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

In the Matter of the First Amended Accusation And Petition to Revoke Probation Against:	)	
Peter Vail Driscoll, M.D.	)	**Case No. 800-2016-028849**
Physician's and Surgeon's Certificate No. A72379	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 7, 2020.

IT IS SO ORDERED January 31, 2020.

MEDICAL BOARD OF CALIFORNIA

By: _____
Christine J. Lally
Interim Executive Director

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: PETER VAIL DRISCOLL, M.D. 807 Forman Avenue Point Pleasant Beach, NJ 08742 Physician's and Surgeon's Certificate No. A 72379, Respondent.	Case No. 800-2016-028849 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the former Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

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2. Peter Vail Driscoll, M.D. ("Respondent") is represented in this proceeding by attorneys Dennis Ames and Pogey Henderson, whose address is 2677 North Main Street, Suite 901, Santa Ana, California 92705-6632.

3. On or about July 1, 2000, the Board issued Physician's and Surgeon's Certificate No. A 72379 to Respondent. That license expired on January 31, 2018, and has not been renewed.

JURISDICTION

4. First Amended Accusation and Petition for Revocation No. 800-2016-028849 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and Petition for Revocation and all other statutorily required documents were properly served on Respondent on September 9, 2019. Respondent filed his Notice of Defense contesting the First Amended Accusation and Petition for Revocation. A copy of First Amended Accusation and Petition for Revocation No. 800-2016-028849 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation and Petition for Revocation No. 800-2016-028849. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation and Petition for Revocation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima* facie case with respect to the charges and allegations contained in First Amended Accusation and Petition for Revocation No. 800-2016-028849, agrees that cause exists for discipline and hereby surrenders his Physician's and Surgeon's Certificate No. A 72379 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

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

11. The parties understand and agree that Portable Document Format ("PDF") and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 72379, issued to Respondent Peter Vail Driscoll, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a cosmetic surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation and Petition for Revocation No. 800-2016-028849 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation and Petition for Revocation No. 800-2016-028849 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorneys Dennis Ames and Pogey Henderson. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 1/24/2020

PETER VAIL DRISCOLL, M.D.
Respondent

I have read and fully discussed with Respondent Peter Vail Driscoll, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 1/24/2020

DENNIS AMES
POGEY HENDERSON
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 1/24/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation and Petition to Revoke Probation against: PETER VAIL DRISCOLL, M.D. 807 Forman Avenue Point Pleasant Beach, New Jersey 08742 Physician's and Surgeon's Certificate No. A 72379, Respondent.	Case No. 800-2016-028849 **FIRST AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this First Amended Accusation and Petition to Revoke Probation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about July 1, 2000, the Medical Board issued Physician's and Surgeon's Certificate No. A 72379 to Peter Vail Driscoll, M.D. ("Respondent"). That license expired on January 31, 2018, and has not been renewed.

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3. In a matter entitled *In the Matter of the Accusation Against Peter Vail Driscoll, M.D.* Case Number 800-2015-016792, the Board issued a decision, effective April 27, 2017. Respondent's license was revoked, that revocation was stayed and Respondent was placed on probation for a period of thirty-five months on certain terms and conditions. A copy of that Decision is attached as Exhibit A and is incorporated herein by this reference.

JURISDICTION

4. This First Amended Accusation and Petition to Revoke Probation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

5. Section 118 of the Code states:

"(a) The withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.

"(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

"(c) As used in this section, 'board' includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and 'license' includes 'certificate,' 'registration,' and 'permit.'"

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6. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

"..."

7. 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."

8. 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.

"...

"(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.

"..."

9. 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."

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FACTUAL ALLEGATIONS

Patient 1[1]

10. Patient 1 was initially seen by Respondent at Boris Cosmetic Center on June 17, 2016, for a cosmetic surgery consult for a "Mommy-Makeover."[2] Respondent recommended a breast augmentation, abdominoplasty and fat transfer to the buttocks. Following the consultation, the patient elected to undergo a breast augmentation, liposuction and abdominoplasty procedure. During this initial visit, the patient arranged financing for the surgery. A fee ticket dated June 17, 2016, indicates a charge of $10,000 for "TT" and "BAM", common abbreviations for tummy tuck and breast augmentation procedures. Surgery was scheduled for June 24, 2016.

11. On the morning of June 24, 2016, Patient 1 presented to West LA Venice Surgery Center (in the same building as the Boris Cosmetic Center) for the surgery. The patient was seen by Respondent pre-operatively at which time she was informed that her Care Credit financing was arranged for breast augmentation, abdominoplasty and fat transfer to the buttocks (BBL). Patient 1 indicated that Respondent informed her that credit could not be applied to other procedures and to proceed with the planned operation she must undergo a fat transfer to the buttocks and pay an additional amount for the necessary liposuction.[3] After a discussion with Respondent, Patient 1 agreed to proceed with the BBL and liposuction. She made an additional payment of $5,000 as reflected on a Care Credit financing receipt dated June 24, 2016.

12. Respondent documented a pre-operative physical on June 24, 2016. No breast asymmetry is noted. Respondent notes that the volume of the breasts are equal with the questionable possibility of the left being greater than the right. Preoperative photos were taken that do not demonstrate a significant asymmetry of breast size. Consent documents were signed by the patient.

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[1] For privacy purposes, the patients in this First Amended Accusation are referred to as Patients 1, 2 and 3, with the identities of the patients disclosed to Respondent in discovery.

[2] A "Mommy-Makeover" as advertised on the Boris Cosmetic website, is a cosmetic surgical procedure that targets areas of the body that are most commonly associated with childbirth, which includes a breast lift or augmentation, liposuction and tummy tuck.

[3] The Care Credit policy does not specify the type of cosmetic surgery that a patient's finance funds are to be applied.

13. Respondent's operative note dated June 24, 2016, reflects that he performed a bilateral saline breast augmentation, full abdominoplasty, liposuction of the abdomen flank and back, and fat transfer to the gluteal areas at West LA Venice Surgery Center. In his operative report, Respondent sets forth that "the real Allergan HP 390-420 implant was placed in the left pocket and filled with saline to 400 cc, and an Allergan 450-420 implant was placed in the right pocket and filled to 500 cc."[4] Full abdominoplasty, liposuction and fat transfer to the buttocks were also performed. No complications were noted.

14. Patient 1 followed up with Respondent post-operatively and complained of size asymmetry in her breasts. The progress notes in the patient's chart reflect that she was seen post-operatively on July 1, 2016, July 8, 2016, July 18, 2016, August 2, 2016, and September 2, 2016. The only progress note written and signed by Respondent is the note dated September 2, 2016. He recalls seeing the patient on July 8, 2016, but did not co-sign the progress note.

15. On September 2, 2016, Respondent's progress note reflects that the patient's left breast implant should be bigger. He recommended a revision of the left side and instructed the patient to return in 3 ½ months. Photographs taken post-operatively appear to demonstrate moderate asymmetry with a smaller left versus right breast.

16. On December 21, 2016, the patient was scheduled to undergo a revision of the left breast implant surgery by Respondent at no charge. The chart notes of that date are incomplete. Respondent did not show up to the scheduled surgery and the patient left the facility without undergoing the surgery. Respondent did not reschedule and perform the revision surgery nor did he refer the patient to another surgeon.

Patient 2

17. On March 16, 2016, Patient 2 executed a 15-page informed consent regarding fat transfer procedures, fat grafts and injections to be performed by Respondent at West LA Venice Surgery Center on March 23, 2016. A History and Physical Form dated March 23, 2016, was signed and dated by Respondent on March 20, 2016. On March 23, 2016, Respondent performed

[4] The device identification cards provided to the patient reflect that the left implant was 390 cc, Style Number 68 MP (Moderate Projection) and the right implant was 450 cc, Style Number 68 MP.

liposuction of abdomen, flanks, lateral thighs, back, and fat transfer to hips and buttocks on Patient 2. The patient's discharge instructions set forth that a follow up appointment with Respondent should take place on March 24, 2016. There are no records of any post-operative follow up visits. Respondent's CURES Report reflects that on April 21, 2017, Patient 2 filled a prescription for Diazepam 10 mg (40 tablets) issued by Respondent. There are no medical records that reflect this Diazepam prescription.

Patient 3

18. On June 19, 2017, Respondent applied for and was granted temporary surgical privileges at Diamond Surgical Institute, an ambulatory surgery center, in order to perform a single cosmetic surgery procedure on Patient 3 on June 20, 2017.

19. On June 20, 2017, Patient 3 underwent a removal and replacement of breast implants and full capsulectomy bilaterally as well as a full abdominoplasty and liposuction of the back by Respondent at Diamond Surgical Institute. General anesthesia was administered during the procedure. In his operative report, Respondent noted that the procedure was performed without complication and at the end of the procedure, the patient's skin was sutured in place with 4-0 silk stitch. Respondent did not document that he left the operating room before the patient's procedure was complete.

20. On July 21, 2017, the Board received a complaint from T.L., a compliance officer at Diamond Surgical Institute, alleging that during Patient 3's June 20, 2017, procedure at Diamond Surgical Institute, Respondent left the operating room with the patient still on the operating table to attend to a personal matter. More specifically, T.L. indicated that Respondent left the operating room and permitted a non-physician scrub technician to complete the suturing of the patient's skin incision without his supervision.

21. During an interview with the Board on December 3, 2018, Respondent admitted that towards the end of the procedure, Respondent received a call from his wife. At the point of the procedure where the patient's incision was being sutured closed, Respondent left the operating room to place a call from his cell phone on a different floor of the facility because his cell phone

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did not have reception on the floor where the operating room was located. He allowed the scrub technician to complete the suturing in his absence.

STANDARD OF CARE

22. The standard of care for a cosmetic surgeon requires that when performing breast augmentation procedures, the cosmetic surgeon assess the patient's breast symmetry and size as part of the pre-operative evaluation and document any significant asymmetry. Further, the standard of care requires the surgeon to have implants available to accommodate any adjustments to size in order to achieve the best symmetry and to use good judgment in selecting the type of implant and final fill volumes.

23. The standard of care for a cosmetic surgeon requires that the surgeon also provide for a transfer of care to another similarly qualified surgeon for treatment of a post-operative complication if the surgeon does not provide the treatment himself.

24. The standard of care for a cosmetic surgeon requires that the surgeon directly supervise any simple technical tasks associated with skin closure performed by scrub technicians in the operative room. The surgeon should not permit a scrub technician to perform a skin closure in his absence from the operating room. The scrub technician must be directly supervised by the surgeon and cannot substitute for the surgeon.

25. The standard of care for a cosmetic surgeon requires that the surgeon accurately record the details of the patient's care and treatment in the patient's medical record.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

26. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he engaged in gross negligence in the care and treatment of Patient 3. Complainant refers to and, by this reference, incorporates herein, paragraphs 18 through 21, and 24 above, as though fully set forth herein. The circumstances are as follows:

27. On June 20, 2017, Respondent left the operating room before Patient 3's surgical procedure was complete, while the patient was still under anesthesia, and allowed the scrub technician to finish the skin suturing without being under the direct supervision of Respondent.

28. Respondent's acts and/or omissions as set forth in paragraphs 18 through 21, 24, 26 and 27 above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he engaged in repeated acts of negligence in the care and treatment of Patients 1, 2 and 3. Complainant refers to and, by this reference, incorporates herein, paragraphs 10 through 27, above, as though fully set forth herein. The circumstances are as follows:

30. Respondent used different size breast implants on Patient 1 which resulted in moderate size asymmetry. Respondent failed to either document an existing asymmetry or appreciate the asymmetry pre-operatively and discuss the need for different size implants with Patient 1 pre-operatively. The sequelae of Respondent's error in clinical examination or documentation resulted in the patient needing an additional revision surgery to correct the cosmetic issue of size asymmetry.

31. Respondent did not correct Patient 1's post-operative complication and failed to transfer the patient's care to another provider for continued care.

32. Respondent failed to see Patient 2 in post-operative follow up or failed to record any post-operative visit with Patient 2.

33. On June 20, 2017, Respondent left the operating room before Patient 3's surgical procedure was complete, while the patient was still under anesthesia, and allowed the scrub technician to finish the skin suturing without being under the direct supervision of Respondent.

34. Respondent's acts and/or omissions as set forth in paragraphs 10 through 33, above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

35. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate records relating to his care and treatment of Patients 1, 2 and 3. Complainant refers to and, by this reference, incorporates herein, paragraphs 10 through 19, and 25, above, as though fully set forth herein.

FIRST CAUSE TO REVOKE PROBATION

(Failure to Comply: Renewal of California Physician's and Surgeon's License)

36. At all times after the effective date of Respondent's probation, Condition 11 regarding general probation requirements, provided in pertinent part:

"...

"License Renewal

"Respondent shall maintain a current and renewed California physician's and surgeon's license.

"..."

37. At all times after the effective date of Respondent's probation, Condition 13 regarding non-practice while on probation provides in pertinent part: "Periods of non-practice for a Respondent residing outside of California, will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation applicable herein: Obey All Laws; General Probation Requirements; and Quarterly Declarations."

38. Respondent's probation is subject to revocation because he failed to comply with Condition 11 of the March 28, 2017, Decision, referenced above. The facts and circumstances regarding this violation are as follows:

39. Respondent's Physician's and Surgeon's Certificate No. A 72379 expired on January 31, 2018, and has not been renewed.

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40. On November 28, 2017, Respondent notified the Board that he was residing out-of-state and he provided an address of record in Texas. At that time, Respondent's probation was placed on non-practice status.

41. On March 14, 2018, Respondent's probation monitor advised him that he was in non-compliance with the terms and conditions of his disciplinary order as a result of his failure to maintain a current and renewed California physician's and surgeon's license.

42. On June 15, 2018, the Board issued a Citation Order pursuant to section 1364.11, subdivision (b), of Title 16 of the California Code of Regulations, to Respondent, for failing to maintain a current and renewed California physician's and surgeon's license as required by the terms and conditions of his probation. Respondent was ordered to renew his California physician's and surgeon's license within thirty (30) days from receipt of the Citation Order. To date, Respondent has not complied with the Order of Abatement.

SECOND CAUSE TO REVOKE PROBATION

(Failure to Comply: Quarterly Declarations)

43. At all times after the effective date of Respondent's probation, Condition 10, provided:

"10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

"..."

44. At all times after the effective date of Respondent's probation, Condition 13 regarding non-practice while on probation provides in pertinent part: "Periods of non-practice for a Respondent residing outside of California, will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation applicable herein: Obey All Laws; General Probation Requirements; and Quarterly Declarations."

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45. Respondent's probation is subject to revocation because he failed to comply with Condition 10 of the March 28, 2017, Decision, referenced above. The facts and circumstances regarding this violation are as follows:

46. On April 18, 2017, Respondent executed his Quarterly Declaration Due Date Statement indicating that he understands that "[f]ailure to comply with the [quarterly declarations] reporting requirements is a **violation of probation and is grounds for administrative action to revoke probation** and carry out the Decision that was stayed." [emphasis in original].

47. On July 10, 2017, Respondent executed a quarterly declaration for the reporting period of April-June 2017. The Board has received no further quarterly declarations from Respondent.

48. Multiple letters were sent to Respondent advising him that his quarterly declarations must be filled out and returned to the Board. On March 14, 2018, Respondent's probation monitor advised him that he was in non-compliance with the terms and conditions of his disciplinary order as a result of his failure to submit his quarterly declarations.

49. On June 15, 2018, the Board issued a Citation Order pursuant to section 1364.11, subdivision (b), of Title 16 of the California Code of Regulations, to Respondent, for failing to submit quarterly declarations as required by the terms and conditions of his probation. Respondent was ordered to submit any overdue quarterly declarations within thirty (30) days from receipt of the Citation Order. To date, Respondent has not complied with the Order of Abatement.

DISCIPLINARY CONSIDERATIONS

50. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that, in a prior disciplinary action entitled, *In the Matter of the Accusation Against Peter Vail Driscoll, M.D.*, before the Medical Board of California, in Case Number 800-2015-016792, Respondent's license was revoked for discipline, restriction, or limitation imposed by another state in the failure to meet the standard of care in his care and treatment of three patients in Texas. However, the revocation of Respondent's license was stayed and Respondent was placed on thirty-five months of probation, effective April 27, 2017, with the requirement that

he complete a Clinical Training Program, maintain a practice monitor and other standard terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

51. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on August 28, 2015, the Texas Medical Board issued an Agreed Order regarding Respondent's license to practice medicine in Texas. The Agreed Order contains findings that Respondent failed to meet the standard of care in his treatment of three patients. Specifically, Respondent failed to meet the standard of care performing an abdominoplasty as to one patient; failed to obtain informed consent from a patient for the use of transcutaneous sutures during the first revision surgery following a breast augmentation; and performed a trans-umbilical breast augmentation on a third patient which was contra-indicated and required revision surgeries that were unsuccessful. In addition, the Texas Board found that Respondent failed to follow Board rules for office-based anesthesia and failed to keep adequate medical records. Pursuant to the Order, Respondent was subject to various terms and conditions. On August 17, 2016, the Texas Medical Board filed a formal complaint against Respondent's license to practice medicine in Texas. That complaint was amended on April 5, 2017, and again on May 31, 2018. On October 4, 2018, Respondent's license to practice medicine in Texas was no longer active. On March 1, 2019, the formal complaint of the Texas Medical Board against Respondent's medical license number M0059 was dismissed secondary to his license no longer being active.

52. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about July 3, 2017, the Medical Board of California issued Citation No. 8002017034286 for violating the terms or conditions of probation and ordered that Respondent enroll in a Medical Record Keeping Course, Professionalism Program (Ethics Course), and Clinical Competence Assessment Program by July 14, 2017. Respondent resolved the citation on November 30, 2018.

53. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about June 15, 2018, the Medical Board of California issued Citation No. 8002018044664 for violating the terms or conditions of probation and ordered that

Respondent renew his California physician's and surgeon's license, submit any overdue quarterly declarations, and report to the Board, in writing, of a change of address. To date, the citation remains outstanding.

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 the probation that was granted by the Medical Board of California in Case No. 800-2015-016792 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate No. A 72379, issued to Peter Vail Driscoll, M.D.;

2. Revoking or suspending Physician's and Surgeon's Certificate No. A 72379, issued to Peter Vail Driscoll, M.D.;

3. Revoking, suspending or denying approval of Peter Vail Driscoll, M.D.'s authority to supervise physician assistants and advanced practice nurses;

4. Ordering Peter Vail Driscoll, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: September 9, 2019

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

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