1 BEFORE THE

2 BOARD OF MEDICAL EXAMINERS

3 STATE OF OREGON

ORIGINAL

4 In the Matter of	)	
	)	
5 TIMOTHY MATHER BROWN, MD	)	FINAL ORDER
License No. MD12786	)	
6	)	

7

8 **BACKGROUND**

9 The Board of Medical Examiners (BME) issued a Complaint and Notice of Proposed
10 Disciplinary Action on May 15, 2000, against Timothy Mather Brown, MD (licensee), pursuant
11 to Oregon Revised Statutes (ORS) 677.205, 677.190(1)(a), 677.188(4)(a) and (b), 677.190(4),
12 677.190(9), and 677.190(14) (Exhibit 1). Licensee requested a hearing.

13 A hearing was held on October 3, 4 and 5, 2000, at the BME offices in Portland, Oregon.
14 Licensee appeared and was represented by attorney Mark Wagner, with assistance from attorney
15 Montgomery Cobb. Dr. Gerald Bernstein, Dr. Bruce Miller, Dr. W. Phillip Werschler, Dr. Ron
16 Cafferky, Dr. Robert Harsany, Dr. John Harris, and Dr. Jeff Albaugh appeared as witnesses on
17 his behalf. The BME was represented by Warren Foote, Assistant Attorney General, with
18 Licensee, Dr. Mark Jewell, Dr. Ronald DeMars, and BME investigator Vickie Wilson as
19 witnesses.

20 The record remained open for submission of a deposition and an affidavit of other
21 witnesses and written closing arguments. The deposition of Dr. Bruce Russell was received from
22 the BME on November 1, 2000, and made part of the record per agreement of the parties. The
23 closing argument of the BME was received on December 12, 2000, and considered. The
24 affidavit of Dr. Michael McDonald on behalf of Licensee was received on January 9, 2001, and

made part of the record per agreement of the parties. Licensee's response was received on January 10, 2001, and considered. The BME's reply was received on January 22, 2001, and considered. The record was then closed.

ISSUES

Are there grounds to take disciplinary action against Licensee? If so, what is the appropriate discipline? See ORS 677.205, 677.190(1)(a), 677.188(4)(a) and (b), 677.190(4), 677.190(9), and 677.190(14).

FINDINGS OF FACT

1. The Board of Medical Examiners (BME) is the state agency responsible for licensing, regulating and disciplining physicians in the State of Oregon. Timothy Mather Brown (Licensee) holds license no. MD12786 from the BME. He has received no prior disciplinary action from the BME.

2. Licensee is board-certified in anatomical and clinical pathology. After a residency at OHSU in dermatology from 1981 to 1984, he passed his dermatology boards in October 1984. Since 1985, he has been in solo private practice as a dermatologist.

3. In about 1990, Licensee became interested in tumescent liposuction as a way to treat patients and not be bound by the financial limits imposed by health maintenance organizations. On October 31, 1990, he attended a cosmetic dermatology seminar for 16 hours. Starting on May 29, 1991, he spent three days observing Dr. Lillis, a nationally recognized expert in performing tumescent liposuction. On October 30, 1991, he attended a cosmetic dermatology seminar for 14 hours. Starting on May 15, 1992, he attended Gary Fanno's Three-Day Live Surgery Workshop in Liposculpting. On October 17, 1992, he attended an international conference on liposuction. On November 12, 1992, Dr. Lillis monitored him while he performed liposuction on two patients. On March 29, 1993, he spent one day observing Dr. Lillis

performing liposuction. Starting on May 27, 1993, he observed and assisted Dr. Lillis performing liposuction for three days. Starting on June 23, 1995, he attended Dr. Lillis' two-day liposuction workshop. On May 3, 1996, and October 9, 1998, he attended the world congress on liposuction. (See Exhibit 5, licensee's log on continuing medical education since 1990.) He thought he learned the most current techniques from Dr. Lillis. The BME concedes that he had sufficient training to perform tumescent liposuction.

4. In early 1994, Licensee began performing tumescent liposuction on patients in his office. He had adopted Dr. Lillis' policies and procedure, although he had no proctor to help him set up his liposuction practice. He preferred tumescent liposuction to dry liposuction because tumescent liposuction was safer. He did not need general anesthesia for tumescent liposuction and could use Epinephrine to reduce the blood flow. He could also do the surgery outpatient and reduce patient costs. The last factor was important because such surgery is considered strictly cosmetic and is rarely covered by insurance plans. He had heard of no deaths from tumescent liposuction.

5. Licensee performed tumescent liposuction only in his office. He administered Lidocaine to his patients for the procedure and understood that if he stayed below 55 to 60 milligrams per kilogram, he would avoid Lidocaine toxicity. He believed Dr. Lillis used higher amounts of Lidocaine without problem. During Licensee's first three years of performing tumescent liposuction, he did not record the amount of Lidocaine he administered to his patients. He later heard the maxim, "If you didn't chart it, it didn't happen", so sometime in 1997, he started recording the amount of Lidocaine he administered to patients.

6. Licensee has been a member of the American Academy of Dermatology since becoming a dermatologist in 1984. He did not become familiar with the Academy's "Guidelines of care for liposuction", issued March 1991 (Exhibit 21) (hereafter, liposuction guidelines), until

1 he stopped doing liposuction in May 1999. Dr. Bernstein testified that he felt the limits in the
2 guidelines on how much fat should be removed at one time were too low for tumescent
3 liposuction. The guidelines were revised in 1997 and 2000 to increase the limits, reflecting the
4 experience that tumescent liposuction turned out to be safer than expected.
5 7. From 1994 until sometime in 1997, Licensee did no intraoperative monitoring of his
6 liposuction patients because he believed Dr. Lillis did not. Licensee mainly relied on pre- and
7 post-operative blood pressure monitoring and visual observation of the patient. Prior to 1997, he
8 did not monitor his patients by pulse oximetry or by pulse or blood pressure during the
9 procedure.
10 8. Part of the information Licensee received from Dr. Lillis was his brochure entitled,
11 "Body Sculpting" (Exhibit 27). On December 27, 1993, Licensee had 500 copies of the brochure
12 made, with the only change replacing Dr. Lillis' name with his own. Licensee used the brochure
13 to advertise and market his liposuction practice. He left them in his office and gave them to
14 prospective patients. The brochure refers in detail to Dr. Lillis' accomplishments and
15 achievements, specifically his experience since 1986, the number of procedures he performed,
16 his authorship of an article on the subject and his privileges at hospitals. Licensee's experience
17 at that point was minimal and much less than what was stated in the brochure. Licensee claimed
18 he made a "sloppy and huge" mistake by not reading the whole brochure before having the
19 brochure printed up with his name. In about May 1995, a patient asked him for a copy of the
20 article referred to in the brochure, and Licensee was confronted with the incorrect information. .
21 He made no attempt to notify past or current liposuction patients about the false statements in the
22 brochure.
23 9. Licensee had a second brochure printed on December 21, 1995, and used that
24 brochure by leaving it in his office for patients to see or providing it to prospective patients until

1 he stopped doing liposuctions in early May 1999. In the new brochure (Exhibit 4), Licensee
2 states that he performs a pre-op physical and monitors vital signs during the procedure. He did
3 not routinely monitor the pulse or blood pressure of his patients until 1997 or 1998 and admitted
4 at the hearing that the statement about monitoring was not accurate. He also admitted that his
5 pre-ops were not what people would consider a physical. He examined prospective patients
6 mainly to see if they would be appropriate candidates.
7 10. From early 1994, when Licensee first started performing tumescent liposuction, until
8 sometime in 1997 or 1998, Licensee performed very brief exams of prospective patients, mostly
9 to determine whether they had blood-based, immune, or heart disease. He understood from Dr.
10 Lillis that most anyone who did not have those problems could be a good candidate for
11 tumescent liposuction if they had dysmorphic fat in a location where the fat could be removed,
12 including older patients who did not have good skin elasticity if their goal was to look good in
13 clothes. The factors he considered were whether the prospective patient was stable from a
14 cardiac viewpoint and could be helped. He believed the question of whether to perform
15 tumescent liposuction on obese patients was controversial, with no consensus among
16 practitioners, although the brochure from Dr. Lillis states, "In general, however, patients should
17 not be obese" (Exhibit 3, pg. 2). A French expert and Dr. Fanno had treated obese patients.
18 Licensee did no preoperative blood work of prospective patients until sometime in 1997. He did
19 not test for renal impairment before then.
20 11. Licensee used Dr. Lillis's consent form. The form listed many potential side effects,
21 but did not state the potential risks of Lidocaine toxicity or fluid overload or record what body
22 parts or areas were to be treated. Licensee later admitted that he should have included these
23 areas in the form for patients to sign. He would orally go over what areas would be treated and
24 for some patients, draw on their bodies where the treatment would occur.

1 12. Licensee instructed all liposuction patients to have a friend or family member drive
2 them home after surgery and monitor the patient while still under the influence of Lidocaine
3 because its effects sometimes peaked 11 hours after administration. Patients who did not have
4 someone to drive them were sent home in a taxicab.
5 13. Licensee worked with a certified medical assistant, who had received CPR training.
6 The assistant handled the patients and took some vital signs before surgery. The assistant also
7 injected the tumescent solution in some patients. On the vast majority of his patients before
8 1998, he did not use an IV and injected the Versed and Demerol intramuscularly. He also gave
9 patients Valium to take before coming in for surgery.
10 14. Licensee felt his learning curve for tumescent liposuction surgery was pretty flat. He
11 noted that contour abnormalities were quite common.
12 15. Dr. Mark Jewell has been in private practice as a plastic surgeon since July 1979 and
13 was requested by the BME to be a consultant in this case. He has performed tumescent
14 liposuction in his office and in the hospital since the early 1990's. He opines that the 1991
15 liposuction guidelines by the American Academy of Dermatology are good, conservative
16 standards (Exhibit 21). Since he first started doing tumescent liposuction, his criteria for patient
17 selection have been realistic expectations, localized fatty deposits, close to ideal body weight,
18 and good skin tone. He understood from his training that it was not what he took out, but what
19 he left in that would make for a good result. In his office, he administers his sedatives
20 intraoperatively through an IV and uses several monitoring systems—pulse oximeter, blood
21 pressure, and EKG. He opines that the standard of care for tumescent liposuction does not vary
22 by area or specialty and consists of the three main areas: patient assessment and selection;
23 performance in a safe and competent fashion; and outcome, with reasonable aftercare. He is
24 familiar with the standard of liposuction care in Oregon after performing the procedure for many

1 years and from reviewing cases and writings in the area. He disagrees with Licensee's first

2 brochure that said no serious complications can occur with tumescent liposuction because

3 bleeding, scarring, drug reactions, water overload, paralysis of motor nerves, pulmonary

4 complications, sarcoma formation, and even death are possible complications. These

5 complications are due in part to the injection of Lidocaine, which was used as a regional

6 anesthetic, but affected the whole system and may cause toxicity.

7 16. Based on his review of Licensee's files for Patients A through M, Dr. Jewell was

8 critical of Licensee's liposuction practice in the following areas: his patient selection; his

9 follow-up; his surgical judgment in regards to how much fluid he used and amount of fat

10 resected; his repeated pattern of touchup, which often caused more problems; his lack of

11 intraoperative monitoring of vital signs during his procedures; his inadequate record keeping,

12 especially his failure to note the amount of Lidocaine administered; his reliance on taxi cab

13 transport after surgery, without proper notation of checking with the patient later; his inadequate

14 amount of sedative; and his failure to state the potential complication of Lidocaine toxicity on

15 the informed consent form. In regards to the patient files he reviewed, Dr. Jewell opined that

16 Licensee violated the standard of practice because his chart notes were inadequate, because he

17 did not monitor Lidocaine administration by documenting fluid volume and amount in his

18 records, and because he did not state in his informed consent form the specific areas where fat

19 would be resected. Dr. Jewell was also concerned that Licensee materially misrepresented his

20 qualifications in the first brochure by claiming to have performed many more procedures than he

21 had and by claiming authorship of an article he did not write. Dr. Jewell opined that the standard

22 of care required intraoperative monitoring of vital signs if more than 2,000 cubic centimeters of

23 fat were being resected, along with physical observation and verbal communication with the

24 patient. He also believed that a registered nurse should be present to help handle any

1 complications.

2 17. Dr. Ronald DeMars has been in private practice as a plastic and reconstructive
3 surgeon in the Portland area for over 20 years and is board certified as a plastic surgeon. He has
4 performed tumescent liposuction in his office and in the hospital since about 1990. The BME
5 subpoenaed him to testify about his physical examination of five of the patients in this case. He
6 opined that the standard of care for tumescent liposuction does not vary by area or specialty. His
7 criteria for a good candidate were patients who are in good physical health, with realistic
8 expectations, and who are not obese, with good skin tone.

9 18. Dr. DeMars opined that the 1991 liposuction guidelines by the American Academy
10 of Dermatology are good, conservative standards (Exhibit 21). In his office, he administers his
11 sedatives intraoperatively through an IV and uses several monitoring systems—pulse oximeter,
12 blood pressure, and EKG. He is familiar with the standard of liposuction care in Oregon after
13 performing the procedure for many years and from reviewing cases and writings in the area. He
14 disagrees with Licensee's first brochure that said no serious complications can occur with
15 tumescent liposuction because bleeding, scarring, drug reactions, water overload, paralysis of
16 motor nerves, pulmonary complications, sarcoma formation, and even death were possible
17 complications. These complications are due in part to the injection of Lidocaine, which was
18 used as a regional anesthetic, but affected the whole system and may cause toxicity.

19 19. Dr. DeMars opined that Licensee's poor surgical techniques that led him to over-
20 resect and his poor selection of patients violated the standard of care. He also opined that he was
21 very concerned with Licensee's ethics in not declining to treat some patients who he knew or
22 should have known would not get good results from surgery.

23 20. Dr. Bruce Russell is a board-certified dermatologist. He has a busy clinical practice
24 and is responsible for all the dermatologic surgery at the VA hospital and laser dermatology at

1 the Oregon Health Sciences University. He also has special training in tumescent liposuction
2 surgery and is a recognized expert in the area, as he believes Drs. Gerald Bernstein and Pat Lillis
3 are. Dr. Russell is very familiar with the "Guidelines of care for liposuction", issued on
4 March 1991 (Exhibit 21) by the American Academy of Dermatology. He believes these
5 Guidelines are a "road map" or "guidelines", but "not requirements of care" (pages 9 and 10,
6 deposition of Dr. Russell).

7 21. In about mid-September 2000, the BME asked Dr. Russell to review the files of
8 Patients A through M and provide his opinion of Licensee's treatment. Dr. Russell performed
9 the review and opined that Licensee violated the standard of care by not monitoring the patient's
10 respiration with pulse oximetry after administering Versed and Demerol, which can act
11 synergistically to depress respiration. Dr. Russell could give no opinion about the results
12 obtained by Licensee because the post-procedure films were so poor. He also felt the record
13 keeping was too poor to make any conclusions regarding whether the dosages of Lidocaine were
14 appropriate.

15 22. Dr. Gerald Bernstein is a board-certified dermatologist who practices in Seattle. He
16 has used tumescent liposuction in his practice for many years and is considered a leader in his
17 field among dermatologists. He has published many articles. He received training from Drs.
18 Lillis and Fanno and taught in their clinics (see his curriculum vitae, Exhibit 31). He believes
19 patients are appropriate candidates unless they cannot achieve their goals or they are very ill. He
20 is familiar with the "Guidelines of care for liposuction" issued by the American Academy of
21 Dermatology in March 1991 (Exhibit 21) and believes they were the standards for dry
22 liposuction that were modified a little for tumescent liposuction. He believes they are only a
23 road map and he has deviated from them if he learned new information. Tumescent liposuction
24 has turned out to be safer than dry liposuction because much less blood was lost than expected.

1 Therefore, the limits on the amount of fat removed in the 1991 liposuction guidelines have been
2 relaxed considerably in practice by Dr. Bernstein and other practitioners and in revisions to the
3 guidelines in 1997 and 2000. Dr. Bernstein agrees that the guidelines did not change in regards
4 to: the need for medical history; the baseline physical examination and examination of the areas
5 to be treated; and the basic lab work if more than 2,000 cubic centimeters of fat is to be removed,
6 especially if the patient has the tendency to bleed or have heart problems.
7 23. Dr. Bernstein was aware of Licensee's practice from 1994 through 1997. He
8 believes Licensee's office and staffing met the standard of care. Licensee did not do
9 intraoperative monitoring from 1994 until sometime in 1997. Dr. Bernstein did such monitoring
10 during that time and believes it was the standard of care, although he knew of others who did not
11 do it. In a 1996 article, a majority of the tumescent liposuction practitioners used intraoperative
12 monitoring for patient safety. Dr. Bernstein noted that tumescent liposuction turned out to be a
13 lot safer than expected. Dr. Bernstein opined that Licensee's patient selection was within the
14 standard of care, as was the prescription of Cephalexin for patients allergic to penicillin. Dr.
15 Bernstein believes that plastic surgeons have tried to prevent all other specialties from
16 performing tumescent liposuction.
17 24. Dr. W. Philip Werschler has been a board-certified dermatologist since 1989. He has
18 performed tumescent liposuction in his office in Spokane, Washington, for many years, starting
19 prior to 1994 (see his curriculum vitae, Exhibit 34). He acted as an expert witness for Licensee
20 in defending against lawsuits filed by Patients B, E and M. He reviewed the files in all 13 cases
21 and his overall impression was that Licensee met the standard of care in all cases, but only at a
22 passing level and just barely passing in some outcomes. He noted that expectation and
23 performance were not matched in some of the cases, which would cause disappointment. Dr.
24 Werschler would have treated the patients differently, listing more information on the operative

flow sheet, describing patients' symptoms and expectations better, and monitoring the patients intraoperatively. Dr. Werschler opined that it was not good practice to fail to take intraoperative vital signs because it has been a standard practice to record such signs for 100 years. Nevertheless, he opined that Licensee's failure was not out of bounds although close to the edge. To Dr. Werschler, the ideal liposuction candidate is one who is mentally stable with localized fat deposits.

PATIENT REVIEW

Patient A

25. Patient A filed a complaint with the BME and filed a lawsuit against Licensee. Her claim was settled. She was one of Licensee's earlier patients and was 65 years old at the time of surgery. She wanted fat removed from her lateral and medial thighs and her lower buttocks. Licensee did not order a baseline cardiogram for her because she stated no history of heart disease. She underwent surgery on April 12, 1995, and 2,250 cubic centimeters of fat were resected (Exhibit 7, page 10). Afterward, she was dissatisfied with contour irregularities in the treated areas that Licensee felt were unacceptable. He felt his inexperience led to the less than optimal result.

26. Licensee performed tumescent liposuction on Patient A again on September 29, 1995, when another 700 cubic centimeters of fat were resected from her inner thighs and 300 cubic centimeters of fat from her buttocks (Exhibit 7, page 12). The patient continued to be dissatisfied with contour irregularities, but declined further treatment from Licensee to correct her concerns.

27. Dr. Jewell opined that under the standard of care in the practice of tumescent liposuction, Patient A was not a suitable candidate for liposuction because of her old age and lack of skin tone, and that these factors would likely preclude a satisfactory result. He opined

1 that under the standard of care, the pre-operative exam was not adequate because Licensee did
2 not do blood tests before the surgery to rule out anemia or heart problems in a patient of her age.
3 He opined that intraoperative monitoring should have been done because of the patient's age and
4 the amount of fat (2600 cubic centimeters) resected over several hours. He opined that fat was
5 over-resected from the patient's right thigh, resulting in rippling and waviness. He noted that
6 this patient was an early patient and that when starting out, Licensee should have accepted
7 patients with few risk factors so he would have a better chance of obtaining a satisfactory result.
8 Regarding the outcome for patient A, Dr. Jewell opined that Licensee violated the standard of
9 care by resecting too much fat and leaving contour irregularities.
10 28. On June 1, 1995, Patient A contacted Dr. DeMars for a cosmetic consult, specifically
11 seeking a facelift and abdominoplasty. On April 24, 1997, she contacted Dr. DeMars, asking for
12 a thigh lift to correct irregularities in her thigh. She was very unhappy with the liposuction done
13 by Licensee two years earlier. Dr. DeMars examined her and noted deep grooves and gouges on
14 her thighs, "with adherence of the skin to the deep fascia where the fat was taken out in excess
15 and in irregular method. This extends from groin to knee, over the medial thigh, anterior thigh,
16 and lateral thigh." (Exhibit 7, page 49). Regarding patient A, Dr. DeMars opined that, under the
17 standard of care in the practice of liposuction, the patient was probably not a suitable candidate
18 for liposuction because of her lack of skin tone. Regarding the outcome for patient A, Dr.
19 DeMars opined that Licensee harmed the patient and violated the standard of care by causing
20 permanent disfigurement.
21 29. Dr. Bernstein opined that he would have sought a hematology and cardiac consult
22 before operating on Patient A. He had done urinalysis of patient's back then, but does not
23 believe it was required by the standard of care. He opines that she was not an ideal patient, but
24 that Licensee wanted to help her. Dr. Bernstein did not think Licensee was negligent because the

1 patient's goal of looking good in clothes had probably been obtained.

2 **Patient B**

3 30. Patient B filed a complaint with the BME and filed a lawsuit against Licensee. Her
4 lawsuit has been appealed. She consulted with Licensee for possible liposuction on her lateral
5 and medial thighs and medial knees. Licensee noted that she had considerable cellulite, which
6 he felt would mask any minor contour abnormalities (Exhibit 8, page 1). She underwent surgery
7 for five hours on December 11, 1997, and 4,400 cubic centimeters of fat were resected from her
8 thighs (Exhibit 8, page 36). Licensee noted the amount of Lidocaine injected during the
9 procedure. He also collected a pre-operative blood sample to detect any potential problems, such
10 as hepatitis or renal or blood problems. She reported that she was allergic to penicillin, so
11 Licensee prescribed Cephalexin as an antibiotic postoperatively, even though he knew there was
12 a 15% chance of cross-reaction. The BME does not allege that the prescription of Cephalexin
13 for people allergic to penicillin is a violation of the standard of care. The patient called Licensee
14 on December 12, 1997, to report a reaction to the Cephalexin (Exhibit 8, page 9). Licensee was
15 not sure the reaction was allergic, but prescribed another antibiotic for her.

16 31. On January 26, 1998, the patient complained to Licensee that she was suffering from
17 considerable pain in all the areas of treatment and about remaining fat in her anterior thigh.
18 Licensee noted that the left leg looked bigger than the right (Exhibit 8, page 9). On March 12,
19 1998, Licensee performed further tumescent liposuction on the same areas and another 1,700
20 cubic centimeters of fat were resected (Exhibit 8, page 33). On June 24, 1998, further tumescent
21 liposuction was performed on the patient's buttocks at no charge and 1,500 cubic centimeters of
22 fat were resected (Exhibit 8, page 29). The patient had a bad reaction during this last surgery.
23 She continued to be dissatisfied and did not return to Licensee for further treatment.

24 32. Dr. Jewell opined that, under the standard of care in the practice of liposuction, too

1 much fat was resected from Patient B, which caused skin contour irregularities of gouges,
2 grooves and hanging skin. He opined that too much Lidocaine was used in the procedure, which
3 posed a risk of Lidocaine toxicity and fluid overload, especially when there was no monitoring of
4 the amounts of Lidocaine administered. Regarding the outcome for patient B, Dr. Jewell opined
5 that Licensee did not meet the standard of care and harmed the patient.

6 33. Patient B was referred to Dr. DeMars by the patient's attorney, who represented all
7 the patients referred to Dr. DeMars. Dr. DeMars examined the patient and opined that, under the
8 standard of care in the practice of liposuction, Licensee had over-resected the areas of treatment,
9 causing permanent deformities. Regarding the outcome for patient B, Dr. DeMars opined that
10 Licensee harmed the patient and breached the standard of care.

11 **Patient C**

12 34. Patient C filed a complaint with the BME and filed a lawsuit against Licensee. Her
13 lawsuit was settled. She sought liposuction from Licensee to reduce her double chin and her
14 abdomen and hips so that she would look better in clothes. She was considered obese by Drs.
15 Jewell and DeMars. She underwent surgery on March 29, 1996, and 5,325 cubic centimeters of
16 fat were resected by Licensee (Exhibit 9, page 7). No preoperative lab work was done. No
17 continuous monitoring was done during the operation. Afterward, she suffered from
18 considerable discoloration in the treated areas and was dissatisfied with contour irregularities in
19 the treated areas, especially in the abdomen, which had deep gouges and ridges (Exhibit 29).
20 She suffered infections where the cannulas were inserted.

21 35. Dr. Jewell opined that under the standard of care in the practice of liposuction,
22 Patient C was not a suitable candidate for liposuction because of the large amount of fat in her
23 abdomen and diminished skin tone, especially in relation to the amount of fat resected. He
24 believed these factors meant Licensee would not likely receive a satisfactory result. He opined

1 that intraoperative monitoring should have been done because of the large amount of fat
2 resected. He opined that fat was over-resected from the patient's abdomen, resulting in major
3 contour irregularities in both her abdomen and submental area. He noted that this patient
4 suffered infection and drainage problems for some time and received inadequate follow up care.
5 He opined that the pre-operative exam of the neck was inadequate because the neck was not an
6 appropriate area for liposuction due to its thickness. Regarding the outcome for patient C, Dr.
7 Jewell opined that Licensee violated the standard of care.
8 36. Patient C was referred to Dr. DeMars by the patient's attorney, who represented all
9 the patients referred to Dr. DeMars. DeMars found the patient very depressed and extremely
10 unhappy with her treatment from Licensee. Dr. DeMars opined that fat was over-resected from
11 the patient's abdomen and neck, resulting in stretched skin, extremely poor skin tone,
12 overhanging tissue, dense grooves under her breasts, and indentations on her hips and back.
13 Regarding the outcome for patient C, Dr. DeMars opined that Licensee harmed the patient and
14 did not meet the standard of care.
15 37. Dr. Bernstein opined that Patient C was not an ideal patient, but that Licensee wanted
16 to help her. Dr. Bernstein ,did not think Licensee was negligent in this case because the patient's
17 goal of looking good in clothes had probably been obtained. Dr. Bernstein believed that
18 Licensee should have used intraoperative monitoring on this patient because of the amount of fat
19 extracted.
20 **Patient D**
21 38. Patient D filed a complaint with the BME. In December 1995, she sought
22 liposuction from Licensee on her submental region and her upper arms. She chose Licensee
23 because his consultation was free and his prices the least expensive. No pre-operative lab work
24 was done. The patient underwent surgery on January 10, 1996, and 400 cubic centimeters of fat

1 were resected from her upper arms and 50 cubic centimeters from her submental region
2 (Exhibit 10, page 5). Licensee examined her on January 12, 1996, and claimed excellent results.
3 On January 23, 1996, the patient complained about pain in the treated areas. She suffers from
4 fibromyalgia, but Licensee did not know that.

5 39. On January 29, 1996, Patient D called Licensee and complained of "lumpy, bumpy
6 look" and increasing pain in the treated areas (Exhibit 10, page 5). Licensee examined her again
7 on January 30, 1996, and noted the patient's continuing complaints, but little if any "lumpy
8 bumpiness". He concluded that the patient was very difficult to please. The patient also became
9 concerned with discoloration and contour irregularities in the areas where her triceps were
10 treated (Exhibit 30). The patient was concerned because the video provided by Licensee for
11 viewing before surgery said that the procedure would cause virtually no pain and recovery would
12 occur within a couple days, neither of which the patient experienced. She was also told the fat
13 would never come back, but then was told later that areas that were gouged would eventually fill
14 in. She later had a face-lift to correct the contour deformities left from the liposuction in her
15 submental area. She has been told that nothing can be done to correct the discoloration and over
16 resection in her arms. The patient later sued Licensee. Licensee did not admit negligence in her
17 case, but agreed that a less than acceptable result had been obtained and allowed a jury to set the
18 amount of damages. The jury awarded damages of $192,000, plus $10,000 to settle other claims.

19 40. Dr. Jewell opined that the outcome for Patient D was poor because fat was over
20 resected from the patient's arms and neck, resulting in contour irregularities. Dr. Jewell noted
21 that the patient's skin was adhering to the muscles in the arm because too much fat was resected.
22 Regarding the outcome for Patient D, Dr. Jewell opined that Licensee violated the standard of
23 care.

24 41. Dr. DeMars first examined Patient D when she saw him for a breast augmentation

1 and evaluation of a mass in her left breast on April 11, 1997. Patient D asked him to look at her
2 upper arms after the prior liposuction by licensee. He examined her and concluded there were
3 tissue irregularities in her upper arms due to over-resection of fat in those areas. He also
4 concluded that the patient likely did have pain, as she reported, due to cannula damage to the
5 nerves and over-resection of fat. Regarding the outcome for Patient D, Dr. DeMars opined that
6 Licensee did not meet the standard of care for this patient because there was too much deformity
7 on her arms and neck.

8 **Patient E**

9 42. Patient E filed a complaint with the BME and filed a lawsuit against Licensee. Her
10 lawsuit has been appealed. She sought liposuction from Licensee to remove dysmorphic fat
11 deposits from her lateral hips and medial and lateral thighs. Licensee performed tumescent
12 liposuction on her on August 21, 1996, and 1,000 cubic centimeters of fat were resected from her
13 lateral thighs, 550 cubic centimeters of fat from her lateral hips, and 1,100 cubic centimeters of
14 fat from her medial thighs (Exhibit 11, page 13). No preoperative lab work was done. No
15 continuous monitoring of blood pressure or pulse was done during the operation. Afterward, she
16 suffered from contour abnormalities on her left lateral thigh. Licensee offered to do a touchup at
17 no charge, but the patient declined.

18 43. On March 3, 1999, Patient E complained to Licensee about a large scar where the
19 procedure was done and believed she looked worse after the procedure. Licensee believed the
20 less than satisfactory result was the result of using only one cannula portal to do the thighs,
21 instead of multiple portals. He had been taught to use the minimum amount of portals as
22 possible in order to avoid additional scarring.

23 44. Dr. Jewell opined that the outcome for Patient E was poor because of contour
24 irregularities on the patient's left lateral thigh from over-resection in that area. Regarding the

1 outcome for patient D, Dr. Jewell opined that Licensee violated the standard of care.

2 **Patient F**

3 45. Patient F filed a complaint with the BME and filed a lawsuit against Licensee. Her
4 lawsuit has been settled. She sought liposuction from Licensee to remove dysmorphic fat
5 deposits from her lateral thighs and small fat deposits on her upper arms. She underwent surgery
6 on July 3, 1996, and 1,300 cubic centimeters of fat were resected from her lateral thighs, 400
7 cubic centimeters of fat from her lateral hips, and 500 cubic centimeters of fat from her upper
8 arms (Exhibit 12, page 1). No preoperative lab work was done. No continuous monitoring of
9 blood pressure or pulse was done during the operation. Afterward, she complained of fat
10 deposits on her right thigh and lateral thigh. Licensee performed four more touchup procedures
11 on her on November 1, 1996, March 20, 1997, September 4, 1997, and April 23, 1998. On
12 August 7, 1998, Licensee performed tumescent liposuction on the patient's abdomen and then
13 transferred the fat to an indented area on her right thigh. Only during the last two procedures did
14 Licensee record the amount of tumescent solution injected. Licensee admits he inadvertently
15 resected too much fat.

16 46. Dr. Jewell opined that Licensee achieved a poor result due to excessive
17 resection of fatty tissue from Patient F after six procedures and violated the standard
18 of care in the practice of liposuction. Dr. Jewell opined that the outcome for this
19 patient was poor because fat was over-resected from the patient's arms and neck,
20 resulting in contour irregularities. Dr. Jewell noted that the patient's skin was
21 adhering to the muscles in the arm because too much fat was resected. Regarding the
22 outcome for patient F, Dr. Jewell opined that Licensee's treatment of patient F was
23 far below the standard of care.

24 **Patient G**

47. Patient G was one of the five patients randomly chosen from 20 patient files provided by Licensee at the BME's request. Patient G sought liposuction from Licensee to remove fat deposits from his chest. He underwent surgery on July 17, 1996, and 950 cubic centimeters of fat were resected from his chest (Exhibit 13, page 3). No preoperative lab work was done. No continuous monitoring of blood pressure or pulse was done during the operation. The patient was sent home by taxi. Licensee has no record of a call to Patient G's home to make sure he had someone to monitor him there, but believes the policy was to call and check. On July 23, 2000, Patient G returned to Licensee for a checkup and expressed no dissatisfaction (Exhibit 13, page 3). Licensee claimed good success with this case.

48. Dr. Jewell opined that the outcome for Patient G was poor because fat was over-resected from the patient's chest, which violated the standard of care. Dr. Jewell also opined that Licensee violated the standard of care by discharging the patient home in a taxi without anyone to monitor the patient and especially without any record of a call later to the patient to see if he had suffered any complications.

Patient H

49. Patient H was one of the five patients randomly chosen from 20 patient files provided by Licensee at the BME's request. She sought liposuction from Licensee on her abdomen, flanks, saddlebag areas, and her chin. She reported a possible bleeding problem, so Licensee ordered a coagulation work up with PT, PTT, platelet count, platelet function studies, and Von Willebrand's factor. She reported allergies to erythromycin and penicillin, so Licensee prescribed Cephalexin for her. She complained of gastrointestinal problems from the Cephalexin, so he prescribed Rifampin for her. Licensee performed tumescent liposuction on her on June 28, 1995, and 500 cubic centimeters of fat were resected from her medical thighs, 700 cubic centimeters of fat from her abdomen, 675 cubic centimeters of fat from her hips and

1 waist areas, and only minimal amounts from her submental area (Exhibit 14, page 3). No
2 continuous monitoring of blood pressure or pulse was done during the operation. The patient
3 was sent home by taxi. Licensee has no record of a call to her home to make sure she was being
4 monitored there. The next day, Licensee examined her and recorded no complaints from the
5 patient besides possible temporary neuropraxia (Exhibit 14, page 6).

6 50. On July 10, 1995, Licensee noted Patient H had quite a bit of induration in her lower
7 abdomen "where we got fairly aggressive trying to get rid of her wings" and that the neuropraxia
8 was disappearing. He also noted quite a bit of ecchymosis in her medial thighs. On December 5,
9 1995, the patient told Licensee that she was dissatisfied with the amount of fat left in her flanks
10 and asked for more reduction in that area. On May 17, 1996, Licensee performed further
11 tumescent liposuction on the patient, resecting 800 cubic centimeters of fat from her lateral hips,
12 400 cubic centimeters of fat from her waist, and 400 cubic centimeters of fat from her triceps
13 (Exhibit 14, page 5). Quite a bit of bruising was noted four days later. Touchup liposuction was
14 done on May 23, 1997, when Licensee resected 225 cubic centimeters of fat from her lumbar
15 back and flanks. No record of Lidocaine dosages was recorded for any of the surgeries, although
16 no Versed or Demerol was used in the last surgery.

17 51. In regards to licensee's treatment of Patient H, Dr. Jewell opined that Licensee
18 violated the standard of care because of contour irregularities, manner of discharge, and the
19 wrong antibiotic in that Refampin is not a first line antibiotic. Regarding the manner of
20 discharge, Dr. Jewell opined that Licensee violated the standard of care by discharging the
21 patient home in a taxi without anyone to monitor the patient and especially without any record of
22 a call later to the patient to see if she had suffered any complications.

23

24 **Patient I**