IN THE MATTER OF	*	**BEFORE THE**
MANSOUR PANAH, M.D.	*	**MARYLAND BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D15506	*	**Case Number: 2006-0475**

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CONSENT ORDER

The Maryland Board of Physicians (the "Board") charged Mansour Panah, M.D. (the "Respondent") (D.O.B. 2-8-40), License Number D15506, with violations under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2005 & 2009 Repl. Vols.)

The pertinent provisions of the Act under H.O. § 14-404 provides the following:

§ 14-404. Denials, reprimands, probations, suspensions, and revocations-----Grounds

(a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; and

(40) Fails to keep adequate records as determined by appropriate peer review.

On Wednesday, March 2, 2011, a Case Resolution Conference was convened regarding this matter. Based on negotiations which occurred as a result of this Case Resolution Conference, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

I. Background

The Board bases its charges on the following facts that the Board has reason to believe are true:

1. At all times relevant to these charges, the Respondent was and is licensed to practice medicine in the State of Maryland under License Number D15506. The Respondent was originally issued a license in the State of Maryland in August 1973.

2. The Respondent is board-certified in Obstetrics and Gynecology and maintains an office for the practice of medicine at the following location: 14300 Gallant Fox Lane, Suite 203.

3. The Respondent performs cosmetic surgery procedures, including Botox treatments, facelifts and liposuctions.

4. The Board initiated an investigation after receiving a complaint from a patient, hereinafter identified as Patient "A", who stated that the Respondent performed a cosmetic surgery procedure, where he transferred fat from her stomach to her chin and cheeks. The patient complained that there was no sink in the office and that the Respondent did not wash his hands before the procedure. She also stated that he processed the fat to make it liquid in a small device in his office. The complainant alleged that her face became infected three weeks after the procedure and she developed unsightly bumps at the site of the surgery, and that she had to seek medical care from another practitioner to treat the infection.

5. Board staff interviewed a nurse practitioner who was employed in the Respondent's office, hereinafter identified as Witness "A",[1] who complained that the Respondent did not follow proper sterile procedures in his office, and did not properly dispose of biological waste. Witness A stated that the Respondent reused disposable equipment after sterilizing the equipment in a sterilizer located in the office. Witness A also stated that the Respondent did not dispose of biological waste products in accordance with biohazard procedures. Witness A reports that she observed fat that had been removed from patients in liposuction procedures drying in a sink in the office kitchen.

6. Witness A stated that she advised the Respondent that the waste material should be placed in a biohazard container and picked up by a biological waste disposal company. The Respondent informed her that he was transporting the waste in his car to another medical office for disposal. Witness A stated that she believed that he was disposing of the waste in a trash can in the office and a dumpster behind the office.

7. The Board referred the case for peer review, and two peer reviewers agreed that the Respondent failed to meet the standard of care for providing medical services in five out of the six cases reviewed.

8. The Board also referred the case for review by a medical consultant, with expertise in plastic surgery, who concluded that the Respondent failed to meet the applicable standard of care, when providing care to cosmetic surgery patients.

[1] The identity of Witness A is not included in this document in order to protect her privacy.

II. Patient Specific Allegations

A. Peer Review

Patient B

9. The Respondent provided care to a 64 year old female, hereinafter identified as Patient "B,"[2] who was seen in the office on December 10, 2004, for a face lift. According to progress notes on December 17, 2004, the patient had a follow-up appointment and the wound was cleansed. Patient B was treated periodically from January 3, 2005, until December 18, 2006, with Restalyne,[3] Botox,[4] fat injections, and laser therapy.[5] The chart notes indicate that the patient received injections of Restalyne to the face on January 3, 2005 and January 10, 2005, with a follow-up on January 20, 2005. There is, however, no documentation of the specifics of physical findings before or after treatment, or the medical indication for the treatment. Also, the record does not contain a consent form for the treatment. The chart also notes that the patient received Restalyne treatments on June 17, 2005 and June 13, 2006. There is a dose lot sticker in the chart, but minimal reference to location of treatment and there is no documentation regarding pre-operative assessment.

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[2] The identities of the patients are not included in this document in order to protect their privacy, but the administrative prosecutor will make this information available to the Respondent upon request.

[3] Restalyne is the trade name for a specific formulation of non-animal sourced hyaluronic acid used for cosmetic surgeries. Restalyne is injected under the skin to remove facial wrinkles and for lip augmentation

[4] Botox is a drug made from a toxin produced by the bacterium Clostridium botulinum, and it is injected under the skin to remove wrinkles.

[5] Laser (electrocautery) treatment is performed with a device that uses an intense beam of light which directs heat towards a specific spot on the body. In cosmetic surgery laser therapy can be used to remove warts, moles, and skin tags.

10. Patient B received facial rejuvenation[6] treatments on February 9, March 2, March 23, and April 13, 2005. A single line in a progress note indicates Botox treatments, but it is unclear if this applies to the facial rejuvenation treatments. There is no corresponding dose or lot numbers in the medical record for the Botox injections administered to the patient. The file contains a note that rejuvenation of both thighs was done on April 22, 2005. There is a limited information consent for suction-assisted lipoplasty,[7] but the chart does not include a note regarding the medical indication for the procedure, or findings regarding a pre-operative physical, or any procedural or post-operative care.

11. Both reviewers agreed that the Respondent did not meet the standard of care with respect to the care provided to Patient B. The Respondent failed to include an operative note regarding the face lift in the file. There was no mention of any sterile preparations for any of the procedures, including the liposuction, the fat replacement, or the face lift. The Respondent did not have adequate facilities, because there was no sink with running water in the office where the procedure was performed.

12. Both reviewers also agreed that the Respondent failed to maintain adequate documentation in the file. The Respondent failed to include an operative note regarding the face lift in the file. There was no mention of any sterile preparations for any of the procedures, including the liposuction, the fat replacement, or the face lift.

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[6] Facial rejuvenation is any cosmetic or medical procedure used to increase or restore the appearance of a younger age to a human face. The term can refer to various cosmetic procedures, such as brow lift, chin lift, physical or chemical peeling, a face lift to eliminate wrinkles, elimination of senile spots, skin aging, or facial sagging.

[7] Lipoplasty (liposuction) is a procedure that slims and reshapes specific areas of the body by removing excess fat deposits.

Patient C

13. The Respondent provided care to a twenty-three year old patient, hereinafter Patient "C." Patient C had a history of obesity. She weighed 154 pounds and had a BMI of 25, but she reported that she had lost over 80 pounds on weight watchers in the past, and gained 10 pounds over the past three years. The physical examination was limited to heart and lungs. No blood work was reviewed or requested. The patient's nutrition for a day was reviewed, but there were no recommendations regarding dietary changes and/or exercise.

14. The Respondent prescribed Adipex (phentermine hydrochloride)[8] for weight loss. Over a period of approximately twenty months Patient C was seen approximately every 4-6 weeks, and treated with Adipex and Vitamin B-12 injections. Patient C was treated with Vitamin B-12 even though there was no indication of anemia [9]or vitamin B-12 deficiency. The Respondent prescribed Adipex for Patient C for twenty months, despite the fact that she had a normal BMI. Patient C was last seen on June 4, 2007, and progress notes indicate that she weighed 163 pounds.

15. Both reviewers agreed that the Respondent failed to meet the standard of care with respect to the care provided to Patient C. The Respondent failed to request or review lab work. The Respondent failed to make recommendations regarding diet and or exercise changes, even though Patient C was seeking treatment for weight loss. The Respondent continued Patient C on Adipex, an addictive drug with significant side effects, even though she was not receiving any apparent benefit from the drug regimen. Patient C actually gained weight while taking Adipex.

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[8] Adipex is a drug containing phentermine, which is stimulant similar to an amphetamine. It is used as an appetite suppressant for weight loss.
[9] Anemia is a decrease in the normal number of red blood cells.

16. One reviewer also opined that the Respondent failed to maintain adequate documentation in the file. The medical record did not contain documentation that lab work was requested or reviewed. Although, Patient C was seeing the Respondent for weight loss for approximately a twenty month period the record did not contain adequate recommendations regarding dietary changes and/or exercise.

Patient D

17. The Respondent provided care to a thirty-nine year old female, hereinafter identified as Patient "D." Patient D was seen on September 22, 2005, for consultation for liposuction. She had a history of abdominal scarring from two Caesarean sections[10] and an abdominal hysterectomy.[11] The patient was seen again on September 29, 2005 for a follow-up consultation. The Respondent performed liposuction on the patient on October 28, 2005, but the medical record only included a minimal summary operative note and no documentation of procedural steps. The patient did well until approximately January 6, 2006, when she developed right suprapubic[12] pain and was found to have cellulitis.[13] The Respondent prescribed Augmentin,[14] and reported one week later that the infection had resolved.

18. Both reviewers agreed that the Respondent did not meet the applicable standard of care with respect to the care provided to Patient D. The Respondent did not document sterile techniques employed while performing this procedure, such as proper

[10] A Caesarean section is a surgical procedure in which one or more incisions are made through a woman's abdomen and uterus to deliver an infant.
[11] A hysterectomy is the surgical removal of the uterus.
[12] Suprapubic refers to the lower central part of the abdomen.
[13] Cellulitis is a diffuse inflammation of dermal and subcutaneous layers of the skin, which is usually caused by a bacterial infection.
[14] Augmentin (amoxicillin) is an antibiotic used to treat bacterial infections.

gowning, hand washing, and use of bacterial soaps or gels. There was no documentation of the patient's lab work and no informed consent form in the file.

Both reviewers also agreed that the Respondent did not maintain adequate documentation in the file. The Respondent did not properly document the patient's lab work, and there was no informed consent in the file.

19. The Respondent provided care to a thirty-two year old female, hereinafter Patient "E," who complained that she had a weight problem and requested liposuction. On April 3, 2006, the patient had liposuction performed on her lower abdomen, and on April 7, 2006, she returned for a follow-up visit. The record contains a minimal history. The Respondent failed to include an adequate treatment plan in the medical record, and did not discuss what the patient's options were for treating her weight problem. The Respondent failed to document a complete physical examination, and the medical record does not include a preoperative or intra-operative physical assessment.

20. Both reviewers agreed that the Respondent did not meet the standard of care with respect to the care provided to Patient E, because the Respondent failed to include an adequate treatment plan in the medical record, and did not discuss what the patient's options were for treating her weight problem. The Respondent failed to document a complete physical examination, and the medical record does not include a pre-operative or intra-operative physical assessment. There was no documentation in the medical record that lab work was performed and/or reviewed prior to the procedure. Also, there was no detailed operative report including the proper sterile technique utilized in the procedure.

21. Both reviewers agreed that the Respondent failed to maintain adequate documentation in the patient's file. The Respondent failed to include in the medical record documentation that a complete physical history was performed. Also, the file did not contain documentation of lab work performed, or any documentation that the proper sterile technique was used in the procedure.

Patient F

22. The Respondent provided treatment to a forty-five year old female patient, hereinafter Patient "F." The Respondent saw Patient F on February 13, 2006, for treatment to remove moles. The medical record indicates that 24 moles were shaved off an unspecified part of the patient's body on that day. Over the next four months Patient F was treated with Botox, Restalyne, laser therapy and liposuction of the thighs and buttocks. On February 17, 2006, the medical record documents that a liposuction procedure was performed on the thighs. The medical record includes a consent form, and a brief operative note. There is a note in the medical record that liposuction was performed again on February 27, 2006, and there is a brief operative note but no consent form. In March 2006, there is a record notation indicating that liposuction was performed, but there is no consent form or operative note. In April of 2006, the Respondent performed liposuction on the patient, and the medical record contains a consent form and an operative note.

23. In March 2006, the medical record indicates that Patient F received two injections with Botox and Restalyne, but the corresponding note contains minimal information regarding dose and site of injection. On April 7, 2006, Patient F was again treated with liposuction. Patient F received laser treatments in July 2006 and February

2007, but the notes do not indicate the reason for treatment or include a procedural discussion, nor is there a consent form for therapy.

24. Both reviewers agreed that the standard of care was not met with respect to the care provided to Patient F. The medical record does not contain an adequate patient history, and the record does not indicate that the Respondent performed a complete physical examination of the patient. The medical record fails to adequately document how the procedures were performed with respect to sterile procedures, including draping and gowning the patient. The narrative in the chart describing the conditions under which the liposuction or laser therapy was performed is inadequate. The basis for treatment was not adequately documented, and the operative notes were inadequate.

25. Both reviewers agreed that the Respondent failed to include adequate documentation in the file. The medical record did not contain a complete patient medical history and did not document that the Respondent performed a complete physical. The procedural and operative reports are not adequate. The medical record does not include a consent form or operative notes for each procedure.

26. Both reviewers also opined that the Respondent had not provided any documentation or credentials establishing that he had the expertise and/or training to perform various cosmetic surgery procedures.

B. Medical Consultant Review

27. The Board referred the case for review by a medical consultant. A board certified plastic surgeon reviewed the charts of the 6 patients and concluded that the

Respondent did not meet the standard of care with respect to the care provided to patients A, B, D, E, and F.

Patient B

28. Patient B sought consultation for a facelift. According to the consultant, there is a brief hand-written consultation note and a short consent form for a facelift, but there is no evidence in the file that the patient's face and wrinkles were ever pre-operatively evaluated by the Respondent. The patient underwent a facelift on January 10, 2004, but there is no operative note, documentation of type of anesthesia used or the patient's medical status during the procedure. The patient underwent liposuction of the lower legs on April 22, 2005, but there is no pre-operative evaluation of her legs, except for a "cryptic" drawing of the patient's lower legs, and there is no operative note in the file.

29. The consultant noted that the consent forms for liposuction and the facelift were inadequate, and did not provide sufficient details on the medical risks of the procedures. The medical consultant opined that the Respondent did not meet the standard of care for the medical treatment provided to Patient B, because he failed to perform and document a proper pre-operative assessment; failed to provide a post-operative assessment in the medical record, and did not provide adequate consent forms for the patient.

Patient D

30. Patient D sought consultation for abdominal contouring. The consultant's report notes that the pre-operative examination and assessment were inadequate, and that the file did not contain a formal consent form for liposuction. The medical notes

document a three stage procedure. The patient underwent the first stage procedure on October 28, 2005, which took approximately 3 1/2 hours, however there is no operative note, so the degree of sterility cannot be assessed. The Respondent administered lidocaine[15] and epinephrine[16] to the patient, but only performed one pulse rate and three blood pressure monitoring readings during the procedure. The medical record does not document that IV fluids were administered to the patient during the procedure. The procedure was not completed, because the patient subsequently developed an infection, which was treated with antibiotics.

31. According to the consultant, the Respondent did not meet the standard of care, because the pre-operative examination and assessment was inadequate. Further, the standard of care required that the Respondent perform constant intra-operative monitoring for blood pressure and pulse rate and provide IV fluids. The consultant noted that the medical record did not contain adequate documentation of the post-operative monitoring, such as blood pressure or heart rate or any criteria for discharge. The patient subsequently developed an infection.

Patient E

32. Patient E sought consultation for abdominal contouring. The patient was 220 lbs at the time of consultation, but the medical record does not note an examination of the patient's abdomen. The patient had the procedure on April 3, 2006, using IM Versed[17] and tumescent solution.[18] During the procedure, which took approximately 2

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[15]Lidocaine is a common local anesthetic, and it is used to relive itching, burning and pain associated from skin inflammation and as a local anesthetic.

[16] Epinephrine is a drug used for the relief of respiratory distress. It is used to provide relief from allergic reactions and to prolong the reaction of local anesthetics.

[17] Versed is a short acting drug used for the treatment of seizures and for inducing sedation and amnesia before medical procedures.

¼ hour, one heart rate and two blood pressure readings were taken. The medical record fails to document that IV fluids were administered to the patient. The file did not contain an operative note, and there was no evidence of post-operative care or monitoring in the medical record.

33. According to the consultant, the Respondent did not meet the standard of care, because the Respondent failed to perform adequate intra-operative monitoring for blood pressure and pulse rate, and failed to properly administer IV fluids. The consultant noted that the record does not contain adequate information regarding post-operative monitoring, such as monitoring of blood pressure or heart rate, and fails to contain any criteria for discharge.

Patient F

34. Patient F sought consultation On February 13, 2006, for mole removal, spots on her chest and liposuction of her anterior thighs. The Respondent removed twenty-four moles with electrocautery (laser therapy). There is no indication that the moles were sent to pathology, and because there is no description of the moles in the medical record, it cannot be determined if pathology was indicated.

35. The record does not contain documentation of a pre-operative physical examination of the patient's thighs, but on February 17, 2006, Patient F underwent liposuction of the outer thighs. The medical record contains a consent form and a brief operative note. Ten days later the patient had inner thigh liposuction, and on April 7, 2006, she had repeat liposuctioning of the inner thigh. The medical consultant noted

[18] Tumescent solution is a liquid with anesthetic properties, which is injected into areas of the body that are storing fat to reduce the post-operative pain and bleeding in liposuction procedures.

that the Respondent failed to perform: an adequate pre-operative examination; or intra-operative monitoring; and failed to provide details of post-operative care.

36. Patient F also had a scelerotherapy procedure[19] on her leg veins, but the medical consultant report notes that the medical record does not indicate that the patient was informed of the medical risks, complications and benefits of this procedure. The medical consultant opined that the Respondent did not meet the standard of care, because the Respondent failed to perform an adequate pre-operative examination; or intra-operative monitoring; and failed to provide details of post operative care.

37. The medical consultant also opined that the Respondent failed to meet the standard of care in providing care to the complainant in this case, Patient A.

38. Overall the medical consultant noted that The Respondent did not meet the standard of care for medical services provided to plastic surgery patients because he failed to document and perform an adequate pre-operative assessment on patients; failed to document and perform adequate intra-operative monitoring; and failed to provide adequate details of post-operative care. The consultant also noted that consent forms were inadequate and/or not in the medical file. The medical consultant also opined that the Respondent had not demonstrated or provided any documentation or credentials establishing that he had the expertise and/or training to perform cosmetic surgery procedures.

[19] Scelerotherapy is a medical procedure used to eliminate varicose veins and spider veins, by injecting a salt solution into the vein.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions as set forth above with respect to the medical care provided to Patients B-F, constitute violation of H.O. § 14-404 (a) (22). (40).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 31st day of May, 2011, by a majority of the quorum of the Board considering this case hereby:

ORDERED that effective the date of this Consent Order, the Respondent's license to practice medicine in the State of Maryland shall be **REPRIMANDED,** and it is further ordered,

ORDERED that the Respondent shall be placed on probation for a minimum of two years, and until all of the following conditions terms and conditions are fully and satisfactorily complied with:

1. The Respondent shall immediately submit to the Board a copy of a biological waste disposal contract entered into between the biological waste disposal company and his employer, or if the Respondent is self employed he shall submit to the Board a copy of his biological waste disposal contract.

2. The Respondent is subject to a chart and/or peer review by the Board or its designee during the probationary period. The Respondent must make his patients' medical records available to the chart and/or peer reviewers upon request. An unsatisfactory chart and/or peer reviewers will be deemed a violation of probation and the Consent Order.

3. Within six months of the date of the Consent Order, the Respondent shall enroll in and complete a Board-approved course in CDC Universal Blood and Body Fluid Precautions and appropriate biological waste disposal.

4. The Respondent shall be responsible for all costs associated with compliance with this Consent Order.

AND BE IT FURTHER ORDERED, that the Respondent agrees not to perform any cosmetic surgical procedures, which includes, but is not limited to liposuctions, facelifts, facial rejuvenation treatments or Botox treatments, and the Respondent agrees that this is a permanent prohibition; and be it further ordered

ORDERED that any violation of the terms/and or conditions of the Consent Order, including an unacceptable peer review as described above, shall be deemed a violation of this Consent Order; and be it further

ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before the Board, may impose any other disciplinary sanction which the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including a reprimand, probation, suspension, revocation and/or a monetary fine, said violation being proven by a preponderance of the evidence; and be it further

ORDERED that after the conclusion of the entire **two (2) year PERIOD OF PROBATION,** the Respondent may file a written petition for termination of the probationary status without further conditions or restrictions, but only if the Respondent has satisfactorily complied with all conditions of the this Consent Order, including all terms and conditions of probation, including the expiration of the two year period of

probation, and if there are no pending complaints regarding the Respondent before the Board; and be it further

ORDERED that the Respondent shall comply with the Maryland Medical Practice Act and all laws, statutes and regulations pertaining to the practice of medicine; and be it further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2009 Repl. Vol. & 2010 Supp.)

5/31/2011
Date

John Papavasiliou, Deputy Director
Maryland Board of Physicians

CONSENT

I, Mansour Panah, M.D., License No. D15506, by affixing my signature hereto, acknowledge that:

1. I have been informed that I am entitled to be represented by an attorney, and I have chosen to represent myself. I have knowingly and voluntarily elected to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.
2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 14-405 (2009 Repl. Vol.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol.).
3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I

would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, I may be subject to disciplinary actions, which may include revocation of my license to practice medicine.

6. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

5-6-11
Date

Mansour Panah, M.D.
Respondent

NOTARY

STATE OF Maryland

City
COUNTY OF Baltimore

I HEREBY CERTIFY that on this 6th day of May, 2011, before me, a Notary Public of the State and County aforesaid, personally appeared Mansour Panah, M.D., License Number D15506, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notarial Seal.

GLORIA TOMEY BROWN NOTARY PUBLIC BALTIMORE CITY, MD

Gloria Tomey Brown
Notary Public

My commission expires: 3/9/13