XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
JASON J. AHN
Deputy Attorney General
State Bar No. 253172
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9433
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **Alexander Arkadievich Krakovsky, M.D.** **P.O. Box 724** **La Jolla, CA 92038-0724** **Physician's and Surgeon's Certificate No. A 81711,** Respondent.	Case No. 800-2019-051847 **A C C U S A T I O N**

PARTIES

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

2. On or about January 24, 2003, the Medical Board issued Physician's and Surgeon's Certificate No. A 81711 to Alexander Arkadievich Krakovsky, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2020, unless renewed.

///

JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states, in pertinent part:

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

...

6. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

7. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A 81711 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A[1], as more particularly alleged hereinafter:

Patient A

9. Patient A presented to Respondent in 2011[2] for a penile lengthening procedure. On or about May 8, 2013, Patient A returned to Respondent for penile augmentation surgery. At that time, Patient A was a thirty-six (36) year-old dentist from Canada. There are no consent forms

[1] References to "Patient A" are used to protect patient privacy.

[2] Conduct occurring more than seven (7) years from the filing of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

signed by Patient A for this procedure. Respondent failed to adequately discuss and/or failed to document having adequately discussed alternatives to the proposed procedure. Respondent failed to provide and/or failed to document having provided Patient A with an adequate opportunity to ask questions, if any, and/or to clarify Patient A's understanding of the procedure to be performed and its complications. Respondent performed "penile triple augmentation" procedure, which consisted of penile suprapubic revision with scar excision and removal, girth enhancement utilizing Belladerm[3] two sheets and glandular enhancement utilizing Belladerm two sheets. Neither the American Urological Association (AUA) nor the American Society of Plastic Surgeons (ASPS) has endorsed and/or approved this procedure. Neither the AUA nor the ASPS regulates this procedure. Respondent is not certified by the American Board of Plastic Surgery. Respondent does not have residency or a board-recognized fellowship in urology.

10. On or about May 23, 2013, Patient A returned to Respondent with a partial wound dehiscence[4].

11. On or about May 24, 2013, Respondent debrided the portion of Patient A's graft that was exposed through the wound, refreshed the edges of the wound, cleaned the wound, and left the graft in place.

12. On or about May 29, 2013, Respondent removed the Belladerm graft from Patient A's penis, performed a debridement of the wound, cleaned the wound, and closed the wound.

13. On or about July 7, 2013, Patient A returned to Respondent because he had developed scar tissue in his suprapubic area with associated severe penis retraction. Respondent recommended removal of the scar tissue in order to release Patient A's retracted penis. Patient A purportedly signed consent forms for this procedure. The consent forms were superfluous and/or redundant and/or difficult for the average person to understand. The consent forms were not signed or dated by a witness. Respondent failed to adequately discuss and/or failed to document having adequately discussed with Patient A alternatives to the proposed procedure. Respondent

[3] Belladerm is a human allograft skin which is minimally processed to remove epidermal and dermal cells and is packaged in an ethanol solution.

[4] Wound dehiscence is when a surgical incision reopens either internally or externally.

failed to provide and/or failed to document having provided Patient A with an adequate opportunity to ask questions, if any, and/or to clarify Patient A's understanding of the procedure to be performed and its complications.

14. On or about July 8, 2013, Patient A returned to Respondent. Respondent performed suprapubic reconstruction on Patient A. During this procedure, Respondent failed to properly identify the location of Patient A's spermatic cord and failed to recognize that he caused vascular injury resulting in a loss of blood supply to Patient A's left testicle. In the medical records, Respondent noted, among other things, that there was "a large amount of very solid scar tissue . . . scar tissue was not only in the suprapubic area, but also spread [to] upper, lower, and to both sides . . . bleeding was encountered but controlled."

15. On or about July 9, 2013 and on or about July 10, 2013, Patient A returned to Respondent for a post-operative visit, following the July 8, 2013 surgery. Respondent failed to examine and/or failed to document having examined Patient A's scrotum on both post-operative visits. Patient A returned to Canada.

16. On or about July 22, 2013, Patient A sent an e-mail to Respondent stating, among other things, "the left testicle is still swollen and hard, it seems fixated." In reply, Respondent sent an e-mail to Patient A, stating, among other things, "the testicle is very far down from where the reconstruction was performed."

17. On or about August 8, 2013, Patient A sent an e-mail to Respondent stating, among other things, that Patient A's [left] testicle is "still blueish."

18. On or about August 10, 2013, Patient A sent an e-mail to Respondent stating, among other things, "is it possible that I have torsion[5] of the testicle?" In response, Respondent sent an e-mail to Patient A, stating, among other things, "if you don't have pain there is no torsion."

19. On or about September 15, 2013, Respondent sent an e-mail to Patient A stating, among other things, "Scar tissue compromised the blood supply recruiting blood vessels from the

[5] Testicular torsion is a twisting of the male organ that makes hormones and sperm (testicle).

testicle supply and upon scar tissue removal the supply to the testicle unfortunately was compromised."

20. Thereafter, Patient A underwent left orchiectomy[6] to remove his dead left testicle.

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

(a) Respondent failed to properly identify the location of Patient A's spermatic cord and failed to recognize that he caused vascular injury resulting in a loss of blood supply to Patient A's left testicle.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

22. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 81711 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A[7], B, C, and D, as more particularly alleged hereinafter:

Patient A

23. Paragraphs 9 through 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

Patient B

24. On or about February 5, 2013, Patient B presented to Respondent seeking "triple augmentation" of his penis, consisting of penial lengthening, girth enhancement, and pubic liposuction. At the time, Patient B was a twenty-six (26) year-old male from the United Kingdom. Patient B purportedly signed consent forms for this procedure. The consent forms were superfluous and/or redundant and/or difficult for the average person to understand. The consent forms were not signed or dated by a witness. Respondent failed to adequately discuss and/or failed to document having adequately discussed with Patient B alternatives to the proposed procedure. Respondent failed to provide and/or failed to document having provided Patient B

[6] Orchiectomy is a surgical procedure in which one or both testicles are removed.

[7] References to "Patients A, B, C, and D" are used to protect patient privacy.

with an adequate opportunity to ask questions, if any, and/or to clarify Patient B's understanding of the procedure to be performed and its complications.

25. On or about February 5, 2013, Respondent performed a penile "triple augmentation" surgery on Patient B. Respondent harvested two grafts from Patient B's buttocks and sewed them together. Respondent then performed a pubic liposuction removing 300 cc of fat. Then, Respondent released Patient B's suspensory ligaments of the penis. Respondent made an incision, created a pocket, and sutured the graft to Patient B's penis. Neither the American Urological Association (AUA) nor the American Society of Plastic Surgeons (ASPS) has endorsed and/or approved this procedure. Neither the AUA nor the ASPS regulates this procedure. Respondent is not certified by the American Board of Plastic Surgery. Respondent does not have residency or a board-recognized fellowship in urology.

Patient C

26. On or about April 15, 2013, Patient C presented to Respondent seeking a penile "triple augmentation" surgery consisting of glandular enhancement, pubic liposuction, and suspensory ligament release, and a placement of Belladerm graft to enhance penile girth. At that time, Patient C was a fifty-three (53) year-old medical doctor. Patient C purportedly signed consent forms for this procedure. The consent forms were superfluous and/or redundant and/or difficult for the average person to understand. The consent forms were not signed or dated by a witness. Respondent failed to adequately discuss and/or failed to document having adequately discussed with Patient C alternatives to the proposed procedure. Respondent failed to provide and/or failed to document having provided Patient C with an adequate opportunity to ask questions, if any, and/or to clarify Patient C's understanding of the procedure to be performed and its complications.

27. On or about April 15, 2013, Respondent performed penile "triple augmentation" surgery on Patient C, consisting of pubic liposuction, penile suspensory ligament release, and "ultra thick" Belladerm graft placement. Neither the American Urological Association (AUA) nor the American Society of Plastic Surgeons (ASPS) has endorsed and/or approved this procedure. Neither the AUA nor the ASPS regulates this procedure. Respondent is not certified

by the American Board of Plastic Surgery. Respondent does not have residency or a board-recognized fellowship in urology.

28. On or about April 22, 2013, Patient C called Respondent's office complaining of a problem with the skin on the shaft of his penis. Respondent received a picture from Patient C and discovered that an area below Patient C's subcoronal[8] incision had turned black. Through a telephonic discussion with Patient C, Respondent determined that Patient C inability to control erections and overuse of Betadine[9] during dressing change "burned" Patient C's skin.

29. On or about May 13, 2013, Patient C returned to Respondent. Respondent noted, among other things, that Patient C's penis had an open wound with the graft visible. Respondent recommended Patient C to undergo a revision of the wound and a possible graft removal.

30. On or about May 14, 2013, Respondent performed revision procedure on Patient C. After wound irrigation, Respondent freshened the skin edges, and closed the wound without removing the graft. Wound cultures were negative.

Patient D

31. On or about May 30, 2013, Patient D presented to Respondent seeking a penile enhancement surgery. Patient D purportedly signed consent forms for this procedure. The consent forms were superfluous and/or redundant and/or difficult for the average person to understand. The consent forms were not signed or dated by a witness. Respondent failed to adequately discuss and/or failed to document having adequately discussed with Patient D alternatives to the proposed procedure. Respondent failed to provide and/or failed to document having provided Patient D with an adequate opportunity to ask questions, if any, and/or to clarify Patient D's understanding of the procedure to be performed and its complications.

32. On or about May 30, 2013, Respondent performed penile enhancement surgery on Patient D with glandular enhancement and implantation of a 4.5 mm thick Belladerm graft to further improve Patient D's penile girth. Neither the American Urological Association (AUA)

---

[8] Subcoronal refers to the area near the head of the penis.

[9] Betadine (Povidone-iodine) is a topical antiseptic that provides infection protection against a variety of germs for minor cuts, scrapes, and burns.

nor the American Society of Plastic Surgeons (ASPS) has endorsed and/or approved this procedure. Neither the AUA nor the ASPS regulates this procedure. Respondent is not certified by the American Board of Plastic Surgery. Respondent does not have residency or a board-recognized fellowship in urology.

33. Respondent committed repeated negligent acts in his care and treatment of Patients A, B, C, and D, which included, but was not limited to, the following:

(a) Respondent failed to properly identify the location of Patient A's spermatic cord and failed to recognize that he caused vascular injury resulting in a loss of blood supply to Patient A's left testicle;

(b) Respondent failed to properly obtain informed consent from Patient A;

(c) Respondent performed an unapproved, unregulated procedure on Patient A without adequate training and/or experience;

(d) Respondent failed to properly obtain informed consent from Patient B;

(e) Respondent performed an unapproved, unregulated procedure on Patient B without adequate training and/or experience;

(f) Respondent failed to properly obtain informed consent from Patient C;

(g) Respondent performed an unapproved, unregulated procedure on Patient C without adequate training and/or experience;

(h) Respondent failed to properly obtain informed consent from Patient D; and

(i) Respondent performed an unapproved, unregulated procedure on Patient D without adequate training and/or experience.

///

///

///

///

///

///

///

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

34. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 81711 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he was incompetent in his care and treatment of Patients A, B, C, and D, as more particularly alleged hereinafter:

Patient A

35. Paragraphs 9 through 21 above, are incorporated by reference and realleged as if fully set forth herein.

36. Respondent was incompetent, in his care and treatment of patient A, including, but not limited to, the following:

(a) Respondent performed an unapproved, unregulated procedure on Patient A without adequate training and/or experience.

Patient B

37. Paragraphs 24 through 25 above, are incorporated by reference and realleged as if fully set forth herein.

38. Respondent was incompetent, in his care and treatment of Patient B, including, but not limited to, the following:

(a) Respondent performed an unapproved, unregulated procedure on Patient B without adequate training and/or experience.

Patient C

39. Paragraphs 26 through 30 above, are incorporated by reference and realleged as if fully set forth herein.

40. Respondent was incompetent, in his care and treatment of Patient C, including, but not limited to, the following:

(a) Respondent performed an unapproved, unregulated procedure on Patient C without adequate training and/or experience.

///

Patient D

41. Paragraphs 31 through 32 above, are incorporated by reference and realleged as if fully set forth herein.

42. Respondent was incompetent, in his care and treatment of Patient D, including, but not limited to, the following:

(a) Respondent performed an unapproved, unregulated procedure on Patient D without adequate training and/or experience.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and/or Accurate Records)

43. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 81711 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and/or accurate records regarding his care and treatment of Patients A, B, C, and D, as more particularly alleged in paragraphs 9 through 32, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

///

///

///

///

///

///

///

///

///

///

///

///

///

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 No. A 81711, issued to Alexander Arkadievich Krakovsky, M.D.;

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

3. Ordering Alexander Arkadievich Krakovsky, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JAN 29 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SD2020700147
72114994.docx