

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **SCOTT A. WASSERMAN, M.D.**

4 Holder of License No. 23328
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-06-0470A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand and Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on June
8 6, 2007. Scott A. Wasserman, M.D., ("Respondent") appeared before the Board without legal
9 counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-
10 1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order
11 after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

13 1. The Board is the duly constituted authority for the regulation and control of the
14 practice of allopathic medicine in the State of Arizona.

15 2. Respondent is the holder of License No. 23328 for the practice of allopathic
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-06-0470A after receiving a complaint
18 regarding Respondent's care and treatment of a fifty year-old female patient ("NJ") who presented
19 to Respondent on November 8, 2005 in consultation for liposuction of the trunk. The
20 documentation of the initial visit consists only of two pre-printed forms. The first form was
21 completed by a "Julia" and lists the areas of "Chief Cosmetic Concern" as "abdomen, hips and
22 waist" and the areas discussed as "flanks, upper abdomen, waist, hips, lower abdomen and inner
23 thighs." Previous surgeries are listed as liposuction in 1994, abdominoplasty, and breast
24 augmentation. "Assessment Plan," "Allergies," and "Medications," are all blank. The second
25 document titled "Consultation Form" lists the cost of the surgery and areas titled "Patient Consult

1 Education," "Patient Medical History," and "Medications," all of which are blank. NJ signed this
2 form. The medical record for this visit does not contain either a dictated or handwritten record
3 prepared by Respondent.

4 4. Respondent performed liposuction on NJ on November 22, 2005 in an office
5 setting after performing a brief history and physical just prior to the procedure. The operative
6 record documents IM sedation was used, but there is no documentation that an IV was
7 established prior to the procedure. During the two and one-half hour procedure NJ's vital signs
8 were recorded both preoperatively and when drugs were administered for a total of three times.
9 The liposuction removed 1650 ccs of aspirate, approximately one half of which was fat. The
10 operative note is a pre-printed form containing a generic narration of a liposuction procedure and
11 filled-in blanks for instrumentations, medications, and doses used, and volumes of fluids injected
12 and aspirated. NJ presented for follow-up visits at one day, one week, and five months post-
13 operation. Respondent's office personnel documented the first two post-op visits and Respondent
14 documented the last with an illegible handwritten note.

15 5. Respondent performed a second liposuction procedure on June 6, 2006 as a
16 "re-do" of the abdomen and waist because NJ was dissatisfied with her initial results and
17 complained there was no noticeable difference in her figure. Respondent's pre-operative history
18 and physical documents NJ's skin as normal, that the abdomen shows no change, and NJ's
19 mental status was anxious, and records NJ's weight. There is no record of an examination of NJ's
20 heart and lungs. The operative record documents IM sedation was used, but there is no
21 documentation that an IV was established prior to the procedure. During the two hour procedure
22 NJ's vital signs were recorded preoperatively and when drugs were administered for a total of
23 three times. The operative record documents IM sedation was not given until well after the
24 initiation of the injection of the local (tumescent) anesthetic. The liposuction removed 1150 ccs of
25 aspirate, 450 ccs of which was fat. The operative note is the same generic pre-printed liposuction

1 form as used in the first procedure with the blanks filled in for instrumentation, medications and
2 fluid volumes. NJ was seen in follow-up on the first post-operative day and again one week later
3 when she refused to be seen by Respondent because of the discomfort she felt during the
4 surgery. NJ then refused any further follow-up.

5 6. Respondent believed what triggered everything was that NJ was not happy with
6 the first procedure, not because Respondent did anything wrong, but because NJ felt more could
7 be done. Respondent's policy is to charge a certain fee for a "touch-up" procedure and he
8 believed NJ was very unhappy with the fee and all communication broke down over NJ's
9 unwillingness to pay. Respondent finally agreed to do the procedure anyway and there were no
10 complaints about the results. Respondent believed NJ was unhappy and subsequently looked to
11 create difficulties for him.

12 7. Respondent claimed to have learned a lot from reviewing NJ's case and, although
13 he is not saying he is free of responsibility of things, he would not have done things differently.
14 Respondent objected to this case being reviewed by a plastic surgeon when he is not a plastic
15 surgeon. Respondent specifically performs a tumescent liposuction procedure, an office-based
16 technique that he considers by and far significantly safer than traditional liposuction under general
17 anesthesia in an operating room facility.

18 8. Respondent completed his residency in internal medicine and he did not complete
19 any formal fellowships after residency. Respondent's board-certification in internal medicine
20 lapsed in 2002 when he failed to re-apply because his career was headed in a different direction.
21 Cosmetic procedures are taught primarily through post-residency courses and one-year
22 fellowships given by physicians around the country. These fellowships are not fellowships in a
23 traditional setting and Respondent is not aware whether they are recognized as subspecialty
24 fellowships by the AAC Boards, but maintained they are recognized by the American Academy of
25 Cosmetic Surgeons. The general training for tumescent liposuction is generally through

1 continuing medical education courses, hands-on courses, and proctorships, but not more formally
2 as with traditional subspecialty residencies and fellowships. Beyond the ten years Respondent
3 spent as an emergency room physician he has no formal training or experience in operative
4 settings. Respondent and his staff in the procedure room are ACLS certified and the facility he
5 has recently moved into is in the process of obtaining his triple AHC certification for an outpatient
6 ambulatory surgery center. NJ's procedures were not performed at a certified facility.

7 9. NJ was brought into the procedure room for the second procedure at 11:30 a.m.
8 and the procedure finished at approximately 1:30 p.m. There are two sets of vital signs recorded
9 during the procedure, one at 12:00 p.m. and one at 12:45 p.m., minus any respiration or
10 temperature recorded for the entire two-hour period in the procedure room. Respondent noted NJ
11 was monitored every fifteen minutes, but this is not in the record. The adequacy of ventilation as
12 measured by respiration is important in a patient receiving sedatives and narcotics, but it was not
13 measured or otherwise stated in the record. Respondent maintained there was a strip printed out
14 every fifteen minutes, but he has no excuse for why it is not in the record for this procedure.
15 However, the operative record for the first procedure is no different from the operative record for
16 the second procedure – there are also no monitoring strips in that record.

17 10. There is no documentation, other than preprinted order notes, that NJ's IV was
18 started and by whom. There is no documentation of the size of the IV. Although it is standard
19 procedure for nursing staff to document their invasive procedures on a patient, such as starting
20 an IV, in many situations Respondent started the IV himself because he was being assisted by
21 either surgical technicians or medical assistants.

22 11. Respondent's template operative report says "[t]he pulse oximeter was attached
23 for continuous cardiac monitoring," but does not document use of an EKG as part of the
24 monitoring. Respondent maintained NJ had leads on as well, but there is no documentation in the
25 record. In comparing the operative chart of the first procedure done on November 22, 2005 and

1 the operative chart of the second procedure on June 6, 2006 there is no substantial change, or
2 difference, other than technical fluid changes. Neither record indicates any complications or
3 patient-related issues. Respondent's written response to the Board states he offered to stop the
4 second procedure because of NJ's discomfort, but he did not document her discomfort or his offer
5 because he did not view it as a complication. The medical record, specifically the operative
6 report, should accurately reflect and document the events surrounding a procedure and
7 Respondent's operative record did not do so. The events during the procedure could not be
8 adequately reconstructed from the record making it impossible to determine whether NJ was
9 appropriately cared for during the second procedure.

10 12. According to Respondent as a general rule it is possible that patients experience
11 more pain in the subsequent liposuction procedure than in the initial procedure, but he does not
12 make patients aware of this preoperatively because it does not occur with any greater frequency
13 that would cause him to make a point of it. Respondent believes there were extenuating
14 circumstances in NJ's case. Respondent does not give patients a choice of having repeat
15 procedures done in another setting because increased pain rarely ever happens and the reason
16 the overwhelming majority of patients choose this technique is to avoid any other type of
17 anesthesia. Respondent's written response to the Board states he explained the possibility of a
18 more painful situation to NJ on follow-up of the first procedure prior to the touch-up procedure, but
19 he could not direct the Board to where he documented this in the record.

20 13. In the follow-up procedure Respondent used a somewhat higher local anesthetic
21 concentration of .1 instead of .075 per cent of tumescent fluid for the liposuction to overcome any
22 anticipated additional pain. When Respondent encounters inadequacies in the analgesia or
23 anesthesia even though the concentration of tumescent fluid is increased, as happened with NJ,
24 the other options for pain relief in the office surgery setting include working all the way up to IV
25 sedation, but in approximately 2,300 cases it has never been an issue with any patient other than

1 NJ. In Respondent's practice he has never stopped a procedure or transferred a patient to
2 another facility. Adequate anesthesia is the amount of sedative and/or analgesics that can be
3 safely given to provide for NJ's comfort during the procedure. NJ was not given adequate
4 anesthesia for the second procedure.

5 14. The standard of care requires a physician to provide adequate anesthesia to a
6 patient suitable to the setting of the procedure.

7 15. Respondent deviated from the standard of care by failing to provide adequate
8 anesthesia when performing a liposuction procedure on NJ.

9 16. NJ experienced extreme pain during the second liposuction procedure.

10 17. A physician is required to maintain adequate medical records. An adequate
11 medical record means a legible record containing, at a minimum, sufficient information to identify
12 the patient, support the diagnosis, justify the treatment, accurately document the results, indicate
13 advice and cautionary warnings provided to the patient and provide sufficient information for
14 another practitioner to assume continuity of the patient's care at any point in the course of
15 treatment. A.R.S. § 32-1401(2). Respondent's records do not meet this standard.

16 CONCLUSIONS OF LAW

17 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof
18 and over Respondent.

19 2. The Board has received substantial evidence supporting the Findings of Fact
20 described above and said findings constitute unprofessional conduct or other grounds for the
21 Board to take disciplinary action.

22 3. The conduct and circumstances described above constitutes unprofessional
23 conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records
24 on a patient") and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful
25 or dangerous to the health of the patient or the public.").

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 10th day of August 2007.



THE ARIZONA MEDICAL BOARD

By *[Signature]*
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 10th day of August, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this 10th
day of August, 2007, to:

Scott A. Wasserman, M.D.
Address of Record

[Signature]