

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

1 ROB BONTA  
Attorney General of California  
2 ROBERT MCKIM BELL  
Supervising Deputy Attorney General  
3 VLADIMIR SHALKEVICH  
Deputy Attorney General  
4 State Bar No. 173955  
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*Attorneys for Complainant*  
7

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

12 In the Matter of the Accusation Against:

Case No. 800-2021-077290

13 **MOHAMAD J. YAGHI, M.D.**  
4301 S. Figueroa, Suite F  
Los Angeles, CA 90037-2671

OAH No. 2023080605

14 **STIPULATED SURRENDER OF**  
15 **LICENSE AND ORDER**

16 **Physician's and Surgeon's Certificate No. A**  
**54524**

Respondent.

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

19 **PARTIES**

20 1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of  
21 California (Board). He brought this action solely in his official capacity and is represented in this  
22 matter by Rob Bonta, Attorney General of the State of California, by Vladimir Shalkevich,  
23 Deputy Attorney General.

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

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

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

3 **JURISDICTION**

4 4. Accusation No. 800-2021-077290 was filed before the Board, and is currently  
5 pending against Respondent. The Accusation and all other statutorily required documents were  
6 properly served on Respondent on or about May 16, 2023. Respondent timely filed his Notice of  
7 Defense contesting the Accusation. A copy of Accusation No. 800-2021-077290 is attached as  
8 Exhibit A and incorporated by reference.

9 **ADVISEMENT AND WAIVERS**

10 5. Respondent has carefully read, fully discussed with counsel, and understands the  
11 charges and allegations in Accusation No. 800-2021-077290. Respondent also has carefully read,  
12 fully discussed with counsel, and understands the effects of this Stipulated Surrender of License  
13 and Order.

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

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

22 **CULPABILITY**

23 8. Respondent understands that the charges and allegations in Accusation No. 800-2021-  
24 077290, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and  
25 Surgeon's Certificate.

26 9. For the purpose of resolving the Accusation without the expense and uncertainty of  
27 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual  
28 basis for the charges in the Accusation and that those charges constitute cause for discipline.

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

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

6 CONTINGENCY

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

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

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

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

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

12 **ADDITIONAL PROVISIONS**

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

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

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

22 **ORDER**

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

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

- 1           2.    Respondent shall lose all rights and privileges as a Physician and Surgeon in  
2 California as of the effective date of the Board's Decision and Order.
- 3           3.    Respondent shall cause to be delivered to the Board his pocket license and, if one was  
4 issued, his wall certificate on or before the effective date of the Decision and Order.
- 5           4.    If Respondent ever files an application for licensure or a petition for reinstatement in  
6 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must  
7 comply with all the laws, regulations and procedures for reinstatement of a revoked or  
8 surrendered license in effect at the time the petition is filed, and all of the charges and allegations  
9 contained in Accusation No. 800-2021-077290 shall be deemed to be true, correct and admitted  
10 by Respondent when the Board determines whether to grant or deny the petition.
- 11          5.    Respondent shall pay the agency its costs of investigation and enforcement in the  
12 amount of \$33,847.25 prior to issuance of a new or reinstated license.
- 13          6.    If Respondent should ever apply or reapply for a new license or certification, or  
14 petition for reinstatement of a license, by any other health care licensing agency in the State of  
15 California, all of the charges and allegations contained in Accusation No. 800-2021-077290 shall  
16 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of  
17 Issues or any other proceeding seeking to deny or restrict licensure.
- 18          7.    If Respondent should ever apply or reapply for a new license or certification, or  
19 petition for reinstatement of a license, by any other health care licensing agency in the State of  
20 California, all of the charges and allegations contained in Accusation No. Medical Board of  
21 California shall be deemed to be true, correct, and admitted by Respondent for the purpose of any  
22 Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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25  
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**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

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


3  
4 DATED: 1/4/2024   
5 MOHAMAD J. YAGHI, M.D.  
6 *Respondent*

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

10 DATED: 1-4-24   
11 NICHOLAS JURKOWITZ  
12 *Attorney for Respondent*

13 **ENDORSEMENT**

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

16 DATED: 1/4/24 Respectfully submitted,  
17  
18 ROB BONTA  
19 Attorney General of California  
20 ROBERT MCKIM BELL  
21 Supervising Deputy Attorney General  
22   
23 VLADIMIR SHALKEVICH  
24 Deputy Attorney General  
25 *Attorneys for Complainant*

**Exhibit A**

**Accusation No. 800-2021-077290**



1 ROB BONTA  
Attorney General of California  
2 ROBERT MCKIM BELL  
Supervising Deputy Attorney General  
3 VLADIMIR SHALKEVICH  
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12 In the Matter of the Accusation Against:

Case No. 800-2021-077290

13 **MOHAMAD J. YAGHI, M.D.**  
4301 South Figueroa, Suite F  
14 Los Angeles, California 90037-2671

**A C C U S A T I O N**

15 **Physician's and Surgeon's Certificate**  
16 **No. A 54524,**

Respondent.  
17

18  
19 **PARTIES**

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

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

26 ///

27 ///

28 ///

1 JURISDICTION

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

5 4. Section 2227 of the Code states:

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

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

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

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

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

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

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

27 5. Section 2234 of the Code, states:

28 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

1 appropriate for that negligent diagnosis of the patient shall constitute a single  
negligent act.

2 (2) When the standard of care requires a change in the diagnosis, act, or  
3 omission that constitutes the negligent act described in paragraph (1), including, but  
4 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.

5 (d) Incompetence.

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

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

9 (g) The failure by a certificate holder, in the absence of good cause, to attend  
10 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.

11 6. Section 2216 of the Code states:

12 On or after July 1, 1996, no physician and surgeon shall perform procedures in  
13 an outpatient setting using anesthesia, except local anesthesia or peripheral nerve  
14 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  
15 patient's life-preserving protective reflexes, unless the setting is specified in [Health  
and Safety Code] Section 1248.1. Outpatient settings where anxiolytics and  
16 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.

17 The definition of outpatient settings contained in subdivision (c) of Section  
18 1248 [of the Health and Safety Code] shall apply to this section.

19 7. Section 2216.1 of the Code states:

20 On or after July 1, 2000, it is unprofessional conduct for a physician and  
21 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,  
22 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  
23 long as a patient is present who has not been discharged from supervised care.

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

25 (a) A physician and surgeon who performs a medical procedure outside of a  
26 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  
27 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  
28 prescribed by the board, that occurrence to the board within 15 days after the  
occurrence.

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

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

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

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

26 (e) On and after January 1, 2002, the data required in subdivision (b) shall be  
27 sent to the Office of Statewide Health Planning and Development (OSHPD) instead  
28 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.

1 (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.

2 (d) The full name of each entity which licenses, certifies or accredits the outpatient setting  
3 where the surgery was performed and the types of outpatient procedures performed at that  
setting.

4 (e) The name and address of the hospital or emergency center to which the patient was  
transferred or admitted.

5 (f) The date of the report and the full name of the person who completed the report.

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

7 (a) A liposuction procedure that is performed under general anesthesia or intravenous  
8 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  
9 Safety Code Section 1248.1.

10 (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  
11 Safety Code Section 1248.1:

12 (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  
13 aspirate and shall be required for procedures that result in the extraction of 2,000 or  
14 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  
15 physician shall ensure that trained personnel, together with adequate and appropriate  
equipment, oxygen, and medication, are onsite and available to handle the procedure  
16 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  
17 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.

18 (2) Anesthesia. Anesthesia shall be provided by a qualified licensed practitioner. The  
19 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  
20 support is present and is monitoring the patient.

21 (3) Monitoring. The following monitoring shall be available for volumes greater than  
22 150 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:

23 (A) Pulse oximeter

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

25 (C) Fluid loss and replacement monitoring and recording

26 (D) Electrocardiogram

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

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

3 (5) Discharge and Postoperative-care Standards.

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

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

12 **COST RECOVERY**

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

19 **FACTUAL ALLEGATIONS**

20 13. Respondent is a pediatrician by training. He began offering aesthetic services in  
21 approximately 2009, initially offering sclerotherapy for unsightly veins and also laser removal of  
22 skin lesions and hair. In 2013, he began offering laser liposuction using local tumescent  
23 anesthesia. Respondent used intravenous anesthesia of midazolam<sup>1</sup> and narcotics, often also  
24 injecting flumazenil<sup>2</sup> as a rescue drug when patients became too sedated by the midazolam. In  
25 2016, Respondent began offering breast augmentations. At all relevant times alleged herein,

26 <sup>1</sup> Midazolam is a Schedule 4 controlled substance also known as Versed. It is a  
27 benzodiazepine. Intravenous midazolam has been associated with respiratory depression and  
28 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.

<sup>2</sup> 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.

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

4 **Patient 1<sup>3</sup>**

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

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

21 16. Patient 1 was a 37-year-old woman at the time of her emergency hospitalization, had  
22 previously undergone laser liposuction of her torso and fat transfer to her buttocks by  
23 Respondent, on or about July 11, 2017. Laser liposuction involves the use of laser heat to "melt"  
24 the fat, thus disrupting fat cells and making them non-viable. Reinjecting such laser-treated fat  
25 would not result in graft survival and thus would put the patient at risk for oil cyst formation and  
26

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

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

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

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

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

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

27  
28 <sup>4</sup> Alprazolam, known also as Xanax, is a benzodiazepine and a Schedule IV controlled  
substance. It is used to treat anxiety and panic disorders.



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

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

14 22. It is the standard of care to avoid lidocaine toxicity. Any physician using local  
15 anesthesia should know and recognize the symptoms of lidocaine toxicity. Respondent calculates  
16 the amount of lidocaine that can be utilized during his liposuction procedures using the 55mg/kg  
17 maximum dosage recommendation. During the June 12, 2018, surgery he documented that he  
18 injected 800 ml of tumescent fluid into the abdomen containing lidocaine 1 mg/ml. He also  
19 documented that he injected 600 ml of tumescent fluid into the breasts, containing lidocaine  
20 1.5ml/ml. He documented the total lidocaine he injected at 1700 mg, which is 27.1 mg/kg. This  
21 should be within a safe level. However, Patient 1 immediately showed signs of lidocaine toxicity  
22 (twitching, disorientation). Respondent administered a benzodiazepine reversing agent,  
23 flumazenil. Respondent documented that Patient 1 stopped twitching for a short time, but then  
24 began having grand mal seizures.

25  
26  
27 <sup>5</sup> Lorazepam, also known as Ativan, is a Schedule IV controlled substance and a  
28 benzodiazepine generally used as a sedative and an anxiolytic in surgical settings. It is also used  
to treat insomnia.

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

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

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

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

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

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

27 \_\_\_\_\_  
28 <sup>6</sup> Dexamethasone is a corticosteroid used to relieve inflammation, swelling, redness or  
pain.

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

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

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

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

14 **Patient 2**

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

22 33. Patient 2 provided laboratory results from September 1, 2020, to Respondent. Her  
23 blood glucose was 192, and her HgbA1c was 8.6, indicating poor control of her diabetes. Her  
24 white blood count was slightly elevated at 10.8. Despite these results, which showed that Patient  
25 2's diabetes was poorly controlled, Respondent decided to proceed with surgery.

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

28 <sup>7</sup> Metformin is a medication to treat type 2 diabetes.

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

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

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

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

27  
28 <sup>8</sup> Naloxone is an opioid antagonist medication designed to rapidly reverse opioid overdose. Respondent did not document administering any opioids to Patient 2.

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

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

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

#### 10 **FIRST CAUSE FOR DISCIPLINE**

##### 11 **(Unprofessional Conduct - Gross Negligence)**

12 40. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section  
13 2234, subdivision (b) of the Code in that he was grossly negligent in the care and treatment of two  
14 patients. The circumstances are as follows:

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

- 18 A) Respondent infused Patient 1 with a toxic level of lidocaine during her liposuction  
19 surgery on June 12, 2018. This represents an extreme departure from the standard of  
20 care.
- 21 B) Respondent administered intravenous sedation that risked loss of Patient 1's life  
22 preserving reflexes at an unaccredited facility on June 12, 2018. This represents an  
23 extreme departure from the standard of care.
- 24 C) Respondent introduced a 5 mg bolus of midazolam intravenously to sedate Patient 1  
25 during her surgery on June 12, 2018. This represents an extreme departure from the  
26 standard of care.
- 27 D) Respondent performed outpatient surgery on Patient 1 on June 12, 2018 and  
28 December 8, 2020, without at the time having a valid ACLS certification. Each

- 1 instance represents unprofessional conduct in violation of section 2216.1 and an  
2 extreme departure from the standard of care.
- 3 E) Respondent's failure to obtain and review emergency hospitalization records of  
4 Patient 1 and performing subsequent surgeries while unaware of the cause of Patient  
5 1's seizure during the June 12, 2018, surgery was an extreme departure from the  
6 standard of care.
- 7 F) Respondent did not inquire, never found out, and never documented what anti-seizure  
8 medication Patient 1 was taking following a serious complication during her June 12,  
9 2018 surgery. Respondent performed subsequent surgeries without knowing what  
10 anti-seizure medications Patient 1 was taking, which represents an extreme departure  
11 from the standard of care.
- 12 G) Respondent's failure to notify the Board of Patient 1's hospital transfer as required  
13 by section 2240, was unprofessional conduct pursuant to section 2240, subdivision (f)  
14 and an extreme departure from the standard of care.
- 15 H) Respondent's failure to provide Patient 1 with adequate security by liability insurance  
16 as required by section 2216.2, is unprofessional conduct and an extreme departure  
17 from the standard of care.
- 18 I) Providing a risk document with inaccurate information to Patient 1 represents an  
19 extreme departure from the standard of care.
- 20 J) Respondent's disregard for patient safety in proceeding with an elective surgical  
21 procedure upon an uncontrolled diabetic (Patient 2) represents an extreme departure  
22 from the standard of care.
- 23 K) Respondent administered intravenous sedation that risked loss of Patient 2's life  
24 preserving reflexes at an unaccredited facility on October 12, 2020. This represents  
25 an extreme departure from the standard of care.
- 26 L) Respondent introduced a 5 mg bolus of midazolam intravenously to sedate Patient 2  
27 during her surgery on October 12, 2020. This represents an extreme departure from  
28 the standard of care.

- 1 M) Respondent performed outpatient surgery on Patient 2 on October 12, 2020, without  
2 at the time having a valid ACLS certification. This represents unprofessional  
3 conduct in violation of section 2216.1 and an extreme departure from the standard of  
4 care.
- 5 N) Respondent's decision to perform elective surgery that involved intravenous sedation  
6 on Patient 2 on October 12, 2020, when he knew or should have known that she had  
7 recently eaten and/or drank (non-NPO status) was an extreme departure from the  
8 standard of care.
- 9 O) Respondent's failure to provide Patient 2 with security by liability insurance, as  
10 required by section 2216.2, is unprofessional conduct and an extreme departure from  
11 the standard of care.
- 12 P) Respondent's failure to notify the Board of Patient 2's death, as required by  
13 Business and Professions Code section 2240 is unprofessional conduct and an  
14 extreme departure from the standard of care.

15 **SECOND CAUSE FOR DISCIPLINE**

16 **(Unprofessional Conduct - Repeated Negligent Acts)**

17 42. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section  
18 2234, subdivision (c) of the Code in that he committed repeated negligent acts in the care and  
19 treatment of two patients. The circumstances are as follows:

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

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

- 23 A) Respondent's failure to administer a pregnancy test to Patient 1 prior to each of her  
24 five surgeries represents five separate and distinct departures from the standard of  
25 care.
- 26 B) Respondent's failure to administer a pregnancy test to Patient 2 prior to her surgery  
27 on October 12, 2020 was a departure from the standard of care.

28

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

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

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

8 **THIRD CAUSE FOR DISCIPLINE**

9 **(Incompetence)**

10 45. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section  
11 2234, subdivision (d) of the Code in that he demonstrated a lack of knowledge or ability in his  
12 care of Patient 1. The circumstances are as follows:

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

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

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

19 **FOURTH CAUSE FOR DISCIPLINE**

20 **(Failure to Report Patient Death or Transfer)**

21 47. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section  
22 2240 of the Code in that he did not report the death or transfer of two patients to the Board as  
23 required by that statute. The circumstances are as follows:

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

25 **FIFTH CAUSE FOR DISCIPLINE**

26 **(Illegal Liposuction)**

27 49. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under sections  
28 2216 and 2216.1 in his care and treatment of two patients in an unaccredited outpatient setting



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

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

4 **SIXTH CAUSE FOR DISCIPLINE**

5 **(Inadequate and Inaccurate Record Keeping)**

6 51. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section  
7 2266 in that Respondent failed to keep accurate and adequate records of his care and treatment of  
8 two patients. The circumstances are as follows:

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

10 **SEVENTH CAUSE FOR DISCIPLINE**

11 **(Failure to Provide Security)**

12 53. Respondent Mohamad J. Yaghi, M.D. is subject to disciplinary action under section  
13 2216.2 in that Respondent failed to have adequate security by liability insurance or by  
14 participation in an interindemnity trust for claims by patients arising out of outpatient cosmetic  
15 surgical procedures, when he operated on two patients. The circumstances are as follows:

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

17 **PRAYER**

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

20 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 54524,  
21 issued to Mohamad J. Yaghi, M.D.;

22 2. Revoking, suspending or denying approval of his authority to supervise physician  
23 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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