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

In the Matter of the Accusation Against: Yakdan Taha Ahmed Al Qaisi, M.D. Physician's and Surgeon's Certificate No. A 88720 Respondent.	Case No.: 800-2018-041010

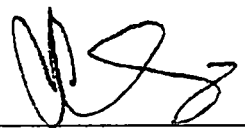
DECISION

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 September 30, 2021.

IT IS SO ORDERED: August 31, 2021.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: YAKDAN TAHA AHMED AL QAISI, M.D. 4040 San Dimas Street, Suite A Bakersfield, CA 93301 Physician's and Surgeon's Certificate No. A 88720, Respondent.	Case No. 800-2018-041010 OAH No. 2021030178 **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 Rob Bonta, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Yakdan Taha Ahmed Al Qaisi, M.D. (Respondent) is represented in this proceeding by attorney Dennis R. Thelen, whose address is 5001 East Commerce Center Drive, Suite 300 Bakersfield, California 93309-1687.

3. On or about September 1, 2004, the Board issued Physician's and Surgeon's Certificate No. A 88720 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-041010, and will expire on March 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-041010 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 1, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-041010 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-041010. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. 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; 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.

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-041010, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2018-041010, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 88720 to disciplinary action.

12. 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

13. 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.

14. 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 Accusation No. 800-2018-041010 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.

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15. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 88720 issued to Respondent YAKDAN TAHA AHMED AL QAISI, 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:

1. EDUCATION COURSE. Within sixty (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 forty (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 sixty (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 fifteen (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. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 fifteen (15) calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within sixty (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 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.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, 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 not resume the practice of medicine until

enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. MONITORING - PRACTICE. Within thirty (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 fifteen (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 sixty (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 sixty (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 ten (10) calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five (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 fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor within sixty (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.

6. 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.

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If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within sixty (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 not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, 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. Respondent shall not resume practice until an appropriate practice setting is established.

7. PROHIBITED PRACTICE. During probation, Respondent is prohibited from practicing as an anesthesiologist, including but not limited to performing conscious sedation and administering general anesthesia. In addition, Respondent is prohibited from participating in any surgical procedures in any operative or office setting, including but not limited to cosmetic surgeries.

Following the successful completion of the Clinical Competency Assessment Program with written approval by the Clinical Competency Assessment Program to the Board, the following specific modifications to the above outlined prohibited practice will be permitted: (1) Respondent will be permitted to perform suture repair on routine lacerations and perform simple skin biopsies and needle biopsies in his medical office utilizing local anesthesia only and (2) Respondent will be permitted to serve as an assistant surgeon during surgeries performed in hospital settings.

After the effective date of this Decision, all patients being treated by Respondent shall be notified that Respondent is prohibited from prohibited from practicing as an anesthesiologist, including but not limited to performing conscious sedation and administering general anesthesia, and that that Respondent is prohibited from participating in any surgical procedures in any

operative or office setting, including but not limited to cosmetic surgeries. Any new patients must be provided this notification at the time of their initial appointment.

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.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, 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.

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

10. 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.

11. 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.

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

12. 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 thirty (30) calendar days prior to the dates of departure and return.

13. 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.

14. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than 30 calendar days and within fifteen (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 forty (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 eighteen (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.

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

16. 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.

17. 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.

18. 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.

19. 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 Accusation No. 800-2019-054186 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, Dennis R. Thelen. 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: 7-5-21

YAKDAN TAHA AHMED AL QAISI, M.D.
Respondent

I have read and fully discussed with Respondent Yakdan Taha Ahmed Al Qaisi, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6-29-21

DENNIS R. THELEN
Attorney for Respondent

ENDORSEMENT

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

DATED: July 9, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-041010

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
State Bar No. 155307
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6453
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Yakdan Taha Ahmed Al Qaisi, M.D.** **4040 San Dimas St., Ste. A** **Bakersfield, CA 93301** **Physician's and Surgeon's Certificate No. A 88720,** Respondent.	Case No. 800-2018-041010 **ACCUSATION**

PARTIES

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

2. On or about September 1, 2004, the Medical Board issued Physician's and Surgeon's Certificate Number A 88720 to Yakdan Taha Ahmed Al Qaisi, 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 March 31, 2022, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

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.

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

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.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

7. Section 2216.2 of the Code states:

(a) It is unprofessional conduct for a physician and surgeon to fail to provide adequate security by liability insurance, or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed outside of a

general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(b) For purposes of this section, the board shall determine what constitutes adequate security.

(c) Nothing in this section shall require an insurer admitted to transact liability insurance in this state to provide coverage to a physician and surgeon.

(d) The security required by this section shall be acceptable only if provided by any one of the following:

(1) An insurer admitted pursuant to Section 700 of the Insurance Code to transact liability insurance in this state.

(2) An insurer that is eligible pursuant to Section 1765.1 of the Insurance Code.

(3) A cooperative corporation authorized by Section 1280.7 of the Insurance Code.

(4) An insurer licensed to transact liability insurance in at least one state of the United States.

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.

9. Health and Safety Code, section 1248 states:

For purposes of this chapter, the following definitions shall apply:

(a) "Division" means the Medical Board of California. All references in this chapter to the division, the Division of Licensing of the Medical Board of California, or the Division of Medical Quality shall be deemed to refer to the Medical Board of California pursuant to Section 2002 of the Business and Professions Code.

(b)(1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

(2) "Outpatient setting" also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55.

(3) "Outpatient setting" does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

(c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the board pursuant to Sections 1248.15 and 1248.4.

10. Health and Safety Code, section 1248.1 states:

No association, corporation, firm, partnership, or person shall operate, manage, conduct, or maintain an outpatient setting in this state, unless the setting is one of the following:

(a) An ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

(b) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 450 or 1601 of Title 25 of the United States Code, and located on land recognized as tribal land by the federal government.

(c) Any clinic directly conducted, maintained, or operated by the United States or by any of its departments, officers, or agencies.

(d) Any primary care clinic licensed under subdivision (a) and any surgical clinic licensed under subdivision (b) of Section 1204.

(e) Any health facility licensed as a general acute care hospital under Chapter 2 (commencing with Section 1250).

(f) Any outpatient setting to the extent that it is used by a dentist or physician and surgeon in compliance with Article 2.7 (commencing with Section 1646) or Article 2.8 (commencing with Section 1647) of Chapter 4 of Division 2 of the Business and Professions Code.

(g) An outpatient setting accredited by an accreditation agency approved by the division pursuant to this chapter.

(h) A setting, including, but not limited to, a mobile van, in which equipment is used to treat patients admitted to a facility described in subdivision (a), (d), or (e), and in which the procedures performed are staffed by the medical staff of, or other healthcare practitioners with clinical privileges at, the facility and are subject to the peer review process of the facility but which setting is not a part of a facility described in subdivision (a), (d), or (e).

Nothing in this section shall relieve an association, corporation, firm, partnership, or person from complying with all other provisions of law that are otherwise applicable.

REGULATIONS

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

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

(b) The following standards apply to any liposuction procedure not required by subsection (a) to be performed in a general acute-care hospital or a setting specified in

and Safety Code Section 1248.1:

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

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

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

(A) Pulse oximeter

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

(C) Fluid Loss and replacement monitoring and recording

(D) Electrocardiogram

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

(5) Discharge and Postoperative-care Standards

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

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

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in the care and treatment of Patient 1.[1] The circumstances are as follows:

13. Respondent and his wife, Dr. S.A., own a clinic named Advanced Healthcare of Bakersfield, Inc./Bella Wellness & Aesthetics/Bella Health and Beauty ("Advanced Healthcare"). In 2016, Respondent maintained a medical-surgical practice with the majority of his time spent specializing in the practice of surgery. Respondent also provided anesthesia services to his patients, including general anesthesia.

14. Respondent has never had staff privileges to practice as a surgeon or anesthesiologist in any hospital or licensed surgery center in California.

15. On or about March 23, 2016, Patient 1, a 43-year-old female, sought consultation from Respondent and Dr. S.A. at Advanced Healthcare for a tumescent liposuction, tummy tuck and fat transfer to the buttocks. Respondent and Dr. S.A. explained the procedures to Patient 1, including the risks and benefits of the three procedures. Respondent claims that he advised Patient 1 that fat embolism was also discussed as a risk of the procedures, but that it was not documented.

16. Patient 1 was scheduled for elective cosmetic surgery to occur on April 13, 2016. Pre-operative laboratory studies were ordered; a pre-operative evaluation was scheduled for April 7, 2016; prescriptions were given for pre-operative Valium, post-operative antibiotics and pain analgesia (Norco); Patient 1 was instructed to start taking Vitamin K on April 1, 2016, to assist in intraoperative and post-operative bleeding; and she was given an information booklet.

17. On or about April 7, 2016, Patient 1 returned to Advanced Healthcare. A pre-operative evaluation was conducted by Respondent and Dr. S.A. The history does not include Patient 1's prior abdominal hysterectomy and salpingectomy. The physical examination does not

[1] The patient is identified herein by number to protect her privacy.

include Patient 1's vital signs, her history of medication-controlled hypertension, history of diet controlled pre-diabetes and mild obesity.

18. Patient 1 signed an "Informed Consent to Surgery" form on April 13, 2016. The consent form is interlineated and indicates that the surgeries will be performed at the office of Advanced Healthcare. It also states that an anesthesiologist will be present and identifies Dr. S.A. and Respondent as the practitioners performing the procedures.

19. The consent form was also provided to (and signed by) Patient 1 in Spanish. It interlineated throughout the document that Patient 1 was fluent in English. Notwithstanding, Respondent has also testified that a Spanish interpreter was used when speaking with Patient 1.

20. On or about April 13, 2016, Respondent and Dr. S.A. performed surgery on Patient 1. Dr. S.A. served as primary surgeon and Respondent was the anesthesiologist. During the tummy tuck procedure, Respondent was the assistant surgeon and anesthesiologist.

21. In preparation for the liposuction procedure, tumescent fluid was infiltrated into Patient 1 between approximately 9:30 a.m. and 10:45 a.m. The liposuction procedure began at approximately 11:00 a.m. and ended at 1:00 p.m. The liposuction procedure was conducted under conscious sedation using Morphine, Versed, Zofran and propofol. Following the conclusion of the liposuction procedure, a break was taken. Anesthesia for the abdominoplasty (tummy tuck) began at approximately 1:50 p.m. with intubation of Patient 1. She was also given isoflurane, a general anesthetic. The surgery started at approximately 2:00 p.m. and ended at approximately 5:35 p.m., with anesthesia ending at 5:45 p.m. The buttock augmentation procedure did not take place because the other two surgeries took too long and Patient 1 was under anesthesia for a prolonged period.

22. The patient was monitored post-operatively, although only four sets of vital signs were taken during the 3 hours and forty-five minutes of monitoring, and fluid in-put and out-put was not closely assessed. Patient 1 was allowed to leave with her family via automobile at approximately 9:30 p.m., allegedly against medical advice, as Respondent recommended that a nurse accompany Patient 1 home, but her family refused. The conversations regarding the recommendation and refusal of the nurse were not documented in Patient 1's medical record.

23. At approximately 4:36 a.m. on or about April 14, 2016, Patient 1's family called 911 because Patient 1 was having difficulty breathing. Paramedics arrived to attend to Patient 1 at approximately 4:43 a.m. Patient 1 was unconscious and pulseless. CPR was rendered to her by Bakersfield Fire Department personnel and the ambulance paramedics with no response. Patient 1 was taken to Mercy Hospital Emergency Room where she was admitted for probable pulmonary embolus. Test and radiology studies ruled out pulmonary embolus, nevertheless, Patient 1 remained unconscious. Patient 1 was ultimately declared deceased by neurological criteria on April 15, 2016.

24. The Kern County Coroner's report noted the following significant findings at Patient 1's autopsy:

- Multi-organ congestion;
- Severe watery pulmonary edema;
- Recent lower abdominal surgical procedures and liposuction;
- Very soft brain with multifocal pinpoint and coalescing red-purple hemorrhages of the arachnoid, cortex, white matter, basal ganglia and pars consistent with fat embolism;
- No other significant natural disease or trauma on the body; and
- Toxicology is negative/non-contributory.

25. Cause of death was fat embolism due to abdominal surgical procedure and liposuction with adult respiratory distress syndrome contributing.

Lack of Accreditation

26. Pursuant to statutes and regulations, the standard of care requires an outpatient surgery clinic to be properly licensed and credentialed to provide surgical and anesthetic services. Patient 1 underwent general endotracheal anesthesia at Advanced Healthcare, an outpatient office, which was not credentialed as an outpatient surgery center. This is an extreme departure from the standard of care.

Insufficient Training to Provide General Anesthesia Services

27. The role of the anesthesiologist includes induction of general anesthesia, maintenance during the surgical procedure and successful recovery. A doctor gains the knowledge and ability

to perform these maneuvers during a residency in anesthesia. According to the Accreditation Council for Graduate Medical Education, a successful completion of residency in anesthesiology includes 36 months of education in clinical anesthesia.

28. Respondent only completed two years of an anesthesia residency.

29. Respondent's provision of general anesthesia services to Patient 1 without adequate training is an extreme departure from the standard of care.

Insufficient Intraoperative Monitoring of Vital Signs

30. Intraoperatively, the anesthesiologist must meticulously monitor the patient's vital signs, oxygenation and fluid status.

31. During Patient 1's surgeries, Respondent was the anesthesiologist. Respondent did not monitor and record her vital signs every fifteen minutes. He never took Patient 1's temperature.

32. Respondent did not provide and record meticulous monitoring and analysis of the patient's oxygenation, CO2 levels and fluid status, all which are critically necessary to safely identify complications and maintain full sedation.

33. Respondent's failure to properly monitor Patient 1's vital signs intraoperatively is an extreme departure from the standard of care.

34. Respondent's failure to take Patient 1's temperature intraoperatively is an extreme departure from the standard of care.

Insufficient Intraoperative Monitoring of Volume/Fluid Status

35. The standard of care requires that the anesthesiologist maintain an accurate assessment of volume status to allow for the proper replacement of blood loss and electrolytes during surgery. This is critical during long and bloody cases to ensure the patient is not under or over resuscitated with intravenous fluids.

36. Blood loss is typically an estimate, but objective measurements such as blood volume within suction canisters and sponge counts are generally used. During long procedures, intraoperative laboratory studies are conducted to ensure adequate volume resuscitation and

prevention of electrolyte abnormalities, which can lead to fatal arrhythmias, especially in cases with high blood loss.

37. Respondent administered three liters of fluid to Patient 1 during the liposuction procedure and nine liters of fluid during the abdominoplasty. Total fluid administered over the course of the day was recorded as fourteen liters.

38. Patient 1's preoperative laboratory studies from March 24, 2016, show that her hemoglobin was 13.2 and hematocrit was 39.0. When Patient 1 was taken to the emergency room on April 14, 2016, her hemoglobin was 8.0 and hematocrit was 26.6, which suggests either significant blood loss and/or fluid over-resuscitation. Although he had the ability to conduct an intraoperative hemoglobin analysis on Patient 1, Respondent did not do so.

39. Respondent's lack of accurate assessments of Patient 1's volume status and laboratories during a lengthy and bloody surgical procedure is an extreme departure from the standard of care.

Failure to Continuously Monitor Patient 1 While Administering General Anesthesia

40. The standard of care requires the anesthesiologist to not only meticulously monitor the patient's vital signs, oxygenation and fluid status, but to properly interpret and assess the information and have the ability to intervene when appropriate.

41. During Patient 1's abdominoplasty Respondent served as both anesthesiologist and assistant surgeon.

42. Respondent's failure to continuously monitor Patient 1 while he was administering general anesthesia to her is an extreme departure from the standard of care.

Unsafe Discharge

43. During the post-operative recovery period, the patient's vital signs and clinical status must be closely monitored to ensure that no perioperative complications exist which could jeopardize a safe discharge. If the patient is not sufficiently stable for discharge home, the patient should be kept until it is safe to discharge or the patient should be admitted to the hospital.

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44. Respondent recommended that Patient 1 be discharged home with nursing care and that Patient 1 be watched all night. However, Respondent allowed Patient 1 to go home with her sister, against medical advice.

45. Respondent discharged Patient 1 home despite his recommendation of a nurse to accompany her and without adequate discussions about an "against medical advice" discharge. Respondent also failed to document both discussions regarding the recommendation and the refusal of the home nursing care in the patient's medical record. This is an extreme departure from the standard of care.

Lack of Proper Documentation/Medical Records

46. The standard of care requires that medical encounters with patients have appropriate clinical documentation to ensure adequate quality of care and provide records for continuity of care. Poor, missing or fraudulent documentation constitutes a violation of the standard of care, especially during the provision of surgical and anesthetic services. Extremely accurate and appropriate records of patient's vital signs, ventilator settings, equipment and medications are critical to safe anesthetic induction and maintenance.

47. Respondent's medical records for Patient 1 demonstrate instances of poor, incomplete and missing medical records encountered in the preoperative, intraoperative and post-operative settings.

48. Respondent gave testimony under oath in connection with the care and treatment rendered to Patient 1. Respondent testified that he made "lots of [preoperative] assessments I did and lots of them I didn't chart." Respondent also stated that he advised Patient 1 on March 23, 2016, that fat embolism was a risk of the three procedures discussed, but that he did not document that risk. Additionally, Patient 1 signed consent forms in English and in Spanish. The consent written in Spanish is interlineated with comments written by Respondent which state that Patient 1 was fluent in English. Respondent also testified that a Spanish interpreter was used when explaining the surgical procedures to Patient 1. It is unclear from the documentation if Patient 1 understood English.

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49. Intraoperatively, during the administration of general anesthesia, there was no documentation of critical markers of the patient's status, including vital signs and volume loss, especially blood loss. Further, CO2, temperature, heating, and DVT prophylaxis, were not charted. Additionally, the administration of medications and fluids cannot clearly be discerned on the anesthesia record.

50. Post-operatively, Patient 1 was discharged in violation of California Code of Regulations, title 16, section 1356.6, subdivision (b)(5), in that Respondent failed to comply with post-operative and discharge standards and did not record an Aldrete or White Scale[2] for Patient 1. Patient 1's fluid volume (intake and output) was not closely monitored during the post-operative period. She was allowed to use the toilet and her urine output was estimated. There is no indication that her drains or dressings were checked for excessive bleeding. Patient 1's vital signs were only taken and documented four times during the post-operative period, in violation of the standard of care.

51. Respondent's maintenance of poor, incomplete and missing medical records for Patient 1 is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

52. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he was negligent in the care and treatment of Patient 1. The circumstances are as follows:

53. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

54. The standard of care requires an anesthesiologist to perform a proper preoperative assessment of anesthetic risks of the patient. A history and physical must be performed, laboratory test are conducted and reviewed and a risk assessment score is rendered using the American Society of Anesthesiologist (ASA) classification system to ensure safe induction and

[2] The Aldrete and White Scales are scoring systems which are commonly used to determine when an individual may be safely discharged from post-operative care.

maintenance of anesthesia. Intraoperatively, meticulous monitoring and analysis of the patient's vital signs, oxygenation and fluid status are critical and necessary to safely identify complications and maintain full sedation.

55. Respondent's preoperative assessment of Patient 1 was insufficient, incomplete and erroneous. Patient 1 had significant comorbidities (diet controlled pre-diabetes, mildly obese, history of medication controlled hypertension) which classify her as ASA II. Respondent classified Patient 1 as ASA I.

56. Respondent's insufficient and inaccurate preoperative anesthetic risk assessment of Patient 1 is a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

57. Intraoperatively, the anesthesiologist must meticulously monitor the patient's vital signs, oxygenation and fluid status. Temperature is a critical vital sign to monitor during general anesthesia because body temperature and thermoregulation is impaired. Fluctuations from normothermia may represent critical difficulties with metabolism of anesthetics, which can be fatal.

58. During Patient 1's surgeries, Respondent was the anesthesiologist. Respondent never took Patient 1's temperature. Further, under oath, Respondent stated that it was not necessary to always assess the patient's temperature during general anesthesia. Respondent also testified that assessment of the patient's core temperature is not taken if you "feel the patient is okay." This explanation is inconsistent with accepted standards of core temperature measurement.

59. The lack of intraoperative monitoring of a critical vital sign (temperature) in Patient 1 and Respondent's defense for his lack of intraoperative temperature monitoring represent a lack of knowledge.

FOURTH CAUSE FOR DISCIPLINE

(Performing Surgery and Administering Anesthesia in an Unaccredited Surgery Center)

60. The allegations of paragraphs 12 through 51, as set forth above, are incorporated herein by reference as if fully set forth.

61. Respondent violated the provisions of Health and Safety Code, section 1248.1, subdivision (g), insofar as he owned and operated an unaccredited outpatient surgery center, Advanced Healthcare Bakersfield, Inc. Respondent performed surgery on Patient 1 and provided general anesthesia to Patient 1, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes. Respondent also allowed and authorized surgery to be performed on Patient 1 in an unaccredited surgery center by him and Dr. SA.

FIFTH CAUSE FOR DISCIPLINE

(Violation of Liposuction Extraction and Postoperative Care Standards)

62. The allegations of paragraphs 12 through 51, as set forth above, are incorporated herein by reference as if fully set forth.

63. Respondent violated the provisions of California Code of Regulations, title 16, section 1356.6, subdivision (b)(2), because he is not a qualified licensed anesthesiologist.

64. Respondent also violated the provisions of California Code of Regulations, title 16, section 1356.6, subdivision (b)(2), because he left Patient 1 unmonitored by a licensed person certified in advanced cardiac life support and scrubbed in to surgery to provide care as the assistant surgeon.

65. Respondent violated the provisions of California Code of Regulations, title 16, section 1356.6, subdivision (b)(4), in that Respondent failed to keep records of Patient 1's surgeries that were in conformance with the standard of practice. The records were incomplete and did not include sufficient information to determine the quantities of drugs and fluids infused and the volume of fat, fluid and supernatant extracted and the nature and duration of all surgical procedures performed during the same session as the liposuction procedure. Although Respondent was the anesthesiologist during Patient 1's surgeries, he did not monitor and record her vital signs every fifteen minutes. He never took Patient 1's temperature. Respondent did not provide and record meticulous monitoring and analysis of the patient's oxygenation, CO2 levels and fluid status, all which are critically necessary to safely identify complications and maintain full sedation.

66. Respondent violated the provisions of California Code of Regulations, title 16, section 1356.6, subdivision (b)(5), in that Respondent failed to comply with post-operative and discharge standards. Respondent failed to properly monitor Patient 1's vital signs post-operatively. He only took her temperature once post-operatively and it was abnormal. There is no indication in the patient's medical record that steps were taken to rectify the patient's abnormal temperature and provide follow-up care. Patient 1 was discharged from Advanced Healthcare even though she did not meet the discharge criteria described in either the Aldrete Scale or the White Scale. At discharge, the patient's activity level was not noted, her vital signs were not taken or charted, and her oxygen saturation was not taken or documented.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Provide Adequate Security by Liability Insurance)

67. Respondent is subject to disciplinary action under section 2216.2 of the Code in that he failed to maintain adequate liability insurance coverage for performing cosmetic surgery at Advance Healthcare. The circumstances are as follows:

68. The allegations of paragraphs 12 through 51, as set forth above, are incorporated herein by reference as if fully set forth.

69. Respondent gave testimony under oath and produced documents in connection with the care and treatment rendered to Patient 1.

70. Respondent produced his liability insurance policy for himself and Dr. S.A. That insurance policy expressly excluded liability coverage for cosmetic procedures and liposuction.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

71. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for Patient 1. The circumstances are as follows:

72. The allegations of the First, Second, Third, Fourth, and Fifth Causes for Discipline as set forth above, are incorporated herein by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 88720, issued to Yakdan Taha Ahmed Al Qaisi, M.D.;

2. Revoking, suspending or denying approval of Yakdan Taha Ahmed Al Qaisi, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Yakdan Taha Ahmed Al Qaisi, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and,

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

DATED: FEB 01 2021

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

LA2021600194