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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
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BY _____ ANALYST

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

In the Matter of the Accusation Against: Jamshid Elist, M.D. 8500 Wilshire Blvd., # 707 Beverly Hills, California 90211 Physician's and Surgeon's Certificate No. A 35400, Respondent.	Case No. 800-2015-016513 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 23, 1980, the Medical Board issued Physician's and Surgeon's Certificate Number A 35400 to Jamshid Elist, M.D. (Respondent). That Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or

omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTS

Patient 1[1]

7. Patient 1 is a 37-year-old man who contacted Respondent expressly for the purpose of undergoing penile enhancement therapy. The records indicate that the patient was aware of

[1] The patients herein are described numerically to protect their privacy.

various options to address his medical problem, aware of the controversial nature of surgery, aware of the pros and cons, risks and benefits of different treatment options and specifically reached out to Respondent from Pennsylvania to undergo a procedure that Respondent advertises and supports. The patient reviewed a brochure and reviewed Respondent's website with respect to this procedure, the indications and the outcomes but was not informed of the complications that might ensue with an explant, if necessary.

8. Respondent evaluated Patient 1 for the first time on February 24, 2014, and the patient was scheduled for surgery on the same day. Respondent diagnosed penile dysmorphia (this is not a recognized clinical diagnosis--the preferred term refers to "Body Dysmorphic Disorder, emphasis on penile size"). Respondent's notes reflect that Patient 1 was dissatisfied with penile length and girth in the flaccid condition. Surgery was performed on February 24, 2014, at which point a suprapubic incision allowed entrance to the dorsum of the penis and a soft silicone rod was trimmed and implanted subcutaneously, oversewn with mesh distally, irrigated with antibiotic solution and given topical antibiotic coverage. This was performed as an outpatient in an ambulatory surgery center and the patient was followed as an outpatient for the next few days.

9. Patient 1 was given explicit instructions on wound care emphasizing that he should not put pressure on the penis, should not engage in sexual activity, should not resume smoking nor the use of alcohol for a number of weeks until the area was well-healed. Patient 1 flew home from Beverly Hills to Pennsylvania but remained in close contact with Respondent's office via e-mail, supplying numerous follow up comments about his course and numerous pictures.

10. Patient 1's communications indicate that he challenged the recommendations from Respondent's office on numerous occasions and resumed alcohol use, tobacco use and vigorous sexual activity before he was fully healed. By the patient's own admission, he was extremely sexually active up to four times a day and had vigorous pressure on the penis from lap dancing at a point in time when Patient 1 felt he was healed but Respondent did not think Patient 1 was healed. As a consequence, the patient developed soreness in the penis and ultimately penile skin breakdown with erosion of the device through the dorsum of the penile shaft. After a lengthy

intensive trial of conservative therapy at a distance, over the phone and via e-mail, the patient returned to California because the device had eroded and become infected. He then underwent device removal.

11. On May 27, 2014, as an outpatient, the device was removed via the same suprapubic incision due to "inappropriate sexual and physical behavior" according to Respondent's notes. Vigorous antibiotic therapy and antibiotic irrigation were used at this surgery and a scar revision was undertaken.

12. Patient 1 returned home and was in frequent contact with Respondent's office regarding his course of therapy. Numerous medications, many of which are not standard therapy, were recommended for wound healing and to enhance the resolution of scar tissue including local Kenalog injections (a steroid). During this interval, the patient was no longer sexually active.

13. Patient 1 was extremely interested in pursuing a new implant and wished to have the re-implant done at the earliest possible opportunity. Respondent's notes indicate that he put the patient off until such time as it appeared the wound had completely healed and risks for re-implant were minimized. Patient 1's demands for the re-implant were aggressive requesting that the surgery be done as early as possible. Respondent's notes and e-mails show that he told Patient 1 that the repeat surgery should wait until the wound was completely healed and risk of further complications were minimized.

14. Patient 1 used a number of nonstandard medications to enhance wound healing. He took a prolonged course of antibiotics after the May 27, 2014, explant to minimize wound infection. Ultimately, a decision was made to re-implant the penile prosthetic. At the same time, Patient 1 requested a bilateral testicular prosthesis be implanted to enhance the size of the testicles.

15. Respondent committed to the testicular implant but did not commit on the penile re-implant until he had examined the patient and determined that he was a good candidate. On October 27, 2014, five months following explant for extrusion, repeat surgery was performed and an "extra large-sized penile prosthesis" (larger than the original implant) was placed into the dorsum of the penile shaft in a subcutaneous position and, at the same time, through separate

lateral high scrotal incisions, bilateral testicular prostheses were also placed. The patient underwent vigorous wound irrigation with antibiotics (but not standard according to AUA protocols), IV antibiotics and a course of oral antibiotics thereafter. This was performed at an ambulatory surgery center as an outpatient, but the patient followed up daily for the next several days to ensure early proper wound healing. Ultimately, the suprapubic drain was removed and the patient was discharged back home.

16. Patient 1 again used numerous nonstandard medications to enhance wound healing and minimize complications but he ultimately developed evidence of erosion again on the dorsum of the penis. By March 2, 2015, the device had eroded once again on the dorsum of the penis in two spots (the same two spots of erosion that had occurred before) and the patient underwent a repeat explant of the second device. The patient returned home to Pennsylvania where he noticed considerable serosanguinous drainage from the penis and ultimately presented to a local emergency room where he underwent repeat surgery for control of bleeding and drainage.

17. Patient 1 healed, but now complains of deformed erections, difficulty achieving erections and scarring that causes retraction and tethering of the penile shaft with erection. He has contacted numerous other urologists to investigate reconstructive surgery but has not undertaken it so far because of the expense involved.

Patient 2

18. Patient 2 is a 54-year-old anesthesiologist from Texas who sought treatment from Respondent on August 4, 2015, for complaints of a tethered left spermatic cord with high-riding left testicle following a left hernia repair in 1994, which caused scarring of the left spermatic cord. On the intake form Patient 2 indicates his displeasure with his penile length and girth. On physical examination Respondent also noted that Patient 2 was dissatisfied with his penile dimensions. Notwithstanding, Respondent's notes indicate that Patient 2's genital size preoperatively was within normal limits. Based on the patient's subjective displeasure with the dimensions of his penis, Respondent diagnosed penile dysmorphia. Rather than recommend counseling for Body Dysmorphic Disorder-emphasis on penile size, Respondent recommended surgical enhancement with a foreign body.

19. Patient 2 maintains that he was misinformed of the complications (only "1 in a million") and was told by Respondent that the implant was free of consequences and free of complications, despite the multipage informed consent form. Patient 2 further claims that he had no preoperative complaints of erectile dysfunction or performance problems.

20. On August 4, 2015, Patient 2 underwent a left spermatic cord release, orchidopexy and penile solid silicone rod subcutaneous implant procedures. He had no intraoperative or initial post-operative complications. He returned home to Texas.

21. Shortly thereafter, Patient 2 complained of irritation and swelling of the penis, painful sexual activity, temporary numbness of the penile shaft and difficulty voiding and ejaculating. Patient 2 sought consultation from a local urologist who found that the penile implant was compressing the urethra leading to obstruction upon erection, causing attempts at voiding or ejaculation to create proximal ballooning of the urethra. The implant device was in imminent danger of eroding the surrounding tissue.

22. By September 20, 2015, Patient 2 advised Respondent of his desire to have the implant removed. Respondent strongly recommended that only he be allowed to perform the removal surgery, as any other urologist would likely lead to disastrous complications. Patient 2 consulted with a second urologist in California, Dr. G.A., who confirmed inappropriate placement of the penile implant causing Patient 2's complications. On December 9, 2015, Dr. G.A. removed Patient 2's penile implant and revised the penile scar tissue. There were no complications and Patient 2 returned to Texas.

23. Patient 2 remained dissatisfied with the resulting scarring of the penis, which caused a dorsal curvature of the penis. Additionally, the penis was now shortened by 2.5 inches. Patient 2 returned to California and consulted with urology reconstruction specialist, Dr. J.G. at the University of California, Irvine. Patient 2 underwent another surgical procedure on March 26, 2016, for exploration, revision and excision of scar tissue and plaque. The surgery was somewhat successful, as the penis was elongated and had less curvature, but was not returned to it's preoperative state.

24. Patient 2 underwent a fourth surgery with Dr. J.G. on November 29, 2016, to correct

the upward dorsal curvature. By December 20, 2016, Patient 2 was improved with less curvature, greater length and less pain, however, he still had not returned to his preoperative state.

25. Respondent's website and letterhead indicate that he is board certified by the American Board of Urology; however, his board certification was dropped as of February 28, 2016.

26. The standard of care requires the surgeon to perform necessary surgery to relieve the effects of illness and injury following a full informed consent, but to deny a patient surgery on demand that is considered unnecessary. A complete and proper evaluation and diagnosis should be made before full informed consent is offered. The informed consent includes indications for surgery, the nature of intervention, pros and cons, risks and benefits, potential complications, outcomes and side effects and the ensuing course of medical therapy. When the patient presents with psychological disorders, it is the surgeon's duty to address the psychological issues and patient dissatisfaction rather than immediately offering surgery. When surgery is offered for cosmetic complaints, it is the duty of the surgeon to offer sufficient time for the patient to consider the pros and cons and the consent discussion before committing to surgery.

27. It is appropriate and within the standard of care to offer surgery for conditions to correct or alleviate the effects of medical disease. All of the patient's complaints should be addressed, but those that are not supported by objective findings should not undergo surgical intervention until all other options have been considered. Surgery, even when reversed, may lead to scarring and other changes that cannot be totally corrected.

28. The standard of care requires that when the surgeon uses subcutaneous materials to enhance penile length and girth, he/she needs to place them deep enough to not cause extrusion, while simultaneously not intruding on existing tissue, especially the urethra. Such devices and materials are generally placed on the dorsal aspect of the penis to avoid urethral compression.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent Jamshid Elist, M.D. is subject to disciplinary action under section 2234, subdivision (c) in that Respondent engaged in repeated negligent acts. The circumstances are as

follows:

Patient 1

30. Respondent's choice to repeat the surgery and place an extra large penile implant five months following explant in the area that had previously extruded, represents a simple departure from the standard of care.

31. Respondent's use of an extra large implant (larger than the original implant) and the failure to use special protocols to reduce subsequent complications represents a simple departure from the standard of care.

Patient 2

32. Respondent failed to give Patient 2 a full informed consent as to the indications for a penile enhancement surgery. Respondent also failed to afford Patient 2 the proper opportunity to consider his other options prior to undergoing surgery. These failures constitute a simple departure from the standard of care.

33. Respondent encouraged Patient 2 to undergo a second, unrelated surgery, without evidence that the penile implant was necessary. It is a simple departure from the standard of care to add an additional unnecessary surgery beyond that which was anticipated, for a condition not previously diagnosed.

34. Respondent improperly placed the penile implant[2] in Patient 2, along with surgical mesh. The improper placement led to compression of the urethra and other complications, including danger of implant extrusion, ballooning of the proximal urethra with ejaculation and voiding, extensive scar formation, and foreshortening of penile length by 2.5 inches. The failure to properly place the implant and surgical mesh is a simple departure from the standard of care.

35. It is a simple departure from the standard of care for Respondent to continue to claim and advertise that he is board certified by the American Board of Urology, when his board certification expired on February 28, 2016.

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[2] Either improper placement of the device or improper size of the implant used caused the urethral compression and danger of implant extrusion.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

36. Respondent is subject to disciplinary action under section 2266, in that he failed to maintain adequate and accurate medical records for Patient 2. The circumstances are as follows:

37. The standard of care requires the physician and surgeon to chart the patient's complaints, pertinent medical history, review of systems, and physical examination at the time or soon after a medical visit. The charting should be complete and sufficient to describe the patient's condition at the time. The charting should be unique to the patient's situation and give a true impression of the patient's condition and diagnosis at that time. Although preprinted forms or computerized systems may be used, they should be adjusted and modified according to the patient's condition.

38. As to Patient 2, Respondent's chart notes are boilerplate and preprinted. He did not specifically refer to Patient 2's condition. The documented physical examination noted that the patient's penile dimensions "are within normal limits." This documentation does not justify the plan for penile augmentation. The impression of "penile dysmorphia" appears to be preprinted. The description that the patient's testicles are atrophic and small appear to justify enhancement. The charting and examinations by other physicians do not support these findings. Respondent's preprinted notes give the appearance that Patient 2 had ample time to think about and consider the procedure and the full informed consent. The timing of the preop visit, the informed consent and time of the surgery, indicate that the consultation was immediately prior to the surgical procedure, evidencing an insufficient time to process and consider the informed consent.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 35400, issued to Jamshid Elist, M.D.;

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

3. Ordering Jamshid Elist, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: August 27, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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