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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

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.

"(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 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.

". . . ."

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

8. Section 2052 of the Code, states:

"(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or

[1] *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.

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.

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

"(c) The remedy provided in this section shall not preclude any other remedy provided by law."

9. Section 2264 of the Code, states:

"The 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."

10. Section 2271 of the Code, states:

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

11. Section 651 of the Code, states:

"(a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated 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 or furnishing of products in connection with the

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

"(b) 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.

". . . ."

"(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.

". . . ."

12. Section 17500 of the Code states:

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

before the public in any state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatever, including over the Internet, any statement, concerning that real or personal property or those services, professional or otherwise, or concerning any circumstance or matter of fact connected with the proposed performance or disposition thereof, 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, or for any person, firm, or corporation to so make or disseminate or cause to be so made or disseminated any such statement as part of a plan or scheme with the intent not to sell that personal property or those services, professional or otherwise, so advertised at the price stated therein, or as so advertised. 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."

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

"In addition to the grounds set forth in section 3527, subd. (a), of the code the board may deny, issue subject to terms and conditions, 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."

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

"(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.

". . .

"(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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"(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.

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

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

"(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 an approved supervising physician.

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

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

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."

COST RECOVERY

18. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to 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.

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FIRST CAUSE OF DISCIPLINE

(Unlicensed Practice of Medicine)

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

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

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

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

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

Liposculpture.

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

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

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

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

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

[5] The liposculpture procedures, which are, in actuality, liposuction surgeries, were performed at "a swank office in Beverly Hills' Rodeo Drive" where the liposuction was advertised as an 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/#.VI9n5tF0vic.

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

26. Pacific Liposculpture's website at www.pacificlipo.com identified respondent, and continues to identify him, as the "Director of Surgery for various lipo procedures at Pacific Liposculpture, a cosmetic surgery firm based out of San Diego, California" and makes numerous references to respondent as the "Director of Surgery" for Pacific Liposuction. The Pacific Liposuction website, which is owned and managed by respondent, now boasts of "over 15,000 procedures performed" and has several photographs and videos of respondent in his surgical scrubs. The website, among other things, states that patients can have "virtual consultations," it provides before

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[6] The asterisk (*) advised potential customers that "Patient may be subject to additional BMI [body mass index] charges."

[7] To "promote yourself," Pacific Liposuction recommends that contestants "Post that same essay on our various Social Media pages and encourage your friends and family to like your story and comment on why you deserve it. The more involved you become with Pacific Lipo and the more support your story has, the better your chances of winning!" Pacific Liposculpture also offers "Some Tips on How to Promote Your Free Lipo Story" which includes "[s]hare your story on our Facebook wall, have friends support you by 'liking' your story and commenting on why you deserve free lipo [include a picture to grab more attention][;] [p]ost your Story on our Events page on the Pacific Lipo 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.

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

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PATIENT L.W.

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

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

surgery consultation with respondent lasted approximately ten minutes.

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

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

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

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

sedation or procedure."[11]

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

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

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

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

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[11] The DSA provides that respondent must "always and immediately" seek consultation with his supervising physician in the following situations: "high risk patients," "complications with 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.)

PATIENT N.C.

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

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

[12] This provision of Pacific Liposculpture, Inc.'s informed consent form was later amended. The amended section, which was used for other patients in the future, provided "I hereby authorize 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.)

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

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

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

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

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

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

PATIENT K.D.

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

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

[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.

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

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

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

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[17] APAP/Hydrocodone Bitartrate (Lorcet®, Lortab®, Vicodin®, Vicoprofen®, Tussionex® and Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which is a 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.

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

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

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

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

PATIENT S.M.

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

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[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."

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

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

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

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

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48. On or about June 11, 2013, patient S.M. texted respondent to express her concern about the "clump" on her right inner thigh area which she reported was "becoming really hard and looks so weird." Patient S.M. texted some photos of her right and left thigh areas which showed a noticeable swollen area on her right inner thigh. Respondent believed the increased post-operative swelling was possibly exercise induced. Respondent recommended that patient S.M. discontinue exercising, that she start on dexamethasone[20] and/or methylprednisolone (Medrol® dosepak),[21] continue with the RICE (rest, ice, compression and elevation) protocol and follow-up in one week. On June 14, 2013, patient S.M. texted respondent to advise him she had started taking the methylprednisolone. The certified medical records fail to indicate that respondent consulted with Dr. J.B., his supervising physician, about these complications at this time.

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

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

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

[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.

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

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

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SECOND CAUSE OF DISCIPLINE

(Gross Negligence)

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

PATIENT L.W.

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

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

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

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

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

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

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

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

PATIENT N.C.

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

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

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

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

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

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

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

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

PATIENT K.D.

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

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

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

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

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

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

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

PATIENT S.M.

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

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

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

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

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

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

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

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

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

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

PATIENT L.W.

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

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

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

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

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

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

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

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

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

PATIENT N.C.

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

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

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

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

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

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

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

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

PATIENT K.D.

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

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

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

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

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

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

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

PATIENT S.M.

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

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

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

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

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

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

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

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

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

FOURTH CAUSE FOR DISCIPLINE

(False and/or Misleading Advertising)

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

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

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

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

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

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

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

liposuction procedures; and

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

FOURTH CAUSE FOR DISCIPLINE

(Dishonesty and/or Corruption)

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

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Record)

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

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

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

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

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

SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

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

DISCIPLINARY CONSIDERATIONS

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

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

PRAYER

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

1. Revoking or suspending Physician Assistant License Number PA19449, issued to respondent Rodney Eugene Davis, P.A.;

2. Ordering respondent Rodney Eugene Davis, P.A. to pay the Physician Assistant Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

DATED: February 3, 2015

GLENN L. MITCHELL, JR.
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

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