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

In the Matter of the Accusation Against: Mohamad J. Yaghi, M.D. Physician's and Surgeon's Certificate No. A 54524 Respondent.	Case No. 800-2021-077290

DECISION

The attached Stipulated Surrender of License and 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 February 9, 2024.

IT IS SO ORDERED January 12, 2024.

MEDICAL BOARD OF CALIFORNIA

JENNA JONES FOR
Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
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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 Accusation Against: **MOHAMAD J. YAGHI, M.D.** **4301 S. Figueroa, Suite F** **Los Angeles, CA 90037-2671** **Physician's and Surgeon's Certificate No. A 54524** Respondent.	Case No. 800-2021-077290 OAH No. 2023080605 **STIPULATED SURRENDER OF LICENSE AND 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. Reji Varghese (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 Vladimir Shalkevich, Deputy Attorney General.

2. MOHAMAD J. YAGHI, M.D. (Respondent) is represented in this proceeding by attorney Nicholas Jurkowitz, whose address is: 1990 South Bundy Drive, Suite 777 Los Angeles, CA 90025.

3. On or about August 16, 1995, the Board issued Physician's and Surgeon's Certificate No. A 54524 to Respondent. That license was in full force and effect at all times relevant to the

charges brought in Accusation No. 800-2021-077290 and will expire on April 30, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-077290 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 or about May 16, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2021-077290 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2021-077290. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and 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; 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 that the charges and allegations in Accusation No. 800-2021-077290, 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 Accusation 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 Accusation and that those charges constitute cause for discipline.

Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

12. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. A 54524 without further notice to, or opportunity to be heard by, Respondent.

13. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the

Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

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

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 54524, issued to Respondent MOHAMAD J. YAGHI, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2021-077290 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $33,847.25 prior to issuance of a new or reinstated license.

6. 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 agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2021-077290 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 licensure.

7. 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 agency in the State of California, all of the charges and allegations contained in Accusation No. Medical Board of California 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 licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Nicholas Jurkowitz. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of

License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 1/4/2024

MOHAMAD J. YAGHI, M.D.
Respondent

I have read and fully discussed with Respondent MOHAMAD J. YAGHI, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 1-4-24

NICHOLAS JURKOWITZ
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 1/4/24

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2021-077290

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

In the Matter of the Accusation Against: **MOHAMAD J. YAGHI, M.D.** **4301 South Figueroa, Suite F** **Los Angeles, California 90037-2671** **Physician's and Surgeon's Certificate No. A 54524,** Respondent.	Case No. 800-2021-077290 **ACCUSATION**

PARTIES

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

2. On August 16, 1995, the Board issued Physician's and Surgeon's Certificate Number A 54524 to Mohamad J. Yaghi, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2025, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 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.

6. Section 2216 of the Code states:

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

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

7. Section 2216.1 of the Code states:

On or after July 1, 2000, it is unprofessional conduct for a physician and surgeon to perform procedures in any outpatient setting except in compliance with Section 2216, unless the setting has a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care.

8. Section 2240 of the Code states, in pertinent part:

(a) A physician and surgeon who performs a medical procedure outside of a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, shall report, in writing on a form prescribed by the board, that occurrence to the board within 15 days after the occurrence.

(b) A physician and surgeon who performs a scheduled medical procedure outside of a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, that results in the transfer to a hospital or emergency center for medical treatment for a period exceeding 24 hours, of any patient on whom that medical procedure was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, shall report, in writing, on a form prescribed by the board that occurrence, within 15 days after the occurrence. The form shall contain all the following information:

(1) Name of the patient's physician in the outpatient setting.
(2) Name of the physician with hospital privileges.
(3) Name of the patient and patient identifying information.
(4) Name of the hospital or emergency center where the patient was transferred.
(5) Type of outpatient procedure being performed.
(6) Events triggering the transfer.
(7) Duration of the hospital stay.
(8) Final disposition or status, if not released from the hospital, of the patient.
(9) Physician's practice specialty and ABMS certification, if applicable.

(c) The form described in subdivision (b) shall be constructed in a format to enable the physician and surgeon to transmit the information in paragraphs (5) to (9), inclusive, to the board in a manner that the physician and surgeon and the patient are anonymous and their identifying information is not transmitted to the board. The entire form containing information described in paragraphs (1) to (9), inclusive, shall be placed in the patient's medical record.

(d) The board shall aggregate the data and publish an annual report on the information collected pursuant to subdivisions (a) and (b).

(e) On and after January 1, 2002, the data required in subdivision (b) shall be sent to the Office of Statewide Health Planning and Development (OSHPD) instead of the board. OSHPD may revise the reporting requirements to fit state and national standards, as applicable. The board shall work with OSHPD in developing the reporting mechanism to satisfy the data collection requirements of this section.

(f) The failure to comply with this section constitutes unprofessional conduct.

9. 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.

10. California Code of Regulations, title 16, section § 1356.4, states:

The reporting of a patient death that is required by Section 2240(a) of the code shall include the following information:
(a) The patients' full name, address, date of birth, social security number, medical record number, and the physical location of the medical record.
(b) The full name, license number, practice specialty and the American Board of Medical Specialties certification or certification by a board-approved specialty board, if any, of the physician who performed the surgery.

(c) The date of the surgery: the name and address of the outpatient setting where the surgery was performed; and the circumstances of the patient's death.
(d) The full name of each entity which licenses, certifies or accredits the outpatient setting where the surgery was performed and the types of outpatient procedures performed at that setting.
(e) The name and address of the hospital or emergency center to which the patient was transferred or admitted.
(f) The date of the report and the full name of the person who completed the report.

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 Health and Safety Code Section 1248.1:

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

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

(3) Monitoring. The following monitoring shall be available for volumes greater than 150 and less than 2,000 cubic centimeters of total aspirate and shall be required for volumes between 2,000 and 5,000 cubic centimeters of total aspirate:
(A) Pulse oximeter
(B) Blood pressure (by manual or automatic means)
(C) Fluid loss and replacement monitoring and recording
(D) Electrocardiogram

(4) Records. Records shall be maintained in the manner necessary to meet the standard of practice and shall include sufficient information to determine the quantities of drugs and fluids infused and the volume of fat, fluid and supranatant

extracted and the nature and duration of any other surgical procedures performed during the same session as the liposuction procedure.

(5) Discharge and Postoperative-care Standards.

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

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

COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

13. Respondent is a pediatrician by training. He began offering aesthetic services in approximately 2009, initially offering sclerotherapy for unsightly veins and also laser removal of skin lesions and hair. In 2013, he began offering laser liposuction using local tumescent anesthesia. Respondent used intravenous anesthesia of midazolam[1] and narcotics, often also injecting flumazenil[2] as a rescue drug when patients became too sedated by the midazolam. In 2016, Respondent began offering breast augmentations. At all relevant times alleged herein,

[1] Midazolam is a Schedule 4 controlled substance also known as Versed. It is a benzodiazepine. Intravenous midazolam has been associated with respiratory depression and respiratory arrest, especially when used for sedation in noncritical care settings. In some cases, where this was not recognized promptly and treated effectively, death or hypoxic encephalopathy has resulted.

[2] Flumazenil is a benzodiazepine antagonist. The primary FDA-approved clinical uses for flumazenil include reversal agents for benzodiazepine overdose and postoperative sedation from benzodiazepine anesthetics. Flumazenil injection is indicated for a complete or partial reversal of the sedative effects of benzodiazepines in conscious sedation and general anesthesia in adult and pediatric populations.

Respondent had no hospital admitting privileges, had no liability insurance covering his cosmetic surgery practice, and the offices where he performed cosmetic surgery were not accredited by any accrediting agency recognized by the Board.

Patient 1[3]

14. During a separate Board investigation of another patient's death at Respondent's practice location, known as Clinica De Los Angeles Medical Group, a non-accredited office where Respondent performed outpatient surgeries, Board investigators discovered a police report that mentioned that the officer was familiar with that location because there were other calls for emergency services there. The Board investigators searched 911 emergency call records and obtained a report of an emergency 911 call that took place on June 12, 2018, when Patient 1 had an adverse event occur during a cosmetic surgery at Clinica De Los Angeles. Patient 1 was transported to the hospital by paramedics. Respondent did not report Patient 1's hospital transfer to the Board as required by Code section 2240. The Board discovered Patient 1's emergency hospital transfer on March 16, 2021, and initiated an investigation of the incident.

15. Patient 1 had been Respondent's patient for many years. She had originally sought care for fertility issues almost ten years prior to the June 12, 2018 incident. Respondent and his staff had helped her to successfully bear two children. Respondent's practice location was initially a family medicine clinic, and his emphasis was on pediatrics. The clinic also had obstetrical staff that provided prenatal care. Starting in or about 2009, Respondent added cosmetic surgery to the services he provided at Clinica De Los Angeles.

16. Patient 1 was a 37-year-old woman at the time of her emergency hospitalization, had previously undergone laser liposuction of her torso and fat transfer to her buttocks by Respondent, on or about July 11, 2017. Laser liposuction involves the use of laser heat to "melt" the fat, thus disrupting fat cells and making them non-viable. Reinjecting such laser-treated fat would not result in graft survival and thus would put the patient at risk for oil cyst formation and

[3] Patients in this Accusation are designated by a number to protect their privacy. Respondent is aware of the identity of the patients. Their identifying information shall also be disclosed to Respondent upon a written Request for Discovery.

not produce the desired result. Respondent failed to document the amount of fat solute injected into Patient 1's buttocks during that procedure.

17. Patient 1 returned to see Respondent in approximately May, 2018, to consult regarding breast augmentation and revision of her prior liposuction. She was unhappy with her contours and some residual fat. Respondent planned a trans umbilical breast augmentation with saline implants and additional liposuction to her abdomen and back.

18. Prior to Patient 1's surgery on June 12, 2018, Respondent prescribed her alprazolam[4] (Xanax) 2mg #3 with the instruction "Toma una tableta antes de la sirugia" (take one tablet prior to surgery). Respondent documented in his record "took Xanax 1mg (po) at 11:30am". However, the patient must have taken at least 2mg since that is what she was prescribed. No record exists to explain what happened to the other two tablets of Xanax that Respondent prescribed. Respondent did not document any reason why he prescribed to Patient 1 more tablets of Xanax than were necessary for this procedure.

19. Patient 1 arrived for surgery on June 12, 2018. On this day, she signed her consent document which had no procedure listed for her to consent to. The document listing her choice of implant sizing is also blank. Her pre-operative photographs demonstrate a contour irregularity with excess fat above the umbilicus and a depression in the lower mid-abdomen.

20. In order to meet the standard of care, a document listing the risks of a surgical procedure should provide an accurate accounting of the risks so as to assist with informed consent. Patient 1 was asked to sign "The Breast Implant Risk" document which contained many syntax and spelling errors. It also contained factual inaccuracies. Implant "Pipping" is listed as a risk, when it should be "Rippling". Striae (that is, linear marks, ridges or grooves) occurring post-implant to the breast skin is described as "Stride". The document states "Textured implants...stay soft and (do) not allow capsule formation" which is inaccurate. "Frequent massage and positioning of the implant after surgery can decrease" capsular contracture, is also not accurate. "The body may recognize the implant as a foreign object and try to reject it" is not

[4] Alprazolam, known also as Xanax, is a benzodiazepine and a Schedule IV controlled substance. It is used to treat anxiety and panic disorders.

accurate. "The most common cause of rupture is injury" is not true. The statement, "Although there are many risks that are known that can be described, most risks are still unknown," also is not true. "It is estimated that a noticeable loss of saline will occur in as many as 50% or more persons who have saline implants for seven or more years" is not true. "The presence of breast implants of any kind interferes with mammography and early detection of breast cancer" is not true.

21. Patient 1 was given lorazepam[5] orally on arrival. She was prepped for surgery and an intravenous line was inserted by Respondent. She was given midazolam 5mg intravenously. Incisions were created in the umbilicus, bilateral lower groin, bilateral upper buttock, and left upper back. After being turned onto her side to inject the back, Patient 1 began seizing. She was returned to the supine position, and flumazenil was given. Her seizure stopped, and Respondent began the laser liposuction of the lower abdomen. However, within 5 minutes, Patient 1 resumed seizing, so Respondent stopped the procedure, and asked his staff to call 911.

22. It is the standard of care to avoid lidocaine toxicity. Any physician using local anesthesia should know and recognize the symptoms of lidocaine toxicity. Respondent calculates the amount of lidocaine that can be utilized during his liposuction procedures using the 55mg/kg maximum dosage recommendation. During the June 12, 2018, surgery he documented that he injected 800 ml of tumescent fluid into the abdomen containing lidocaine 1mg/ml. He also documented that he injected 600 ml of tumescent fluid into the breasts, containing lidocaine 1.5ml/ml. He documented the total lidocaine he injected at 1700 mg, which is 27.1mg/kg. This should be within a safe level. However, Patient 1 immediately showed signs of lidocaine toxicity (twitching, disorientation). Respondent administered a benzodiazepine reversing agent, flumazenil. Respondent documented that Patient 1 stopped twitching for a short time, but then began having grand mal seizures.

[5] Lorazepam, also known as Ativan, is a Schedule IV controlled substance and a benzodiazepine generally used as a sedative and an anxiolytic in surgical settings. It is also used to treat insomnia.

23. Patient 1 continued seizing during her transport to the hospital, and was given midazolam 5gm intravenously three times by paramedics. On arrival at LA County/USC Medical Center, she was intubated, sedated, and placed in the neurologic intensive care unit. Her daughter reported to Patient 1's emergency room physicians that Patient 1 had no prior history of seizures.

24. After Patient 1 was rushed to the hospital, her blood level of lidocaine was measured and reported at 2:15 p.m. at LA County/USC, and it was more than 24 mg/liter, a toxic level. This was verified by repeat analysis.

25. Patient 1 received this lidocaine during her surgery, either because the lidocaine concentration of the tumescent was higher than calculated, the amount of tumescent solution given to her by Respondent was greater than documented, or the tumescent fluid was inadvertently injected intravenously.

26. Since her electrocardiogram was normal (no widened QRS noted), no intravenous lipid emulsion was given. Patient 1 was started on levetiracetam 1000mg twice daily, an anti-seizure medication, and was told to continue that for at least one month. She was discharged from LA County/USC two days later. She returned to Respondent's office that day. She was noted to have some swelling and Respondent injected her with dexamethasone[6] 10 mg intramuscularly. He instructed her to continue her medications as prescribed at LA County/USC. He asked Patient 1 to bring the list of the medications prescribed, and he noted he will obtain her hospital records, but he never did. Respondent did not report Patient 1's hospital transfer to the Board.

27. Patient 1 saw Respondent again on June 19, 2018, and he noted that Patient 1 doesn't know the "name of medication currently taking (all requested to be documented in pt. chart)". The only document from LA County/USC in the chart is the "Discharge Instructions" that lists the discharge diagnosis as "other intractable generalized seizure with status epilepticus".

28. Patient 1 returned to have her surgery with Respondent on August 23, 2018. Apparently, Respondent believed her seizure was due to the benzodiazepines, as he performed the procedure with tumescent local anesthesia only. His pre-operative note states that Patient 1 is

[6] Dexamethasone is a corticosteroid used to relieve inflammation, swelling, redness or pain.

"taking anti-sz meds but does not know name". He proceeded with surgery despite this lack of information.

29. Patient 1 had a fourth procedure on or about June 4, 2019, at which time Respondent performed additional liposuction. The operative note for that procedure describes a "tiny adiposity" but also documents that "2800 ml fibrous aspirate removed" after injecting 1600 ml of tumescent local anesthetic. The pre-operative note for this procedure describes an "adverse reaction to Versed during surgery 1 y ago".

30. A fifth procedure was performed on or about December 8, 2020, with liposuction of the back and bra line. Patient 1 was given no medication intravenously. Tumescent fluid 300ml was injected, and 400ml of aspirate was removed.

31. During the investigation of this matter, Respondent provided the Board with his Advanced Cardiac Life Support (ACLS) certificates. Respondent's ACLS certification was expired when he operated on Patient 1 on June 12, 2018, and December 8, 2020.

Patient 2

32. Patient 2 was a 28-year-old mother of four children who consulted with Respondent regarding liposuction of her torso and fat transfer into her buttocks. A friend of hers who had undergone surgery with Respondent recommended him, so Patient 2 and her boyfriend traveled from Las Vegas on or about September 24, 2020, for the consultation with Respondent. Patient 2 was diabetic, on metformin[7] 500mg twice daily. She used no contraceptive medication. She signed a consent for liposuction of the abdomen, flanks, and arms, as well as fat graft to her buttocks.

33. Patient 2 provided laboratory results from September 1, 2020, to Respondent. Her blood glucose was 192, and her HgbA1c was 8.6, indicating poor control of her diabetes. Her white blood count was slightly elevated at 10.8. Despite these results, which showed that Patient 2's diabetes was poorly controlled, Respondent decided to proceed with surgery.

34. On October 12, 2020, Patient 2 arrived for surgery, accompanied by her boyfriend. Respondent documented on the Pre-operative Form that the patient "ate before coming today".

[7] Metformin is a medication to treat type 2 diabetes.

There is also a "sticky note" attached to this page that says "last ate yesterday dinner Had liquids. 3 hours ago BS this AM 160mg/dl". The two records about Patient 2's NPO (nothing by mouth) status are not consistent, and both cannot be accurate. Patient 2 did not have a urine pregnancy test performed, and her last menstrual period was noted as October 5, 2020. Her weight was 138 pounds (62.7kg). The maximal amount of lidocaine that could be infused in the tumescent solution was calculated to be 3450mg. The tumescent fluid used contained 1000mg lidocaine/liter. An intravenous line was started by Respondent, and he documented that he injected a 5 mg bolus of midazolam through the IV.

35. He then created skin incisions and through these incisions the tumescent fluid was infused. Respondent documented that 2300ml was infused between 8:35 a.m. and 8:55 a.m. The liposuction procedure was begun. Patient 2 immediately felt dizzy and was disoriented. Respondent had his assistant inject flumazenil 0.2 mg at around 9:00 a.m. Patient 2 began "twitching" and was still over sedated, so a second injection of flumazenil 0.1 mg was given. Patient 2 began seizing, and Respondent ordered naloxone[8]. At 9:12 a.m., 911 was called. Respondent wrote that the patient had "good breathing and a good pulse".

36. The last vitals recorded by clinic staff are timed at 9:19 a.m. and show a blood pressure of 135/90, pulse 128, and oxygen saturation 96%. The standard forms used by Respondent for his surgical patients includes a form titled "End of the Procedure". All of the boxes on this page were "checked" even though the procedure was never completed. This document is inaccurate and misleading, because it indicates that the documentation check-list intended to be completed at the end of the procedure was completed prior to the beginning of the procedure.

37. Emergency responders arrived at 9:17 a.m. and found Patient 2 apneic (not breathing) with vomit on her face and chest. They applied oxygen via a bag valve mask. Patient 2 suffered a cardiac arrest at 9:22 a.m. CPR was instituted and an advanced airway was inserted at 9:24 a.m. Resuscitation returned Patient 2 to sinus rhythm, and she was transported to the Emergency Room

[8] Naloxone is an opioid antagonist medication designed to rapidly reverse opioid overdose. Respondent did not document administering any opioids to Patient 2.

at Good Samaritan Hospital, arriving at 9:54 a.m. She was admitted to the Intensive Care Unit on a hypothermia protocol in an effort to ameliorate her anoxic brain injury, but she did not recover.

38. Patient 2 was declared brain dead on October 19, 2020. Her family donated her organs on October 28, 2020. An autopsy performed by the Los Angeles County Medical Examiner's Office lists the cause of death as anoxic encephalopathy due to cardiopulmonary arrest. Respondent did not report the hospital transfer or the death of Patient 2 to the Board.

39. Patient 2's boyfriend and father of her last child filed a civil malpractice lawsuit on behalf of two of Patient 2's children on December 22, 2021. On April 21, 2021, Respondent wrote a refund check to Patient 2 for $6,500.00.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Gross Negligence)

40. Respondent Mohamad J. Yaghi, M.D. 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 two patients. The circumstances are as follows:

41. The allegations of paragraphs 13 through 39 are incorporated herein by reference. Each of the following represents and extreme departure from the standard of care and an instance of gross negligence:

A) Respondent infused Patient 1 with a toxic level of lidocaine during her liposuction surgery on June 12, 2018. This represents an extreme departure from the standard of care.

B) Respondent administered intravenous sedation that risked loss of Patient 1's life preserving reflexes at an unaccredited facility on June 12, 2018. This represents an extreme departure from the standard of care.

C) Respondent introduced a 5 mg bolus of midazolam intravenously to sedate Patient 1 during her surgery on June 12, 2018. This represents an extreme departure from the standard of care.

D) Respondent performed outpatient surgery on Patient 1 on June 12, 2018 and December 8, 2020, without at the time having a valid ACLS certification. Each

instance represents unprofessional conduct in violation of section 2216.1 and an extreme departure from the standard of care.

E) Respondent's failure to obtain and review emergency hospitalization records of Patient 1 and performing subsequent surgeries while unaware of the cause of Patient 1's seizure during the June 12, 2018, surgery was an extreme departure from the standard of care.

F) Respondent did not inquire, never found out, and never documented what anti-seizure medication Patient 1 was taking following a serious complication during her June 12, 2018 surgery. Respondent performed subsequent surgeries without knowing what anti-seizure medications Patient 1 was taking, which represents an extreme departure from the standard of care.

G) Respondent's failure to notify the Board of Patient 1's hospital transfer as required by section 2240, was unprofessional conduct pursuant to section 2240, subdivision (f) and an extreme departure from the standard of care.

H) Respondent's failure to provide Patient 1 with adequate security by liability insurance as required by section 2216.2, is unprofessional conduct and an extreme departure from the standard of care.

I) Providing a risk document with inaccurate information to Patient 1 represents an extreme departure from the standard of care.

J) Respondent's disregard for patient safety in proceeding with an elective surgical procedure upon an uncontrolled diabetic (Patient 2) represents an extreme departure from the standard of care.

K) Respondent administered intravenous sedation that risked loss of Patient 2's life preserving reflexes at an unaccredited facility on October 12, 2020. This represents an extreme departure from the standard of care.

L) Respondent introduced a 5 mg bolus of midazolam intravenously to sedate Patient 2 during her surgery on October 12, 2020. This represents an extreme departure from the standard of care.

M) Respondent performed outpatient surgery on Patient 2 on October 12, 2020, without at the time having a valid ACLS certification. This represents unprofessional conduct in violation of section 2216.1 and an extreme departure from the standard of care.

N) Respondent's decision to perform elective surgery that involved intravenous sedation on Patient 2 on October 12, 2020, when he knew or should have known that she had recently eaten and/or drank (non-NPO status) was an extreme departure from the standard of care.

O) Respondent's failure to provide Patient 2 with security by liability insurance, as required by section 2216.2, is unprofessional conduct and an extreme departure from the standard of care.

P) Respondent's failure to notify the Board of Patient 2's death, as required by Business and Professions Code section 2240 is unprofessional conduct and an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Repeated Negligent Acts)

42. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he committed repeated negligent acts in the care and treatment of two patients. The circumstances are as follows:

43. The allegations of Paragraphs 13 through 41 are incorporated herein by reference.

44. In addition to the allegations in Paragraph 41, Respondent departed from the standard of care as follows:

A) Respondent's failure to administer a pregnancy test to Patient 1 prior to each of her five surgeries represents five separate and distinct departures from the standard of care.

B) Respondent's failure to administer a pregnancy test to Patient 2 prior to her surgery on October 12, 2020 was a departure from the standard of care.

C) Respondent's inaccurate documentation of medication given to Patient 1 prior to her surgery on June 12, 2018 represents a departure from the standard of care.

D) Respondent's informed consent form for Patient 1's procedure on June 12, 2018 has no procedure listed and does not document the size of planned breast implants, and as such represents a departure from the standard of care.

E) Respondent's completion of the "end of procedure" checklist for Patient 2 before the surgery was performed represents a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

45. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section 2234, subdivision (d) of the Code in that he demonstrated a lack of knowledge or ability in his care of Patient 1. The circumstances are as follows:

46. The allegations of Paragraphs 13 through 31 and Paragraph 44 are incorporated herein by reference.

A) Respondent's failure to recognize Patient 1's symptoms as due to lidocaine toxicity represents a lack of knowledge or ability.

B) Respondent's transferring of laser-treated fat into the buttocks of Patient 1 during the surgery on July 11, 2017 represents a lack of knowledge or ability.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Report Patient Death or Transfer)

47. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section 2240 of the Code in that he did not report the death or transfer of two patients to the Board as required by that statute. The circumstances are as follows:

48. The allegations of Paragraphs 13 through 39 are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Illegal Liposuction)

49. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under sections 2216 and 2216.1 in his care and treatment of two patients in an unaccredited outpatient setting

while administering intravenous sedation that could possibly interfere with patients' life preserving reflexes and with no valid ACLS certification. The circumstances are as follows:

50. The allegations of Paragraphs 13 through 39 are incorporated herein by reference.

SIXTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Record Keeping)

51. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section 2266 in that Respondent failed to keep accurate and adequate records of his care and treatment of two patients. The circumstances are as follows:

52. The allegations of Paragraphs 13 through 39 are incorporated herein by reference.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Provide Security)

53. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section 2216.2 in that Respondent failed to have adequate security by liability insurance or by participation in an interindemnity trust for claims by patients arising out of outpatient cosmetic surgical procedures, when he operated on two patients. The circumstances are as follows:

54. The allegations of Paragraphs 13 through 39 are incorporated herein by reference.

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 54524, issued to Mohamad J. Yaghi, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

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3. Ordering him to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: MAY 16 2023

REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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