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STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
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BY Jan K. McBlone ANALYST

1 KAMALA D. HARRIS
Attorney General of California
2 THOMAS S. LAZAR
Supervising Deputy Attorney General
3 MARTIN W. HAGAN
Deputy Attorney General
4 State Bar No. 155553
110 West "A" Street, Suite 1100
5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
Telephone: (619) 645-2094
7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

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BEFORE THE
PHYSICIAN ASSISTANT BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:
RODNEY EUGENE DAVIS, P.A.
8899 University Center Lane, Suite 250
San Diego, CA 92122
Physician Assistant License No. PA19449
Respondent.

Case No. 1E-2013-230309

ACCUSATION

Complainant alleges:

PARTIES

1. Glenn L. Mitchell, Jr. (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs.
2. On or about October 30, 2007, the Physician Assistant Board of California issued Physician Assistant License Number PA19449 to Rodney Eugene Davis, P.A. (Respondent). The Physician Assistant License was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on August 31, 2015, unless renewed.

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JURISDICTION

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3. This Accusation is brought before the Physician Assistant Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 3527 of the Code states:

“(a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

“... ”

“(f) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.

“... ”

5. Section 3502 of the Code states:

“(a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon or of physicians and surgeons approved by the board, except as provided in Section 3502.5.

“... ”

6. Section 2234 of the Code, states:

“The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

“(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

“(b) Gross negligence.

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

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

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

13 “... ”

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

17 “(f) Any action or conduct which would have warranted the denial of a
18 certificate.

19 “... ”

20 7. Unprofessional conduct under California Business and Professions Code section 2234 is
21 conduct which breaches the rules or ethical code of the medical profession, or conduct which is
22 unbecoming to a member in good standing of the medical profession, and which demonstrates an
23 unfitness to practice medicine.¹

24 8. Section 2052 of the Code, states:

25 “(a) Notwithstanding Section 146, any person who practices or attempts to
26 practice, or who advertises or holds himself or herself out as practicing, any system or
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28 ¹ *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.

1 mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for,
2 or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder,
3 injury, or other physical or mental condition of any person, without having at the time
4 of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or
5 without being authorized to perform the act pursuant to a certificate obtained in
6 accordance with some other provision of law is guilty of a public offense, punishable
7 by a fine not exceeding ten thousand dollars (\$10,000), by imprisonment pursuant to
8 subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not
9 exceeding one year, or by both the fine and either imprisonment.

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

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

15 9. Section 2264 of the Code, states:

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

20 10. Section 2271 of the Code, states:

21 “Any advertising in violation of Section 17500 relating to false or
22 misleading advertising, constitutes unprofessional conduct.

23 11. Section 651 of the Code, states:

24 “(a) It is unlawful for any person licensed under this division or under any
25 initiative act referred to in this division to disseminate or cause to be disseminated any
26 form of public communication containing a false, fraudulent, misleading, or deceptive
27 statement, claim, or image for the purpose of or likely to induce, directly or indirectly,
28 the rendering of professional services or furnishing of products in connection with the

1 professional practice or business for which he or she is licensed. A "public
2 communication" as used in this section includes, but is not limited to, communication
3 by means of mail, television, radio, motion picture, newspaper, book, list or directory
4 of healing arts practitioners, Internet, or other electronic communication.

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

7 "(1) Contains a misrepresentation of fact.

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

10 "...

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

13 "..."

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

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

21 "..."

22 12. Section 17500 of the Code states:

23 "It is unlawful for any person, firm, corporation or association, or any
24 employee thereof with intent directly or indirectly to dispose of real or personal
25 property or to perform services, professional or otherwise, or anything of any nature
26 whatsoever or to induce the public to enter into any obligation relating thereto, to
27 make or disseminate or cause to be made or disseminated before the public in this
28 state, or to make or disseminate or cause to be made or disseminated from this state

1 before the public in any state, in any newspaper or other publication, or any
2 advertising device, or by public outcry or proclamation, or in any other manner or
3 means whatever, including over the Internet, any statement, concerning that real or
4 personal property or those services, professional or otherwise, or concerning any
5 circumstance or matter of fact connected with the proposed performance or
6 disposition thereof, which is untrue or misleading, and which is known, or which by
7 the exercise of reasonable care should be known, to be untrue or misleading, or for
8 any person, firm, or corporation to so make or disseminate or cause to be so made or
9 disseminated any such statement as part of a plan or scheme with the intent not to sell
10 that personal property or those services, professional or otherwise, so advertised at
11 the price stated therein, or as so advertised. Any violation of the provisions of this
12 section is a misdemeanor punishable by imprisonment in the county jail not
13 exceeding six months, or by a fine not exceeding two thousand five hundred dollars
14 (\$2,500), or by both that imprisonment and fine."

15 13. California Code of Regulations, title 16, section 1399.521 states:

16 "In addition to the grounds set forth in section 3527, subd. (a), of the code the
17 board may deny, issue subject to terms and conditions, suspend, revoke or place on
18 probation a physician assistant for the following causes:

19 "(a) Any violation of the State Medical Practice Act which would constitute
20 unprofessional conduct for a physician and surgeon.

21 "...

22 "(d) Performing medical tasks which exceed the scope of practice of a
23 physician assistant as prescribed in these regulations."

24 14. California Code of Regulations, title 16, section 1399.540, states:

25 "(a) A physician assistant may only provide those medical services which he or
26 she is competent to perform and which are consistent with the physician assistant's
27 education, training, and experience, and which are delegated in writing by a
28 supervising physician who is responsible for the patients cared for by that physician

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assistant.

“(b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

“... ”

“(d) A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician.”

15. California Code of Regulations, title 16, section 1399.541, states:

“Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician. In any setting, including for example, any licensed health facility, out-patient settings, patients’ residences, residential facilities, and hospices, as applicable, a physician assistant may, pursuant to a delegation and protocols where present:

“(a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.

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1 “(b) Order or transmit an order for x-ray, other studies, therapeutic diets,
2 physical therapy, occupational therapy, respiratory therapy, and nursing services.

3 “(c) Order, transmit an order for, perform, or assist in the performance of
4 laboratory procedures, screening procedures and therapeutic procedures.

5 “(d) Recognize and evaluate situations which call for immediate attention of a
6 physician and institute, when necessary, treatment procedures essential for the life of
7 the patient.

8 “(e) Instruct and counsel patients regarding matters pertaining to their physical
9 and mental health. Counseling may include topics such as medications, diets, social
10 habits, family planning, normal growth and development, aging, and understanding of
11 and long-term management of their diseases.

12 “(f) Initiate arrangements for admissions, complete forms and charts pertinent
13 to the patient’s medical record, and provide services to patients requiring continuing
14 care, including patients at home.

15 “(g) Initiate and facilitate the referral of patients to the appropriate health
16 facilities, agencies, and resources of the community.

17 “(h) Administer or provide medication to a patient, or issue or transmit drug
18 orders orally or in writing in accordance with the provisions of subdivisions (a)-(f),
19 inclusive, of Section 3502.1 of the Code.

20 “(i)(1) Perform surgical procedures without the personal presence of the
21 supervising physician which are customarily performed under local anesthesia. Prior to
22 delegating any such surgical procedures, the supervising physician shall review
23 documentation which indicates that the physician assistant is trained to perform the
24 surgical procedures. All other surgical procedures requiring other forms of anesthesia
25 may be performed by a physician assistant only in the personal presence of an approved
26 supervising physician.

27 “(2) A physician assistant may also act as first or second assistant in surgery
28 under the supervision of an approved supervising physician.”

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16. California Code of Regulations, title 16, section 1399.542, states:

“The delegation of procedures to a physician assistant under Section 1399.541, subsections (b) and (c) shall not relieve the supervising physician of primary continued responsibility for the welfare of the patient.”

17. California Code of Regulations, title 16, section 1399.545, states:

“(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

“(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician’s specialty or usual and customary practice and with the patient’s health and condition.

“(c) A supervising physician shall observe or review evidence of the physician assistant’s performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

“(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant’s scope of practice for such times when a supervising physician is not on the premises.

“(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

“(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

“(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

“(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall

1 include the presence or absence of symptoms, signs, and other data necessary to
2 establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to
3 recommend to the patient, and education to be given the patient. For protocols
4 governing procedures, the protocol shall state the information to be given the patient,
5 the nature of the consent to be obtained from the patient, the preparation and
6 technique of the procedure, and the follow-up care. Protocols shall be developed by
7 the physician, adopted from, or referenced to, texts or other sources. Protocols shall
8 be signed and dated by the supervising physician and the physician assistant. The
9 supervising physician shall review, countersign, and date a minimum of 5% sample
10 of medical records of patients treated by the physician assistant functioning under
11 these protocols within thirty (30) days. The physician shall select for review those
12 cases which by diagnosis, problem, treatment or procedure represent, in his or her
13 judgment, the most significant risk to the patient;

14 "(4) Other mechanisms approved in advance by the board.

15 "(f) The supervising physician has continuing responsibility to follow the
16 progress of the patient and to make sure that the physician assistant does not function
17 autonomously. The supervising physician shall be responsible for all medical services
18 provided by a physician assistant under his or her supervision."

19 COST RECOVERY

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

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1 FIRST CAUSE OF DISCIPLINE

2 (Unlicensed Practice of Medicine)

3 19. Respondent is subject to disciplinary action under sections 3527, 2234, 2234,
4 subdivision (a), as defined by sections 2052 and 3502, of the Code, and California Code of
5 Regulations, title 16, section 1399.521, subdivision (d), in that he has engaged in the unlicensed
6 practice of medicine, as more particularly alleged hereinafter:

7 20. On or about August 3, 2010, respondent formed Pacific Liposculpture, Inc., a duly
8 registered domestic corporation in the State of California. According to documents filed with the
9 State of California, the address for Pacific Liposculpture, Inc., was listed as 8899 University Avenue,
10 University Lane, Suite 250, San Diego, CA 92122, and the stated purpose of the business was
11 "Liposculpture."² Respondent was identified as holding the positions of Chief Executive Officer,
12 Secretary and Financial Officer for Pacific Liposculpture, Inc..

13 21. After issues arose with respondent's former "supervising physician," respondent sought
14 out another physician to fill the role as his new "supervising physician" in furtherance of the
15 liposculpture enterprise. Respondent ended up connecting with Dr. J.B. after Dr. J.B. saw a Craigslist
16 advertisement. After respondent and Dr. J.B. met with each other, they entered into their business
17 arrangement concerning Pacific Liposculpture. A delegation of services agreement was prepared and
18 it was agreed between the two that respondent would perform all of the liposuction procedures at
19 Pacific Liposculpture.

20 22. On or about December 21, 2010, Dr. J.B., applied for a fictitious name permit (FNP) for
21 the business name of Pacific Liposculpture which also had the business location of 8899 University
22 Avenue, University Lane, Suite 250, San Diego, CA 92122. The FNP request was approved by the
23 Board effective January 14, 2011, with an expiration date of January 30, 2013, unless renewed.
24 According to respondent, he was employed by Pacific Liposculpture as an independent contractor
25 under his dba name of Davis Medical wherein he performed "all the lipo procedures" at Pacific

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27 ² The State of California, Secretary of State, Statement of Information form filed by
28 respondent on May 16, 2013, modified the type of business description to "Management Services for
Liposculpture office."

1 Liposculpture.

2 23. Pacific Liposculpture³ advertised, among other things, that “our team is comprised of
3 only the most skilled medical professionals who long ago decided to specialize in advanced
4 liposculpture (lipo) techniques” and our “body contouring procedures achieve amazing results in a
5 spa-like outpatient setting.” The Pacific Liposculpture’s website identified Dr. J.B. as “your Pacific
6 Liposculpture Medical Director” and touted that he was “an accomplished board certified physician
7 with more than 20 years experience” and that he, “along with his highly trained liposuction team, will
8 help to minimize your risks while offering you the best possible care all under local anesthesia.” The
9 website further advertised that “[b]ecause of Dr. [J.B.’s] advanced training and experience in
10 liposuction technology, Pacific Lipo’s procedures significantly reduce pain, swelling and bruising,
11 while providing you with smoother results, tighter skin, permanent improvement and no unsightly
12 scars.” Pacific Liposculpture’s advertising further proclaimed that “Dr. [J.B.] supervises a team of
13 highly trained liposuctionists with a combined experience of well over 10,000 lipo procedures” and
14 “[a]s Medical Director of Pacific Liposculpture, Dr. [J.B.] offers patients a lifetime of experience and
15 knowledge in his state-of-the-art outpatient surgical setting.” The Pacific Liposculpture advertising
16 concerning Dr. J.B. was false and misleading. Dr. J.B., in truth and fact, did not specialize in any
17 advanced liposuction techniques, did not have advanced training and experience in liposuction
18 technology, he did not supervise a highly trained team of liposuctionists, and the “outpatient surgical
19 setting” was not “his” and was not “state-of-the art.” In truth and fact, Dr. J.B. was an
20 anesthesiologist, and not a formally trained surgeon, he had not practiced medicine for approximately
21 ten years because he had been recovering from a medical condition, and his training in liposuction
22 was limited to a weekend course in Florida that he took in September 2010. Moreover, Dr. J.B. never
23 had any intention of performing any liposuction procedures at Pacific Liposculpture and, in truth and
24 fact, he never performed a single liposuction procedure for the three years he was the Medical
25 Director at Pacific Liposculpture. Instead, Dr. J.B. delegated all of the liposuction surgeries to

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27 ³ Unless otherwise noted, Pacific Liposculpture shall generally refer to the Pacific
28 Liposculpture operation including, but not limited to, Pacific Liposculpture, Pacific Liposculpture,
Inc., Davis Medical, and respondent and Dr. J.B., as individuals.

1 respondent, a physician's assistant as the "Director of Surgery" for Pacific Liposuction. Respondent's
2 advertised "state of the art surgery center" was not an accredited surgery center and consisted of a
3 single room where the liposuctions were performed. The "surgery center" contained equipment
4 respondent acquired through respondent's management services organization (MSO) and did not have
5 a fully stocked crash cart in case of a medical emergency.

6 24. Respondent, as a physician assistant, has no formal surgical training. As a physician
7 assistant, he has not attended an accredited medical school nor has he ever finished a medical
8 internship program, surgical residency program or any fellowship program in cosmetic and/or plastic
9 surgery as his "Director of Surgery" title implies. According to respondent's curriculum vitae, he
10 received his "cosmetic surgery" experience as physician assistant while working at Beverly Hills
11 Liposculpture and then with a Dr. K.C. Beverly Hills Liposculpture was established by Dr. C.B.,⁴ a
12 radiologist, who ultimately surrendered his medical license after being convicted of practicing
13 medicine without a license by aiding and abetting the practice of medicine by an unlicensed person.
14 In surrendering his medical license, respondent admitted to aiding and abetting the unlicensed
15 practice of medicine. The business operation at Beverly Hills Liposculpture was similar, in many
16 respects, to Pacific Liposculpture, with the procurement of an upscale office space, heavy advertising,
17 and medical procedures that were not performed by a formally trained and skilled cosmetic and/or
18 plastic surgeon.⁵ Respondent's curriculum vitae also indicates he worked with Dr. K.C. from
19 approximately March 2009 to September 2009. Dr. K.C. was formerly board certified in emergency
20 medicine and had no formal training in cosmetic or plastic surgery. His liposuction experience was
21 limited to a couple of two to three day courses in liposuction in 2007 and 2009.

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23 ⁴ Respondent's curriculum vitae omits the name of Dr. C.B. while his curriculum vitae lists
24 the names of the other physicians that respondent was associated with in performing liposuction
25 procedures.

26 ⁵ The liposculpture procedures, which are, in actuality, liposuction surgeries, were performed
27 at "a swank office in Beverly Hills' Rodeo Drive" where the liposuction was advertised as an
28 advanced technique with "mailings showing before-and-after pictures of women's love handles,
thighs and abdomens." See generally, *What to Know Before Going Under the Liposuction Knife* at
www.wsj.com/news/articles/SB123483369375096025 and *Nipped, Tucked and Wide Awake* at
www.nbcnews.com/id/40950317/ns/health-womens_health/#.V19n5tFvic.

1 25. Pacific Liposculpture advertises heavily through various forums, including the internet
2 and social media, and offers various package deals including, but not limited to, the "Pacific Mommy
3 Makeover" which offers "Upper and Lower Abdomen Love Handles, Flanks and Hips for \$5,995 -
4 All Inclusive*"⁶ and the "Pacific Manly Makeover" which offers "Upper and Lower Abdomen Love
5 Handles, Flanks and Chest for \$6,500 - All Inclusive*" Pacific Liposculpture also advertises how
6 patients can "Get Free Lipo With These Easy Steps" which includes registering by filling out the
7 "Free Lipo Registry" form; preparing a short story or statement as to "why you, a friend or family
8 member, deserve free lipo with Pacific Lipo," and, most importantly; "Promot[ing] Yourself" with
9 tips on how to "increase your chances" and "Promote Your Free Lipo Story."⁷ Some of the Pacific
10 Liposculpture testimonials and Yelp⁸ reviews refer to respondent as "Dr. Rod" and "doc."

11 26. Pacific Liposculpture's website at www.pacificlipo.com identified respondent, and
12 continues to identify him, as the "Director of Surgery for various lipo procedures at Pacific
13 Liposculpture, a cosmetic surgery firm based out of San Diego, California" and makes numerous
14 references to respondent as the "Director of Surgery" for Pacific Liposuction. The Pacific Liposuction
15 website, which is owned and managed by respondent, now boasts of "over 15,000 procedures
16 performed" and has several photographs and videos of respondent in his surgical scrubs. The
17 website, among other things, states that patients can have "virtual consultations," it provides before
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19 ⁶ The asterisk (*) advised potential customers that "Patient may be subject to additional BMI
20 [body mass index] charges."

21 ⁷ To "promote yourself," Pacific Liposuction recommends that contestants "Post that same
22 essay on our various Social Media pages and encourage your friends and family to like your story and
23 comment on why you deserve it. The more involved you become with Pacific Lipo and the more
24 support your story has, the better your chances of winning!" Pacific Liposculpture also offers "Some
25 Tips on How to Promote Your Free Lipo Story" which includes "[s]hare your story on our Facebook
26 wall, have friends support you by 'liking' your story and commenting on why you deserve free lipo
27 [include a picture to grab more attention][:] [p]ost your Story on our Events page on the Pacific Lipo
28 Blogspot. Your friends can reply to your post and comment on why you deserve free lipo[:] [and]
[g]o all out and take a photo of video of yourself sharing your story and post it on YouTube with the
title of your essay. You can promote that link on our Facebook and have your friends vote not only
on Facebook, but on your YouTube as well!" (See <http://roddavispa.wordpress.com>) (12-12-2014).

⁸ Respondent clarified some of these references on Yelp with some posts of his own in
August 2014, which stated, in pertinent part, "[j]ust a reminder that I'm a Physician Assistant so no
need to call me Doctor" or words to that effect. The references to respondent as "Dr. Rod" or "doc"
had remained in place for approximately two to three years before being clarified by respondent.

1 and after photos, has links to the Pacific Liposculpture blog, has various pricing and financing
2 options, and provides the option for potential patients and/or actual patients to view and/or create
3 patient testimonials. While on the website, potential patients can click on the "Video and Photos" tab
4 where they can view various videos and photo galleries or they can "visit [Pacific Liposuction's]
5 YouTube Channel to see more videos of different procedures & testimonials." The website's photo
6 galleries include the "Pacific Lipo Before & After Pictures" and the "Happy Patients with Happy
7 Results" gallery which contains photographs of patients by themselves or, in some of the photos, with
8 respondent next to the patient in his surgical scrubs with one or both of them holding a canister or
9 canisters of the fat that was extracted from the patient's body. The Pacific Liposculpture videos,
10 which can be viewed online or by using the link to Youtube, promote, among other things,
11 respondent's skill in performing the liposculpture procedures, the benefits of the liposculpture
12 procedure, and the pain-free nature of liposuction. In some of the videos, "sexy Terry" tells the
13 viewing public the liposuction is "no pain, all gain." Another patient informs viewers that the
14 liposuction "feels like a day at the spa...like getting a massage," there is "no pain, no discomfort" and
15 she's "just hanging out." In another video, viewers can watch "Terry," one of Pacific Liposculpture's
16 medical assistants, get liposuction on her inner thigh area. In many of these videos, respondent is
17 prominently featured in his surgical scrubs while performing the actual liposuction (liposculpture)
18 surgeries on patients. In some of these videos, respondent introduces himself as the "Director of
19 Surgery" for Pacific Liposculpture and may or may not identify himself as a physician assistant. On
20 those limited occasions in the videos when respondent does makes reference to his physician assistant
21 qualifications, it is through the use of a "PA-C" next to his name in the text of the video, or there is a
22 passing reference to him being a "P.A." with no indication to the general public as to what "PA-C" or
23 "P.A." means or that he is not a licensed physician. In some of the videos, there is no introduction of
24 respondent at all and no mention of respondent's qualifications or that he is a physician assistant, and
25 not a licensed physician.

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1 PATIENT L.W.

2 27. At some time in March or early-April 2011, patient L.W., who resided at the time in
3 Arizona, became interested in possibly having liposuction on his abdomen area. Patient L.W.
4 searched the internet and came across the website for Pacific Liposculpture which, among other
5 things, advertised respondent as the Director of Surgery. Patient L.W. was impressed with the
6 appearance of the facilities as advertised on the website. Patient L.W. called Pacific Liposculpture
7 and spoke to Stephanie who informed him Pacific Liposuction only used state-of-the-art equipment
8 and they had done over 10,000 procedures. After reviewing the website, and speaking with
9 Stephanie, patient L.W. was impressed, made a \$250 deposit, and scheduled an appointment to have
10 his liposuction performed at Pacific Liposculpture.

11 28. On or about April 14, 2011, patient L.W. arrived from Arizona and drove himself to
12 Pacific Liposculpture for his initial consultation and to have his liposuction surgery performed on his
13 abdomen and love-handle areas. Prior to the consultation, patient L.W. was given paperwork to fill
14 out which included, but was not limited to, a Payment Agreement and Cancellation Form and an
15 Informed Consent Liposuction form. The Payment Agreement and Cancellation Form provided that
16 “[p]ayment is due in full prior to Liposuction surgery” and that “if you cancel your appointment with
17 less than 72 hour notice, your credit card will be charged a \$500.00 fee.” By this point in time, of
18 course, the 72 hour period to cancel had already expired. The Informed Consent Liposuction form
19 indicated, among other things, that there were various risks associated with liposuction and “I hereby
20 authorize Dr. [J.B.], MD, Rod Davis, PA, and such assistants as may be selected to perform the
21 procedure or treatment.” After signing the pre-procedure paperwork, patient L.W. was escorted into
22 the room where his liposuction surgery would be performed, where his blood pressure, height and
23 weight were recorded, and measurements were taken of his upper and lower abdomen. When
24 respondent arrived, he told patient L.W. that he was the “Chief of Surgery” and further stated he was
25 a physician’s assistant and not a medical doctor. At this point, patient was not overly concerned that
26 respondent would be performing his liposuction procedure because he was told that the scheduled
27 liposuction was a relatively minor procedure, respondent claimed to have performed liposuction on
28 numerous occasions, and he was told there was going to be a supervising physician onsite. The pre-

1 surgery consultation with respondent lasted approximately ten minutes.

2 29. According to respondent's Liposuction Procedure Note of April 14, 2011, respondent
3 gave patient L.W. 100 milligrams (mg) of Atenolol and infiltrated him with 2400 cc's of tumescent
4 anesthetic solution in preparation for the liposuction surgery targeting his upper and lower abdomen
5 areas and his love handle areas. As part of the liposuction procedure, respondent removed 350 cc's of
6 fat from the left abdomen area, 350 cc's from the right abdomen area; 200 cc's from the left love
7 handle area and 200 cc's from the right love handle area. According to patient L.W., he experienced
8 moderate pain during the procedure which required additional pain medication. There was no
9 supervising physician present when the liposuction was performed and patient never spoke with any
10 supervising physician during his course of treatment. The procedure had a notation of follow-up in
11 seven days. The certified medical records fail to indicate that any follow-up took place seven days
12 later.⁹

13 30. Approximately three to four months after the liposuction surgery, patient L.W. was
14 still feeling pain around the areas where the liposuction was performed and placed a call into
15 respondent.¹⁰ According to patient L.W., respondent assured him everything was fine and the pain
16 may last more than three to four months. Respondent recommended that patient L.W. take Aleve
17 twice-a-day to relieve any inflammation he might be experiencing and told patient L.W. to call back
18 at the nine to twelve month post-operative mark if he was still experiencing pain. According to
19 patient L.W., he had never experienced such pain prior to the liposuction surgery and he could no
20 longer do anything which required much physical activity due to the pain. The certified medical
21 records fail to indicate that respondent followed up at this time with Dr. J.B., his supervising
22 physician, despite the fact that the Delegation of Service Agreement (DSA) provides, under the
23 "Consultation Requirements" section, that "[t]he PA is required to always and immediately seek
24 consultation on the following types of patients and situations...[c]omplications with anesthesia,

25
26 ⁹ There was also no notation of any follow up at the one, three or six month post-operation
timeframes.

27 ¹⁰ Patient L.W. was initially advised he might have slight pain around the procedure areas for
28 three to four months.

1 sedation or procedure.”¹¹

2 31. On or about February 23, 2012, patient L.W. followed up again with respondent.
3 Patient L.W. complained of lumpiness in his abdomen area and that he was still experiencing pain
4 approximately 10 months after his liposuction surgery. According to respondent, patient L.W.
5 disclosed to respondent that he had a history of Crohn’s disease. Respondent examined the
6 liposuction areas and could see no problems with any lumpiness. Respondent’s assessment was that
7 “there was a good outcome from the lipo procedure.” In regard to the complaint of residual pain,
8 respondent recommended that patient L.W. follow-up with his physician regarding his Crohn’s
9 disease and/or see a psychiatrist to discuss the issue of his pain in further detail. Respondent also
10 recommended endermologie, a mechanical messaging process, which purportedly can be used to
11 address lumpiness or uneven skin appearance. The certified medical records fail to indicate that
12 respondent consulted with Dr. J.B., his supervising physician, about these complications at this time.

13 32. On or about January 10, 2013, patient L.W. underwent umbilical hernia repair surgery
14 in Phoenix, Arizona, with placement of a graft to repair a “small umbilical hernia sac.”

15 33. On or about February 6, 2013, patient L.W. requested a copy of his medical records
16 from respondent and stated he was still having soreness and swelling which he attributed to the
17 liposuction surgery. According to respondent, patient L.W. told him that “you must have clipped
18 something” and further indicated that he had been to several doctors and “they can’t find anything.”
19 Respondent recommended that patient L.W. continue to follow up with his physicians and sent the
20 patient a copy of his medical records.

21 34. On or about February 15, 2013, respondent added an “addendum” to his follow-up
22 note of February 6, 2013, indicating “F/U [follow-up] Dr. [J.B.] today pt [patient] still c/o [complains
23 of] soreness & to F/U [with] MD [doctor] in AZ [Arizona].” There was no chart notation to indicate
24 specifically what was discussed with respondent’s supervising physician and what, if any,
25 recommendations there were from Dr. [J.B.] as the supervising physician.

26 ¹¹ The DSA provides that respondent must “always and immediately” seek consultation with
27 his supervising physician in the following situations: “high risk patients,” “complications with
28 anesthesia, sedation or procedure,” “patient’s desire to see physician” or “any condition which the PA
feels exceeds his/her ability to manage, etc.” (DSA, at ¶ V.)

1 PATIENT N.C.

2 35. On or about September or early-October 2011, patient N.C., a then-25 year old female,
3 contacted Pacific Liposculpture about liposuction surgery for her abdomen area and to get "a better
4 idea of what the financials/costs will be." The patient was preparing to go on her honeymoon to
5 Cancun, Mexico, and wanted to be "bathing suit ready." Patient N.C. spoke with a Pacific
6 Liposuction associate by the name of Stephanie who advised her the total cost of the liposuction
7 would be \$1,500 which included the costs for the procedure, medications and any required body
8 wraps. Patient N.C. emphasized to Stephanie that she needed to be completely healed within three
9 weeks or she would not go through with the procedure. Stephanie told patient N.C. she would be
10 able to return to work in two days and also told her that one of her co-workers had a similar procedure
11 done and was able to return to work the next day. Patient N.C. was advised, among other things, that
12 her liposuction would be done under a local anesthesia, the procedure would be performed by
13 respondent, a physician assistant, who would be overseen by a physician, that respondent had 10 to 15
14 years experience performing liposuctions with no complaints or patient deaths. After several
15 conversations with Stephanie, patient N.C. felt comfortable enough to proceed with the liposuction
16 and an appointment was scheduled.

17 36. On or about October 13, 2011, patient N.C. arrived at Pacific Liposuction for her
18 liposuction procedure. She checked-in and was charged \$1,500 for the liposuction that was to be
19 performed. Patient N.C. was also provided with an informed consent form that she signed which
20 indicated "I hereby authorize Dr. [J.B.], MD, Rod Davis, PA, and such assistants as may be selected
21 to perform the procedure or treatment."¹² Patient N.C. was sent to a room where she changed into a
22 gown, was weighed, and her vital signs were obtained and recorded. Shortly thereafter, respondent
23 came in and "marked [her] problem areas" around patient N.C.'s abdomen and then told her he would
24 only feel comfortable doing the procedure if patient N.C. chose the upper and lower part of her

25 _____
26 ¹² This provision of Pacific Liposculpture, Inc.'s informed consent form was later amended.
27 The amended section, which was used for other patients in the future, provided "I hereby authorize
28 Dr. Jerrell Borup, MD, OR Rod Davis, PA and such other qualified assistants as may be selected to
perform the procedure or treatment." In truth and fact, respondent was the one who was performing
all of the liposuction procedures. (Emphasis added.)

1 abdomen for "the best look" which she agreed to do based on respondent's recommendation.
2 Respondent told patient N.C. that she would not feel anything during the procedure. According to
3 patient N.C., the entire encounter with respondent lasted approximately two minutes with no focused
4 physical examination nor any work-up in regard to, among other things, patient N.C.'s tachycardia
5 condition. Patient N.C. was then escorted to the room where the liposuction was to be performed.

6 37. Once in the liposuction procedure room, patient N.C. was told to lie down and recalled
7 hearing country music playing loudly in the background. According to patient N.C., she was given
8 two pills "to keep her heart calm."¹³ Insertion points were identified for the insertion of the cannulas
9 that would be used to extract the fat from the left and right quadrants of patient N.C.'s upper and
10 lower abdomen areas. According to respondent's procedure note, patient N.C. was infiltrated with
11 3200 cc's of tumescent anesthetic solution prior to performing the liposuction to remove the fat in the
12 different quadrants of the upper and lower abdomen areas. The amount of tumescent anesthetic
13 solution exceeded the scope of the Delegation of Services Agreement (DSA) between Dr. J.B. and
14 respondent.¹⁴ Respondent removed 800 cc's of fat from the upper abdomen area and 800 cc's from
15 the lower abdomen area. According to patient N.C., the procedure "was so damn painful that I kept
16 saying over and over to [respondent] that it burned beyond all belief all around [her] mid-stomach
17 area around the belly button area" at which time more of the tumescent solution was provided with
18 respondent indicating "I'm administering more than I'm supposed to you shouldn't be feeling this."
19 According to patient N.C., the liposuction procedure continued and she "kept reiterating how much it
20 stung and felt like a fire under [her] skin." During the procedure, there was no monitoring of
21 respondent's physiological condition such as frequent checking of her vital signs, pulse oximetry and/
22 or telemetry. After some time had passed, respondent told patient N.C. "okay we're done, we got two
23 liters out of you, the most I've seen in a long time..." Patient N.C. was sent home without being

24
25 ¹³ Prior to the procedure, patient N.C. advised respondent she had a history of heart problems
which she identified as tachycardia.

26 ¹⁴ The DSA provided that volume range for the "Anesthetic Lidocaine with epinephrine" for
27 the lower abdomen was 200-700 cc's and the upper abdomen was 200-700 cc's. Patient N.C. was
28 infiltrated with a total of 3200 cc's during the course of the liposuction on her upper and lower
abdomen areas.

1 given, in advance, any instructions or a list of any supplies that she might need postoperatively.¹⁵

2 38. Later in the evening on or about October 13, 2011, and into the next morning, patient
3 N.C. began experiencing "a lot of pain." In the morning, she changed her dressings which were maxi-
4 pads that had been applied by respondent following her liposuction surgery. Over the next few days,
5 patient N.C. contacted respondent to report that her heart wouldn't stop racing. Respondent told her
6 it was because of the adrenaline and she was just "too sensitive." Patient N.C. made additional calls
7 to the clinic to complain that "something didn't feel right." Respondent returned patient N.C.'s call
8 and told her that she should text him photos of her abdomen front and side. She did as instructed and
9 respondent texted back that "Everything looks fine." The certified medical records fail to indicate
10 that respondent consulted with Dr. J.B., his supervising physician, about these complications at this
11 time. According to patient N.C., her abdomen "is extremely sore" and she has two lumps in the same
12 area where she was experiencing pain during the liposuction procedure.

13 PATIENT K.D.

14 39. On or about March 1, 2012, patient K.D., a then-46 year old female, went to Pacific
15 Liposculpture for liposuction. She identified her areas of concern as her upper and lower abdomen,
16 love handles, back bra area and hips. Patient K.D.'s body measurements were taken and her vital
17 signs were recorded followed by a brief pre-operative consultation with respondent. Patient K.D. was
18 not aware that respondent was a physician assistant as opposed to a medical doctor. According to
19 respondent's Liposuction Procedure Note, patient K.D. was given 50 milligrams (mg) of Atenolol¹⁶
20 and infiltrated with 2800 cc's of tumescent anesthetic solution in preparation for the liposuction
21 surgery targeting her back bra and inner thigh areas. As part of the liposuction procedure, respondent
22 removed 200 cc's of fat from the left back bra area, 200 cc's from the right back bra area; 200 cc's

23
24 ¹⁵ According to patient N.C., prior to the date of her surgery, she was never given a list of
25 instructions as to what supplies she should have purchased in advance and, thus, she was not prepared
26 ahead of time to have those items available to her when she returned home. The certified medical
27 records for patient N.C. do contain a document entitled "Post-Operative Instructions."

28 ¹⁶ Atenolol (Tenormin®) is used alone or in combination with other medications to manage
hypertension (high blood pressure). It can also be used to prevent angina (chest pain) and improve
survival after a heart attack. Atenolol is in a class of medications called beta blockers. It works by
relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure.

1 from the left inner thigh and 200 cc's from the right inner thigh. The procedure note indicates patient
2 K.D. was given 500 mg of Keflex to be used for three days and subsequently requested pain
3 medication with respondent calling in a prescription of Vicodin® 5/500 to a nearby pharmacy.¹⁷

4 40. On or about March 2, 2012, patient K.D. returned to Pacific Liposculpture for
5 liposuction on her remaining areas of concern which were the upper and lower abdomen and flank
6 (love handle) areas. According to the procedure note for this visit, patient K.D. "requested stronger
7 pain med[ication] prior to procedure" and respondent asked her to take two tabs of the previously
8 prescribed Vicodin® plus Ibuprofen to see if that would help her. Patient K.D. was infiltrated with
9 3700 cc's of tumescent anesthetic solution in preparation the liposuction procedure targeting her
10 upper and lower abdomen and her love handle areas. As part of the liposuction procedure, respondent
11 removed 650 cc's of fat from the left abdominal area; 650 cc's from the right abdominal area; 300
12 cc's from the left love handle area and 300 cc's from the right love handle area.

13 41. On or about March 5, 2012, patient K.D. called respondent stating she needed "Norco
14 ... or something stronger" to alleviate the pain she was experiencing in her legs, midsection, abdomen
15 and love handle area. Respondent noted in a "follow-up note" that patient K.D. had a history of pain
16 management issues, that he did not believe that increasing her pain medications would help and
17 instead she should follow up with a pain management specialist or go to the emergency room. The
18 respondent did, however, call in a prescription of hydrocodone (Norco®) 5/325 mg for patient K.D.¹⁸
19 Respondent also recommended that patient K.D. continue with icing and continue to wear her spanx-
20 type garment. The certified medical records fail to indicate that respondent consulted with Dr. J.B.,
21 his supervising physician, about these complications at this time.

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23
24 ¹⁷ APAP/Hydrocodone Bitartrate (Lorcet®, Lortab®, Vicodin®, Vicoprofen®, Tussionex®
25 and Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which is a
26 Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e),
and a dangerous drug pursuant to Business and Professions Code section 4022. When properly
prescribed and indicated, it is used for the treatment of moderate to severe pain. The procedure note
does not list the quantity of Vicodin® prescribed by respondent to patient K.D.

27 ¹⁸ There is no indication in the follow-up note of the quantity of this Norco prescription nor
28 any instructions given to patient K.D. regarding the schedule for taking the Norco.

1 42. On or about April 19, 2012, patient K.D. called respondent and indicated she had a
2 hernia and was still experiencing pain. Respondent requested that patient K.D. send him photographs
3 via text message (text) so he could compare the current photographs with the photographs taken on
4 the day of her liposuction procedure to see if her shape had improved. Respondent and patient K.D.
5 exchanged e-mails and/or texts. In one communication at 8:16 p.m., patient K.D. wrote:

6 "I agree I look better but my stomach is still bloated and not what I expected. I never
7 knew I would still be in excruciating pain almost 2 months later with a hernia from a
8 puncture in my muscles, losing another months work to recuperate from the hernia
9 surgery. I am very disappointed in the surgery performed at your office. I should never
10 have to have [sic] surgery to repair a hernia I got as a result of a puncture in my muscle."

11 Patient K.D. sent another communication at 8:19 p.m., which stated, "Pain, suffering and
12 additional cost to repair damage done to me in addition to the \$5900.00 I paid to you is just not an
13 acceptable outcome to something I was assured was simple surgery."¹⁹ The certified medical records
14 fail to indicate that respondent consulted with Dr. J.B., his supervising physician, about these
15 complications at this time.

16 PATIENT S.M.

17 43. On or about February 22, 2013, patient S.M., a then-42 year old female, had her first
18 visit and consultation at Pacific Liposculpture where she was seen by respondent. Patient S.M.
19 decided to seek a consultation at Pacific Liposculpture because she was looking to have some
20 liposuction done on her inner thighs and was impressed with the professional appearance of the
21 Pacific Liposculpture medical office. During this visit, patient S.M. filled out financial forms and a
22 personal medical history form prior to meeting with respondent who examined her inner thighs and
23 explained the liposuction procedure that would be performed. No focused physical examination of
24 patient S.M. was performed by respondent at this visit, nor was patient S.M. provided with any
25 informed consent documents to review.

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28 ¹⁹ There were a few more communications between patient K.D. and respondent on the
evening of April 19, 2012. Respondent ultimately ended the communications after noting "[t]his
conversation is not going well so I prefer to let our attorneys handle this moving forward. Sometimes
lawyers are necessary and this appears to be one of those cases."

1 44. In approximately mid-March 2013, patient S.M. called Pacific Liposculpture and spoke
2 with "Stephanie" and advised her that she wanted to proceed with the liposuction on her inner thighs
3 and an appointment was made for the procedure.

4 45. On or about April 17, 2013, patient S.M. arrived for her scheduled liposuction surgery
5 to be performed on her inner thighs. After paying the \$1,500 fee for her procedure, patient S.M. was
6 given an informed consent form which she had little time to review before her procedure was
7 scheduled to begin. No detailed and/or focused physical examination was conducted on patient S.M.
8 by respondent. Patient S.M. was prepped for the procedure and given 200 mg of Atenolol. Patient
9 S.M. was then infiltrated with 1650 cc's of tumescent anesthetic solution in preparation of the
10 liposuction procedure which targeted her inner thigh areas. As part of the liposuction procedure,
11 respondent removed 275 cc's of fat from the left inner thigh area and 275 cc's from the right inner
12 thigh area. After the liposuction procedure, gauze was wrapped around patient S.M.'s inner thigh
13 area and shortly thereafter she drove herself home.

14 46. On or about May 22, 2013, patient S.M. called Pacific Liposculpture to express her
15 concern about a "pocket of swelling on [her] right thigh" which she wanted to have examined before
16 her next scheduled follow-up appointment of May 29, 2013. A Pacific Liposculpture staff member
17 advised patient S.M. that an earlier appointment could not be scheduled.

18 47. On or about May 29, 2013, patient S.M. had her follow-up appointment in which she
19 again expressed her concern over the swelling in her right inner thigh area. Respondent examined the
20 inner thigh areas and noted "residual swelling" minimal on the left inner thigh and moderate on the
21 right inner thigh. Respondent's assessment was post-operative swelling six weeks post-liposuction.
22 According to respondent, he recommended patient S.M. remove her compression garment at night but
23 continue to wear it during the day when she was "gravity dependent." Respondent also advised
24 patient S.M. she could start walking and doing some light weights but recommended that she hold-off
25 on any running. The certified medical records fail to indicate that respondent consulted with Dr. J.B.,
26 his supervising physician, about these complications at this time.

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1 48. On or about June 11, 2013, patient S.M. texted respondent to express her concern about
2 the "clump" on her right inner thigh area which she reported was "becoming really hard and looks so
3 weird." Patient S.M. texted some photos of her right and left thigh areas which showed a noticeable
4 swollen area on her right inner thigh. Respondent believed the increased post-operative swelling was
5 possibly exercise induced. Respondent recommended that patient S.M. discontinue exercising, that
6 she start on dexamethasone²⁰ and/or methylprednisolone (Medrol® dosepak),²¹ continue with the
7 RICE (rest, ice, compression and elevation) protocol and follow-up in one week. On June 14, 2013,
8 patient S.M. texted respondent to advise him she had started taking the methylprednisolone. The
9 certified medical records fail to indicate that respondent consulted with Dr. J.B., his supervising
10 physician, about these complications at this time.

11 49. On or about June 18, 2013, respondent texted patient S.M. wondering if there was
12 "[a]ny progress [concerning her right inner thigh area]?" Patient S.M. responded "...[n]one, it hasn't
13 shrunk at all, it's very hard and a couple days ago I woke up and it was starting to form a bruise." She
14 further indicated, among other things, that she had not been exercising, she was following the RICE
15 protocol and had been taking the methylprednisolone as directed. The certified medical records fail to
16 indicate that respondent consulted with Dr. J.B., his supervising physician, about these complications
17 at this time.

18 50. On or about June 21, 2013, patient S.M. texted respondent to express, among other
19 things, her concern that "the swelling has not gone down at all," her right inner thigh area was now
20 "black and blue" and she asked "is that normal?" The certified medical records fail to indicate that
21 respondent consulted with Dr. J.B., his supervising physician, about these complications at this time.

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24 ²⁰ Dexamethasone is a corticosteroid that prevents the release of substances in the body that
25 cause inflammation. Dexamethasone is generally used to treat many different inflammatory
26 conditions such as allergic disorders, skin conditions, ulcerative colitis, arthritis, lupus, psoriasis, or
27 breathing disorders.

28 ²¹ Methylprednisolone is a steroid that prevents the release of substances in the body that
cause inflammation. Methylprednisolone is generally used to treat many different inflammatory
conditions such as arthritis, lupus, psoriasis, ulcerative colitis, allergic disorders, gland (endocrine)
disorders, and conditions that affect the skin, eyes, lungs, stomach, nervous system or blood cells.

1 51. Between June 21 and August 23, 2013, respondent and patient S.M. continued to
2 exchange texts about the continuing problem with her right inner thigh area with patient S.M.
3 wondering "could this lump [on the right inner thigh] be a localized hematoma (collection of blood
4 from bleeding)" and expressing concern that she had read "[t]hese [hernatomas] can take up to a year
5 to absorb and, occasionally, need to be surgically removed?" During this period of time, respondent
6 sent occasional follow-up text messages to check on patient S.M.'s progress, and patient S.M. began
7 making arrangements to obtain a second opinion from a physician. The certified medical records fail
8 to indicate that respondent consulted with Dr. J.B., his supervising physician, about these
9 complications at this time.

10 52. On or about September 11, 2013, patient S.M. was examined by Dr. M.B., a board
11 certified plastic surgeon, who immediately diagnosed patient S.M. as having a pseudobursa on her
12 right inner thigh which would require surgical removal and corrective surgery. Dr. MB also
13 examined patient S.M.'s left thigh and informed her it appeared her left thigh had been over suctioned
14 and she would need a fat transfer to give her left thigh a smooth and even appearance. During the
15 course of Dr. M.B.'s discussions with patient S.M., Dr. M.B. learned that the procedure was not
16 performed by a licensed physician and surgeon but, instead, by a physician's assistant, which caused
17 Dr. M.B. great concern. Dr. M.B. searched the web and found information over the internet in which
18 respondent was advertising himself as the "Director of Surgery" at Pacific Liposculpture which Dr.
19 M.B. found very troubling. Dr. M.B. ultimately called respondent's alleged supervising physician,
20 Dr. J.B., to report his diagnosis of a pseudo-bursa on patient S.M.'s right inner thigh and to express
21 his concerns over, among other things, respondent performing liposuction procedures and advertising
22 himself as the "Director of Surgery" for Pacific Liposuction. According to Dr. M.B., respondent's
23 supervising physician, Dr. J.B., told Dr. M.B. that it would not happen again.

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1 SECOND CAUSE OF DISCIPLINE

2 (Gross Negligence)

3 53. Respondent is further subject to disciplinary action under sections 3527, 2234 and 2234,
4 subdivision (a), of the Code, and California Code of Regulations, title 16, section 1399.521,
5 subdivision (a), as defined by section 2234, subdivision (b), of the Code, in that he committed gross
6 negligence in his care and treatment of patients L.W., N.C., K.D. and S.M., as more particularly
7 alleged hereinafter:

8 PATIENT L.W.

9 54. Respondent committed gross negligence in his care and treatment of L.W., which
10 included, but was not limited to, the following:

11 (a) Paragraphs 19 through 34, above, are hereby incorporated by reference and
12 realleged as if fully set forth herein;

13 (b) Respondent, as a physician assistant, engaged in the unlicensed practice of
14 medicine by performing liposuction surgery on patient L.W.;

15 (c) Respondent's informed consent with patient L.W. was improper and
16 inadequate because, among other things, the informed consent was not detailed or
17 thorough, patient L.W. was informed the liposuction procedure would be overseen by
18 an onsite medical doctor when, in truth and fact, it was not, and the written informed
19 consent stated the liposuction surgery would be performed by Dr. J.B. and respondent
20 when, in truth and fact, the surgery was performed solely by respondent;

21 (d) Respondent's pre-operative and perioperative care and treatment for
22 patient L.W. was inadequate and/or represented a disregard for patient safety because,
23 among other things, respondent failed to obtain a detailed history and failed to
24 perform a proper and focused preoperative physical examination on patient L.W.;
25 respondent premedicated patient L.W. with Atenolol which blocks the physiological
26 response to tachycardia; there was no physiological monitoring of patient L.W. during
27 his liposuction procedure such as frequent checking of vital signs, pulse oximetry and/
28 or telemetry; the emergency crash cart in the procedure room was not fully stocked;

1 the procedures for instrument sterilization were inadequate; and the liposuction
2 surgery was not performed in an accredited surgery center;

3 (e) Respondent failed to properly perform the liposuction of the abdomen on
4 patient L.W. in a manner that achieved optimal results; and

5 (f) Respondent failed to provide proper post-operative care by, among other
6 things, failing to provide patient L.W. with an appropriate compression garment, and
7 failing to respond appropriately to patient L.W.'s post-operative concerns.

8 PATIENT N.C.

9 55. Respondent committed gross negligence in his care and treatment of N.C., which
10 included, but was not limited to, the following:

11 (a) Paragraphs 19 through 26 and 35 through 38, above, are hereby
12 incorporated by reference and realleged as if fully set forth herein;

13 (b) Respondent, as a physician assistant, engaged in the unlicensed practice of
14 medicine by performing liposuction surgery on patient N.C.;

15 (c) Respondent's informed consent with patient N.C. was improper and
16 inadequate because, among other things, the informed consent was not detailed or
17 thorough, patient N.C. was informed the liposuction procedure would be overseen by
18 a medical doctor when, in truth and fact, it was not, and the written informed consent
19 stated the liposuction surgery would be performed by Dr. J.B. and respondent when, in
20 truth and fact, the surgery was performed by respondent;

21 (d) Respondent's pre-operative and perioperative care and treatment for
22 patient N.C. was inadequate and/or represented a disregard for patient safety because,
23 among other things, respondent failed to obtain a detailed history from, and failed to
24 perform a proper preoperative physical examination of patient N.C.; respondent failed
25 to perform a proper work-up regarding patient N.C.'s reported tachycardia; respondent
26 premedicated patient N.C. with Atenolol which blocks the physiological response to
27 tachycardia; there was no physiological monitoring of patient N.C. during her
28 liposuction procedure such as frequent checking of vital signs, pulse oximetry and/ or

1 telemetry; respondent failed to terminate the liposuction procedure despite patient
2 N.C.'s repeated complaints of extreme pain; the emergency crash cart in the procedure
3 room was not fully stocked; the procedures for instrument sterilization were
4 inadequate; and the liposuction surgery was not performed in an accredited surgery
5 center;

6 (e) Respondent failed to perform the proper procedure on patient N.C. which
7 should have been an abdominoplasty with flank liposuction, and failed to properly
8 perform the liposuction of the abdomen on patient N.C. in a manner that achieved
9 optimal results; and

10 (f) Respondent failed to provide proper post-operative care by, among other
11 things, failing to provide patient N.C. with adequate post-operative instructions,
12 failing to provide patient N.C. with an appropriate compression garment, and failed to
13 respond appropriately to patient N.C.'s post-operative concerns of tachycardia.

14 **PATIENT K.D.**

15 56. Respondent committed gross negligence in his care and treatment of K.D., which
16 included, but was not limited to, the following:

17 (a) Paragraphs 19 through 26 and 39 through 42, above, are hereby
18 incorporated by reference and realleged as if fully set forth herein;

19 (b) Respondent, as a physician assistant, engaged in the unlicensed practice of
20 medicine by performing liposuction surgery on patient K.D.;

21 (c) Respondent's informed consent with patient K.D. was improper and
22 inadequate because, among other things, the informed consent was not detailed or
23 thorough, patient K.D. was not clearly informed respondent was a physician assistant,
24 and the written informed consent stated the liposuction surgery would be performed
25 by Dr. J.B. and respondent when, in truth and fact, the surgery was performed solely
26 by respondent;

27 (d) Respondent's pre-operative and perioperative care and treatment for
28 patient K.D. was inadequate and/or represented a disregard for patient safety because,

1 among other things, respondent failed to obtain a detailed history and failed to
2 perform a proper and focused preoperative physical examination on patient K.D.;
3 respondent premedicated patient K.D. with Atenolol which blocks the physiological
4 response to tachycardia; there was no physiological monitoring of patient K.D. during
5 his liposuction procedure such as frequent checking of vital signs, pulse oximetry and/
6 or telemetry; the emergency crash cart in the procedure room was not fully stocked;
7 the procedures for instrument sterilization were inadequate; and the liposuction
8 surgery was not performed in an accredited surgery center; and

9 (e) Respondent's communications with patient K.D. through text messages
10 and/or e-mails were not HIPAA compliant.

11 PATIENT S.M.

12 57. Respondent committed gross negligence in his care and treatment of SM, which included,
13 but was not limited to, the following:

14 (a) Paragraphs 19 through 26 and 43 through 52, above, are hereby
15 incorporated by reference and realleged as if fully set forth herein;

16 (b) Respondent, as a physician assistant, engaged in the unlicensed practice of
17 medicine by performing liposuction surgery on patient S.M.;

18 (c) Respondent's informed consent with patient S.M. was improper and
19 inadequate because, among other things, the informed consent was not detailed or
20 thorough and patient S.M. was led to believe the liposuction procedure would be
21 overseen by an onsite medical doctor, when, in truth and fact, it was not, and the
22 written informed consent form did not clearly indicate the liposuction surgery would
23 be performed solely by respondent;

24 (d) Respondent's pre-operative and perioperative care and treatment for
25 patient S.M. was inadequate and/or represented a disregard for patient safety because,
26 among other things, respondent failed to obtain a detailed history from, and failed to
27 perform a proper and focused preoperative physical examination of, patient S.M.;
28 respondent premedicated patient S.M. with Atenolol which blocks the physiological

1 response to tachycardia; there was no physiological monitoring of patient S.M. during
2 her liposuction procedure such as frequent checking of vital signs, pulse oximetry and/
3 or telemetry; the emergency crash cart in the procedure room was not fully stocked;
4 the procedures for instrument sterilization were inadequate; and the liposuction
5 surgery was not performed in an accredited surgery center;

6 (e) Respondent failed to properly perform the liposuction on patient S.M.'s
7 inner thighs in a manner that achieved optimal results;

8 (f) Respondent failed to provide proper post-operative care to patient S.M. by
9 failing to properly manage, respond and/or treat the complication to her right inner
10 thigh which developed a pseudo-bursa; and

11 (g) Respondent's communications with patient S.M. through text messages
12 and/or e-mails were not HIPAA compliant.

13 THIRD CAUSE FOR DISCIPLINE

14 (Repeated Negligent Acts)

15 58. Respondent is further subject to disciplinary action under sections 3527, 2234, and 2234,
16 subdivision (a), of the Code, and California Code of Regulations, title 16, section 1399.521,
17 subdivision (a), as defined by section 2234, subdivision (c), of the Code, in that he committed
18 repeated negligent acts in his care and treatment of patients L.W., N.C., K.D. and S.M., as more
19 particularly alleged hereinafter:

20 PATIENT L.W.

21 59. Respondent committed repeated negligent acts in his care and treatment of L.W., which
22 included, but was not limited to, the following:

23 (a) Paragraphs 19 through 34, and 54, above, are hereby incorporated by
24 reference and realleged as if fully set forth herein;

25 (b) Respondent, as a physician assistant, engaged in the unlicensed practice of
26 medicine by performing liposuction surgery on patient L.W.;

27 (c) Respondent's informed consent with patient L.W. was improper and
28 inadequate because, among other things, the informed consent was not detailed or

1 thorough, patient L.W. was informed the liposuction procedure would be overseen by
2 an onsite medical doctor when, in truth and fact, it was not, and the written informed
3 consent stated the liposuction surgery would be performed by Dr. J.B. and respondent
4 when, in truth and fact, the surgery was performed solely by respondent;

5 (d) Respondent's pre-operative and perioperative care and treatment for
6 patient L.W. was inadequate and/or represented a disregard for patient safety because,
7 among other things, respondent failed to obtain a detailed history and failed to
8 perform a proper and focused preoperative physical examination on patient L.W.;
9 respondent premedicated patient L.W. with Atenolol which blocks the physiological
10 response to tachycardia; there was no physiological monitoring of patient L.W. during
11 his liposuction procedure such as frequent checking of vital signs, pulse oximetry and/
12 or telemetry; the emergency crash cart in the procedure room was not fully stocked;
13 the procedures for instrument sterilization were inadequate; and the liposuction
14 surgery was not performed in an accredited surgery center;

15 (e) Respondent failed to properly perform the liposuction of the abdomen on
16 patient L.W. in a manner that achieved optimal results;

17 (f) Respondent failed to provide proper post-operative care by, among other
18 things, failing to provide patient L.W. with an appropriate compression garment, and
19 failing to respond appropriately to patient L.W.'s post-operative concerns; and

20 (g) Respondent's standardized operative report for patient L.W. was
21 inadequate and failed to convey meaningful information.

22 PATIENT N.C.

23 60. Respondent committed gross negligence in his care and treatment of N.C., which
24 included, but was not limited to, the following:

25 (a) Paragraphs 19 through 26 and 35 through 38, and 55, above, are hereby
26 incorporated by reference and realleged as if fully set forth herein;

27 (b) Respondent, as a physician assistant, engaged in the unlicensed practice of
28 medicine by performing liposuction surgery on patient N.C.;

1 (c) Respondent's informed consent with patient N.C. was improper and
2 inadequate because, among other things, the informed consent was not detailed or
3 thorough and patient N.C. was informed the liposuction procedure would be overseen
4 by a medical doctor when, in truth and fact, it was not, and the written informed
5 consent stated the liposuction surgery would be performed by Dr. J.B. and respondent
6 when, in truth and fact, the surgery was performed by respondent;

7 (d) Respondent's pre-operative and perioperative care and treatment for
8 patient N.C. was inadequate and/or represented a disregard for patient safety because,
9 among other things, respondent failed to obtain a detailed history and failed to
10 perform a proper preoperative physical examination on patient N.C.; respondent failed
11 to perform a proper work-up regarding patient N.C.'s reported tachycardia; respondent
12 premedicated patient N.C. with Atenolol which blocks the physiological response to
13 tachycardia; there was no physiological monitoring of patient N.C. during her
14 liposuction procedure such as frequent checking of vital signs, pulse oximetry and/or
15 telemetry; respondent failed to terminate the liposuction procedure despite patient
16 N.C.'s repeated complaints of extreme pain; the emergency crash cart in the procedure
17 room was not fully stocked; the procedures for instrument sterilization were
18 inadequate; and the liposuction surgery was not performed in an accredited surgery
19 center;

20 (e) Respondent failed to perform the proper procedure on patient N.C. which
21 should have been an abdominoplasty with flank liposuction, and failed to properly
22 perform the liposuction of the abdomen on patient N.C. in a manner that achieved
23 optimal results;

24 (f) Respondent failed to provide proper post-operative care by, among other
25 things, failing to provide patient N.C. with adequate post-operative instructions,
26 failing to provide patient N.C. with an appropriate compression garment, and failed to
27 respond appropriately to patient N.C.'s post-operative concerns of tachycardia; and

28 ////

1 (g) Respondent's standardized operative report for patient N.C. was
2 inadequate and failed to convey meaningful information.

3 PATIENT K.D.

4 61. Respondent committed gross negligence in his care and treatment of K.D., which
5 included, but was not limited to, the following:

6 (a) Paragraphs 19 through 26, 39 through 42, and 56, above, are hereby
7 incorporated by reference and realleged as if fully set forth herein;

8 (b) Respondent, as a physician assistant, engaged in the unlicensed practice of
9 medicine by performing liposuction surgery on patient K.D.;

10 (c) Respondent's informed consent with patient K.D. was improper and
11 inadequate because, among other things, the informed consent was not detailed or
12 thorough, patient K.D. was not clearly informed respondent was a physician assistant,
13 and the written informed consent stated the liposuction surgery would be performed
14 by Dr. J.B. and respondent when, in truth and fact, the surgery was performed solely
15 by respondent;

16 (d) Respondent's pre-operative and perioperative care and treatment for
17 patient K.D. was inadequate and/or represented a disregard for patient safety because,
18 among other things, respondent failed to obtain a detailed history and failed to
19 perform a proper and focused preoperative physical examination on patient K.D.;
20 respondent premedicated patient K.D. with Atenolol which blocks the physiological
21 response to tachycardia; there was no physiological monitoring of patient K.D. during
22 his liposuction procedure such as frequent checking of vital signs, pulse oximetry and/
23 or telemetry; the emergency crash cart in the procedure room was not fully stocked;
24 the procedures for instrument sterilization were inadequate; and the liposuction
25 surgery was not performed in an accredited surgery center;

26 (e) Respondent's communications with patient K.D. through text messages
27 and/or e-mails were not HIPAA compliant; and

28 ////

1 (f) Respondent's standardized operative report for patient K.D. was
2 inadequate and failed to convey meaningful information.

3 PATIENT S.M.

4 62. Respondent committed gross negligence in his care and treatment of S.M., which
5 included, but was not limited to, the following:

6 (a) Paragraphs 19 through 26, 43 through 52, and 57, above, are hereby
7 incorporated by reference and realleged as if fully set forth herein;

8 (b) Respondent, as a physician assistant, engaged in the unlicensed practice of
9 medicine by performing liposuction surgery on patient S.M.;

10 (c) Respondent's informed consent with patient S.M. was improper and
11 inadequate because, among other things, the informed consent was not detailed or
12 thorough and patient S.M. was led to believe the liposuction procedure would be
13 overseen by an onsite medical doctor, when, in truth and fact, it was not, and the
14 written informed consent form did not clearly indicate the liposuction surgery would
15 be performed solely by respondent;

16 (d) Respondent's pre-operative and perioperative care and treatment for
17 patient S.M. was inadequate and/or represented a disregard for patient safety because,
18 among other things, respondent failed to obtain a detailed history from, and failed to
19 perform a proper and focused preoperative physical examination of patient S.M.;
20 respondent premedicated patient S.M. with Atenolol which blocks the physiological
21 response to tachycardia; there was no physiological monitoring of patient S.M. during
22 her liposuction procedure such as frequent checking of vital signs, pulse oximetry and/
23 or telemetry; the emergency crash cart in the procedure room was not fully stocked;
24 the procedures for instrument sterilization were inadequate; and the liposuction
25 surgery was not performed in an accredited surgery center;

26 (e) Respondent failed to properly perform the liposuction on patient S.M.'s
27 inner thighs in a manner that achieved optimal results;

28 ////

1 (f) Respondent failed to provide proper post-operative care to patient S.M. by
2 failing to properly manage, respond and/or treat the complication to her right inner
3 thigh which developed a pseudo-bursa;

4 (g) Respondent's communications with patient S.M. through text messages
5 and/or e-mails were not HIPAA compliant; and

6 (h) Respondent's standardized operative report for patient S.M. was
7 inadequate and failed to convey meaningful information.

8 **FOURTH CAUSE FOR DISCIPLINE**

9 **(False and/or Misleading Advertising)**

10 63. Respondent is further subject to disciplinary action under sections 3527, 2234, 2234,
11 subdivision (a), of the Code, and California Code of Regulations, title 16, section 1399.521,
12 subdivision (a), as defined by sections 651 and 2271, of the Code, in that he has made and
13 disseminated, or caused to be made and disseminated, false and/or misleading advertising in violation
14 of section 17500 of the Code, as more particularly alleged in paragraphs 23 through 52, above, which
15 are hereby incorporated by reference and realleged as if fully set forth herein. The false and/or
16 misleading statements include, but are not limited to the following:

17 (a) Respondent being identified as the "Director of Surgery" or words to that
18 effect which is misleading because it conveys, among other things, that respondent has
19 a higher level of education, training and/or experience than he actually possesses
20 and/or that he is a licensed physician and surgeon;

21 (b) Failing to clearly define the term "P.A.," "PA-C" or other words to that
22 effect whenever used in any advertising which is misleading because many potential
23 or actual patients would not know the meaning of these terms and would assume,
24 especially with the title of "Director of Surgery," that respondent has a higher level of
25 education, training and/or experience than he actually possesses and/or that he is a
26 licensed physician and surgeon;

27 (c) False and/or misleading statements concerning Dr. J.B.'s training and
28 qualifications in the area of liposuction surgery including, but not limited to, "that Dr.

1 [J.B.], along with his highly trained liposuction team, will help to minimize your risks
2 while offering you the best possible care all under local anesthesia," that "[b]ecause
3 of Dr. [J.B.'s] advanced training and experience in liposuction technology, Pacific
4 Lipo's procedures significantly reduce pain, swelling and bruising, while providing
5 you with smoother results, tighter skin, permanent improvement and no unsightly
6 scars," that "Dr. [J.B.] supervises a team of highly trained liposuctionists with a
7 combined experience of well over 10,000 lipo procedures," that "[a]s Medical
8 Director of Pacific Liposculpture, Dr. [J.B.] offers patients a lifetime of experience
9 and knowledge in his state-of-the-art outpatient surgical setting." The aforementioned
10 statements were false and/or misleading because, among other things, they
11 misrepresented and inflated Dr. J.B.'s training, experience and/or qualifications in the
12 area of liposuction surgery and were designed to give patients the impression that Dr.
13 J.B., was, in fact, a highly-qualified physician in the area of liposuction surgery, would
14 be performing the liposuction surgery or, at a minimum, would be closely supervising
15 any liposuction surgery that was performed. In truth and fact, Dr. J.B. had no
16 "advanced training and experience in liposuction technology," was not interested in
17 performing any procedures, never performed a single liposuction procedure while at
18 Pacific Liposculpture, and his supervision, if any, was minimal;

19 (d) Failing to timely correct statements in patient testimonials and/or Yelp
20 reviews, that could be accessed on or through the Pacific Liposculpture website,
21 which referred to respondent as "Dr. Rod" and/or "doc," or other words to that effect.
22 These statements were false and/or misleading because they inferred that respondent
23 had a higher level of education and/or training than he actually possesses and/or that
24 he is a licensed physician and surgeon instead of a physician's assistant;

25 (e) Photographs of respondent in surgical scrubs and/or photographs or video
26 of respondent performing liposuction surgery, which combined with the other false
27 and/or misleading advertising referenced herein, led patients to believe that respondent
28 possessed the education, training and/or qualifications to legally perform the

1 liposuction procedures; and

2 (f) The posting of patient testimonials which were not a true and accurate
3 description of liposuction surgery and any risks associated therewith which state,
4 among other things, that liposuction is "no pain, all gain," that liposuction "feels like a
5 day at the spa... like getting a massage," that there is "no pain, no discomfort" or other
6 words to that effect which falsely convey the procedure is pain free and without risk of
7 any surgical or other complications.

8 **FOURTH CAUSE FOR DISCIPLINE**

9 **(Dishonesty and/or Corruption)**

10 64. Respondent is further subject to disciplinary action under sections 3527, 2234, 2234,
11 subdivision (a), of the Code, and California Code of Regulations, title 16, section 1399.521,
12 subdivision (a), as defined by section 2234, subdivision (e), of the Code, in that he committed an act
13 or acts of dishonesty and/or corruption in regard to his false and deceptive advertising, as more
14 particularly alleged in paragraphs 23 through 52, and 63, above, which are hereby incorporated by
15 reference and realleged as if fully set forth herein.

16 **FIFTH CAUSE FOR DISCIPLINE**

17 **(Failure to Maintain Adequate and Accurate Medical Record)**

18 65. Respondent is further subject to disciplinary action under sections 3527, 2234, 2234,
19 subdivision (a), of the Code, and California Code of Regulations, title 16, section 1399.521,
20 subdivision (a), as defined by 2266, of the Code, in that respondent failed to maintain adequate and
21 accurate records regarding his care and treatment of L.W., N.C., K.D. and S.M., as more fully
22 particularly alleged herein:

23 (a) Paragraphs 27 through 62, above, are hereby incorporated by reference and
24 realleged as if fully set forth herein;

25 (b) Respondent's operative reports for patient's L.W., N.C., K.D. and S.M.
26 were inadequate and failed to convey meaningful information; and

27 (c) Respondent's informed consent forms for patients L.W., N.C., K.D. were
28 improper and inadequate because, among other things, they falsely stated the

1 liposuction surgery would be performed by Dr. J.B. and respondent when, in truth and
2 fact, the surgery was performed solely by respondent; and the written informed
3 consent form for patient S.M. did not clearly indicate the liposuction surgery would be
4 performed solely by respondent

5 **SIXTH CAUSE FOR DISCIPLINE**

6 **(General Unprofessional Conduct)**

7 66. Respondent is further subject to disciplinary action under sections 3527, 2234,
8 2234, subdivision (a), of the Code, and California Code of Regulations, title 16, section 1399.521,
9 subdivision (a), as defined by 2234 of the Code, in that he has engaged in conduct which breached the
10 rules or ethical code of the medical profession or which was unbecoming a member in good standing
11 of the medical profession, and which demonstrates an unfitness to practice medicine, as more
12 particularly alleged in paragraphs 19 through 65, above, are hereby incorporated by reference and
13 realleged as if fully set forth herein.

14 **DISCIPLINARY CONSIDERATIONS**

15 67. To determine the degree of discipline, if any, to be imposed on respondent, complainant
16 alleges that on or about October 26, 2007, respondent was issued a probationary Physician Assistant
17 license based on a Stipulation For a Probationary License (Stipulation) adopted by the then Physician
18 Assistant Committee (Committee). According to the Stipulation, respondent was formerly licensed to
19 practice as a Physician Assistant in New York. On May 29, 2007, respondent submitted an
20 application for physician assistant licensure to the Committee. As part of his application, respondent
21 was asked "Have you ever been convicted or pled nolo contendere to any violation (including
22 misdemeanor or felony) of any local, state, or federal law in any state, territory, country or U.S.
23 federal jurisdiction?" A notice printed above the question warned applicants that "you are required to
24 include any conviction that has been set aside and dismissed or expunged, or where a stay of
25 execution has been issued." Respondent responded "no" which was false because he had been
26 convicted in 1992 in Randolph Township Municipal Court of a violation of N.J.S. 2C:20-3(a), Theft
27 by Unlawful Taking. As a result, respondent was issued a physician assistant license on a
28 probationary basis, subject to the following terms and conditions: three years probation; successful

1 completion of ethics course; requirement to provide notification to his employer and supervision
2 physician concerning his probationary status; monitoring and supervision by a supervising physician;
3 and other standard terms and conditions of probation.

4 PRAYER

5 WHEREFORE, complainant requests that a hearing be held on the matters herein alleged,
6 and that following the hearing, the Physician Assistant Board of California issue a decision:

- 7 1. Revoking or suspending Physician Assistant License Number PA19449, issued to
8 respondent Rodney Eugene Davis, P.A.;
- 9 2. Ordering respondent Rodney Eugene Davis, P.A. to pay the Physician Assistant Board of
10 California the reasonable costs of the investigation and enforcement of this case, pursuant to Business
11 and Professions Code section 125.3; and
- 12 3. Taking such other and further action as deemed necessary and proper.

13
14 DATED: February 3, 2015


15 _____
16 GLENN L. MITCHELL, JR.
17 Executive Officer
18 Physician Assistant Board
19 Department of Consumer Affairs
20 State of California
21 Complainant

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**BEFORE THE
PHYSICIAN ASSISTANT BOARD
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation)
Against:)

RODNEY EUGENE DAVIS, P.A.)

Case No. 1E-2013-230309

Physician Assistant)
License No. PA 19449)

Respondent)
_____)

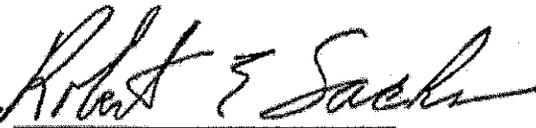
DECISION AND ORDER

The attached Proposed Decision is hereby adopted as the Decision and Order of the Physician Assistant Board, Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 10, 2016.

IT IS SO ORDERED May 13, 2016.

PHYSICIAN ASSISTANT BOARD

By: 
Robert E. Sachs, P.A., President

BEFORE THE
PHYSICIAN ASSISTANT BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

RODNEY EUGENE DAVIS, P.A.,

Physician Assistant License No. PA19449

Respondent.

Case No. 1E-2013-230309

OAH No. 2015040372

PROPOSED DECISION

Susan J. Boyle, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Diego, California, on February 16 through 26, and March 2, 2016.

Martin W. Hagan, Deputy Attorney General, Department of Justice, State of California, represented complainant, Glenn L. Mitchell, Jr., Executive Officer, Physician Assistant Board, Department of Consumer Affairs, State of California.

Robert W. Frank, Attorney at Law, Neil, Dymott, Frank, McFall, Trexler, McCabe & Hudson, APLC, represented respondent, Rodney Eugene Davis, who was present.

The matter was submitted on March 2, 2016.

PROTECTIVE ORDER

The names of the patients in this matter are subject to a protective order. No court reporter or transcription service shall transcribe the name of a patient but shall instead refer to the patient by his or her initials, which were identified during the administrative hearing, are listed in the Confidential Names List (Exhibit 108), and are used in this decision.

SEALING ORDER

Exhibits were admitted into evidence that contain confidential information that is protected from public disclosure. It was not practical to delete this information from these

exhibits. To protect privacy and confidential information from inappropriate disclosure, a written Protective Order Sealing Confidential Records was issued on February 26, 2016, was provided to the parties on the record, and has been marked and admitted as Exhibit 115. This Protective Order governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to this order, provided that such documents are protected from release to the public.

FACTUAL FINDINGS

Jurisdictional Matters

1. On October 30, 2007, the board issued Physician Assistant License No. PA19449 to respondent, Rodney Eugene Davis. The license will expire on August 31, 2017, unless it is renewed.

2. On February 3, 2015, complainant filed the accusation against respondent. Respondent filed a Notice of Defense and Response to Accusation, and this hearing followed.

The Accusation

3. The accusation concerned respondent's ownership of, and employment by, a business entity formed to manage a clinic that provided liposuction surgery. The accusation alleged that respondent engaged in the unlicensed practice of medicine by performing liposuctions without proper skill or supervision (First Cause for Discipline), engaged in gross negligence and committed repeated negligent acts in his care and treatment of four patients (Second and Third Causes for Discipline), engaged in dishonesty and/or corruption by disseminating false and/or misleading advertising (Fourth¹ Causes for Discipline), failed to maintain adequate records (Fifth Cause for Discipline), and engaged in general unprofessional conduct (Sixth Cause for Discipline). Complainant also requested costs of investigation and enforcement pursuant to Business and Professions Code section 125.3.

Respondent's Background and Experience as a Physician Assistant

EDUCATION, LICENSE, AND EXPERIENCE IN PENNSYLVANIA

4. Respondent received a Bachelor of Science degree in exercise science from Rutgers University in 1998. He was admitted to a Physical Therapist program at Touro College in Bay Shore, New York. After one year in the Physical Therapist program, he transferred to the Physician Assistant program, from which he graduated with a Bachelor of

¹ The accusation contains two causes for discipline that are entitled "Fourth Cause for Discipline." Both involve claims of false and misleading advertising; one alleges dishonesty.

Science degree in 2002. He received certification from the National Commission on Certification of Physician Assistants (NCCPA) in 2002.

Respondent described the physician assistant program at Touro College as including hands-on experiences and course work. The first year consisted of coursework that respondent likened to abbreviated medical school classes. After the first year, students participated in five to six week rotations in a variety of medical fields, such as internal medicine, pediatrics, cardiology, thoracic, general, emergency and long term care. He was not required to complete a residency.

5. In his first position after NCCPA certification, respondent worked for one year for a physician who specialized in sports medicine. He worked with patients in the doctor's office and did not assist in the operating room. His job duties included inserting needle-like instruments into knee joints, fingers, joints, aspirating knee joints, and injecting cortisone. His supervising doctor taught him these procedures.

From 2004 to 2007, respondent worked for Brookhaven Orthopedic Associates. He assisted a physician during surgeries and with clinical procedures. He also assisted in reducing fractures and correcting shoulder dislocations. He worked with five or six supervising doctors in the group. As the Brookhaven physicians became more trusting of respondent, he was placed in the on-call rotation with the physicians at a local hospital.

While respondent worked at the Brooklyn clinic, and for an additional year afterwards, he worked weekends at Good Samaritan hospital in West Islip, N.Y. His work involved all tasks except those that involved critical care. Good Samaritan was also a teaching hospital for physician assistants. During his time there, respondent taught and supervised students in the physician assistant program.

LICENSE AND EXPERIENCE IN CALIFORNIA – PRE – PACIFIC LIPOSCULPTURE

6. In 2007, respondent was unhappy in his work environment. He believed his responsibilities and hours of work had increased but he was not being adequately compensated for the extra work. The physician's group he worked for fell behind in payments. Around this time, respondent received a telephone call from a fellow physician assistant who had moved to California. The friend told respondent he was working for a busy doctor in Beverly Hills who was looking for another PA, and he asked respondent if he was interested in applying for the job. The friend said the doctor's practice was limited to performing outpatient liposuctions during which the patients were awake, happy and healthy.

7. Respondent was interested and traveled to Beverly Hills to interview for the job. Respondent met with Dr. Craig A. Bittner, owner of Beverly Hills Liposculpture.² Respondent was impressed with the facility, and Dr. Bittner appeared to be friendly, smart

² The parties stipulated that the term "liposculpture" and "liposuction" are synonymous."

and knowledgeable. When Dr. Bittner offered respondent the position a few months after the interview, respondent gave notice at Brookhaven Orthopedic Associates, and he and his wife moved to California.

APPLICATION FOR LICENSURE AND PROBATIONARY LICENSE

8. On May 26, 2007, respondent signed an application for a California Physician Assistant license. Respondent checked, "No," in response to the question, "Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?"

By letter dated July 26, 2007, the board notified respondent that it had received a report indicating that respondent was convicted of "'theft by unlawful taking' in 1992." The board noted that respondent did not acknowledge the conviction in his application and requested respondent provide an explanation of his failure to disclose the conviction and the facts upon which the conviction was based.

By letter dated August 8, 2007, respondent provided his explanation for the conviction he had not disclosed. He stated he was "deeply disturbed and embarrassed" by the incident that occurred "only weeks after [his] 18th birthday" and was the basis for his being convicted of being a "disorderly person." He said he had not recalled the incident or conviction when he completed his application.

Respondent testified in this hearing consistently with what he wrote in his letter. According to respondent, he and a friend were working at a gas station when respondent was 18 years old. They learned that they could easily access their employer's cash box. They removed small amounts of cash from several envelopes in the cash box over a period of days. Ultimately the employer became suspicious and confronted respondent. Respondent admitted he had been taking cash from the cash box, and the employer called the police. According to respondent, the police officer told him that, if he returned the money to his employer, the officer would not call respondent's parents and the incident would not be a part of respondent's record. Respondent signed some paperwork, paid a fine, and forgot about the incident. Following this incident, respondent obtained his degree from Rutgers University, graduated from the Physician Assistant program, and obtained a license from the State of New York.

As part of his license application process in 2007, respondent provided the board with prosecution and court records relating to his conviction. According to the 1992 records, respondent was charged with two counts of theft of a total of \$690, but the charges were reduced, and he was convicted of a "disorderly persons offense" in municipal court.

Respondent's 2007 letter asked the board to "[p]lease excuse my mistake and accept my sincerest apology."

By letter dated August 14, 2007³, the board, after reviewing respondent's application, letter of explanation and court records, offered to issue respondent a probationary license rather than deny his application. Respondent accepted the offer. Respondent and the board's Executive Officer signed a Stipulation for Probationary License. On October 30, 2007, the board issued respondent a license with a three year probationary term. The terms of probation required respondent to successfully complete an ethics course approved by the board; provide a plan of practice to be monitored by an approved supervising physician; and have a board appointed probation monitor. Upon respondent's successful completion of probation in 2010, his license was fully restored.

Work Performed with Craig Bittner, M.D. at Beverly Hills Liposculpture

DR. BITTNER'S BACKGROUND

9. As noted above in paragraph 7, respondent came to California in 2007 to work with Craig Bittner, M.D., who operated a liposuction clinic. Dr. Bittner was a licensed radiologist before he transitioned into cosmetic surgery. He was not licensed as a plastic surgeon or dermatologist, nor was he board certified in any surgical subspecialty. Radiologists graduate from medical school and then enter a four year residency program that involves specialty medical education and clinical work. Radiologists do not participate in a general surgery internship or a residency. Dr. Bittner was an interventional radiologist, a specialty that involves additional training relating to the use of catheters, wires and other probes.

RESPONDENT'S RESPONSIBILITIES WHILE WORKING FOR DR. BITTNER

10. While respondent was waiting to be licensed, Dr. Bittner allowed him to work as a medical assistant doing tasks that did not require a Physician Assistant license. Respondent also shadowed Dr. Bittner and observed him performing liposuction surgeries.

Dr. Bittner performed tumescent liposuctions. Tumescent is a form of local anesthesia. When undergoing a liposuction using tumescent anesthesia, the patient remains awake. The technique involves infiltration of fat with a solution of saline, lidocaine, and epinephrine (the tumescent fluid). The medical professional makes two or more small incisions in the area of the body to be liposuctioned. Tumescent fluid is infused through the incisions into the fat under the skin, and it numbs the area.

The fat and tumescent fluid is extracted from the body through an instrument called a "cannula." A cannula is a blunt, hollow tube shaped instrument, approximately 12 to 18 inches long, attached to a source of suction. During liposuction, the cannula is repeatedly thrust into and out of the patient's body through the small incisions. Fat, blood and infiltration fluid is suctioned from the patient through the cannula into a container.

³ The first page of the letter is erroneously dated August 14, 2006; the second page contains the correct date.

11. As part of respondent's training, Dr. Bittner required respondent to hold the cannula to feel its weight and become familiar with it.

12. When respondent's probationary license was issued, Dr. Bittner became respondent's supervising physician. The board assigned Dennis Rodriguez to be respondent's probation monitor.

After respondent received his Physician Assistant license, he learned and performed part of the tumescent infiltration phase of the liposuction surgery under Dr. Bittner's direct supervision. Respondent testified that, under Dr. Bittner, he administered an anesthetic which was 95% local and 5% nitrous oxide.⁴ After he became more experienced, respondent performed the full tumescent infiltration phase of the liposuction surgery.

After respondent performed the full tumescent phase successfully for all of Dr. Bittner's patients in a one week period, Dr. Bittner began to allow him to perform the suctioning work. First he watched Dr. Bittner, and then he performed the procedure while Dr. Bittner watched him. After some time, respondent performed the entire procedure himself. For the first two to three months after he began performing the liposuction surgery himself, Dr. Bittner came into the procedure room and checked his work. When Dr. Bittner believed respondent could competently perform the liposuction surgery, respondent performed the procedure by himself in a separate operating suite with limited oversight from Dr. Bittner.

Respondent testified patients often wanted liposuction surgery on three to four areas of the body. The abdomen and love handles were the most common areas where patients sought liposuction. Respondent made two or more incisions in each area for the cannula to be inserted. In the beginning of his work with Dr. Bittner, respondent was involved in some way with the procedures performed on approximately five patients per day. Respondent testified that he performed "several thousand procedures"⁵ alone while he was working for Dr. Bittner.

Respondent became disillusioned with Dr. Bittner. Dr. Bittner was beginning to have problems with patients, and one patient started a website to damage Dr. Bittner's reputation.

⁴ Using nitrous oxide converts the procedure to one categorized as being performed under general anesthesia.

⁵ Respondent assisted Dr. Bittner and performed liposuctions for a maximum of 12 months, which includes the time he was doing only the tumescent portion of the procedure. To have performed 2,000 liposuctions in one year, respondent would have had to have done more than five procedures every single day of the year. To have performed 3,000 liposuctions in one year, respondent would have had to have done more than eight procedures every day of the year. To justify his numbers, it appears respondent counted each section of the body on which he performed liposuction as a "procedure," even when the surgery is performed on the same patient.

This website included a section about respondent, which Dr. Bittner knew about but did not disclose to respondent. There were other aspects of Dr. Bittner's practice that respondent did not like, and he left Dr. Bittner's employ in September 2008.⁶

13. No evidence was presented to suggest that respondent's probation monitor, Mr. Rodriguez, disapproved of respondent working for Dr. Bittner. No charges were brought by the board against respondent, and no challenges to respondent's working arrangement were raised while he worked for Dr. Bittner.

14. After leaving Dr. Bittner's employment, respondent went to work for Physicians and Surgeons Network where he reviewed requests for approval of medical procedures submitted to insurance companies. It was a sedentary job and respondent stayed there for only three to four months.

Work Performed with Dr. Calhoun

15. In early 2009, respondent answered an advertisement for a physician assistant placed by Dr. Kevin Calhoun. Dr. Calhoun had two offices in which he performed cosmetic surgery – chiefly liposuction, and he was opening another location in Los Angeles. He was looking for staff for the new location. Respondent told Dr. Calhoun that he had a probationary license and what that entailed. Dr. Calhoun offered respondent a position with his clinic and provided him a Delegation of Services Agreement (DSA). The DSA described the services respondent was authorized by Dr. Calhoun to provide on Dr. Calhoun's behalf.

On April 13, 2009, respondent emailed Mr. Rodriguez and advised him that Dr. Calhoun offered him a position as a physician assistant. He noted that Dr. Calhoun had two cosmetic clinics in San Diego and was opening a third in Los Angeles. Respondent stated that "initially" he would be commuting to each of the three offices. He told Mr. Rodriguez that the clinics did "laser procedures, injectables, and outpatient liposuction." Mr. Rodriguez responded that Dr. Calhoun would be approved as respondent's supervising physician once all required documents, including the DSA, were received. In a subsequent email, Mr. Rodriguez acknowledged that he had received some documents from respondent but was waiting for the DSA. He stated that "as soon as I receive [the agreement], you can start [working for Dr. Calhoun]."

No evidence was presented that Mr. Rodriguez disapproved of respondent working for Dr. Calhoun. The only evidence of what Mr. Rodriguez was told about respondent's working arrangement with Dr. Calhoun was provided by respondent and contained in the emails between respondent and Mr. Rodriguez. No charges were brought by the board against respondent when he worked for Dr. Calhoun.

⁶ Subsequent to respondent's leaving his employ, the Medical Board filed disciplinary charges against Dr. Bittner, and Dr. Bittner surrendered his medical license.

DR. CALHOUN'S BACKGROUND

16. Dr. Calhoun was board certified in Emergency Medicine. He transitioned to performing liposuction after taking a two to three day course in 2007 and a three day course in 2009. Emergency room physicians must complete a residency. They do not complete a general surgery rotation, but may participate in rotations in various specialties, such as trauma surgery. They are also taught some procedures in general surgery, such as placing chest tubes.

RESPONDENT'S RESPONSIBILITIES WHILE WORKING FOR DR. CALHOUN

17. Despite his original understanding, respondent worked primarily at Dr. Calhoun's clinics in San Diego where he performed liposuction procedures by himself.⁷ In "maybe two" cases patients specifically requested Dr. Calhoun; in those cases respondent assisted Dr. Calhoun.

As he did in Dr. Bittner's office, respondent administered an anesthetic which was 95% local and 5% nitrous oxide. Respondent stated his use of nitrous oxide was permitted in the DSA with Dr. Calhoun and he did not know a physician assistant was not permitted to administer nitrous oxide. Respondent did not know whether Mr. Rodriguez was aware that respondent was administering nitrous oxide.

Dr. Calhoun's clinic was not as efficient as it could have been, and respondent was sometimes concerned that Dr. Calhoun would go out of business. Within the first few minutes of respondent's first day with Dr. Calhoun, 90% of the staff quit. There were some days when Dr. Calhoun did not have any patients booked for procedures.

Dr. Calhoun made changes in his office procedures and business gradually increased to an average of four patients per day. Dr. Calhoun also downsized to two clinics. Respondent worked six days a week and traveled between the clinics. Respondent testified he did "a lot" of liposuction surgeries when he was employed by Dr. Calhoun. He estimated that in the one and one-half years he worked with Dr. Calhoun, he performed 3,500 to 4,000 liposuctions.⁸ He estimated that if he did 4,000 procedures, only 200 were with nitrous oxide.⁹

⁷ It was not clear if Dr. Calhoun was in the clinic when respondent performed liposuction by himself.

⁸ Again, respondent appears to have calculated these numbers by counting each part of the body upon which liposuction was performed and not by counting each patient.

⁹ The numbers are difficult to compare. If nitrous oxide was given, it was to a patient who may have had more than one area worked on; therefore, the percentage of procedures performed under nitrous oxide would increase. The accusation does not allege that

18. Dario Moscoso was Dr. Calhoun's business manager. Mr. Moscoso and respondent complained to each other about Dr. Calhoun and his business practices and the increasing responsibilities he placed on them. Respondent stated that Mr. Moscoso told him he had a master degree in business administration from University of Southern California (USC). Respondent believed Mr. Moscoso's representations in the beginning, but later began to doubt him.

19. One day after Dr. Calhoun required respondent perform a liposuction surgery that Dr. Calhoun was scheduled to perform, respondent had a "heated discussion" with Dr. Calhoun. Respondent was upset because he and Dr. Calhoun had an agreement about the number of patients respondent would handle, and respondent believed that Dr. Calhoun's actions violated their agreement. Respondent was frustrated with the way Dr. Calhoun ran the business. Respondent felt that he (respondent) was doing all the work at the clinic but not receiving a fair compensation. He wanted more control over the management side of the business.

Mr. Moscoso overheard the argument between respondent and Dr. Calhoun and tried to mediate it. Dr. Calhoun "dared" respondent to find a better deal than the one offered by Dr. Calhoun.

Afterwards, Mr. Moscoso pulled respondent aside. He told respondent that respondent did not have to stay with Dr. Calhoun. Mr. Moscoso said there were a lot of physicians that would love to have a physician assistant with respondent's skills. In fact, Mr. Moscoso said he had already been looking into what a physician assistant could do on his or her own. Respondent told Mr. Moscoso that he was tired of working for someone who was making all the money for respondent's work.

In June 2010, Mr. Moscoso and respondent began talking about starting their own business. They contacted California Academy of Physician Assistants (CAPA) and San Diego attorney, Michael Scarano. Mr. Scarano wrote a handbook for physician assistants that was approved by CAPA.

CREATION OF PACIFIC LIPOSCULPTURE, INC.

20. After his falling out with Dr. Calhoun, respondent and Mr. Moscoso made the decision to go into business together, and they formed a management services organization (MSO) to manage a liposuction clinic. In order to have the control he wanted and get the pay he believed he deserved, respondent determined that he would be the only person who would perform liposuctions for Pacific Liposculpture, Inc. On August 3, 2010, weeks before respondent left his position with Dr. Calhoun, respondent and Mr. Moscoso formed Pacific Liposculpture, Inc., and filed its Articles of Incorporation with the California Secretary of State. Respondent was listed as CEO for the corporation, and Mr. Moscoso was listed as the

respondent is subject to discipline because he improperly used nitrous oxide when he performed liposuction surgeries.

agent for service of process. The type of business was described as providing “[m]anagement services for liposculpture office.” Mr. Moscoso stated that he held a 30 percent interest and respondent held a 70 percent interest. Respondent was in charge of all the clinical aspects of the business, and Mr. Moscoso was in charge of all the administrative aspects. By November 21, 2011, the company was 100 percent in respondent’s name.

In accordance with their plan, respondent left his employment with Dr. Calhoun.¹⁰ He and Mr. Moscoso obtained a lease for an office and equipped the office with the necessary equipment and furniture. They hired staff, and set up accounts for vendors. Mr. Moscoso worked on creating a preliminary website, which responsibility was later transferred to a professional web designing company.

ADVERTISING FOR A MEDICAL DIRECTOR

21. Respondent knew he could perform liposuctions only in a medical office, and he knew that to have a medical office he needed a Medical Director. He also knew that the Medical Director had to be a physician trained in liposuction. Respondent and Mr. Moscoso intended from the inception that respondent would perform all of the liposuction surgeries for the business their corporation would manage. To that end, respondent and Mr. Moscoso set out to find a figurehead who would not interfere in the business. This strategy would allow respondent to have control over the surgeries he performed and make the amount of money he felt he should have been receiving from Drs. Bittner and Calhoun.

Mr. Moscoso placed an advertisement on Craigslist seeking a medical director for a liposuction clinic.¹¹ Seven or eight physicians responded to the advertisement, including Jerrell Lawrence Borup, M.D. Five physicians were interviewed by telephone and two, Dr. Borup and another, were invited in for an in-person interview.¹²

DR. BORUP’S BACKGROUND AND EXPERIENCE

22. Dr. Borup graduated from the Universidad Autonoma de Guadalajara, Guadalajara, Mexico in 1978. From 1978 until 1998, Dr. Borup specialized in anesthesia. In 1983, he published an article. In February 1998, he suffered a stroke that left him unable to practice medicine while he underwent rehabilitation and recuperation.

¹⁰ Subsequent to respondent’s leaving his employment with Dr. Calhoun, the Medical Board filed charges against Dr. Calhoun and his license was disciplined by the Medical Board.

¹¹ Although it was not raised at the hearing, it is noted that non-physician owned corporations cannot employ physicians. (Bus. & Prof. Code, § 2400; *Conrad v. Medical Bd. Of California* (1996) 48 Cal.App.4th 1038.) Exceptions to this rule of law are not applicable here.

¹² Dr. Borup testified at the hearing.

In March 2010, Dr. Borup believed he was able to return to some form of medicine. He had an interest in anti-aging medicine and took courses to learn to perform medical aesthetic procedures, such those using fillers and laser technology. He also had an interest in liposuction surgery.

Dr. Borup had no surgical experience, with the exception of a one and one-half month rotation in surgery during his internship, when he assisted a physician and did "grunt work." His internship also included a short rotation in dermatology.

From 1984 to 1998, Dr. Borup worked as an anesthesiologist, and he provided general anesthesia for, and was present during, hundreds of liposuction surgeries. In the mid-1980s physicians began to perform liposuctions under local anesthesia. Dr. Borup believed tumescent liposuction was safer for the patient than general anesthesia. Dr. Borup also administered epidurals in which he was required to find space in tissue planes, which he testified was similar to what is done in liposuction.

In 2010, Dr. Borup did not have staff privileges at any hospital. He testified that a position as medical director of a liposuction clinic, with an experienced physician assistant overseeing the business, was appealing to him. He believed he could learn how to become proficient in the procedure from respondent.

HIRING A MEDICAL DIRECTOR

Respondent had input into which doctors were to be interviewed for the medical director position. According to Mr. Moscoso, respondent's primary consideration was that he did not want someone as medical director who wanted to be involved in the business.

Respondent interviewed Dr. Borup and learned of his lack of experience and training in liposuction. When Dr. Borup told respondent that he hoped to perform some liposuction surgeries, respondent convinced him to leave those procedures up to him.

Respondent stated that because he and Mr. Moscoso were just starting a business, they could not risk negative patient feedback by allowing an inexperienced physician to perform liposuctions for Pacific Liposculpture. Respondent stated that liposuction involved "safety and art." He knew Dr. Borup's attempts would not be up to "acceptable standards" and respondent could "take care of the art side and keep a good reputation." Respondent also stated prospective patients were looking at before and after photographs of liposuctions that respondent had performed. He believed it was "more straightforward" for him, as the person whose photographs they saw, to do the procedure. Dr. Borup testified that when he observed respondent, he saw how proficient respondent was at performing liposuction, and he agreed that respondent should perform all of them.

Respondent suggested that, although Dr. Borup's only real experience and training was in anesthesia, with the exception of limited experience in anti-aging cosmetic

procedures,¹³ Dr. Borup's "new specialty" was liposuction despite the fact that Dr. Borup had not had any training related to liposuction to that point.

Respondent told Mr. Moscoso that Dr. Borup was perfect for what they needed. A second interview was scheduled for Dr. Borup and was held at the Pacific Liposculpture, Inc., office. In this interview, respondent and Mr. Moscoso went over the structure of Pacific Liposculpture, Inc., and what they were looking for from a medical director. Respondent and Mr. Moscoso told Dr. Borup that they had incorporated a MSO that would provide everything needed to open a liposuction clinic, other than a physician to run it. Pacific Liposculpture, Inc., procured the lease on the premises, obtained the equipment and office furniture, provided the décor, and hired the staff. Mr. Moscoso acted as an office manager. Dr. Borup was to establish a business called Pacific Liposculpture and that business was to hire respondent as an independent contractor to perform liposuction surgeries. Respondent set up a separate business for his independent contractor services. For his role as medical director, Dr. Borup was to receive a percentage of the gross revenue generated by Pacific Liposculpture. During this process, respondent consulted with attorneys to determine how to set up these businesses, and he consulted Mr. Scarano's handbook, which respondent said he read through many times.¹⁴

Respondent testified that he liked Dr. Borup and Dr. Borup liked him. Respondent appreciated that Dr. Borup's experience was in anesthesiology, and he felt Dr. Borup could help ensure the procedures at Pacific Liposculpture focused on patient safety. Along these lines, both Dr. Borup and respondent agreed that Dr. Borup refused to allow respondent to administer nitrous oxide to any patient.

THE DELEGATION OF SERVICES AGREEMENT

23. On August 11, 2010, Dr. Borup and respondent signed a "Delegation of Services Agreement Between Supervising Physician and Physician Assistant (Title 16, CCR Section 1399.540) and Protocols." The DSA authorized respondent to perform specific tasks permitted by the California Code of Regulations and other tasks as authorized "when acting under [Dr. Borup's] supervision."

The DSA specifically authorized respondent to evaluate whether a patient was an appropriate candidate for liposuction, unless the patient is a "high risk patient with any kidney, liver, or heart disease . . ." High risk patients were to be referred to Dr. Borup and

¹³ In or around this time Dr. Borup was, or became, the medical director of a business called "Spa324" that did laser and filler work.

¹⁴ Mr. Scarano's book, at Chapter 2, page 5, in discussing the requirement that a supervising physician can delegate only tasks and procedures consistent with his or her usual and customary practice, states, "On the other hand, a family practitioner with no training or experience in laser dermatology would not be able to hire a PA with such training in order to expand his or her practice to include dermatological laser procedures."

were required to obtain a "full physical and clearance" by their primary doctor or cardiologist. The DSA authorized respondent to determine whether the areas of the body a patient sought to have liposuctioned were appropriate for liposuction. He was authorized to discuss risks, benefits and alternatives of liposuction with patients, review the informed consent form with them, answer questions, educate the patient and obtain their signatures on the forms. He was authorized to perform a history and physical exam prior to anesthesia and liposuction. Any patient with contraindications was required to have his or her case reviewed by Dr. Borup before the procedure began.

The DSA authorized respondent to inject the "saline-based lidocaine/epinephrine anesthesia into the patient's subcutaneous fat in the area marked to be treated until the targeted tissues become swollen and firm ('tumescent')." The DSA provided a chart with the range of volume of tumescent anesthesia that could be used depending on the area to be treated. It was explained at the hearing that the acceptable volume is determined by a standardized formula that relies on the amounts of anesthesia listed in the chart and the patient's body weight as its main factors. Despite Dr. Borup and respondent's assurances that Dr. Borup would not permit respondent to administer nitrous oxide, the DSA authorized respondent to use nitrous oxide "as an additional sedative for patients who require additional, further sedation and pain relief." The amount of nitrous oxide permitted was limited to 30 percent nitrous oxide to 70 percent oxygen. Neither Dr. Borup nor respondent explained why the DSA authorized respondent to administer nitrous oxide.

Respondent was authorized to provide post-procedure medications as described in the DSA.

The DSA authorized respondent to mark the areas of the patient's body that were to be treated; to make "round skin biopsy punches" (incisions) in the marked areas; inject the tumescent anesthesia; insert the cannula through the incisions and perform the liposuction (debulking). After debulking, "the PA or Dr. Borup will review the liposuction and perform or oversee the desired blending to ensure optimal contouring of the subject area."

The DSA also provided for post-procedure evaluation and discharge, which included wrapping the patient and assisting him or her into a post-operative compression garment; providing post-operative instructions to the patient; taking post-operative photographs; asking the patient about pain or discomfort; completing a discharge form; and discharging the patient to a responsible adult.

The DSA required respondent to consult with Dr. Borup for any high risk patients when complications arise, when the patient requested to speak to a physician, or when any condition occurs "which the PA feels exceeds his/her ability to manage, etc."

The DSA required respondent to be familiar with the Medical Emergency Plan which included directing staff to call 911.

The DSA was sent to respondent's probation monitor, Mr. Rodriguez, for approval of respondent's relationship with Dr. Borup. It is noted that it would be difficult, if not impossible, for any individual to evaluate or determine the true nature of respondent's and Dr. Borup's relationship by looking only at the DSA.

24. On August 14, 2010, after signing the DSA, respondent sent an email to Mr. Moscoso that initially referenced Mr. Rodriguez.¹⁵ The remainder of the email stated:

I sent Dr. Borup some info this morning about the course but he didn't reply back. I hope that he will be able to stick with our system once [he] has some knowledge. It's good to know that Dr. Caldron would be willing to be the medical director for both offices if we ever asked. I'm glad that we're making a contract that will allow for us to make immediate changes in that position if ever needed. **We don't want another clumsy physician getting in the way.** (Emphasis added.)

Although respondent at the hearing attempted to interpret this email otherwise, it clearly stated respondent's position that he wanted to operate the liposuction business without interference from anyone, particularly a physician. The email reflected respondent's desire that Dr. Borup be and remain a silent partner in the liposuction business. Respondent's "system" did not include a physician who wanted to perform liposuctions.

25. On or about September 20, 2010, Mr. Moscoso, as Chief Financial Officer of Pacific Liposculpture, Inc., and Dr. Borup signed a 14 page Management Services Agreement (agreement). Dr. Borup was described as a "Group" in the agreement. The agreement provided that Dr. Borup would "retain the services" of Pacific Liposculpture, Inc. to "provide the facilities, equipment, supplies, and management and administrative personnel and services required for [Dr. Borup] to conduct [his] Practice related to the provision of liposuction and similar cosmetic procedures." The agreement specifically stated that Pacific Liposculpture, Inc. "shall have no authority over medical aspects of [Dr. Borup's business.]" Under the agreement, the name Pacific Liposculpture and all derivations remained the property of Pacific Liposculpture, Inc.

26. In September 2010, after he had agreed to be the medical director of Pacific Liposculpture, and after the DSA was signed, Dr. Borup attended a one week video training course about liposuction and one weekend of hands-on training in liposuctions. During the weekend course, Dr. Borup performed two liposuctions under the direct supervision of an instructor. It was not clear if Dr. Borup performed the entire procedure or participated in part of a procedure. Dr. Borup never performed or participated in another liposuction procedure.

¹⁵ Respondent's probationary period would terminate two months later.

On December 21, 2010, Dr. Borup filed a fictitious business name statement for "Pacific Liposculpture" with the San Diego County Clerk. Dr. Borup represented that the business started on September 20, 2010, and that it was conducted by an individual.

Dr. Borup left Pacific Liposculpture on September 30, 2013, to retire with his wife.

False or Misleading Advertising

27. In the accusation, complainant alleged respondent "made and disseminated or caused to be made and disseminated, false and/or misleading advertising . . ." Complainant alleged respondent engaged in false or misleading advertising when he assumed the title of Director of Surgery, failed to define "PA" or "PA-C," made false statements about Dr. Borup's training and qualifications, failed to timely correct patient testimonials or reviews on-line that referred to respondent as "Dr. Rod," posted photographs and videos of himself in scrubs and performing liposuctions, and posted patient testimonials that did not accurately convey liposuction surgeries and risks associated with the surgeries.

28. On September 17, 2010, respondent sent an email to Mr. Moscoso. The email stated that respondent "changed around a few things" in Dr. Borup's bio. He requested that Mr. Moscoso remove Dr. Borup's resume on Pacific Liposculpture's website and replace it with the attached bio entitled "Meet our Medical Director." The attachment to respondent's email includes the following:

Dr. Jerrell Borup is an accomplished board certified physician with over 20 years experience. His highly trained liposculpture team will help to minimize your risks while offering you the best possible care with *awake liposculpture* under local anesthesia! You'll benefit from all of his training and expertise in advanced technologies and anti-aging medicine

Throughout his career, Dr. Borup was Chief of Staff, Chief of Anesthesia department, and chair of quality assessment at Cox Medical Centers, as well as president of Ozark Anesthesia Associates in Springfield, MO. Dr. Borup is a published physician and a captain in US Naval Medical Corps for more than 30 years which allowed him to develop extensive experience in medicine. (Emphasis in original.)

[¶] . . . [¶]

Dr. Borup's bio was misleading on its face and by implication. Although Dr. Borup had 20 years' experience as a physician, it was not in the field of cosmetic or plastic surgery or liposuction. His "highly trained team" consisted only of respondent. No patient would benefit from Dr. Borup's training and expertise as he had none in liposuction and would not be performing any. His experience in anti-aging medicine was completely unrelated to

liposuction surgeries: Although technically Dr. Borup was a published physician – he published only one article, and the quality of the publication in which his article appeared is unknown. Dr. Borup may have been an excellent anesthesiologist; however, the evidence did not support a finding that he had extensive experience in cosmetic or plastic surgery or liposuction.

29. In another email that day, respondent told Mr. Moscoso that Merchant eNet Technologies, Inc. (Merchant), a company hired to redesign Pacific Liposculpture's website, was starting that day, and he and Mr. Moscoso would have "plenty of opportunities to make sure that [the website] is in line with our vision as they work on it and get our feedback." Emails from Merchant concerning the redesign were directed to respondent, and he forwarded them to Mr. Moscoso. Respondent did not include Dr. Borup in the loop.

30. A September 29, 2010, press release announced that "Pacific Liposculpture, Inc. has officially opened the doors to their new premier lipo clinic in the UTC area."¹⁶ The press release went on to say that "Pacific Lipo is the premier practice for San Diegan's liposuction needs. . . . Pacific Lipo uses the most technologically advanced medical techniques and skilled professionals, having performed over 10,000¹⁷ procedures – liposculpture is all they do and thus makes them the most experienced and best at what they do!"

Although it is unlikely that Pacific Liposculpture was the "premier practice" for liposuction if it had just opened its doors, this language is found to be puffing. However, Pacific Liposculpture did not have the most "skilled professionals," it had respondent, a physician assistant.

The same day, Pacific Liposculpture received an inquiry from a perspective patient. Respondent responded that he was "now the Director of Surgery for the Pacific Lipo team and perform all of our procedures."

31. On October 2, 2010, respondent circulated to Pacific Liposculpture's staff a list of common questions that may be asked by patients and prospective patients and suggested responses to those questions. Among the questions and answers were:

¹⁶ A copy of the press release was attached to an October 2, 2010, email from respondent to Mr. Moscoso.

¹⁷ This calculation claims 11 liposuctions per day, seven days a week, given the maximum time respondent could have been performing liposuctions was two years, six months. The number increases to 13 a day if Sundays, but no holidays or vacations, are removed.

Who does the procedure?

Rod Davis is our **Director of Surgery** and he performs all of our procedures. He is **nationally certified** and **specializes in liposculpture**. He has **performed over 10,000 procedures**, more than most physicians. **Our office has a perfect safety record, not even an infection and we have never experienced a serious complication.** Rod is licensed in both California and New York. (Emphasis in original.)

[¶] . . . [¶]

What supplies are included with the procedure?

All patients will be given the initial stage postoperative garment and all necessary medications including an antibiotic and a pain reliever. A care package complete with extra pads and bed liners will also be provided as well as written postoperative care instructions.

[¶] . . . [¶]

Will I need to return to the office for follow up visits?

Our patients are encouraged to return to the office for follow up visits at 1 week, 1 month, 3 months, and 6, and 9 months. Those patients that don't live locally are asked to email updated photos to our office which allows for virtual follow-up evaluations to be conducted by phone with one of our specialists.

It was disingenuous and misleading to tell prospective patients that Pacific Liposculpture had a perfect safety record when it had been opened only a few weeks. Respondent explained he used this language because the business had just opened, he was committed to a lease of the office, and he was nervous about attracting customers and having income. He believed the statement was not misleading because he was the practitioner doing the procedures and, in the past, he had not had complaints of infection or complications from his patients.

The suggestion that the Director of Surgery was nationally certified, specialized in liposculpture, and was licensed in California and New York without mentioning he was a physician assistant intentionally obscured the fact that he was not a medical doctor. The statement that respondent had performed more liposuction "than most physicians" was particularly misleading given it can have two meanings.

Assuring patients that they can have a virtual follow-up with “one of our specialists” was also misleading since the only “specialist” on staff was respondent, who was not a physician.

32. On October 12, 2010, Merchant provided respondent and others with an update on the progress of the new website. Merchant indicated the website would be launched after it received final approval. This email chain was forwarded to Mr. Moscoso by respondent.

On November 26, 2010, in an email to Mr. Moscoso, respondent noted, “We get questions about Borup being an anesthesiologist so now I wonder if those descriptions are helpful or if they just bring more attention to the fact that he is not a plastic surgeon.”

In an email dated December 6, 2010, respondent sent an email to Pacific Liposculpture’s staff and Mr. Moscoso to which he attached “bullet points regarding [his] background to make it easier to answer questions over the phone.” The bullet points mentioned that respondent was a certified physician assistant and contained a description of physician assistants as a “highly trained health care professionals licensed to practice medicine under a Medical Director or supervising physician.” This description identified respondent as a physician assistant and more accurately stated the limitations of his ability to perform medical procedures.

On January 13, 2011, respondent told his marketing company not to create a bio for himself or Dr. Borup. He stated, “We prefer to keep the current bio for Dr. Borup so we can go live on the main site.”

33. A screen capture of Pacific Liposculpture’s website¹⁸ from February 11, 2011, contained a section called, “Meet your Pacific Liposculpture Medical Director.” This section almost entirely consisted of falsehoods and misleading statements as follows:

Dr. Borup, along with his highly trained liposculpture team, will help to minimize your risks while offering you the best possible care;¹⁹

Because of Dr. Borup’s advanced training and expertise in liposuction technology Pacific Liposculpture’s procedures significant reduce pain, swelling and bruising²⁰

¹⁸ The board provided snapshots of Pacific Liposculpture’s website content as captured by a business that provides this service.

¹⁹ This statement was also contained on the website on August 19, 2011; September 2, 2011; December 19, 2011; and June 23, 2012.

[Dr. Borup] is highly published and has extensive experience in his field²¹

Dr. Borup supervises a team of highly trained liposuctionists with a combined experience of well over 10,000 lipo procedures.²²

Members of his team have participated in the liposculpture training of physicians and have authored several articles on various subjects from advanced lipo techniques to health and wellness.²³

As Medical Director of PL, Dr. Borup offers patients a lifetime of experience and knowledge in his state-of-the-art outpatient surgical center.²⁴

34. In a screen capture of Pacific Liposculpture's website from February 14, 2011, Pacific Liposculpture represented, among other things, that the team was "comprised of only the most skilled medical professional who long ago decided to specialize in advanced liposculpture (lipo) techniques."²⁵ The website also contained a section for patients traveling from out of town. The website offered out of town patients a "virtual consultation" and asked patients to "please send along digital photos of the areas in question" to Pacific Liposculpture's email address.²⁶

²⁰ This statement was also contained on the website on August 19, 2011; September 2, 2011; December 19, 2011; and June 23, 2012.

²¹ This statement was also contained on the website on August 19, 2011; September 2, 2011; December 19, 2011; and June 23, 2012.

²² This statement was also contained on the website on August 19, 2011; September 2, 2011; and December 19, 2011. The statement was contained on the website on June 23, 2012, but the number was increased to 15,000.

²³ This statement was also contained on the website on September 2, 2011; December 19, 2011; and June 23, 2012.

²⁴ This statement was also contained on the website on December 19, 2011, and June 23, 2012.

²⁵ This statement was also contained on the website on August 8, 2011; September 3, 2011; January 10, 2012; and June 28, 2012.

²⁶ This statement was also contained on the website on September 1, 2011; January 14, 2012; and June 23, 2012.

35. By email on March 1, 2011, respondent referenced an upcoming meeting he and Mr. Moscoso were having with their attorney concerning Dr. Calhoun. The email included a list of talking points that respondent told Mr. Moscoso they should mention at the meeting. The substance of the talking points implied that Dr. Calhoun was blaming respondent for the downfall of his office and accusing Pacific Liposculpture of wrongdoing. The talking points included the following:

a. Respondent wrote that all of the photographs on the website were of patients whose procedures were performed solely by respondent. Respondent also claimed to have taken the photographs. Because respondent was "the only practitioner performing lipo at Pacific Lipo," the photographs accurately reflected his work. He asserted that Dr. Calhoun had photographs of patients on his website whose procedures were performed by respondent.

b. Respondent asserted that Dr. Calhoun's practice was failing because "he is not experienced in performing liposculpture"

c. Respondent asserted that it was his ideas, including marketing to the military, offering free touch ups, and picking up Airgas in person rather than paying for delivery, which helped save Dr. Calhoun's business from failure.

36. In an email dated May 18, 2011, to Mr. Moscoso and Pacific Liposculpture's staff, respondent provided a more detailed description of who he was and his experience. He suggested his "bio" be included in emails for patients expressing a concern about "the qualifications of the treating practitioner." The bio clearly described respondent as a "Professional Physicians Assistant (PA)." It also provided information about professional physician assistant organizations he was accredited or credentialed through. The bio discussed activities respondent was involved in "[i]n addition to his work as a Physician Assistant."

37. In a screen capture of Pacific Liposculpture's website from June 23, 2012, Pacific Liposculpture offered out of town patients "an in-person consultation and procedure in the same day."

38. On June 10, 2013, respondent sent an email to Pacific Liposculpture's marketing director that included a direction to have the webmaster "add a bio about [respondent] under Dr. Borup's bio."

39. On October 14, 2014, Pacific Liposculpture's website, contained a section entitled "About Us," and referred "[o]ur highly trained experts" The description was somewhat of a departure from the earlier website content and stated:

Our team is comprised of only the most skilled medical professionals who long ago decided to specialize in advanced liposculpture (lipo) techniques. You will also have the

advantage of being treated in our state-of-the-art outpatient surgical suite which provides the latest in technical sophistication that features pleasing, elegant décor.

The website described respondent as a physician's assistant who held various certifications and endorsements and who was the "Director of Surgery" for various liposuction procedures.

RESPONDENT'S TESTIMONY

RE: MISLEADING STATEMENTS

40. Respondent stated that he used a webmaster to design Pacific Liposculpture's website, and that he never had access to website himself. However, the email exchanges described above confirm that respondent reviewed the content of the website, was required to approve it, and had the ability to instruct the webmaster to make changes. Respondent testified he had improvements made to Pacific Liposculpture's website to make it less misleading by adding his credentials above photographs on the site. Respondent conceded, however, that it would have been clearer to expressly state that he was a physician assistant rather than to cite to his credentials by using the abbreviation "PA" or "PC-c." Respondent's assertion that the average lay person knew that "PA" stood for physician assistant is rejected. Given the widespread use of initials for every medical professional and specialty area, it is found that most individuals would not have known what the initials "PA" stood for or their significance.

Respondent did not believe that referring to Dr. Borup as "highly trained" was misleading because he had 20 years experience as an anesthesiologist and he took courses in anti-aging medicine and liposuction. He also did not believe it was misleading to refer to a "trained team." The team was him, a medical assistant, and Dr. Borup. He understood that portions of the statement could be misunderstood. Respondent agreed that the description of Dr. Borup as having "advanced training and expertise in liposuction technology" and as being "highly published" was not accurate, and he wished it was worded differently. In retrospect, he also would not emphasize in marketing materials that Dr. Borup was the medical director of Pacific Liposculpture. He did not believe other statements were inaccurate. Although respondent considered himself the only "highly trained expert" at Pacific Liposculpture, he used the plural of expert because he planned to grow and add more trained individuals to the staff.

Dr. Borup testified he had no involvement in creating or managing Pacific Liposculpture's website. He stated he provided materials that he believed might be used on the website. The wording of the information he provided was changed when it was put on the website. He reviewed the content of the website and did not find anything to be inaccurate. He testified he was not involved in the videos that were on the website. His testimony in this regard was credible.

RE: DIRECTOR OF SURGERY

41. Respondent testified that Dr. Calhoun suggested respondent have the title Director of Surgery. When he opened Pacific Liposculpture, he decided to keep the title, and Dr. Borup agreed. He thought the title communicated to patients that the doctor above him [Dr. Borup] trusted him with the duties he was performing. He did not think the title was misleading; he thought it was helpful. He noted that his bio referred to him as a physician assistant.

Respondent testified that he does not use the title "Director of Surgery" any longer because the medical board thought it was misleading and it was not necessary, so "why invite scrutiny." Respondent submitted evidence of five nurses and one physician assistant who have used the title "Director of Surgery" in other states. The evidence does not describe the duties of the individuals using the title, and the evidence submitted does not suggest the individuals were performing surgery as part of their duties. Respondent's use of the title Director of Surgery was misleading because respondent was not coordinating surgery, but performing it himself.

Respondent conceded that video content connected to Pacific Liposculpture's website may still have identified him as the "Director of Surgery. He stated he was trying to remove that title from all of Pacific Liposculpture's marketing materials.

EXPERT TESTIMONY RE: RESPONDENT CALLING HIMSELF "DIRECTOR OF SURGERY"

42. Michael J. Sundine M.D., F.A.C.S., testified as an expert in this matter.²⁷ Dr. Sundine testified that, in his experience of having practiced in 14 hospitals and 14 surgical centers, the title Director of Surgery was not given to non-physician staff. He stated the title Director of Surgery is the same as Chief of Surgery. These titles are given to a senior surgeon with a long track record of leadership and positive results in a surgical setting. In his experience, he had never heard of a physician assistant being given the title of Director of Surgery.

Dr. Sundine believed that respondent, as the person in charge and most knowledgeable of the day-to-day operations of Pacific Liposculpture may have been the Director of Operations, but he could not properly identify himself with the title "Director of Surgery." Dr. Sundine opined that the use of the title had the effect of bestowing credentials on respondent that respondent did not have, and that its use was misleading. Dr. Sundine's opinion was reasonable.

43. Terry J. Dubrow, M.D., F.A.C.S., also testified as an expert in this matter.²⁸ Dr. Dubrow testified that he was familiar with the title "Director of Surgery." His

²⁷ Dr. Sundine's credentials are described *infra*.

²⁸ Dr. Dubrow's credentials are described *infra*.

understanding was that the title described a person "charged with directing surgery." Dr. Dubrow was familiar with the title being given to a nurse at University of California, Irvine Medical Center approximately seven to eight years ago. Dr. Dubrow did not state whether the nurse was performing surgical procedures or administering the surgical program. He stated he knew of other non-physicians who had this title, but he agreed the title was typically used by a medical doctor who had completed a surgical residency. Nonetheless, Dr. Dubrow testified the use of the title by respondent was not misleading because, in his opinion, respondent was acting as the director of surgery. He testified the title would "not necessarily lead people to think [respondent] was a doctor," but he conceded it could. Dr. Dubrow's testimony on this issue was not persuasive.

Using, Encouraging, or Failing to Correct Reference to Respondent as "Doctor"

44. Complainant alleged that respondent referred to himself, encouraged others, and/or failed to correct individuals when they referred to him as "Doctor." Evidence was presented that from 2011 through 2015, ten of respondent's former patients left comments about Pacific Liposculpture on yelp.com (Yelp) that referred to respondent as "Dr. Rod." Respondent responded to eight of the ten comments and pointed out that, "I'm a Physician Assistant, not a doctor so no need to call me "Dr. Rod." Respondent's responses were posted from November 2013 to August 2015.

45. Respondent stated that he began to affirmatively respond to patients who posted Yelp reviews and remind them he was not a doctor as a result of patient complaints and the board's actions against him. He believed the board might determine it was his responsibility to correct people who referred to him as "doctor" on a website although he disagreed that it was, or should be, his responsibility to do so. He contended that he cannot control what individuals post on Yelp or other social media websites. He testified that he does not have time to "police" every social media website that might have something written about him on it. Because Yelp is a major social media site, he has lately tried to review it more often and respond when he was referred to as doctor.

Respondent testified that Yelp filters some patient reviews and others may be posted, and then removed, by Yelp. He also stated that he posted a bio on Yelp in which he identifies himself as a physician assistant, but that the bio is not immediately seen due to the format used by Yelp. He cannot control where the bio is located on the website; he must follow Yelp's protocols.

Respondent stated he has trained his staff not to refer to him as "doctor" and to correct anyone they hear refer to him as "doctor." He has also instructed his staff to let him know if they hear a potential patient refer to him as "doctor" so that he can make sure to address the issue with the patient during the consultation.

46. Complainant suggested that photographs of respondent in his surgical scrubs posted to the website encourage prospective patients to believe respondent is a physician. Respondent, under the proper circumstances, may perform some surgical procedures that

would require him to wear scrubs. The fact that photographs show respondent in his scrubs is not, without more, misleading.

Posting Videos that Falsely Represent that the Liposuction Procedure is Painless

47. Complainant alleged respondent posted videotaped procedures and testimonial videos that falsely asserted that liposuction is a painless procedure. Three former patients testified at the hearing that they experienced pain during their procedures. Some of the patients who posted Yelp reviews also mentioned that they experienced some pain and/or discomfort during or after liposuction.

48. Respondent stated that some patients are very comfortable and happy during liposuction, and some patients find it more difficult. The videos respondent posted are of actual procedures and the patients were being truthful in their commentary. He admitted that most of the videos that were posted show the procedure after the tumescent infiltration aspect of the procedure, which is the more uncomfortable part of the procedure. Respondent did not feel the videos mislead prospective patients about the fact that there could be some discomfort.

Is Respondent Competent or Qualified to Perform Liposuction Surgeries?

BOARD'S EXPERT - MICHAEL J. SUNDINE, M.D., F.A.C.S.

49. Michael J. Sundine, M.D., F.A.C.S., testified as an expert in this matter. Dr. Sundine received his medical degree from St. Louis University School of Medicine in 1987. He completed a residency in general surgery in 1992 and a three year fellowship in Plastic Surgery (1992-1995), a one year fellowship in Craniofacial Surgery (1998) and a six year fellowship in Advanced Facial Cosmetic Surgery (2003-2009). He has had several academic appointments. Dr. Sundine is certified by the National Board of Medical Examiners, American Board of Surgery, and American Board of Plastic Surgery. He practices cosmetic and reconstructive surgery, with a concentration of facial reconstructions. He has performed approximately 500 liposuctions in his career. He is qualified to provide an expert opinion in this case.

50. Dr. Sundine was asked by the board to review the allegations against respondent. Dr. Sundine reviewed multiple documents, including the accusation, Pacific Liposculpture patient records, investigation reports, transcripts of interviews, materials relating to other experts, deposition testimony, and articles concerning the standard of care relating to liposuction surgery. He prepared written reports of his findings as they relate to each of the four patients who testified at the hearing. He concluded that respondent was not competent to perform liposuctions, failed to comply with the standards of care, and engaged in the unlicensed practice of medicine. He also found respondent engaged in repeated negligent acts, gross negligence, and failed to maintain adequate and accurate medical records.

RESPONDENT'S EXPERT

Terry J. Dubrow, MD, F.A.C.S. testified as an expert at the hearing. Dr. Dubrow received his medical degree from the University of California, Los Angeles in 1986. He completed a General Surgery Internship at UCLA Medical Center in 1987, a General Surgery Residency at UCLA Medical Center in 1993, and a Fellowship in plastic surgery at UCLA Medical Center in 1995. He has been licensed in the State of California since 1988. He has been certified by the American Board of Plastic Surgery from 1999 to the present. He is a certified expert reviewer for the Medical Board of California. He has a high volume practice and has performed thousands of liposuction surgeries. He is qualified to provide an expert opinion in this case.

CONTENTION THAT RESPONDENT LACKED PROPER TRAINING

51. Dr. Sundine believed respondent was not competent to perform liposuction surgery without a physician present because he was not a medical doctor or doctor of osteopathy. Respondent did not go through the intense training of a physician, particularly in areas such as how to avoid infection, maintain a sterile surgical environment, control excessive bleeding, and handle medical emergencies such as a perforated organ or fragmentation of medical instruments that may occur during a liposuction procedure. At a bare minimum, Dr. Sundine opined that, if respondent performed liposuction surgeries, he needed extended training plus supervision and proctoring by a physician who was familiar with the procedure. Dr. Borup did not, and could not, provide such supervision. Dr. Sundine disagreed that respondent had received proper training in liposuction surgeries in his prior employment since neither Dr. Bittner nor Dr. Calhoun were specialists in cosmetic surgeries; Dr. Bittner was trained as a radiologist, and Dr. Calhoun was trained as an emergency room physician. Thus, neither doctor had the proper qualifications to train respondent. Dr. Sundine noted that guidelines published by the American Society for Dermatologic Surgery (ASDS) and the National Center for Biotechnology Information (NCBI) stated that liposuction should be performed by a physician who has completed postgraduate training in dermatology or a surgical specialty and have adequate "hands on" training under the supervision of an experienced and trained liposuction surgeon.

Dr. Sundine was aware that some medical professionals claim some expertise in performing cosmetic surgery without having gone through formal residency training. He did not agree that those medical professionals should be doing cosmetic surgery. He believed that a person performing liposuction must be certified by one of the surgical boards.

Dr. Sundine stated that since, in his opinion, respondent was not qualified to perform liposuction surgeries, he is not competent to perform them.

52. Dr. Dubrow "strongly disagree[d]" with Dr. Sundine's assessment that respondent was not competent to perform liposuction surgeries. He reviewed the medical records of the four patients who testified at the hearing, was familiar with the number of liposuctions respondent had performed, and understood the way respondent conducted

himself clinically. Dr. Dubrow stated that respondent, who does nothing but liposuctions and who represented he has performed more than 10,000 procedures, had 99 percent more experience than other physicians. Dr. Dubrow opined the complaints raised by four of respondent's former patients were "extraordinarily minor complications." Nonetheless, Dr. Dubrow conceded he always advises patients to always go to a board certified plastic surgeon for any cosmetic procedure. Dr. Dubrow also agreed that respondent did not meet the ASDS education and training guidelines for performing tumescent liposuction.

Dr. Dubrow conceded that a plastic surgeon had more qualifications to handle potential complications from liposuction surgery than a physician assistant, but he testified that as between a medical doctor who had just completed a residency and a physician assistant, it would depend on the relative experience each had. In general, a medical doctor would be more qualified unless the physician assistant had "tons of experience." In this case, Dr. Dubrow believed that respondent had tons of experience and was competent to perform liposuction surgeries.

Did Respondent Engage in the Unlawful Practice of Medicine Without a License?

53. Complainant alleged respondent engaged in the unlawful practice of medicine without a license by, amongst other things, performing liposuction surgeries with little or no supervision from Dr. Borup.

54. Dr. Sundine opined that respondent definitely was practicing medicine without a license. Dr. Sundine was not aware of any medical office or facility that permitted a physician assistant to perform liposuction surgeries without supervision.

55. Dr. Dubrow believed the law allowed a physician assistant to perform certain surgical procedures even when a doctor was not on the premises. Respondent had "significant experience" in liposuction and, in Dr. Dubrow's opinion, was adequately trained to perform liposuction. Dr. Dubrow believed it was reasonable for respondent to do liposuction under Dr. Borup's supervision, even if Dr. Borup was not on the premises; provided however, that Dr. Borup was familiar with liposuction surgeries, understood which patients were proper candidates for the procedure, and was aware of what complications could arise. In those circumstances, it was appropriate for respondent to perform liposuction surgeries even when Dr. Borup was not on the premises. The evidence did not support a finding that Dr. Borup satisfied the proviso offered by Dr. Dubrow.

Dr. Dubrow was familiar with the academy that Dr. Borup attended to obtain his limited experience with liposuction surgery and stated the instruction and training in this academy was similar to that received by cosmetic surgeons learning liposuction.

Dr. Dubrow testified that it was not common or standard in the community for a physician assistant to perform liposuction surgeries, but the standard of care is not determined by who performs the surgery but, instead, by the practitioner's qualifications. Dr. Dubrow testified that liposuction was not as serious a procedure as brain tumor or heart

surgery. However, an informational video received in evidence showed Dr. Dubrow telling prospective patients cosmetic surgery was as serious as brain tumor or heart surgery. The video was meant to impress upon prospective patients that they should always seek out a specialist if they were considering cosmetic surgery.

Was Liposuction Surgery Dr. Borup's Usual and Customary Practice

56. A physician may delegate to a physician assistant "only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition." (Cal. Code Regs., tit. 16, § 1399.545.) Dr. Borup delegated all tasks and procedures related to liposuction surgeries to respondent. Dr. Borup had been an accomplished anesthesiologist for 20 years when he suffered a stroke. After 12 years, he desired to get back in the medical profession. At the time he and respondent signed the DSA, Dr. Borup's experience outside of anesthesiology was limited to his having taken some modular courses in anti-aging cosmetic procedures; he had never performed liposuction. After the DSA was signed and Pacific Liposuction had opened, Dr. Borup took a weekend course in liposuction where he participated in two liposuctions under supervision. He never performed another. Although he had no personal experience, other than administering anesthesia during liposuction surgeries when he was an anesthesiologist, Dr. Borup concluded that respondent was competent to perform liposuction surgeries without a physician on the premises by observing him and determining he did a good job.

57. Dr. Sundine opined that, based on Dr. Borup's history, liposuction surgery was not part of his usual and customary practice and he was, therefore, prohibited from delegating liposuction surgical procedures to respondent.

58. Dr. Dubrow agreed that taking the module training in anti-aging and performing two liposuction procedures did not make liposuction surgery part of Dr. Borup's usual and customary practice. However, Dr. Dubrow stated that even though Dr. Borup was not a specialist in tumescent procedures, it was acceptable for him to supervise someone with "great experience." To the extent Dr. Dubrow's opined that Dr. Borup was an appropriate physician to supervise respondent, his opinion on this topic is rejected.

Did Dr. Borup Supervise Respondent?

59. Dr. Borup's only participation in Pacific Liposculpture was to go to the office occasionally, review medical records and speak with respondent in a general sense about the cases respondent was handling. Dr. Borup and respondent contended that Dr. Borup was only required to review five percent of the files; however, Dr. Borup in fact, reviewed approximately sixty percent of Pacific Liposculpture's medical records. The evidence did not, however, support a finding that Dr. Borup had any other involvement with patients or in the business.

Dr. Borup testified that he was the Medical Director of another company called Medspa 324 part of the time he was the Medical Director of Pacific Liposculpture. Medspa

324 was in the same building as Pacific Liposculpture, so he was nearby if needed. Otherwise, Dr. Borup lived about 20 to 25 miles away from Pacific Liposculpture. He stated he went to Pacific Liposculpture's offices a minimum of once a week.

Dr. Borup stated that his supervision included teaching respondent about anesthesia. He also contended that, because respondent had done thousands of liposuctions, a way to direct him "was to let him do what he wanted." When responding to questions about his ability to supervise respondent, Dr. Borup appeared to have difficulty formulating his answers.

60. Dr. Sundine testified that Dr. Borup's review of files and appearance at the office did not constitute supervision. He opined instead that Dr. Borup allowed respondent to operate Pacific Liposculpture autonomously, which is prohibited by California regulations.

Can Respondent Perform Liposuction Surgery Because it is Done Under Local Anesthetic

61. California Code of Regulations, title 16, section 1399.541, subdivision (i)(1) authorizes a physician assistant to "[p]erform surgical procedures without the personal presence of the supervising physician **which are customarily performed under local anesthesia.**" (Emphasis added.) The subdivision further provides that "[a]ll other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of a supervising physician." Respondent contended this regulation permitted him to perform liposuction surgeries without Dr. Borup's physical presence because the liposuctions he performed were all under local anesthesia.

ARE LIPOSUCTIONS CUSTOMARILY PERFORMED UNDER A LOCAL ANESTHESIA

62. Dr. Sundine disagreed that liposuctions are "customarily" performed under a local anesthesia, although he acknowledged they can be done in that fashion. Liposuction can be performed under a local anesthetic, a general mixed with a local anesthetic, or a 100 percent general anesthetic. He stated most liposuctions are done with a mix of local and general anesthesia. Dr. Sundine stated that performing liposuction under a general anesthesia allows the physician to focus on the procedure and not be limited by what areas of the patient are numb, and it is more pleasant for the patient. Dr. Sundine believed general anesthesia is much safer than it was at one time.

63. Dr. Dubrow disagreed with Dr. Sundine and testified that there are benefits to performing liposuction under a local anesthesia. He stated that using a local anesthesia permits the medical professional to obtain feedback from the patient regarding whether the procedure was going too deep or near areas that were not anesthetized. Dr. Dubrow testified most straight liposuctions were done under local anesthesia.

64. Dr. Calvert performs liposuctions in his practice. He stated that ten percent of the procedures are performed under straight local anesthesia, sixty percent are performed under intravenous sedation with local anesthesia, and thirty percent are performed under a

general anesthesia. Dr. Calvert stated that contouring results are aesthetically better if the patient is awake during the procedure. The medical professional can have the patient stand up, move around and better assess how the contouring looks. He stated if he could perform all of his liposuctions under local anesthesia he would, but his patients are under a general anesthesia for other reasons when they also have liposuction.

IF LIPOSUCTIONS ARE CUSTOMARILY PERFORMED UNDER A LOCAL ANESTHESIA,
SHOULD A PHYSICIAN ASSISTANT BE PERMITTED TO PERFORM THEM

65. Dr. Sundine opined that even if most liposuctions are performed under a local anesthetic, that fact alone does not permit a physician assistant to perform them unsupervised. He reasoned that there are many complex, highly technical procedures such as brain tumor surgeries that are done under a local anesthetic that clearly should not be performed by a physician assistant. He contended that because the wording of the statute appears to permit a physician assistant to do some procedures without supervision, that does not mean he or she should do them. He believed the standard of care requires that a medical doctor perform liposuctions even when they are done under a local anesthetic.

66. Dr. Munish Batra, a plastic surgeon who treated one of respondent's patients, testified that 90 percent of the liposuctions he performed were done under general anesthesia. However, he stated that dermatologist who cannot get hospital privileges or access to a surgical center, do all their liposuctions using local anesthesia.

67. Dr. Calvert²⁹ testified that he performs liposuction under a local anesthetic for about 10 to 15 patients per year, depending upon his patient's preference. He stated that sometimes the difference for the patient is cost; it is less expensive to perform the procedure under a local anesthesia than general anesthesia. Dr. Calvert estimated that 60 percent of his liposuctions were done with a local plus an IV, 10 percent with straight local, and 20 percent were straight general.

68. Dr. Dubrow agreed that Dr. Calvert's percentages applied to the plastic surgery community.

Care and Treatment of Patients

69. Four patients whose liposuction surgery was performed by respondent at Pacific Liposculpture between 2011 and 2013 filed complaints with the medical board. The four patients complained of continuing pain and discomfort and of lumps in the areas where the liposuction was performed. The four patients testified at the hearing.

²⁹ Dr. Calvert testified as an expert. His credentials are provided infra.

Patient LW³⁰ is a 56-year-old man. In 2011 he lived in Arizona, six hours from San Diego. On April 14, 2011, LW had liposuction surgery on his abdomen and "love handle" areas. LW complained of lumpiness and pain after the surgery. In January 2013, LW underwent umbilical hernia surgery which he believed was a result of the liposuction surgery. As of the date of the hearing, he continued to have soreness and swelling which he also attributed to the liposuction surgery.

Patient CN³¹ is a 30-year-old woman. In 2011, she served in the military and lived in Joshua Tree, California, a few hours from San Diego. On October 13, 2011, CN had liposuction performed by Pacific Liposculpture on her upper and lower abdomen. CN complained of lumps and continuing discomfort in her bellybutton area where the surgery was performed.

Patient KD is a 58-year-old woman. In 2012 she lived in Northern California, several hours from San Diego. On March 1, 2012, KD had liposuction surgery on her "back bra area" and thighs. On March 2, 2102, KD had liposuction surgery on her upper and lower abdomen and "love handle" areas. KD complained of a hernia and continued pain and bloating which she attributed to the liposuction surgery.

Patient SM is a 45-year-old woman. In 2013 she lived in Carlsbad, California. On April 17, 2013, SM had liposuction surgery on her inner thighs. SM complained of a pocket of swelling on her right thigh which was later diagnosed by Dr. Munish Batra, a plastic surgeon, as a pseudo bursa that requires surgical removal and corrective surgery. Dr. Batra opined that the pseudo bursa resulted from respondent's failure to properly treat a seroma that developed after SM's liposuction surgery. Dr. Batra also opined that SM's left thigh was over suctioned and resulted in a contour deformity.

Issues In Common

INSUFFICIENT TIME TO REVIEW THE CONSENT FORM

70. CN, KD and SM testified that they were given a packet of documents on the day they arrived for their liposuction surgeries. They each said they had between five and ten minutes to read the form and sign it. No one asked them if they had any questions about the consent form and no one explained the form.

CN said she signed the form even though she did not have sufficient time to look at all it. She did not read the consent form in its entirety and no one went over the consent form

³⁰ Patient initials are used to protect the patients' privacy.

³¹ Patient CN had a name change which caused a confusion in the initials used for this patient in the accusation. The correct initials are CN. All parties agreed that the allegations in the accusation concerning NC, in fact related to CN.

with her. She was aware that all surgeries carry some risk. She believed that either Dr. Borup or respondent, both of whom she believed were doctors, would perform her surgery

KD testified that, other than discussions about her flying home after the procedure, no one at Pacific Liposculpture talked to her about the safety of the liposuction procedure. KD felt she was not given sufficient time to read and understand the form. When she was taken to the consultation room, no one explained what the procedure involved or what the potential risks were. KD testified that she understood that infection was a risk associated with liposuction because she got an infection after a tummy tuck surgery in 2010. She did not ask questions about the risks or possible complications because she had read about Dr. Borup on Pacific Liposculpture's website and felt he was experienced and competent. She knew what the procedure entailed as she had had prior cosmetic surgery. She believed the liposuction would be performed by a medical doctor.

SM testified that she went to Pacific Liposculpture for a consultation on February 23, 2013. Although Pacific Liposculpture emailed her financial documents before the day of her surgery, she was not provided with a copy of the consent form at the consultation or by email before the surgery. When she was presented with the consent form on the day of the surgery, she was upset that it had not been sent to her before. She told receptionist/staff member Stephanie³² she did not have enough time to review and understand the consent form and asked why it had not been given to her before. Stephanie said, "That is just how we do it." When someone came to get her for her surgery, SM said she had not had enough time to read the consent form, and she was given more time. When someone came to get her again, she still had not finished reading the form, but she felt rushed and just signed it. She did not recall any discussion with her about the potential risks of surgery, including bleeding, infection, scarring, seroma (fluid accumulation), or pain. Respondent told SM that the numbing was most painful part of procedure. SM believed respondent was a medical doctor.

71. LW's experience was different. He testified that he was given paperwork, including the consent form, in the consultation room by a medical assistant. Either respondent or the medical assistant summarized the contents of the form. He believed he had adequate time to review the forms and did not feel rushed. LW understood that there were risks involved in the procedure and he did not have any questions. LW learned that respondent was a physician assistant and not a medical doctor after he was already prepped and ready for the surgery. He decided to go through with it because he understood Dr. Borup oversaw and supervised the office.

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³² Stephanie spoke to all the patients that testified at the hearing. She provided information to them and answered their questions. Her exact title was not established.

MISLEADING INFORMATION IN THE INFORMED CONSENT FORM

FORM SIGNED BY CN, KD AND LW

72. CN, KD, and LW signed an "Informed Consent Liposuction" form that was four pages long and discussed generally the purpose of and procedure used to perform, liposuction. It included a section entitled "Risks of Liposuction Surgery," which listed bleeding, infection, skin scarring, change in skin sensation, skin discoloration and swelling, skin contour irregularities, asymmetry, seroma, fluid overload or reaction to tumescent medications, disappointment in results, pulmonary complications, skin loss, and chronic pain as possible complications. Under the section entitled "Consent for Surgery/Procedure or Treatment," the form provided: "I hereby authorize Dr. Jerrell Borup, MD, Rod Davis PA, and such assistants as may be selected to perform the procedure or treatment." The second sentence authorized "the above physician and assistants or designees" to perform other procedures as may be necessary due to unforeseen conditions.

FORM SIGNED BY SM

73. SM signed a revised consent form that was seven pages long and contained additional risks of surgery not set forth in the earlier form, including surgical anesthesia, skin sensitivity, delayed healing, fat necrosis, and umbilicus. This form also warned that the patient "will experience pain after your surgery." The consent form was modified so that the patient authorized "Dr. Jerrell Borup, MD OR Rod Davis PA and such qualified assistants as may be selected to perform the procedure or treatment." (Capitalization in original.) The revised consent form contains the following:

Please be advised that California law allows a certified and trained "PA" (Physician Assistant) to perform medical procedures customarily performed under local anesthesia without the personal physical presence of the supervision physician provided that the physician is available in person or by electronic communication. (see Business & Professions Code § 3502 and California Code of Regulations §§ 1399.541 & 1399.545)

RESPONDENT'S AND DR. BORUP'S RESPONSE TO ISSUES RE: CONSENT FORMS

74. Respondent did not create consent forms when he started treating patients for Pacific Liposculpture. He used the forms that were used in Dr. Bittner and Dr. Calhoun's offices and he followed the informed consent procedures he learned from those doctors.

75. Respondent testified that he and his staff complied with the following procedures: The day of the procedure, Pacific Liposculpture staff provided the consent form to the patient. The staff told the patient to read the form through and let them know if there were any questions. Staff told the patient to return the form to them or, if the patient had

questions, to bring the form to the consultation room to discuss them with respondent. Respondent went over the more common risks of liposuction, including infection, blood clots, unwanted skin, potential asymmetry, and unhappiness at the outcome, at the beginning of the consultation with each patient. He then discussed anything the patient did not understand. Respondent advised each patient that there might be some discomfort at the beginning of the procedure until the local anesthetic is administered. He told the patient that after the anesthesia was administered, most patients are numb and don't feel much; however, there are some patients that do feel discomfort. When a patient was having liposuction on his or her abdomen and love handles, respondent advised the patient that there could be some pain and discomfort for the first 20 minutes of the procedure. Respondent told each patient to let him know if he or she was uncomfortable, and he would stop the procedure to administer additional numbing medications.

76. Dr. Borup read over the first consent forms respondent proposed to use at Pacific Liposculpture and approved them. At the hearing, Dr. Borup testified he wished he had not approved the consent forms because he understood now that some sections could be misinterpreted. He explained that his original idea was that he was also going to perform liposuction surgeries, so his name was on the form. He understood how that language could lead patients to believe that more than one person would be present in the procedure room. But he defended the use of the form by pointing out that there were three or four employees around who were available to answer any questions.

Dr. Borup testified the consent form, as signed by SM, was revised after discussions with counsel. Despite the fact that his name was still on the revised form, Dr. Borup believed that the revised form was not misleading.

Dr. Borup noted the pre-printed form respondent used to document his operating procedures included a representation by respondent that he had discussed specific risks, potential complications and treatment alternatives with the patient prior to the surgery. Dr. Borup delegated the responsibility to obtain informed consent from each patient to respondent under the DSA. He understood respondent would be discussing all of the things listed on the form with the patient. If respondent was not doing that, he would be violating the DSA. Dr. Borup was confident that respondent would let him know if he was not following the DSA.

EXPERT TESTIMONY RELATING TO CONSENT FORMS

77. Dr. Sundine opined the informed consent forms used by Pacific Liposculpture from 2011 to 2016 violated the standard of care because the form "hinted" that Dr. Borup would perform, or supervise, the liposuction surgery. He stated that all Pacific Liposculpture patients should be clear before a procedure was performed who was going to perform the surgery.

Dr. Sundine was critical of the way the informed consent forms were provided to Pacific Liposculpture's patients. He stated the informed consent process takes time. The

standard of care in the cosmetic surgery community requires a verbal discussion with the patient before the procedure of the potential risks and complications. The goal is to have a well-informed patient who understands the benefits and risks of the procedure and who has time to further investigate the proposed procedure on their own, either by obtaining a second consultation or conducting research. Providing a patient with a written form and then whisking them off to surgery is not adequate to obtain informed consent. Dr. Sundine found the process used by Pacific Liposculpture to be an extreme departure from the standard of care.

78. Dr. Dubrow opined the informed consent form provided to Pacific Liposculpture's patients was "adequate to inform patients of possible consequences" of liposuction surgery.

Dr. Dubrow stated that providing the form to a patient seeking liposuction under a local anesthetic the day they arrive for surgery was acceptable as long as the patient had "ample opportunity" to read the form and ask questions. The standard of care requires that consent be obtained before the procedure, the patient has ample time to understand the risks, and the patient has a verbal discussion with the person who is performing the procedure about the key points of the consent form. Dr. Dubrow stated that it is not a violation of the standard of care to fail to discuss every possible risk or potential complication – they are too voluminous. Instead, the standard of care required the medical personnel to discuss the more common risks and/or complications and anything the patient does not understand.

Dr. Dubrow indicated that the standard of care differs with the procedure contemplated. In his practice, he meets the patient twice before performing surgery. However, his practice involves general anesthesia and complicated procedures taking several hours. Because of this, there are a lot of things for him and the patient to think about, and to make sure the patient understands what he can or cannot deliver as a result. Nonetheless, if a patient came in for a procedure under local anesthetic and he believed the patient was an appropriate candidate for the procedure and fully understood the risks, potential complications, and expected outcome, he would likely do the procedure the same day he obtained informed consent.

79. Dr. Dubrow did not find five minutes to be a sufficient amount of time for a patient to read and understand the informed consent form that was used by Pacific Liposculpture. If respondent's patients felt they did not have adequate time to read the consent form and respondent did not expressly discuss the risks with the patients, respondent would have violated the standard of care.

80. Dr. Dubrow was aware that Dr. Borup delegated the obligation to obtain patient consent and discuss the risks and potential complications with Pacific Liposculpture's patients to respondent in the DSA. Dr. Dubrow agreed that if respondent failed to do these, it would constitute a violation of the DSA as written.

81. As to whether the consent form should have listed both respondent and Dr. Borup, Dr. Dubrow believed that was a "gray area." He stated that the consent forms he provides to his patients say "Dr. Dubrow and his associates;" however, in the present case, respondent was always the person who was performing the procedure. Nonetheless, given the nature of the physician/physician assistant relationship, Dr. Dubrow did not believe it was inappropriate to have Dr. Borup's name on the form. However, Dr. Dubrow admitted that, "in a vacuum," Dr. Borup's name on the form could lead to confusion about who was doing the procedure and whether Dr. Borup would be present in the surgical room. If other misleading statements were made to, or known by the patient, then the consent form could be misleading.

EVALUATION

82. The consent form used by respondent adequately advised patients of the potential risks and complications of liposuction. Providing patients with no more than five to ten minutes to read and understand the extensive form was inadequate. However, the patients had some responsibility to let Pacific Liposculpture staff know they required additional time to read the form and to refrain from signing it until they were satisfied they were familiar with and understand the terms in the consent form. Respondent had an absolute obligation to have a conversation with all prospective patients about risks and potential complications, whether the patient asked questions or not. Three of the four patients either did not have a conversation with respondent about risks, or it was so minimal that they did not recall it happening at all. In either case, the patient's perception strongly relates to their understanding of the procedure and risks involved.

The consent form, in either version, was misleading. Patients were led to believe Dr. Borup had some role in their care and treatment. This was not the case. Dr. Borup never performed a procedure, never was present during a procedure, never treated a patient, and never met patients of Pacific Liposculpture. Dr. Borup explained that his name was on the first form because he contemplated doing procedures when he first spoke to respondent about being Medical Director of Pacific Liposculpture. If in fact that was Dr. Borup's intent, he quickly was discouraged from doing that and he agreed. His name should have been removed from the consent form as soon as it was clear he would not be doing any procedures, and his relationship with Pacific Liposculpture should have been clarified. There was no justification for Dr. Borup's name being included in the revised consent form, and none was provided by respondent or Dr. Borup. The change in the consent form was intended to let people know that the procedure would be performed by respondent OR Dr. Borup – not AND Dr. Borup. This statement was equally false since Dr. Borup would never perform a liposuction. The fact that his name remained on the consent form lends more credence to the false impression that Dr. Borup was more than a mere figurehead at Pacific Liposculpture.

The failure to properly advise patients of the risks and potential complications from liposuction surgery is a basis upon which discipline may be imposed. The misleading nature of the consent forms in listing both respondent and Dr. Borup as individuals who might be

involved in performing liposuction or who were involved in patient care is a basis on which discipline may be imposed.

PRE-OPERATIVE ASSESSMENT

83. Complainant alleged that respondent failed to perform a competent pre-operative assessment. Dr. Sundine testified the standard of care required respondent to take a careful history and perform a physical examination of each patient prior to liposuction surgery. The extent of the examination should be based on the patient's age and other health factors. Dr. Sundine suggested it is a good practice to obtain an authorization for surgery from the patient's primary care physician. He stated he did not see much evidence in the patient records that respondent had performed appropriate pre-operative assessments of his patients. The evidence he saw concerning a pre-operative assessment was inadequate.

Respondent testified, and the medical records confirmed, that each patient's weight, height, blood pressure, and heart rate were measured, and some physical examination was performed.

PRE-MEDICATION WITH ATENOLOL

84. Complainant alleged respondent improperly used Atenolol to pre-medicate his patients. Dr. Sundine testified that removing fluids from the body increases the heart rate. Atenolol causes a drop in blood pressure and masks the patient's physiological response to tachycardia (rapid heartbeat). To gauge how a patient is handling anesthesia, the medical professional relies on blood pressure readings; Atenolol changes these readings. Respondent gave Atenolol to blunt the body's natural response and ability to regulate blood pressure. Dr. Sundine also stated that Atenolol is a long acting agent that could not be adjusted if a problem occurred during the procedure. He opined a short acting agent should have been used.

85. Dr. Borup approved of respondent's use of Atenolol as part of the pre-operative medication regime for liposuction surgery performed under a local anesthetic. He said the epinephrine in the tumescent fluid restricted the blood vessels so there was less bleeding in the procedure, but Atenolol can cause tachycardia – rapid heart rate. The Atenolol is used to counter balance the effect of the epinephrine.

86. Dr. Dubrow testified that respondent's use of Atenolol was appropriate in tumescent liposuctions. He also stated that its use helps limit a patient's anxiety.

FAILURE TO MONITOR VITAL SIGNS

87. None of the four patients who testified were aware of any monitoring of their vital signs during their liposuction procedures. LW recalled that his blood pressure and heart rate were measured by the medical assistant before he underwent his liposuction procedure. The medical records maintained by Pacific Liposculpture confirm that LW, CN, KD and

SM's blood pressure and heart rate were measured prior to the procedure and their height and weight were recorded.

RESPONDENT'S AND DR. BORUP'S RESPONSE

88. Respondent testified that the patient's vital signs and weight were taken and documented on the chart before respondent walked in to the consultation room. Respondent reviewed the vital signs, age and medical history of each patient to determine whether the patient was good candidate for liposuction. After the procedure, the patient's vitals were taken again, unless there were signs the patient was not feeling well before that. Respondent believed his procedures meet the standard of care in the community for outpatient surgeries. Respondent testified that, since the accusation was filed, he checks vital signs more often. He made the change to be more cautious and so he would "not get the same scrutiny" he had been getting.

89. Dr. Borup testified that because Pacific Liposculpture's patients were awake throughout their procedure, it was not necessary to continuously monitor their vitals. He stated that when patients are awake and alert, the medical professional receives more information from the patient about how he or she is tolerating the procedure than the medical professional would obtain from vitals monitoring equipment.

EXPERT OPINION TESTIMONY

90. Dr. Sundine testified that he believed a patient's vital signs were required to be monitored during liposuction surgery performed under local anesthesia. This was necessary because it was important to know on an ongoing basis how the patient was doing — were they comfortable, did they require more fluids. He believed this was required because he spoke to anesthesiologists who advised him that this was a requirement. He did not provide authority for his position.

91. Jay Wynn Calvert, M.D., F.A.C.S. testified as an expert relating to issues and procedures pertaining to patient LW. Dr. Calvert received his medical degree from Cornell University Medical College in 1994. He completed a residency in general surgery in 1997 and completed a two year research fellowship in Tissue Engineering (1997-1999), and a two year residency in Plastic Surgery (1999 – 2001). He has had several academic and hospital appointments. Dr. Calvert was certified by the American Board of Plastic Surgery in 2002. He is a plastic surgeon, with a concentration in nasal facial esthetic surgeries and complex breast and body contouring. He has performed approximately 500 liposuctions in his career. Approximately ten percent of his practice involves liposuction. Dr. Calvert has worked with a physician assistant in his career. He is qualified to provide an expert opinion in this case.

92. Dr. Calvert testified that it was not required to monitor a patient's vital signs during a tumescent liposuction procedure for the same reasons stated by Dr. Borup. A requirement to monitor a patient's vital signs every five minutes is only required for general anesthesia. He found that respondent did not violate the standard of care with regard to

monitoring a patient's vitals. Dr. Dubrow agreed with Dr. Calvert. He stated that it was within the standard of care to take a patient's vitals before and after the procedure, which was done here.

Respondent's failure to monitor patient vital statistics during liposuction procedures is not a basis on which to impose discipline.

ELECTRONIC TRANSFER OF MEDICAL INFORMATION AND PHOTOGRAPHS

ISSUE

93. LW, CN, KD and SM all sent photographs of areas of their bodies to respondent either by email or text, and some patients communicated medical information to respondent by email or text messages. In some cases the patient initiated the communications or photographs and, in other cases, respondent requested the patient send photographs. Patients who lived farther from the Pacific Liposculpture facility were told prior to their surgeries that respondent could provide follow-up care and consultation from a distance by evaluating photographs the patient would send to Pacific Liposculpture after surgery. The patients were not advised that electronic transmittal of medical information and/or photographs to Pacific Liposculpture was not encrypted and could not be guaranteed to be secure.

RESPONDENT'S RESPONSE TO ISSUE OF ELECTRONIC TRANSFER

94. Respondent offered patients the option to conduct follow-up appointments through photographs if the patients lived a substantial distance from his office. In the event a patient had a concern about his or her procedure, respondent preferred the patient come into the office to be seen by respondent in person. However, it was often the case that a review of a photograph of the area of concern and a discussion with the patient resolved the patient's concern and avoided the patient having to make a long trip. Respondent believed this method of communication was very effective.

95. Pacific Liposculpture's website contained information offering "virtual" consultations by electronic communications and photographs for approximately two to three years. Respondent did not think he was violating the Health Insurance Portability and Accountability Act (HIPPA) through these communications because he was not sending private patient information electronically and the patient was initiating contact with him, although he acknowledged that on occasion he requested that a patient send him a photograph. If the patient contacted him first, he assumed they had given implied consent to electronic exchanges.

EXPERT TESTIMONY RE: ISSUE OF ELECTRONIC TRANSFER

96. Dr. Sundine opined the photographs and other medical information exchanged between respondent and his patients were required to be HIPPA compliant. He stated the

standard of care was to protect the privacy of patients by insuring that electronic communications were on a secure and encrypted platform so they could not be intercepted by the public. Dr. Sundine also stated that if communications were not through an encrypted platform, respondent had a duty to advise his patients of that fact. Dr. Sundine did not conduct research to determine whether other physicians used electronic means to communicate with their patients. Even if they did so, Dr. Sundine believed unencrypted electronic transfer of information violated the standard of care. By failing to comply with HIPPA, respondent violated the standard of care. Dr. Sundine provides his cell phone number to his patients and they could send photos unbidden, but Dr. Sundine would not ask patients to send photos. Dr. Sundine testified he only knows of this requirement through discussions with his malpractice carrier and other training courses.

97. Dr. Dubrow testified it is not a violation of the standard of care for patients to send photographs and descriptions of post surgery concerns electronically. He stated he does it, and it is a very common practice in the plastic surgery/cosmetic surgery community. Dr. Dubrow believed the capacity to transmit information electronically has elevated a physician's ability to provide quality post-operative care and monitoring for patients by providing instant medical advice. He acknowledged there was a potential that photographs and medical information may be sent to the wrong phone number or email address. Nonetheless, he believed this method of communication was an appropriate way to provide quality care to patients. He suggested if a patient initiated the exchange, the medical personnel should point out potential issues and obtain the patient's consent to continue the electronic communications.

EVALUATION

98. The standard of care is defined as the "level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful persons performing liposuction would use in the same or similar circumstances." California Civil Jury Instructions (CACI) 501. It appears that plastic surgeons and others who perform liposuction and other cosmetic surgeries rely on electronic communications to provide quality and immediate treatment for their patients. While physicians and other medical professionals should exercise caution given the possible problems inherent in unencrypted exchanges, these communications are occurring in the medical community. It would be prudent to, at a minimum, advise patients of the possible breaches that could occur with electronic communications, that the physician does not have an encryption platform, and instruct the patient to be circumspect about the information and photographs sent electronically. That respondent and his patients communicated electronically is not a basis on which to impose discipline.

OPERATING IN A NON-ACCREDITED FACILITY

ISSUE

99. Certain medical facilities may be accredited by a recognized accrediting agency. Most plastic surgeons seek accreditation of their facilities through the American

Association for Accreditation of Ambulatory Surgical Facilities, Inc. (AAAASF). The accreditation agency reviews all aspects of surgical facilities to ensure patient safety, including cleanliness, implementation of proper procedures, maintenance of all equipment and medications that might be required in an emergency, and proper handling and inventory of narcotics. To be accredited by the AAAASF, the Operating Room Suite must be separate and physically segregated from the general office area. Amongst other things, the Operating Room Suite must include a clean room and a dirty room. An autoclave (sterilizer) must be kept in a clean room, and there must be a partition that separates the clean and dirty areas if a single location is used. The AAAASF also conducts peer reviews. Pacific Liposculpture's facility was not accredited by AAAASF or any other accreditation agency until approximately 2015.

RESPONSE ON BEHALF OF RESPONDENT

100. According to respondent, Pacific Liposculpture received accreditation with a national accreditation agency for ambulatory surgical centers one year ago. The office underwent intense scrutiny to receive the accreditation. Prior to receiving accreditation, respondent believed the offices were compliant with requirements to ensure patient safety for outpatient surgeries performed under local anesthesia. The office was not a surgery center prior to its accreditation.

101. Dr. Borup believed the Pacific Liposculpture offices met the appropriate standards for patient safety. All medications, fluids and oxygen were available as necessary for the procedures that were performed there. Respondent was certified in advanced life support services, and Pacific Liposculpture had everything needed to keep a patient sustained in an emergency until emergency personnel arrived. The procedure room was cleaned after each patient. At Pacific Liposculpture, all instruments were cleaned and sterilized by an autoclave when patients were out of the room. Dr. Borup contended that the fact that no patient developed an infection demonstrated that the offices were clean and safe. He was aware that other physicians perform liposuction surgeries in non-accredited facilities.

EXPERT TESTIMONY RE: ISSUE OF ACCREDITED FACILITY

102. Dr. Sundline opined that the fact that Pacific Liposculpture was not accredited was a violation of the standard of care. His opinion was based on his belief that it was below the standard of care to perform significant surgical procedures, including liposuction, in unaccredited facilities. He found the violation to be an extreme departure of care, particularly because Pacific Liposculpture did not have a complete crash cart and did not have a separate room for sterilization. Dr. Sundline did not know how many doctors perform liposuction in non-accredited facilities; he did not research the issue. He did not know whether a minority or majority of reasonable and prudent medical professionals perform liposuction in non-accredited facilities.

103. Dr. Dubrow testified that procedures strictly involving local tumescent liposuctions are usually performed in non-certified centers. If a patient requires general

anesthesia, the procedure must be done in an accredited surgical center. For surgical center accreditation, a separate procedure room and separate area for disinfected and clean instruments is required. These are not required for procedures performed in-office, and under local anesthesia.

Dr. Dubrow also opined the standard of care did not require a facility in which only tumescent liposuction procedures are performed to have a fully stocked crash cart. He stated that the crash cart is there for the use of an anesthesiologist. When local anesthesia is used, a crash cart does not equate with increased patient safety or care.

104. That Pacific Liposculpture was not an accredited facility and did not have a fully stocked crash cart is not a basis on which to impose discipline.

INADEQUATE MEDICAL RECORDS

ISSUE

105. Respondent used pre-printed forms entitled "Liposuction Procedure Note" after he performed liposuction surgeries. He did not write or dictate original notes for each procedure. The pre-printed form contained options respondent could circle to indicate what kind and the amount of pre-operative medications he gave, percent of tumescent anesthesia administered, areas that were liposuctioned, and the size of cannulas used in the procedure. The form had blank spaces where respondent entered the volume of tumescent fluids injected, the volume of fluids removed and the days the patient was to return for a follow-up visit. Complainant alleged that using pre-printed forms for operating notes violated the standard of care.

RESPONDENT'S AND DR. BORUP'S RESPONSE

106. Respondent disagreed that the use of the pre-printed forms violated the standard of care. He believed all necessary information pertaining to the procedures he performed were contained on the form.

107. Dr. Borup testified he was not involved in creating the procedure note, but he went over the form with respondent when he became associated with Pacific Liposculpture. He did not believe the pre-printed form violated the standard of care since respondent could, and did, customize the information added to the form to the patient.

EXPERT TESTIMONY RE: ISSUE OF USE OF PRE-PRINTED FORMS

108. Dr. Sundine testified that using a pre-printed form violated the standard of care because an operative report should be prepared specifically for each patient. He stated that the operative report is helpful for self-improvement in the event any complications or undesired effects occurred during the procedure. Dr. Sundine classified this as a simple departure.

109. Dr. Dubrow testified the standard of care required that an operative report be prepared after every surgery. He agreed one purpose of the operative report was to serve as a learning tool for the practitioner should a complication arise. Additionally, the operative report is used by other doctors treating the patient to review what the practitioner did. Dr. Dubrow did not believe using a pre-printed form violated the standard of care so long as it accurately described what the practitioner did. He stated that liposuction surgery is a "very standard" procedure so the pre-printed form with options to note differences in the procedure for each patient adequately addressed the purposes of a post-operative report.

EVALUATION

110. The operative reports used by respondent provided sufficient information about the procedure performed on each patient and achieved customization by requiring respondent to select specific options as they applied to the patient. The use of the pre-printed form is not a basis on which to impose discipline.

Care and Treatment of CN

TESTIMONY OF PATENT CN

111. In early October 2011, CN saw an advertisement for Pacific Liposculpture in a circular that was geared to military personnel and their families. The advertisement promised she would be able to fit into her "camis" (uniform) faster if she had liposuction. The special rate for military personnel was \$700 per area. CN was interested in having her lower abdomen done.

CN accessed Pacific Liposculpture's website and browsed its content. She focused on specific information, including that the procedure would be painless; patients were awake during the procedure; the medical director had 20 years' experience and was a chief of staff at one time in his career; and the facility used state-of-the-art equipment.

CN called Pacific Liposculpture and spoke to Stephanie. She told Stephanie she was going on her honeymoon and wanted to slim down a bit for that. Stephanie told CN that she would absolutely be healed within several days and certainly in time for her honeymoon. Stephanie told CN that a co-worker who had the procedure went out the same night and to work the following day.

CN called Pacific Liposculpture twice more before her surgery. During each call, CN spoke to Stephanie. In one telephone call CN expressed her concern about the procedure and that she could die from it. Stephanie laughed off her concern and told her no one ever died or was injured by the procedure. In another call, Stephanie assured CN that the person who would be performing the procedure was the director of surgery who had extensive training and had taught the procedure to others. Stephanie did not specify who would perform the procedure, but, based on the advertisement and website, CN believed either a medical doctor with 20 years' experience would perform the liposuction or the medical doctor would be part

of a team of medical professionals who would do the surgery. CN testified that she was not told that she needed specific compression undergarments to use after the procedure.

Because she lived a few hours from Pacific Liposculpture, Stephanie asked CN to send photographs of the area she contemplated having liposuction to Pacific Liposculpture for a virtual consultation. CN sent the photographs on October 10, 2011. Stephanie also told CN that follow up care could be achieved by sending photographs rather than driving in to Pacific Liposculpture's location.

112. On October 13, 2011, respondent and her husband drove to San Diego from Joshua Tree. When she got to Pacific Liposculpture, Stephanie's recommended, and CN agreed, to have liposuction on her upper as well as lower abdomen.

CN was taken to a pre-operative room where a staff person weighed her and took photographs of the areas of her body to be liposuctioned. She was taken to the surgical procedure room and told the "doctor would be in next."

Respondent entered the room and introduced himself to CN. He told her he was either a "PA" or "Physician Assistant," the Director of Surgery, and would be performing her liposuction. CN believed that a medical doctor would be in – or at least in and out – of the surgical room while her procedures were being performed. Respondent marked the areas of her body where fat would be removed. He confirmed that having the upper and lower abdomen would provide her with better results than just the lower area. He also confirmed that CN would not feel anything, and the procedure would take about one hour.

According to CN, respondent did not discuss potential complications or risks from the surgery, including blood clot formation; pain; bleeding; or asymmetries. She claimed that respondent did not discuss skin laxity or suggest she have a tummy tuck procedure instead of liposculpture.

CN testified that she told respondent that she was under the care of a cardiologist for tachycardia but that she did not know what kind or its cause. Respondent told her she would be fine. Respondent did not ask to consult with CN's cardiologist, discuss her family history or discuss postponing the surgery to obtain additional testing or further evaluation of her tachycardia.

CN completed a pre-surgery information sheet in which she represented she did not have any "ongoing medical problems" and that her last EKG was eight months prior. She testified she did not feel her tachycardia was "important" enough to write down on the form, but she mentioned it to respondent and the Pacific Liposculpture staff.

113. Respondent began the procedure by cleaning CN's abdomen. She was wearing her own underwear under a hospital gown. Respondent numbed the area and made four small incisions. No one else was in the room until the end of the procedure. Dr. Borup never entered the room and CN never met him. CN was vulnerable and scared and did not

think to ask where the doctor was. By the time she realized a physician would not be part of the team, the incisions had already been made and respondent was doing the surgery. CN did not recall her vital signs, including heart rate, being monitored during the procedure.

After about 15 minutes into the procedure, CN felt a "burning like fire" around the area of her bellybutton. She told respondent she felt something was wrong and she could feel everything he was doing. He administered more anesthesia and waited a short time for the effects to kick in. Respondent began to perform liposuction on her other side, but with the same painful result; CN felt painful burning. Respondent told her he had already given her more medication than he was supposed to and she should not be feeling any pain. Nonetheless, CN continued to be in what she described as level 9 pain throughout the procedure. She stated she was crying, but there was loud music in the room and she was crying softly. Respondent did not offer to stop procedure. CN testified she just wanted the procedure to be over.

When the procedure was completed, respondent said he had gotten "more out of [CN] than he had seen in a long time." CN was upset at how respondent treated her. She felt he was rude and standoffish and had dismissed her when she said she was in pain.

114. Immediately after the procedure, CN had pain around her bellybutton. She was told she had to wear spanx or the procedure would be "worthless" and she would not have good results. She testified spanx were not given to her by Pacific Liposculpture and she had not been told in advance that she needed them. CN and her husband drove for 45 minutes and went to two stores before she located spanx. She stated she was not told what size to get and, because she was not feeling well, she grabbed whatever she could find.

CN recalled being given a one page document with instructions for after-care that were limited to advising her to use clean maxi pads on the incision sites and to take care to avoid infection. She denied getting a three page document that contained more extensive instructions for after-care.

115. The next day, CN called Pacific Liposculpture and spoke to Stephanie. She told Stephanie she was in a lot of pain and something did not feel right. Respondent telephoned CN one or two days later. CN was crying when she told respondent she did not feel well, her heart was racing, she felt lightheaded, and she was in pain. Respondent told CN that she was feeling the effect of the medication she was given. He told her to calm down and everything would be all right.

Three days after the procedure, CN called Pacific Liposculpture again. She reported the pain was getting worse, she was black and blue, and she couldn't move. A few hours later, respondent called CN. He told her she was "over exaggerating"³³ and to take two to four Motrin. He asked her to send him a photograph of her abdomen, which she did; he did

³³ In a complaint to the board, CN said respondent told her she was "over reacting."

not tell discuss with her the potential dangers of sending photographs or other medical information by telephone or email.

Respondent told her the photograph showed that everything was fine. This was the last time CN spoke to respondent. She did not receive any calls from Pacific Liposculpture for follow-up appointments.

116. CN developed lumps in the area where the liposuction was performed and the area continues to be painful. CN came to believe she had been misled about the entire process when she still had lumps six months after her surgery. She also felt respondent was not helping her with her concerns. CN stated was aware that extensive liposuctions done under general anesthesia could be painful, but she believed the advertisement and personnel at Pacific Liposculpture when they told her she would not feel pain with the type of procedure performed by Pacific Liposculpture.

117. On cross examination, CN admitted that she had not spoken to a doctor about pain in her abdomen in the year following her surgery. She explained that after respondent told her she was exaggerating the pain, she felt embarrassed to tell a doctor about it. CN testified after six weeks the level of pain subsided, but it still hurt.

118. On June 26, 2013, CN filed a complaint with the medical board about the treatment she received from respondent. The complaint related to her experience at Pacific Liposculpture and was substantially consistent with her testimony at the hearing. The complaint did not, however, allege that CN told respondent about her tachycardia, nor did it allege that CN believed a physician would be overseeing her surgery.

119. CN's testimony was credible. She responded carefully to questions and did not volunteer information to expand her claims; she appeared genuine and did not appear to exaggerate.

EXPERT TESTIMONY AND RESPONDENT'S RESPONSE TO ISSUES RELATING TO CN

TACHYCARDIA

120. Respondent "sort of recall[ed]" CN, but based his testimony primarily upon his review of her records. Respondent correctly pointed out, as noted above, that CN's records do not contain a reference to tachycardia. Respondent made hand written notes on CN's records during his conversation with her, but those notes similarly do not reference tachycardia.

Respondent testified that if CN reported tachycardia, he would not have performed liposuction surgery on her. He would have asked more questions and requested her medical records before he would perform the surgery. Respondent stated if a patient registered a high pulse rate, he would question the patient and, in all likelihood, not do the procedure that day. CN did not have a high pulse rate when she was at Pacific Liposculpture.

121. Dr. Borup found it "shocking" that CN claimed she was diagnosed with tachycardia and did not report it to Pacific Liposculpture. If CN did report tachycardia, respondent should have consulted with Dr. Borup and obtained a note from her cardiologist before proceeding with liposuction surgery. Dr. Borup questioned CN's claim because he believed respondent had never hesitated to contact him about important issues. Dr. Borup signed the "Liposuction Procedure Note" concerning CN's procedure; however, his signature is not dated, and it cannot be determined when he signed the note.

122. Drs. Sundine and Dubrow agreed with Dr. Borup that, had CN advised respondent she had been evaluated for tachycardia, respondent was required to advise Dr. Borup and obtain further documentation of her condition before proceeding with liposuction surgery. Drs. Sundine and Dubrow said it would be a violation of the standard of care to perform a liposuction on a patient who reported tachycardia without following up with the patient's physicians. Dr. Dubrow said it was reasonable to rely on the patient to provide accurate information about his or her medical history. He found nothing in CN's medical records to indicate she was not an appropriate candidate for liposuction surgery.

123. The evidence did not establish that CN advised respondent she had been seen for possible tachycardia.

TUMMY TUCK

124. Respondent testified he advised CN she had skin laxity (loose skin) and recommended she would have better results if she had a tummy tuck procedure, which respondent could not perform. Respondent documented his conversation with CN in her file. Despite his opinion that CN would have better results with a tummy tuck, respondent advised her she was, nonetheless, an appropriate candidate for liposuction. He determined she had enough fat cells in the abdomen area such that, even if the skin was not tightened, she should feel flatter after the procedure. CN told respondent she was not interested in having a tummy tuck and wanted to proceed with the liposuction.

125. Dr. Sundine opined CN should not have been given liposuction surgery because a tummy tuck, combined with flank liposuction, was the proper procedure for her. He stated respondent violated the standard of care because he did not understand the alternatives available to CN, and he should have sent her to a physician who could perform the proper procedure.

126. Dr. Dubrow opined that, although CN was a candidate for a tummy tuck, it was within the standard of care to perform a liposuction when she said she did not want a tummy tuck. Dr. Dubrow stated the decision to go forward depended upon CN's expectations of the surgery. If she wanted tightening of the skin, she needed a tummy tuck. If she wanted a reduction in size and to look better in clothes, then liposuction was appropriate. Dr. Dubrow saw CN's post-procedure photographs and stated the results were within the reasonable expectation.

127. The evidence did not establish that CN was not an appropriate candidate for liposuction surgery.

TUMESCENT DOSAGE

128. Complainant alleged the amount of tumescent anesthesia respondent administered to CN was in excess of that allowed by the DSA between respondent and Dr. Borup. Respondent recorded in CN's medical records that he administered 3,200 ccs of tumescent anesthesia to CN.

129. Respondent testified he considered CN's weight and calculated the amount of anesthesia he could administer to her. He stated the amount he administered was under the maximum dosage authorized by the DSA. He stated he did not need to contact Dr. Borup because the amount of tumescent anesthesia he administered did not violate the DSA.

130. Dr. Borup originally testified the only time he expected to speak to respondent about exceeding the maximum volume range was if the patient was heavier than contemplated in the DSA chart. He stated "as far as he knew," respondent did not exceed the volume ranges in the DSA. However, Dr. Borup later explained the guidelines in the DSA were written for the average patient who weighed 70 kilos (154 pounds). CN's weight on the day of her procedure was recorded as 177.2. Using the standardized formula for determining maximum volume, the maximum volume of tumescent fluid that could be administered to CN was 3,600 mls. She was given 3,200 mls, which is within the appropriate range. However, the maximum permitted under the DSA chart was 3,000. Dr. Borup acknowledged the DSA should have been clearer.

131. Dr. Dubrow reviewed the DSA and CN's medical records. He testified the amount of tumescent fluid administered to CN was "easily within the maximum dosage" permitted using the standard formula.

132. The evidence established respondent administered an appropriate amount of tumescent fluid according to accepted standards in the community, but in an amount in excess of that authorized under the DSA.

PAIN DURING THE PROCEDURE

133. Respondent disputed CN's claim that she was in extreme pain during her liposuction surgery. He stated patients should expect some discomfort until the areas to be treated are numb. He tells patients there is a chance they may feel discomfort at some point during the procedure, and if that happens, they should let him know. He stated some patients handle pain better than others. Respondent did not note in CN's chart that she experienced pain. Respondent said he would have stopped the procedure and called Dr. Borup if CN complained of extreme pain.

134. Dr. Sundline testified that if CN was experiencing pain, and respondent could not administer additional numbing solution, the procedure should have been stopped and CN should have returned on another day to complete the procedure. He opined it was a violation of the standard of care to simply carry on and try to get through the procedure.

135. Dr. Dubrow testified pain or discomfort is common in liposuction procedures; the level of, and tolerance for, pain varies from patient to patient. He did not believe a medical professional performing a liposuction was required to document that a patient had pain during the procedure. He stated the "beauty" of doing a liposuction under a local anesthetic was that the medical professional can continue to communicate with the patient and can stop the procedure if the patient does not want to continue. He suggested the medical professional ask the patient, "Are you ok with this?" and work with the patient as to whether to stop or continue.

136. The evidence was inconclusive as to whether CN communicated her level of pain to respondent and he failed to address it and/or stop the procedure.

PAIN AFTER THE PROCEDURE

137. Respondent stated soreness and drainage of the surgical incisions are common within a day or so after liposuction. Pain medications are given to all patients after surgery to address pain that may occur after the anesthesia wears off. In some patients, respondent changes the type of medication prescribed to better address their level of discomfort.

138. Dr. Borup testified he was not "sure" about which patients he spoke about with respondent, but he believed he "probably" discussed CN's post-operative pain with him because they "talked about a lot of things like that." He noted pain was subjective.

139. The evidence was inconclusive as to whether CN experienced a higher level of pain than should have been expected. She stopped communicating with respondent just a few days after her procedure.

COMPRESSION GARMENTS

140. Respondent stated it has been Pacific Liposculpture's practice from the day it opened to the present to provide patients with post operative garments. He said he would not perform a surgery if Pacific Liposculpture did not have the proper garment to give a patient after surgery. Every patient is wrapped by a medical assistant and provided with instructions about wearing the compression garment. The first garment the patient wears following surgery is included in the procedure fee. Subsequent garments must be purchased by the patients; however, they can purchase additional garments from Pacific Liposculpture at a discounted price.

141. Dr. Sundline agreed patients should wear a compression garment after liposuction surgery; however, it was up to the medical professional whether to provide the

garment or have the patient obtain one. He did not favor ace bandage wrap, but it does not violate the standard of care to use ace bandages and maxi pads wrap after liposuction.

142. The evidence did not establish respondent violated the standard of care by failing to provide CN with a compression garment. The other three patients that testified confirmed that respondent provided them with a compression garment after their surgeries.

POST-OPERATIVE CARE

143. Complainant alleged respondent failed to provide appropriate post-operative care for CN. Dr. Sundine criticized respondent for telling CN that her heart was racing because he had given her adrenaline the day before and she needed to calm down. Dr. Sundine noted that the duration of adrenaline was four to six hours and could not be the cause of CN's feeling her heart was racing.

144. Dr. Sundine also criticized respondent for relying on texts and photographs rather than an in-person examination to provide post-operative care.

145. Dr. Dubrow disagreed with Dr. Sundine and testified respondent's post-operative care of CN was within the standard of care. He stated because CN lived three hours away, it was within the standard of care to send her home and check in at regular intervals to see how she was doing. He said it was "done all the time this way." He felt CN's concerns were within the range of what is expected following liposuction surgery and respondent's post-operative instructions were appropriate.

146. Respondent's post-operative care of CN, though not without room for improvement, did not violate the standard of care and is not a basis on which to impose discipline.

Care and Treatment of Patient LW

TESTIMONY OF PATIENT LW

147. Respondent performed liposuction surgery on LW's abdomen and flank area (love handles) on April 1, 2011. Prior to the procedure, LW researched liposuction procedures and facilities on the internet. Pacific Liposculpture appeared to offer professional, "top-notch" medical services. He recalled the website indicated the staff at Pacific Liposculpture had performed over 10,000 procedures. The representations contained on the website and conveyed to him in telephone calls to Pacific Liposculpture were that the procedure was safe and minimally invasive, caused minimal discomfort, and was performed with state-of-the-art equipment in a state-of-the-art facility by a very experienced "Director of Surgery" were very important to him.

LW had an active lifestyle prior to liposuction that included hiking, biking and exercising. He had not had cosmetic surgery before, and it was very important the procedure was minimally invasive.

LW was advised that "Rodney, the Director of Surgery" would be performing the liposuction surgery. No one specifically told him respondent was a physician, but LW assumed by the title that a doctor would be performing the procedure. He believed the title of Director of Surgery connoted a doctor with a lot of experience.

LW drove six hours from Arizona to San Diego for his surgery. He had informed Pacific Liposculpture he would be driving to San Diego on a Friday and returning to Arizona on the following Monday. He was assured he would be fine to travel.

When LW arrived, he was impressed by the beautiful office. The staff were warm, friendly, and inviting, and he felt comfortable. He and respondent discussed the liposuction procedure, and respondent marked the areas to be done. Respondent told LW he could achieve a good result for LW.

148. After they spoke, LW said, "Thanks, Doc." It was then that respondent told LW he was not a medical doctor, but he had performed thousands of operations. Respondent told LW the office was managed or operated by a physician. LW said the revelation that respondent was not a doctor "stopped [him] in his tracks," but he was already in a hospital gown and ready to go, so he decided to proceed. He stated, "the train was in motion already" and respondent appeared friendly and trustworthy. Additionally, LW still believed the procedure was minimally invasive and safe, and he was comforted by the fact the facility was overseen by a doctor.

149. Respondent administered a local anesthesia on LW's abdomen and flank area. LW testified the procedure felt rough and hurried. LW was being moved around a lot and was in a lot of pain. He was "moaning and groaning" throughout the procedure. Respondent administered more pain medication and went on. LW described the one and one-half hour procedure as "pretty grueling;" he was in pain at a level of nine to ten the entire time. After respondent completed the procedure, he seemed to rush out of the procedure room like he had somewhere else to be. An assistant wrapped LW, gave him post-procedures instructions, pain medications and a compression garment, "and showed him the door." He felt the staff was not as warm and fuzzy after the procedure as they were when he arrived. LW could hear another person in the next room.

150. LW felt the most pain on his right side, which he continued to feel through the time of the hearing. He said his right side is flatter than the left and is still tender near his belly button.

After the procedure, LW's pain was six to seven on a scale of 10. When he awoke the next day, the pain was level seven and his entire chest area and "privates" were black and blue. LP cleared him to drive so, despite the pain, he "soldiered up" and drove home.

151. Two to three days after the procedure, respondent telephoned to see how LW was feeling. LW appreciated that respondent was concerned and called to ask about him. Respondent told LW it was normal to be sore for up to a month.

LW testified that, after several weeks went by, he called or texted respondent to advise that the pain was not resolving. Respondent told him that in his case, it could take up to one year to resolve. Respondent told LW to continue wearing the compression garment and try gentle massaging of the area.

LW experienced a slight improvement, but after several months he was not happy. His pain level was four to five and if he did anything that involved his abdomen, such as yard work or playing with his dogs, the pain rose to eight or nine. After a year LW realized it was not going to get better. The more his abdomen was involved in an activity, the more pain he felt.

152. LW returned to Pacific Liposculpture ten months after his surgery for a follow-up visit. He complained of soreness and lumpiness in the abdominal area. Respondent did not find any complications and wrote in LW's chart that he advised LW to see a medical doctor regarding Crohn's Disease, get enderiology massage, and see a physiatrist to try to determine the cause of his pain. LW testified he never had Crohn's Disease.

153. The pain LW has endured has changed his life. He can continue to do things, but he must do them in moderation. He feels unhappy and depressed even though he tries not to dwell on it. The pain and discomfort has affected "things in the private part of [his] life with [his] girlfriend." He gets "blue" when he thinks about how healthy he was before and that he now is not because he elected to have liposuction.

154. LW sought medical help with the pain. In a note, the doctor LW saw wrote that LW reported he had "intermittent pain" after doing abdominal exercises, sit-ups or crunches for the past eight months. If this note is correct, LW's pain began over one year after his liposuction surgery. The doctor told LW that "it could very well be" that a small umbilical hernia could be the cause of his pain, but that he "couldn't guarantee that this is the case." According to the doctor's letter, LW reported that he had no surgeries in the past. On January 10, 2013, LW had outpatient umbilical hernia repair surgery at Paradise Valley Hospital. The surgery did not resolve the pain.

155. LW filed a complaint with the Medical Board against respondent in February 2013. The complaint was based on his being falsely told a physician oversaw the Pacific Liposculpture office, yet he never saw a physician and the results of the liposuction left him lopsided with permanent nerve damage and scar tissue and caused a hernia. LW did not present medical evidence that his condition was directly related to his liposuction surgery.

RESPONDENT'S AND EXPERTS' TESTIMONY REGARDING LW'S CLAIMS

156. Respondent does not believe he caused LW to have a hernia. LW's medical records do not contain any evidence of a pre-procedural hernia, and the liposuction surgery went fine. If respondent had pushed a cannula through an interior wall or "nicked" something during the procedure, LW would have "jumped off the table" in pain and the procedure would have stopped. Respondent believed LW's results look good; there is no bulge in his belly button. Continuing pain is a possible outcome of liposuction surgery.

LW's records indicate that he was to have a follow-up seven days after the procedure. LW did not come for that follow-up visit. Respondent did not recall that LW telephoned after three or four months complaining of continuing pain; however he said it is not uncommon to have residual soreness.

157. In follow-up notes dated February 23, 2012, respondent wrote that LW had a history of Crohn's Disease. However, LW testified he did not have Crohn's Disease and he told respondent that he did not. Nonetheless, in a narrative of LW's procedure and outcome written by respondent and sent by his lawyer to the Physician Assistant board in mid-May 2013, respondent continued to assert that LW had told him during the procedure that he has a history of Crohn's Disease.

158. Respondent questioned why LW waited so long after his surgery to advise respondent that he was having continued soreness and lumpiness. However, in his narrative regarding LW's case, he noted that, "[o]ver the next several weeks [after his surgery], the patient sent fairly routine questions via text regarding asymmetrical swelling, some residual soreness, and numbness of skin in the areas that were recently treated with lipo." Respondent stated he told LW these after effects were normal.

159. Respondent could not recall if he discussed LW's case with Dr. Borup. There are no notes in LW's file that suggest respondent spoke to Dr. Borup about the case, and Dr. Borup did not sign the Liposuction Procedure Note. Based on his professional judgment, respondent determined LW had a normal physical examination and there was no need to consult with Dr. Borup. He did not feel LW's concerns constituted complications under the DSA, and he felt it was within his expertise to handle them.

160. To form an expert opinion in relating to LW's care and treatment, Dr. Calvert reviewed the accusation, LW's medical records from Pacific Liposuction and Paradise Valley Hospital, documents relating to the board's investigation of LW's complaints and Dr. Sundine's report relating to LW.

Dr. Calvert observed that LW was a pretty healthy individual and one would not expect he would experience any difficulty with liposuction surgery. Respondent used the proper amount of tumescent fluid and withdrew the appropriate amount of fat for the procedure. Dr. Calvert stated LW's "after" photographs showed an aesthetically good result.

Dr. Calvert said liposuction can be painful as muscle fascia can be "stirred up," and the pain could continue for a while.

Dr. Calvert opined it was "unlikely" that respondent caused LW's hernia. Dr. Calvert said if respondent caused a hernia in the liposuction procedure, the hernia would be the least of LW's problems. The cannula would have had to have stabbed and punctured the abdomen wall. If that happened, stool would be sucked through the cannula and LW would be near death in the ICU with infection, sepsis and/or peritonitis. Such an injury would be immediately apparent. Dr. Calvert stated LW may have had a re-existing hernia, or one developed after his procedure, but respondent did not cause it.

Dr. Calvert disagreed with Dr. Sundine's conclusion that respondent has shown an inability to diagnose a hernia. Dr. Calvert said there was nothing in LW's records that indicated LW had any symptoms of a hernia when he went to Pacific Liposculpture. Dr. Calvert stated there were many scenarios that could explain how LW got a hernia, but it was not possible to determine the cause without speculation.

161. Dr. Calvert treats out of town patients in his practice. He opined respondent provided proper post-operative care to LW; he kept in contact with him; and he was available to discuss LW's concerns with him. Respondent's follow-up care was within the acceptable standards of care. Dr. Calvert questioned why LW waited so long to return to Pacific Liposculpture for an in-person examination with respondent.

Dr. Calvert testified respondent's course of treatment for LW's concerns - massage, avoid exercise and wear the compression garment - was appropriate. He did not believe the pain reported by LW after surgery was anything out of the ordinary. After LW had an office visit with respondent 10 months after the procedure, respondent also recommended endermologie treatments. When LW still did not improve, he lost faith in Pacific Liposculpture and stopped contacting them. Dr. Calvert stated respondent did the best he could in the situation and that his actions were within the standard of care.

162. Dr. Dubrow agreed it was not possible to create a hernia in a patient by performing liposuction surgery. He testified a hernia was a defect in an abdominal wall which can have a genetic origin or result from a surgical incision through the abdominal wall that is sewn up but fails. He stated that during a liposuction procedure, the cannula does not go through abdominal walls. If a cannula did go through an abdominal wall, the patient and medical professional would know it immediately because of the intense pain.

163. Dr. Sundine suggested LW had a pre-existing umbilical hernia and criticized respondent for failing to diagnose that prior to performing liposuction surgery. Dr. Sundine stated that respondent's inability to diagnose a pre-existing hernia made him very reckless in performing abdominal liposuctions. Alternatively, Dr. Sundine speculated that respondent performed liposuction in a manner to create a hernia. However, Dr. Sundine did not point to evidence in LW's records that lead him to his opinion. With relation to another patient who asserted she had a hernia following liposuction, Dr. Sundine stated he could not determine if

her hernia pre-existed the liposuction. No evidence was presented to suggest that such determination could be made in LW's case.

164. The evidence did not sustain a finding that respondent caused LW's hernia. Additionally, the evidence was insufficient to prove that respondent failed to diagnose a hernia. LW's claim that the liposuction respondent performed caused him continued pain was not proved and is not a basis on which to impose discipline.

Care and Treatment of Patient KD

TESTIMONY OF PATIENT KD

165. KD underwent liposuction surgery at Pacific Liposculpture on March 1 and 2, 2012. Prior to seeking liposuction, KD viewed Pacific Liposculpture's website. She looked at before and after photographs posted on the site, information posted about the ease of travel to get to/from Pacific Liposculpture's facility, and services offered by Pacific Liposculpture to help make travel arrangements. She was very impressed with the image of the clinic and particularly liked that Dr. Borup had twenty years' experience and was a chief of staff experienced in anesthesia. She was comforted by the fact that, as she understood it, Dr. Borup was very experienced and had performed liposuction surgery many times before. She relied on his credentials when she scheduled her surgery at Pacific Liposculpture. She did not see anything on the website that advised her that the surgery would be performed by someone who was not a physician.

Because she was flying to San Diego from Northern California for her liposuction surgeries, KD had several telephone calls with Stephanie to discuss the surgeries and to receive assurances that she would be able to fly home afterwards. Stephanie never told KD her surgery would be performed by someone who was not a physician.

166. Prior to the surgery, KD told respondent she had an infection following a tummy tuck in 2010. Respondent did not discuss with her how, or if, that would affect her proposed liposuction surgeries. KD wrote on her intake form that she had had gall bladder surgery in 2010; a hysterectomy in 1996, and exploratory surgery in 1988. When she told respondent of her other surgeries, he said they would not cause a problem for the liposuction surgeries.

167. In the procedure room, respondent introduced himself as "Rodney." He did not mention his title. KD believed respondent was a medical doctor.

Respondent told KD he would give her a local anesthetic, and if she felt any pain, he could increase the anesthetic.

168. KD experienced pain when respondent was performing the liposuction near the area she had exploratory surgery. In response, respondent told her he would increase the anesthesia. Throughout the entire procedure on the first day, KD rated her pain level as a 6

of 10. Her pain increased each time respondent got near the scar tissue from her prior surgeries. The increase in pain happened more than 10 times during the surgery.

Respondent remained calm and did not seem concerned with KD's expressions of pain. Respondent did not suggest bringing someone else into the procedure room to make sure everything was all right. He did not address her pain other than to add more medications.

169. KD returned to Pacific Liposculpture the following day for additional liposuction on different areas of her body. She still believed respondent was a doctor. The second day, her pain level was 4 out of 10.

170. KD flew home a few days after her surgery; she was in pain during the flight. When she returned home, KD experienced pain at a level she rated to be 8 to 9 all over her body. On March 5, 2012, three days after her surgeries, KD telephoned Pacific Liposculpture to report her pain and obtain stronger pain medication. KD testified the medication lessened the pain but her pain level was worse when it wore off. Follow-up notes in her medical chart state that KD complained of pain in her legs and midsection.

In a note concerning that telephone call, respondent wrote that KD asked for Norco by name and had been requesting pain medications even before her procedures. Respondent explained to KD that increased pain medication will "probably not help" and told her she should follow up with a pain management doctor or go to the emergency room for an examination.

According to KD, respondent referred to her as a drug seeker. He told her that no other patients had pain after their procedures and implied he did not believe she was in pain. He did not tell her he had a supervising physician with whom she could consult. She did not ask to speak with a supervising doctor because she thought respondent was the doctor.

171. On April 19, 2012, KD and respondent had a series of conversations by telephone and email. The essence of the conversations was that KD was unhappy with the liposuction surgeries respondent performed because her stomach "still has fat," she was in constant pain, and she was diagnosed with a hernia which required surgery. She attributed the hernia to the liposuction surgeries. Respondent requested KD send him a photograph of her stomach, which she did. Respondent sent "before" photographs for KD to compare. She acknowledged she looked better, but she said she was still bloated and in excruciating pain. She told respondent she did not anticipate the pain and suffering she was suffering. She also said she did not anticipate having to pay more money to repair "damage done to me" from what she was told was a "simple surgery." Respondent told KD no one could determine how she got a hernia. He suggested that because she had a lot of fat tissue, the liposuction could have revealed a "pre-existing umbilical hernia from prior surgeries or from no prior surgeries at all." Respondent asked KD to send records of her hernia diagnosis and surgery for their files. KD told respondent she was most bothered by the fact that she had expressed to him that she had a very bad experience at another cosmetic surgery facility and was assured she

would have a good experience at Pacific Liposculpture. Respondent noted in KD's records that, to that point, she had not followed up with him since her telephone call on March 5, 2012. Respondent ultimately determined the conversation with KD was not going well, and he said he would refer the matter to his attorneys.

172. It is unclear whether KD had hernia surgery sometime before or shortly after her communications with respondent. She testified at the hearing that she is still in pain every day of her life where she has scar tissue. When water touches her, she feels as though a hot poker is in contact with her skin. She does not take pain medication because she has children and grandchildren and does not want to be on drugs around them. She testified she would never have had the surgeries at Pacific Liposculpture if she had known that respondent was not a doctor.

173. KD filed a complaint against respondent with the Medical Board in April 2013. The complaint was based on the fact that respondent was not a medical doctor, and she did not consent to a procedure that was performed by anyone other than a medical doctor. She asserted she did not learn that respondent was not a doctor until she saw a neurologist for the symptoms she experienced after the liposuction.

RESPONDENT'S AND EXPERTS' TESTIMONY REGARDING KD'S TREATMENT

174. Respondent stated that with the back-to-back procedures KD had, there was the potential she would have pain afterwards, although he found it unusual for her to need pain medication on a daily basis. Because respondent requested pain medication before and for longer than expected after the surgeries he considered whether she could be seeking narcotics. But, respondent is not signed up with Controlled Substance Utilization Review and Evaluation System (CURES) so he could not determine whether KD had a history of narcotics abuse. In any case, respondent did prescribe additional medication.

Respondent stated he spoke to Dr. Borup about KD; however the only suggestion that Dr. Borup was at all involved in KD's case was his undated signature on the Liposuction Procedure Note in KD's file.

175. Dr. Borup recalled KD telephoned Pacific Liposculpture several times to request pain medication before and after her procedure. It was not clear whether Dr. Borup learned of the telephone calls at the time they were made or later. Although, in his testimony, Dr. Borup appeared to be critical of KD for requesting pain medications, he agreed it "could be legitimate to ask for pain medication" for a few days following back-to-back surgeries. Respondent prescribed the medication requested by KD.

Dr. Borup expected respondent to notify him if respondent recommended a patient to go to the emergency room. He did not affirmatively say respondent did, in fact, notify him that he made that recommendation to KD. KD's medical records do not document a conversation between respondent and Dr. Borup on this issue.

Dr. Borup believed that KD would not have waited as long as she did for medical intervention if she had sustained a hernia during the liposuction procedure.

176. Respondent asserted that it was impossible to create a hernia, continue the procedure and then have the patient return the following day for additional procedures. When KD returned for more liposuction the second day, she seemed fine and was not in pain. He noted that Dr. Sundine's report is inconclusive about the cause of KD's hernia and continuing pain.

Respondent believed he provided reasonable care of KD, including follow-up monitoring and treatment.

177. For the reasons stated above with regard to LW, Dr. Dubrow agreed it was not possible for respondent to have created a hernia in KD. In addition, Dr. Dubrow stated there was nothing in KD's medical record that suggested she was not a good candidate for liposuction. Respondent found no indicators in his examination that KD should not have liposuction surgery. KD's records showed she had isolated fatty pockets in areas that were appropriate to perform liposuction. Dr. Dubrow said it was not clear whether KD had, or did not have, a pre-existing hernia. Dr. Dubrow reviewed KD's photographs from after her procedure and he opined she obtained a very good result.

178. Dr. Sundine's report noted that respondent found no palpable defects or masses in KD's abdomen when he examined her prior to performing liposuction. Dr. Sundine found it was "not clear from reviewing the record as to whether the hernia was pre-existing or caused by the procedure." He further noted it was "not clear as to the etiology for the abdominal pain."

179. The evidence did not sustain a finding that respondent caused KD's hernia. Additionally, the evidence was insufficient to prove that respondent failed to diagnose a hernia. KD claim that the liposuction respondent performed caused her continued pain was not proved and is not a basis on which to impose discipline.

Care and Treatment of Patient SM

TESTIMONY OF PATIENT SM

180. SM became familiar with Pacific Liposculpture in early 2013 because she was going to an esthetician who was renting space in respondent's offices. She was impressed with the professional office and décor. When she was there, she saw respondent at the office in his scrubs and heard girls in the office refer to him as Dr. Rod. Because of what she saw and heard, SM believed respondent was a doctor. When she started contemplating liposuction, she went on the internet to Pacific Liposculpture's website, Facebook and Yelp. She recalled references on Facebook and Yelp to "Dr. Rod." She also recalled that Pacific Liposculpture had performed thousands of procedures, the personnel were highly trained in liposuction, and the website was very professional looking.

181. On February 22, 2013, SM went to Pacific Liposculpture for a consultation for liposuction to her thighs. Respondent introduced himself as "Rod." He told her she was a good candidate for liposuction and she would be happy with the results. SM agreed to have the surgery.

182. On April 17, 2013, SM went to Pacific Liposculpture to have the liposuction surgery. After signing the consent form, she was taken to a room where a medical assistant weighted and photographed her. She was then taken to the procedure room where respondent marked the areas to be liposuctioned. SM knew respondent's title was Director of Surgery, but she did not know he was a physician assistant.³⁴ Respondent gave her an oral pain medication and then numbed her thighs with a long tube. The numbing process was the only part of the procedure that was uncomfortable; SM did not experience any pain during the procedure. After the procedure was completed, respondent left and the medical assistant bandaged and wrapped her. She received a compression garment to wear from Pacific Liposculpture. She drove herself home with no discomfort.

183. SM had a follow up visit with respondent on May 1, 2013.³⁵ The follow up notes indicate SM had moderate swelling in her thighs. She was directed to rest, apply ice, use compression, and elevate and massage her legs. Respondent directed her to wear a smaller compression garment all day each day, and he gave her one without charge.

184. On May 20, 2013, SM texted respondent about a sac of fluid she noticed in her right thigh. Her next appointment was scheduled for May 29, 2013, and she tried to get an earlier appointment to discuss it, but could not. During her May 29, 2013, follow-up appointment, SM said she discussed the sac of fluid with respondent but he told her it was normal and not to worry about it. She trusted his professional opinion. The notes from that appointment reflect that SM was doing better.

The originally soft sac of fluid SM reported on her right thigh was getting harder. On June 11, 2013, SM sent photographs of the lump on her thigh to respondent. She told respondent that "the lump on my inner right thigh has moved up a bit but it's gotten really hard." SM was concerned the lump would not go away.

³⁴ There are discrepancies between SM's testimony at the hearing and what the board's investigator said she told him as to whether she knew respondent was a doctor when she agreed to have him perform liposuction surgery. The board's investigator said SM told him she knew respondent was not a doctor from Pacific Liposuction's website. At the hearing, she said she knew he had "PA" behind his name but did not know what that meant. Whether SM knew respondent was not a doctor is not dispositive of the issues in this case.

³⁵ SM denies she had a follow-up, in-person visit with respondent on May 1, 2013. However, the notes in the file are quite precise and specific and included her weight and measurements of her thighs. She testified the only follow-up appointment she had with respondent was on May 29, 2013.

Respondent responded by email. He told SM that she had a pocketed area of swelling which sometimes happens when patients become more active. He advised continued icing, gentle massage, elevation and wearing a tight compression garment full time for a week. He recommended taking Dexamethasone, which he offered to call into her pharmacy. Respondent assured SM the lump would "go down no matter what you do."

185. On June 18, 2013, SM texted with respondent and advised him there was no improvement in the lump and she was now seeing bruising.

On June 21, 2013, SM told respondent the bruising around the lump had increased. Respondent instructed her to send more photographs, which she did. At a follow up appointment on June 25, 2013,³⁶ respondent determined SM's garment was too tight and told her to stop wearing it and use massage. He noted a "mild ecchymosis"³⁷ on her right thigh.

186. Between June 27 and August 23, 2013, respondent and SM continued to discuss the lump on her right thigh. SM asked respondent whether she should consider endermologie.³⁸ Respondent told her if she knew an experienced facility, it could not hurt. In July, SM told respondent she had been doing some research. She was concerned the lump might be a hematoma and it might need to be surgically removed. Respondent suggested SM contact a plastic surgeon for a second opinion. On August 23, 2013, SM told respondent she made an appointment with a plastic surgeon. At no point during their discussions did respondent offer SM to speak with, or see, Dr. Borup.

187. On September 11, 2013, SM saw plastic surgeon, Munish K. Batra, M.D., F.A.C.S.³⁹ Dr. Batra examined SM and diagnosed a pseudo bursa. When he investigated where SM had her liposuction performed, Dr. Batra was shocked to learn that her liposuction surgery was performed by a physician assistant. Dr. Batra told SM it would cost between \$11,000 and 13,000 to surgically repair the mistakes from her liposuction.

That same day, Dr. Batra telephoned Pacific Liposculpture. He would not speak to respondent and insisted that Dr. Borup return his call. Respondent told Dr. Borup what had been happening with SM, and Dr. Borup telephoned Dr. Batra. In his conversation, Dr. Borup told Dr. Batra that he was no longer practicing medicine.

³⁶ SM also denies she attended a follow-up, in-person visit with respondent on June 25, 2013. The medical records in the file for this date are also precise and specific and include her weight and measurements of her thighs.

³⁷ A purplish patch caused by extravasations of blood into the skin.

³⁸ A process to reduce dimpling caused by cellulite (fat under the skin).

³⁹ Dr. Batra's deposition was taken in lieu of his testifying at the hearing. Portions of his deposition testimony were received in evidence.

188. Dr. Batra was concerned because to perform liposuction on an individual's thighs, the medical professional must insert the cannula in an area just over the femoral vessels. He stated there is not a lot of room for error and the medical professional could easily injure a femoral nerve. Dr. Batra was concerned a physician assistant had performed this potentially dangerous liposuction on SM.

Dr. Batra testified a seroma or pseudo bursa could result even if a liposuction was performed correctly. But, Dr. Batra explained, the individual performing the liposuction should recognize a seroma/pseudo bursa and treat it by draining it before it becomes permanent and must be removed surgically. He stated there was no other treatment for a seroma other than draining it, unless it is very small and might resolve on its own. When Dr. Batra first saw SM, the seroma/pseudo bursa had become permanent.

Dr. Batra also found contour irregularities in SM's left thigh where her thigh was either over suctioned or the liposuction was performed in the wrong plane of fat close to the skin. SM did not initially complain to Dr. Batra about her left thigh.

189. SM testified she has not worn a bathing suit in three years because the lump on her thigh is very visible. Before the liposuction, SM engaged in weight lifting which she continues to do. She has not had the repairs performed because she can't afford it.

SM believed she was misled and deceived by Pacific Liposculpture and respondent. She believed the title of Director of Surgery was "extremely misleading." She also was critical of the after-care given to her. She asserted the lump should have been drained in the beginning rather than waiting until it required surgery to repair.

190. SM filed a lawsuit against respondent in June 2014. Her lawsuit is still pending.

RESPONDENT'S AND EXPERTS' TESTIMONY REGARDING SM'S CLAIMS

191. Respondent acknowledged he had contact with SM regarding the lump forming on her right thigh after her liposuction surgery. Although respondent believed he may have spoken to Dr. Borup about SM's concerns earlier on, there is no mention in SM's records that respondent talked to Dr. Borup about SM until after Dr. Batra contacted Pacific Liposculpture and demanded to speak to Dr. Borup.

When SM contacted respondent about her concerns, she told him the lump felt firm. He said a seroma would not present as firm, but would push over to the side. He did not suggest aspirating the lump because SM described the lump as firm. Respondent treated the lump conservatively by recommending different sizes of compression garments, prescribing RICE (rest, ice, compression and elevation), and massage. He was not concerned about the lump as described and shown in photographs as it was a common result after liposuction that typically went away after time. He did not believe he needed to consult with Dr. Borup as it was something he felt he was competent to address.

When SM continued to have concerns about the lump, he suggested she obtain another opinion. Even after SM went to Dr. Batra and said she no longer wanted to deal with Pacific Liposculpture, respondent continued to follow up with SM and her progress. Respondent felt the treatment he prescribed was appropriate for the information he had.

192. Dr. Borup did not recall whether respondent consulted with him about SM's concerns after her liposuction surgery. He stated respondent should have, and may have, reported it to him, but in any case, Dr. Borup trusted respondent's judgment. He recalled that at some point, he reviewed the medical notes and wrote something. The medical records indicate Dr. Borup wrote in SM's records after he spoke to Dr. Batra.

Dr. Borup recalled his telephone conversation with Dr. Batra. Dr. Batra expressed his displeasure with the fact that SM's procedure was performed by a physician assistant and now she had a pseudo bursa. Dr. Borup told Dr. Batra he was sorry for SM's condition and for the breakdown in communication between himself and respondent. He said he would make sure he and respondent communicated better and reviewed cases more thoroughly.

When Dr. Borup reviewed SM's medical records, he did not see anything that indicated SM had a pseudo bursa. He agreed with respondent's diagnosis that SM had a seroma, and with respondent's recommendations for conservative treatment. Dr. Borup stated most seromas spontaneously resolve. Dr. Borup testified that any physician could diagnose a seroma, but agreed a plastic surgeon "probably" had more knowledge on the subject.

193. Dr. Sundine noted, "[l]iposuction of the inner thighs is a technically difficult area to treat and it is easy to over treat the area and create contour irregularities." He opined that SM had both a contour deformity and a pseudo bursa which were improperly treated by respondent. He opined respondent's failure to timely address the seroma put SM in a worse position. He stated respondent's initial management of SM's concerns was not unreasonable, but when the lump persisted, respondent failed to take the necessary steps to avoid long term damage. Dr. Sundine testified respondent should have ordered an ultrasound and/or aspirated the lump when it did not go away after a few weeks of conservative treatment. Dr. Sundine also opined respondent violated the standard of care when he did not bring SM's concerns to Dr. Borup's attention in a timely fashion and did not provide competent post-operative care.

194. Dr. Dubrow reviewed SM's medical records, including those from Dr. Batra. He testified that one risk of liposuction surgery is fluid collection in the area liposuctioned. A seroma is the collection of protein in the blood. If a seroma is drained and keeps coming back, the tissue inside can form a shiny capsule that is a bursal cavity. If that happens, the capsule must be surgically removed.

A seroma or pseudo bursa is clinically diagnosed. Fluid is aspirated from the area and a dry compress is applied. If the fluid is yellow, it is a seroma. If lump is aspirated two to three times, but continues to come back at the same volume, it is a sign a capsule is

developing. The goal is to get the sides of the capsule to collapse against itself. Dr. Dubrow stated a pseudo bursa could not be diagnosed without aspirating the lump. He did not see reference to an aspiration of the lump in Dr. Batra's records. Dr. Dubrow stated that surgery was not appropriate option "at first blush" for a collection of fluid.

Dr. Dubrow observed in a photograph that SM also had a concavity irregularity in her right inner thigh. Dr. Dubrow testified a hematoma could result from liposuction surgery. A hematoma results from blood bleeding into tissue. If a hematoma is not drained it can cause scarification, the tissues can contract, and a concavity forms. He stated the first course of treatment is compression, which was the treatment respondent advised.

According to SM's reports, she was doing better and both sides of her thighs were improving. Dr. Dubrow reviewed respondent's treatment plan for SM as her concerns progressed and determined that respondent had prescribed the appropriate "evolving" treatment of the situation at all stages, including advising her to obtain a second opinion. He stated the standard of care was to treat conservatively for several weeks and then consider other options, which respondent did.

Dr. Dubrow challenged Dr. Batra's diagnosis of pseudo bursa. He stated that if SM has a pseudo bursa that had not be treated or aspirated, it would not look like the lump on her thigh. He testified that SM's lump was "clearly not a pseudo bursa."

Dr. Dubrow did not believe SM's condition was outside of the bounds of what respondent could handle. He stated SM had a rare condition that could only be seen by a high volume liposuction provider; a seroma is a common occurrence and most resolve without significant intervention. He testified respondent did not violate the standard of care when he did not consult with Dr. Borup unless the condition was getting worse and had not gone away after six to nine months of conservative treatment.

195. Clear and convincing evidence supports a finding that respondent violated the standard of care when he failed to consult with Dr. Borup regarding SM and when he failed to provide proper post-operative care and treatment to SM.

Respondent's Evidence of Mitigation

196. In 2010 – 2011, the Medical Board of California investigated a complaint that Dr. Borup was aiding and abetting the illegal practice of medicine by respondent concerning his work at Pacific Liposculpture. On February 11, 2011, Dr. Borup received a letter from the Medical Board advising him that it had concluded its review of the complaint and that no further action would be taken. Respondent was aware of the Medical Board's investigation, and Dr. Borup told him when the investigation was closed. Respondent felt relieved and believed the Medical Board's action was tacit support of the work he was doing at Pacific Liposuction. No evidence was presented concerning the evidence the Medical Board considered when it reached its decision.

197. Respondent had only two more months of probation when he began to work with Dr. Borup. Mr. Rodriguez did not have an in-person meeting with respondent and Dr. Borup, but he approved Dr. Borup as his supervising physician. Respondent interpreted Mr. Rodriguez's approval of Dr. Borup as a sanctioning of his work at Pacific Liposculpture.

198. Respondent is currently working with Harrison M. Robbins, M.D. Dr. Robbins has been certified by the American Board of Cosmetic Surgery since 1981. He is the medical director and principal surgeon of the Cosmetic Surgery and Liposuction Center of San Diego. Dr. Robbins did not testify at the hearing and little evidence was presented about respondent's duties and responsibilities in his work with Dr. Robbins.

Cost Recovery

199. Complainant filed declarations to seek costs related to the investigation and prosecution of this matter in the amount of \$113,201.50. This amount was based on \$17,171.50 for investigative and expert review costs and \$96,030 for costs incurred by the Attorney General's Office. Respondent did not testify about his ability to pay costs, if awarded.

LEGAL CONCLUSIONS

The Purpose of Disciplinary Proceedings

1. The purpose of an administrative disciplinary proceeding is not to punish; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

Burden and Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the accusation are true.

3. The standard of proof required is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This is a heavy burden. Guilt must be established to a reasonable certainty and cannot be based on surmise or conjecture, suspicion or theoretical conclusions, or uncorroborated hearsay. (*Pettit v. State Board of Education* (1973) 10 Cal.3d 29, 37.) It requires a finding of high probability; it is evidence so clear as to leave no substantial doubt, or evidence so sufficiently strong that it commands the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Applicable Statutory and Regulatory Authority

4. Business and Professions Code section 3527, subdivision (a), provides that the Physician Assistant Board may suspend or revoke or impose probationary conditions on a physician assistant license "for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California."

5. Business and Professions Code section 3527, subdivision (f), authorizes the board to "order the licensee to pay the costs of monitoring the probationary conditions imposed on the license."

6. Business and Professions Code section 3502, subdivision (a), authorizes a physician assistant to perform certain medical services as are set forth in adopted regulations "when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant." Subdivision (a) requires that the patient's "medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant."

7. Business and Professions Code section 3502, subdivision (c), provides:

(1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2) (A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other law, the Medical Board of California or the board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

8. Business and Professions Code section 2234 provides, in 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:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

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

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

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

[¶] . . . [¶]

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

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

9. Business and Professions Code section 2052, subdivision (a), provides:

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

10. Business and Professions Code section 2264 provides that “[t]he employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.”

11. Business and Professions Code section 2271 provides that “[a]ny advertising in violation of Section 17500, relating to false or misleading advertising, constitutes unprofessional conduct.”

12. Business and Professions Code section 651, subdivision (a), prohibits a licensee from disseminating “any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services . . . in connection with the professional practice or business for which he or she is licensed.” A “public communication” includes communication on the internet and other electronic communication.

13. Business and Professions Code section 651, subdivision (b) provides:

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

(1) Contains a misrepresentation of fact.

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

[¶] . . . [¶]

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

[¶] . . . [¶]

14. Business and Professions Code section 651, subdivisions (e) and (g) provide:

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

[¶] . . . [¶]

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

15. Business and Professions Code section 17500 provides that it is unlawful for any business or employee of a business "with intent directly or indirectly . . . to perform services, professional or otherwise" to disseminate an advertisement to the public of any state, "any statement, concerning . . . those services, . . . or concerning any circumstance or matter of fact connected with the proposed performance . . . which is untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading Any violation of the provisions of this section is a misdemeanor punishable by imprisonment in the county jail not exceeding six months, or by a fine not exceeding two thousand five hundred dollars (\$2,500), or by both that imprisonment and fine."

16. California Code of Regulations, title 16, section 1399.521, provides:

In addition to the grounds set forth in section 3527, subd. (a), of the code the board may deny . . . suspend, revoke or place on probation a physician assistant for the following causes:

(a) Any violation of the State Medical Practice Act which would constitute unprofessional conduct for a physician and surgeon.

[¶] . . . [¶]

(d) Performing medical tasks which exceed the scope of practice of a physician assistant as prescribed in these regulations.

17. California Code of Regulations, title 16, section 1399.540, provides:

(a) A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

(b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

(c) The board or Medical Board of California or their representative may require proof or demonstration of competence from any physician assistant for any tasks, procedures or management he or she is performing.

(d) A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician.

18. California Code of Regulations, title 16, section 1399.541, describes the tasks and activities that may be performed by a physician assistant and provides:

Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician.

In any setting, including for example, any . . . out-patient settings . . . a physician assistant may, pursuant to a delegation and protocols where present:

(a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.

(b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.

(c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

(d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

(e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.

[¶] . . . [¶]

(h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code.

(i)(1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of a supervising physician.

(2) A physician assistant may also act as first or second assistant in surgery under the supervision of a supervising physician. The physician assistant may so act without the personal presence of the supervising physician if the supervising physician is immediately available to the physician assistant. "Immediately available" means the physician is physically accessible and able to return to the patient, without any delay, upon the request of the physician assistant to address any situation requiring the supervising physician's services.

19. California Code of Regulations, title 16, section 1399.542, provides that the supervising physician continues to be responsible for the welfare of a patient even if the care of the patient has been delegated to a physician assistant.

20. California Code of Regulations, title 16, section 1399.543, subdivision (a), provides that "[a] physician assistant may be trained to perform medical services which augment his or her current areas of competency" by being in "the physical presence of a supervising physician who is directly in attendance and assisting the physician assistant in the performance of the procedure."

21. California Code of Regulations, title 16, section 1399.545 describes the responsibilities of a supervising physician as follows:

(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem,

treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

(4) Other mechanisms approved in advance by the board.

(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision.

Resolving Conflicting Expert Testimony

22. In resolving any conflict in the testimony of expert witnesses, the opinion of one expert should be weighed against that of another. Consideration should be given to the qualifications and believability of each witness, the reasons for each opinion, and the matter upon which it is based. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reason upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

23. The determinative factor is whether the expert has sufficient skill or experience in the field so that his or her testimony would assist in the search for the truth. (*Chavez v. Glock, Inc.* (2012) 207 Cal.App.4th 1283, 1319.)

24. In this case, each of the experts was qualified to provide expert opinions. A trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal. 3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.)

Here, in some instances as discussed above, one or more of the experts was more qualified or provided more reasoned, credible testimony, and was therefore more persuasive on particular issues. Additionally, there were significant areas in which the experts' opinions overlapped. Relying on certain portions of an expert's opinion, as was done here, is entirely appropriate.

The Standard of Care, Gross, and Repeated Negligence

25. A medical professional need only exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of the professional specialty under

similar circumstances. (See, *Tarasoff v. Regents of University of California* (1976) 17 Cal.3d 425, 438.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a health care professional acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

26. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-198; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

27. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.)

28. Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

Evaluation and Analysis

RESPONDENT ENGAGED IN THE UNLAWFUL PRACTICE OF MEDICINE WITHOUT A LICENSE

RESPONDENT HIRED DR. BORUP TO ENSURE HE WOULD NOT BE SUPERVISED, AND DR. BORUP FAILED TO ADEQUATELY SUPERVISE RESPONDENT

29. Throughout the hearing, respondent made it clear that he resented performing liposuction surgeries for doctors who he felt were less qualified than him, and who made their living from his work, skills and talents. In order to have the control he wanted and get the pay he believed he deserved, respondent purposefully and intentionally set out to create a business arrangement that looked legitimate on paper, but allowed him to manipulate the system and run a liposuction business without the interference of a physician.

Respondent hired Dr. Borup, who may have been well-intentioned, but lacked recent medical experience and was trying to return to medicine after suffering a debilitating stroke that left him unable to practice for 12 years. Respondent determined, even before the DSA was signed, that Dr. Borup would never perform a liposuction at Pacific Liposculpture. Dr. Borup's entire experience performing liposuction was obtained at a weekend course he attended after he signed the DSA, during which he participated in two liposuctions. He never performed another liposuction. Dr. Borup watched several liposuctions respondent performed in the beginning of their business relationship; however he had already agreed not to perform any himself. Dr. Borup was exactly what respondent was looking for: a physician who was inexperienced in performing liposuction and was grateful to be associated

with the practice of medicine, who would not insist on having input into the business operations, who would not make demands or perform liposuctions, and who would provide respondent the cover of a physician that he needed to conduct his business.

30. After his initial observations, Dr. Borup had no involvement in Pacific Liposculpture other than coming by the office occasionally to review a stack of medical records and to pick up his check. Dr. Borup and respondent contended that Dr. Borup went above and beyond his obligation to review five percent of the medical records he was required to review in his capacity as a supervising physician, and that Dr. Borup actually reviewed ninety percent of them. That contention is rejected. California Code of Regulations, title 16, section 1339.5445, subdivision (e)(3), requires that, when protocols are in effect between a supervising physician and a physician assistant, the supervising physician "shall review, countersign, and date a minimum of 5 percent sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days." In the medical records presented at the hearing, the ones signed by Dr. Borup were not dated, and it was not possible to determine whether he reviewed those records within 30 days of the treatment. The only note Dr. Borup dated was the one he drafted after his conversation with Dr. Batra.

Dr. Borup did not see patients, did not consult with patients, did not perform any administrative duties, and did not participate in Pacific Liposculpture's business. Dr. Borup's contention that he and respondent spoke often about the cases respondent handled was not persuasive, given respondent's testimony that he felt no need to consult with Dr. Borup when CN, LW, KD and SM were contacting him with continuing concerns about their surgeries. In fact, when respondent determined his discussions with KD were not going well, he said he would turn the matter over to his attorneys – not Dr. Borup. It is more likely that respondent's talks with Dr. Borup were idle conversations about perfunctory matters related to the business and were not significant conversations about patients or other aspects of the business.

31. Dr. Borup allowed respondent to operate autonomously and without proper supervision. Although the DSA and other business related agreements complied, on their faces, with the statutes and regulations governing physician assistants and supervising physicians, in practice, the agreements were ignored. In discussing SM's complaints, Dr. Borup testified that he "might" have spoken to respondent about them, but if he didn't he trusted respondent to do the right thing. Dr. Borup did not appear to be deceitful or coy in his testimony, and it is found that his testimony was sincere; however, there were several times when he was confused and uncertain. Dr. Borup had little, if any, idea of what was going on at Pacific Liposculpture.

32. The evidence demonstrated by clear and convincing proof that Dr. Borup allowed respondent to operate autonomously in violation of California Code of Regulations, title 16, section 1399.545, subdivision (f).

DR. BORUP WAS NOT COMPETENT TO DELEGATE AUTHORITY TO RESPONDENT

33. A supervising physician may delegate to the physician assistant "only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice." (Cal. Regs., tit. 16, § 1399.545, subdivision (b).) The evidence demonstrated by clear and convincing proof that liposuction surgery was not consistent with Dr. Borup's specialty or his usual and customary practice. He improperly delegated medical tasks and procedures to respondent.

CONCLUSION RE: UNLAWFUL PRACTICE OF MEDICINE

34. Respondent's liposuction practice was not conducted under the type and level of physician supervision required within the meaning of Business and Professions Code, section 3502. Business and Professions Code section 3500, states the purpose of the Physician Assistant Practice Act:

The purpose of this chapter is to encourage the more effective utilization of the skills of physicians, and physicians and podiatrists practicing in the same medical group practice, by enabling them to delegate health care tasks to qualified physician assistants where this delegation is consistent with the patient's health and welfare and with the laws and regulations relating to physician assistants.

35. Respondent's actions and business relationship with Dr. Borup circumvented this purpose and the supervision required before respondent could perform certain medical services. Under Business and Professions Code section 2052, an individual must have a valid medical license to advertise or hold himself out as practicing any system or mode of treating the sick, or to diagnose or treat any blemish, deformity, disfigurement, or other physical or mental condition. Section 3502 authorizes a licensed physician assistant to perform medical services authorized by the regulations "when the services are rendered under the supervision of a licensed physician and surgeon." As established above, respondent did not render services under Dr. Borup's supervision. He practiced medicine without appropriate delegated authority, exceeded the delegated scope of practice, and practiced without adequate supervision. Clear and convincing evidence established that respondent engaged in the unlawful practice of medicine without a license.

36. Respondent contended that his actions did not constitute the unlawful practice of medicine without a license. In support, he argued that the regulations allow physician assistants to perform liposuctions under a local anesthesia without the personal presence of a supervising physician. Respondent's argument is misplaced.

Had respondent been properly supervised as required by law, he may have been allowed to perform liposuctions under a local anesthetic, but this decision does not reach that

issue. The conclusion that respondent engaged in the unlawful practice of medicine does not rely on whether liposuction is regularly performed under local anesthesia.

The statutes governing the tasks, duties and responsibilities that may be delegated to a physician assistant are extremely broad. Under California Code of Regulations, title 16, section 1399.541, subdivision (i)(1), a physician assistant may perform a surgical procedure customarily performed under local anesthesia without the personal presence of the supervising physician. The evidence established it is not unusual or a violation of a standard of care to perform liposuction surgery under a local anesthetic. Dr. Batra testified that dermatologists, who regularly perform liposuctions, always perform them under local anesthesia. The remaining experts testified that they perform some liposuctions under local anesthetic. However, for them, liposuction is typically a part of a larger, more complicated surgery that must be performed under a general anesthesia; in those cases, the standard of care is to use a general anesthesia.

37. Although complainant failed to establish that liposuction is a procedure that is not customarily performed under local anesthesia, this decision nonetheless finds that respondent choreographed a medical practice that ensured he would not be properly supervised as a physician assistant. Clear and convincing evidence established that respondent engaged in the unlawful practice of medicine without a license.

RESPONDENT WAS GROSSLY NEGLIGENT IN HIS CARE & TREATMENT OF PATIENT SM

38. Clear and convincing evidence established that respondent engaged in an extreme departure from the standard of care and that he committed gross negligence in his post-operative care and treatment of patient SM. Dr. Sundine opined that respondent should have aspirated the patient's lump and referred her to Dr. Borup, and that his failure to do so was an extreme departure from the standard of care. Although Dr. Dubrow disputed that SM had a pseudo bursa and agreed with respondent's initial recommended post-operative care, Dr. Dubrow did not examine SM. Additionally, he conceded that SM's lump should have been drained if it had not resolved itself after a period of time. Dr. Batra, a plastic surgeon and SM's subsequent treating physician, examined SM, and concluded that she had a pseudo bursa that should have been aspirated. Based on the totality of the evidence, Dr. Sundine's opinion was more persuasive than Dr. Dubrow's on this issue. Respondent was grossly negligent in his care and treatment of patient SM.

RESPONDENT ENGAGED IN REPEATED NEGLIGENT ACTS

39. Respondent engaged in repeated negligent acts in his care and treatment of LW, CN, KD and SM. Respondent used consent forms for each patient that were misleading and did not adequately inform the patients who would be performing their surgeries. Respondent's false and misleading advertisement and the confusing use of the title Director of Surgery caused patients to reasonably believe a medical doctor would have some involvement in their procedures. Each of these constituted departures from the standard of

care. In addition, respondent's post-operative care of SM constitutes additional repeated negligence. Clear and convincing evidence established that respondent engaged in repeated negligent acts.

RESPONDENT ENGAGED IN FALSE AND/OR MISLEADING ADVERTISING

40. Pacific Liposculpture advertised its services on the internet. At various times, the advertisements contained false and misleading statements, particularly as related to Dr. Borup and the "experienced team" of professionals who performed liposuctions. Respondent admitted the falsity of some of the content of Pacific Liposculpture's website, but contended he was not responsible for posting content on the website. Evidence at the hearing established respondent was involved in approving the content of the website and, as CEO of Pacific Liposculpture, Inc., he was further responsible for its content. The evidence also showed respondent regularly reviewed Pacific Liposculpture's website and knew, or should have known, it contained false and misleading statements.

Statements that the liposuction procedure was painless do not rise to the level of false and misleading. The level of pain or discomfort varies with each patient and many patients do not have pain with the procedure.

Respondent's use of the title Director of Surgery, in conjunction with his being the medical practitioner performing all the liposuction surgery at Pacific Liposuction and his failure to define his credentials and rely instead upon the abbreviations "P.A." or "PA - C," constitutes misleading advertising.

41. The evidence showed by clear and convincing proof that respondent disseminated false and misleading advertising.

RESPONDENT ENGAGED IN DISHONESTY

42. Clear and convincing evidence established that respondent was dishonest by his false and misleading advertising.

GENERAL UNPROFESSIONAL CONDUCT

43. Pursuant to the findings of facts and discussions above, respondent engaged in acts that constituted engaging in the unlawful practice of medicine, gross negligence, repeated negligent acts, and disseminating false and misleading advertising. Clear and convincing evidence established that respondent engaged in unprofessional conduct that is unbecoming a member in good standing in the medical profession, breached the rules and ethical codes of a physician assistant, and demonstrates an unfitness to practice as a physician assistant. (See *Shea v. Board of medical Examiners* (1978) 81 Cal.App.3d 565, 575.).

Cause Exists to Impose Discipline on Respondent's License

44. Cause exists under Business and Professions Code sections 3527, 2234, and California Code of Regulations, title 16, section 1399.521, subdivision (d), to impose discipline on respondent's license. Clear and convincing evidence established respondent engaged in the unlicensed practice of medicine, as described in the Findings of Fact and Evaluation above.

45. Cause exists under Business and Professions Code sections 3527, 2234, and California Code of Regulations, title 16, section 1399.521, subdivision (a), to impose discipline on respondent's license. Clear and convincing evidence established respondent was grossly negligent in his post-operative treatment of SM, in violation of Business and Professions Code section 2234, subdivision (b), as described in the Findings of Fact and Evaluation above.

46. Cause exists under Business and Professions Code sections 3527, 2234, and California Code of Regulations, title 16, section 1399.521, subdivision (a), to impose discipline on respondent's license. Clear and convincing evidence established respondent engaged in repeated acts of negligence in his care and treatment of LW, CN, KD, and SM, in violation of Business and Professions Code, section 2234, subdivision (c), as described in the Findings of Fact and Evaluation above.

47. Cause exists under Business and Professions Code sections 3527, 2234, and California Code of Regulations, title 16, section 1399.521, subdivision (a), to impose discipline on respondent's license. Clear and convincing evidence established respondent disseminated false and misleading advertising in violation of Business and Professions Code sections 651, subdivisions (a), (b), and (e) and section 2271, as described in the Findings of Fact and Evaluation above.

48. Cause exists under Business and Professions Code sections 3527, 2234, and California Code of Regulations, title 16, section 1399.521, subdivision (a), to impose discipline on respondent's license. Clear and convincing evidence established that respondent engaged in acts of dishonesty, in violation of Business and Professions Code section 2234, subdivision (e), when he disseminated false and misleading advertising, as described in the Findings of Fact and Evaluation above.

49. Cause exists under Business and Professions Code sections 3527, 2234, and California Code of Regulations, title 16, section 1399.521, subdivision (a), to impose discipline on respondent's license for general unprofessional conduct. Clear and convincing evidence established respondent engaged in conduct that breached the rules or ethical code for physician assistants and which was unbecoming of a physician assistant in good standing in the medical profession, as described in the Findings of Fact and Evaluation above.

Cause for Discipline was Not Established for All Charges

50. As explained above, clear and convincing evidence did not establish respondent failed to maintain adequate and accurate medical records in violation of Business and Professions Code section 2266.

51. As explained above, clear and convincing evidence did not establish that respondent engaged in an extreme departure from the standard of care in his care and treatment of patients LW, NC, or KD, in violation of Business and Professions Code sections 2234, subdivision (b).

The Appropriate Measure of Discipline

52. The board has issued Disciplinary Guidelines to assist in determining the proper measure of discipline to be imposed for a licensee's violations. For findings of deceptive advertising, the guidelines recommend a minimum penalty of stayed revocation with at least two years' probation to a maximum of revocation. For findings of gross negligence and repeated acts of negligence, the guidelines recommend a minimum penalty of stayed revocation with at least five years' probation to a maximum of revocation. For findings of dishonesty, the guidelines recommend a minimum penalty of stayed revocation with at least five years' probation to a maximum of revocation. For findings of practicing medicine without delegated authority, exceeding the delegated scope of practice and without adequate supervision, the guidelines recommend a minimum penalty of stayed revocation with at least three years' probation to a maximum of revocation.

The absence of prior discipline is an important mitigating circumstance, and it is a particularly strong factor when the professional has engaged a professional practice for a substantial time. (*Waysman v. State Bar* (1986) 41 Cal.3d 452, 457 [12 years of practice].) A professional's good faith is a matter to consider in determining whether discipline should be imposed for acts done through ignorance or mistake. (*Black v. State Bar* (1972) 7 Cal.3d 676, 692.)

53. In this case, respondent has a history of discipline. His license was issued on a probationary basis because he failed to disclose a criminal conviction for being a "disorderly person" he received in 1992, when he was 18 years old. The prior discipline of respondent's license was based on conduct that was remote in time, and does not require enhanced discipline here.

However, the allegations in this case, and the findings on those allegations, are extremely serious. Respondent does not have a medical degree, yet he believed himself to be more experienced, trained, and skilled than a medical doctor. Although respondent may be skilled at performing liposuction surgeries, he is not a physician. Respondent does not have the breadth of experience and knowledge gained by going through medical school courses, and successfully completing an internship and residency. Respondent (and the public) were

fortunate that respondent was not faced with a life threatening medical complication that could have presented during the procedures.

Perhaps more disturbing, and certainly reflective of respondent's character and judgment, was his conduct in establishing Pacific Liposculpture with the clear intent to practice medicine without competent supervision. He obtained the services of a physician who had absolutely no experience in liposuctions, who agreed not to perform any liposuctions, and who was content to stop by occasionally to look at some records and pick up a check. And there is a serious question as to whether Dr. Borup was competent to evaluate the standard of care represented by those records.

Although respondent sought a physician with little or no experience, he disseminated, or caused to be disseminated, advertisements that misrepresented and exaggerated Dr. Borup's credentials and the make-up of the Pacific Liposculpture's professional "team." At the time he was touting Pacific Liposculpture's vast experience, training and knowledge, he had only been licensed as a physician assistant in California for three years. Respondent testified he tried to change and/or remove any potentially misleading information and he stated he no longer uses the title Director of Surgery. However, his testimony lacked a sincere demonstration of admission of error, remorse or contrition; instead he testified he took these actions because he thought the board wanted him to, and to avoid the strict scrutiny of the board.

It was suggested that respondent is currently working for a board certified plastic surgeon, and is now properly supervised. However, that physician did not appear at the hearing and no evidence was presented about the terms and conditions of respondent's current employment.

54. The board's highest priority in exercising its licensing, regulatory, and disciplinary functions is protection of the public. "Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount." (Bus. & Prof. Code, § 3504.2.) Under the totality of the circumstances presented, the public would not be protected if respondent were to retain his license. Careful thought and deliberation was given to alternate disciplinary measures; however, the cumulative nature of respondent's conduct, his intentional scheme to circumvent the rules and regulations governing physician assistants, and consideration of the overriding concern for public safety require this result. Revocation is the only appropriate measure of discipline that will protect the public.

The Reasonable Costs of Investigation and Prosecution

55. Under Business and Professions Code section 125.3, complainant may request that an administrative law judge "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."

The Office of Administrative Hearings (OAH) has enacted regulations for use when evaluating an agency's request for costs under Business and Professions Code section 125.3. (Cal. Code Regs., tit. 1, § 1042.) Under the regulations, a cost request must be accompanied by a declaration or certification of costs. The declaration "may be executed by the agency or its designee and shall describe the general tasks performed, the time spent on each task and the method of calculating the cost." Alternatively, the agency may provide a bill or invoice. (Cal. Code Regs., tit. 1, § 1042, subd. (b)(1).) For services provided by persons who are not agency employees, the declaration must be executed by the person providing the service and must describe the general tasks performed, the time spent on each task and the hourly rate. In lieu of the declaration, the agency may attach copies of the time and billing records submitted by the service provider. (Cal. Code Regs., tit. 1, § 1042, subd. (b)(2).)

56. Complainant seeks costs related to the investigation and prosecution of this matter in the amount of \$113,201.50, based on \$17,171.50 for investigative costs and expert review services, and \$96,030.00 for costs incurred by the Attorney General's Office through February 15, 2016. Under Business and Professions Code section 125.3, costs awarded may not exceed the reasonable costs of investigation and enforcement of the case with respect to the licensing act violations. In this case, all of the charges alleged in the Accusation were allegations that respondents violated the rules, regulations and policies that govern physician assistants.

57. Five documents certified by Thomas Morris, Supervising Investigator for the Division of Investigation, related to investigative and expert review services costs incurred with regard to the accusation against respondent. Each document referenced as different "Division of Investigation Case Number." For the investigative services costs, each document listed the hourly rate and total number of hours spent on its respective sub-case for the years "2013/2014" and "2014/2015."⁴⁰ The hours were broken down into an approximation of how many hours were spent on conducting interviews, records review, travel and report writing. For example, the document relating to Division of Investigation Case Number IE-2013-230309 provided, "Of the costs shown above, approximately 4 hours were spent on conducting interview; 4 hours spent on records review; 3 hours spent on travel; 4 hours spent on report writing."

For the Expert Review Services, dates, hours, and the hourly rate were provided. No other information, not even the name of the expert reviewer, was provided.

None of the documents included information regarding, the specific tasks performed, the date they were performed, or how long each task took. Further, one of the certifications related to an investigation of a complaint presumptively filed by a patient whose allegations were not included in the accusation. Because the certifications did not comply with the OAH regulation, it is impossible to determine if the costs claimed are permissible charges under Business and Professions Code section 125.3, or to determine the reasonableness of the costs

⁴⁰ It is assumed the reference is to the fiscal year.

being sought. As a result, complainant's request for investigative and expert review costs must be denied.

58. The Certification of Prosecution Costs prepared by Deputy Attorney General Martin W. Hagan suffers from the same infirmities. The certification from Mr. Hagan requested costs of enforcement in the amount of \$96,030. The certification failed to include a breakdown of tasks by the professional who performed them, their general nature, the amount of time spent on each task, and the amount charged; it listed only a cumulative amount of hours incurred by four persons from October 2014 through February 2016, their hourly rate and the total claimed. Because the certification did not comply with the OAH regulation, it is impossible to determine if the costs claimed are permissible charges under Business and Professions Code section 125.3, or to determine the reasonableness of the costs being sought. As a result, complainant's request for prosecution fees and costs must be denied.

ORDER

IT IS HEREBY ORDERED THAT Physician Assistant License PA19449 issued to respondent, Rodney Eugene Davis, is revoked.

DATED: April 25, 2016

DocuSigned by:

Susan J. Boyle

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SUSAN J. BOYLE
Administrative Law Judge
Office of Administrative Hearings

**BEFORE THE
PHYSICIAN ASSISTANT BOARD
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation)	Case No: 1E-2013-230309
)	
RODNEY EUGENE DAVIS, P.A.)	
)	
Physician Assistant)	
License Number PA 19449)	
)	
<u>Respondent</u>)	

ORDER GRANTING STAY

On June 7, 2016, Robert W. Frank, Esq. on behalf of Rodney Eugene Davis, P.A., filed a Petition for Reconsideration of the Decision in this matter. The Decision was made and entered on May 13, 2016, with an effective date of June 10, 2016.

Execution is stayed until June 20, 2016.

This stay is granted solely for the purpose of allowing the Board time to evaluate and consider the Petition for Reconsideration of Decision.

DATED: June 8, 2016

PHYSICIAN ASSISTANT BOARD

By: 

Glenn L. Mitchell, Jr.
Executive Officer

**BEFORE THE
PHYSICIAN ASSISTANT BOARD
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:)
)
RODNEY EUGENE DAVIS, P.A.)
)
Physician Assistant)
License Number PA 19449)
)
Petitioner)
)
_____)

Case No. 1E-2013-230309

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Robert W. Frank, Esq. on behalf of Rodney Eugene Davis, P.A. for the reconsideration of the decision in the above-entitled matter having been read and considered by the Physician Assistant Board, Medical Board of California, is hereby denied.

This Decision remains effective at 12:01 a.m. on June 20, 2016.

IT IS SO ORDERED: June 16, 2016



Robert E. Sachs, P.A., President