

1 ROB BONTA
Attorney General of California
2 TESSA L. HEUNIS
Supervising Deputy Attorney General
3 NISHA S. LAKHANI
Deputy Attorney General
4 State Bar No. 354231
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 269-6779
6 Facsimile: (916) 731-2117
E-mail: Nisha.Lakhani@doj.ca.gov
7 *Attorneys for Complainant*

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

11 In the Matter of the First Amended Accusation
Against:

Case No. 800-2022-090962

12 **FOUAD IBRAHIM GHALY, M.D.**
13 **20911 Earl Street, Suite 260**
Torrance, CA 90503-4352

FIRST AMENDED ACCUSATION

14
15 **Physician's and Surgeon's Certificate**
16 **No. C 39588,**

17 Respondent.

18
19 **PARTIES**

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

23 2. On or about January 26, 1981, the Board issued Physician's and Surgeon's Certificate
24 Number C 39588 to Fouad Ibrahim Ghaly, M.D. (Respondent). The Physician's and Surgeon's
25 Certificate was in effect at all times relevant to the charges brought herein and will expire on
26 October 31, 2026, unless renewed.

27 ///

28 ///

1 **PRIOR DISCIPLINE**

2 3. In a prior disciplinary action entitled *In the Matter of the Accusation Against Fouad*
3 *Ibrahim Ghaly, M.D.*, MBC Case No. 06-1999-95440, the Board issued a Decision and Order on
4 June 14, 2005, effective July 14, 2005, in which Respondent's Physician's and Surgeon's
5 Certificate No. C 39588 was revoked. The revocation was stayed, however, and Respondent's
6 Physician's and Surgeon's Certificate No. C 39588 was placed on probation for a period of five
7 (5) years with certain terms and conditions. A true and correct copy of that Decision and Order is
8 attached hereto as Exhibit A.

9 **JURISDICTION**

10 4. This First Amended Accusation, which supersedes Accusation No. 800-2022-090962
11 filed on August 13, 2025, is brought before the Board under the authority of the following laws.
12 All section references are to the Business and Professions Code unless otherwise indicated.

13 5. Section 2004 of the Code states:

14 The board shall have the responsibility for the following:

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

17 (b) The administration and hearing of disciplinary actions.

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

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

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

22 (f) Approving undergraduate and graduate medical education programs.

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

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

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

27 6. Section 2220 of the Code states:

28 Except as otherwise provided by law, the board may take action against all

1 persons guilty of violating this chapter. The board shall enforce and administer this
2 article as to physician and surgeon certificate holders, including those who hold
3 certificates that do not permit them to practice medicine, such as, but not limited to,
4 retired, inactive, or disabled status certificate holders, and the board shall have all the
5 powers granted in this chapter for these purposes including, but not limited to:

6 (a) Investigating complaints from the public, from other licensees, from health
7 care facilities, or from the board that a physician and surgeon may be guilty of
8 unprofessional conduct. The board shall investigate the circumstances underlying a
9 report received pursuant to Section 805 or 805.01 within 30 days to determine if an
10 interim suspension order or temporary restraining order should be issued. The board
11 shall otherwise provide timely disposition of the reports received pursuant to Section
12 805 and Section 805.01.

13 ...

14 7. Section 2227 of the Code states:

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

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

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

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

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

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

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

8. Section 2234 of the Code states, in pertinent part:

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:

...

(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

1 separate and distinct departure from the applicable standard of care shall constitute
2 repeated negligent acts.

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

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

11 9. Section 2266 of the Code states:

12 The failure of a physician and surgeon to maintain adequate and accurate
13 records relating to the provision of services to their patients constitutes unprofessional
14 conduct.

15 10. The American Medical Association Code of Medical Ethics, Opinion 2.1.5.,
16 Reporting Clinical Test Results, provides in pertinent part:

17 To ensure that test results are communicated appropriately to patients,
18 physicians should adopt, or advocate for, policies and procedures that:

19 The patient (or surrogate decision maker if the patient lacks decision-making
20 capacity) is informed about when he or she can reasonably expect to learn the results
21 of clinical tests and how those results will be conveyed.

22 11. Unprofessional conduct under Business and Professions Code Section 2234 is
23 conduct which breaches the rule or ethical code of the medical profession, or conduct which is
24 unbecoming of a member of good standing of the medical profession, and which demonstrates an
25 unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564,
26 575.)

27 COST RECOVERY

28 12. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a
disciplinary proceeding before any board within the department or before the
Osteopathic Medical Board, upon request of the entity bringing the proceeding, the
administrative law judge may direct a licensee found to have committed a violation or
violations of the licensing act to pay a sum not to exceed the reasonable costs of the
investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the
order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where

1 actual costs are not available, signed by the entity bringing the proceeding or its
2 designated representative shall be prima facie evidence of reasonable costs of
3 investigation and prosecution of the case. The costs shall include the amount of

4 (d) The administrative law judge shall make a proposed finding of the amount
5 of reasonable costs of investigation and prosecution of the case when requested
6 pursuant to subdivision (a). The finding of the administrative law judge with regard to
7 costs shall not be reviewable by the board to increase the cost award. The board may
8 reduce or eliminate the cost award, or remand to the administrative law judge if the
9 proposed decision fails to make a finding on costs requested pursuant to subdivision
10 (a).

11 (e) If an order for recovery of costs is made and timely payment is not made as
12 directed in the board's decision, the board may enforce the order for repayment in any
13 appropriate court. This right of enforcement shall be in addition to any other rights
14 the board may have as to any licensee to pay costs.

15 (f) In any action for recovery of costs, proof of the board's decision shall be
16 conclusive proof of the validity of the order of payment and the terms for payment.

17 (g) (1) Except as provided in paragraph (2), the board shall not renew or
18 reinstate the license of any licensee who has failed to pay all of the costs ordered
19 under this section.

20 (2) Notwithstanding paragraph (1), the board may, in its discretion,
21 conditionally renew or reinstate for a maximum of one year the license of any
22 licensee who demonstrates financial hardship and who enters into a formal agreement
23 with the board to reimburse the board within that one-year period for the unpaid
24 costs.

25 (h) All costs recovered under this section shall be considered a reimbursement
26 for costs incurred and shall be deposited in the fund of the board recovering the costs
27 to be available upon appropriation by the Legislature.

28 (i) Nothing in this section shall preclude a board from including the recovery of
the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in
that board's licensing act provides for recovery of costs in an administrative
disciplinary proceeding.

///

///

///

///

///

///

///

FACTUAL ALLEGATIONS

Patient 1¹

13. On or about May 8, 2022, Patient 1, a then 27-year-old male, presented to Respondent with complaints of generalized myalgia that occurred even without exercise, fatigue, and a depressed mood. Patient 1 had lost fifteen (15) pounds since 2019, and reported a fever with a headache and sore throat in July 2021. Respondent ordered a myriad of laboratory scans.

14. On or about May 9, 2022, Patient 1's laboratory results were received detailing some abnormalities. Thereafter, Respondent provided intravenous (IV) therapies to Patient 1.

15. On or about May 10, 2022, Patient 1 again presented to Respondent, who administered IV therapies in conjunction with a dose of 10 grams (10,000 mg) of vitamin C.

16. The standard of care provides that a patient's quantitative glucose-6-phosphate dehydrogenase (G6PD) level² must be obtained to rule out a G6PD deficiency before administering high doses of vitamin C. A high dose of vitamin C, such as 10 grams of vitamin C, can act as a pro-oxidant, and can potentially cause oxidative stress and hemolysis (destruction of red blood cells) in G6PD-deficient individuals.

17. Respondent did not order a test for Patient 1's G6PD levels.

18. On or about May 11, 2022, Patient 1 presented to Respondent for additional IV therapies. Respondent documented that he administered exosome 450 billion particles to Patient 1.

19. On or about March 19, 2024, during a subject interview, Respondent clarified that on May 11, 2022, he administered exosome 45 billion particles to Patient 1 instead of the documented 450 billion particles.

///

///

¹ The patients in this Accusation are identified as Patient 1 and Patient 2 to address privacy concerns. The patients' identities are known to Respondent or will be disclosed to Respondent upon a duly issued request for discovery and in accordance with Government Code section 11507.6.

² G6PD is a protein that supports red blood cell function. Low G6PD may lead to hemolytic anemia.

Patient 2

20. On or about May 9, 2022, Patient 2 presented to Respondent for treatment with complaints of fatigue. Patient 2 signed a consent for IV therapy, a HIPAA agreement, and a physician-patient arbitration agreement. Patient 2 also signed a "Consent to Elective Treatment" form; however, the "elective treatment" section was marked with a question mark with no specific treatments listed. Thereafter, Respondent administered IV therapies to Patient 2.

21. On or about May 10, 2022, Patient 2 presented to Respondent for further IV treatment.

22. On or about May 11, 2022, Patient 2 presented to Respondent for further IV treatment. Respondent documented that he administered exosome 450 billion particles in 100 ml normal saline 0.9%. On or about March 19, 2024, during a subject interview, Respondent clarified that on May 11, 2022, he administered exosome 45 billion particles to Patient 2 instead of the documented 450 billion particles.

23. During the May 11, 2022 visit, Patient 2 also presented with complaints of vaginal discharge. Respondent collected a specimen.

24. On or about May 26, 2022, the results for Patient 2's vaginal specimen revealed the presence of candida albicans and ureaplasma species infections. Respondent failed to communicate these results to Patient 2.

25. Also during Patient 2's visit on or about May 11, 2022, Respondent administered an exosome injection to Patient 2's labial area, a therapy that is considered experimental as there is no established clinical evidence supporting its efficacy in treating vaginal infections.

26. Patient 2's chart does not contain any documentation of either the administration of the labial exosome injection or of her informed consent thereto, specific to the experimental nature of the injection.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

27. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated acts of negligence in

1 connection with his care and treatment of Patient 1 and Patient 2, as more particularly alleged
2 hereinafter.

3 Patient 1

4 28. Paragraphs 13 through 19, above, are hereby incorporated by reference as if fully set
5 forth herein.

6 29. Respondent committed negligence in connection with his care and treatment of
7 Patient 1, for failing to test Patient 1's quantitative glucose-6-phosphate dehydrogenase (G6PD)
8 levels to rule out G6PD deficiency prior to administering a high dose vitamin C infusion.

9 30. Respondent committed negligence in connection with his care and treatment of
10 Patient 1, for failing to accurately document the correct amount of exosomes administered.

11 Patient 2

12 31. Paragraphs 20 through 26, above, are hereby incorporated by reference as if fully set
13 forth herein.

14 32. Respondent committed negligence in connection with his care and treatment of
15 Patient 2, for failing to obtain informed consent specific to the exosome injection in her labial
16 area.

17 33. Respondent committed negligence in connection with his care and treatment of
18 Patient 2, for failing to document in the medical records the exosome injection in her labial area.

19 34. Respondent committed negligence in connection with his care and treatment of
20 Patient 2, for failing to communicate her positive laboratory test results of candida albicans and
21 ureaplasma.

22 35. Respondent committed negligence in connection with his care and treatment of
23 Patient 2, for failing to accurately document the correct dosage amount of exosomes
24 administered.

25 **SECOND CAUSE FOR DISCIPLINE**

26 **(Failure to Maintain Accurate and Adequate Records)**

27 36. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
28 defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records

1 in connection with his care and treatment of Patient 1 and Patient 2, as more particularly alleged
2 in paragraphs 13 through 26, above, which are hereby incorporated by reference and realleged as
3 if fully set forth herein.

4 **THIRD CAUSE FOR DISCIPLINE**

5 **(Unprofessional Conduct)**

6 37. Respondent is subjected to disciplinary action under sections 2227 and 2234 of the
7 Code, in that he has engaged in conduct which breaches the rules or ethical code of the practice of
8 medicine, or conduct which is unbecoming to a member in good standing of the medical
9 profession as more particularly described in paragraphs 13 through 26, above.

10 **ADDITIONAL DISCIPLINARY CONSIDERATIONS**

11 22. In a disciplinary action entitled *In the Matter of the Accusation Against Fouad*
12 *Ibrahim Ghaly, M.D.*, Case No. 800-2019-054052 (involving conduct occurring in 2017), the
13 Board issued a Decision and Order on July 7, 2023, effective August 4, 2023, in which
14 Respondent's Physician's and Surgeon's Certificate No. C 39588 was revoked. The revocation
15 was stayed, however, and Respondent's Physician's and Surgeon's Certificate No. C 39588 was
16 placed on probation for a period of four (4) years with certain terms and conditions.

17 **PRAYER**

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

- 20 1. Revoking or suspending Physician's and Surgeon's Certificate No. C 39588, issued to
21 Respondent Fouad Ibrahim Ghaly, M.D.;
- 22 2. Revoking, suspending or denying approval of Respondent Fouad Ibrahim Ghaly,
23 M.D.'s authority to supervise physician assistants and advanced practice nurses;
- 24 3. Ordering Respondent Fouad Ibrahim Ghaly, M.D., to pay the Board the costs of the
25 investigation and enforcement of this case, and if placed on probation, the costs of probation
26 monitoring; and
- 27 4. Taking such other and further action as deemed necessary and proper.
- 28

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

DATED: OCT 28 2025



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

LA2025600675

Exhibit A

Stipulated Settlement and Disciplinary Order No. 06-1999-095440

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

In the Matter of the Accusation Against:)

FOUAD GHALY, M.D.)

File No. 06-1999-95440

Physician's and Surgeon's
Certificate No. C 39588)

Respondent.)

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 14, 2005.

IT IS SO ORDERED June 14, 2005.

MEDICAL BOARD OF CALIFORNIA

By: 
Ronald L. Morton, M.D., Chair
Panel A
Division of Medical Quality

1 BILL LOCKYER, Attorney General
2 of the State of California
3 ROBERT McKIM BELL, State Bar No. 56332
4 Deputy Attorney General
5 California Department of Justice
6 300 So. Spring Street, Suite 1702
7 Los Angeles, CA 90013
8 Telephone: (213) 897-2556
9 Facsimile: (213) 897-9395

10 Attorneys for Complainant

11 **BEFORE THE**
12 **DIVISION OF MEDICAL QUALITY**
13 **MEDICAL BOARD OF CALIFORNIA**
14 **DEPARTMENT OF CONSUMER AFFAIRS**
15 **STATE OF CALIFORNIA**

16 In the Matter of the Accusation Against:

17 FOUAD GHALY, M.D.
18 31335 Marne Drive
19 Rancho Palos Verdes, California 90275

20 Physician & Surgeon Certificate No. C 39588,

21 Respondent.

Case No. 06-1999-95440

OAH No. L-2002010669

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

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

24 **PARTIES**

25 1. The Executive Director of the Medical Board of California ("Board") brought
26 this action solely in his official capacity and is represented in this matter by Bill Lockyer, Attorney
27 General of the State of California, by Robert McKim Bell, Supervising Deputy Attorney General.

28 2. Respondent Fouad Ghaly, M.D. ("Respondent") is represented in this
proceeding by attorney Michael Miretsky of the law firm of McCurdy & Leibl, LLP, 12925 Riverside
Drive, 3rd Floor, Sherman Oaks, California 91423.

3. On January 26, 1981, the Board issued Physician & Surgeon Certificate No.
C 39588 to Dr. Ghaly. The Certificate was in full force and effect at all times relevant to the charges
brought in Accusation No. 06-1999-95440.

[illegible]

2
3
4
5
6

7

8
9
0
1

2
3
4
5
5
7
8

90

1

11

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

CONTINGENCY

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

10. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician & Surgeon Certificate No. C 39588 issued to Respondent Fouad Ghaly, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

Within 15 days after the effective date of this decision the respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or at any other facility where respondent engages in the practice of medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

1. PROHIBITED PRACTICE During probation, and for so long as he practices

1 medicine, respondent is prohibited from performing any cosmetic or plastic surgery procedures,
2 including laser hair removal. Any violation of this term during the five-year period of probation
3 shall constitute a violation of probation; thereafter, breach of Dr. Ghaly's covenant to no longer
4 perform cosmetic or plastic surgery, including laser hair removal, shall constitute general
5 unprofessional conduct within the meaning of section 2234 of the Business and Professions Code
6 for which disciplinary action may be taken. At the earliest opportunity, respondent shall inform any
7 applicable patients that he is unable to perform cosmetic or plastic surgery, including laser hair
8 removal.

9 2. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the
10 effective date of this decision, respondent shall enroll in a course in medical record keeping, at
11 respondent's expense, approved in advance by the Division or its designee. Failure to successfully
12 complete the course during the first 6 months of probation is a violation of probation.

13 A medical record keeping course taken after the acts that gave rise to the charges in
14 the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the
15 Division or its designee, be accepted towards the fulfillment of this condition if the course would
16 have been approved by the Division or its designee had the course been taken after the effective date
17 of this Decision.

18 Respondent shall submit a certification of successful completion to the Division or
19 its designee not later than 15 calendar days after successfully completing the course, or not later than
20 15 calendar days after the effective date of the Decision, whichever is later.

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

24 4. QUARTERLY REPORTS Respondent shall submit quarterly declarations
25 under penalty of perjury on forms provided by the Division, stating whether there has been
26 compliance with all the conditions of probation.

27 5. PROBATION SURVEILLANCE PROGRAM COMPLIANCE Respondent
28 shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep

1 the Division informed of his business and residence addresses which shall both serve as addresses
2 of record. Changes of such addresses shall be immediately communicated in writing to the Division.
3 Under no circumstances shall a post office box serve as an address of record, except as allowed by
4 Business and Professions Code section 2021(b).

5 Respondent shall, at all times, maintain a current and renewed physician's and
6 surgeon's license.

7 Respondent shall also immediately inform the Division, in writing, of any travel to
8 any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than
9 thirty (30) days.

10 6. INTERVIEW WITH THE DIVISION, ITS DESIGNEE OR ITS
11 DESIGNATED PHYSICIAN(S) Respondent shall appear in person for interviews with the
12 Division, its designee or its designated physician(s) upon request at various intervals and with
13 reasonable notice.

14 7. TOLLING FOR OUT-OF-STATE PRACTICE, RESIDENCE OR IN-STATE
15 NON-PRACTICE In the event respondent should leave California to reside or to practice outside
16 the State or for any reason should respondent stop practicing medicine in California, respondent shall
17 notify the Division or its designee in writing within ten (10) days of the dates of departure and return
18 or the dates of non-practice within California. Non-practice is defined as any period of time
19 exceeding thirty (30) days in which respondent is not engaging in any activities defined in Sections
20 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training
21 program approved by the Division or its designee shall be considered as time spent in the practice
22 of medicine. A Board-ordered suspension of practice shall not be considered as a period of non-
23 practice. Periods of temporary or permanent residence or practice outside California or of non-
24 practice within California, as defined in this condition, will not apply to the reduction of the
25 probationary order.

26 8. COMPLETION OF PROBATION Upon successful completion of probation,
27 respondent's certificate shall be fully restored.

28 9. VIOLATION OF PROBATION If respondent violates probation in any

1 respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke
2 probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke
3 probation is filed against respondent during probation, the Division shall have continuing jurisdiction
4 until the matter is final, and the period of probation shall be extended until the matter is final.

5 10. COST RECOVERY The respondent is hereby ordered to reimburse the
6 Division the amount of two thousand five hundred dollars (\$2,500) as the liquidated amount of the
7 agency's costs of investigation and prosecution of the case against him. Such payment shall be made
8 within ninety (90) days of the effective date of this decision. Failure to reimburse the Division's cost
9 of investigation and prosecution shall constitute a violation of the probation order, unless the
10 Division agrees in writing to payment by an installment plan because of financial hardship. The
11 filing of bankruptcy by the respondent shall not relieve the respondent of his responsibility to
12 reimburse the Division for its investigative and prosecution costs.

13 11. PROBATION COSTS Respondent shall pay the costs associated with
14 probation monitoring each and every year of probation, as designated by the Division, which are
15 currently set at two thousand four hundred eighty-eight dollars \$2,488.00, but may be adjusted on
16 an annual basis. Such costs shall be payable to the Division of Medical Quality and delivered to the
17 designated probation surveillance monitor no later than January 31 of each calendar year. Failure
18 to pay costs within 30 days of the due date shall constitute a violation of probation.

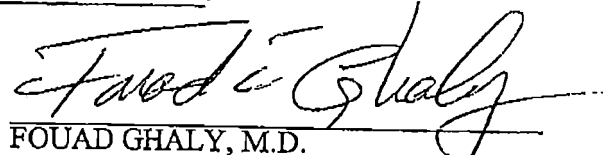
19 12. LICENSE SURRENDER Following the effective date of this decision, if
20 respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the
21 terms and conditions of probation, respondent may voluntarily tender his certificate to the Board.
22 The Division reserves the right to evaluate the respondent's request and to exercise its discretion
23 whether to grant the request, or to take any other action deemed appropriate and reasonable under
24 the circumstances. Upon formal acceptance of the tendered license, respondent will not longer be
25 subject to the terms and conditions of probation.

26
27 ACCEPTANCE

28 I have carefully read the above Stipulated Settlement and Disciplinary Order and have

1 fully discussed it with my attorney, Michael Miretsky. I understand the stipulation and the effect it
2 will have on my Physician & Surgeon Certificate. I enter into this Stipulated Settlement and
3 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision
4 and Order of the Division of Medical Quality, Medical Board of California.

5 DATED: 5/12/05

6
7 
8 FOUAD GHALY, M.D.
Respondent

9
10 I have read and fully discussed with Respondent Fouad Ghaly, M.D. the terms and
11 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
12 I approve its form and content.

13 DATED: 5/12/05

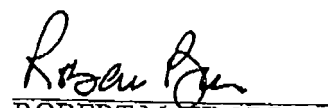
14
15 
16 MICHAEL MIRETSKY
Attorney for Respondent

17
18 **ENDORSEMENT**

19 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
20 submitted for consideration by the Division of Medical Quality, Medical Board of California of the
21 Department of Consumer Affairs.

22 DATED: May 5, 2005.

23 BILL LOCKYER, Attorney General
24 of the State of California

25 
26 ROBERT McKIM BELL
27 Deputy Attorney General

28 Attorneys for Complainant

Appendix 1
Accusation No. 06-1999-95440

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO September 5 20 01
BY Franka D. Mosher

1 BILL LOCKYER, Attorney General
of the State of California
2 E. A. JONES III, State Bar No. 71375
Deputy Attorney General for
3 Robert McKim Bell
Deputy Attorney General
4 California Department of Justice
300 South Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 897-2543
6 Facsimile: (213) 897-1071

7 Attorneys for Complainant

8
9
10 BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
11 DEPARTMENT OF CONSUME AFFAIRS
STATE OF CALIFORNIA
12

13 In the Matter of the Accusation Against:

Case No. 06-1999-95440

14 FOUAD GHALY, M.D.
3250 Lomita Blvd., Suite 208
15 Torrance, CA 90505

ACCUSATION

16 Physician's and Surgeon's Certificate No.
C39588

17 Respondent.
18

19
20 Complainant alleges:
21

22 PARTIES

23 1. Ron Joseph ("Complainant") brings this Accusation solely in his official
24 capacity as the Executive Director of the Medical Board of California.

25 2. On or about January 26, 1981, the Medical Board of California issued
26 Physician's and Surgeon's Certificate Number C39588 to Fouad Ghaly, M.D. ("Respondent").
27 The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the
28 charges brought herein and will expire on October 31, 2002, unless renewed.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, State of California (Division"), under the authority of the following sections of the Business and Professions Code ("Code"). Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have 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 Division deems proper.

4. Section 2234 of the code states that the Division of Medical Quality 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, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.
- (b) Gross negligence.
- (c) Repeated negligent acts.
- (d) Incompetence.
- (e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.
- (f) Any action or conduct which would have warranted the denial of a certificate.
- (g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine.

Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

5. Section 125.3 of the states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

1 6. Section 14124.12 of the Welfare and Institutions Code states:

2 (a) Upon receipt of written notice from the Medical Board of California,
3 the Osteopathic Medical Board of California, or the Board of Dental Examiners of
4 California, that a licensee's license has been placed on probation as a result of a
5 disciplinary action, the department may not reimburse any Medi-Cal claim for the
6 type of surgical service or invasive procedure that gave rise to the probation,
7 including any dental surgery or invasive procedure, that was performed by the
8 licensee on or after the effective date of probation and until the termination of all
9 probationary terms and conditions or until the probationary period has ended,
10 whichever occurs first. This section shall apply except in any case in which the
11 relevant licensing board determines that compelling circumstances warrant the
12 continued reimbursement during the probationary period of any Medi-Cal claim,
13 including any claim for dental services, as so described. In such a case, the
14 department shall continue to reimburse the licensee for all procedures, except for
15 those invasive or surgical procedures for which the licensee was placed on
16 probation.

17 **FIRST CAUSE FOR DISCIPLINE**

18 (Gross Negligence)

19 7. Respondent is subject to disciplinary action under section 2234,
20 subdivision (b) of the Code in that respondent was grossly negligent in the care and treatment of
21 patients. The circumstances are as follows:

22 Patient R.T.

23 A. On or about June 22, 1998, patient R. T. presented to respondent with a
24 complaint of prominent blood vessels in her right leg. There is no evidence that
25 respondent examined patient R.T. or otherwise evaluated her skin. Patient signed a
26 consent for sclerotherapy and photo (laser) therapy for treatment of the blood vessels.
27 Pursuant to the consent, photographs were to be taken. There is no evidence that
28 photographs were taken. Pursuant to the patient laser information sheet, test patches were

1 to be performed prior to the procedure. There is no evidence that test patches were
2 performed. On or about July 17, 1998, respondent performed sclerotherapy and laser
3 treatment of patient R.T.'s right leg. Thereafter she was seen in follow-up on July 20,
4 1998, July 25, 1998, July 28, 1998, and September 10, 1998. Patient failed to make her
5 appointment for September 17, 1998. On or about July 28, 1998, patient R.T. was
6 prescribed Soloquin for hyperpigmentation but the patient did not have the prescription
7 filled. On or about September 10, 1998, a compounded prescription was filled and paid
8 for by respondent. The July 17, 1998 procedure resulted in long term hyperpigmentation,
9 dark hair and possible dermal scarring.

10 B. On or about June 22, 1998, respondent was grossly negligent when he failed
11 to examine patient R.T. and determine her skin type in order to take necessary precautions
12 to protect the patient from untoward results.

13 C. On or about July 17, 1998, respondent was grossly negligent when he failed
14 to perform a laser treatment test of the patient's healing in an area where scarring could
15 be hidden if it occurred.

16 D. On or about July 17, 1998, respondent was grossly negligent when he
17 performed sclerotherapy and laser treatment of patient R.T.'s right leg without adequate
18 training and experience.

19 Patient R.I.

20 E. In or around August 1998, patient R.I. presented to respondent for a routine
21 physical exam and check-up. Respondent advised patient R.I. that respondent could
22 remove hair from patient R.I.'s face. Thereafter respondent performed a hair removal
23 procedure on patient R.I.'s face. Respondent's procedure resulted in areas of second
24 degree and deep second degree burns on patient R.I.'s right face, right neck and chin.
25 Respondent failed to maintain medical records regarding patient R.I.

26 F. In or around August 1998, respondent was grossly negligent when he failed
27 to maintain medical records on patient R.I.

28 G. In or around August 1998, respondent was grossly negligent when he

1 performed a hair removal procedure on the face of patient R.I. without adequate training
2 and experience.

3 Patient T.C.

4 H. On or about November 3, 1998, patient T.C. presented to respondent seeking
5 a consultation for facial cosmetic surgery. Respondent's records indicate that patient T.C.
6 was on a skin bleaching protocol but does not indicate who started it or when. There is
7 no evidence of an initial history and physical being performed on patient T.C. There is no
8 evidence of a preoperative screen before her laser resurfacing. On or about November 6,
9 1998, respondent performed a laser resurfacing procedure on patient T.C.'s face. The
10 operative note indicates that the patient was given pre medication (the type, dosage and
11 route of administration are not noted) and Versed intra-muscularly. There is not
12 anesthesia or monitoring record indicating that vital signs were taken while the patient
13 was under sedation.

14 I. The office records of respondent for patient T.C. indicate that respondent
15 started patient T.C. on a diet regimen but no history and physical relating to that regimen
16 is present. There is no diagnostic work up relating to any possible metabolic cause for the
17 patient's alleged excessive weight. The office record of patient T.C. regarding the weight
18 regimen reflects that on numerous occasions neither her weight nor blood pressure was
19 taken.

20 J. Respondent saw patient T.C. in follow-up for the November 6, 1998 surgery
21 on November 9, 1998, November 11, 1998, November 16, 1998, December 15, 1998,
22 December 22, 1998, January 22, 1999, March 1, 1999, and April 27, 1999. Respondent's
23 records did not indicate the deep burns or delayed healing that patient T.C. was
24 experiencing until the March 1999 visit. On the April 27, 1999 visit, patient T.C.'s scars
25 were injected with Celestone. The records contain no other indication of treatment of the
26 scars.

27 K. Patient T.C. was prescribed a narcotic on or about January 21, 1999. A
28 nurse's note in respondent's office chart reflects that patient T.C. was prescribed Vicodin

1 ES (a narcotic) on or about March 3, 1999. A further nurse note indicates that the patient
2 was prescribed Vicodin ES 100# on or about March 25, 1999 because the patient was to
3 have surgery on April 2, 1999. The note does not indicate the type of surgery. The chart
4 does not document any surgery performed by respondent on patient T.C. in April 1999
5 nor is there any indication that respondent saw the patient between January 22, 1999 and
6 April 27, 1999. There is no evidence in the chart justifying the usage of the narcotic
7 medication.

8 L. On or about November 3, 1998, respondent was grossly negligent when he
9 failed to perform an initial history and physical on patient T.C.

10 M. On or about November 3, 1998, respondent was grossly negligent when he
11 failed to perform a pre-operative screen before laser surgery on patient T.C.

12 N. On or about November 6, 1998, respondent was grossly negligent when he
13 failed to maintain adequate records of the anesthesia and/or monitor patient T.C. during
14 the laser facial surgery performed on patient T.C.

15 O. On or about November 6, 1998, respondent was grossly negligent when he
16 performed laser facial resurfacing on patient T.C. without adequate training and
17 experience in such surgery..

18 P. On or about December 29, 1998, and thereafter, respondent was grossly
19 negligent when he failed to perform an initial history and physical and diagnostic work-up
20 on patient T.C. in connection with the weight control regimen for patient T.C.

21 Q. On or about December 29, 1998, and thereafter, respondent was grossly
22 negligent when he failed to properly monitor patient T.C. in connection with the weight
23 control regimen for patient T.C.

24 R. On or about March 3, 1999, and March 25, 1999, respondent was grossly
25 negligent when he excessively prescribed narcotic medications to patient T.C.

26 Patient C.M.

27 S. On or about May 12, 1998, respondent performed a bilateral
28 transconjunctival blepharoplasty using CO2 laser under local anesthesia at his office on

1 patient C.M., a fifty year old female employee of respondent. Respondent's medical chart
2 for patient C.M. does not contain patient information such as allergies or previous or
3 current medical conditions. It does not contain a pre-surgical evaluation of the patient's
4 heart, lungs or eyelids. There are no post-operative notes. There is no operative note or
5 dictation.

6 T. On or about May 26, 1998, patient C.M. complained to respondent of
7 diplopia.

8 U. On or about August 3, 1998, respondent was seen and diagnosed as having a
9 transection of the left inferior rectus muscle by Dr. K.S., M.D., who referred patient C.M.
10 to Dr. A.R., M.D., at UCLA Medical Center for corrective surgery on February 24, 1999.
11 Dr. A.R., M.D. has performed three strabismus operations to correct the resultant muscle
12 imbalance in patient C.M.'s eye.

13 V. On or about May 12, 1998, respondent was grossly negligent when he
14 transected the inferior rectus muscle of patient C.M. during the course of a bilateral
15 transconjunctival blepharoplasty.

16 W. On or about May 12, 1998, and thereafter, respondent was grossly negligent
17 when he failed to maintain adequate medical records of the care and treatment proved to
18 patient C.M.

19 SECOND CAUSE FOR DISCIPLINE

20 (Repeated Negligent Acts)

21 8. Respondent is subject to disciplinary action under section 2234,
22 subdivision (c) of the Code in that respondent committed repeated negligent acts in the care and
23 treatment of patients. The circumstances are as follows:

24 A. The facts and circumstances alleged in paragraph 7 above are incorporated
25 here as if fully set forth.

26 Patient R.T.

27 B. On or about June 22, 1998, respondent was negligent when he failed to
28 examine patient R.T. and determine her skin type in order to take necessary precautions to

1 protect the patient from untoward results.

2 C. On or about July 17, 1998, respondent was negligent when he failed to
3 perform a laser treatment test of the patient's healing in an area where scarring could be
4 hidden if it occurred.

5 D. On or about July 17, 1998, respondent was negligent when he performed
6 sclerotherapy and laser treatment of patient R.T.'s right leg without adequate training and
7 experience.

8 Patient R.I.

9 E. In or around August 1998, respondent was negligent when he failed to
10 maintain medical records on patient R.I.

11 F. In or around August 1998, respondent was negligent when he performed a
12 hair removal procedure on the face of patient R.I. without adequate training and
13 experience.

14 Patient T.C.

15 G. On or about November 3, 1998, respondent was negligent when he failed to
16 perform an initial history and physical on patient T.C.

17 H. On or about November 3, 1998, respondent was negligent when he failed to
18 perform a pre-operative screen before laser surgery on patient T.C.

19 I. On or about November 6, 1998, respondent was negligent when he failed to
20 maintain adequate records of the anesthesia and/or monitor patient T.C. during the laser
21 facial surgery performed on patient T.C.

22 J. On or about November 6, 1998, respondent was negligent when he
23 performed laser facial resurfacing on patient T.C. without adequate training and
24 experience in such surgery..

25 K. On or about December 29, 1998, and thereafter, respondent was negligent
26 when he failed to perform an initial history and physical and diagnostic work-up on
27 patient T.C. in connection with the weight control regimen for patient T.C.

28 L. On or about December 29, 1998, and thereafter, respondent was negligent

1 when he failed to properly monitor patient T.C. in connection with the weight control
2 regimen for patient T.C.

3 M. On or about March 3, 1999, and March 25, 1999, respondent was negligent
4 when he excessively prescribed narcotic medications to patient T.C.

5 Patient C.M.

6 N. On or about May 12, 1998, respondent was negligent when he transected the
7 inferior rectus muscle of patient C.M. during the course of a bilateral transconjunctival
8 blepharoplasty.

9 O. On or about May 12, 1998, and thereafter, respondent was negligent when
10 he failed to maintain adequate medical records of the care and treatment provided to patient
11 C.M.

12 Patient C.C.

13 P. On or about September 7, 1999, patient C.C., a 52 year old male, presented
14 to respondent with chief complaints of low energy and low sex drive. Patient C.C. filled
15 out a questionnaire on diet, exercise and emotions and indicated a life goal of being the
16 way he was physically at age 25. Respondent examined the patient and ordered extensive
17 blood testing. Respondent saw patient C.C. on September 23, 1999 to review the lab
18 results. Respondent concluded that patient C.C. was depressed and was suffering from
19 chronic fatigue syndrome. Respondent began injecting patient C.C. with Human Growth
20 Hormone (HGH). Respondent did not refer patient C.C. to an endocrinologist before
21 starting the treatment with HGH. Respondent also started the patient on trazadone, an
22 antidepressant. The medical record does not indicate that respondent attempted to rule
23 out other diagnoses that may have been reflected in the lab reports and/or history taken on
24 patient C.C. Respondent did not acknowledge or pursue other abnormalities found in the
25 lab results: the elevated random glucose and the elevated transaminase and bilirubin.

26 Q. On or about September 23, 1999, and thereafter, respondent was negligent
27 when he prescribed an unusual treatment (HGH) for chronic fatigue and depression
28 without adequate work up or offering more conventional options.

1 R. On or about September 23, 1999, and thereafter, respondent was negligent
2 when he failed to pursue or refer for further evaluation laboratory abnormalities which
3 could lead do (or rule out) diagnoses that may have explained the presenting symptoms.

4 THIRD CAUSE FOR DISCIPLINE

5 (Incompetence)

6 9. Respondent is subject to disciplinary action under section 2234,
7 subdivision (d) of the Code in that respondent was incompetent in the care and treatment of
8 patients. The circumstances are as follows:

9 A. The facts and circumstances alleged in paragraphs 7 and 8 above are
10 incorporated here as if fully set forth.

11 FOURTH CAUSE FOR DISCIPLINE

12 (Unprofessional Conduct)

13 10. Respondent is subject to disciplinary action under section 2234,
14 subdivision (a) of the Code in that respondent committed acts of unprofessional conduct in the
15 care and treatment of patients. The circumstances are as follows:

16 A. The facts and circumstances alleged in paragraphs 7, 8 and 9 above are
17 incorporated here as if fully set forth.

18 ///

1 PRAYER

2 WHEREFORE, Complainant requests that a hearing be held on the matters herein
3 alleged, and that following the hearing, the Division issue a decision:

4 1. Revoking or suspending Physician's and Surgeon's Certificate Number
5 C39588, issued to Fouad Ghaly, M.D.;

6 2. Revoking, suspending or denying approval of Fouad Ghaly, M.D.'s
7 authority to supervise physician's assistants, pursuant to section 3527 of the Code;

8 3. Ordering Fouad Ghaly, M.D. to pay the Division the reasonable costs of
9 the investigation and enforcement of this case, and, if placed on probation, the costs of probation
10 monitoring;

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

12 DATED: September 5, 2001

13
14
15 
16 _____
17 RON JOSEPH
18 Executive Director
19 Medical Board of California
20 State of California
21 Complainant
22
23
24
25
26
27
28