BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **PETER J. NORMANN, M.D.,** Holder of License No. 33254 For the Practice of Allopathic Medicine in the State of Arizona	Docket No. **07A-070589-MDX** Case No. MD-07-0328A MD-07-0589A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR REVOCATION OF LICENSE.**

On October 10, 2007 this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge ("ALJ") Daniel G. Martin's proposed Findings of Fact and Conclusions of Law and Recommended Order involving Peter J. Normann, M.D. ("Respondent"). Respondent was notified of the Board's intent to consider this matter at the Board's public meeting. Respondent did not appear and was not represented by counsel. The State was represented by Assistant Attorney General Anne Froedge. Christine Cassetta, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office, provided legal advice to the Board.

The Board having considered the ALJ's recommended decision and the entire record in this matter hereby issues the following Findings of Fact, Conclusion of Law and Order.

FINDINGS OF FACT

1. The Arizona Medical Board (the "Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 33254 for the practice of allopathic medicine in the State of Arizona.

3. On July 10, 2007, the Board issued Interim Findings of Fact and Conclusions of Law under which the Board concluded that Respondent had violated A.R.S. § 32-1401(27)(a) (violating any federal or state laws, rules or regulations applicable to the practice of medicine), 32-1401(27)(e) (failing or refusing to maintain adequate records on a patient), 32-1401(27)(q) (any conduct or practice that is or might be harmful or dangerous to the health of the patient or the

public), 32-1401(27)(t) (knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution), 32-1401(27)(cc) (maintaining a professional connection with or lending one's name to enhance or continue the activities of an illegal practitioner of medicine), 32-1401(27)(jj) (knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board), 32-1401(27)(kk) (failing to dispense drugs and devices in compliance with Arizona Revised Statutes Title 32, Chapter 13, Article 6), and 32-1401(27)(ll) (conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient). The Board concluded that emergency action was required under A.R.S. § 32-1451(D) and summarily suspended Respondent's license [1]

4. On July 18, 2007, the Board issued a Notice of Hearing setting this matter for formal administrative hearing before the Office of Administrative Hearings ("OAH"), an independent state agency. The Board incorporated, by reference into the Notice of Hearing, its Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License..

5. On August 8, 2007, Dr. Normann, through counsel, filed a Response whereby he notified OAH and the Office of the Attorney General that he would not participate in the formal hearing and that the hearing may be conducted as a default proceeding.

6. The hearing in this matter convened on August 20 and 21, 2007. Consistent with his August 8, 2007 notification, Respondent elected not to appear and defend. In consequence of this decision, Respondent did not present any evidence to controvert or mitigate any of the evidence presented by the State.

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[1] On July 12, 2007, the Board issued Amended Interim Findings of Fact and Conclusions of Law under which it added a finding of imminent harm.

7. Vicki Johansen, one of the Board's case managers, and Dr. Edward Eades, M.D., an outside medical consultant, appeared and gave testimony at hearing. That testimony, in combination with the documentary evidence of record (exhibits 1-76), supports the Interim Findings of Fact set forth by the Board in its July 10, 2007 Order for Summary Suspension of License, as amended on July 12, 2007.

8. In view of the fact that Respondent elected not to appear and defend, and specifically advised that the hearing may be conducted as a default proceeding, and because the evidence of record supports the Board's Interim Findings of Fact, the Board adopts and incorporates its Interim Findings of Fact as follows:

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9. The Board initiated case number MD-07-0328A on May 1, 2007 after being notified that two of Respondent's patients RG, a thirty-three year-old male and AS, a forty-one year-old female, were brought to a hospital's emergency department over a four month period after suffering cardiac arrest during liposuction procedures performed by Respondent at his office. Both patients died.

10. RG was an otherwise healthy male who presented to Respondent's office on March 10, 2006 for an initial consultation for liposuction of the abdomen and waist. RG was seen again on May 3, 2006 for a pre-op visit. Respondent performed surgery in his office on May 16, 2006 under local (tumescent) anesthesia with minimal p.o. sedation except that Respondent gave Demerol 50 mg and Phenergan 25 mg IM at the very end of the procedure. RG was discharged home approximately twenty-five minutes after the surgery ended. RG recovered uneventfully and subsequent follow-up was unremarkable. RG was again seen by Respondent on December 4, 2006 and plans were made for repeat liposuction of the same areas treated on May 16, 2006. It is

not clear from the records whether the indication for the repeat procedure was residual or re-accumulated fat.

11. Respondent performed the repeat procedure in his office on December 12, 2006 using a Propofol drip and IV ketamine for conscious sedation since RG had experienced significant pain during the first procedure. Approximately thirty-five minutes into the procedure RG experienced oxygen desaturation followed by cardiac arrest. Respondent's staff called 911 and Respondent began a code. Respondent intubated and ventilated RG with an ambu bag and gave atropine, epinephrine and Lidocaine. Emergency medical technicians ("EMT") arrived within a few minutes of the 911 call to find cardio pulmonary resuscitation ("CPR") in progress. An EMT was unable to verify breath sounds on auscultation of the chest and so advised Respondent. The EMT also noted RG's abdomen was severely distended, but Respondent told him it was due to the two liters of tumescent solution injected into RG's subcutaneous abdominal fat. RG was then transported in persistent full arrest to the local hospital.

12. Respondent insisted on riding along and re-intubated RG just before arrival at the hospital. The EMT still could not verify breath sounds, but Respondent told him the "tube was good." RG was turned over to hospital staff in complete arrest, mottled, and without positive tube placement. RG's pupils were noted to be fixed and dilated and a CO2 sensor indicated incorrect endotracheal tube placement. Hospital staff re-intubated RG and the CO2 sensor immediately indicated proper tube placement. RG was pronounced dead shortly thereafter.

13. The Medical Examiner ruled RG's death a result of an adverse reaction to medications administered for cosmetic liposuction. The Medical Examiner found RG to be otherwise previously healthy, found no evidence of cardiac or pulmonary disease, found no evidence of pulmonary emboli or myocardial infarction and found no evidence of an anaphylactoid reaction.

14. AS, an otherwise healthy female presented to Respondent's office on September 9, 2006 and was seen by a licensed massage therapist ("LMT") employed by Respondent as a medical assistant. Respondent was out of town attending a medical conference. AS next presented on September 25, 2006 and was seen by LMT in consultation for liposuction. The visit note is written and signed by LMT. AS's liposuction of the waist, abdomen, back and outer thighs was performed on September 27, 2006. LMT filled out and signed the intra-operative record. AS received eight liters of tumescent fluid, over six liters were aspirated and AS spent approximately twenty minutes in recovery before being sent home. AS received no resuscitative IV fluids and her urine output was not monitored. Respondent left for a trip to Germany two days after the surgery and all of the follow-up care was done by LMT. AS did not physically return for follow-up, but LMT placed calls to her. There is no operative note written by Respondent for AS's procedure and no documentation that Respondent ever participated in AS's pre-operative evaluation, surgery or follow-up.

15. On March 19, 2006 AS was seen in Respondent's office for a deflated right breast implant. Respondent handwrote and signed a brief note. Surgery was scheduled to replace the implant. On March 23, 2006 AS underwent that procedure under conscious sedation in Respondent's office. There is a typed operative note of the procedure, but it states both implants were replaced, not just the problematic right side. Respondent saw AS in follow-up at four and nine days post-op. The right breast implant was noted to be positioned too high on both visits. On the second visit, plans were made to return to surgery for touch-up liposuction of the abdomen and waist and for primary liposuction of the neck and breasts and fat injections to the buttocks. This surgery was done on April 13, 2007 under conscious sedation with IV ketamine and Propofol drip. There is no operative note for this surgery; the intra-operative records are not signed, but appear to have been filled out by LMT. There is no record of vital signs taken in recovery or disposition of AS

at discharge. The fat injections for buttock augmentation were not performed and there is no documentation why they were omitted. There is no documentation that Respondent participated in this surgery.

16. AS was seen for her first follow-up three days later on April 16, 2007. It appears that plans were made to perform the previously omitted fat injections that day, but then it was discovered that fat had not been saved from the previous liposuction surgery and the surgery was not performed. The surgery was rescheduled for a later date. AS was returned to surgery one week later during which she experienced oxygen desaturation and cardiac arrest. All of the documentation from Respondent's office is dated April 24, 2007, but all emergency medical service and hospital records are dated April 25, 2007. This surgery was done under conscious sedation with IV ketamine and a continuous Propofol drip.

17. The "Liposuction Operative Note" from surgery indicates a plan to perform liposuction of the hips, revision of the right breast, and buttock augmentation. Review of the drawings on that sheet reveals all areas were injected with tumescent solution in anticipation of surgery, including the buttocks. At the bottom of the sheet, there is a handwritten note that the buttock augmentation was not performed and AS coded after the breast revision and liposuction were performed. That notation conflicts with another entry in the chart that was supposedly a contemporaneous record of the surgery. The graph in that record notes "fat AUG." in two separate places, indicating that the fat augmentation was done. The "Conscious Sedation Record" shows the Propofol drip was turned off at between 1735 and 1740 hours and AS coded some twenty or twenty-five minutes later at 1800. According to this record, the Propofol drip was discontinued after the breast revision and liposuction was completed and well before AS arrested. The record is not consistent with a sequence of events in which the buttock augmentation was omitted as a result of the code, as implied by the handwritten note, and Respondent's account of the sequence of events

(that AS arrested after the procedure had been completed) is not consistent with the records from surgery since all of planned procedures had not been completed. After AS arrested, 911 was called, and AS was intubated and ventilated and quickly went into asystole. CPR was begun, defibrillator pads were placed and she received epinephrine, atropine, flumazenil and narcan. AS was subsequently transported to the local hospital where a pulse and pressure were re-established, but she coded again and expired shortly after transfer to the CCU.

18. The autopsy report for AS lists the cause of death as "pulmonary fat embolization due to cosmetic surgery procedures". The state's expert testified that the injection of fat tissue for augmentation purposes, if it was incorrectly injected directly into a blood vessel, could find its way to the heart into the lungs and cause AS's death exactly as the Medical Examiner described. Injection of fat into the body was the only explanation for how the type of fat emboli experienced by AS occurred.

19. On May 3, 2007 Respondent signed an Interim Consent Agreement for Practice Restriction prohibiting him from performing office procedures or surgeries using conscious sedation until further Order of the Board.

20 During investigational interviews with Board Staff Respondent made several false statements. Respondent stated he did not do formal tummy tucks, but records of patient LL describe a full abdominoplasty with placation of the rectus sheath. Respondent stated his staff did not do any procedure without him first doing the consultation and approving the plan, but the medical records of numerous patients indicate they received treatment and office staff performed procedures during times Respondent was out of the office. Respondent stated his bookkeeper had no patient contact, but he later admitted she assisted in surgical procedures. Respondent stated LMT did not do any cutting of skin or suturing, but patient NL, an office employee, LMT and even Respondent confirmed LMT sutured patients.

21. In every operative report in each patient file reviewed by Board Staff Respondent referred to his employees who assisted in procedures as "medical assistants," including his bookkeeper. None of Respondent's staff has completed an approved medical assistant training program nor met the qualifications for exemption under the applicable Administrative Rules.

22. Respondent facilitated the illegal practice of medicine by allowing LMT to perform liposuction, suture, perform post-operative examinations; allowing another employee, a former restaurant owner, to assist in twenty or twenty-five liposuction procedures, of which eight or ten were performed by LMT with Respondent present; and allowing a homeopathic physician not licensed as an allopathic physician by this Board to practice allopathic medicine.

23. Respondent dispensed medications to approximately fifteen patients on more than one occasion from February 2, 2007 through May 1, 2007. Respondent does not have a dispensing certificate from the Board.

24. Respondent was performing procedures involving laser equipment that was not registered with the Arizona Radiation Regulatory Agency.

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25. On July 9, 2007 the Board was informed by a local fire department that on July 3, 2007 they received a 911 call from Respondent's office requesting emergency response to a patient in cardiac arrest. This patient, LR, a fifty-three year-old female, later died at a local hospital. LR first presented to Respondent on May 22, 2007 for a consultation for a liposuction procedure. LR made three payments to Respondent, the last payment being made on July 3, 2007, the day of surgery.

26. Subsequent to signing the Interim Consent Agreement Respondent entered into an agreement with a licensed Homeopathic physician ("Homeopath"). Homeopath is not licensed by

the Board as an allopathic physician. Respondent maintains: Homeopath evaluated LR the day of the procedure and performed the procedure (liposuction of LR's thighs) using local tumescent anesthesia combined with IM morphine and Phenergan; the procedure began approximately 1:00 p.m. and completed at 5:50 p.m; LR was given IV normal saline; was ambulatory at 6:40 p.m. and vomited at 7:00 p.m.; Homeopath left the building at 7:10 p.m., leaving Respondent to monitor LR in recovery until her ride arrived. Respondent also maintains: LR was snoring loudly and at 9:50 p.m. he tried to arouse her from snoring, but was unable to do so; he started an IV and placed a tourniquet on her arm; he noticed LR had stopped snoring and breathing; he started CPR and called 911 at 10:07 p.m.; he used the defibrillator and it advised a shock was completed; his physical examination showed LR had spontaneous breath sounds, good color, but he could not feel a pulse or heart signs with a stethoscope; EMS arrived and took over LR's care. LR was transferred to a hospital where she later died. Fire Department records indicate when they responded the treating physician was Homeopath, but the records reflect and Respondent maintains, Homeopath had left the facility three hours earlier. Later interviews with EMS personnel indicate that the male person working with LR was not Respondent, although the exact identity of that person is unknown.

Standard of Care

27. The standard of care for a physician performing liposuction includes an appropriate preoperative evaluation, history and physical examination, explanation of benefits and risks, performance of the surgery in a safe and technically correct fashion and provision of appropriate post-operative care.

28. Respondent deviated from the standard of care by failing to perform appropriate preoperative evaluation, history and physical examination, explanation of benefits and risks, performance of the surgery in a safe and technically correct fashion and provision of appropriate post-operative care in a safe environment on multiple patients.

29. The standard of care requires a physician who is performing conscious sedation in the office using Propofol to follow the American Society of Anesthesiologists ("ASA") Statement on Safe Use of Propofol, including employing certified and adequately trained personnel to monitor the patients during surgery; being adequately educated and trained in the hours-long use of Propofol required for the liposuction procedures; being physically present while a patient is under conscious sedation; adequately monitor patients who are under conscious sedation; and demonstrate a complete understanding of Propofol.

30. Respondent deviated from the standard of care by not employing certified and adequately trained personnel to monitor the patients during surgery; not being adequately educated and trained in the hours-long use of Propofol required for the liposuction procedures; not being physically present while a patient is under conscious sedation; not adequately monitoring patients who are under conscious sedation; and not demonstrating a complete understanding of Propofol.

31. The standard of care requires a physician to employ certified or appropriately trained personnel to assist in surgery to provide a safe surgical environment.

32. Respondent deviated from the standard of care by failing to employ certified or appropriately trained personnel to assist in surgery and failing to provide a safe surgical environment.

33. The standard of care requires a physician to provide appropriate and timely post-operative care either personally or by appropriately supervised and trained personnel.

34. Respondent deviated from the standard of care by failing to provide appropriate and timely post-operative care to AS either personally or by appropriately supervised and trained personnel.

35. The standard of care requires a physician performing conscious sedation in the office to be adequately trained to address an emergent situation, including the ability to correctly intubate a patient.

36. Respondent deviated from the standard of care by failing to intubate RG correctly.

37. Three patients died.

Medical Records

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

CONCLUSIONS OF LAW

1. In this proceeding, the Board bears the burden to prove, by a preponderance of the evidence, that Dr. Normann engaged in unprofessional conduct as defined in A.R.S. § 32-1401(27)(a), (e), (q), (t), (cc), (jj), (kk), and/or (ll), and that he is subject to disciplinary action pursuant to A.R.S. § 32-1451. *See* A.A.C. R2-19-119.

2. A preponderance of the evidence is "such proof as convinces the trier of fact that the contention is more probably true than not." Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

3. Based on the evidence presented, and the absence of any mitigating or controverting evidence, the Board sustained its burden of proof as to each of Respondent's alleged violations of A.R.S. § 32-1401(27).

4. A.R.S. § 32-1451(M) provides:

> Any doctor of medicine who after a formal hearing is found by the board to be guilty of unprofessional conduct, to be mentally or physically unable safely to engage in the practice of medicine or to be medically incompetent is subject to censure, probation as provided in this section, suspension of license or revocation of license or any combination of these, including a stay of action, and for a period of time or permanently and under conditions as the board deems appropriate for the protection of the public health and safety and just in the circumstance. The board may charge the costs of formal hearings to the licensee who it finds to be in violation of this chapter.

5. Respondent is subject to disciplinary action because he is found to have engaged in unprofessional conduct based on his violations of A.R.S. § 32-1401(27)(a), (e), (q), (t), (cc), (jj), (kk), and (ll). A.R.S. § 32-1451(M).

6. Based upon Respondent's demonstrated violations of A.R.S. § 32-1401(27), and the extremely serious and egregious nature of those violations, revocation of Respondent's license is the proper disciplinary action.

ORDER

1. The Board's July 10, 2007 Order summarily suspending Dr. Normann's license to practice medicine in the State of Arizona, as amended on July 12, 2007, is affirmed and shall remain in full force and effect until the effective date of this Order.

2. Respondent's license No. 33254 is revoked on the effective date of this Order and Respondent shall return his wallet card and certificate of licensure to the Board.

3. Respondent is assessed the costs of the formal hearing to be paid by Respondent to the Board within sixty days of being invoiced by the Board, unless such deadline is otherwise extended by the Board or authorized Board Staff.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review by filing a petition with the Board's Executive Director within thirty (30) days after service of this Order.

A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons for granting a rehearing. A.C.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing 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 is required to preserve any rights of appeal to the Superior Court.

(SEAL)

ARIZONA MEDICAL BOARD

By: _____
Timothy C. Miller, J.D.
Executive Director

Original of the foregoing filed this 11th day of October, 2007, with:

Arizona Medical Board
9545 East Doubletree Ranch Road
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Copy of the foregoing filed this 11th day of October, 2007, with:

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Executed copy of the foregoing mailed by US Mail this 11th day of October, 2007, to:

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