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

In the Matter of the First Amended Accusation Against: Richard McInnis Hodnett, M.D. Physician's and Surgeon's Certificate No. C 51707 Respondent.	Case No.: 800-2018-050292

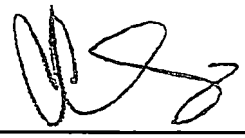
DECISION

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

This Decision shall become effective at 5:00 p.m. on January 5, 2023.

IT IS SO ORDERED: December 6, 2022.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the First Amended Accusation Against: **RICHARD MCINNIS HODNETT, M.D.** **115 Jensen Court, Suite 201** **Thousand Oaks, CA 91360** **Physician's and Surgeon's Certificate No. C 51707,** Respondent.	Case No. 800-2018-050292 OAH No. 2022010183 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Peggie Bradford Tarwater, Deputy Attorney General.

2. Respondent Richard McInnis Hodnett, M.D. (Respondent) is represented in this proceeding by attorney Gil Burkwitz, whose address is Peterson, Bradford, and Burkwitz, 100 North First Street, Suite 300, Burbank, CA 91502.

3. On August 25, 2004, the Board issued Physician's and Surgeon's Certificate No. C 51707 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2018-050292, and will expire on January 31, 2024, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2018-050292 was filed before the Board and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on August 2, 2022. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 800-2018-050292 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2018-050292. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2018-050292, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline, and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

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

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2018-050292 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 51707 issued to Respondent Richard McInnis Hodnett, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five years on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) that shall not be less than 20 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE (Condition Satisfied). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical

Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days

of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

5. NOTIFICATION. Within seven days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

7. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

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8. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $7,208.75. Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Board. Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California Physician's and Surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar

months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate

and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

17. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 800-2018-050292 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Gil Burkwitz. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: August 8, 2022

RICHARD MCINNIS HODNETT, M.D.
Respondent

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I have read and fully discussed with Respondent Richard McInnis Hodnett, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8/9/2022

Gil Burkewitz
GIL BURKWITZ
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: August 9, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

Peggie Bradford Tarwater
Digitally signed by Peggie Bradford Tarwater
Date: 2022.08.09 10:07:57 -07'00'

PEGGIE BRADFORD TARWATER
Deputy Attorney General
Attorneys for Complainant

LA2020603918

Exhibit A

First Amended Accusation No. 800-2018-050292

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **Richard McInnis Hodnett, M.D.** **115 Jensen Court, Suite 201** **Thousand Oaks, CA 91362** **Physician's and Surgeon's Certificate No. C 51707,** Respondent.	Case No. 800-2018-050292 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 25, 2004, the Board issued Physician's and Surgeon's Certificate Number C 51707 to Richard McInnis Hodnett, 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 January 31, 2024, unless renewed.

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JURISDICTION

3. This First Amended 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2228 of the Code states:

> The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:
>
> (a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.
>
> (b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.
>
> (c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.
>
> (d) Providing the option of alternative community service in cases other than violations relating to quality of care.

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.

. . . .

7. Section 2266 of the Code states:

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

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

9. Mastopexy is a breast lift procedure designed to improve the appearance of sagging or ptotic breasts.

10. The Wise pattern technique is used in breast reduction and mastopexy surgery and consists of removal of skin in both vertical and horizontal dimensions, allowing for lifting and coning of the breast into a less ptotic shape.

11. Eschar is dead tissue that sheds or falls off from the skin.

12. Cellulitis is a bacterial infection of the skin.

13. Staphylococcus aureus (staph) is a type of bacteria found on people's skin that is usually harmless, but can cause serious infections that can lead to sepsis or death. Methicillin-resistant staph aureus (MRSA) is a type of staph infection that is difficult to treat because of antibiotic resistance.

14. TissuGlu is a surgical adhesive applied in drops between tissue layers during an abdominoplasty (tummy tuck). TissuGlu was approved by the FDA for internal use in the United States in 2015. As of 2019, it is no longer being manufactured.

15. Phlegmon is inflammation of soft tissue that spreads under the skin or inside the body, usually caused by an infection and producing pus. It is different from an abscess in that a phlegmon is unbounded and can continue to spread out along connective tissue and muscle fiber.

16. A seroma is a collection of fluid under the skin, usually at the site of a surgical incision.

FACTUAL ALLEGATIONS

17. Respondent is board-certified in plastic surgery. He is a sole practitioner. He also practices as an independent contractor for Beverly Hills Physicians and performs surgeries at various surgery centers, including Thousand Oaks Surgical Institute.

18. From June 1994 through June 2019, Respondent was also licensed to practice medicine by the Nevada State Board of Medical Examiners. That license expired on June 30, 2019.

Patient 1[1]

19. Respondent first treated Patient 1 in Las Vegas, Nevada in approximately 2003. Patient 1 was referred to Respondent by her boyfriend, who was a friend of Respondent, for issues relating to prior breast implant procedures. She had undergone bilateral Wise pattern mastopexy with implants, leaving her with severe scarring.

20. Respondent performed minor surgery to excise a portion of the scar to improve appearance. Thereafter, he revised all of Patient 1's incisions and replaced her implants.

21. Respondent saw Patient 1 again in 2011 in California, where he had moved his practice. Patient 1 discussed mammograms with him. Respondent did not advise Patient 1 that her implants needed to be changed at that time.

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[1] Patients are referred to by number to protect their identities.

22. Respondent saw Patient 1 in consultation in 2016 at Thousand Oaks Surgical Institute. He diagnosed a grade III capsule, meaning the breasts were moderately hard. Respondent suggested the implants be checked and that they be removed and replaced.

23. Patient 1 traveled from her home in Las Vegas to California for the breast surgery with Respondent. During the operation performed on January 11, 2017, Respondent found ruptured implants, which were removed. He found capsules[2] and removed 80 percent of them, leaving 20 percent to enable him to close the lateral pockets. He washed and sterilized the pocket and removed all the silicone. He replaced the implants.

24. Respondent prescribed medications to Patient 1, including an antibiotic, but he failed to document the prescriptions in the patient's record.

25. Respondent's records relating to Patient 1's follow-up care contain handwritten and signed progress notes for the following visits: January 13, January 20, January 24, and February 15, 2017. Also contained in Respondent's record is a typed timeline of events relating to Patient 1 with entries for the following dates: January 11, January 13, January 20, January 24, January 25, January 26, January 27, February 2, February 3, February 7, February 8, February 11, February 14, February 15, February 18, February 19, February 20, February 22, February 28, March 2, March 4, and March 5, 2017. There is no indication as to when this timeline was created, and none of the entries are signed.

26. Patient 1 stayed at a hotel post-procedure. Respondent acknowledged that he and his wife had dinner with Patient 1 on January 12, 2017. After dinner, Respondent examined Patient 1's breasts. Respondent did not document the examination.

27. Respondent visited Patient 1 again on January 13, 2017. She appeared to be doing fine and had no complaints other than pain at the incision line. Respondent's note of the visit indicates that the areola was bruised but appeared viable and a good overall result. The instructions were to "keep dressed" and follow up in one week. The note contains no detailed examination or vital signs.

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[2] Once a breast implant is in place, fibrous scar tissue forms around it, creating a tissue capsule. The tissue capsules help keep the breast implants in place.

28. Respondent saw Patient 1 on January 15, 2017, at which time Patient 1 complained of pain. There is no documentation of the visit in Patient 1's medical record.

29. Respondent saw Patient 1 on January 20, 2017. Respondent documented necrosis of the right nipple at 30 percent and of the left nipple at 15 percent. He indicated that the nipples were viable except for the necrotic areas. He also documented tenderness in the sutured area. His note states that Patient 1 had a fever that broke three days prior, possibly due to the flu. No detailed examination or vital signs are recorded in the patient's record.

30. On approximately January 22, 2017, Respondent and his wife had dinner with Patient 1. Afterward, Respondent examined Patient 1's breasts in the company of his wife. He did not notice anything that required a hospital visit. Respondent described the breasts as having slight necrosis. Respondent did not document this examination.

31. Respondent saw Patient 1 again on January 24, 2017. He noted that she was doing well with no fevers, eschar was stable, and the breasts were non-tender. No detailed examination or vital signs are documented in the patient's record.

32. Patient 1 was taken to Los Robles Hospital Emergency Department in the early morning hours of January 25, 2017, with a chief complaint of left breast pain. The emergency room physician diagnosed cellulitis for which he prescribed the antibiotic, clindamycin. Upon discharge, Patient 1 was instructed to follow up with Respondent. In an unsigned note, Respondent documented that Patient 1 had presented to the emergency room and that the emergency room physician had assured him that all was well, except for mild cellulitis.

33. Patient 1 returned to Los Robles Hospital Emergency Department on January 26, 2017. She indicated she suffered from spontaneous hip pain, anxiety, and pain under the left breast. The emergency department physician documented his impressions, including a small fluid collection in the left breast and possible post-operative changes. Respondent presented to the emergency department and discussed Patient 1's care with the emergency department physician. In an unsigned timeline entry, Respondent indicated he found mild eschar and minimal cellulitis.

34. Respondent states that after the emergency department visits, he discussed with Patient 1 her history of anxiety and suggested she be evaluated by her primary care physician

upon return to her home in Las Vegas, Nevada. However, the patient's record contains no notation of anxiety.

35. Patient 1 returned to Las Vegas on or about January 27, 2017 and presented to the St. Rose Dominican Hospital Emergency Department with a complaint of difficulty breathing. She was released in stable condition on January 28, 2017.

36. Respondent saw Patient 1 in follow-up on February 15, 2017. At that time, he documented that the eschar on both breasts was almost gone and everything was healing. No physical examination or vital signs are recorded in the patient's record. Respondent states, but did not document, that he released Patient 1 to the care of her primary treating physician in Las Vegas.

37. Patient 1 was seen in the St. Rose Dominican Hospital Emergency Department twice over the next two days after her return to Nevada. She was transferred to University Medical Center in Las Vegas on February 18, 2017. She was diagnosed with an exposed implant, MRSA infection, and generalized sepsis. Her implants were removed.

Patient 2

38. Patient 2 presented to Respondent at Thousand Oaks Surgical Institute on October 20, 2017 for a plastic surgery consultation, during which she was scheduled for an abdominoplasty, lower blepharoplasty (eyelid lift), liposuction of the flanks, and a pubic lift. Respondent's documentation of the initial consultation lacks details relating to the indication for surgery and the operative plan.

39. Prior to Patient 2's procedure, TissuGlu was ordered from Cohera Medical, Inc. and was to be used in Patient 2's surgery. Respondent indicated he had used TissuGlu approximately three times previously at Thousand Oaks Surgical Institute, even though documentation sent to Cohera Medical, Inc. (Cohera), the maker of TissuGlu, indicated that the TissuGlu ordered for Patient 2's surgery was the first order made.

40. Respondent did not discuss and/or document the risks, benefits, or alternatives to the use of TissuGlu with Patient 2 prior to her surgery.

41. After obtaining medical clearance, Patient 2 presented for surgery on November 27,

2017, and Respondent performed the indicated procedures. TissuGlu was used in the abdominoplasty to hold tissue layers together.

42. On the date of the surgery, a sales representative from Cohera conducted a demonstration in the pre-op area of Thousand Oaks Surgical Institute. The representative showed Respondent and staff how to open the TissuGlu package and to prepare and dispense the TissuGlu.

43. Product labels from the TissuGlu packaging were placed in Patient 2's chart. They bore a product expiration date of August 31, 2017, a date occurring before Patient 2's surgery. Cohera's instructions expressly warned that expired product should not be used.

44. Approximately three days after surgery, Patient 2 developed a seroma. She underwent approximately eight to ten needle aspirations, but they were ineffective in resolving the seroma. On approximately January 9, 2018, a seroma catheter was placed to assist with drainage, but it did not work.

45. Respondent's chart note of January 17, 2018 indicates that Patient 2 needed surgery for the seroma, she had recent fevers, and there was a need to explore "ASAP." There is no physical examination and/or vital signs in Respondent's note of the visit.

46. On January 19, 2018, Respondent performed surgery to remove the chronic seroma of the abdomen. At the time of surgery, Patient 2 had a white blood cell count of 12,400 and a pulse of 105 bpm. There is no explanation for the two-day delay in surgery after the January 17, 2018 visit. Although the patient was ill, no cultures were taken and sent for pathology analysis, and the patient was not evaluated for IV antibiotics. There is no documented decision-making relating to these issues.

47. During the procedure to remove the chronic seroma, Respondent used Techni-Care, a topical antiseptic, in the abdominal cavity prior to closing the cavity. Techni-Care is for external use only and is not approved for internal use during surgery. Respondent did not discuss his use of this product with Patient 2.

48. On June 7, 2018, Patient 2 underwent a CT scan of the abdomen ordered by her primary care physician. The scan showed fluid collection consistent with a seroma on the left

side of the abdomen.

49. On July 2, 2018, Respondent performed another surgery. The abdomen was opened and phlegmon was found. Small pieces of hard tissue were removed. Cultures were not taken, and the pieces were not sent for pathology analysis.

50. After the July surgery, Patient 2 developed several dark patches on the skin of her upper and middle abdomen. Respondent suggested an ultrasound. Patient 2 underwent an ultrasound which Respondent believed may have resulted in a blister. Respondent placed a wick in the ruptured black wound. No antibiotics were prescribed.

51. Respondent's notes reflect that on July 31, 2018, Patient 2 underwent a surgical incision and drainage of a hematoma. No documentation is included indicating that the risks, benefits, and alternatives to the procedure were discussed with Patient 2, and the record does not reflect the details of the surgical incision, including how the skin was prepared, the type of anesthetic used, and what was found.

52. Respondent's notes reflect that on August 2, 2018, an exploration was conducted, but there is no documentation of the nature of the exploration.

53. On August 23, 2018, Patient 2 underwent a CT scan of the abdomen ordered by her primary care physician. The CT scan revealed possible inflammation and fibrotic scarring on the left side of the abdomen and a band of scarring/fibrosis/granulation tissue in the area of the previously seen seroma. Respondent reviewed the August 2018 CT scan report and noted no seroma.

54. Patient 2 sought treatment from a wound care specialist. On August 24, 2018, the specialist noted an unhealed surgical wound with a moderate amount of drainage. A culture was positive for staph infection. Patient 2 was prescribed the antibiotic doxycycline hydrate.

55. On approximately October 8, 2018, Patient 2 presented to another plastic surgeon, Dr. A.C., with an open wound in the left upper abdomen, which was exuding pus. Dr. A.C. had concerns of possible tissue glue remnants or undissolved stitches in the left upper abdomen. During examination, pus was also located in the area of the belly button. After discussions with Patient 2 about treatment options and consultation with multiple colleagues, the decision was

made to wash out the left abdominal wound and to explore the wound for undissolved stitches or any type of foreign body, excise skin, and close the wound. Patient 2 was advised that the purpose of the surgery was not for cosmetic purposes, but rather to allow healing. She was advised she would have an incision in her left upper abdomen.

56. On October 12, 2018, Dr. A.C. performed surgery at Cedars Sinai for an abdominal infection. He noted a three to four millimeter wound on the left side of Patient 2's upper abdomen with surrounding necrotic tissue. The necrotic tissue was sent to pathology for culture and sensitivity testing. A gritty substance was found in the left abdomen, which was washed out and the pieces removed. The umbilical incision was opened, and pus and necrotic tissue were removed from that area. The umbilicus and the abdomen were closed and a drain was placed. Pathology results indicated remnants of insoluble particles and a staph infection. Dr. A.C. prescribed doxycycline.

57. Respondent's medical record of care for Patient 2 contains approximately 32 handwritten progress notes for the time-period beginning on November 29, 2017 and ending on August 24, 2018. The notes are largely illegible. None of the notes document a physical examination and/or medical decision-making and/or plan of care. No vital signs are recorded. Visits are recorded on January 5, 2018 and May 15, 2018, but there are no notes discussing what occurred on those dates. Medical care is recorded in handwriting that differs from Respondent's on January 23, 2018, January 29, 2018, July 31, 2018, and August 2, 2018. There is no indication as to who treated the patient or their role in the treatment.

58. Respondent failed to sign the operative reports for the surgeries conducted on November 28, 2017, January 19, 2018, and July 2, 2018.

59. Respondent maintained photos and videos of Patient 2 and her procedures on his mobile phone. These materials were not maintained as a part of Patient 2's medical record.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

60. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he was grossly negligent in the treatment of two patients. The circumstances are as follows:

Patient 1

61. The allegations in paragraphs 19 through 37 are incorporated as if fully set forth.

62. Respondent was grossly negligent in his care and treatment of Patient 1 as follows:

a. Respondent failed to conduct and/or document examinations of care and treatment rendered to Patient 1 in follow-up, including taking vital signs, as required by the standard of care.

b. Respondent failed to sign and/or date chart notes as required by the standard of care.

Patient 2

63. The allegations in paragraphs 38 through 59 are incorporated as if fully set forth.

64. Respondent was grossly negligent in his care and treatment of Patient 2 as follows:

a. Respondent failed to maintain accurate, legible, and adequate medical records documenting Patient 2's visits, the reasons for the visits, and the plan of care as required by the standard of care.

b. Respondent failed to discuss with Patient 2 and/or document the use of TissuGlu, including the risks, benefits, and alternatives to its use, in Patient 2's surgery as required by the standard of care.

c. Respondent failed to ensure that non-expired TissuGlu was used in Patient 2's surgery and/or to ensure that the appropriate product labeling was documented in Patient 2's record as required by the standard of care.

d. Respondent failed to sign his operative notes for November 28, 2017, January 19, 2018, and July 2, 2018, as required by the standard of care.

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e. For a January 17, 2018 visit, Respondent failed to document the patient complaint, physical examination with vital signs, diagnosis, reasons for surgery, and the reasons for a 48-hour delay in surgery when the January 17, 2018 note describes the need for surgery "ASAP" as required by the standard of care.

f. During the January 19, 2018 surgery, Respondent failed to obtain cultures of the area of the seroma and to send excised tissue and cultures for pathology testing as required by the standard of care.

g. During the January 19, 2018 surgery, Respondent used Techni-Care for internal use when the product is for external use only in violation of the standard of care and/or failed to discuss the use of the product with Patient 2 as required by the standard of care.

h. Respondent failed to obtain informed consent for the July 31, 2018 surgical incision and drainage of a hematoma as required by the standard of care.

i. Respondent failed to order CT scans or other imaging studies to evaluate Patient 2's chronic seromas as required by the standard of care.

j. Respondent maintained patient photos and videos of Patient 2 on his mobile phone rather than in the patient's record as required by the standard of care.

65. Respondent's acts and/or omissions, whether considered collectively or individually, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code, and his license is subject to discipline.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

66. Respondent Richard McInnis Hodnett, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he committed repeated negligent acts in the care and treatment of two patients. The circumstances are as follows:

67. The allegations in the First Cause for Discipline are incorporated here as if fully set forth.

68. Respondent's acts and/or omissions constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code, and his license is subject to discipline.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

69. Respondent Richard McInnis Hodnett, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records in his care and treatment of two patients. The circumstances are as follows:

70. The allegations in the First and Second Causes for Discipline are incorporated here as if fully set forth.

71. Respondent's acts and/or omissions constitute a failure to maintain adequate and accurate records pursuant to section 2266 of the Code, and his license is subject to discipline.

DISCIPLINARY CONSIDERATIONS

72. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on December 13, 2019, in a prior disciplinary action entitled *In the Matter of the First Amended Accusation Against Richard McInnis Hodnett, M.D.*, before the Medical Board of California, in Case Number 800-2016-020630, Respondent was issued a Public Reprimand for failure to maintain adequate and accurate records in violation of section 2266 of the Code. He was ordered to complete an education course and a medical record keeping course. That Decision is final and is incorporated by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 51707, issued to Respondent Richard McInnis Hodnett, M.D.;

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

3. Ordering Respondent Richard McInnis Hodnett, M.D. to pay the Board the costs of the investigation and enforcement of this case, and 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: AUG 0 2 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2020603918