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

In the Matter of the Accusation Against: **JASON JOEL EMER, M.D.** **9201 W. Sunset Boulevard, Suite 510,** **West Hollywood, California 90069** **Physician's and Surgeon's Certificate No. A 123791,** Respondent.	Case No. 800-2021-074219 **A C C U S A T I O N**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California (Board).

2. On December 5, 2012, the Board issued Physician's and Surgeon's Certificate Number A 123791 to Jason Joel Emer, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2024, unless renewed.

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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 (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:
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> (1) Have his or her license revoked upon order of the board.
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> (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.
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> (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 2225 of the Code, states, in pertinent part:

> (a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter....
>
> (e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and

surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

6. Section 2225.5 of the Code, states, in pertinent part:

(a) (1) A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause...

7. 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 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.

(g) The 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.

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8. Section 2242 of the Code states in pertinent part:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

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.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee 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, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

11. On January 8, 2021, the Board received a Business and Professions Code section 2240 report from Respondent, informing the Board about Patient 1's[1] death on December 22, 2020.

12. Patient 1, a 36-year-old male who was a resident of Florida, was interested in having cosmetic surgery, and after seeing Respondent's promotions on Instagram, contacted Respondent at his office in Beverly Hills, California.

13. Respondent had a virtual consultation with Patient 1 on or about August 26, 2020. Respondent's consultation note from that date is mostly blank, and does not include Patient 1's weight, but Respondent did document that Patient 1 was interested in "HD Lipo," that Patient 1 has had three prior back surgeries and was not able to work out as much, and also that Patient 1 "has never had done surgery" and wanted "full definition." Respondent documented in the

[1] The patient is referenced by number for privacy reasons. Respondent is aware of the patient's identity, and further identifying information will be provided in response to a written Request for Discovery.

margins of the consultation note that Patient 1 was planning to have cosmetic surgery at the end of September or November, 2020, but that he was first going to have a knee surgery on October 15, before undergoing the cosmetic surgery with Respondent. Respondent's "immediate plan" was documented as "Lipo to torso and chest, J-plasma – all areas and fat grafting chest and buttock."

14. Patient 1 agreed to pay approximately $50,000 for the procedure before discounts, and paid an approximately $10,000 deposit, on or about September 24, 2020.

15. Respondent's internal office communications on or about September 24, 2020 contained a "breakdown of the planned procedure in detail." Respondent, or his office staff, recorded that two surgeons would be involved in the operation. Respondent would perform "High Def Lipo of the Torso, Chest, & Arms. J Plasma of the Torso, Chest, & Arms. Bodytite to the sides of chest. Fat transfer to the Buttock, Chest, & Possible shoulder." This part of the operation was estimated at that time to take six hours. A second surgeon was estimated to take two hours to perform a "Nipple Lift and Gland Removal."

16. Thereafter, Respondent's surgical coordinator sent Patient 1 a letter advising him, among other things:

> "...Prior to surgery you are required to be medically cleared by a cardiologist. You will need to schedule your pre-operative clearance with one of Dr. Emer's preferred cardiologists (please see below). Your surgical clearance must be completed within 30 days of your surgery date, not before. ALL surgeries require a written surgical clearance letter from the cardiologist in order to proceed with surgery. The letter must state that, 'patient is cleared for surgery based on my findings and Is at no or Is low-risk for: (procedure and surgery date.)' A copy of the medical clearance must be received no later than 2 weeks prior to your surgery date..."

17. On or about December 10, 2020, a cardiologist from Florida FAXed to Respondent a report that constituted Patient 1's cardiac clearance for surgery. Respondent did not create and/or maintain any record of making this referral. The cardiac clearance indicated that the cardiologist was aware that Patient 1 was going to undergo cosmetic surgery, but it does not appear that the cardiologist was informed about the extent or duration of the planned cosmetic surgery. This information was not provided to the cardiologist, and was not described in his report. Instead, the

cardiologist indicated that Patient 1 "does have problems with his knee and was going to have knee surgery in October. He changed his mind and now going for a calf implant."

18. The cardiologist noted that Patient 1 had a significant history of hypertension and was taking Amlodipine, Clonidine HCl and Metoprolol to control his blood pressure. The blood pressure was under "fair to poor control" and was measured at 160/100 by the cardiologist. Patient 1 had a history of obesity (he weighed 339 pounds according to the cardiologist's report) and has been gaining weight. Patient 1's active problems included high blood pressure and heart palpitations. The review of systems by the cardiologist included a statement that there were no palpitations. Respondent never clarified this inconsistency. The cardiac exam noted findings that included an EKG that showed a left axis deviation, indicating left ventricular enlargement, and an RSR pattern, considered a normal variant. Laboratory evaluation revealed a significant elevation in the patient's triglycerides of 2177 (normal to 150), with his cholesterol/HDL ratio elevated at 14.4 (normal <5) and his non-HDL cholesterol elevated at 188 (normal <130). Patient 1's glucose was elevated at 149 (normal 65-99). His liver function tests for AST and ALT were both elevated. The cardiologist's report concluded that after Patient 1 had been examined and the labs reviewed, his risk was "low for surgery under local or general," and that Patient 1 was "clear for the pending surgery with no contraindications to anesthesia or the surgery." He strongly advised Patient 1 to control his appetite.

19. On or about December 21, 2020, Patient 1 traveled from Florida to Beverly Hills and had his preoperative visit with Respondent. Patient 1 filled out a patient intake form at Respondent's office on December 21, 2020, indicating that he was 6 feet 5 inches tall and weighed 305 lbs. Other than this self-reported height and weight, both of which were inaccurate, Respondent did not obtain and did not record Patient 1's height and weight anywhere else in his records. Respondent noted in the chart that Patient 1 had knee surgeries in 2000 and 2010, as well as back surgeries in 2010 and 2019. Respondent also noted that Patient 1 had a lap-band placement surgery, but did not note how long ago that surgery took place. Respondent noted, inaccurately, that Patient 1 "has been told he has 'high blood pressure' although his physician has cleared him for complex cosmetic procedures."

20. Respondent examined Patient 1 on December 21, 2021. Respondent documented that "Physical examination confirmed significant skin laxity of the chest and lower stomach; localized areas of fat on the torso/sides/back, chest, and arms; cellulite of the buttock; Indentations and Irregularities on the lower stomach with "port" felt above the belly button; softness to palpation in the belly button; and volume loss of the shoulders, chest, buttock and penis (penis uncircumsized [sic] with enlarged mons pubis and small size in length and girth); multiple small scars appreciated on the torso; hardness behind the nipples (gynecomastia) L>>R; enlarged belly with significant projection signifying a large amount of visceral fat or muscular splitting."

21. Respondent further documented on December 21, 2020, "It was stressed that this full comprehensive plan written below was needed to get him 'improvement," but that 'cure' or 'perfection' would be unattainable. If he was not to choose this full comprehensive plan we cannot guarantee any improved outcome." The recommended procedures were expanded to include: "tummy tuck, chest lift and gland removal, liposuction of all areas with definition on the chest and arms". Respondent noted softness on palpation in the belly button, and volume loss of the shoulders, chest, buttock, and penis. In addition to liposuction of torso and chest, Respondent added suctioning of the arms, with J Plasma/Renuvion treatment for skin tightening, Body Tite (another radio-frequency device) treatment to the lateral chest wall skin, and fat transfer to the buttocks, shoulders, chest and penis. Respondent planned to have a second surgeon perform the umbilical hernia repair, abdominoplasty, gynecomastia excision, and breast lift. Respondent also signed Patient 1 up for postoperative IV therapy, lymphatic massage, and hyperbaric oxygen treatments.

22. On the day before surgery, Respondent prescribed antibiotics Azithromycin 500 mg daily and Doxycycline 100 mg twice daily for Patient 1 to take post-operatively. Both Azithromycin and Doxycycline are dangerous drugs under section 4022 of the Code, and there was no medical indication for their use. Respondent did not document why this medication was prescribed.

23. On the day before surgery, Respondent prescribed Amphetamine / Dextroamphetamine, a stimulant known as Adderall, a Schedule II controlled substance and a

dangerous drug under section 4022 of the Code, for Patient 1 to take 20 mg daily for 30 days, with no medical indication for doing so. In prescribing Adderall to Patient 1, Respondent also failed to comply and/or document his compliance with Health and Safety Code section 11165.4.

24. On the day before surgery, Respondent prescribed Diazepam, a benzodiazepine known as Valium, a Schedule IV controlled substance and a dangerous drug under section 4022 of the Code, for Patient 1 to take 10 mg twice a day for 15 days, with no medical indication for doing so. In prescribing Valium to Patient 1, Respondent also failed to comply and/or document his compliance with Health and Safety Code section 11165.4. Respondent did not document why this medication was prescribed, or that Patient 1 was advised that the prescription was for off-label use.

25. On the day before surgery, Respondent prescribed Patient 1 a 30-day supply of hydrochlorothiazide, an exogenous diuretic, 25 mg to take after surgery. Hydrochlorothiazide is a dangerous drug under section 4022 of the Code. Patient 1 was already being prescribed medications to control his blood pressure, and there was no medical indication for hydrochlorothiazide, which could have unpredictable effects on Patient 1's blood pressure. Respondent did not discuss or document a discussion of the use of this medication with Patient 1 or with Patient 1's physician who prescribed blood pressure medications to Patient 1 before. Respondent did not advise Patient 1 to supplement his potassium intake and made no plans to monitor Patient 1's potassium after the surgery.

26. Patient 1 signed all of the consents presented to him by Respondent, including, inexplicably, a consent for liposuction of his penis. The surgery time for all of these planned procedures was estimated to be at least 8 hours. All of the consents listed alternative treatment options, but none of these written consents, and none of Respondent's notes, documented informing Patient 1 of the alternative to stage, or separate, the planned procedures into separate surgeries on different days, for patient safety. Respondent documented that Patient 1 "wants to do 'the full procedure of what I tell him to do' and get the best look for his body." Respondent further documented that Patient 1 "decided to move forward with the full recommended plan."

27. Respondent took Patient 1 to surgery, now estimated to take 10 hours, the next day, on December 22, 2020. Respondent's Operative Report and other medical records documented that Patient 1 was digitally photographed prior to the operation. During the investigation of this matter, the Board requested a complete, certified copy of Respondent's records for Patient 1. The request was accompanied by an authorization by the patient's next of kin – his mother. Respondent failed to produce complete copies of his records, as he omitted the photographs from the documents provided to the Board.

28. On the pre-op checklist, Patient 1's weight was listed, again inaccurately, at 300 pounds, and his blood pressure was recorded at 152/89. The nurse documented that she "confirmed with patient that he is only taking metoprolol and is not taking all other meds from current med list." Respondent did not react to the information showing that Patient 1 was not taking two of the three blood pressure medications that were prescribed to him by his primary care physician.

29. Respondent's portion of Patient 1's operation on December 22, 2020 began at 6:50 a.m. with induction of anesthesia, and lasted more than six hours. Large portions of Respondent's Operative Report are generated from an existing pre-written form, which did not include important details, such as a precise description of Patient 1's body where liposuction was performed. Respondent documented that he infiltrated tumescent anesthesia, which the Surgical Tracking Log and other records state consisted of Lactated Ringer's solution to which 10 ml of 2% lidocaine, 2 mg of epinephrine, and 10 mg of triamcinolone were added per liter. Respondent's canned procedure note stated that the basis for the tumescent solution was normal saline. Respondent never clarified this inconsistency. Once the back and arm liposuction/fat transfer were completed, Patient 1 was turned supine, prepped, and again infiltrated with tumescent solution. Total tumescent fluid infiltrated is recorded as 8000 ml. The 16 mg of epinephrine Respondent infused into Patient 1 represents 0.1mg/kg, well above what is considered a maximum safe dose, especially for a patient suffering from hypertension.

30. For small volumes of tumescent infiltration, the 4 milliequivalents (meq) of Potassium contained per liter of Lactated Ringer's does not add significant risk. However, for

larger volume infiltrations, the amount of Potassium can become problematic. Patient 1's 8 liters of tumescent solution infused by Respondent contained 32 meq of Potassium. Patient 1 also received, in total, 6.2 liters of IV Lactated Ringer's for a total of almost 57 meq of Potassium, which is an unsafe level.

31. Respondent's tumescent formula included 10 mg triamcinolone/liter. Patient 1 was thus infiltrated with 80 mg of this steroid. The use of the triamcinolone in Patient 1's tumescent solution was not indicated.

32. The total lipoaspirate removed was recorded as 5700 ml. The excessive level of tumescent fluid infiltrated by Respondent, together with the intravenous fluid infused by anesthesia, caused Patient 1 to be significantly fluid – overloaded. Patient 1's body weight during the autopsy was 362 pounds in comparison to the 339 pounds reported by the cardiologist from Florida. The excess fluid infused by Respondent weighed over 21 pounds.

33. Respondent completed his portion of the surgery at 1:45 pm, and the remainder of the operation was performed by a second surgeon. The other surgeon started with the gynecomastia excision and breast lift surgery, proceeded to the umbilical hernia repair, and then the mini-abdominoplasty. Patient 1 was then flexed at the waist to reduce the tension while the abdominal skin closure was performed. When Patient 1's position was changed from supine to "reverse Trend" at approximately 4:00 p.m., Patient 1 developed bradycardia and then cardiac arrest. The attending anesthesiologist administered Atropine and began CPR. Two additional 1 mg epinephrine boluses were administered. Fire Department Paramedics were called, but despite their efforts, which included additional epinephrine, Patient 1 could not be revived. His death was pronounced at 4:19 p.m.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

34. Respondent Jason Joel Emer, M.D. is subject to disciplinary action under section 22334, subdivision (b) of the Code in that he committed gross negligence in the care and treatment of Patient 1. The circumstances are as follows:

35. The allegations of paragraphs 11 through 33 are incorporated herein by reference.

A) Respondent's decision to proceed with a prolonged elective surgery involving general anesthesia in a morbidly obese and hypertensive patient, without attempting to mitigate the modifiable risk factors, including staging of the operative procedures, constitutes an extreme departure from the standard of care.

B) Respondent's administering more than the safe maximum amount of epinephrine to Patient 1 constitutes an extreme departure from the standard of care.

C) Administering the amount of fluid to Patient 1 and causing him to be fluid overloaded was an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

36. Respondent Jason Joel Emer, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he committed repeated acts of negligence in the care and treatment of Patient 1. The circumstances are as follows:

37. The allegations of the First Cause for Discipline are incorporated herein by reference. In addition to the allegations in paragraph 35, A through C. Respondent departed from the standard of care as follows:

A) Respondent's belief and corresponding statement that the Florida cardiologist cleared Patient 1 for "complex cosmetic procedures" is inaccurate and is a departure from the standard of care.

B) Respondent's use of Lactated Ringer's as the basis for tumescent solution used on Patient 1 was a departure from the standard of care.

C) Respondent's inclusion of 10 mg of triamcinolone per liter of tumescent solution was a departure from the standard of care.

D) Respondent's prescription of Azithromycin and Doxycycline to Patient 1 to take after the surgery was a departure from the standard of care.

E) Respondent's prescription of Hydrochlorothiazide to Patient 1 to take after the surgery was a departure from the standard of care.

F) Respondent's prescription of Adderall to Patient 1 to take after the surgery was a departure from the standard of care.

G) Respondent's prescription of Valium to Patient 1 to take after the surgery was a departure from the standard of care.

H) Respondent's failure to include Patient 1's photographs when responding to the Board's request for Patient 1's records was a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Inadequate or Inaccurate Record Keeping)

38. Respondent Jason Joel Emer, M.D. is subject to disciplinary action under section 2266 of the Code in that his records of his care and treatment of Patient 1 were inadequate or inaccurate. The circumstances are as follows:

39. The allegations of the First and Second Causes for Discipline are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Controlled Substances and Dangerous Drugs Without Medical Indication)

40. Respondent Jason Joel Emer, M.D. is subject to disciplinary action under section 2242 of the Code in that he prescribed controlled substances and dangerous drugs to Patient 1 without medical indication. The circumstances are as follows:

41. The allegations of the First, Second and Third Causes for Discipline are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Failure To Produce Complete Records)

42. Respondent Jason Joel Emer, M.D. is subject to disciplinary action under section 2225 and 2225.5 of the Code in that he failed to produce Patient 1's complete certified medical records in response to a request from the Board that was accompanied by a release from Patient 1's next-of-kin. The circumstances are as follows:

38. Allegations of paragraphs 11 through 33 are incorporated herein by reference.

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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 123791, issued to Respondent, Jason Joel Emer, M.D.;

2. Revoking, suspending or denying approval of Respondent, Jason Joel Emer, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Jason Joel Emer, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent Jason Joel Emer, M.D., to pay a civil penalty to the Board in the amount of $10,000 for his failure to produce a complete certified copy of Patient 1's medical records.

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

DATED: JAN 04 2024

JENNA JONES FOR
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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