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. **SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES**. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. **OBEY ALL LAWS**. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. **QUARTERLY DECLARATIONS**. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. **GENERAL PROBATION REQUIREMENTS**

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event Respondent should leave the State of California to reside or to practice ,Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

12. **INTERVIEW WITH THE BOARD OR ITS DESIGNEE**. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. **NON-PRACTICE WHILE ON PROBATION**. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is

defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

14. **COMPLETION OF PROBATION**. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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15. **VIOLATION OF PROBATION**. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. **LICENSE SURRENDER**. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. **PROBATION MONITORING COSTS**. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

18. **FUTURE ADMISSIONS CLAUSE**. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in First Amended Accusation/Petition to Revoke Probation No. 800-2019-056493 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

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

DATED: 1/30/2021

MARK ANTHONY KNIGHT, M.D.
Respondent

I have read and fully discussed with Respondent Mark Anthony Knight, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve of its form and content.

DATED: 1/30/20

JOHN D. HARWELL, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: February 1, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation/Petition to Revoke Probation No. 800-2019-056493

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation/Petition to Revoke Probation Against: **Mark Anthony Knight, M.D.** **17731 Irvine Blvd., Suite 101** **Tustin, CA 92780-3235** **Physician's and Surgeon's Certificate No. A78828,** Respondent.	Case No. 800-2019-056493 **FIRST AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation and Petition to Revoke Probation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about April 24, 2002, the Medical Board issued Physician's and Surgeon's Certificate Number A78828 to Mark Anthony Knight, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2020, unless renewed.

JURISDICTION

3. This First Amended Accusation and Petition to Revoke Probation is brought before the Board, under the authority of the following laws and the prior disciplinary action entitled *In the Matter of the Accusation Against Mark Anthony Knight, M.D.* before the Medical Board of California, in Case Number 06-2008-190093. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. In the prior disciplinary action entitled *In the Matter of the Accusation Against Mark Anthony Knight, M.D.* before the Medical Board of California, in Case Number 06-2008-190093, Respondent surrendered his medical license effective December 15, 2010, with an Accusation pending against him concerning allegations of professional misconduct. On January 8, 2014, Respondent filed a Petition for Reinstatement of his medical license that was granted on February 6, 2015, with an effective date of March 6, 2015. As a result of the granting of the Petition for Reinstatement, Respondent's license was reinstated and then immediately revoked, with said revocation stayed, and Respondent placed on probation for a period of five years from the effective date of March 6, 2015, under various terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein

5. Section 2227 of the Code states:

> "(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> "(1) Have his or her license revoked upon order of the board.
>
> "(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> "(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> "(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> "(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

". . . ."

STATUTORY PROVISIONS

6. 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:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

"(d) Incompetence."

". . .

"(f) Any action or conduct which would have warranted the denial of a certificate.

". . . ."

7. Unprofessional conduct under Business and Professions Code section 2234 is 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. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

8. 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."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patient A, B and C,[1] as more particularly alleged hereinafter:

PATIENT A

10. On or about November 27, 2017, patient A, a then-34-year old male, presented to Respondent for liposuction surgery to remove excess fat around his midsection and submental (under the chin) region. According to Respondent's procedure note for the liposuction surgery, Respondent performed suction assisted lipectomy (liposuction surgery), under general anesthesia in an outpatient setting, to patient A's bilateral upper abdomen, bilateral lower abdomen, bilateral flanks, bilateral lower back, and the submental area. According to the procedure note, approximately 3,000 cc's of tumescent fluid was infiltrated with approximately 5,000 cc's of tumescent fluid and fat being aspirated. Following the procedure, patient A was dressed with abdominal pads, taken to the recovery room, and was subsequently discharged. Patient A's discharge instructions included, among other things, instructions to take one to two tablets of Norco every 4 to 6 hours as needed for pain, avoid heavy lifting and strenuous exercise, return to clinic for follow up in one week and contact Respondent if any unusual or unexpected post-operative events.

11. On or about November 29 or 30, 2017, patient A was not feeling well. According to patient A's fiancé, she called Respondent to express concern over patient A's symptoms which included, among other things, severe stomach pain, an "over inflated" stomach, a foul smell coming from his navel area, and a rash and bumps on his stomach. Respondent told patient A to come into his office to be evaluated, which he did. Respondent examined patient A and informed him his incisions looked fine and the symptoms he was experiencing were part of the recovery process. Respondent did not order any imaging or request any laboratory studies. Respondent

[1] Patient A, B, and C are being used in place of the patients' names or initials to maintain patient confidentiality. Respondent is aware of the identity of the patient referred to herein.

had no documentation of this post-operative visit and could not produce any other documents which should have been included as part of patient A's medical records.[2]

12. On or about November 30 or December 1, 2017, patient A's fiancé called Respondent to report patient A was still not doing well. Respondent assured her that everything was fine and told her that if patient A's condition got worse she should consider taking him to the Emergency Department.

13. On or about December 2, 2017, patient A was taken to the Emergency Department at Chino Valley Medical Center (CVMC) in the morning for increasing abdominal pain and subsequent shortness of breath. On admission, patient A complained of diffuse abdominal pain, no bowel movement since the liposuction surgery, inability to tolerate food, weakness, dizziness and nausea. A CT with contrast was taken of the abdomen and pelvis and reported on December 2 at 8:20 a.m.[3] The initial lab results indicated, among other things, a white blood cell count

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[2] The Department of Consumer Affairs, Division of Investigation, Health Quality Enforcement Unit (HQIU) requested any and all of patient A's medical records from Respondent pursuant to an Authorization for Release of Medical Information signed by patient A. In response, Respondent produced eight (8) pages of medical records and indicated, in pertinent part, "I am responding to your request for records relating to this patient. The surgery center at which the procedure was performed was abruptly closed in December of 2017. I have not been there since. I have contacted the owner, [name omitted]. And requested the chart on multiple occasions. I have been told that the chart is not available. I don't know what has happened to this or any of the other charts from this facility...The only documents available in my possession are the photographs that I took and a copy of the operative report that you will find attached." Respondent admitted at his subject interview with an HQIU investigator that "there are a lot of items" missing from the records including, but not limited to, nursing notes, the anesthesia records, certain legal forms, and preoperative instructions. Respondent informed the HQIU investigator "I just gave you what I have access to, the photographs...[and] the operative note..." (Respondent's Interview Transcript, at p. 23.)

[3] The CT was reported as follows, in pertinent part, "PERITONEUM, PETROPERITONEUM: No free air. There is extensive subcutaneous fat stranding and gas seen throughout the subcutaneous tissues of the anterolateral abdominal walls. There is a 22.2 x 5.1 x 19.2 cm complex gas-containing fluid collection within the subcutaneous tissues of the left lateral hemiabdomen...IMPRESSION: (1) Extensive subcutaneous fat stranding in gas seen throughout the anterolateral abdominal walls consistent with abdominoplasty changes. A 22-cm complex gas-containing collection within the subcutaneous tissues at the left lateral abdomen wall may represent a gas containing hematoma related to liposuction changes. However, superimposed infection not excluded; (2) Multiple dilated loops of fluid-filled small bowel within the right hemiabdomen without discrete transition point. Notably, the duodenum does not appear to cross expected region of the ligament of Treitz. Small bowel obstruction related to malrotation not excluded. Alternatively, this may reflect postoperative ileus; (3) Small bowel and pelvic ascites; [and] (4) Mild bibasilar atelectasis...."

(WBC) of 9.0 K/mm.[3] After work-up in the Emergency Department, patient A was transferred to the Intensive Care Unit (ICU) for stabilization and closer observation. On December 2, Dr. H.O., the on-call and consulting surgeon, called Respondent to discuss patient A's condition, with Respondent eventually coming to CVMC to check on patient A, with the encounter documented as follows:

> "ASSESSMENT AND PLAN: Status post liposuction. I am quite concerned about necrotizing fascitis [sic][4]; however, I do not deal with patients status post liposuction. Therefore, we made a call over to Dr. Mark Knight, who did answer the phone with the resident next to me. We did explain to him the lab values as well as CT findings. Dr. Mark Knight reported these are all normal findings for status post liposuction. He believes that the patient was on too much narcotics and that is why his bowels are starting to not move, perhaps leading to his ileus and a narcotic bowel and causing him to have the vomiting. We explained to him the gas findings. He said that is all normal since he has used air to insufflate the abdomen in order to [get] fat out. Secondly, we offered to transfer the patient to a facility that he has privileges at and he declined saying that the patient is going to simply follow up in his clinic.
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> "Status post liposuction. Again, I am not familiar with Plastic Surgery postops. We are going to watch him in the ICU, give him IV fluids, resuscitate him, put catheter to get accurate findings and every 6 hours labs and abdominal exams and see how he does. Hopefully, he does improve." (Consultation Report dated December 2, 2017.)

The attending resident documented the following:

> "Plastic surgeon, Dr. Mark Knight; was contacted, briefed, regarding patient's history/imaging/vitals/labs. Concern regarding patient's clinical condition by Chino's on call surgeon, Dr. [H.O.], was also expressed. Transfer was offered, but Dr. Knight denied transfer and reported that patient was experiencing a normal procedural outcome. Dr. Knight came to CVMC to assess patient, with the patient's consent. He again reported there was no need to transfer patient. [¶] Consult general surgery, Dr. [H.O.]; recommended transfer to hospital where plastic surgeon who performed liposuction procedure has privileges, due to patient's condition." (CVMC History and Physical with service date and time of December 2, 2017, 2:21 p.m.)

During this time, Respondent did not have privileges at any hospital. While at CVMC, there were consultations with various specialists including, general surgery, infectious disease, and pulmonology based on the assessments concerning patient A's condition which included, but were not limited to, acute hypoxemic respiratory failure, sepsis, septicemia, possible abdominal wall infection, left shift with leukocytosis, possible abdominal wall hematoma versus abscess and

[4] Necrotizing fasciitis, commonly referred to as the flesh-eating disease, is an acute disease of sudden onset in which inflammation of the fasciae (soft tissue) of muscles or other organs spreads rapidly and results in rapid destruction of overlying soft tissues. Symptoms can include red or purple skin in the affected area, severe pain, fever, and vomiting. Necrotizing fasciitis is typically treated with surgery to remove the affected tissue and intravenous antibiotics.

possible necrotizing fasciitis. The general plan for patient A's treatment included, but was not limited to, aggressive support measures, stabilization of patient A's condition, and possible exploratory surgery. On December 3, Dr. H.O., documented that patient A "does feel somewhat better," he had a bowel movement after an enema, and his WBC was within normal limits. On December 4, patient A's condition declined with him having persistent hiccups, voiding dark amber colored urine, his abdomen was firm and distended, and discharge was noted through his umbilicus. The lab results of December 4 indicated an elevated WBC of 14.8 K/mm,^{3} which was outside of normal limits. A CT without contrast was ordered of the abdomen and pelvis and reported on December 4 at 3:04 p.m.[5] Around this time, the decision was made to transfer patient A, whose condition on discharge was listed as "guarded," to St. Joseph's Hospital (St. Joseph's) for further care. Patient A was transferred to St. Joseph's on December 4 at approximately 10:00 p.m.

14. On or about December 4, 2017, patient A was admitted to St. Joseph's where he remained until his discharge on or about December 28, 2017. During his hospital stay, patient A was attended to by several specialists including, but not limited to, general surgery (Dr. S.L.), infectious disease, and intensivists for critical care needs. On December 6, Dr. S.L. performed an emergent exploratory laparotomy for the various preoperative diagnoses which included, but were not limited to, small bowel perforation from outside institution by the plastic surgeon, intestinal subcutaneous fistula, necrotizing fasciitis, septic shock, and status post liposuction from outside

[5] The CT was reported as follows, in pertinent part, "FINDING: Previously noted extensive subcutaneous inflammation in the anterolateral wall is again noted, with previously seen subcutaneous emphysema mostly replaced by fluid collection. Persistent bibasilar dependent atelectasis within noted. There is decreasing gastric distention with unchanged dilated proximal small bowel loops in the right hemiabdomen and nonvisualization of duodenum extending beyond ligament of Treitz, unchanged compare [to] prior study. Previously noted pelvic ascites has resolved. No other acute interval changes noted. [¶] IMPRESSION: persistent extensive subcutaneous inflammation along bilateral anterolateral abdominal wall, now more fluid filled compared to previous is [sic] seen emphysematous changes. Resolved free intrapelvic fluid. [¶] No change in bibasilar atelectasis and dilated proximal small bowel loops, which may represent postoperative ileus or bowel obstruction related to malrotation. Appearance remains unchanged compared to 12-2-17."

facility with iatrogenic small bowel perforation and small bowel obstruction.[6] The Operative Report for the emergent surgery noted the following, in pertinent part:

> "FINDINGS: The patient unfortunately had 3 small bowel enterotomies[7] in the mid jejunum. This happened during the iatrogenic injuries that were not found out until today and from outside facility by plastic surgeon. The patient was undergoing a liposuction and liposuction wand penetrated the anterior abdominal fascia, just slightly to the right of the umbilicus and this caused multiple iatrogenic injuries to the small bowel causing enterotomies and 1 large enterotomy was stuck to the ventral hernia or the incisional hernia that was created by the ultrasonic wand from the liposuction causing massive intestinal content spillage into the subcutaneous tissue where all the fat was removed, creating a huge amount of necrotizing fasciitis..." (Operative Report dated December 6, 2017.)

In addition to the above, patient A had four additional surgeries on December 8, 15, 19, and 20, 2017, to address problems associated with infection, necrotizing fasciitis and/or abdominal wounds. Patient A was discharged from St. Joseph's Hospital on December 28, 2017.

15. On or about January 18, 2018, patient A had follow up at St. Joseph's for wound care.

16. On or about January 25, 2018, patient A had follow up at St. Joseph's for wound care.

17. On or about February 1, 2018, patient A had follow up at St. Joseph's for wound care.

18. Respondent committed gross negligence in his care and treatment of patient A which included, but was not limited to, the following:

(a) Respondent failed to perform patient A's liposuction surgery on November 27, 2017 in a competent manner and with a lack of knowledge which resulted in harm to the patient; and

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[6] The operative report generally lists the following procedures/operations: (1) emergency exploratory laparotomy; (2) resection of 3 small bowel enterotomies with bowel anastomosis; (3) incidental appendectomy due to malrotation of the gut and wrong location of the appendix; (4) multiple washout of the intra-abdominal cavity; (5) evacuation of the intestinal contents; (6) application of 2 Seprafilms to the pelvis and anterior abdominal contents; (7) excision of the intestinal fistulas, intestinal cutaneous fistulectomy; (8) application of the AmnioFix Allograft 12 x 2 cm in length to the primary anastomotic sites of the small bowel; (9) bilateral flank necrotizing fasciitis, wide excision of the fascia and multiple fasciectomy right a left flanks; (10) deep necrotic tissue biopsy and culture of the left flank area; (11) wound VAC; (12) placement of drains; and (13) midline fascial defect closure, primary incisional hernia repairs." (Operative Report dated December 6, 2017.)

[7] An enterotomy is a surgical incision into an intestine which can be purposeful or the result of an unexpected surgical complication.

(b) Respondent failed to properly recognize and/or treat patient A's post-surgical complications following his liposuction surgery of November 27, 2017, and exhibited a lack of knowledge in regard to recognizing and properly treating the post-surgical complications.

PATIENT B

19. On or about October 14, 2017, patient B, a then-27-year old female, had her initial consultation with Respondent. As part of her history, patient B reported having a third child three months ago and three prior C-section deliveries, her height was recorded as 64 inches with her weight at 170 pounds. Respondent recommended abdominoplasty (sometimes referred to as a tummy tuck) with bilateral liposuction of the flanks and lower back area, as well as mastoplexy (breast lift) and tubal ligation.

20. On or about February 9, 2018, patient B had a follow up visit with Respondent. Her weight at this time was listed as 190 pounds with Respondent recommending abdominoplasty and bilateral liposuction of the flanks, lower back, and bra line areas.

21. On or about March 3, 2018, patient B visited the surgical center to sign informed consent documents and other documents related to her upcoming abdominoplasty and liposuction.

22. On or about March 9, 2018, Respondent performed the abdominoplasty and bilateral liposuction on patient B's bra line, flank and lower back areas. According to the procedure notes, patient B was placed under general anesthesia with 1500 cc's of tumescent fluid being infiltrated with approximately 1800 cc's of tumescent fluid and fat being aspirated for the liposuction. However, another record entitled "Operative Note," signed by Respondent, indicated "In 1000 out 1200 cc."[8] The Operative Report in describing the "Abdominal Operative Procedure" indicates:

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[8] One part of the operative report, in the "Abdominal Operative Procedure" section states that 1800 cc was aspirated from the bilateral bra line, flank, and lower back areas while other areas indicate "[u]sing multiple cross pattern passing 1800 cc was aspirated from each flank and lower abdomen. The separate "Operative Note" states "In 1000 out 1200 cc." (Surgical Center Certified Medication Records, at pp. 98, 101, 108.)

"The dissection was then carried down perpendicular to the anterior abdominal wall through the Campers fatty layer to the aponeurosis of the external oblique and the fascia of the anterior rectus sheath. The dissection was then carried out above the level of Gallaudet's fascia (innominate fascia) using electrocautery."

After two JP drains were placed, patient B was taken to the recovery room, and was subsequently discharged. Patient B's discharge instructions included, among other things, contacting Respondent for any usual or unexpected events, return to clinic in one week, no heavy lifting or strenuous exercise, "wear the surgical binder for 3 hrs. then open for one hour [and] then repeat cycle," and strip the JP drains every 4 hours. Medications on discharge included Keflex 500 mg, one tab four times daily for 7 days; Norco 10/325 mg, one or two tablets every 4-6 hours as needed for pain; and Robaxin 750 mg every 8 hours.

23. Respondent's reference to Gallaudet's fascia in the Operative Report and his later references in describing the procedure are incorrect and exhibit a lack of knowledge because Gallaudet's fascia is the perineal fascia, not present on the abdomen. The fascial layers of the abdominal skin and subcutaneous tissue are Camper's fascia and Scarpa's fascia. Respondent also stated later in describing the procedure that "the superior epigastric is a dominant vascular inflow at that point," which was also incorrect and exhibits a lack of knowledge because the superior epigastric artery supplies the upper rectus muscle and sends perforators to the skin. However, the perforators are divided in elevating the abdominoplasty flap and, thus, the flap relies on the lateral intercostal perforators for survival. Respondent also stated later in describing the procedure that he covered the surgical dressing with "xeroform gauze, it's iodine impregnated," which is also inaccurate and further displays a lack of knowledge because Xeroform does not contain iodine. Respondent also stated in his Operative Report that he plicated patient B's anterior rectus sheath by 16 cm which displays a lack of knowledge as to the appropriate method of rectus plication. Such a plication would not bring the rectus muscles back to the side-by-side normal anatomy and instead would bunch the two muscles together in the midline which could change the patient's abdominal strength, put pressure on the abdominal wall (due to the unfolding of the anterior abdominal wall), and result in an abnormal abdominal contour. Lastly, the operative report also incorrectly identifies the anesthesia provider as Dr. K.J.

when the perioperative record and other anesthesia records identify the anesthesiologist as Dr. A.S.

24. On or about March 10, 2018, patient B called the clinic to report leakage out of the right side of her incision. She was asked to take a photograph of the area and send the photographs to the clinic. Patient B sent three photos, only one of which was delivered, which showed the right drain entering the incision line. Patient B was also told to unclog the drain.

25. On or about March 11, 2018, Respondent wrote prescriptions for Ultram and Nitropaste for patient B. There was no record of any corresponding office visit.

26. On or about March 14, 2018, patient B had a follow up office visit with Respondent who noted evidence of ischemia (insufficient blood flow which can lead to decay of skin tissue referred to as necrosis) on patient B's lower abdomen. Respondent documented that patient B allegedly did not follow her post-operative instructions in regard to periodically releasing her surgical binder.

27. On or about March 16, 2018, patient B had a follow up office visit with Respondent who wrote two notes for the visit. In one note, the patient was described as being in "guarded condition," with recommendations to continue to apply the nitroglycerin ointment and massage the area of the ischemia. Respondent also documented a discussion with patient B about the need for debridement (procedure to remove decayed or nonviable skin to assist with wound healing) and reclosure of the wound. In the other note, patient B was told to continue her local wound care only. In both notes, Respondent documented that patient B was told to return in one week.

28. On or about March 21, 2018, patient B had a follow up visit with Respondent who documented "[d]iscrete demarcated area of dermal necrosis [with] [n]o evidence of complete dermal necrosis" and noted the "[patient] in guarded condition." Respondent advised patient B to continue local wound care, begin taking aspirin 81 mg daily, and to return to clinic for follow up on March 23, 2018.

29. On or about March 29, 2018, patient B had a follow up visit with Respondent who documented a "symptomatic area of necrosis 2.5 x 2.5 cm." Respondent further documented, among other things, that patient B complained of coughing up blood believed to be secondary to

the Bactrim (sulfamethoxazole and trimethoprim) antibiotic which was discontinued with Cipro (another antibiotic) being continued. Coughing up blood is not a known side effect of Bactrim (sulfamethoxazole and trimethoprim) and exhibits a lack of knowledge. Respondent [a]dvised patient to consider revision/debridement to remove area of nonviable tissue. There was also a "pre-operative phone call" in which the pre-operative instructions were provided.

30. On or about March 30, 2018, patient B had a follow up visit with Respondent who performed the recommended revision/debridement procedure. According to the operative report, the diagnosis was "[i]schemic necrosis of abdominoplasty flap, suprapubic" region with the planned procedure described as [e]xcisional debridement of suprapubic wound." The abdomen was "noted for an area of ischemic necrosis 3 cm x 3 cm centrally with surrounding superficial necrosis for 7 cm x 3 cm in the suprapubic region" with "no evidence of purulent drainage, fluctuance or active infection." There were no documented complications and the patient was subsequently discharged with instructions to, among other things, follow up in one week.

31. On or about April 4, 2018, patient B had a follow up visit with Respondent. According to Respondent's chart note, the patient's abdomen continued to display swelling and ecchymosis (bruising). The patient was noted to be in "fair condition [and] progressing well" with recommendations to continue wound care and return to clinic in two days for follow up.

32. On or about April 5, 2018, Respondent documented a telephone conversation with patient B in which he discussed the wound care plan which was to "continue to clean with peroxide and dress with dry gauze." On this same day, patient B also saw her primary care physician, Dr. I.S., who recommended excision of the wound noting the wound "needs to be debrided by operating surgeon."

33. On or about April 6 through April 16, 2018, patient B sent Respondent text messages and photographs expressing concern over her condition including, but not limited to, wound opening, having drainage, bleeding, and an odor. The text messages were not included in the certified medical records provided to the Board.

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34. On or about April 18, 2018, patient B had a follow up visit with Respondent who noted an open wound with peroxide and packed with gauze. The progress note for this visit failed to document any of the recent text dialogue with patient B.

35. On or about April 20, 2018, patient B had a follow up visit with Respondent in which she complained of an odor from her wound. Respondent examined the area of the wound, noted stable eschar 3 cm x 7 cm, documented the patient was "in fair condition [and] progressing well," recommended continued wound care and reviewed "dressing change instructions" with the patient.

36. On or about April 25, 2018, patient B and Respondent spoke over the phone. According to the progress note, Respondent reviewed the plan for wound care, discussed another debridement when the wound was stable, and placement of a vacuum device for wound care. Patient B complained that she had lost her job "and doesn't want to go to the other job like this." Respondent advised the patient "to prioritize and focus on healing."

37. On or about April 27, 2018, patient B had a follow up visit with Respondent who noted a lower abdominal open with eschar, no evidence of petulance or infection, with the recommendation to continue with local wound care, and return to clinic in two days for follow up.

38. On or about April 30, 2018, Respondent documented a phone conversation with patient B in which they discussed her wound status and the "renewed plan for [vacuum] wound device as next step." Respondent further "[d]iscussed with patient that I will continue to take care of her wound and proceed as planned if she so desires." Respondent instituted no further contact with patient B despite her having an open necrotic abdominal wound.

39. On or about May 4, 2018, patient B signed a request for a copy of her medical records. The medical records provided to patient B differed from those certified records provided to the Board. Among other things, medical records provided to patient B contained only the progress note for March 16, 2018, while the medical records provided to the Board contained two notes; and there was no progress note for April 27, 2018 provided to patient B, as contained in the medical records provided to the Board. Additionally, the medical records

provided to patient B did not contain a copy of any of her text message exchanges with Respondent which should have been printed out and included as part of her medical record.

40. On or about May 7, 2018, patient B consulted with Dr. T.D., another plastic surgeon, about possible revision of the abdominoplasty. Dr. T.D. documented patient B as having "large eschar with deep wound dehiscence [wound opening completely or partially along the sutures]" with the patient reporting pus and drainage. The assessment was "delayed wound healing with necrosis to lower abdomen [after] abdominoplasty." Patient B was referred to Dr. M.B., another plastic surgeon and wound care specialist, for wound care with revisional abdominoplasty to be considered in the future

41. On or about May 14, 2018, patient B was seen by Dr. M.B., who described patient B's wound as 11 cm x 10 cm, and performed an in-office debridement. Dr. M.B. recommended intravenous antibiotics and also referred patient M.B. to the emergency department of a local hospital for further evaluation and to rule out sepsis. According to the ER provider note, "Patient's physical exam is significant for large area of wound dehiscence and purulent subcutaneous tissue approximately the size of my hand." The plan was to treat patient B with IV antibiotics and admit her for a general surgery consultation.

42. On or about May 17, 2018, the wound was debrided in the operating room by another plastic surgeon, Dr. B.D. Patient B was subsequently discharged with further antibiotics and wound care to be provided by a home health agency including, but not limited to, Etrapenem antibiotic, Micafungin anti-yeast medication, and initiation of wound vacuum assisted closure.

43. During the period of on or about May 22, 2018, through August 4, 2018, patient B continued to have wound care treatment. The wound care was primarily provided by the home health agency with, among other things, a visit to a wound care center on May 25, 2018, where patient B's wound was described as being 11.8 cm x 16.7 cm. The home health agency records contain an entry on August 4, 2018, indicating "Skilled nurse told [patient] that [the home health agency] will stop visit due to noncompliance with her MD visits and follow up."

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44. Respondent committed gross negligence in his care and treatment of patient B which included, but was not limited to, the following:

(a) Respondent's failed to properly perform the abdominoplasty with bilateral liposuction on patient B which resulted in vascular compromise of patient B's lower abdominal flap and subsequent necrosis; and

(b) Respondent had no further contact with patient B after April 30, 2018, despite the patient having an open necrotic abdominal wound.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

45. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patient A, B and C, as more particularly alleged herein:

PATIENT A

(a) Paragraphs 10 through 18, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to perform patient A's liposuction surgery on November 27, 2017 in a competent manner which resulted in harm to the patient;

(c) Respondent failed to properly recognize and/or treat patient A's post-surgical complications following his liposuction surgery of November 27, 2017, and exhibited a lack of knowledge in regard to recognizing and properly treating the post-surgical complications; and

(d) Respondent failed to maintain and/or produce a complete set of medical records for patient A.

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PATIENT B

(a) Paragraphs 19 through 44, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent's failed to properly perform the abdominoplasty with bilateral liposuction on patient B which resulted in vascular compromise of patient B's lower abdominal flap and subsequent necrosis;

(c) Respondent had no further contact with patient B after April 30, 2018, despite her having an open necrotic abdominal wound;

(d) Respondent's failed to maintain adequate and accurate records including, but not limited to, listing the wrong anesthesia provider for the procedures of March 9, 2018; maintaining two different notes for March 16, 2018; and failing to include the dialogue of the texts between patient B and Respondent which occurred between April 6 through April 16, 2018;

(e) Respondent performed liposuction on patient B's lateral chest/bra-line area where the flap's blood supply was at risk;

(f) Respondent over-plicated patient B's anterior rectus sheath; and

(g) Respondent failed to provide a complete set of medical records to patient B.

PATIENT C

46. On or about April 2019, patient C, a then-36-year old female, underwent breast augmentation surgery performed by Dr. D.G., at the same surgery center where Respondent performed procedures. As part of that procedure, Dr. D. G. placed 600 gram silicone implants to enhance the size of patient C's breasts.

47. On or about September 11, 2019, patient C returned to the surgical center to have larger implants placed. This was the first time that patient C met Respondent, who was scheduled to perform the breast augmentation. The consent form signed by the patient and Respondent provided for bilateral removal and replacement of silicone implants. The pre-operative diagnoses was documented as "asymmetry of bilateral breasts" with inadequate description of how the

breasts where asymmetric. Patient C's husband wanted his wife's new implants to be 1000 ml. According to Respondent's certified medical records, he discussed the downside of such large implants[9] and ultimately the decision was made to remove patient C's 600 ml implants and replace them with 630 cc high profile implants that would be maximally filled to 750 cc. The operative note lists the procedures performed as bilateral breast silicone implant removal, revision of right breast implant pocket, and replacement of bilateral saline implant with new saline breast implants. The operative summary indicated, "Breasts are symmetric in volume with right smaller than left due to implant rupture and deflation" which was an inadequate and confusing description considering, among other things, the nature of silicone breast implants.[10] Following the procedure, patient A was given instructions regarding medications which included Keflex (cephalexin), an oral antibiotic, 500 mg one tab four times daily for 7 days; and Ultram (tramadol hydrochloride)[11] 50 mg one or two tablets every six hours as needed for pain control.

48. According to Respondent's certified medical records, there was an incident with patient C's husband, who was upset that his wife did not have the larger implants placed. One of the surgical center nurses documented that the husband, among other things, barged into the recovery room and "then proceeded to remove her [patient C's] bandages...and when he saw the results [the smaller size] he immediately demanded his money back and he threatened the staff." According to the "Nurses Progress Note, "[t]he whole staff felt very threatened with the whole situation since this is the first time such things ever happen[ed]."

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[9] Respondent's medical records contained a handwritten note, signed by patient C and Respondent, stating, "[Patient's] husband sent pictures indicating that he wants her to have VERY LARGE implants placed. I have advised the patient that with time, age and gravity such large implants will cause stretch marks, muscle aches, shoulder pain, back and neck strain. In addition, the implants will accelerate the drooping of the breasts. The patient was advised that the largest size high profile Mentor implants are 630 630 cc HP [high profile]. I informed the patient that this was her choice and her body and she would live with the size and any problems. The patient agreed to have the Mentor 630 cc HP implants placed." Similar language was also included within the consent section of the operative report.

[10] The implants that were removed were silicone, so there could be no "deflation" since silicone cannot be absorbed by the body. Moreover, the operative report indicates the right implant was removed "uneventfully" with no indication that the implant was ruptured.

[11] Tramadol Hydrochloride (Ultram®, Ultracet®), an opioid analgesic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

49. On or about September 13, 2019, one of the surgical center nurse's called patient C to come to the surgical center to be evaluated. The patient indicated she could not come in because she had no one to transport her to the surgical center. Patient C denied any pain or discomfort. The nurse told her to call if she had any questions or concerns.

50. On or about October 9, 2019, patient C returned to the surgical center for a follow up visit. According to the progress note, "[w]hen the Patient was in the room, her husband complained about him wanting bigger implants for her and saying that he did not see any difference from the last surgery [performed by another physician]. Respondent generally explained he had discussed the risks associated with larger implants with his wife who consented to the 630 cc high profile implants after being advised of the risks of larger implants. Among other things, the husband added that his wife did not speak English and "[h]e was then told that the risk, size and procedure was discussed with the patient in Spanish by Dr. Knight himself as he is fluent in Spanish.

51. Respondent committed repeated negligent acts in his care and treatment of patient C which included, but was not limited to, the following:

(a) Respondent did not have a separate consultation with patient C on a date prior to September 11, 2019, when her treatment plan was decided and her breast augmentation was performed;

(b) Respondent prescribed an excessive course of Keflex to patient C which also exhibited a lack of knowledge;

(c) Respondent failed to provide an adequate and clear pre-operative description of patient C's breasts including, but not limited to, failing to appropriately document patient C's breast anatomy; describing a failed implant without further corroboration; inaccurately describing the right breast silicone implant as deflated; failing to document any evidence of an actual failed right breast silicone implant; and failing to document a contracture as a source of patient C's breast asymmetry; and

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(d) Respondent provided patient C with large implants that he knew were potentially detrimental to the well-being of patient C instead of declining to augment her breasts with the larger implants.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

52. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he exhibited incompetence and/or a lack of knowledge in his care and treatment of patients A, B, and C, as more particularly alleged in paragraphs 9 through 51, above, which are incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

53. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he has failed to maintain adequate and accurate records in his care and treatment of patient A, B, and C, as more particularly alleged in paragraphs 9 through 51, above, which are incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

54. Respondent is further subject to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 9 through 53, above, which are incorporated by reference and realleged as if fully set forth herein.

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FIRST CAUSE TO REVOKE PROBATION

(Failure to Obey All Laws)

55. In a prior disciplinary action entitled *In the Matter of the Accusation Against Mark Anthony Knight, M.D.* before the Medical Board of California, in Case Number 06-2008-190093, Respondent surrendered his medical license effective December 15, 2010, while an Accusation was pending against him for sexual abuse, sexual misconduct and/or sexual relations with patients B.D. and A.D.; gross negligence in the care and treatment of patients B.D. and A.D.; and dishonest or corrupt acts with patients B.D. and A.D. Respondent subsequently sought reinstatement of his license through a Petition for Reinstatement which was granted on February 6, 2015, with an effective date of March 6, 2015. As a result of the Petition for Reinstatement being granted, Respondent's license was reinstated and then immediately revoked, with said revocation stayed, and Respondent placed on probation for a period of five years from the effective date of March 6, 2015, under various terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

56. At all times after the effective date of respondent's probation in Case No. 800-2014-002269, Condition No. 7 of Respondent's probation provided:

> "7. Obey All Laws [¶] [Respondent] shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders."

57. Respondent's probation in Case No. 800-2014-002269 is subject to revocation because he failed to comply with Probation Condition 7, referenced above, in that he has violated rules governing the practice of medicine, as more particularly alleged in paragraphs 9 through 53, above, which are incorporated by reference and realleged as if fully set forth herein.

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SECOND CAUSE TO REVOKE PROBATION

(Violation of Probation)

58. At all times after the effective date of respondent's probation in Case No. 800-2014-002269, Condition No. 13 of Respondent's probation provided:

"13. Violation of Probation [¶] Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final."

59. Respondent's probation in Case No. 800-2014-002269 is subject to revocation because he failed to comply with Probation Condition 13, referenced above, in that he failed to fulfill condition(s) of probation, as alleged in paragraphs 9 through 57, above, which are incorporated by reference as if fully set forth herein.

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 the probation that was imposed by the Medical Board of California in Case No. 800-2014-002269, effective March 6, 2015, and imposing the disciplinary order that was stayed, thereby revoking Physician's and Surgeon's Certificate Number A78828, issued to Respondent Mark Anthony Knight, M.D.

2. Revoking or suspending Physician's and Surgeon's Certificate Number A78828, issued to Respondent Mark Anthony Knight, M.D.;

3. Revoking, suspending or denying approval of Respondent Mark Anthony Knight, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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4. Ordering Respondent Mark Anthony Knight, 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: OCT 28 2020

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

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