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

In the Matter of the Second Amended Accusation Against: Mahmoud Khattab, M.D. Physician's and Surgeon's Certificate No. A 97693 Respondent.	Case No. 800-2017-039667

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 June 17, 2021.

IT IS SO ORDERED June 17, 2021.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
MEGAN R. O'CARROLL
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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 Second Amended Accusation Against: **MAHMOUD KHATTAB, M.D.** 9250 Big Horn Blvd., Ste. 100 Elk Grove, CA 95758-1299 Physician's and Surgeon's Certificate No. A 97693 Respondent.	Case No. 800-2017-039667 OAH No. 2021020486 **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. William Prasifka ("Complainant") is the Executive Director of the Medical Board of California ("Board"). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Megan R. O'Carroll, Deputy Attorney General.

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2. Mahmoud Khattab, M.D. ("Respondent") is represented in this proceeding by attorney Peter R. Osinoff, Esq., whose address is:

Bonne Bridges Mueller O'Keefe & Nichols
355 South Grand Avenue, Suite 1750
Los Angeles, CA 90071-1562

3. On or about October 13, 2006, the Board issued Physician's and Surgeon's Certificate No. A 97693 to Respondent. On May 29, 2020, Respondent entered into a stipulated suspension of his Physician's and Surgeon's Certificate, pending a noticed hearing on the Board's *ex parte* application for an Interim Suspension Order. On July 20, 2020, the Office of Administrative Hearings, following a hearing on the Board's application for an Interim Suspension Order, suspended Respondent's Physician's and Surgeon's Certificate pending the outcome of the Second Amended Accusation No. 800-2017-039667 brought by the Board against Respondent's license. The Physician's and Surgeon's Certificate was in full force and effect, aside from the afore-mentioned interim suspension orders, at all times relevant to the charges brought in Accusation No. 800-2017-039667 and will expire on February 28, 2022, unless renewed.

JURISDICTION

4. Second Amended Accusation No. 800-2017-039667 was filed before the Board, and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondent on May 4, 2021. Respondent timely filed his Notice of Defense contesting the Second Amended Accusation. A copy of Second Amended Accusation No. 800-2017-039667 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 Second Amended Accusation No. 800-2017-039667. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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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 Second Amended 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 Second Amended Accusation No. 800-2017-039667, 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 Second Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a *prima facie* basis for the charges in the Second Amended 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. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order,

the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 97693, issued to Respondent Mahmoud Khattab, 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 Second Amended Accusation No. 800-2017-039667 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition. Notwithstanding the provisions of Bus. & Prof. Code § 2307, the parties agree that Respondent may petition the Board no sooner than two (2) years from the effective date of the decision and order in Case No. 800-2017-039667 for reinstatement of his license.

5. 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 Second Amended Accusation No. 800-2017-039667 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, Peter R. Osinoff, Esq. 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: 6-15-2021

MAHMOUD KHATTAB, M.D.
Respondent

I have read and fully discussed with Respondent Mahmoud Khattab, 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: 6/15/2021

PETER R. OSINOFF, ESQ.
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: June 16, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

FOR MEGAN R. O'CARROLL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Second Amended Accusation No. 800-2017-039667

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

In the Matter of the Second Amended Accusation Against: **Mahmoud Khattab, M.D.** **9250 Big Horn Blvd., Ste. 100** **Elk Grove, CA 95758-1299** **Physician's and Surgeon's Certificate No. A 97693,** Respondent.	Case No. 800-2017-039667 OAH No. 2021020486 **SECOND AMENDED ACCUSATION**

PARTIES

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

2. On or about October 13, 2006, the Medical Board issued Physician's and Surgeon's Certificate Number A 97693 to Mahmoud Khattab, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2022, unless renewed. On or about May 29, 2020, the

Office of Administrative Hearings issued an Order approving a stipulation for an interim order of suspension of Physician's and Surgeon's License No. A 97693. On or about July 30, 2020, the Office of Administrative Hearings issued a Decision for an interim order of suspension of Respondent's License until a final decision is adopted on this Second Amended Accusation.

JURISDICTION

3. This Second Amended 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 118 of the Code states:

> (a) The withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.
>
> (b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.
>
> (c) As used in this section, "board" includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and "license" includes "certificate," "registration," and "permit."

6. Section 2234 of the Code, states:

> "The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

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

7. Section 2052 of the Code states:

(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter [Chapter 5, the Medical Practice Act], or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

(b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.

(c) The remedy provided in this section shall not preclude any other remedy provided by law.

8. 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 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.

9. Section 2259.7 of the Code states:

The Medical Board of California shall adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician and surgeon outside a general acute care hospital, as defined in Section 1250 of the Health and Safety Code. In adopting those regulations, the Medical Board of California shall take into account the most current clinical and scientific information available. A violation of these extraction and postoperative care standards shall constitute unprofessional conduct.

10. 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.

11. Section 2261 of the Code states:

Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

12. Section 2262 of the Code states:

Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section.

13. Section 2263 of the Code states: The willful, unauthorized violation of professional confidence constitutes unprofessional conduct.

14. Section 2264 of the Code states:

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

15. 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.

16. Section 2271 of the Code states: Any advertising in violation of Section 17500, relating to false or misleading advertising, constitutes unprofessional conduct.

17. Section 2272 of the Code states: Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct.

18. Section 2286 of the Code states:

> It shall constitute unprofessional conduct for any licensee to violate, to attempt to violate, directly or indirectly, to assist in or abet the violation of, or to conspire to violate any provision or term of Article 18 (commencing with Section 2400), of the Moscone-Knox Professional Corporation Act (Part 4 commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), or of any rules and regulations duly adopted under those laws.

19. Section 2415 of the Code states:

> (a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing, or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section.
>
> (b) The division or the board shall issue a fictitious-name permit authorizing the holder thereof to use the name specified in the permit in connection with his, her, or its practice if the division or the board finds to its satisfaction that:
>
> (1) The applicant or applicants or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons or doctors of podiatric medicine, as the case may be.
>
> (2) The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants.
>
> (3) The name under which the applicant or applicants propose to practice is not deceptive, misleading, or confusing.
>
> (c) Each permit shall be accompanied by a notice that shall be displayed in a location readily visible to patients and staff. The notice shall be displayed at each place of business identified in the permit.
>
> (d) This section shall not apply to licensees who contract with, are employed

by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with that medical school.

(e) Fictitious-name permits issued under this section shall be subject to Article 19 (commencing with Section 2421) pertaining to renewal of licenses.

(f) The division or the board may revoke or suspend any permit issued if it finds that the holder or holders of the permit are not in compliance with the provisions of this section or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a fictitious-name permit shall be conducted in accordance with Section 2230.

(g) A fictitious-name permit issued to any licensee in a sole practice is automatically revoked in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

(h) The division or the board may delegate to the executive director, or to another official of the board, its authority to review and approve applications for fictitious-name permits and to issue those permits.

(i) The California Board of Podiatric Medicine shall administer and enforce this section as to doctors of podiatric medicine and shall adopt and administer regulations specifying appropriate podiatric medical name designations.

20. Section 125 of the Code states:

Any person, licensed under Division 1 (commencing with Section 100), Division 2 (commencing with Section 500), or Division 3 (commencing with Section 5000) is guilty of a misdemeanor and subject to the disciplinary provisions of this code applicable to them, who conspires with a person not so licensed to violate any provision of this code, or who, with intent to aid or assist that person in violating those provisions does either of the following:

(a) Allows their license to be used by that person.

(b) Acts as their agent or partner.

21. Section 651 states:

(a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.

(b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes a statement or claim that does any of the following:

(1) Contains a misrepresentation of fact.

(2) Is likely to mislead or deceive because of a failure to disclose material facts.

(3)(A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

(B) Use of any photograph or other image of a model without clearly stating in a prominent location in easily readable type the fact that the photograph or image is of a model is a violation of subdivision (a). For purposes of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure being advertised, of the licensee who is advertising for his or her services.

(C) Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size what procedures were performed on that patient is a violation of subdivision (a). Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.

(4) Relates to fees, other than a standard consultation fee or a range of fees for specific types of services, without fully and specifically disclosing all variables and other material factors.

(5) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) Makes a claim either of professional superiority or of performing services in a superior manner, unless that claim is relevant to the service being performed and can be substantiated with objective scientific evidence.

(7) Makes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.

(8) Includes any statement, endorsement, or testimonial that is likely to mislead or deceive because of a failure to disclose material facts.

(c) Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(d) Any person so licensed shall not compensate or give anything of value to a representative of the press, radio, television, or other communication medium in anticipation of, or in return for, professional publicity unless the fact of compensation is made known in that publicity.

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

(f) Any person so licensed who violates this section is guilty of a misdemeanor. A bona fide mistake of fact shall be a defense to this subdivision, but only to this subdivision.

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.

(h) Advertising by any person so licensed may include the following:

(1) A statement of the name of the practitioner.

(2) A statement of addresses and telephone numbers of the offices maintained by the practitioner.

(3) A statement of office hours regularly maintained by the practitioner.

(4) A statement of languages, other than English, fluently spoken by the practitioner or a person in the practitioner's office.

(5)(A) A statement that the practitioner is certified by a private or public board or agency or a statement that the practitioner limits his or her practice to specific fields.

(B) A statement of certification by a practitioner licensed under Chapter 7 (commencing with Section 3000) shall only include a statement that he or she is certified or eligible for certification by a private or public board or parent association recognized by that practitioner's licensing board.

(C) A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician and surgeon's licensing board prior to January 1, 2019, or (iii) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section

1600) and the use of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for certifying medical doctors and other health care professionals that is based on the applicant's education, training, and experience. A multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2019, shall retain that approval.

For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician and surgeon's licensing board prior to January 1, 2019, or an organization with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.

(D) A doctor of podiatric medicine licensed under Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Article (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

The California Board of Podiatric Medicine shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph, to be deposited in the State Treasury in the Podiatry Fund, pursuant to Section 2499. The fee shall not exceed the cost of administering this subparagraph.

(6) A statement that the practitioner provides services under a specified private or public insurance plan or health care plan.

(7) A statement of names of schools and postgraduate clinical training programs from which the practitioner has graduated, together with the degrees received.

(8) A statement of publications authored by the practitioner.

(9) A statement of teaching positions currently or formerly held by the practitioner, together with pertinent dates.

(10) A statement of his or her affiliations with hospitals or clinics.

(11) A statement of the charges or fees for services or commodities offered by the practitioner.

(12) A statement that the practitioner regularly accepts installment payments of fees.

(13) Otherwise lawful images of a practitioner, his or her physical facilities, or of a commodity to be advertised.

(14) A statement of the manufacturer, designer, style, make, trade name, brand name, color, size, or type of commodities advertised.

(15) An advertisement of a registered dispensing optician may include statements in addition to those specified in paragraphs (1) to (14), inclusive, provided that any statement shall not violate subdivision (a), (b), (c), or (e) or any other section of this code.

(16) A statement, or statements, providing public health information encouraging preventative or corrective care.

(17) Any other item of factual information that is not false, fraudulent, misleading, or likely to deceive.

(i) Each of the healing arts boards and examining committees within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

(j) The Attorney General shall commence legal proceedings in the appropriate forum to enjoin advertisements disseminated or about to be disseminated in violation of this section and seek other appropriate relief to enforce this section. Notwithstanding any other provision of law, the costs of enforcing this section to the respective licensing boards or committees may be awarded against any licensee found to be in violation of any provision of this section. This shall not diminish the power of district attorneys, county counsels, or city attorneys pursuant to existing law to seek appropriate relief.

(k) A physician and surgeon or doctor licensed pursuant to Chapter 5 (commencing with Section 2000) by the Medical Board of California or a doctor of podiatric medicine licensed pursuant to Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who knowingly and intentionally violates this section may be cited and assessed an administrative fine not to exceed ten thousand dollars ($10,000) per event. Section 125.9 shall govern the issuance of this citation and fine except that the fine limitations prescribed in paragraph (3) of subdivision (b) of Section 125.9 shall not apply to a fine under this subdivision.

22. Section 2306 of the Code states:

If a licensee's right to practice medicine is suspended, he or she shall not engage in the practice of medicine during the term of such suspension. Upon the expiration of the term of suspension, the certificate shall be reinstated by Medical Board, unless the licensee during the term of suspension is found to have engaged in the practice of medicine in this state. In that event, the division shall revoke the licensee's certificate to engage in the practice of medicine.

FACTUAL ALLEGATIONS

Practice Information

23. Respondent opened a private practice in Elk Grove, California in approximately 2011, practicing internal medicine. He is Board-certified in Internal Medicine. In approximately 2014, he began increasing the cosmetic aspects of his practice and began performing liposuctions in 2015. His practice is now exclusively cosmetic. Respondent advertises his practice as "Precision M.D. Cosmetic Surgery Center." This is the name posted on the outside of the building, it is the name printed on all the office documents and patient records, and it is the name under which he advertises on his website, on television and online. But Respondent's practice is not an accredited surgery center, it is merely a medical office. Respondent holds a Fictitious Name Permit (FNP), allowing him to practice under the name of "Precision M.D." Between December 2019 and March of 2020, Respondent's FNP for "Precision M.D." was delinquent. Respondent has since renewed the permit.

24. Respondent is the only physician at Precision M.D., despite a very high volume of patients. Respondent estimates that on any business day his practice sees approximately 25-30 patients. He employs approximately 14 staff members, including three Medical Assistants, four receptionists, two estheticians, an office manager, two consultants, and an Executive Director. In addition to nonsurgical procedures like laser treatments and injections, he performs surgeries including liposuction, breast augmentations, and hair transplantations. Respondent estimates that he performs approximately 500 liposuction procedures each year.

25. Respondent performs these surgeries in a room in his medical office. He is not Board-certified in plastic surgery. He does not have hospital privileges at any hospital. As of March of 2020, Respondent's office did not have a crash cart and did not monitor patients' blood pressures and cardiac rhythms during surgeries. When asked by the Board's Medical Consultant in March of 2020 whether he was "ACLS certified," Respondent did not know what ACLS means. As of March 3, 2020, Respondent did not have a transfer agreement with any hospital. As of March 3, 2020, Respondent did not have a locking device for controlled medications in his office, did not maintain a log of their use, and did not document waste of these substances to prevent diversion.

26. Before approximately October of 2017, Respondent did not have an automatic external defibrillator (AED), available during the surgeries, and did not prepare patients with an intravenous line during surgeries, or have opioid reversal medications available. Respondent began using intravenous opioids and benzodiazepines in surgeries in approximately November of 2017. He allows Medical Assistants to mix intravenous drugs and push them through the lines during surgeries. Respondent allows patients to leave the surgical table during procedures to use the restroom, and takes breaks himself during surgery to meet with other patients while the surgical patient is left on the table with only Medical Assistants in the room. He does not maintain a sterile surgical field, occasionally breaking during surgery to take a telephone call, and only uses hand sanitizer to clean his hands before resuming surgery. He leaves the surgical room immediately after the surgical procedure is done, allowing nurses and even Medical Assistants to evaluate whether a patient is safe to leave. He does not have a set of rules or criteria in place for

the staff members to evaluate whether a patient may safely leave after a procedure. When asked by the Board's Medical Consultant in March of 2020 whether he was familiar with Aldrete's Scale or White's Scale, he responded that he was not, and believed that those principles were only applicable to general anesthesia.

Patient 1

27. Patient 1 sought a cosmetic procedure to reduce the size of her stomach. In September of 2017, she called Respondent's office, Precision M.D., and spoke with the Office Manager to inquire about cosmetic procedures. The Office Manager, Ms. L.A., has no medical licensure. Despite having no medical licensure, Ms. L.A. receives a commission of 2% on all patients she enters into Respondent's surgical calendar. Ms. L.A. exchanged emails and photos with Patient 1, and advised her that she was a good candidate for Vaser liposuction.[1] Ms. L.A. invited Patient 1 to come into the office for a preoperative appointment, but told her it was not required. Patient 1 preferred not to drive to the office for a preoperative appointment, and declined. Thereafter, Patient 1 agreed to the procedure, and Respondent's Office charged her credit card $6,000.00. Her procedure was scheduled for October 11, 2017. Patient 1 forwarded laboratory results to the office by email before the appointment.

28. When Patient 1 arrived at Precision M.D. on October 11, 2017, she was given forms to sign. Surgical Tech A.A. took photographs of her, took her blood pressure, and she took a Xanax pill by mouth. Patient 1 told Surgical Tech A.A. that she was allergic to Norco, (hydrocodone and acetaminophen), and the Surgical Tech wrote that down. The Surgical Tech took Patient 1 to a different area of the office where Respondent performed procedures, and gave her paper garments to put on. Patient 1 found the surgical area to be dirty with debris and boxes everywhere and carpet on the floor. She was shown to a bathroom adjacent to the surgical area to change into the paper garments. Patient 1 and Surgical Tech A.A. waited in this area for Respondent for approximately 45 minutes while a workman was working on a machine. When

[1] The Vaser liposuction process requires mixing a solution of saline, epinephrine, and a local anesthetic (tumescent solution), and injecting it under the skin. A titanium probe is then inserted under the skin to deliver ultrasound energy to loosen fat cells, before vacuuming out the liquid aspirate, which consists of a mixture of the infiltrated solution, blood, and fat. He also performs injections and laser skin treatments.

Respondent came into the room, it was the first time Patient 1 had ever seen him, and he did not immediately address her. Instead, he interacted with the workman, and appeared angry and spoke on the telephone and signed the workman's paperwork.

29. The first time Respondent ever spoke to Patient 1 was after he had instructed Surgical Tech A.A. to have Patient 1 remove her paper garments and stand up by the wall. As she was naked against the wall, Respondent came over to mark her body with a pen and addressed her for the first time, asking "how are you?" He never asked her any medical questions, never spoke about any side effects of the procedure, and never listened to her heart or lungs. When Patient 1 later reviewed her medical records from Precision M.D., she saw that Respondent had signed a "consultation note," dated October 11, 2017, stating that he listened to her heart and lungs, and discussed the risks and benefits of Vaser liposuction, identifying potential complication such as bleeding, infections, and contour irregularities before obtaining her consent to the procedure. All of this was false.

30. Patient 1 had an oxygen monitor on her for the procedure, but no blood pressure monitor or EKG leads were attached to her. She had no intravenous line placed. As soon as the procedure began Patient 1 was in extreme pain. She felt like she was being tortured. Respondent did not wait for the tumescent (local anesthetic) solution to work before beginning the suctioning. During his March 2020 interview with the Board's Medical Consultant, Respondent was asked how long he allows for the tumescent solution to work, and he incorrectly responded that as soon as the fluid is in it is appropriate to begin the surgery. This is false, as the tumescent solution requires time to take effect without causing excessive pain to a patient. Patient 1 requested pain relief four times during the procedure. At one point, she heard Respondent tell the Surgical Tech to give her Norco. Patient 1 was terrified because she was allergic to Norco, but she then heard Surgical Tech A.A. tell Respondent that Patient 1 was allergic to Norco, and he directed Surgical Tech A.A. to give her Valium and extra strength Tylenol.

31. Respondent infiltrated 4,330 cubic centimeter (ccs) of tumescent solution, and aspirated 2,400 ccs of total aspirate. Respondent's use of medication during the procedure constituted conscious sedation. Respondent's operative note falsely states that Patient 1 had an

I.V. placed, that her blood pressure and heart rhythms were monitored throughout the procedure, and that she tolerated the procedure well. After the procedure ended, Respondent immediately left the room and she never saw him again that day. The Surgical Tech remained with Patient 1, and was the one to determine when it was safe for Patient 1 to leave. Respondent has no written discharge criteria for these unlicensed staff members to follow to determine when it is safe for a patient to go home. After the surgery Patient 1's blood pressure was 82/52 at 4:20 p.m., and 95/58 at 4:50 p.m. when she was discharged. There are no further post operative vital signs, and no record of ACLS certified staff monitoring the patient after surgery. There were no written discharge protocols noted or established before discharge.

32. A few days after the procedure, Patient 1 began to feel that she had an infection. At a post operative appointment with Respondent on or about October 17, 2017, she became overwhelmed with everything she had been through and told Respondent that she did not like him. Respondent raised his voice and broke into a verbal assault, telling her that she was the worst patient he had ever had, and the rudest woman he had ever met, and that he was not her slave.

33. After this verbal altercation at the appointment, Patient 1 called Respondent's office and asked that he refer her to a different physician. Respondent stated that she could see him for follow up care. Patient 1 instead sought care with her regular provider, and was admitted to the hospital for three days where she had abdominal abscesses drained, which were not found to be infected. Patient 1 did not have a good cosmetic result. Ms. L.A. had told Patient 1 that she would have a recovery period of about two days, but Patient 1 did not find this to be true, and was out of work for two weeks.

Patient 2

34. Patient 2 and her husband met with Office Manager L.A. at Precision M.D. on or about February 22, 2019. Ms. L.A. told Patient 2 that she would recommend a liposuction procedure over a coolsculpting procedure for Patient 2 because it would provide good results with minimal downtime of about 2 days. Respondent joined the consultation for about two minutes and agreed with the planned procedure. He reiterated that Patient 2 would have a two-day recovery

period. He did not discuss any potential risks or complications from the procedure. Ms. L.A. continued to speak with Patient 2 and her husband about financing options.

35. Respondent falsely signed a consultation note, dated February 18, 2019 stating that he conducted an examination and warned Patient 2 of potential risks and side effects during the consultation, including vaser burns, scars, and infections. Respondent never performed a physical examination on Patient 2 before the surgery, or had a discussion with her about the risks and benefits of the procedures.

36. In the weeks after the February 18, 2019 consultation, Respondent's office continued to call Patient 2 to ask if she was going to go through with the procedure. Eventually Patient 2 decided that she would, and Ms. L.A. contacted CareCredit company to get Patient 2's credit limit raised. Even with the limit raised it was not enough to cover the $12,000 cost, so Ms. L.A. assisted Patient 2's husband to open a CareCredit card. On or about May 22, 2019, Patient 2 and her husband's cards were charged a total of $12,000.00.

37. Patient 2 arrived at Precision M.D. for her procedure on or about May 31, 2019 at 8:00 a.m. She was provided with consent forms to sign on that morning, but did not have time to read them or ask questions before signing. Patient 2 changed into paper garments and two female staff members placed an intravenous line in her right hand. Patient 2 found the procedure excruciatingly painful and screamed out for Respondent to stop the procedure. Respondent paused briefly to infiltrate more local anesthetic, but began the procedure again almost immediately without waiting for the solution to take effect. Patient 2 again screamed out for Respondent to stop the procedure, but he did not. When the procedure was over, Patient 2 was unable to stand or use her right arm. Two female staff members assisted her into her clothes.

38. Respondent documented in his operating note that he infiltrated 4,444 cc of tumescent solution and extracted 6,000 cc of total aspirate. He documented 60 minutes of Vaser time. The operating note further states that Patient 2 had continuous EKG cardiac and blood pressure monitoring during the procedure, with results printed every 30 minutes. This is false. Patient 2 was not attached to an EKG or blood pressure monitor during the procedure. The operative note further states that Patient 2 tolerated the procedure well and was discharged home,

ambulatory, in good condition. The handwritten notes by Respondent's staff indicate that Patient 2 was given two Norco 5/325 tablets, and two Valium 5 mg tablets to take by mouth before the procedure. She was given additional intravenous medications of Fentanyl and Ativan during the procedure in the amount of 300 mcg fentanyl and 2 mg of Ativan. Respondent lacks knowledge and understanding to use these drugs. The level of sedation of Patient 2 constituted conscious sedation. Only two blood pressures are recorded for Patient 2, at 9:00 a.m. and 2:33 p.m. There are no further post operative vital signs, and no record of ACLS certified staff monitoring the patient after surgery. There were no written discharge protocols noted or established before discharge.

39. Several days later Patient 2 and her husband returned to Precision M.D. for a follow up appointment with Respondent. Although she had been told that the recovery for the procedure was two days, Patient 2 was still unable to walk and had to come in a wheelchair. Patient 2's husband asked Respondent why he did not stop the procedure when Patient 2 asked him to, and Respondent said that he did not do that. Patient 2's husband stood up and began advancing toward Respondent and Respondent called for his staff to contact the police. When Patient 2's husband showed the police pictures of her abdomen, they did not arrest him.

40. Under the bandages the entire width of Patient 2's abdomen was burned with areas of black, charred skin, and areas where blood and pus were oozing. The skin was burned from the inside of the abdominal wall out. Photographs show a large area of disfigured, severely burned skin covering Patient 2's entire mid-section. Patient 2's husband was distraught by the pain and suffering he witnessed his wife experiencing.

41. Respondent continued to see Patient 2 for follow up every week for approximately six weeks. He repeatedly told her that her skin was doing fine and would heal normally. Finally, at a follow up appointment on July 12, 2019, Respondent told Patient 2 that he wanted to remove "a chunk of dead skin" on the side of her abdomen. Patient 2 asked him if he would have to cut her skin, and he said he would not. Respondent did not explain that he was planning to surgically debride her wound, and did not obtain informed consent for any procedure. Patient 2 was brought to the surgical room and asked to lay on the table. Respondent did not explain the procedure he

planned to do, and did not provide her with any consent forms to sign. Patient 2 asked whether the procedure would hurt, and she was told it would not. Patient 2 spoke up then and asked Respondent if he was going to inject her stomach. When Patient 2 saw that she was being draped with surgical sheets, she began to cry and refused to go through with the procedure. Respondent became angry and left the room.

42. Patient 2 went to her primary care physician who referred her to a proper wound clinic. Patient 2 required several months of treatment at the wound care clinic. She was diagnosed with a third degree burn and suffered extensive scarring.

Patient 3

43. On or about June 12, 2019, Patient 3 went to Respondent's office for a consultation for cosmetic surgery on her thighs and underneath both arms. The Office Manager, Ms. L.A. examined her and said she was a candidate for liposuction on her arms. Ms. L.A. discussed treatments to Patient 3's thighs and neck, and brought Respondent in to discuss these treatments. Respondent told Patient 3 that the liposuction to her arms would be an "easy fix" and agreed with threading to her neck. He further recommended that Patient 3 have an additional liposuction procedure to her thighs, but Patient 3 refused. As soon as Patient 3 declined the more expensive procedure to her thighs, he left her to Ms. L.A. Ms. L.A. charged Patient 3's CareCredit card $8,400.00 that day, June 12, 2019, and scheduled the surgery for June 17, 2019. Patient 3 paid for liposuction to her arms, a thread lift for her neck, and J. Plasma for her thighs.[2]

44. Respondent signed a consultation note, dated June 12, 2019, claiming that on this date he discussed treatment options with Patient 3, and warned her about potential side effects such as burns, scars, asymmetry, lumps and infections. This note is totally false. Respondent never spoke with Patient 3 about any negative possibilities from the planned procedures. He only spoke of positive outcomes she could expect.

[2] A "thread neck lift" is a procedure to insert sutures into the neck to tighten the skin in that area. A "J. Plasma" procedure is process of inserting gaseous material under the skin in an effort to promote skin tightening in the area. J. Plasma is not approved by the FDA for skin tightening, and any use of it is considered off label. There is not even a template consent form with an electronic signature for use of J. Plasma in Patient 3's medical records.

45. On June 17, 2019, a friend drove Patient 3 to Respondent's office. Before the procedure, she signed an electronic pad with both her signature and initials, but did not have time to review what she was signing. A staff member took photos of her thighs, arms, and neck, and then took her to the procedure room. She had an I.V. placed, and felt very relaxed, and then believes she became unconscious. The medical record states that Respondent infiltrated 4,142 cc of tumescent solution and suctioned 1,900 ccs. He administered anxiolytics, Valium, analgesics, and Norco to Patient 3 constituting conscious sedation. He started infiltration at 2:17 p.m., the Vaser at 2:21 p.m., and the suctioning at 2:39 p.m. There is no documentation of the procedures done to Patient 3's neck or thighs.

46. Patient 3 recalled waking up several times during the procedure and feeling pain near her elbow. At one point during the procedure, she recalls hearing sounds of women chatting and laughing so she asked the women what they were doing and if they were on a break. They responded that they were on a break, and that Respondent was not in the room. She fell back to sleep and the next thing she recalled was being in her friend's car with no memory of how she got there or who dressed her in a compression suit. She did not receive any discharge instructions or paperwork. Respondent's use of medication during the procedure constituted conscious sedation. Patient 3's medical record showed inadequate post operative documentation of vital signs, and no record of ACLS certified staff monitoring her after surgery. There were no written discharge protocols noted or established before discharge.

47. The next day, Patient 3 returned for a follow up appointment and told Respondent that she was in extreme pain. Respondent told her it was all normal and to keep wearing the bandages and compression suit for three more days. Patient 3 continued to call the office to report that she was in extreme pain, and was continually reassured, and told to drink pineapple juice to help with swelling. On or about June 21, 2019, she removed the compression suit and for the first time saw her underarms. She was alarmed to see chunks of blackened skin on the back of her arms.

48. On June 25, 2019, at another follow-up appointment, she again told Respondent how distressed she was and that she was experiencing terrible pain and her arm skin was peeling off.

Respondent told her it was all normal, and to apply xerofoam (an antibiotic bandage) to her arms. After the June 25, 2019 appointment, Patient 3 felt constant pain and began to detect a foul odor coming from the back of her arms. She reported the odor to Respondent at another follow up appointment or about July 2, 2019, and he advised her to stop wearing the compression suit.

49. On July 9, 2019, Patient 3 had an appointment with Respondent when he finally removed the bandages to look at her arms. When he saw her arms his face turned white and he looked shocked. He started yelling orders to his staff and told them to prepare the surgery room immediately. Photographs of Patient 3's arms demonstrate that they were severely burned and disfigured. Patient 3 became very frightened at Respondent's reaction to seeing her arms and began to cry. Respondent did not tell Patient 3 what was wrong, or what he was going to do, and never gave her any consent forms to sign for any kind of treatment or procedure. He just told her he was going to fix her arms.

50. As Patient 3 was lying down on the surgical table she saw that Respondent had multiple long needles and scissors prepared. Respondent took a needle and injected her arms. She believes it numbed her arms. Patient 3 closed her eyes and cried, as she could hear Respondent using scissors to cut away skin from her arms and stitch them back up. After the procedure Respondent told her that she did not need to worry about anything and that he would take of her himself and that she should not go see any other doctor. He told her to return every few days so he could change the bandages personally. He prescribed antibiotics and pain medication to her and told her she would be healed in two-to-three weeks.

51. During the rest of July 2019, and through September of 2019, Patient 3 returned and saw Respondent at least eleven times. At one of these appointments Respondent told Patient 3 that the reason her arms were burned was because the company that manufactured the metal probe he used during her surgery had made a defective product. He showed her a probe and claimed it was missing the tip that regulated the heat properly. He blamed the manufacturer for the poor results and the excessive pain Patient 3 had endured and said that he contacted the manufacturer to request all new probes. At the visits, Respondent repeatedly told her that he was giving her the best and most expensive skin care possible.

52. On July 28, 2019, Patient 3 was in such pain that she went to Mercy General Hospital Emergency Room. At the Emergency Room, the physicians gave her pain medicine and changed her antibiotics. The Emergency Room physician noted that she would likely need a referral to a wound care clinic. When Patient 3 returned to see Respondent the next day and told him that she had been to the Emergency Room he became livid. He told Patient 3 that he was giving her the best, most expensive care possible, and that she was not to go to any other doctors to treat her arms.

53. Patient 3 found Respondent's reaction to her Emergency Room visit suspicious and began to lose trust in him. As the weeks wore on and her arms did not heal in the time Respondent had told her they would, she became angry at him. She stopped calling him "Dr. Khattab" and referred to him only as "Khattab." He took offense at that and told her that she needs to refer to him properly as "Dr. Khattab." At her last appointment with Respondent, the two had a heated argument. She told him he was a butcher, and he shouted at her to get out of his office. As she was attempting to leave through the door she came in, he prevented her and ushered her to the private door at the back. She exited at the back, but walked around to the front office and made a scene. She warned patients in the lobby not to see Respondent and that he butchered her. He yelled at everyone that she was "trash."

Patient 4

54. In November of 2017, Patient 4 met with Ms. L.A. for a consultation for liposuction. Ms. L.A. told Patient 4 that she was a candidate for Vaser liposuction and quoted her a price for the procedure. Patient 4 complained that the price was too high, so Ms. L.A. went and got Respondent. Respondent spent approximately a minute with Patient 4, and quoted her a price of $5,000.00 for a liposuction on her lower flanks and abdomen, but assured her that he would be able to blend her lower abdomen with the upper abdomen. Patient 4 opened a CareCredit card with Ms. L.A., and she was billed for the procedure that day, November 6, 2017. Ms. L.A. told Patient 4 that she would only require a few days to recover from the procedure. Patient 4 received prescriptions for Keflex and Norco.

55. Respondent signed a document in Patient 4's medical record, dated November 6, 2017, entitled "Consult Form." Respondent documented that he examined Patient 4's heart, lungs, and abdomen. He documented that her vital signs were normal. Neither Respondent, nor any other staff member at Precision M.D. ever listened to Patient 4's heart, or lungs, on November 6, 2017, and her vital signs were not taken. Respondent documented that he discussed all options for fat reduction with Patient 4, and informed her of the risks and benefits of the procedures. This is not true. Respondent never discussed other alternatives to liposuction with Patient 4, and did not mention any risks associated with the procedure. Respondent documented that he warned Patient 4 that her decision to do only the lower abdomen and flanks would increase the possibility of unevenness since she was not having the upper abdomen done. This is the exact opposite of what Respondent told Patient 4. He told her that he would be able to "blend" the upper and lower abdomen.

56. On or about November 22, 2017, Patient 4 arrived at Respondent's Office for the procedure. Patient 4 was asked to initial and sign a large packet of forms. She did not have time to read the forms or ask questions about them. Instead, she signed an electronic tablet with her initials and an electronic signature. An employee took Patient 4's photographs, and led her to a surgical suite. The room was dirty and cluttered with boxes and debris and Patient 4 was concerned that the environment did not seem clean or safe.

57. Patient 4 was given narcotics and anxiolytics in amounts and doses that are not entirely clear from the records. The records show that Norco was given orally, and that Patient 4 received 5 mg of Valium at some point, although the route of administration is not documented. Respondent's use of medication during the procedure constituted conscious sedation. Patient 4 was also given intra-muscular Ceftriaxone in the right deltoid.

58. Surgical Tech A.A. signed the pre-surgical procedure checklist. Tech A.A. took a set of pre-procedure vitals and documented a weight of 149.7 pounds. The record shows that a staff member mixed up three one-liter bags of tumescent solution with 1,000 mg of lidocaine per liter and calculated the maximum dose of lidocaine. Three total bags were infused for a total volume of 3.33 Liters. Respondent did not sign this medication documentation. Staff members at

Precision M.D. reported that the unlicensed staff, not Respondent, routinely mix up the tumescent solutions for liposuction procedures. Unlicensed staff members also routinely administer I.V. medications during the surgery.

59. There is a handwritten chart note, not signed by Respondent, documenting the procedure. It states that an I.V. was placed in the left arm, incisions were made to the abdomen at 1:37 p.m., the infiltration was begun at 1:39 p.m., and the total amount infiltrated was 3,333 cc. The Vaser was started at 1:45 p.m., lasted for 28 minutes, and suction began at 2:19 p.m., with 2,900 ml suctioned. The procedure ended at 2:55 p.m. The note states that 1 milliliter of atropine was administered at 3:15 p.m., but there is no explanation for this. The note states that Patient 4 tolerated the procedure well.

60. Patient 4 recounts that she experienced an enormous amount of pain during the procedure. She recalled feeling Respondent jerking the cannula aggressively. Patient 4 cried out in pain approximately six times during the procedure, asking Respondent to stop the procedure. He would not immediately stop. On some occasions he would eventually stop and seemed to be administering more pain medication, but she could not see because there was a drape between her head and her body. It is not clear what other local anesthesia was provided or the amounts or times of dosages.

61. Patient 4's medical record also contains a typed surgical report. It is signed by Tech A.A. on November 24, 2017 and by Respondent on November 28, 2017. It also states that Patient 4 had liposuction on November 22, 2017 with 2,900 milliliters of fat removed. While it contains some of the same information as the chart notes, it contains several additional statements that are false. It states that a Registered Nurse began the preoperative assessment. It refers to an anesthesia record, although there is no anesthesia record in Patient 4's medical record. It states that Patient 4 was monitored with continuous blood pressure readings and EKG monitoring and that these records were printed every thirty minutes. This is false. Patient 4 had no blood pressure monitoring during the procedure and at no time was she connected to an EKG monitor or leads. Staff present during the procedure confirmed that Respondent did not have intraoperative EKG or blood pressure monitoring available at his practice. Patients at Precision M.D. were only

hooked up to an oxygen monitor on their finger. The operative report further states that Patient 4 was given nitrous oxide, but she does not recall breathing into any tube or receiving nitrous oxide. The template surgical report states that a "standard manual technique" was used in the liposuction. There is no more specific description, and there are no end points noted.

62. Surgical Tech A.A. reported that she and other staff prepared the operative notes using a template per Respondent's direction. The templates contained the language about preoperative procedures and continuous blood pressure and cardiac monitoring. The staff would attempt to obtain Respondent's electronic signature on these reports, but after several days if he had not signed them, they would affix his electronic signature. The staff completed all the charting for the practice and they had access to Respondent's electronic signature.

63. There are four blood pressure readings in Patient 4's chart, at 12:30 p.m., 3:18 p.m., 3:26 p.m. and 3:56 p.m. At 3:18 p.m. Patient 4's blood pressure had decreased to 64/37 with a heartrate of 50. At 3:26 p.m., her pulse was 51, and her blood pressure was 90/62 HR. Only one set of vitals were taken after that time, at 3:56 p.m. Patient 4 was discharged home with her friend to drive her after the procedure. There are no further post-operative vital signs, and no record of ACLS certified staff monitoring the patient after surgery. There were no written discharge protocols noted or established before discharge.

64. Patient 4 had been under the impression she would be able to return to work the following week after the surgery, but she found she was in so much pain after the procedure that she was unable to return to work for approximately two weeks. She returned for follow up appointments with Respondent on or about November 24, 2017, December 6, 2017, and February 21, 2018. The February 21, 2018 note states, "one-hour touch up Vaser lipo" but there is no physician note that day.

65. Patient 4 reported that following her procedure, she complained to Respondent that she was experiencing lumpiness and unevenness in her abdomen. Respondent documented that this was the result of Patient 4's failure to wear her compression garment as directed. Patient 4 stated that she wore the compression garment for three weeks. After several months, Patient 4 noted she had a roll around her midsection that was not going away. Respondent told her she

needed another procedure to remove the roll. He told Patient 4 it would cost $2,000.00. Patient 4 reluctantly agreed.

66. On March 1, 2018, Patient 4 returned to Precision M.D. for a procedure on her upper abdomen. Her CareCredit card was charged $2,000.00 on March 1, 2018. Again, she signed an electronic tablet on March 1, 2018, and her electronic signature was added to a large package of consents and waivers that she did not review, and many of which were not applicable to her procedure. Respondent did not document any history or physical. There was no clearance for surgery or discussion of the need for atropine at the last surgery. Patient 4 was provided Norco again, and two doses of Valium 5 mg. Patient 4 was given Ceftriaxone intramuscularly in the right deltoid.

67. Tech A.A. documented mixing up the bags of tumescent solution. She mixed four bags, although only two of the bags were documented to have been infused, for a total of 2,222 cc. As with the first surgery, there is a handwritten report without Respondent's signature, and typed surgical reports with Tech A.A. and Respondent's electronic signatures. The procedure started at 12:06 p.m. and ended at 1:05 p.m. Vital signs were taken at 10:30 a.m. and 1:13 p.m. A total of 1,100 ccs were noted to be suctioned. Patient 4 reported that this procedure was even more painful than the first, despite Respondent having assured her it would not be as painful as the first. She found the pain to be excruciating and requested more pain medication several times.

68. For this procedure, there are two typewritten surgical reports, both signed electronically by Tech A.A. and Respondent. Both falsely state that Patient 4 was continuously monitored with a blood pressure machine and an EKG throughout the procedure. Both refer to a non-existent anesthesia record and history and physical. One of the reports, however, falsely reports that Patient 4 had fat transfer to the buttocks of 775 milliliters per side. This note is electronically signed by Respondent on March 1, 2018, the day of the surgery.

69. Patient 4 suffered severe pain after the procedure, and found that she used up all the medication Respondent prescribed. He prescribed more medication for her. In the weeks after the second procedure, Patient 4 noticed her abdomen becoming more and more lumpy. Photographs of the area show folds and creases of skin covering the abdomen. Patient 4 raised

the issue with Respondent who told her that different people heal differently. Respondent recommended Patient 4 undergo Venus Legacy treatments to temporarily improve the appearance of her stomach. Patient 4 paid an additional $2,000.00 for this treatment. During August or September of 2018, Respondent's office performed an additional procedure for skin tightening that involved a red light being pressed over her abdomen. This procedure was not painful. Respondent did not charge Patient 4 for this procedure.

70. Finally, Respondent recommended Patient 4 undergo a procedure that involved J-Plasma. This time, Patient 4 was unwilling to undergo any more treatments with Respondent. She sought treatment from a Board-certified Plastic Surgeon who told her that he could not perform surgery because Respondent removed too much fat. Patient 4 continues to experience nerve pain in her abdomen to this day.

Patient 5

71. During October and November of 2018, Patient 5 performed internet research looking for a physician who performed facial freckle removal. On or about November 29, 2018, Patient 5 had her first appointment at Respondent's Office for a consultation. At her initial consultation, Patient 5 only met with Ms. L.A., and did not meet with Respondent. Ms. L.A. examined Patient 5's face and diagnosed Patient 5 as having freckles and stated that she was a candidate for a PicoWay Resolve Treatment.[3] Ms. L.A. told Patient 5 that the PicoWay Resolve Treatment would remove her freckles. Patient 5 did not have freckles and instead had dermatosis papulose nigra, which is grouped, in the same family of non-malignant skin lesions called seborrheic keratoses.[4] Nonetheless, based on Ms. L.A.'s representations, Patient 5 agreed to have the PicoWay Resolve Treatment performed. Patient 5 agreed to pay Respondent's practice a total of $2,400.00 for three PicoWay Resolve Treatments. Ms. L.A. assisted Patient 5 to open a

[3] PicoWay Resolve is a laser device used for benign pigmented lesions such as freckles and age spots. The technology uses an ultra-short laser pulse to breakdown the pigment into smaller particles.

[4] Management of dermatosis papulose nigra, if treated at all, is most commonly achieved for cosmetic reasons only; they are not medically necessary to remove. Because these lesions are relatively small and supervision, the most common treatment is light electrodesiccation using low power settings. Lasers are not a preferred first line of treatment. PicoWay Resolve has not been cleared by the FDA to treat dermatosis papulose nigra.

CareCredit to pay for the procedures and the required creams and medications that are used post-operatively. Patient 5 did not receive a complete treatment plan to coincide with the opening of her CareCredit account. Patient 5 electronically signed an electronic tablet and her signature and initials were applied to various consent forms, cancellation policies, waivers, and non-disclosure agreements. Respondent failed to examine Patient 5 on November 29, 2018, and failed to perform a consultation of her on that date. Patient 5 did not meet Respondent in any way on that date.

72. On or about December 21, 2018, Patient 5 arrived at Respondent's clinic for her first PicoWay Resolve Treatment. Nurse K.S. performed a PicoWay Resolve laser treatment for "freckles and moles" on Patient 5's face using the following settings: 2.5 J/cm, 6 mm x 6 mm. spot size, 3,272 pulses at 1064 nm wavelength; and .30 J/cm, 6 mm x 6 mm spot size, 2,152 pulses at 532 nm wavelength. Respondent failed to document a consultation note clearing Patient 5 for this laser treatment, did not meet Patient 5 on December 21, 2018, and failed to supervise Nurse K.S. in any way as she performed this laser procedure on Patient 5's face. A treatment record documented by Nurse K.S. stated that pictures of Patient 5's face were taken before the PicoWay Resolve cosmetic procedure was performed but there are no photos from December 21, 2018, documented in Patient 5's medical record. The procedure took approximately 15 minutes and following the procedure, Nurse K.S. told Patient 5 that healing could take up to five days.

73. In the beginning of 2019, Patient 5 attempted to call and cancel her scheduled second PicoWay Resolve Treatment. Despite previously signing a cancellation policy on November 29, 2018, that stated she risked a cancellation fee of $250.00, Respondent's staff told Patient 5 that she would lose the entire $800.00 for the PicoWay Resolve laser treatment because she was cancelling within seven days of the scheduled procedure. Patient 5 wanted to cancel her appointment because she felt the recovery time was too long and she was going to miss too much work. Out of concern that she would be forced to lose the full $800.00, rather than a portion of the amount, Patient 5 felt compelled to go forward with the second PicoWay Resolve procedure. Patient 5 specifically requested a consultation with the Respondent on the date scheduled for her second PicoWay Resolve procedure to ensure that she was receiving proper treatment.

74. On or about January 10, 2019, Patient 5 went to Respondent's office for a second PicoWay Resolve procedure. At this visit, for the first time, Respondent performed a consultation, he examined and felt Patient 5's face, and he diagnosed her with having moles. Based on Respondent's examination, Patient 5 was given the impression that she actually had moles and not freckles. Respondent misdiagnosed Patient 5 by failing to diagnose her with dermatosis papulose nigra. Respondent recommended that Patient 5 undergo a "TRL single spot" procedure rather than the PicoWay Resolve laser because the Respondent stated this was the best treatment option to remove moles.[5] Respondent told Patient 5 that she would feel some pain and that her face would be red for two to three days after having the TRL laser treatment. Respondent failed to articulate that Patient 5 could experience burning and scarring as a result of the procedure, nor did he offer her less invasive alternatives. Respondent failed to articulate the nature of the procedure and delineate the goals of Patient 5's treatment. Respondent failed to obtain Patient 5's written consent prior to carrying out the TRL treatment. Patient 5 verbally agreed to have Respondent perform the TRL treatment.

75. Prior to performing the TRL treatment, Respondent failed to recognize that the patient's skin color was a Fitzpatrick phototype 4, which placed Patient 5 at risk of excessive scarring and pigmentary complications following treatment with ablative lasers. Respondent did not explain to Patient 5 that her skin color placed her at a greater risk for complications. Photos were taken of Patient 5 prior to the procedure being carried out which clearly show her skin color and that she had evidence of dermatosis papulose nigra. There is no evidence of burning or scarring in the photos taken on January 10, 2019, before Respondent performed the laser procedure. Respondent did not perform a test spot with the TRL on patient 5, nor did he undergo the process of treating just one lesion to determine if Patient's 5's skin type was at risk for post inflammatory hyperpigmentation and scarring. Respondent falsely documented in Patient 5's medical chart that on or about January 10, 2019, that he or someone in his office asked her whether any of her lesions had changes in color, texture or depth. Respondent falsely

[5] The Contour TRL ("tunable resurfacing laser") is an ablative laser, which removes the top layer of skin by vaporizing the tissue. The length of recovery time will depend on the depth of the treatment.

documented in his medical chart that on or about January 10, 2019, he explained to Patient 5 that she has, "Asian skin type 4 and there is possibility of hypo and hyper pigmentation that can last for few months." Patient 5 reported that Respondent never mentioned her "Asian skin" until February 2019 and that the assessment paragraph contained in Respondent's January 10, 2019, progress note is false.[6]

76. On or about January 10, 2019, Respondent treated Patient 5 with a TRL single spot at the following settings: 2940 nm Erbium:YAK laser at a rate of 8.0, 25 micron depth, and 2 mm spot size. The TRL single spot procedure took approximately 15 minutes to go over Patient 5's entire face. Immediately, following the procedure, Patient 5 was shown a mirror and she felt that Respondent had "messed up." Following the TRL procedure, Patient 5 signed a written consent form for the TRL procedure.

77. Between January 10, 2019, and February 13, 2019, Patient 5 repeatedly returned to Respondent's office for follow-up after the TRL procedure. During that time, photos were taken of Patient 5's face. The photos showed extensive burning and scarring across Patient 5's face where Respondent had performed the TRL treatment. During that time, Respondent often failed to document follow-up treatment notes, such as January 15, 2019, and January 28, 2019, and he refused to perform a close up physical examination on January 18, 2019, and January 28, 2019. On February 13, 2019, at a follow-up appointment, Respondent mentioned for the first time to Patient 5 that she had "Asian skin" and that her skin color would heal differently and be darker for a longer period following TRL treatment. Patient 5 felt information on healing related to her skin tone and color would have factored into her decision to have the TRL procedure performed in the first place. Following the February 13, 2019, visit, Patient 5 lost all faith and trust in Respondent and chose to seek a second opinion.

78. Between March 7, 2019, and through September 16, 2019, Patient 5 has had multiple follow-up procedures performed by a Board-Certified Dermatologist to correct the burning, redness, and scarring caused by Respondent's use of lasers on Patient 5's face.

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[6] Respondent mislabeled the January 10, 2019, progress note as occurring on January 11, 2019, and signed off on the chart on February 20, 2019.

Patient 6

79. On or about early 2018, Patient 6 sought out cosmetic medical services for treatment of her history of acne on her jawline and face. Patient 6 contacted Respondent's clinic for a "free" consultation and Respondent's office was told that she needed to provide a credit card number. Patient 6 later attempted to cancel this consultation, but she was informed that if she cancelled or no-showed to the consultation, her credit card would be charged $100.00. On or about March 1, 2018, Patient 6 went to Respondent's clinic for her consultation. At her initial consultation, Patient 6 only met with Ms. L.A. Patient 6 informed Ms. L.A. that she had a history of acne and had received facials and chemical peels in the past to treat her skin. Ms. L.A. informed Patient 6 that she was a candidate for the Halo™ procedure.[7] Ms. L.A. did not mention any other treatment options and stated that the Halo procedure had "promising results," and that Patient 6 would be happy with the outcome. Ms. L.A. documented on a consultation note that she recommended two Halo procedures at a total cost of $3600.00.

80. Patient 6 was hesitant about moving forward but Ms. L.A. strongly urged her to agree to the procedure, and assured her she would have wonderful results. Patient 6 was told that she would need to purchase topical treatments and two Halo procedures at a cost of $3,600.00[8]. Patient 6 placed a little more than half of the amount on her credit card and was asked to electronically sign documents. Respondent failed to examine Patient 6 on or about March 1, 2018, failed to perform a consultation with Patient 6, nor did Patient 6 meet Respondent in any way on that date. Respondent falsely documented a "consult form" for March 1, 2018, where he stated that he had performed a full consultation with Patient 6.

81. Immediately following her consultation with Ms. L.A., Patient 6 began to have second thoughts regarding her upcoming Halo procedure. On or about March 2, 2018, Patient 6 went to Respondent's clinic and requested that the office cancel her procedure and she explained

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[7] Halo Laser Treatment uses hybrid technology of a non-ablative laser, combined with an ablative laser to create controlled zones of coagulation to chosen depths unto the dermis that stimulate new collagen and fractionally vaporize micro laser channels into the epidermis; addressing time and texture of the skin.

[8] $2000.00 for the first procedure and a discounted rate of $1600.00 for the second procedure.

that she needed to be out of the country to take care of her sick grandmother. The receptionist, after consulting with Ms. L.A., told Patent 6 that Respondent's clinic would not refund her credit card or cancel her procedure. Respondent's refusal to refund Patient 6's credit card was in violation of his Office's own cancellation agreement that Patient 6 had previously electronically signed and initialed on March 1, 2018, which specifically stated that Patient 6 was subject a $250.00 cancellation fee if the procedure was cancelled within seven business days of the planned procedure. Instead, Respondent's office staff offered to refund Patient 6's personal credit card if Patient 6 opened a third party medical credit company account through CareCredit to pay for the two Halo procedures and for the required creams and medications that were to be used post-operatively. Patient 6 agreed to open a CareCredit account in exchange for having her personal credit card refunded. After refunding Patient 6's credit card, Respondent's office staff billed Patient 6's newly opened CareCredit account a total of $3,884.46.

82. On March 8, 2018, Patient 6 returned to Respondent's clinic for the Halo laser procedure. Patient 6 requested that the procedure be cancelled but was informed that she could not cancel the procedure without forfeiting the $2000.00 fee. Prior to the procedure, Patient 6 electronically signed on an electronic pad and was told that her signature would be cut and pasted onto the consent forms. Patient 6 was not provided an opportunity to read or review the consent forms before the procedure. Respondent's clinic staff took photos of Patient 6's face and uploaded the photos in to her medical chart. Respondent's staff then brought Patient 6 to a procedure room. Respondent did not perform a consultation, nor perform an examination prior to Patient 6's Halo procedure.

83. Nurse K.S. performed the Halo procedure on Patient 6. Respondent did not supervise Nurse K.S. as she performed the Halo procedure. The Halo procedure took approximately 10 to 15 minutes and Patient 6 felt nothing during the procedure. There was no pain, no heat, or pressure. After the procedure, Patient 6 did not notice any change in the feeling or appearance of her skin. Patient 6 was unsure whether the Halo machine was actually operational during the procedure. According to Nurse K.S.'s procedure note she used the following settings while performing Patient 6's procedure: 1,470 nm laser at 450 microns and 50% coverage, and the

2,940 nm laser at 50 microns and 20% coverage and energy was delivered in the range of 91-494 Joules. After the procedure, Respondent's staff provided Patient 6 a copy of her consent forms as she was walking out of Respondent's clinic.

84. On or about March 15, 2018, Patient 6 went to Respondent's office for a follow-up appointment. Patient 6 met Respondent for the first time at the follow-up appointment. Patient 6 informed Respondent that she was not satisfied with the procedure and stated that she had new acne and pimples from the topical medications that she had purchased from Respondent's clinic. Respondent stated the medications she had received were too greasy for her skin and recommended that she purchase two additional skin care products from Respondent's clinic. Respondent stated that it appeared based on his review of the before procedure photos that Patient 6 had experienced a big improvement from the Halo procedure. Patient 6 stated that she did not wish to go forward with a second Halo procedure because she was unhappy with the results and felt there was no difference. Respondent stated that Patient 6 needed multiple Halo procedures, at least three more, to get the results that she desired. Patient 6 was shocked and dismayed to hear this as Ms. L.A. had told her that she would receive the desired results after no more than two treatments. On or about March 28, 2018, Respondent's office cancelled Patient 6's second Halo procedure and refunded her $1,600.00. Respondent failed to document progress notes for March 15, 2018, and March 28, 2018, in Patient 6's chart. Patient 6 did not seek a second opinion regarding Respondent's Halo procedure or the treatment that she received.

Patient 7

85. In and around May 2018, Patient 7 began searching for a physician who performs cosmetic procedures to treat unwanted loose skin and fat on her underarms. After finding Respondent's website on the internet that advertised cosmetic procedures, Patient 7 called Respondent's clinic. After a couple of phone calls with Ms. L.A. regarding her concerns and desires in having the loose skin tightened up, Patient 7 scheduled a face to face consultation with Ms. L.A.

86. On May 9, 2018, Patient 7 attended a consultation with Ms. L.A. at Respondent's office. Respondent did not attend the consultation and did not examine Patient 7. During the

consultation, Ms. L.A. informed Patient 7 that she was a candidate for liposuction under her arms. Ms. L.A. informed Patient 7 that she had a girlfriend who had liposuction under her arms and that her friend was able to return to work the following day. Ms. L.A. did not discuss any other treatment options with Patient 7, nor did Ms. L.A. mention any risks or complications associated with liposuction. Ms. L.A. did not advise Patient 7 that she needed to have a consultation with Respondent prior to proceeding with the liposuction procedure. At the end of the visit, Ms. L.A. convinced Patient 7 to open a third party medical credit company account through CareCredit to pay for the $4000.00 cost of the liposuction procedure.

87. Following the consultation with Ms. L.A., Patient 7 requested that she meet with Respondent to receive assurance that the liposuction procedure was an appropriate treatment. On May 15, 2018, Patient 7 attended a consultation with Respondent at his office. Respondent told Patient 7 that she was a good candidate for liposuction. Respondent stated she would be "very happy" with the outcome and that he would "sculpt" her underarms as part of the procedure. Respondent did not discuss any other possible treatment options with Patient 7, and he did not suggest that she would need additional procedures and treatments to achieve the cosmetic results that she wished to receive. Respondent did not tell Patient 7 about any risks and complications related to having liposuction. Patient 7 was nervous about proceeding with the procedure and Respondent leaned over and gave her a hug and told her everything would be fine. Patient 7 decided to go forward with the procedure. Patient 7 was not provided any documents to review or sign prior to the date of her scheduled liposuction procedure on May 31, 2018.

88. Respondent documented a progress note for the May 15, 2018, consultation with Patient 7. Respondent falsely documented that he explained the risks and complications of liposuction to Patient 7. Respondent falsely documented that he explained alternative treatments to Patient 7. Respondent falsely documented that he explained to Patient 7 that she would need additional treatments beyond liposuction to achieve the cosmetic results that she was looking for by having the procedure performed. Respondent's progress note failed to document an adequate history and physical prior to Patient 7 being scheduled for liposuction. Respondent failed to document that he addressed Patient 7's history of depression, and failed to document a past

surgical history. Respondent failed to document a history of the medications that Patient 7 was actually taking and Respondent failed to document a past surgical history. Respondent did not document a complete history and physical which included a cardiac and pulmonary examination. Respondent's May 15, 2018, consultation note while signed by Respondent, is not dated and was not completed within Respondent's electronic health record system and lacks an appropriate time stamp to indicate when it was actually drafted and signed.

89. On May 31, 2018, Patient 7 arrived at Respondent's office location for her liposuction procedure. Patient 7 had a friend drive her to the office and planned on having the friend drive her home following the procedure. Respondent's office staff provided Patient 7 an electronic tablet and they told her to sign her name on the tablet. Patient 7 signed her name into the tablet. Patient 7 was not provided an opportunity to read and review any of the documents and she did not know how many documents her signature and initials would be affixed to. The first time Patient 7 saw all the forms her signature applied to was on July 25, 2018, when she requested a complete set of records. After Patient 7 provided the electronic signature, she was wheeled outside of the main office to the surgical suite around the corner from Respondent's main office.

90. Upon entering the surgical suite, Patient 7 observed that the suite was dirty and disorganized. She observed that there appeared to be a full garbage bag of medical waste in the corner from a previous procedure. Patient 7 was told to change into her surgical garments and was provided a Valium, hydrocodone and other medications prior to her procedure. Respondent's staff took photos of Patient 7's arms. Respondent failed to document Patient 7's BMI (body mass index) and patient weight prior to starting surgery.

91. According to a May 31, 2019 handwritten chart note, Respondent made his incision in the right arm at 9:41 a.m., began infiltrating the tumescent solution into Patient 7's right arm at 9:41 a.m., and began the Vaser procedure on Patient 7's right arm at 9:46 a.m. The tumescent fluid was prepared by a medical assistant. Respondent began suctioning Patient 7's right arm at 10:02 a.m. and collected 650 cc of fluid from the right arm. According to the handwritten note in Patient 7's chart, Respondent made an incision on Patient 7's left arm at 10:22 a.m., started

infiltration at 10:23 a.m., and started the Vaser procedure at 10:19 a.m. Respondent began suctioning at 10:30 a.m. and collected 850 cc of fluid from the left arm. According to the medical records, only two vital signs were taken of Patient 7 during the procedure, one at 8:30 a.m., and one at the end of the procedure. There is no record of continuous intraoperative monitoring for Patient 7's vital signs every 15 minutes, including her heart rhythm, blood pressure, pulse, and oxygen saturation, despite having Patient 7 under conscious sedation and being highly dosed with lidocaine. Patient 7 did not have EKG pads or a blood pressuring device placed on her during the liposuction procedure. During the procedure, Patient 7 also received nitrous oxide and was not properly monitored during the process. Respondent did not document the times when Patient 7 was placed on and off nitrous oxide, the flow rate, and how the nitrous oxide was administered.

92. Patient 7 felt immediate pain upon Respondent beginning the Vaser liposuction procedure on her right arm. Patient 7 kept moving around and the Respondent kept scolding her to "stop moving." The Respondent did not inquire in to why the procedure was causing Patient 7 so much pain. Despite Respondent's documentation stating that his office would wait up to an hour to let the tumescent solution diminish the pain receptors in Patient 7's right arm, Respondent proceeded a mere five minutes after insertion of the fluid which likely had not had enough time to numb the area that was being liposuctioned. Respondent then proceeded to Vaser Patient 7's left arm. Patient 7 reported that her left arm hurt very badly as well, but not as badly as the right arm. Respondent failed to use and establish appropriate liposuction endpoints, including visual inspection, pinch test, and bloody aspirate, prior to concluding the liposuction procedure on Patient 7. Following the completion of the liposuction procedure, Respondent immediately left the room and left his assistants to get Patient 7 up, dressed, and discharged from his office. As she was being discharged, Patient 7 was told for the first time that she needed someone to stay with her that night and ensure that she was safe. Patient 7 was discharged by Respondent's medical assistants, not Respondent, and was not provided any instructions on how long she needed to wear the compression garments on her arms. There is no documentation that a series of post-operative vitals were taken, no documentation that Respondent evaluated Patient 7 at discharge and there is no record that the discharging staff who were observing Patient 7 were

ACLS certified. Respondent prescribed an antibiotic, Keflex, 500 mg. two times a day for ten days, rather than the appropriate dosage of 500 mg. four times a day for one day. Respondent used ceftriazone for surgical prophylaxis despite no evidence that Patient 7 had allergies rather than the more appropriate cefazolin.

93. On June 1, 2018, Patient 7 saw Respondent for her one-day follow-up examination. In Respondent's notes he documented that she had liposuction on her arms but under comments stated that Patient 7 was in clinic for post 1 day liposuction on her abdomen. During the follow-up examination, Patient 7 became "hot and sweaty," light-headed and almost fainted. Respondent failed to document that Patient 7 experienced heat related complications and almost fainted in the June 1, 2018, examination note. Respondent informed Patient 7 that she needed to wear her compression garments for two to three weeks, that the procedure went smoothly and that everything looked good.

94. On or about June 6, 2018, Patient 7 went to Respondent's clinic and had a follow-up appointment regarding a rash on her hands. Vital signs were documented. Respondent did not document a progress note. On or about June 19, 2018, Patient 7 went to Respondent's clinic and had a follow-up appointment regarding bumps on the back of her triceps and to discuss massaging. Respondent did not document a progress note. During the visit on or about June 19, 2018, Respondent informed Patient 7 that she no longer needed to wear the compression garments. Patient 7 complained that her arms were not turning out as Respondent had promised. Respondent informed Patient 7 that she should have the Venus Legacy[9] treatment. This was the first time anyone from Respondent's clinic indicated to Patient 7 that she may need additional treatments and procedures beyond liposuction in order to get the results that she wanted.

95. On or about July 19, 2018, Patient 7 had a seven-week follow-up appointment regarding her liposuction procedure with Respondent. Respondent authored a treatment note. Patient 7 told Respondent that she was not happy with the results of the liposuction procedure and

[9] Venus Legacy™ is a non-invasive devise that uses multi-polar radio frequency and pulsed magnetic fields to create a therapeutic heat matrix over the skin. It creates a thermal reaction under the tissue that stimulates the body's natural healing response, increasing blood circulation and causing the skin to contract.

that she was frustrated with him and his office. Patient 7 told Respondent that she felt that he and his staff had not been truthful about the procedure and what she should expect following the procedure. Respondent stated that he did nothing wrong and that it's "just your arms." Respondent documented that Patient 7 had asked for injections to remove the lumps and wrinkles from her arms but that he had refused because the requested injections were not within the standard of care. Respondent documented that he recommended the Venus Legacy treatment but that Patient 7 stated she could not pay for additional procedures. According to Respondent, Patient 7 made numerous phone calls and sent numerous e-mails to the clinic complaining about his care however, there is no record that any of these communications were documented in Patient 7's medical chart.

Patient 8

96. Patient 8 was a 66-year old woman when she met with Respondent on January 5, 2019 to address her concerns about acne on her face. She inquired about the Halo treatment for the acne. She had received Botox and Juvederm from Respondent on previous occasions. Respondent told Patient 8 that she had melasma and that the Halo procedure had a good success rate for treatment of melasma. He did not warn her of any risks or side effects of the Halo treatment or discuss any other possibilities for treatment of her concerns. He inquired what the limit was on her CareCredit card, and when she told him it was $2,000.00, he immediately got on the phone and had the limit raised to $6,000.00. Respondent told Patient 8 that he recommended two treatments with the Halo machine, and that both procedures would cost $4,000.00 but that he would give her a $400.00 discount. He charged her CareCredit card for both procedures on that day and told her that she would not be able to receive a refund if she canceled the second procedure. He also charged her approximately $400.00 for various topical skincare products his office sells under a Precision M.D. label, including hydroquinone. Patient 8 asked if she could obtain the products online for a lower price, and he told her that she needed to purchase the ones he sold at his practice.

97. Patient 8 has Fitzpatrick Phototype 6 skin, which places her at higher risk for complications from the Halo laser treatment. Respondent did not inquire whether Patient 8 had

any history of attempting other less invasive treatments for melasma before recommending the Halo treatment. He did not recommend that Patient 8 attempt topical lightening creams such as hydroquinone, tretinoin, or niacinamide before proceeding to the laser treatment. Although he recommended that she use hydroquinone cream, he did not allow it time to work before proceeding with the laser treatment. He did not recommend oral tranexamic acid, or chemical peeling before proceeding to the Halo laser, which is a more expensive procedure, and has increased risks for Patient 8's skin type.

98. An employee at Respondent's office brought Patient 8 an electronic tablet and asked her to sign and initial it. Her signature and initials were subsequently applied to a large amount of paperwork, including waivers and releases and informed consents. Patient 8 did not have an opportunity to review these documents before signing or before the procedure. One of the documents Patient's 8 signature was applied to was an informed consent for use of nitrous oxide, which was not applicable to her treatment. A female staff member brought Patient 8 to a treatment room and performed the Halo procedure without Respondent present. Patient 8 did not know that Respondent would not be performing the procedure himself.

99. The treatment records show that Registered Nurse K.S. performed the procedure on Patient 8. She documented using settings recommended by Respondent, and treating the full face. The employee did not perform a patch skin test on Patient 8's skin before using the Halo laser on her face. Patient 8 was wearing a personal hat as part of her outfit that day, and the employee who performed the procedure did not ask her to remove it. Patient 8 found the Halo laser procedure was very painful. Patient 8 had not been warned that the procedure would be painful and she was shocked by how painful it was. The treatment records states that Nurse K.S. applied anti-inflammatory and anti-bacterial cream, provided post treatment instructions and made an appointment for a one-week follow up.

100. When Patient 8 returned home after the procedure, she noticed that the areas of her skin that had been treated were much darker than before the treatment. She also noticed that the areas where her hat had been covering her face were not treated, and were not darker. She had

not been warned that the treatment could make her face darker, and was concerned that the procedure had not been done correctly.

101. At a follow up appointment on January 15, 2019, Respondent diagnosed Patient 8 with a fungal infection and prescribed anti-fungal treatment. He directed her to stop using certain topical products she purchased from his office and to return in a week. As of January 15, 2019, Patient 8 was still listed as having two Halo treatments scheduled. Respondent documented a February 19, 2019 follow up appointment in which he stated that Patient 8 was unhappy that her melasma was not gone. He wrote that he had successfully treated Patient 8's fungal infection and that Patient 8 had not been compliant with the hdryoquinone treatment and was only having one Halo treatment. On March 12, 2019, Patient 8 was refunded $1,600.00 on her CareCredit Card, apparently for the second Halo treatment, which she canceled.

102. Respondent backdated and falsified a consultation note, dated January 5, 2019. He documented that on January 5, 2019, he recommended Patient 8 undergo two Halo treatments for treatment of melasma, and that she elected to only undergo one treatment. He falsely stated that he warned her of risks of treatment, such as worsening melasma, and laser burns, and that she understood and elected to proceed with the single Halo treatment.

103. Patient 8 found that the darkening of her skin has not improved. She has continued to seek treatment for her darkened skin with other providers and using other treatments.

Patient 9

104. Patient 9 is a Spanish-speaking woman who saw Respondent's cosmetic services advertised on a local Spanish-language television channel. She went to Precision M.D. on or about March 14, 2018, seeking injections to improve the appearance of wrinkles in her face at the outside edges of her eyes (frequently referred to as "crow's eyes"), and lines between the outside of her lips and the bottom of the chin (frequently referred to as "marionette lines"). Patient 9 spoke to a Spanish-speaking employee at Precision M.D., Ms. C.J. She explained to Ms. C.J. that she wanted Voluma injections in the two areas. Ms. C.J. told Patient 9 that Botox works well around the eyes. Patient 9 agreed to have Botox around the crow's feet and Voluma in the marionette lines.

105. Patient 9 was provided with a series of paperwork and consent forms in English. She signed and dated the forms. Another female employee took Patient 9 to pay for the procedures. Patient 9 paid $240.00 for the Botox treatment and $850.00 for the Voluma treatment. After paying for the procedures, a staff member took her to the treatment room and took photographs of her face. At no point prior to payment did any nurse or physician evaluate her or discuss her treatment options or recommendations with her.

106. Respondent then entered the room and walked over to Patient 9 without speaking to her or introducing himself. He silently began performing injections. He injected her around her eyes. He then injected directly into the middle of her chin. At this point Patient 9 spoke to Respondent and asked him if he was going to inject the sides of her chin. He responded that he already had done so. Patient 9 knew this was false because she felt where he injected her chin and it was in the middle. He then abruptly left the room.

107. Respondent signed a consultation note, dated March 14, 2018, falsely stating that he spoke with Patient 9, and explained the risk and benefits of Voluma and Botox, and answered all her questions. At his interview with Board investigators, Respondent claimed that he did speak with Patient 9 and provide her with the information and advice. Respondent did not document the locations of the injection sites or the lot or serial number of the substances injected. Patient 9 subsequently called Precision M.D. to explain that she was unhappy with the results of her treatment on the chin because the area she wanted treated was not addressed. Patient 9 was told that she would be charged $100.00 for any follow up appointment or consultation, and therefore elected not to return.

Unlawful Electronic Signatures and Forms at Precision M.D.

108. Respondent instituted a policy at Precision M.D. where patients would not have an opportunity to review and sign documents in hard copies while signing. Instead, patients are provided with an electronic tablet on which to place their signature and initials. Respondent's staff would then apply the initials and signature to various packages of documents without the patient's specific knowledge and input. The patient does not have control over the specific documents and areas of documents to which their initials and signatures are applied. This does

not constitute a knowing and intelligent acknowledgment or agreement to any of the terms the patients' signatures and initials are applied to.

109. Often, the employees who apply the patients' signatures and initials have no more understanding of the documents than the patients do. This leads to the employees applying signatures and initials to documents purporting that the patients acknowledged and consented to treatments that neither the patient nor Respondent even contemplated. For example, Patients 1, 2, 3, 4, and 7 all received Vaser liposuction procedures. But Precision M.D. applied all these patients' electronic signature to consent forms for both Vaser Liposuction and Smart Liposuction procedures. Respondent has not performed Smart Liposuction procedures for several years and did not perform it on these patients. Similarly, Respondent's staff applied Patient 9's electronic signature and initials to a consent form for nitrous oxide. Because Patient 9 was not undergoing any type of surgical procedure, neither she nor Respondent had any intention of using this gas during her injections. Respondent even failed to correct a cut and pasted name of a different medical facility in his boiler-plate documents.[10] This demonstrates that the electronic signatures applied by these patients to various consent forms were not knowing or intelligent acknowledgments or waivers to any of the procedures. Moreover, with the exception of Patient 6,[11] all the patients alleged in this Second Amended Accusation had their electronic signatures applied to consent forms on the very day of their procedures. These documents contain instructions to patients that they should have received before the procedure, such as information about stopping certain medications two weeks before the procedure.

110. Before any of the patients could even meet with Ms. L.A., Respondent required them to have their electronic signature applied to a packet of documents relating to cancellation polices, non-disclosure, arbitration, and privacy waivers. Many of the terms in these agreements are unconscionable contract provisions. For example, all nine patients had their electronic signature affixed to a form entitled "HIPAA Policy" in which the following provision occurs:

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[10] The Nitrous Oxide consent form refers to the business "Sculpted Contours Luxury Medical Aesthetics" instead of Precision M.D. This is business in Atlanta, Georgia.

[11] Patient 6 did not even sign a tablet for staff to electronically apply her signature on the date of her first treatment.

> I understand and acknowledge that in the event I designate (*sic*) or criticize Precision M.D. Cosmetic Surgery Center And/Or Dr. Mahmoud Khattab, online or in any public form, I hereby unconditionally authorize Precision M.D. Cosmetic Surgery Center And/Or Dr. Mahmoud Khattab to make specific reference in his response to my statements to the medical care Precision M.D. Cosmetic Surgery Center And/Or Dr. Mahmoud Khattab provided to me and I waive any HIPAA protections or any other protections or defenses that I would otherwise have for the privacy of my medical records.

Respondent uses this provision to silence and intimidate patients from speaking about the illegal and fraudulent activities at his practice. Respondent has gone so far as to sue patients in Superior Court for defamation due to the patients' negative online review. The Sacramento Superior Court has dismissed one of these lawsuits under Anti-SLAPP laws.

111. The nine patients alleged in this Second Amended Accusation further had their signature applied to an agreement stating that they acknowledge that Respondent may use the photographs in their medical records for advertising purposes, and that the photographs belong to Precision M.D., and do not belong to the patient. The patients also had their electronic signature prematurely applied to a general release and to onerous cancellation policies that prohibited cancellation for even medical purposes, or imposed excessive fees.

CareCredit Card Issues:

112. Patients 2, 3, 4, 5, 6, 7, and 8 used CareCredit Cards for their treatment at Precision M.D. None of the patients received a written financial disclosure form setting forth the credit and debt obligations of the CareCredit account. None of the patients received a timely, truthful, and complete treatment plan setting forth the procedure that the CareCredit account was established to finance.

Advertising Violations

113. Respondent advertises himself online as "Board-certified and a member of the Academy of Cosmetic Surgery." The Academy of Cosmetic Surgery is not part of the American Board of Medical Specialties (ABMS). Respondent is Board-certified in Internal Medicine. Respondent uses the term "Board-certified" in his advertising without specifying that his certification is from the American Board of Internal Medicine, thereby falsely giving the

impression that he has ABMS certification in a medical field relating to the cosmetic services he advertises.

114. Respondent falsely advertises that prospective patients can obtain a free consultation, but he charges a $100.00 fee if the prospective patient attempts to cancel or reschedule the consultation. Respondent and his staff provide false and misleading information about cosmetic results and downtime from surgery in both written and verbal representations. Respondent seeks and encourages staff members to obtain positive reviews in online forums like Yelp and RealSelf, and provides payments to the staff for obtaining these reviews without notifying the public of this fact.

Dishonest Statements

115. On December 5, 2019, an Investigator working on behalf of the Board sent Respondent a letter requesting that he participate in an interview regarding his care to the nine patients alleged in the Second Amended Accusation. On December 16, 2019, the Investigator provided Respondent's counsel with possible dates for an interview between January 15, 2020 and January 23, 2020. Respondent's counsel replied that Respondent would be out of the country between January 15 through 26, 2020. On January 22, 2020, Board investigators observed Respondent at his office at Precision M.D. When the interview was rescheduled, in March 3, 2020, Respondent initially told Board investigators that he was in fact out of the country in mid-to-late January of 2020. At a follow up interview on March 12, 2020, Respondent admitted that he had not actually left the country, but contended that he had originally planned a trip, which he subsequently canceled.

116. During the interviews, Respondent falsely stated that he had only had two malpractice cases filed against him. At the first interview, Respondent claimed that he did in fact have a crash cart, in his surgical suite, that he uses an EKG and blood pressure monitor continuously during surgery, and that he had written discharge policies at his practice for determining when patients were able to be safely released from care. At his second interview, he admitted that these statements were false, but provided documentation of having corrected these violations. In both interviews, Respondent continued to maintain that the consultation notes in each of the patients'

records are true and correct statements. Respondent falsely stated that he personally meets with every liposuction patient before the day of surgery and that he never meets a liposuction patient for the first time on the day of surgery. Respondent falsely stated that liposuction patients do not sign consent forms on the day of surgery.

117. Respondent falsely claims that he is the only person with access to his electronic signature. He initially claimed that he personally signed the template consent forms in each of the patients' medical records, but contradicted himself by stating that his electronic signature automatically populates when the patient signs. Respondent falsely claimed that he never leaves the practice while a patient is still being monitored by staff members after a procedure.

Liposuction Violations

118. Respondent failed to comply with safety precautions for the treatment of Patients 1, 2, 3, 4, and 7. He performed procedures on these patients in his medical office without having written discharge criteria, a transfer agreement with a nearby hospital, or hospital privileges. He allowed unlicensed staff to mix the tumescent solution, push intravenous medications, and monitor the patients during and after surgery and to discharge the patients without his input. He used conscious sedation with the patients. He failed to have endpoints for the use of the Vaser liposuction equipment, and failed to maintain it safely or understand its use. Respondent failed to use and establish appropriate liposuction endpoints on these patients, including visual inspection, pinch test, and bloody aspirate, prior to concluding the liposuction procedures.

119. Respondent performed these surgical procedures on Patients 1, 2, 3, 4, and 7, without sufficient knowledge and in a facility that was not safe and sanitary for the procedures. Respondent removed excess amounts of aspirate in all the patients than he was permitted to remove for the surgical environment and safety precautions he had in place. He removed 6,000 milliliters of aspirate from Patient 2, which is forbidden under any circumstances in an unaccredited surgical center. He failed to have the required safety measures in place for the amount of aspirate he suctioned from Patients 1, 3, 4, and 7, including measurement of fluid loss and replacement and monitoring. He used conscious sedation on all the liposuction patients, which is prohibited in a medical office.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

120. Respondent is subject to disciplinary action under section 2234, subdivision (d), in that he was incompetent in his care and treatment of Patients 1, 2, 3, 4, and 7.

121. Paragraphs 23 through 119 are incorporated as if fully set forth here.

122. Respondent was incompetent in his care and treatment of Patients 1, 2, 3, 4, and 7 for his acts and omissions, including but not limited to, the following:

a. Failing to understand the action of the Vaser liposuction equipment and to maintain it safely and use it in a way that is not harmful to patients;

b. Failing to understand and use endpoints in Vaser liposuction procedures of one minute of Vaser per 100 cc of infiltration or lack of resistance and visual inspection, pinch test or bloody aspirate;

c. Mismanaging burn injuries in Patients 2 and 3, including dissuading the patients from obtaining specialized or emergency treatment for conditions he was not qualified to treat;

d. Misusing the tissue autorgraft products in Patient 3; and

e. Using hand sanitizer as a surgical scrub.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

123. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9.

124. Paragraphs 23 through 119 are incorporated as if fully set forth here.

125. Respondent was grossly negligent in his care and treatment of Patient 1, 2, 3, 4, 5, 6, 7, 8, and 9 for his acts and omissions, including but not limited to, the following:

a. Failing to understand the action of the Vaser liposuction equipment and to maintain it safely and use it in a way that is not harmful to Patients 1, 2, 3, 5, and 7;

b. Failing to understand and use endpoints in Vaser liposuction procedures of one minute of Vaser per 100 cc of infiltration or lack of resistance and visual inspection, pinch test or bloody aspirate for Patients 1, 2, 3, 4, and 7;

c. Mismanaging burn injuries in Patients 2 and 3, including dissuading the patients from obtaining specialized or emergency treatment for conditions he was not qualified to treat;

d. Misusing the tissue autorgraft products in Patient 3;

e. Using hand sanitizer as a surgical scrub for Patients 1, 2, 3, 4, and 7;

f. Failing to obtain informed consent for Vaser liposuction for Patients 1, 2, 3, 4, and 7;

g. Using at or near the maximum amount of lidocaine in combination with other analgesics and anxiolytics for Patients 1, 2, 3, 4, and 7;

h. Performing surgery in an unsanitary and unsafe environment for Patients 1, 2, 3, 4, and 7;

i. Failing to document intra-surgical and post-surgical vital signs during use of conscious sedation at an unaccredited facility for Patients 1, 2, 3, 5, and 7;

j. Failing to maintain an anesthesia record for Patients 1, 2, 3, 4, and 7;

k. Failing to adequately document the surgical procedures for Patients 1, 2, 3, 4, and 7;

l. Failing to document waste of controlled substances for Patients 1, 2, 3, 4, and 7;

m. Allowing unlicensed staff to mix tumescent solution for Patients 1, 2, 3, 4, and 7;

n. Allowing unlicensed staff to push intravenous controlled substances and to furnish controlled substances for Patients 1, 2, 3, 4, and 7;

o. Failing to perform and document an adequate clearance for surgery within 30 days including a history and physical for Patients 1, 2, 3, 4, and 7;

p. Failing to have hospital privileges or a transfer agreement while performing liposuction in a medical office for Patients 1, 2, 3, 4, and 7;

q. Allowing unlicensed staff to consult with liposuction patients, provide surgical recommendations, and take payment without his presence or input for Patients 1, 2, 3, 4, and 7;

r. Failing to comply with liposuction statutes for monitoring and safety for Patients 1, 2, 3, 4, and 7;

s. Failing to obtain informed consent, either verbally or in writing, for wound debridement procedures in Patient 3 or for the proposed treatment of Patient 2;

t. Leaving Patient 3 alone with unlicensed staff in the middle of a liposuction procedure while he took a break;

u. Removing over 5 liters of aspirate from Patient 2;

v. Failing to obtain informed consent for use of J. Plasma in Patient 3, for a procedure that is not FDA approved;

w. Failing to document the lot or serial number of the allograft products used on Patient 3;

x. Failing to document any procedure notes of the neck or thigh treatments of Patient 3;

y. Failing to stop the procedure when Patient 2 unequivocally withdrew consent during the Vaser procedure;

z. Using nitrous oxide in an unsafe manner and failing to adequately document the use in Patient 7;

aa. Failing to document the reason for the use of atropine in Patient 4;

bb. Performing a second procedure on Patient 4 without having cleared her after requiring atropine in the prior procedure;

cc. Performing liposuction on Patient 4 despite her not being a proper candidate for the procedure;

dd. Falsely documenting consultation notes for all Patients;

ee. Allowing Nurse K.S. to perform a laser treatment on or about December 21, 2018, on Patient 5 without Respondent first examining the patient, nor did Respondent document a consultation note, before prescribing laser therapy for a skin condition that is treated by less invasive means;

ff. Misdiagnosing Patient 5's skin condition of dermatosis papulose nigra as "freckles and moles" and by performing laser treatment on Patient 5's face rather than a less invasive electrodesiccation procedure leading to excessive burning and scarring;

gg. Failing to fully articulate the risks of laser treatment on Patient 5's skin condition of dermatosis papulose nigra and failed to properly assess the goals of treatment for the patient before providing treatment prior to using the TRL procedure;

hh. Providing dermatological services to Patient 5 despite being only board certified in internal medicine and lacking the proper knowledge and skills to treat dermatosis papulose nigra with lasers;

ii. Allowing Nurse K.S. to perform a laser treatment on or about March 8, 2018, on Patient 6 without first consulting with Patient 6 and examining her before prescribing laser therapy for a skin condition that should have been treated by less invasive means;

jj. Performing a Halo laser treatment on Patient 8 before completing a trial of the required less invasive, less risky procedures for treatments of melasma;

kk. Failing to perform a test on Patient 8 despite her having Fitzpatrick phototype 6 skin;

ll. Failing to discuss the specific risks of the Halo laser procedure despite her skintype and concerns;

mm. Failing to have the required expertise to treat Patient 8's skin concern or to properly supervise the nurse who performed the Halo procedure on Patient 8;

nn. Placing his own financial interests over the best treatment options for Patient 8;

oo. Failing to document the location of injections and lot or serial number of products injected into Patient 9;

pp. Failing to consult with and listen to Patient 9's requests or to conduct a follow up without requiring additional payment;

qq. Failing to obtain a knowing and intelligent informed consent from any of the patients by applying their electronic signature to templated documents; and

rr. Applying the patients' signatures to unconscionable contracts.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

126. Respondent is subject to disciplinary action under section 2234, subsection (c), in that he committed repeated negligent acts in his care and treatment of Patients 1,2,3,4, 5, 6, 7, 8,and 9.

127. Paragraphs 23 through 119 are incorporated as if fully set forth here.

128. Respondent was repeatedly negligent in his care and treatment of Patient 1, 2, 3, 4, 5, 6, 7, 8, and 9 for his acts and omissions, including but not limited to, the following:

a. Failing to understand the action of the Vaser liposuction equipment and to maintain it safely and use it in a way that is not harmful to for Patients 1, 2, 3, 4, and 7;

b. Failing to understand and use endpoints in Vaser liposuction procedures of one minute of Vaser per 100 cc of infiltration or lack of resistance and visual inspection, pinch test or bloody aspirate for Patients 1, 2, 3, 4, and 7;

c. Mismanaging burn injuries in Patients 2 and 3, including dissuading the patients from obtaining specialized or emergency treatment for conditions he was not qualified to treat;

d. Misusing the tissue autorgraft products in Patient 3;

e. Using hand sanitizer as a surgical scrub for Patients 1, 2, 3, 4, and 7;

f. Failing to obtain informed consent for Vaser liposuction for Patients 1, 2, 3, 4, and 7;

g. Using at or near the maximum amount of lidocaine in combination with other analgesics and anxiolytics for Patients 1, 2, 3, 4, and 7;

h. Performing surgery in an unsanitary and unsafe environment for Patients 1, 2, 3, 4, and 7;

i. Failing to document intra-surgical and post-surgical vital signs during use of conscious sedation at an unaccredited facility for Patients 1, 2, 3, 4, and 7;

j. Failing to maintain an anesthesia record for Patients 1, 2, 3, 4, and 7;

k. Failing to adequately document the surgical procedures for Patients 1, 2, 3, 4, and 7;

l. Failing to document waste of controlled substances for Patients 1, 2, 3, 4, and 7;

m. Allowing unlicensed staff to mix tumescent solution for Patients 1, 2, 3, 4, and 7;

n. Allowing unlicensed staff to push intravenous controlled substances and to furnish controlled substances for Patients 1, 2, 3, 4, and 7;

o. Failing to perform and document an adequate clearance for surgery within 30 days including a history and physical for Patients 1, 2, 3, 4, and 7;

p. Failing to have hospital privileges or a transfer agreement while performing liposuction in a medical office for Patients 1, 2, 3, 4, and 7;

q. Allowing unlicensed staff to consult with liposuction patients, provide surgical recommendations, and take payment without his presence or input for Patients 1, 2, 3, 4, and 7;

r. Failing to comply with liposuction statutes for monitoring and safety for Patients 1, 2, 3, 4, and 7;

s. Failing to obtain informed consent, either verbally or in writing, for wound debridement procedures in Patient 3 or for the proposed treatment of Patient 2;

t. Leaving Patient 3 alone with unlicensed staff in the middle of a liposuction procedure while he took a break;

u. Removing over 5 liters of aspirate from Patient 2;

v. Failing to obtain informed consent for use of J. Plasma in Patient 3, for a procedure that is not FDA approved;

w. Failing to document the lot or serial number allograft products in Patient 3;

x. Failing to document any procedure notes of the neck or thigh treatments of Patient 3;

y. Failing to stop the procedure when Patient 2 unequivocally withdrew consent during the Vaser procedure;

z. Using nitrous oxide in an unsafe manner and failing to adequately document the use in Patient 7;

aa. Failing to document the reason for the use of atropine in Patient 4;

bb. Performing a second procedure on Patient 4 without having cleared her after requiring atropine in the prior procedure;

cc. Performing liposuction on Patient 4 despite her not being a proper candidate for the procedure;

dd. Falsely documenting consultation notes for all Patients;

ee. Allowing Nurse K.S. to perform a laser treatment on or about December 21, 2018, on Patient 5 without Respondent first examining the patient, nor did Respondent document a consultation note, before prescribing laser therapy for a skin condition that is treated by less invasive means;

ff. Misdiagnosing Patient 5's skin condition of dermatosis papulose nigra as "freckles and moles" and by performing laser treatment on Patient 5's face rather than a less invasive electrodesiccation procedure leading to excessive burning and scarring;

gg. Failing to fully articulate the risks of laser treatment on Patient 5's skin condition of dermatosis papulose nigra and failed to properly assess the goals of treatment for the patient before providing treatment prior to using the TRL procedure;

hh. Providing dermatological services to Patient 5 despite being only board certified in internal medicine and lacking the proper knowledge and skills to treat dermatosis papulose nigra with lasers;

ii. Allowing Nurse K.S. to perform a laser treatment on or about March 8, 2018, on Patient 6 without first consulting with Patient 6 and examining her before prescribing laser therapy for a skin condition that should have been treated by less invasive means;

jj. Performing a Halo laser treatment on Patient 8 before completing a trial of the required less invasive, less risky procedures for treatments of melasma;

kk. Failing to perform a test on Patient 8 despite her having Fitzpatrick phototype 6 skin;

ll. Failing to discuss the specific risks of the Halo laser procedure despite her skintype and concerns;

mm. Failing to have the required expertise to treat Patient 8's skin concern or to properly supervise the nurse who performed the Halo procedure on Patient 8;

nn. Placing his own financial interests over the best treatment options for Patient 8;

oo. Failing to document the location of injections and lot or serial number of products injected into Patient 9;

pp. Failing to consult with and listen to Patient 9's requests or to conduct a follow up without requiring additional payment;

qq. Failing to obtain a knowing and intelligent informed consent from any of the patients by applying their electronic signature to templated documents;

rr. Applying the patients' signatures to unconscionable contracts.

ss. Prescribing Keflex, 500 mg. two times a day for ten days to Patients 1, 2, 3, 4, and 7, rather than the appropriate dosage of 500 mg. four times a day for one day; and

tt. Prescribing ceftriazone for surgical prophylaxis to Patient 7 instead of the more appropriate cefazolin, without documenting a reason.

FOURTH CAUSE FOR DISCIPLINE

(Falsification of Medical Records)

129. Respondent is subject to disciplinary action under section 2261 and 2262 of the Code in that he falsified medical records with fraudulent intent and he documented consultations that did not occur.

130. Paragraphs 23 through 119, above, are incorporated by reference as if fully set forth here.

131. Respondent's acts of documenting consultations and consents that did not occur with Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9, documenting surgical monitoring and conditions that did not occur, and altering medical records to prevent detection of illegal practices constitutes falsification of medical records, and fraud, thereby subjecting his license to discipline.

FIFTH CAUSE FOR DISCIPLINE

(Aiding and Abetting the Unlicensed Practice of Medicine)

132. Respondent is subject to disciplinary action under section 2052, and 2264, in that he permitted and participated in the unlicensed practice of medicine.

133. Paragraphs 23 through 119 are incorporated as if fully set forth here.

134. Respondent's acts of permitting and encouraging Ms. L.A. to conduct patient consultations, receive a commission, make treatment recommendations and accept payment for medical services at his practice, with limited or no input from a physician constitutes aiding and abetting the unlicensed practice of medicine. Respondent's practice of allowing medical assistants and unlicensed staff to push intravenous medications, distribute controlled medications, and monitor and discharge patients after surgery constitutes aiding and abetting the unlicensed practice of medicine. Respondent has thereby subjected his license to discipline.

SIXTH CAUSE FOR DISCIPLINE

(Dishonest or Fraudulent Acts)

135. Respondent is subject to disciplinary action under section 2234, subdivision (e), in that he committed dishonest and fraudulent acts.

136. Paragraphs 23 through 119, above, are incorporated by reference as if fully set forth here.

137. Respondent committed dishonest and fraudulent acts related the practice of medicine for his acts and omissions, including but not limited to, the following:

a. Misrepresenting his credentials and services to patients;

b. Providing inadequate and inaccurate medical information to patients 1, 2, 3, 4, 5, 6, 7, 8, and 9;

c. Providing treatment recommendations based on his financial gain rather than sound medical advice;

d. Providing an incentive for Ms. L.A. to upsell patients on medical treatments;

e. Lying to Board investigators repeatedly;

f. Falsifying medical records;

g. Conducting false advertising;

h. Intimidating patients into not filing complaints or lawsuits about his treatment;

i. Applying Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9's electronic signature to forms they did not see or discuss, including unconscionable contract provisions; and

j. Dissuading Patients 2 and 3 from seeking outside or expert treatment for his medical errors.

SEVENTH CAUSE FOR DISCIPLINE

(Advertising Violations)

138. Respondent is subject to disciplinary action under sections 2271, 2272, 2415, and 651, in that he disseminated false and misleading advertising in connection with Precision M.D

139. Paragraphs 23 through 119, above, are incorporated by reference as if fully set forth here.

140. Respondent conducted false and misleading advertising in connection with Precision M.D. for his acts and omissions, including but not limited to, the following:

a. Advertising a free consultation to Patient 6, but attempting to charge her for wishing to cancel the free consultation;

b. Representing himself on television and internet sites to be "Board-certified" without including the fact that he is Board certified in Internal Medicine, and placing a non-ABMS group next to the words "Board-certified";

c. Representing his practice name on the internet, building sign, and letterhead to be "Precision M.D. Cosmetic Surgery Center," when his FNP was for "Precision M.D." and his facility is an unaccredited medical office, and even the FNP for "Precision M.D." was delinquent during the Fall of 2019;

d. Falsely representing to patients, and permitting and encouraging Ms. L.A. to represent to patients, that they would receive exaggerated cosmetic results and misrepresenting the risks and downtime from the procedures;

e. Encouraging patients to seek more expensive services than they requested;

f. Failing to provide consultations and treatment plans before charging patients for services on CareCredit financing;

g. Failing to provide timely, truthful, and complete treatment plan setting forth the procedure that the CareCredit account was established to finance for Patients 2, 3, 4, 5, 6, 7, and 8;

h. Failing to provide financial disclosures for all the terms of the CareCredit cards opened by Patients 2, 3, 4, 5, 6, 7, and 8;

i. Imposing onerous cancellation clauses and unconscionable contract provisions in written agreements that Patients signatures and initials were applied to without them being able to observe and sign or initial the actual documents at the time the signature or initials were applied; and

j. Advertising that Sculptra gluteal injections were safe and non-surgical without citing the risks of intravascular injection and embolism.

EIGHTH CAUSE FOR DISCIPLINE

(Violation of Liposuction and Practice Setting Statutes)

141. Respondent is subject to disciplinary action under sections 2216 and 2259.7 of the Code, and California Code of Regulations, title 16, section 1356.6, in that he violated the laws applicable to the provision of liposuction services to Patients 1, 2, 3, 4, and 7.

142. Paragraphs 23 through 119, above, are incorporated by reference as if fully set forth here.

143. Respondent violated statutes governing liposuction procedures and the use of conscious sedation for his acts and omissions, including but not limited to, the following:

a. Performing conscious sedation in a medical office;

b. Performing a liposuction procedure that removed more than 5 liters of aspirate from Patient 2 in a medical office;

c. Performing liposuction procedures of greater than 2,000 cc total aspirate, but less than 5,000 cc on Patients 1 and 4 without having continuous blood pressure and electrocardiogram and fluid loss and replacement monitoring;

d. Failing to have continuous blood pressure and electrocardiogram and fluid loss and replacement monitoring available for Patients 3 and 7;

e. Failing to have written discharge criteria and to ensure an ACLS certified staff member remained at all time with Patients 1, 2, 3, 4, and 7;

f. Failing to have intravenous access for Patients 1 or 4; and

g. Failing to have a transfer agreement or hospital privileges and a written emergency plan in place during any of the liposuction procedures.

NINTH CAUSE FOR DISCIPLINE

(Inadequate or Inaccurate Medical Records)

144. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records relating to the provision of services to Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9.

145. Paragraphs 23 through 119, above, are incorporated here as if fully set forth.

146. As set forth in paragraphs 23 through 119, Respondent failed to adequately and accurately document the provision of care to Patients 1, 2, 3, 4, 5, 6, 7, 8, and 9, thus subjecting his license to discipline.

TENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

147. Respondent Mahmoud Khattab, M.D. is subject to disciplinary action under section 2234, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. Paragraphs 23 through 119 are incorporated as if fully set forth here.

FACTUAL ALLEGATIONS RELATING TO PATIENT 10[12]

148. Patient 10 was a 56-year old woman interested in a cosmetic enhancement to enlarge her buttocks when she went to Precision M.D. for a consultation on or about March 12, 2020. Respondent's website advertised that he performs "non-surgical" buttocks lifts using Sculptra injections, which are "uniquely safe" among buttocks procedures. This site failed to note the risks of buttock injections, including intravascular injection, leading to pulmonary embolism. Patient 10 met with Ms. L.A. at Precision M.D., and Ms. L.A. advised her that she did not have sufficient fat on her body to transfer to her buttocks, and instead recommended Patient 10 undergo an injection of artificial fat filler, Sculptra, into her buttocks. Patient 10 agreed to undergo an injection of 10 vials of Sculptra to her buttocks by Respondent at the cost of $6,400.00. She paid a $50 consultation fee to Ms. L.A. and put down a deposit of $500.00 on March 12, 2020. Her procedure was scheduled for May 12, 2020.

149. At the time Patient 10 sought cosmetic treatment from him, Respondent was aware that the Board was investigating his practice. Board investigators interviewed Respondent for several hours on March 3, 2020, and again on March 12, 2020 (the second interview fell on the same day Patient 10 had her consultation with the unlicensed Ms. L.A.) Respondent claimed at

[12] The facts alleged in this section, and subsequent sections, pertain to information the Board discovered after it suspended Respondent's medical license on May 28, 2020, and after it filed the original Accusation on August 14, 2020.

both interviews that he always met with the patient before their procedure, and that he always performed a history and physical. At the second interview, on March 12, 2020, he admitted that he had not been current on his ACLS certification and that his office did not have a crash cart. At his March 12, 2020 interview, however, he reassured Board investigators that he had corrected any deficiencies in patient safety protocols at his practice. He provided receipts showing he had purchased a brand new crash cart, with oxygen and reversal agents. He provided Board investigators with a photograph of the crash cart he stated he had purchased. He claimed he had just taken a training course in ACLS, and even showed his certification card. He also told Board staff that he had revised his HIPPA form, removing the provision in which patients acknowledged that they "waived" their HIPPA rights in the event that they criticize Precision M.D. and/or Dr. Mahmoud Khattab.

150. Despite Respondent's claim to have implemented these reforms, no one performed a history or physical examination of Patient 10 before the procedure. Respondent never met with or spoke to Patient 10 on the day of the consultation, or any day thereafter before she arrived at Precision M.D. for her procedure on May 12, 2020. No one from Respondent's office performed an examination of Patient 10 at any time before the procedure on May 12, 2020. On March 12, 2020, the same day that Respondent assured Board investigators he had removed the unconscionable provision from his forms, Patient 10 initialed and signed a form stating that she understood that she waived her HIPPA rights and any privacy protections in the event that she should criticize Respondent or his treatment.

151. Patient 10 drove herself to Precision M.D. for her appointment, on or about May 12, 2020, and arrived at approximately 1:30 p.m. Before Patient 10's appointment, Respondent had permitted unlicensed Medical Assistants to mix and prepare the prescription medications to be injected into Patient 10's buttocks. The Medical Assistant who mixed up the solution of saline, lidocaine, and Sculptra was a new employee. A more experienced Medical Assistant was instructing the new Medical Assistant in how to mix the medications, but the experienced Medical Assistant was called away during the process. When the experienced Medical Assistant returned, she realized that the new Medical Assistant had made an error, resulting in a mixture

that had far too much lidocaine mixed in with the Sculptra and saline. The Medical Assistants reported the error to Respondent, but Respondent refused to discard the solution on the grounds that the Sculptra is expensive and he would lose too much money by discarding it. One of the Medical Assistants believed she heard Respondent indicating he planned to dilute the mixture in some way. It is not clear whether he did so.

152. Patient 10 was unaware of any problems with the medication Respondent planned to inject into her body. After driving herself to the appointment at Precision M.D. on the afternoon of May 12, 2020, the last thing she remembered was sitting down in the waiting room. She recalled nothing after that until she woke up several days later in the ICU. During the May 12, 2020 appointment, Respondent began injecting Patient 10 with the unknown mixture of lidocaine, saline and Sculptra. Respondent injected approximately eight and a half vials of the mixture into Patient 10's buttocks at 50 ccs per syringe, when, during the injection of the eighth vial, Patient 10 had an apparent seizure and began flailing around. Respondent claims that he injected her with 2 mg of Ativan before she suddenly lost consciousness, stopped breathing and lost her pulse.[13] Someone in the office called 911 at approximately five minutes after 3:00 p.m. to report a medical emergency.

153. A Police Officer with the Elk Grove Police Department (EGPD), was near the Precision M.D. building when the 911 call came through. He arrived at the medical office within a few minutes of the call. His body camera recorded what was occurring when he ran into the office building. Respondent was standing next to Patient 10, who was lying on her back, unconscious, on a medical table with her legs dangling down off the side. A nurse and two medical assistants were moving around the small room in a confused manner. The nurse appeared to be attempting to untangle the tubing on an oxygen tank. There was no crash cart visible in the video. One of the assistants attempted to lift up Patient 10's legs for a few seconds before moving again to assist the nurse with the oxygen tank that was not working. No one was

[13] Seizures, cardiac complications, and respiratory failure are known symptoms of lidocaine toxicity.

maintaining Patient 10's airway open by forcing her chin up. She did not have an intravenous line placed.

154. Respondent was not providing any instructions to the multiple staff moving around the room. Despite claiming to have completed ACLS certification just two months before, he was compressing Patient 10's chest lightly, with slow, arrhythmic motions and stopping to shout at her to "wake up." The EGPD Officer politely reminded Respondent to maintain the compressions continuously. When Respondent continued to seem unsure, the Officer asked Respondent if he could take over, and Respondent immediately agreed. The Officer began deep, rhythmic compressions while asking Respondent and the staff to start a metronome at 110 beats per minute. Neither Respondent nor the other staff appeared to understand the request, so the Officer repeated it several times, explaining to use a smartphone, to look up metronome, and to type in 110 beats per minute. Respondent eventually managed to follow the instructions to play a recording of a metronome sounding at 110 beats per minute. The Officer continued chest compressions at the speed of the metronome for several more minutes until the paramedics arrived.

155. Paramedics arrived and assessed Patient 10 while the Officer continued chest compressions. The paramedics asked Respondent for Patient 10's medical information but he was unable to provide a medical history. The paramedics asked Respondent for Patient 10's weight and he responded that he did not know. He gave an estimate. The paramedics asked what happened to Patient 10. Respondent said he was injecting her buttocks, but did not tell the EMS staff or the EGPD Officers about the medication error in the solution he injected, or that Patient 10's symptoms were likely due to lidocaine toxicity. Respondent's withholding of information prevented the EMS staff from providing optimal, life-saving care to Patient 10.

156. The paramedics lifted Patient 10 to the hallway where she could lay flat and secured her airway with an advanced airway device. They provided physical ventilation with a bag until she was connected to oxygen for the transport. The EGPD Officer's partner took over CPR and continued chest compressions while the paramedics worked. The paramedics established an intravenous line and administered epinephrine. After approximately 10 minutes and four rounds

of CPR, Patient 10 had a return of circulation, but with an abnormal rhythm indicative of cardiac abnormalities.

157. The paramedics used a backboard to carry Patient 10 to the ambulance for transport to the hospital. Although Respondent had recently entered into a transfer agreement with Methodist Hospital, Respondent indicated to the paramedics that Patient 10 was a Kaiser patient. Regardless of this, the paramedics transported Patient 10 to Methodist Hospital in Sacramento. In the ambulance on the way to the hospital, Patient 10's blood pressure dropped dangerously. The paramedics could no longer feel pulses in her extremities, and they gave her another dose of epinephrine. If the EMS staff had been aware of the lidocaine issue, they could have altered the dose of epinephrine required to support Patient 10.

158. After Patient 10 left in the ambulance with the paramedics, the EGPD Officer remained at Precision M.D., and interviewed Respondent and the nurse who treated Patient 10. The nurse told the Officer that Respondent called out for Ativan, and she brought it to him. An EGPD Officer also interviewed Respondent, who also told the Officer that he injected Ativan, intramuscularly, into Patient 10 after she showed signs of distress. The Officer asked Respondent how much Ativan he injected into Patient 10, and Respondent became vague in his answers. After speaking with the EGPD Officer, Respondent went back into his office and documented in Patient 10's chart that he injected her with 2 mg of Ativan. He did not note the storage or waste of the Ativan in Patient 10's medical record. Methodist Hospital performed a drug screen on Patient 10 when she arrived via ambulance and found no Ativan in her system.

159. At Methodist Emergency Room, Patient 10 was intubated and she was admitted to the ICU. The workup performed in the ICU showed elevated troponin levels and ground glass opacities in the radiological imagining of her lungs. Based on these findings, Methodist physicians opined that she most likely experienced micropulmonary embolisms due to the depth and amount of fat injected in her buttocks. The Methodist physicians were not aware that Patient 10 received an unsafe mixture with excessive lidocaine. Respondent's withholding of the lidocaine error prevented subsequent treating physicians from being able to start Patient 10 on lipid emulsion therapy.

160. Patient 10 remained in the ICU for three days. On May 14, 2020, she was extubated, and on May 15, 2020, she was transferred to Kaiser Hospital for continuing care. She was discharged from Kaiser on May 18, 2020. Subsequent hospital records show that Patient 10 required chronic opioid therapy before her surgical procedure with Respondent. The Respondent failed to document any information related to Patient 10's chronic opioid therapy even though it could have affected her treatment during a gluteal injection procedure.

161. Respondent and his staff never contacted Patient 10's emergency contacts or next of kin to notify them that she had a medical emergency in his care and had been transferred to the hospital. Patient 10's sister was listed as the emergency contact on Precision M.D.'s records. When Patient 10 did not return home after her procedure on May 12, 2020, Patients 10's relatives called her sister to ask if the sister had heard from Patient 10. No one had heard from Patient 10, and so her sister and relatives contacted Precision M.D., but there was no answer. Patient 10's family had to call the local fire departments around the Respondent's office to learn that she had been transported to Methodist Hospital following an emergency during the procedure the Respondent had performed.

162. The Respondent's medical records for Patient 10 show that she signed a consent for Sculptra treatment, but it is only a consent for facial injections. There is no consent for gluteal injection in the records, and no documentation showing that Patient 10 was notified that the use of Sculptra to inject the buttocks is not approved by the FDA, nor the risks of gluteal injections. Patient 10's signatures in the medical records are copied and pasted, as are her initials. Respondent's operative note states that the Sculptra was mixed with 4 cc of lidocaine and 4 cc of sterile saline per vial the night before the procedure and was reconstituted with 50 cc of normal saline the day of the procedure. The note falsely states that all 10 vials of Sculptra were injected into Patient 10's buttocks. It falsely states five vials were injected into each side of her buttocks with an 18-gauge needle.

163. After Patient 10 was released from the Hospital, she returned to Respondent's Office. Respondent's Officer Manager told Patient 10 that they had done her a favor by saving her life. Respondent's Office Manager told her that on the day of the procedure he came into her exam

room and found she had fallen to the floor after having had a seizure between the 9th and 10th vial of injections. Patient 10 asked to speak to Respondent. Respondent then came into the room and repeated that she had experienced a seizure between the 9th and 10th vial of injections, but would not give her any more information. Patient 10 told Respondent that her bottom did not look any different and he told her that she would have to wait several months to see the results of the procedure. Respondent's Office scheduled Patient 10 for a follow up appointment in July of 2020, but Patient 10 did not want to return to his office after what had happened to her.

ELEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

164. Respondent is subject to disciplinary action under section 2234, subdivisions (b), and or (c), in that he was grossly negligent and/or repeatedly negligent in his care and treatment of Patient 10.

165. Paragraphs 148 through 163, above, are incorporated as if fully set forth here.

166. Respondent was grossly negligent in his care and treatment of Patient 10 for his acts and omissions, including but not limited to, the following:

a. Allowing an unlicensed person, Ms. L.A. to recommend an invasive procedure to Patient 10, make medical recommendations, collect a fee for the consultation, and collect a deposit on or about March 12, 2020;

b. Failing to conduct a history and physical before an invasive procedure, including failing to perform a cardiac and pulmonary examination at least 30 days before Patient 10's procedure, failing to perform a physical examination, and failing to obtain Patient 10's past medical history, medications and allergies;

c. Failing to notify Patient 10's next of kin or emergency contact after she experienced medical emergency in his care and was transported to the hospital;

d. Failing to perform basic CPR and life support when Patient 10 experienced a medical emergency or to ensure his staff did so;

e. Failing to document the storage or waste of controlled substances used on Patient 10 at a medical office;

f. Failing to document Patient 10's use of chronic opioid pain medication in a patient undergoing a high volume filler treatment to be placed in subcutaneous space or deeper;

g. Affixing Patient 10's electronic signature and initials on unconscionable contract provisions such as non-disclosure agreements and HIPAA waivers with boilerplate language that contained errors such as another provider's practice name;

h. Performing a medically unnecessary cosmetic procedure during the Covid-19 lockdown during which time the Governor had implemented a stay-at-home order and the Department of Public Health cautioned against elective and cosmetic procedures;

i. Failing to obtain Patient 10's informed consent for the gluteal and off-label Scultra injection;

j. Using normal saline instead of sterile water to reconstitute Scupltra for Patient 10's procedure;

k. Failing to document the injection sites of each of the vials of Patient 10's procedure;

l. Using an 18-gauge needle to inject Sculptra into Patient 10's buttocks;

m. Failing to note and document Patient 10's stretch marks and explain how Sculptra injections will affect this skin type;

n. Allowing an unlicensed Medical Assistant to mix lidocaine and Sculptra for injection;

o. Knowingly injecting a dangerous, incorrectly mixed dose of medications into Patient 10 leading to seizure and cardiac arrest; and,

p. Withholding information from paramedics and subsequent treating physicians, thus preventing them from using the correct dose of epinephrine and/or treating Patient 10 with lipid emulsion therapy.

TWELFTH CAUSE FOR DISCIPLINE

(Falsification/Fraudulent Medical Records)

167. Respondent is subject to disciplinary action under sections 2261 and 2262 for preparing false and fraudulent medical records for Patient 10.

168. Paragraphs 148 through 163, above, are incorporated as if fully set forth here.

169. Respondent is subject to discipline for preparing false and fraudulent records in the care and treatment of Patient 10, including but not limited to:

a. Documenting that he was at the March 12, 2020 initial consultation with Patient 10 and explained that "we usually start with 10 vials" when he was not present and Patient 10 never met Respondent before her procedure;

b. Documenting that he injected 10 vials of Scupltra into Patient 10 when the video clearly shows he only injected eight and a half vials[14];

c. Documenting that he performed chest compressions at 110 beats per minute on Patient 10, although the body camera footage shows he was not performing adequate chest compressions and was not compressing at 110 beats per minute;

d. Documenting that he injected Patient 10 with 2 mg of Ativan despite no Ativan being found in Patient 10's system, and despite telling the EGPD Officer that he did not know how much Ativan he injected; and

e. Falsely documenting the mixture of medications in the solution that he injected into Patient 10; and,

f. Omitting significant medical information from Patient 10's chart in order to hide his misconduct.

THIRTEENTH CAUSE FOR DISCIPLINE

(Dishonest or Fraudulent Acts)

170. Respondent is subject to disciplinary action under section 2234, subdivision (e), in that he committed dishonest and fraudulent acts.

171. Paragraphs 148 through 163, above, are incorporated by reference as if fully set forth here.

172. Respondent committed dishonest and fraudulent acts related to his treatment of Patient 10 for his acts and omissions, including but not limited to, the following:

[14] Time stamp 1:44 of the EGPD Officer's body camera footage shows the used and unused vials on the surgical tray being wheeled out of Patient 10's procedure room.

a. Putting Patient 10 at risk for death by refusing to discard an improperly mixed, potentially lethal medication solution for the purpose of financial gain;

b. Falsely telling Board investigators that he had implemented patient safety procedures, a transfer agreement, and become proficient at ACLS on March 12, 2020;

c. Falsely telling Board investigators that he had removed unconscionable contract provisions from his patient documents on March 12, 2020, which was the very day Patient 10 signed such a document; and,

d. Withholding potentially life-saving information about Patient 10 from paramedics and subsequent treating physicians to hide his illegal acts.

FACTUAL ALLEGATIONS RELATING TO RESPONDENT'S UNLICENSED PRACTICE OF MEDICINE AND PRACTICE WHILE SUSPENDED

173. On May 28, 2020, Complainant filed a Petition before the Office of Administrative Hearings (OAH), for an ex parte hearing to determine whether Respondent's medical license should be immediately suspended in the interest of public safety. On May 29, 2020, the OAH issued an Order approving a stipulation for an interim order of suspension of Respondent's Physician's and Surgeon's Certificate Number A 97693. Administrative Law Judge Tiffany King issued the order upon stipulation between the parties that Respondent signed and dated May 29, 2020, in which he agreed:

> "Respondent shall not practice or attempt to practice any aspect of medicine in the State of California pending further adjudication of this matter;
> Respondent shall not advertise, by any means, or hold himself out as practicing or available to practice medicine in any capacity; and
> Respondent shall not be present in any location or office which is maintained for the practice of medicine, or at which medicine is actively practiced for any purpose, except as needed when Respondent is receiving treatment or evaluation as a patient or as a visitor to family and friends, or attending training facilitated by the U.C. San Diego Clinical Assessment Program."

174. Respondent willingly signed a second stipulation dated June 16, 2020, renewing his intent to adhere to the same terms pending a decision by an Administrative Law Judge concerning the interim order of suspension in order to continue the hearing on the noticed petition for suspension. Respondent willingly signed a third stipulation dated July 2, 2020, again renewing

his intent to adhere to the same terms suspending his practice of medicine in order to obtain a further continuance.

175. On July 15, 2020, the matter finally came on for hearing on the merits of the petition to suspend Respondent's license before Administrative Law Judge Erin Koch-Goodman. On or about July 30, 2020, Administrative Law Judge Koch-Goodman issued a Decision suspending Respondent's medical license until a final decision is adopted in the underlying matters. Judge Koch-Goodman's July 30, 2020 Decision held that permitting Respondent to continue to engage in the practice of medicine would endanger the public, that there is a reasonable probability that Complainant will succeed on the merits of the underlying action, and that the likelihood of injury to the public outweighs any potential injury to Respondent. The final Decision stated,

> "During the time this interim order in in effect, Respondent is prohibited from engaging in the practice of medicine. He shall surrender to the Medical Board all indicia of his licensure as a physician."

176. When Respondent's license was suspended, he did not shut down Precision M.D. During June of 2020, his website, PrecisionMDCA.com remained up and active. It continued to show a photograph of him, listing his title as "Chief Physician," and claiming that he was Board-certified, without indicating the Board specialty, or clarifying that his medical license was currently suspended. At least as recently as August of 2020, Respondent maintained a Facebook page for Precision M.D. that showed a large picture of him along with his name and biographical information stating that he was "Board-certified" without clarifying that his certification was in Internal Medicine, or that he was currently unlicensed to practice any form of medicine. The Facebook page continued to falsely represent that the business name was "Precision M.D. Cosmetic Surgery Center," although the practice has never been a licensed outpatient surgical center. Respondent also continued to advertise on Twitter, with the handle "PrecisionMDCA" and a photograph of himself in a white coat with his name and an "M.D." after the name embroidered on the coat, again without clarifying that he was not licensed to practice medicine. On all these media sites, Respondent advertised medical procedures, such as liposuction, Brazilian butt lifts, hair transplants, laser treatments, and injections. As of the filing of this

Second Amended Accusation, a patient who searches for certain medical procedures in and around the zip code of Sacramento and Elk Grove is directed to a website showing Precision M.D.'s address and contact information, with a photograph of Respondent, and his name Mahmoud Khattab, M.D. appearing without information showing that his license is suspended.

177. The medical office at Big Horn Drive also continued to remain open and active after the OAH ordered Respondent's medical license was suspended. Respondent is the sole owner of the medical practice. Respondent both continued and continues to own, operate and profit from the business. Two days before the Board filed the petition to suspend Respondent's medical license, he hired a Board-certified plastic surgeon, Dr. S.C., to work at Precision M.D. as an employee. When patients arrived for treatment or follow-up procedures expecting to find Respondent and instead saw Dr. S.C., Respondent directed his staff to tell the patients that Respondent had voluntarily stepped back from medical duties to travel or obtain additional medical training.

178. Respondent continued to employ a large number of staff members, including business managers, receptionists, Medical Assistants, Registered Nurses, and Dr. S.C. Although Dr. S.C. had no prior experience with laser or injection procedures, the nursing staff continued to perform laser and injection procedures at Precision M.D. after Respondent's suspension, ostensibly under the supervision of Dr. S.C. In reality, Respondent continued to involve himself in the actual supervision of medical and non-medical staff at Precision M.D. He made decisions as to what staff would be hired and fired. Most Precision M.D. staff members were not even aware that Respondent's license had been suspended. He was constantly communicating with staff at Precision M.D. by telephone, email and text messaging. Precision M.D. had video cameras set up throughout and Respondent would watch this video feed and contact staff in real time to direct operations. On or about June 3, 2020, he instructed staff to purchase a specific medical fat-transfer device intended to correct the problem of fat clogging one of the cosmetic procedure machines. He frequently gave advice and training to Dr. S.C. over the telephone when Dr. S.C. first began using medical equipment with which he was unfamiliar.

179. In early June of 2020, Respondent directly engaged in the hands-on practice of medicine at his home. After attempting to instruct Dr. S.C. over the phone on non-plastic surgery procedures, Respondent found it was insufficient and that Dr. S.C. needed in-person training. In the beginning of June, 2020, Respondent directed Dr. S.C. to come to his personal residence after the workday was over, so he could train Dr. S.C. on "threading" procedures.[15] Respondent arranged for his friend to be present at his home as well that evening, and Respondent performed the part of the procedure on his friend first to demonstrate and then allowed Dr. S.C. to complete the procedure.

180. During the remainder of June of 2020, Respondent trained Dr. S.C. at his home on at least five other occasions. Respondent directed his Office Manger to gather a series of medical supplies and equipment and bring them to his home to use in medical procedures to be performed at his home during June of 2020. Often Respondent would perform half the procedure and then have Dr. S.C. perform the remainder once he had demonstrated it. Some of the equipment and medications Respondent directed his Office Manager to bring to the residence included prescription topical numbing cream, gloves, skin sutures, a Gainswave machine, and a Halo laser machine.[16] Respondent specifically directed his Office Manager to keep the information that he was training Dr. S.C. in medical procedures at his home a secret. On June 9, 2020, at approximately 3:25 p.m., Respondent sent a text message to his Officer Manager, stating "(d)on't tell anyone that you are(sic) Cuber are coming to my house or that I am training him."

181. While Respondent's license was suspended, between June and September of 2020, he performed medical procedures on patients, both at his home and at the Precision M.D. medical office. In early September of 2020, whiling training Dr. S.C., Respondent performed a laser procedure on the wife of his barber at the Precision M.D. medical office. Respondent used the Halo full-field laser on his barber's wife, which is a device restricted to licensed practitioners. Respondent continued to go to the Precision M.D. medical office regularly after his license was

[15] As noted above in the case of Patient 3, a threading procedure involves a physician placing a suture in the patient's neck to lift or manipulate the skin.

[16] The Halo laser is an FDA-regulated hybrid fractional skin resurfacing laser machine. The Gainswave machine is an FDA-regulated shockwave therapy device applied to the male genitals with the stated goal of increasing blood flow to the penis.

suspended, falsely claiming that he was only performing administrative tasks, unrelated to the practice of medicine.

FOURTEENTH CAUSE FOR DISCIPLINE

(Unlicensed Practice of Medicine/Practice While Suspended)

182. Respondent is subject to disciplinary action under section 2052 and 2306 in that he practiced medicine without a valid license and while his license was suspended.

183. Paragraphs 173 through 181, above, are incorporated by reference as if fully set forth here.

184. Respondent is subject to discipline under sections 2052 and 2306 for his acts and omissions, including but not limited to, the following:

a. Being sole owner of an active medical practice despite lacking licensure as a physician;

b. Advertising as a licensed physician while his license was suspended;

c. Holding himself out as available to practice medicine while suspended;

d. Supervising medical staff while suspended;

e. Training nurses and physicians to practice medicine while suspended; and

f. Actually performing hands-on medical procedures on patient while suspended, including shockwave therapy, laser procedures, and implanting sutures.

FACTUAL ALLEGATIONS PERTAINING TO PATIENT 11

185. Patient 11 was a 69-year-old woman when she sought cosmetic treatment at Precision M.D. in approximately July of 2019. She had sought cosmetic services at other medical practices in the Sacramento area to improve the appearance of her midsection, but was told she was not a candidate due to her medical history. Patient 11 has an extensive medical history including a history of hypertension, atrial fibrillation, COPD, recurrent lower gastrointestinal bleeds, a perforated gastric ulcer, and functional quadriplegia. She requires a cane to ambulate. Approximately a year and half before going to Precision M.D., she was hospitalized for nearly three months due to influenza, septic shock, and respiratory failure. She was intubated during the hospital stay for acute respiratory distress syndrome. Most significant to this case, in January of

2018, Patient 11 had undergone major abdominal surgery for a gastric perforation that left her with a midline incision. The midline incision is a large, highly visible scar running the length of her torso, down the middle of her stomach.

186. On or about July 19, 2019, Patient 11 had a consultation with Officer Manger Ms. L.A. at Precision M.D. Ms. L.A. recommended Patient 11 undergo a liposuction procedure to reduce a bulge around the midsection. Patient 11 never saw or spoke to Respondent on July 19, 2019, or any day before the day of her procedure. No one performed a medical history or physical examination of Patient 11 before the procedure. Nonetheless, Respondent falsified a medical record claiming that he performed a history and physical examination of Patient 11 on July 19, 2019. Respondent falsely claimed that he examined Patient 11 on July 19, 2019, that he palpated her abdomen, listened to her heart and lungs, and felt her legs for pulses. The medical history Respondent documented, dated July 19, 2019, stated that Patient 11 had a midline incision from an abdominal surgery approximately 18 months ago to repair a ruptured gastric ulcer. The record does not document a hernia although a large epigastric hernia is clearly visible under the skin in the photographs Respondent's staff took of Patient 11. Respondent falsely documented that Patient 11 was able to ambulate without assistance. The record omits significant medical history and medication information. Respondent falsely documented that he warned Patient 11, on July 19, 2019, that she was at risk for bowel perforation during the liposuction procedure because of her past medical history. Patient 11 signed an electronic pad that applied her signature to consent forms without any discussion of specific risks.

187. On or about July 31, 2019, Respondent performed a liposuction procedure on Patient 11. The first time he saw Patient 11 or her abdomen was when she was prepped for surgery and he was about to begin. It would have been impossible for Respondent not to have seen the large epigastric hernia visible to the naked eye. The brief surgical chart note of July 31, 2019 notes the presence of the hernia near the midline incision. Liposuction is absolutely contraindicated in the presence of a large epigastric hernia like Patient 11's. Despite this visible evidence of contraindication, Respondent did not abort the procedure when he saw Patient 11's abdomen on the day of the surgery.

188. Respondent performed liposuction on Patient 11, perforating her bowel five separate times during the procedure. Respondent gave Patient 11 10 mg each of Percocet and Valium by mouth before the procedure. He administered intravenous antibiotics and fentanyl eight minutes before the aspiration of fat. He reportedly suctioned 3,000 milliliters of fat. Patient 11 reported extreme pain during the surgery. She continued to have pain after the surgery was complete. Respondent falsely documented that Patient 11 "tolerated the procedure well."

189. There are no vital signs recorded for Patient 11 during the procedure. There is an operative note and a brief operative chart note. The operative note was prepared by Medical Assistant X.C., on July 31, 2019, and the handwritten chart note is unsigned but appears to have been done by X.C. There is no nurse or licensed practitioner documented as having been present during the procedure to assist Respondent even though conscious sedation was used and Patient 11 received intravenous medications. Respondent did not sign the operative note until nearly three weeks after the procedure on August 20, 2019. There is no documentation in the records of the amount or method of administration of the fentanyl.

190. Since there is no nurse or other assistant listed other than Medical Assistant X.C., and Respondent should have been scrubbed in to perform the surgery, the records indicate that Medical Assistant X.C., who is unlicensed, administered intravenous fentanyl. There is no documentation of the waste or storage of the fentanyl. Patient 11's records do not document the liposuction injection sites, or direction of liposuction. There is no record of the depth of injection, methods used to prevent bowel injury or endpoints of the liposuction. Patient 11, like the other Patient's alleged above, had her electronic signature applied to consent forms on the day of surgery, July 31, 2019. As in the other patients' cases, Patient 11's paperwork contained erroneous boilerplate language and unconscionable contract provisions, including provisions supposedly waiving her right to medical privacy should she "designate" or criticize Dr. Mahmoud Khattab or Precision M.D.

191. On or about August 5, 2019, five days after the surgery, Patient 11 had a follow up visit with Respondent. She had been in too much pain to return for her scheduled follow up the day after the procedure. At the follow up appointment, Patient 11's heartrate was documented to

be 108. Respondent did not document an abdominal examination. He discharged Patient 11 to her home.

192. Approximately 10 days after the procedure, Patient 11 went to Kaiser Hospital complaining of abdominal pain and stool coming out of her incision sites. Upon admission, the surgeon at Kaiser Hospital noted the hernia, and that Respondent had perforated her bowel during the liposuction procedure, which had led to an enterocutaneous fistula and an infection in the lower abdomen. Initially the physicians tried to manage Patient 11 conservatively, by debriding her wounds and providing medication to encourage the abscesses to heal. By Patient 11's second day in the Hospital, her prognosis worsened, with multiple fistulas forming in her colon and a large amount of stool draining from the wounds.

193. The Kaiser surgeons decided that Patient 11 required surgery. On August 13, 2019, Patient 11 was taken to the operating room and underwent surgery on her colon. The surgeon found five perforations of Patient 11's colon. The surgeon had to create an ostomy to allow drainage of stool and protect the tissue from necrotizing and infection. Patient 11 continues to require the ostomy to this day.

FIFTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

194. Respondent is subject to disciplinary action under section 2234, subdivisions (b), and or (c), in that he was grossly negligent and/or repeatedly negligent in his care and treatment of Patient 11.

195. Paragraphs 185 through 193, above, are incorporated as if fully set forth here.

196. Respondent was grossly negligent in his care and treatment of Patient 11 for his acts and omissions, including but not limited to, the following:

a. Allowing unlicensed Office Manager Ms. L.A. to recommend an invasive medical procedure to Patient 11;

b. Failing to perform a history and physical examination of Patient 11 at any time, and at least 30 days before the surgery;

c. Creating a medical record falsely indicating that he performed a history and examination of Patient 11 on July 19, 2019;

d. Agreeing to perform a liposuction on Patient 11 who was not a proper candidate for liposuction due to her age, medical history, and weight;

e. Failing to abort the liposuction procedure when he observed the large midline incision and a clearly visible epigastric hernia on Patient 11 on the day of the procedure;

f. Failing to properly document the administration of intravenous fentanyl and its waste in the medical record;

g. Administering intravenous medications in combination constituting conscious sedation in an unaccredited medical office setting without proper monitoring and discharge criteria;

h. Failing to record and act on Patient 11's history of chronic opioid therapy;

i. Allowing Patient 11 to sign unconscionable contract provisions;

j. Failing to adequately document the procedure he performed and sign and date chart records promptly;

k. Removing over 2L of aspirate without fluid replacement, continuous monitoring of vital signs, or other safeguards in place;

l. Failing to obtain appropriate informed consent before the procedure; and,

m. Perforating Patient 11's bowel multiple times during the surgery.

SIXTEENTH CAUSE FOR DISCIPLINE

(Violation of Liposuction and Practice Setting Statutes)

197. Respondent is subject to disciplinary action under sections 2216 and 2259.7 of the Code, and California Code of Regulations, title 16, section 1356.6, in that he violated the laws applicable to the provision of liposuction services to Patient 11.

198. Paragraphs 23 to 26, 108-111, 118-119, and 185 through 193, above, are incorporated by reference as if fully set forth here.

199. Respondent violated statutes governing liposuction procedures and the use of conscious sedation for his acts and omissions, including but not limited to, the following:

a. Performing conscious sedation in a medical office;

b. Performing liposuction procedures of greater than 2,000 cc total aspirate, but less than 5,000 cc on Patient 11 without having continuous blood pressure and electrocardiogram and fluid loss and replacement monitoring;

c. Failing to have continuous blood pressure and electrocardiogram and fluid loss and replacement monitoring available for Patient 11;

d. Failing to have written discharge criteria and to ensure an ACLS certified staff member remained at all time with Patient 11; and,

e. Failing to have a transfer agreement or hospital privileges and a written emergency plan in place during any of the liposuction procedures.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Falsification/Fraudulent Medical Records)

200. Respondent is subject to disciplinary action under sections 2261 and 2262 for preparing false and fraudulent medical records for Patient 11.

201. Paragraphs 185 through 193, above, are incorporated as if fully set forth here.

202. Respondent is subject to discipline for preparing false and fraudulent records in the care and treatment of Patient 11, for creating a false, backdated medical record, dated July 17, 2019 in which he falsely claimed he performed history and physical and warned Patient 11 of the risk of bowel perforation if she chose to proceed with a liposuction procedure.

EIGHTEENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

203. Respondent is subject to disciplinary action under section 2234 in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. The circumstances are set forth in paragraphs 23 through 202, above, which are incorporated here by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 97693, issued to Mahmoud Khattab, M.D.;

2. Revoking, suspending or denying approval of Mahmoud Khattab, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Revoking the FNP "Precision M.D.";

4. Ordering Mahmoud Khattab, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: MAY 0 4 2021

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

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