

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
BOARD OF MEDICINE**

IN RE :
 :
HENOK ARAYA, M.D. :
MD034551 :
Respondent :

FINAL DECISION AND ORDER OF THE BOARD

This matter comes before the District of Columbia Board of Medicine (the “Board”) pursuant to the Health Occupations Revision Act (HORA), D.C. Code § 3-1201.01 *et seq.* The Board has broad jurisdiction to regulate the practice of medicine and to impose a variety of disciplinary sanctions upon a finding of a violation of the HORA. D.C. Code, § 3-1201.03; *Mannan v. District of Columbia of Medicine*, 558 A.2d 329,333 (D.C. 1989). The Council of the District of Columbia, in amending the HORA, “intended to strengthen enforcement of its licensing laws.” *Davidson v. District of Columbia Board of Medicine*, 562 A.2d 109, 113 (D.C. 1989). And the HORA “was designed to ‘address modern advances and community needs *with the paramount consideration of protecting public interest.*’” *Joseph v. District of Columbia Board of Medicine*, 587 A.2d 1085,1088 (D.C. 1991) (*quoting* Report of the D.C. Council on Consumer and Regulatory Affairs on Bill 6-317, at 7 (November 26, 1985)) (emphasis added by court).

D.C. Code § 3-1205.19 authorizes the Board to conduct hearings and issue final decisions. The Board may delegate its authority to conduct a hearing to an Administrative Law Judge (ALJ) (*See* D.C. Code § 3-1205.19(i); *see also* 17 D.C. Mun. Regs. § 4114 (Hearings by Administrative Law Judges)). The ALJ shall issue a recommended decision which the Board may accept or reject in whole or in part in issuing its final decision. 17 D.C. Mun. Regs. § 4114. If the decision of the Board is adverse to the Respondent, it shall issue its proposed order to the

Respondent with an opportunity to file exceptions and written argument within ten (10) days of service. 17 D.C. Mun. Regs. §4114.7. The Board shall consider any exceptions filed in issuing its final decision.

Background

Dr. Henok Araya (“Respondent”) was originally licensed in the District of Columbia on September 29, 2003. The Board issued Respondent a *Notice of Intent to Take Disciplinary Action* (NOI) on July 2, 2019. The NOI was based on complaints the Board had received from four (4) different patients, all of whom had received liposuction from the Respondent. The NOI listed the following charges:

1. Respondent failed to conform to standards of acceptable conduct and prevailing practice within the health profession in violation of D.C. Code § 3-1205.14(a)(26) for patients A.S., T.H., J.H., and J.P.;
2. Respondent demonstrated a willful or careless disregard for the health, welfare or safety of a patient in violation of D.C. Code § 3-1205.14(a)(28) for patients A.S., T.H., J.H., and J.P.;
3. Respondent made a misrepresentation or false promise to influence, persuade or induce patronage in violation of D.C. Code § 3-1205.14(a)(38) as his website advertised expertise in a wide variety of cosmetic surgery procedures, despite not offering most of them;
4. Respondent made a misrepresentation or false promise to influence, persuade or induce patronage in violation of D.C. Code § 3-1205.14(a)(38) in that he publicly represented his facility as a “surgical center” when it was not licensed as an ambulatory surgical center;

5. Respondent made a false or misleading statement regarding his skill or the efficacy or a medicine, treatment or remedy that he prescribed or recommended at his discretion, in the treatment of a disease or other condition for the body or mind in violation of D.C. Code § 3-1205.14(a)(40), in that he made statements to the four patients that liposuction alone would help them achieve the results they wanted; and
6. Respondent committed fraud by making false claims in connection with the practice of medicine in violation of D.C. Code § 3-1205.14(a)(45), based on the allegations in the previous charges.

Respondent submitted a timely request for a hearing, and the Board elected to refer the hearing to the Office of Administrative Hearings (OAH).

The hearing in this matter took place on February 10, 2020, (“Feb. 2020 Tr.”), March 9, 2020, (“Mar. 2020 Tr.”), and January 11, 2021,¹ (“Jan. 2021 Tr.”) before an Administrative Law Judge (“ALJ”). A *de bene esse* deposition was taken by the Parties of Respondent’s expert witness on February 6, 2020, (“Dep. Tr.”) which the ALJ considered in addition to the live testimony. Witnesses for the Government included Patients T.H. and J.P, investigator for the Board Emilia Moran, and expert witness Dr. Robert Dennis. Witnesses for Respondent included the respondent and expert witness Dr. Brady Harris. Both the Board and Respondent admitted exhibits into evidence (“G. Ex.” and “R. Ex.” respectively).

The ALJ issued a *Recommended Final Order* (“Recommended Decision” or “Rec. Dec.”) on February 12, 2024. The Board considered the Recommended Decision at its May 29, 2024, meeting and while it appreciated the significant time and consideration given by the ALJ, it disagreed with many of the factual and legal conclusions and therefore voted to reject it in part.

¹ Shortly after the second day of the hearing, the COVID pandemic began, causing significant delays.

See 17 D.C. Mun. Regs. § 4114.5 (A board may accept or reject the recommended decision of an ALJ in whole or in part). A *Proposed Final Order and Decision of the Board* was served on Respondent's counsel, who informed the Board that he no longer represented Respondent and requested an extension for Respondent to identify alternate counsel and file exceptions. Two additional extensions were granted to Respondent, and he timely filed his exceptions on April 16, 2025. Respondent also submitted a motion to dismiss the proposed final decision, and a separate "Exceptions to the 2013-2015 Original charges and the new charges of 2024 in the 'proposed final decision' and Motion to Dismiss all NOI." The Board considered Respondent's exceptions and motions at its meeting on May 28, 2025.

Motions' Decisions

The Board denies Respondent's motion to dismiss the proposed final decision, and his motion to dismiss "all NOI". His arguments to dismiss the proposed final decision are in essence exceptions to the proposed final decision and are therefore treated as such. Similarly, to the extent that Respondent's exceptions to the NOI and his motion to dismiss the NOI are exceptions to the proposed final decision, they will also be addressed as appropriate below. However, Respondent makes two arguments that will be addressed preliminarily: first, his assertion that the OAH decision in 2010 regarding a summary suspension (*In re Henok Araya, MD*, OAH Case No.: 2010 -DOH-00228) ("2010 Araya case") is controlling law for this case, and secondly, his assertion that because there were two plastic surgeons on the Board at different points in time during the pendency of this case, those physicians have or had conflicts of interest as business competitors and therefore the Board is acting in a "biased and discriminatory" manner.

First, contrary to Respondent's arguments, the hearing and decision in the 2010 Araya case has no precedential value. The hearing occurred in July 2010 and the decision was issued

on July 30, 2010. It did involve a like circumstance, in that it involved an allegation of violations of the standard of care regarding Dr. Araya's liposuction procedures on four individual patients, notably not the same as the ones involved in the immediate case before the Board. However, that case was a hearing on a summary suspension brought by the Department of Health, not the Board, pursuant to D.C. Code 3-1205.15(a). Secondly, the ALJ in that case found that the government had not proved a national standard of care because the expert opined there was no national standard, contrary to the evidence in this case. The ALJ also stated that a lack of regulation on liposuction "undermines the prosecution of this case..." which Respondent has taken as a legal binding requirement that liposuction regulations must exist in order for him to be found to have violated a standard of care. Respondent misunderstands the regulation of medicine. Medicine as a practice does not lend itself to practice regulations for every procedure, given both the innumerable different procedures that exist and the ever-changing nature of many treatments. And the ALJ's opinion regarding regulations in the 2010 Araya case does not have any precedential authority here. Finally, and perhaps most importantly for Respondent's understanding, is that the OAH Order's only legal authority was over the summary suspension action that was taken against the Respondent at that time. Respondent's statement in his exceptions that the 2010 Order is "the law of the case" in the immediate case now before the Board is simply wrong.

Secondly, Respondent calls into question the integrity of the Board's actions and orders because there were two plastic surgeons on the Board at differing times during the pendency of this case. This argument was not raised during the hearing and therefore does not need to be addressed. However for the sake of argument, the Board will state the following in response to Respondent's unwarranted and meritless claims of bias.

First, Respondent now claims, without having offered any evidence during the hearing, that the two plastic surgeons on the Board were biased against him because they were active competitors. The makeup of the Board is designed to have a variety of medical professionals representing different medical specialties², and the fact that some Board members may conduct some of the same procedures as a physician against whom a complaint has been received is of benefit to the Board as they can offer insight into the action. However, the Board's evidentiary expert opinion must be from individuals not connected to the Board³. Following receipt of a peer reviewer's opinion, the Board determines if it should proceed with pursuing disciplinary action. In this particular case, on June 27, 2018, a vote to pursue disciplinary action was made by a consumer member of the Board, and seconded by a physician member, neither of whom were plastic surgeons or, per Respondent's self-identification, cosmetic surgeons. The one plastic surgeon on the Board at the time did vote in favor of the motion. At that particular time, the second plastic surgeon complained about by Respondent was not a member of the Board. On May 29, 2024 when the Board voted for findings against the Respondent after receiving the ALJ's *Recommended Order*, none of the Board members were plastic surgeons⁴. And on May 28, 2025, when the Board considered Respondent's motion and exceptions, the plastic surgeon now a member of the Board was absent and thus had no participation in the Board vote. Thus Respondent's claims of bias have no legitimacy in law and no basis in fact.

² D.C. Code § 3-1202.03(a)(4). In selecting nominees to the Board, the Mayor shall consult with the appropriate officials of professional medical societies and schools of medicine located in the District, and shall submit nominees whose professional training and experience provide a representative sample of the medical specialties in the District.

³ Respondent also alleges that the government's external expert witness, Dr. Dennis, whose testimony is discussed below, was biased against Respondent as a market competitor. As Respondent did not present any evidence to thus bias at hearing, and his allegations is simply that he is in the same field as Respondent, the Board declines to address this meritless argument. Argument against the actual testimony is addressed below.

⁴ Respondent requested and received copies of the minutes from these two meetings pursuant to a Freedom of Information (FOIA) request.

Respondent's exceptions primarily depend on his mistaken belief that all of the allegations were resolved in his favor by the 2010 Araya case and cannot be raised again. He is incorrect. Additionally, Respondent provides numerous bits of information that were not raised at the hearing at which he was ably represented by counsel and where the opportunity for cross-examination existed. The exceptions which depend on his asserting new alleged facts will not be recognized. That primarily leaves his assertion that certain conclusions of law do not fall under the allegations contained in the NOI; those will be addressed in the appropriate section below.

Findings of Fact

1. Respondent graduated from the University of Michigan with an undergraduate degree and graduated in 1999 with a medical degree from the Michigan State College of Human Medicine. He attended the first year of residency at a general surgery program at the University of California, San Francisco, and completed another year of residency at an Ophthalmology program at Howard University Hospital in Washington, D.C. in July 2001. Respondent had no other graduate medical education and did not complete any residency program. From July 2001 until he was licensed in 2003, Respondent managed a clinic that other doctors used to perform cosmetic procedures. After receiving his license, Respondent began performing cosmetic procedures on his own. Jan. 2021 Tr. pp. 15 – 17. Respondent's exceptions regarding his history and education are not accepted as the above paragraph accurately reflects the information offered at the hearing.

2. Since 2003, Respondent testified has "done over 6,500 liposuction surgeries." He also testified he performs "Botox, fillers, [and] hair removals, but 99 percent" of his practice is liposuction surgery. Jan. 2021 Tr. p. 19. Respondent uses the name "Vita Surgical" for his business. His primary office and the only place he conducts liposuction procedures is on New

Hampshire Ave. Northwest in Washington D.C. He also has an office in Bethesda, Maryland, with office hours every other Monday, and an office in Columbia, Maryland, with office hours on Tuesday afternoons. Jan. 2021 Tr. p. 22. However, he visits these offices “by appointment only.” Jan 2021 Tr. pp. 22 – 23. Contrary to Respondent’s public advertising, he does not have an office in Alexandria, Virginia; he closed it in 2008 or 2009. Jan. 2021 Tr. p. 24. Respondent offered no testimony at the hearing to contradict these findings.

3. Respondent maintains a website for his business: www.vitasurgical.com (G. Ex. 101, Ex. 4). The website contains numerous misleading entries. For example, excerpts from the website printed on March 8, 2017, include:

a. A section on “Liposuction Training Courses: The Liposuction training course is taught by Dr. Henok Araya. MD and staff at Vita Surgical Group in Washington DC.” G. Ex. 101, p. 229. None of Respondent’s staff, when visited by the DC Health Investigator knew of any trainings, and no evidence of any training having occurred or were scheduled in the future could be found. Feb. 2020 Tr. pp. 71 – 75. “It is undisputed that Dr. Araya and his staff did not conduct liposuction training.” Rec. Dec. p. 7.

b. Advertisements regarding a wide range of surgical cosmetic services including liposuction, G. Ex. 101, p. 231; tummy tuck/mini tucks, *id.* at 233; blepharoplasty or “eyelid surgery”, *id.* at 234; ultrasonic microdermabrasion, *id.* at 245; acne scars treatment, *id.* at 246; chemical peel, *id.* at 247; dermabrasion, *id.* at 248; butt augmentation, *id.* at 249; breast enlargement, *id.* at 250; breast lift, *id.* at 252; and gynecomastia/male breast reduction, *id.* at 254.

i. Alongside the title page for each advertised procedure except the butt augmentation is a link to “[Schedule or cancel an appointment](#)”. Such a link is

deliberately placed to cause a viewer to believe an appointment for that specific procedure (e.g. tummy tuck/mini tucks) can be scheduled by clicking on the link.

ii. For blepharoplasty, the description of the service includes numerous statements regarding the performance by Respondent. “Dr. Araya customizes the *Blepharoplasty or eyelid surgery in Washington dc surgical clinic* for each individual.” *Id.* At 235 (italics in original). “Occasionally, patients may need both a **Blepharoplasty or eyelid surgery and brow lift** to rejuvenate the eyelid-eyebrow area which we can do under local in our Washington dc surgical clinic.” *Id.* (bold in original). “After the fat is removed, I tighten the eyelid muscle.” *Id.* at 237. “I begin the free consultation with a frank discussion about the specific issues and concern that the patient has.” *Id.* at 238. “The cost of the upper Blepharoplasty or eyelid surgery with Dr. Araya ranges from \$1495 – 2500, and includes operating room fees and all follow ups.” *Id.* at 238 – 39. “Dr. Araya will see you on the second day and the fifth day after surgery.” *Id.* at 241.

iii. In the website discussion of gynecomastia services, the description includes the following: “We will help you achieve a better shape by removing the breast tissue with a small incision, a size of half a staple, all under local anesthesia. . . . We have guaranteed financing option and 0 down and 0% financing options and payment plans. Come in for you (sic) free consult for Gynecomastia surgery dc (sic).” *Id.* at 254.

c. Testimonial links that appear under some of these other procedures, such as under the “Tummy tuck” menu, and under the “Breast” menu, populate to testimonials about liposuction cases. Thus, the website encourages people to both believe that there are testimonials about services that appear to be available at Vita Surgical but in fact these services are not provided.

According to Respondent, the testimonials and rankings are for liposuction, not for the services under which the links appeared. Jan. 2021 Tr. pp. 265-66.

d. Respondent advertises offices in Maryland and Virginia yet, as identified above, he has not had an office in Virginia since “2008 or 2009.” Jan. 2021 Tr. p. 24.

e. Despite advertising all these services on his website, Respondent only does “liposuction procedures, the hair removal, the Botox, the fillers, the chemical peels.” Jan. 2021 Tr. p. 20. Respondent does not do tummy tucks, breast procedures, butt augmentation, blepharoplasty, or gynecomastia surgery. Respondent said the services listed are “for informational purposes for patients that are looking for information about different surgeries, but I don’t physically do those procedures.” *Id.* at 24 – 25. In his practice, Respondent has never done any of the services (tummy tucks, breast procedures, butt augmentation, blepharoplasty, or gynecomastia surgery) that he said are listed on his website “for informational purposes.” *Id.* at 25.

4. Respondent included false information on his website regarding the procedures he performs and the trainings he purports to offer. He did this to inflate his advertised skill and experience, and to induce people looking for these other services, either in addition to or independent of liposuction procedures, to contact his office. This finding is in agreement with the Recommended Decision (“I find that the only inference to be made from the statements on Dr. Araya’s website regarding his Virginia satellite office, the procedures which Dr. Araya does not offer and that he and his staff conduct liposuction training is that they were false claims or statements made to influence, persuade or induce patronage.” Rec. Dec. p. 7.)

5. Respondent performs tumescent liposuction, the “removal of fat after the infiltration of a dilute concentration of lidocaine to anesthetize the patient and also to aid in the removal of the fat.” Feb. 2020 Tr. p. 140.

6. Dr. Robert Dennis, M.D., provided testimony as an expert in the fields of plastic surgery and tumescent liposuction. He has practiced plastic surgery, an area of medicine in which cosmetic surgery and liposuction fall within, since 1988. Dr. Dennis has performed thousands of liposuction procedures, taught plastic surgery for eight years to students in a plastic surgery fellowship at Georgetown University and Howard University medical schools, and is board-certified in plastic surgery through the American Board of Medical Specialties (ABMS). Feb. 2020 Tr. pp. 117 – 121.

7. Dr. Brady Harris, MD, provided testimony as an expert in the field of cosmetic surgery. Dr. Harris graduated medical school in 2009, and is board-certified in cosmetic surgery by the American Board of Cosmetic Surgery and two other certification boards, but not by the AMBS, which does not recognize board certification in cosmetic surgery, and in fact some states (albeit not the District of Columbia) prohibit physicians from advertising themselves as board-certified if not through the AMBS. Dr. Harris has “done thousands of liposuction cases” and has also “given lectures regarding various techniques in liposuction all over the world. . .” Dep. Tr. pp. 9-10.

8. There is a national standard of care to performing liposuction, for the assessment, preoperative, operative and post-operative care of the patients, regardless of the specialty of the physician performing the operation.⁵ Feb. 2020 Tr. pp. 232 – 233. “We get that from the

⁵ “All doctors who practice liposuction are held to the same standards.” Feb. 2020 pp. 232-233; *see also* Mar. 2020 Tr. pp. 94 – 103, that the same standards for plastic surgeons are applicable to cosmetic surgeons as outlined in the American Academy of Cosmetic Surgery’s 2006 *Guidelines for Liposuction Surgery*.

literature that has been published nationally and internationally, from meetings that discuss liposuction, and also from patient care of general patients, how you should manage. ...”⁶ Feb. 2020 Tr. p. 181. Specifically, Dr. Dennis testified, and the Board accepts as the national standard for liposuction, the following:

a. Preoperative evaluation, which requires both an assessment of a patient’s history and general health and a clinical examination of patient, with a detailed examination of the area to be operated on, (Feb. 2020 Tr. pp. 157 - 161) and an honest discussion about what a patient would need other than liposuction, if such further treatment was needed (Mar. 2020 Tr. pp. 108-109);⁷

b. Liposuction technique, including a maximum limit of 45 – 55 kilograms per kilogram for lidocaine infiltrated into tumescent fluid (Feb. 2020 Tr. pp. 187 – 188);

c. 5,000 milliliters recommended volume limit of supernatant fat removed in an outpatient procedure (Mar. 2020 Tr. p. 98);

d. Sterilizing and draping the operation site (Feb. 2020 Tr. p. 183);

e. Monitoring vital signs during procedures (Feb. 2020 Tr. pp. 183 – 186);

f. Management of outcome expectations (Mar. 2020 Tr. p. 102);

g. Appropriate documentation, including *inter alia* patient’s pre-procedure weight and the total amount of fat and fluid actually extracted during a procedure (Feb. 2020 Tr. pp. 162, 187 – 188, 192); and

h. Sterile drainage of any resulting seromas to prevent infection (Feb. 2020 Tr. pp. 201-202).

⁶ See also testimony from Dr. Dennis regarding his sources from which he determined a national standard of care. (Feb. 2020 Tr. pp. 140 – 142; 144 – 146).

⁷ See also testimony of Dr. Harris: You know, if you have, you know, for example, skin that’s hanging down, you can still be a candidate for liposuction **if you have a discussion with the patient and let them know that liposuction won’t fix the skin.** (emphasis added) (Dep. Tr. p. 38).

The Board disagrees with the Recommended Decision in which the ALJ found that the government had failed to prove a national standard of care. (“The Board failed to prove by the preponderance of the evidence that there was such a national standard of care, however.” Rec. Dec. p. 9.). The reference to the 2010 Araya case by the ALJ is confusing. The patients in that case are different from the patients in the current case, the expert testimony is different, and a lack of regulations about a particular surgical procedure, particularly given the myriad surgical procedures that occur, is not evidence that no standard of care exists. As discussed previously, the Board finds the 2010 case neither persuasive nor precedential.

Respondent in his exceptions claims that what Dr. Dennis testified to is the Florida regulatory standards which have no relevance for a case in D.C. Respondent’s attempt to introduce evidence that was not raised at the hearing is disallowed. Further, the fact that other states’ regulatory construct may echo or have led to a national standard does not in any way diminish the testimony regarding a national standard of care.

While it is the burden of the government to prove that standard of care, Respondent’s expert witness Dr. Harris’s testimony regarding the standard of care has to be disregarded. First, although eminently experienced in liposuction, Dr. Haris said there was no standard of care. Then he agreed that that there is a “bare minimum level of competence that a reasonably prudent doctor would exercise in a particular medical situation.”⁸ Dep. Tr. p. 88. He also testified:

“I’m not saying there’s not an applicable standard of care. I’m saying there’s not a national, you know, set-in-stone standard of care that applies to every patient in every situation.

There is a standard of care, I believe, based on what to do in certain situations, but each situation is not defined. And I feel that Dr. Araya, when – if you have a complication, I think he met the standard of care based on my past surgical experience and my liposuction experience.”

⁸ Dep. Tr. p. 88: “Q: okay. But you would agree that there’s a bare minimum level of competence that a reasonably prudent doctor would exercise in a particular medical situation, correct? A: Yes, I would agree with that.”

Dec. Tr. pp. 91 – 92.

The Board agrees with the Recommended Decision that “the personal opinion of the testifying expert as what he or she would do in a particular case, without reference to a standard of care, is insufficient to prove the applicable standard of care.” (See *Travers v. District of Columbia*, 672A.2d 566, 568 (1996) (cited in *Strickland v. Pinder*, 899 A.2d 770, 773)). Therefore Dr. Harris’ testimony that Dr. Araya “met the standard of care based on my past surgical experience and my liposuction experience” must be disregarded.

9. Respondent violated the standard of care in his treatment of Patient A.S.⁹ in the liposuction surgery that he performed on Sep. 3, 2013, in that he:

a. Failed to appropriately assess her for the liposuction surgery. At the initial meeting, Respondent did not weigh her, nor assess her body mass index. Nor did he make a record of her scars, hernias, stretch marks, fatty deposits, skin folds or skin elasticity. Based on the medical records and pictures, Dr. Dennis testified that Patient A.S. was “markedly overweight/obese with poor skin preoperatively.” Feb. 2020 Tr. pp 13-14. Respondent in fact testified that he does not weigh patients at their consultation unless they have previously had bypass surgery, “because the amount of fat that they lose is so drastic,” which can affect the elasticity of the skin. Jan. 2021 Tr. pp. 316-317. Respondent’s position that only bypass surgery affects the elasticity of the skin is indicative of his failure to appreciate or properly assess his liposuction patients.

b. Failed to inform the patient from the beginning that additional procedures were necessary to achieve her desired results, due to the excessive skin that would need to be removed. While Respondent’s testimony and consent form state that “additional surgeries MAY

⁹ Because the Final Order is a public document, only the initials of the patients are used.

be needed (emphasis added), (Jan. 2021 Tr. pp. 87, 97), it was clear that additional surgeries would be required. Patient A.S. was obese with significant striae, a panniculus and poor skin quality that required “special evaluation” as indicators of damaged skin elasticity. In this patient’s case, Respondent knew or should have known that liposuction alone would not be sufficient. Feb. 2020 Tr. pp. 171 – 172. However, Respondent not only failed to inform the patient that she would need additional surgeries, he failed to inform her that he did not perform those surgeries despite his misleading advertising that he did do so. *See supra* Findings of Fact ¶ 3.

c. Failed to record the amount of fat removed during the procedure. He recorded the tumescent fluid but only used his preprinted form of .5/1.0 ratio of fat to tumescent solution to record total amounts. Feb. 2020 Tr. p. 188; Jan. 2021 Tr. pp. 326 – 327.

d. Failed to monitor vital signs during the procedure. Apart from the patient, Respondent was the only person present in the room, and he testified he does not check vital signs during a procedure because “there has to be an indication for checking the vital sign the middle of the procedure. If there is no indications (sic) we don’t check the vitals.” Jan. 2021 Tr. p. 331.

e. Failed to properly drain the seroma that developed post-surgery. Rather than using a “closed system” so that no bacteria enters the drainage site, Respondent had the patient hold an open trash bag for the drainage to leak into. Such as system was not sterile and left the seroma open to infection. Feb. 2020 Tr. pp. 201 – 202.

10. Respondent violated the standard of care in respect to patient T.H. regarding the liposuction surgery that he performed on her on March 25, 2014, in that he:

a. Failed to appropriately assess her for the liposuction surgery. At the initial meeting, Respondent did not weigh her, nor assess her body mass index. Although he physically examined her stomach, he did not discuss her history with weight issues. He did not lift her stomach to look at the skin under the panniculus,¹⁰ nor did he make a record of her stretch marks, fatty deposits, skin folds or skin elasticity.

b. Failed to inform the patient from the beginning that additional procedures were necessary to achieve her desired results, due to the excessive skin that would need to be removed. While his testimony and consent form state that “additional surgeries MAY be needed (emphasis added), the Board credits the Patient’s testimony that Respondent told her she would get the “body that she wants” from his surgery. Mar. 2020 Tr. at 163. However, a patient with a panniculus and poor skin quality will have excess and wrinkled skin after the liposuction procedure. Mar. 2020 Tr. p. 108. “In order to get that smooth contour that patients are looking for, you need to cut out that excess skin.” *Id.* Respondent failed to inform the patient that she would need additional surgeries to remove the excess skin, which was below the standard of care. “The patient should be told directly that liposuction alone is not going to give you the results that you... want.” Mar. 2020 Tr. pp. 108 - 109. Respondent also failed to inform her that he himself did not perform any additional procedures beyond liposuction, despite his misleading advertising that he did do so. *See supra* Findings of Fact ¶ 3.

c. Failed to perform the liposuction in a sterile and draped environment; instead, he conducted the liposuction on a patient chair using only a paper cover. Mar. 2020 Tr. p. 171.

d. Failed to record the amount of fat removed during the procedure, as he used his pre-printed aspiration of 0.5/1.0 ratio of fat to total fluid.

¹⁰ A sheet or layer of overhanging tissue.

e. Failed to monitor vital signs during the procedure. Mar. 2020 Tr. p. 174.

f. Failed to perform the liposuction properly, in that it caused skin necrosis¹¹ on the area in which the liposuction was performed, a complication that is usually very rare after liposuction. Feb. 2020 Tr. p. 204. “Skin necrosis can occur after liposuction procedure for several reasons.” *Id.* First, it can occur by performing the liposuction immediately against the skin which damages the skin’s blood supply, secondly, by overusing tumescent fluid and increasing pressure in the body that cuts off the blood supply, or third, overheating the tumescent fluid and creating coagulation of the blood burns on the abdomen. Any one of these is below the standard of care when performing liposuction. *Id.* at 205. The patient testified, and the Board credits, that Respondent told the patient both that her problems were something he had never seen before and that everything was normal. Feb. 2020 Tr. at 189. The necrosis on Patient T.H.’s skin was caused by Respondent performing the liposuction procedure below the standard of care.

g. Failed to properly drain the seroma that developed post-surgery. Drainage of a seroma requires the physician to use a sterile syringe, sterilize and numb the skin, aspirate the fluid and remove it. This creates a closed system, which prevents bacteria from entering the surgical site where the fluid is drained. Feb. 2020 Tr. pp. 200-201. Respondent instead used an open percutaneous drainage, and had the patient hold a trash bag open against her stomach for the fluid to drain into. G. Ex. 108; Mar. 2020 Tr. pp. 182 – 183, 188.

h. The patient left Respondent’s inadequate treatment for her stomach and sought care through her primary insurance for follow-up care. The Board credits her testimony that she

¹¹ Skin necrosis is skin death from lack of blood flow. See. Feb Tr. at 204.

was referred to the wound care clinic to treat the deleterious aftereffects of the liposuction surgery. Mar. 2020 Tr. p. 193.

11. Respondent violated the standard of care in respect to patient J.H. regarding the liposuction surgery that he performed on her on January 10, 2015 in that he:

a. Failed to appropriately assess her for the liposuction surgery. At the initial meeting, Respondent did not weigh her, assess her body mass index or assess her skin quality. Similar to the other patients, Patient J.H. had “poor skin quality, a lot of stria, and excess skin.” (Feb. 2020 Tr. p. 179).

b. Failed to inform the patient from the beginning that additional procedures were necessary to achieve her desired results, due to the excessive skin that would need to be removed. (Mar. 2020 Tr. p. 109). Respondent not only failed to inform the patient that she would need additional surgeries, he failed to inform her that he himself did not perform those surgeries to remove excess skin despite his misleading advertising that he did do so. (*See supra* Findings of Facts ¶ 3).

c. Failed to perform the liposuction properly, in that it caused skin necrosis¹² on the area in which the liposuction was performed, (G. Ex. 115 p. 2), a complication that is usually very rare after liposuction. (Feb. 2020 Tr. p. 204). The necrosis on Patient J.H.’s skin was caused by Respondent performing the liposuction procedure below the standard of care.

d. Patient J.H. returned to Respondent for post-operative care due to developing fever and chills. He prescribed and injected her with Cipro, an antibiotic. G. Ex. 112 p. 104. Upon the return of her fever, Patient J.H. went to her own healthcare provider who determined she needed additional medication and drained the fluid still in her abdomen. G. Ex. 113 p. 84.

¹² Skin necrosis is skin death from lack of blood flow. *See* Feb Tr. at 204.

12. Respondent violated the standard of care in respect to patient J.P. regarding the liposuction surgery that he performed on her on April 11, 2015 in that he:

a. Failed to appropriately assess her for the liposuction surgery. At the initial meeting, Respondent did not weigh her, assess her body mass index or discuss with her history of weight gain or body issues. Mar. 2020 Tr. p. 256. He also did not lift her stomach to examine the skin underneath. *Id.* at 254.

b. Failed to inform the patient from the beginning that additional procedures were necessary to achieve her desired results, due to the excessive skin that would need to be removed. While his testimony and consent form state that “additional surgeries MAY be needed (emphasis added), the Board credits the Patient J.P.’s testimony that when she asked Respondent if she could avoid a “tummy tuck” and still get rid of a line at the bottom of her stomach, “so permanent it’s like a scar,” he replied “I prefer to do lipo and you will be fine with lipo.” Mar. 2020 Tr. p. 269. Respondent failed to inform the patient that she would need additional surgeries to remove the excess skin, which was below the standard of care. Respondent also failed to inform her that he himself did not perform such a procedure, despite his misleading advertising that he did do so. *See supra* Findings of Fact ¶ 3. The Board credits Patient J.P.’s testimony that one of the reasons she went to see Respondent was due to his website from which she understood “that he did lipo, tummy tuck, breast augmentation, and a host of other stuff that falls in the arena of cosmetic surgery.” Mar. 2020 Tr. p. 248.

c. Misled Patient J.P when he informed her that he was associated with George Washington Hospital, which was important to her. “I was very specific on asking about his association with the hospital. He told me he was associated with GW.” Mar. 2020 Tr. p. 253. He told her that “in the event that there was an emergency or something happened, a

complication, I would be able to be seen and treated there.” Mar. 2020 Tr. p. 256. The Board appreciates that the Administrative Law Judge did not find this misleading as there was no testimony about the definition of “affiliated.” However it is common knowledge among the medical profession, and the Board does not need external evidence to know that “affiliated with” a hospital generally means a physician is credentialed with a hospital and authorized to perform medical procedures therein, sometimes with admitting privileges. Respondent is also well aware of what “affiliated with” means as he was clearly admitted he was not. *See* Jan Tr. at 292: Q: You don’t have affiliation with the GW Hospital, do you? A: I don’t.

d. Failed to perform the liposuction in a sterile and draped environment. There were no bed sheets or lining, just a paper sheet. Mar. 2020 Tr. p. 271; G. Ex. 116. The Respondent did not cover his face or hair, and his gown was poorly secured and falling off. *Id.*

e. Failed to monitor vital signs during the procedure.

f. Failed to properly drain the seroma that developed post-surgery. Respondent used an open percutaneous drainage, and had the patient hold a trash bag open against her stomach for the fluid to drain into. G. Ex. 108; Mar. 2020 Tr. p. 287. Patient J.P. testified that Respondent tossed his gloves into the trash bag into which her seroma was draining. Mar. 2020 Tr. pp. 287 – 288; G. Ex. 117. The Board also credits Patient J.P.’s testimony that she was left alone during the drainage procedure. *Id.* Of note, Respondent at the time of the procedures had no other licensed healthcare professionals working in his office or assisting him in any manner. Jan. 2021 Tr. p. 338.

13. Respondent falsely advertised his business as a surgical center, “designed exclusively for out-patient surgery” . . . and “a convenient, comfortable, and generally less costly alternative to a hospital with the same standards of care.” Jan. Tr. 2021 p. 30. The liposuction

performed by Respondent at his office is a surgical procedure performed on an outpatient basis, and as he testified, his liposuction business comprises “99% of his practice.” As such, his practice does fall under the definition of an ambulatory surgical center. The Recommended Order cites to the definition contained in D.C. Code §44-531.02(1)(A):

“Ambulatory Surgical Treatment Center” means any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures on an outpatient basis including facilities where family planning procedures are performed. Such facility shall not provide beds or other accommodations for the overnight stay of patients. Individual patients shall be discharged in an ambulatory condition without danger to the continued well being of the patients or shall be transferred to a hospital.

On January 7, 2024, an amendment to the D.C. Code §44-501 was passed which provided an updated definition of both ambulatory surgery and ambulatory surgical facility:

(1) “Ambulatory surgery” means a surgical procedure performed in an ambulatory surgical facility requiring a period of post-operative observation of less than 24 hours and not requiring admission to a hospital following the procedure.

(1A) “Ambulatory surgical facility” means any facility, other than a hospital, dental office, or maternity center, but including an office-based facility, a physician outpatient surgery center, or a surgical facility connected to but physically separated from a hospital, at which ambulatory surgery is performed in either an operating room or procedure room.

D.C. Code § 44-501(a)(13A) makes it clear that liposuction does not fall within the exceptions to the term “surgery”:

(B) The term “surgery” does not include:
(i) The administration of subcutaneous, intramuscular or intravenous injections by an authorized health professional;
(ii) Topical treatments; or
(iii) **Generally non-invasive procedures which do not require an aseptic surgical field.**
(emphasis added)

Under either definition, a license is required to perform surgery in an outpatient facility. D.C. Official Code § 44-502; D.C. Official Code § 44-532.01. Respondent’s use of the term “surgery center” without a license to operate as such was a fraudulent statement designed to induce

patronage by his customers who thought they were being treated in a professional surgical facility. Similarly, his “facility” was an office space in which he was the only licensed healthcare professional, he had no electronic monitoring equipment to measure vitals, only equipment that was operated by his unlicensed staff, and he had no affiliation with any hospital to assist in hospitalization or continuity of care if that was necessary. Respondent is incapable of providing the same “standards of care” as a hospital. Respondent used this phrase to make unsuspecting patients believe they would be treated with the highest levels of care.

Conclusions of Law

The Board makes the following Conclusions of Law:

1. As a preliminary matter, no due process violation of Respondent’s hearing rights occurred during the hearing. The Board adopts in full the Recommended Decision in its discussion of denying Respondent’s objection to “new charges,” and excluding testimony from a second expert on behalf of the Respondent. Rec. Dec. pp. 3-4. Repetitious evidence may be excluded. 17 D.C. Mun. Reg. § 4110.3. Respondent’s exceptions regarding the Board identifying violations that go beyond those found in the NOI will be addressed below as needed.
2. Respondent violated D.C. Code § 3-1205.14(a)(26) (failed to conform to standards of acceptable conduct and prevailing within the health profession) and D.C. Code § 3-1205.14(a)(28)(demonstrated a willful or careless disregard for the health, welfare or safety of a patient) when he failed to properly assess Patients A.S., T.H., J.H., and J.P. for liposuction, failed to properly record their necessary medical information for each, failed to utilize appropriate sterile techniques to ensure the safety of the patients, failed to utilize the proper liposuction techniques for Patients T.H. and J.P., and failed to appropriately treat the resulting seromas of

Patients T.H. and J.P. These failures fall squarely within the allegations contained in Charges I and II of the NOI.

3. Respondent violated D.C. Code § 3-1205.14(a)(38) (made a misrepresentation or false promise to influence, persuade or induce patronage), in that on his website he represented that he had expertise in and performed numerous surgical procedures including liposuction, tummy tucks, blepharoplasty, butt augmentations, breast enlargements and lifts, and bariatric weight-loss surgery, when the only surgical procedure he performs is liposuction. These false claims were designed to induce patronage and give the impression that if other surgeries, such as a tummy tuck, were needed, that he would be able to provide them. He also included on his website the location of an office in Virginia which had been closed for years.

4. Respondent violated D.C. Code § 3-1205.14(a)(38) (made a misrepresentation or false promise to influence, persuade or induce patronage) when he publicly represented that his facility was a “surgical center,” with the “same standards of care” as a hospital. Respondent is not licensed as an ambulatory surgical center, and his office, at which he is the only licensed health professional and in an office with rudimentary medical equipment, does not maintain the same standard of care as an accredited hospital. Respondent made these statements with the intent to induce patients into a false sense of security about the level of care they would receive in his office. The Board agrees that the findings made by the ALJ and this Board that Respondent wrongly claimed he was “affiliated” with the George Washington Hospital was not in the NOI and is therefore not used to support this violation.

5. Respondent violated D.C. Code § 3-1205.14(a)(40) (made a false or misleading statement regarding your skill or the efficacy or value of a treatment that you recommended in your discretion, in the treatment of a condition of the body) when he either directly or indirectly

made statements to the all four patients that the liposuction would achieve their desired results, knowing that their physical condition negated any possibility that liposuction alone (or liposuction with diet exercise) would be sufficient. Respondent also failed to inform them that he did not perform any of the additional surgeries they would need even though the procedures were advertised on his website.

6. Respondent violated D.C. Code § 3-1205.14(a) (committed fraud or made false claims in connection with the practice of medicine) when he induced these four patients to utilize his services through his misleading website and false statements about his expertise and his “facility,” and pointed lack of honesty about the extent of the treatment all four women would need to get the results they desired.

7. Pursuant to D.C. Code § 3-1205.14(c), the Board may impose a variety of disciplinary actions upon a determination of a violation of D.C. Code § 3-1205.14(a).

ORDER

UPON CONSIDERATION of the evidence and testimony presented at the hearings in the matter on February 10, 2020, March 9, 2020, and January 11, 2021, the *de bene esse* deposition on February 6, 2020 and the entire record herein, in accordance with D.C. Code § 3-1205.14(c), it is this 20th day of August, 2025,

ORDERED that Respondent is on **PROBATION** in accordance with the following terms:

1. The website for Respondent and his business, VitaSurgical, shall within one week of the signed date of this Order be corrected to ensure that:
 - a. The services provided by Respondent are clearly distinguished from other procedures that are not provided by Respondent. This means that until Respondent has completed the terms of probation in paragraph 2, below, and identified and had

- approved the practice monitor as detailed in paragraph 3, below, it shall not indicate that Respondent performs liposuction, although it may indicate that he has done so in the past.
- b. All statements made on the website or in any advertising material, including statements about classes, staff, former clients, etc., must have documentary evidence of the statements' veracity.
 - c. If Respondent chooses to have an informational section about other cosmetic procedures, that section shall be clearly identified as "For Informational Purposes Only", and the sources of the information shall be included. A statement to the effect that Respondent does not provide the service described (if Respondent does not provide that service) shall be stated clearly and in a manner designed to notify viewers that the service described is not provided by Respondent.
 - d. All pictures depicting services that Respondent does provide shall only be of pictures of Respondent's patients who have consented to any "before" and "after" pictures posted, and such documented consent shall be maintained in the patient's records. Any pictures contained in the informational section shall be clearly identified as not pictures of Respondent's patients.
 - e. Respondent shall pay a fine of \$1000 per day for information posted on his website that violates the terms of this Order.
2. Respondent's practice shall be immediately **RESTRICTED** from performing any surgical procedures, including all liposuction procedures, until he provides evidence to the Board of the following:

- a. Completion of a minimum three-day (minimum 20 hours of continuing medical educational credit) course that is pre-approved by the Board in liposuction techniques which includes a review of sterile techniques in surgical procedures or Respondent may provide evidence of a separate minimum five-hour course in sterile techniques; and
 - b. Either employment in a licensed ambulatory surgical center, or licensure of his facility as an ambulatory surgical center. Respondent shall not conduct any surgical procedures outside of a licensed ambulatory surgical center.
3. Upon completion of the above, and prior to conducting any surgical procedures, Respondent shall identify a surgeon, board-certified in either Plastic Surgery or Surgery by the American Board of Medical Specialties (ABMS) who is approved by the Board as a practice monitor.
- a. The practice monitor shall supervise in person three to four surgeries per month conducted by Respondent for a period of three months. At the conclusion of each month the practice monitor shall submit a report to the Board regarding Respondent's techniques and maintenance of the sterile fields. The practice monitor shall notify the Board immediately of any concerns about Respondent's practice.
 - b. At the conclusion of three months of acceptable reports from the practice monitor, Respondent may petition the Board to terminate his probation. It is further

ORDERED that Respondent shall bear all costs for compliance with this Order; and it is further

ORDERED that Respondent shall comply with all laws, rules, and regulations of the District of Columbia, while within its jurisdiction; and it is further

ORDERED, that if Respondent fails to satisfactorily fulfill the terms of this Consent Order the Board may issue a notice of intent to take additional formal disciplinary action against Respondent's license; and it is further

ORDERED, that this is a public document.

DISTRICT OF COLUMBIA BOARD OF MEDICINE

Aug. 20, 2025

Date



By: Andrea Anderson, MD, MEd, FAAFP
Chairperson

Judicial Review of Final Actions by a Board

Pursuant to D.C. Official Code § 3-1205.20:

Any person aggrieved by a final decision of a board or the Mayor may appeal the decision to the District of Columbia Court of Appeals pursuant to D.C. Official Code § 2-510.

NOTE: Any appeal noted to the Court of Appeals must be filed within 30 days of the final decision of the Board. See D.C. Court of Appeals Rule 15(a)(2).

D.C. Official Code, §2-510 provides:

(a) Any person suffering a legal wrong, or adversely affected or aggrieved, by an order or decision of the Mayor or an agency in a contested case, is entitled to a judicial review thereof in accordance with this subchapter upon filing in the District of Columbia Court of Appeals a written petition for review. If the jurisdiction of the Mayor or an agency is challenged at any time in any proceeding and the Mayor or the agency, as the case may be, takes jurisdiction, the person challenging jurisdiction shall be entitled to an immediate judicial review of that action, unless the Court shall otherwise hold. The reviewing Court may by rule prescribe the forms and contents of the petition and, subject to this subchapter, regulate generally all matters relating to proceedings on such appeals. A petition for review shall be filed in such Court within such time as such Court may by rule prescribe and a copy of such petition shall forthwith be served by mail by the clerk of the Court upon the Mayor or upon the agency, as the case may be. Within such time as may be fixed by rule of the Court, the Mayor or such agency shall certify and file in the Court the exclusive record for decision and any supplementary proceedings, and the clerk of the Court shall immediately notify the petitioner of the filing thereof. Upon the filing of a petition for review, the Court shall have jurisdiction of the proceeding, and shall have power to affirm, modify, or set aside the order or decision complained of, in whole or in part, and, if need be, to remand the case for further proceedings, as justice may require. Filing of a petition for review shall not in itself stay enforcement of the order or decision of the Mayor or the agency, as the case may be. The Mayor or the agency may grant, or the reviewing Court may order, a stay upon appropriate terms. The Court shall hear and determine all appeals upon the exclusive record for decision before the Mayor or the agency. The review of all administrative orders and decisions by the Court shall be limited to such issues of law or fact as are subject to review on appeal under applicable statutory law, other than this subchapter. In all other cases the review by the Court of administrative orders and decisions shall be in accordance with the rules of law which define the scope and limitations of review of administrative proceedings. Such rules shall include, but not be limited to, the power of the Court:

(1) Subject to subsections (c) and (d) of this section and so far as necessary to decision and where presented, to decide all relevant questions of law, to interpret constitutional and statutory provisions, and to determine the meaning or applicability of the terms of any action;

(2) To compel agency action unlawfully withheld or unreasonably delayed; and

(3) To hold unlawful and set aside any action or findings and conclusions found to be:

(A) Arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) Contrary to constitutional right, power, privilege, or immunity;

(C) In excess of statutory jurisdiction, authority, or limitations or short of statutory jurisdiction, authority, or limitations or short of statutory rights;

(D) Without observance of procedure required by law, including any applicable procedure provided by this subchapter; or

(E) Unsupported by substantial evidence in the record of the proceedings before the Court.

(b) In reviewing administrative orders and decisions, the Court shall review such portions of the exclusive record as may be designated by any party. The Court may invoke the rule of prejudicial error.

(c) In reviewing an order or decision of the Mayor or an agency in any court or administrative proceeding, including but not limited to proceedings under subsection (a) of this section, the reviewing tribunal shall defer to the Mayor's or agency's reasonable interpretation of a statute or regulation it administers; provided, that the interpretation is not plainly wrong, or inconsistent with the statutory or regulatory language or the legislature's intent.

(d) In reviewing a rule adopted by the Mayor or an agency, the reviewing tribunal shall defer to the Mayor's or agency's reasonable interpretation of a statute it administers; provided, that the interpretation is not plainly wrong or inconsistent with the statutory language or the legislature's intent.

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