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COURT OF APPEALS
FRANKLIN CO. OHIO

IN THE COURT OF APPEALS OF OHIO

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TENTH APPELLATE DISTRICT

CLERK OF COURTS

Alan Parks, M.D.,

:

Appellant-Appellant,

:

v.

:

Ohio State Medical Board,

:

Appellee-Appellee.

:

No. 08AP-68

(C.P.C. No. 07CVF-03-4500)

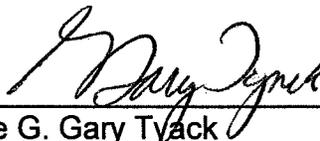
(REGULAR CALENDAR)

JUDGMENT ENTRY

For the reasons stated in the opinion of this court rendered herein on June 30, 2008, appellant's assignments of error are overruled. Therefore, it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs are assessed against appellant.

TYACK, BROWN & FRENCH, JJ.

By



Judge G. Gary Tyack

HEALTH & HUMAN

JUL 03 2008

SERVICES SECTION

[Cite as *Parks v. Ohio State Med. Bd.*, 2008-Ohio-3304.]

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

Alan Parks, M.D.,	:	
Appellant-Appellant,	:	
v.	:	No. 08AP-68 (C.P.C. No. 07CVF-03-4500)
Ohio State Medical Board,	:	(REGULAR CALENDAR)
Appellee-Appellee.	:	

O P I N I O N

Rendered on June 30, 2008

Buckingham Doolittle & Burroughs LLP, and Eric J. Plinke, for appellant.

Nancy H. Rogers, Attorney General, and Kyle C. Wilcox, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

TYACK, J.

{¶1} In 2007, the Ohio State Medical Board ("board"), ordered a six-month suspension of Dr. Alan J. Parks' license to practice medicine for his alleged failure to conform to minimal standards of care concerning the treatment of three patients between 1995 and 2001. The chief witness against Dr. Parks in the administrative hearings was Dwight A. Scarborough, M.D., with whom Dr. Parks had previously worked while still a resident, and a physician who competes, to some extent, for the same patients with Dr.

Parks. The medical board found, based largely on the testimony of Dr. Scarborough, that Dr. Parks failed to conform to the minimum standards of care. Dr. Parks appealed the medical board's decision to the Franklin County Court of Common Pleas, which upheld the order on December 28, 2007. Our review of the common pleas court's decision is limited to whether the court abused its discretion in finding that the medical board's order was supported by reliable, substantial, and probative evidence. Our review is limited, and does not permit us to independently re-weigh the record. Based on our limited review, we affirm the decision of the trial court.

{¶2} Dr. Parks assigns five errors for our review:

[I.] THE TRIAL COURT'S DECISION IS IN ERROR BECAUSE THE BOARD'S ORDER IS CONTRARY TO LAW AS TO THE FINDING THAT DR. PARKS FAILED TO OBTAIN INFORMED CONSENT AS TO ALTERNATIVE TREATMENT OPTIONS FOR PATIENT 1.

[II.] THE TRIAL COURT ERRED IN AFFIRMING THE BOARD'S ORDER DESPITE BOARD'S BASIS OF ACTION BEING ON NEW ISSUES NOT RAISED IN ACCORDANCE WITH R.C. 119.

[III.] THE TRIAL COURT'S DECISION IS IN ERROR BECAUSE THE BOARD'S ORDER IS CONTRARY TO LAW AND NOT SUPPORTED BY SUBSTANTIAL, RELIABLE, AND PROBATIVE EVIDENCE AS IT WAS BASED UPON EXPERT TESTIMONY FROM AN EXPERT WITH AN UNAVOIDABLE AND PREJUDICIAL CONFLICT OF INTEREST.

[IV.] THE TRIAL COURT'S DECISION IS IN ERROR BECAUSE THE BOARD'S ORDER IS CONTRARY TO LAW AND NOT SUPPORTED BY SUBSTANTIAL, RELIABLE, AND PROBATIVE EVIDENCE AS THE BOARD'S FINDINGS AT 1a AND 1c ARE UNSUPPORTED AS TO PATIENT 1.

[V.] THE TRIAL COURT'S DECISION IS IN ERROR BECAUSE THE BOARD'S ORDER IS CONTRARY TO LAW

AS THE BOARD'S FINDINGS ARE UNSUPPORTED AND EXCEEDED THE SCOPE OF THE CHARGE OF THE CITE LETTER AS TO PATIENT 3.

{¶3} The Ohio Revised Code vests the medical board with broad authority to regulate the medical profession in this state, and to discipline any physician whose care constitutes: “A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established[.]” R.C. 4731.22(B)(6).

{¶4} The common pleas court is the reviewing tribunal for appeals from administrative agencies, such as the medical board, and the standard of review is provided by R.C. 119.12. That statute provides that the trial court may affirm the agency's order if, after considering the entire record, the court finds that the order is supported by reliable, probative, and substantial evidence, and is in accordance with law. R.C. 119.12; *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619, 621, 614 N.E.2d 748. On appeal, courts must defer to the medical board's interpretation of the technical and ethical requirements of that profession. *Id.* at syllabus.

{¶5} Our review is even more limited than that of the trial court, because it is the trial court's function to examine the evidence. *Id.* at 621. The court of appeals' function is solely to determine whether the trial court abused its discretion—“not merely an error of judgment, but perversity of will, passion, prejudice, partiality, or moral delinquency.” *Id.* Furthermore, neither we, nor the trial court may substitute our judgment for that of the medical board. See *id.* (citing *Lorain City Sch. Dist. Bd. of Edn. v. State Employment Relations Bd.* [1988], 40 Ohio St.3d 257, 260-261, 533 N.E.2d 264).

{¶6} To understand the nature of Dr. Parks' assignments of error, we must first summarize the facts and medical history of three former patients. These facts come directly from the medical board's Report and Recommendation ("board report"), prepared by R. Gregory Porter, Esq., a medical board hearing examiner. The hearing examiner heard all the evidence in this matter, including expert testimony, fact testimony from the patients themselves, and testimony from subsequent treating physicians. The hearing examiner also considered scholarly articles, publications, and other documents pertinent to the relevant standards of care. After considering all of this evidence, the hearing examiner issued a 51-page board report. The record on appeal also contains the transcript of the proceedings before the medical board ("transcript"). To protect patient confidentiality, their identities were redacted from the hearing transcripts, and identified by the board as Patients 1–3. We will refer to them in the same manner.

{¶7} Dr. Parks performed three outpatient liposuction procedures on Patient 1, a female, in December 1995, and in April and May 1996. The primary focus of these procedures was Patient 1's neck, but Dr. Parks also performed liposuction on her abdomen, thighs, and hips.

{¶8} Patient 1 was apparently dissatisfied with Dr. Parks' treatment, because she sued him for malpractice in 1997. The lawsuit was terminated after the trial court granted summary judgment in favor of Dr. Parks.

{¶9} The medical board took issue with two aspects of Dr. Parks' care concerning Patient 1: (1) Dr. Parks allegedly failed to discuss and document possible alternative treatments with Patient 1; and (2) Dr. Parks neglected to record Patient 1's bodyweight before the first liposuction procedure, which may have resulted in Patient 1

receiving an excessive dose of the anesthetic drug lidocaine. The former is the subject of the first assignment of error herein.

{¶10} Patient 1 was approximately 55 years old when she first came to see Dr. Parks. In the months leading up to her first liposuction procedure on her neck and chin, Patient 1 lost about 40 pounds, and was concerned about sagging, loose skin. Dr. Parks testified that he counseled Patient 1 about possibly performing a face-lift or neck-lift to correct the problem, but that Patient 1 opted for liposuction instead, because it was less expensive, and involved a much quicker recovery period. Patient 1 testified that Dr. Parks did not discuss these alternative treatment options with her; however, the medical board hearing examiner determined that Patient 1's testimony was unreliable based on her poor memory.

{¶11} Nonetheless, the medical board hearing examiner determined that Dr. Parks failed to recognize the basic problem regarding Patient 1, and, in doing so, neglected to recommend appropriate alternative treatment options, causing Patient 1 to undergo inappropriate surgery on three separate occasions.

{¶12} Dr. Parks follows what is known in the medical field as the Klein-formula for tumescent liposuction, which is named after Jeffery A. Klein, M.D., regarded as a pioneer of this cosmetic procedure. See, generally, Jeffery A. Klein, Tumescent Technique for Regional Anesthesia Permits Lidocaine Doses of 35 mg/kg for Liposuction, *J. Dermatol. Surg. Oncol.* 16:3 (1990); (Board Report, at 11-13.) Dr. Klein's formula revolutionized the liposuction procedure by using a local anesthetic—injecting the numbing agent lidocaine directly into the area—rather than using a general anesthetic, which was commonplace in the 1980s, and which resulted in a number of patient deaths. The key to Klein's formula

is the dosage of lidocaine: too little lidocaine would result in unbearable pain to the patient, and too much lidocaine is toxic. This is relevant to Dr. Parks' care of Patient 1 because the medical board determined that Dr. Parks gave her an incorrect dosage of lidocaine.

{¶13} According to Patient 1's medical records, Dr. Parks administered 5,000 milligrams of lidocaine to her during the second liposuction procedure, but he did not record Patient 1's body weight at that time. At other times, Dr. Parks documented Patient 1's weight as high as 182 pounds, but stated that she had since lost weight (about 40 pounds). Dr. Scarborough testified that, assuming Patient 1 weighed 182 (which, in all probability was a substantial overestimate), a 5,000 milligram dose of lidocaine exceeded 60 milligrams per kilogram of bodyweight. Although other experts testified that some of the more aggressive surgeons might use "as much as 80 to 100" milligrams per kilogram, in Dr. Scarborough's opinion, 60 milligrams per kilogram was too much, and fell below the minimum standard of care. Dr. Klein now recommends a lidocaine dosage of 35 milligrams per kilogram, but this is not an absolute number. It is merely a guide. Furthermore, the proper lidocaine dosage was still being established during the period when Patient 1 saw Dr. Parks.

{¶14} Dr. Parks treated Patient 2 in 2000, for a malignant melanoma (skin cancer) on the patient's neck. Dr. Parks performed a biopsy on July 13, 2000, and removed the remainder of the malignant lesion on August 3, 2000.

{¶15} The medical board initially charged Dr. Parks with failing to remove a large enough portion of the malignant lesion, but later determined that "the evidence [did] not support a finding that Dr. Parks' surgery had been inadequate." (Board Report, at 46.)

The board did find fault, however, in Dr. Parks' method of documentation of the procedure he performed on Patient 2. "The evidence is clear that Dr. Parks did not perform or document any vital signs for Patient 2 at the time of surgery. However, persuasive evidence was presented that, in an office setting using only local anesthesia, with the patient fully conscious and communicating with the physician, the standard of care had not required him to do so." Id. at 46-47.

{¶16} Dr. Parks first saw Patient 3 on September 5, 2000. The patient was male, 62 years old at that time, and sought treatment for multiple skin lesions behind his left ear. After the first evaluation, Dr. Parks believed that the lesions were probably related to seborrheic dermatitis, and, given that diagnosis, he prescribed a mild cortisone cream. Five months later, Dr. Parks performed a biopsy of that same area, which revealed "Bowen's disease with superficial squamous cell carcinoma." Id. at 47. Dr. Parks then referred Patient 3 to a Dr. Siegle for a procedure known as Mohs surgery, which was performed on March 13, 2001.

{¶17} The medical board found that Dr. Parks should have followed-up with Patient 3 much sooner than five months, to determine whether the cortisone treatment was effective, or whether a new diagnosis was required. "The evidence supports a finding that the tumor behind Patient 3's ear that was excised on March 13, 2001, occupied or overlapped the area that Dr. Parks described on September 5, 2000, as possibly being seborrheic dermatitis." Id. The report does not include any mitigating evidence with respect to Dr. Parks' treatment of Patient 3.

{¶18} The first assigned error challenges the board's finding that Dr. Parks failed to obtain Patient 1's informed consent, and failed to advise Patient 1 that a chin/neck-lift would have yielded more favorable results than the multiple liposuction procedures.

{¶19} The facts, as found by the board, were as follows: Dr. Parks testified that he discussed the possible alternate treatment options with Patient 1. Patient 1 testified that he did not. The board also found that Patient 1's testimony lacked credibility. The medical board's expert witness, Dr. Scarborough, testified "convincingly," that Patient 1's primary cosmetic issue was not related to excess fat; rather, it was the result of loose, hanging skin resulting from her losing 40 pounds. The board noted that "liposuction can tighten the skin as well as remove fat" but, also, stated that a neck-lift might have produced better results. (Board Report, at 44.)

{¶20} Dr. Parks' expert witnesses, Drs. Siegle and Lillis, testified that Dr. Parks' care did not fall below the minimum standard with regard to this issue. They also testified that they would have proceeded with the same liposuction procedure Dr. Parks used, but only after the patient had opted not to have a chin/neck-lift.

{¶21} Although Dr. Parks documented his discussions with Patient 1 concerning the advisable chin/neck-lift and her refusal to elect the alternative procedure before one of the surgeries, the board found that there was no similar documentation for the other two. Whether this means that Dr. Parks failed to have this discussion with Patient 1, or whether he simply failed to document it, we cannot know. We must, however, defer to the board's finding in concluding the former.

{¶22} Because the board ultimately found that Dr. Parks failed to obtain Patient 1's informed consent for two of the three procedures, there is evidence supporting the

board's order as it relates to that issue. Dr. Scarborough testified: "As physicians, we're very aware of the requirements for charting when we deal with insurance companies * * *. If something is not charted, it's assumed it is not done." (Board Report, 17.)

{¶23} The first assignment of error is overruled.

{¶24} The fourth assigned error is similar to the first, to the extent it relates to Patient 1. Here, Dr. Parks again challenges the board's finding that he failed to obtain Patient 1's informed consent but, also, challenges the board's finding that Dr. Parks made a critical error by failing to record Patient 1's weight before the April 26, 1996 liposuction procedure. We have already discussed the informed consent issue, we therefore overrule that part of the assigned error.

{¶25} With regard to Dr. Parks' failure to document Patient 1's weight issue, Dr. Scarborough believed that Dr. Parks administered too much lidocaine to Patient 1, because Dr. Scarborough follows a more conservative surgical approach. On the other hand, Dr. Parks submitted evidence, including expert testimony, and scholarly articles written by Dr. Jeffrey Klein—the physician credited for being the father of the modern liposuction procedure—suggesting that although Dr. Parks' administration of lidocaine may have been on the progressive side of the scale, it was within an acceptable range nonetheless. However, the testimony of Dr. Scarborough could be found and was found by the trial court to constitute reliable, substantial and probative evidence. Based upon this testimony, the trial court determined: "Clearly documenting a patient's weight immediately [before] surgery is critical in calculating the total drug dosage given to that patient." (Decision and Entry, at 13.) We cannot overturn the board's decision on this issue without finding an abuse of discretion by the common pleas court, and we cannot

say that the trial court abused its discretion in its findings. We, therefore, overrule the remaining portions of the fourth assignment of error.

{¶26} The second assigned error alleges that the board's decision to discipline Dr. Parks was based, at least in part, on the board's belief that Dr. Parks sees too many patients to provide each with adequate care. Dr. Parks testified that he typically sees 900 patients within any given month. Although the board did not specifically state that Dr. Parks' caseload constituted any of the basis for his discipline, individual members of the board were very critical of the fact that Dr. Parks saw this volume of patients on a regular basis. Board minutes demonstrate that board members Drs. Steinbergh and Kumar expressed reservations about the caseload. Dr. Kumar stated that, as far as he was concerned, Dr. Parks represented what is really wrong with some medical professionals. Dr. Robbins stated that he believed Dr. Parks was "overloaded," and "seeing way too many people," and also said that, "If Dr. Parks would cut his load in half, he would probably do a fairly fine job, by and large." (Board Minutes, at 16581.) Board member Dr. Buchan concurred with Dr. Robbins' statement. Dr. Parks asserted that those statements were unfair and unreasonable if for no other reason than because none of the board members practice in the same area as he.

{¶27} Dr. Parks was not given an opportunity to respond to, or defend the allegations of some members of the board that he was overloaded, or seeing too many patients. However, there is no evidence that the board actually based its decision to discipline Dr. Parks on the statements about his caseload, as opposed to the medical errors found by the board.

{¶28} There are no references to Dr. Parks' caseload in any part of the hearing examiner's report except on page 17, which states the fact that Dr. Parks testified that he sees 900 patients per month. There are no comments or conclusions in the report relating to this evidence. Thus, the caseload comments may be seen as an explanation for some board members as to why the medical errors occurred, but caseload issues did not constitute independent grounds for discipline.

{¶29} The second assignment of error is overruled.

{¶30} The third assigned error concerns the board's treatment of Dr. Scarborough's testimony, which Dr. Parks argues should have been excluded based on the witness's unavoidable conflict of interest.

{¶31} Dr. Parks argued to the board, and to the trial court, that Dr. Scarborough's testimony should have been excluded or given little weight. However, the board hearing officer determined that whatever conflict of interest existed as to Dr. Scarborough had a minimal effect on Dr. Scarborough's credibility. (Report and Recommendation, at Finding of Fact, ¶2.)

{¶32} Indeed, the medical board does have a policy requiring witnesses to disclose any potential conflict of interest, but as the trial court noted, the policy does not mandate exclusion of the testimony. Dr. Scarborough did disclose the conflict of interest in this instance, and at least one board member, Dr. Robbins, was "bothered by the fact that [Dr. Parks] previously worked for Dr. Scarborough," but the hearing examiner and the board ultimately concluded that the conflict of interest did not taint Dr. Scarborough's testimony.

{¶33} In dealing with this issue, the trial court noted that the medical board members are physicians—i.e. experts—in their own right, which deemphasizes the need to exclude expert testimony which may come from a source with potential bias. However, courts handling administrative appeals are not in the best position to judge Dr. Scarborough’s credibility or the credibility of an expert with an arguable bias. We do not hear or see the testimony generally, and this record does not demonstrate any obvious defect that would warrant a reversal. Again, it is not our role to substitute our judgment for that of the medical board.

{¶34} Accordingly, we overrule the third assignment error.

{¶35} The fifth assigned error concerns the board’s findings relating to Patient 3. Dr. Parks claims that these findings exceed the scope of the charges filed in the citation letter the board issued to him on January 12, 2005. This citation letter is the administrative equivalent of an indictment, which puts the respondent on notice of the charges against him. Dr. Parks now argues that, by exceeding the charges in the citation letter, which is prohibited by R.C. 119.07, the board’s order violates due process. We again are not in a position to overturn the medical board’s finding of fact related to this issue, which would be a prerequisite to establishing Dr. Parks’ due process argument.

{¶36} Dr. Parks wrote in Patient 3’s medical chart that he initially diagnosed the patient with seborrheic dermatitis behind the left ear. The board’s citation letter referred to this area as the “left posterior auricular zone.” Dr. Parks’ own expert witness, Dr. Siegle, testified that, in his initial review of Patient 3’s records, he was uncertain as to the specific location Dr. Parks was referring to when he wrote “back of,” or “behind” the ear. (Tr. 557-559.) Dr. Siegle stated that, based on the record alone, and without any

clarification of the record from Dr. Parks, in his opinion, Dr. Parks' standard of care fell below the minimum. Dr. Siegle stated that he was only able to understand what Dr. Parks meant after consulting with him personally, and having Dr. Parks draw him a diagram of the area being treated.

{¶37} Because we are not in a position to throw out the medical board's factual determination that Dr. Parks failed to document the area he initially treated on Patient 3's head, we must overrule the fifth assignment of error.

{¶38} Having overruled all the assignments of error, we affirm the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed.

BROWN and FRENCH, JJ., concur.

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

Alan Parks, M.D.,

Appellant,

v.

The State Medical Board of Ohio,

Appellee.

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: Case No. 07 CVF-03-4500
:
: Judge Brown
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CLERK OF COURTS

NOTICE OF APPEAL

Notice is hereby given that Alan Parks, M.D. hereby appeals to the Court of Appeals of Franklin County, Ohio, Tenth Appellate District, the December 28, 2007 Decision and Entry Affirming the March 14, 2007 Order of the State Medical Board of Ohio. A copy of the Decision and Entry is attached as Exhibit A and incorporated herein by reference.

Respectfully submitted,

BUCKINGHAM, DOOLITTLE & BURROUGHS, LLP



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OHIO ATTORNEY
GENERAL'S OFFICE
JAN 23 2008
HEALTH AND
HUMAN SERVICES

CERTIFICATE OF SERVICE

I certify that on this 25th day of January 2008 the foregoing Notice of Appeal was filed via hand delivery with the Court of Common Pleas of Franklin County, Court of Appeals of Franklin County, Tenth Appellate District, and that a copy was served via regular mail upon:

Barbara Pfeiffer
Kyle Wilcox
Assistant Attorneys General
Health & Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3428



Eric J. Plinke

«CO2:402629_v1»

**IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
GENERAL DIVISION**

ALAN PARKS, M.D.,	:	
Appellant,	:	CASE NO. 07CVF-03-4500
vs.	:	JUDGE BROWN
THE STATE MEDICAL BOARD OF OHIO	:	
Appellee.	:	

FILED
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FRANKLIN CO. OHIO
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CLERK OF COURTS-CV

**DECISION AND ENTRY AFFIRMING THE MARCH 14, 2007 ORDER
OF THE STATE MEDICAL BOARD OF OHIO**

BROWN, J.

This matter is before this Court pursuant to R.C. 119.12 from a March 14, 2007 Order of the State Medical Board of Ohio ("Board") suspending Appellant's medical license for 180 days, but staying that suspension subject to probationary terms. The Board alleged that Appellant violated R.C. 4731.22(B)(6) when he fell below the standard of care as a dermatologist in his documentation, treatment and care of three patients.¹

Upon a review of the record, before the Court can address the merits of this appeal, it is incumbent upon the Court to address whether

¹ The record protects the identity of these patients and refers to them by number.

it has subject matter jurisdiction to decide the case on the merits, particularly in light of the recent Ohio Supreme Court decision in *Hughes v. Ohio Dept. Commerce* (2007), 114 Ohio St. 3d 47.

JURISDICTION

The issue of subject matter jurisdiction cannot be waived. It is well established that the issue of subject matter jurisdiction can be raised at any stage of the proceeding. Moreover, a court may, *sua sponte*, address the issue of jurisdiction based on its inherent powers, including the power to vacate void judgments and orders. See *Total Office Products v. Dept. of Adminis. Serv.*, 2006 Ohio App. LEXIS 3230. Upon a review of the record, this Court finds that the administrative agency strictly complied with the procedural requirements of R.C. 119.09 for serving the final order of adjudication. See *Hughes* at 50.

A common pleas court has power to review proceedings of administrative agencies and officers only to the extent granted by law. The provisions of R.C. 119.12 relating to time, place, and manner of filing the notice of appeal are conditions precedent to this court's subject matter jurisdiction. *Id.* at *P11-12. R.C. 119.12 provides, in pertinent part:

Any party desiring to appeal shall file a notice of appeal with the agency setting forth the order appealed from and the grounds of the party's appeal. A copy of such notice of appeal shall also be filed by the appellant with the court. See R.C. 119.12

By its express terms, R.C. 119.12 requires that a notice of appeal be filed with the agency and a “copy of such notice” be filed with the common pleas court. By the statute’s own language, it is clear that the phrase “copy of such notice” means an *exact* duplicate of the notice of appeal filed with the agency. See *Berus v. Ohio Dept. Adminis Serv.* 2005 Ohio 3384; see also *Hughes v. Ohio Dept. Commerce* (2007), 114 Ohio St. 3d 47. The court held in *Berus* that the court lacked jurisdiction when the appellant filed two original notices of appeal. *Berus* at 5, ¶ 11. However, this Court finds that the holding in *Berus* and the holding in *Hughes* are confusing not only for the attorneys practicing in this area but also for the many *pro se* litigants, such as the Appellant in this case, who file their own appeals.

It appears that with modern technology, an “exact duplicate” as referred to in *Hughes*, and the “two originals” referred to in *Berus* must be referring to the same thing and are thus, a distinction without a difference. Many practitioners will print two (or more) copies of the same exact document and sign both copies, ostensibly with the “original” being the electronic version remaining on the hard drive of the computer. However, the language of R.C. 119.12 focuses upon the sequence of filing and is directing a sequential order: (1) that the notice of appeal must be filed **first** with the agency; and (2) once the notice of appeal has been filed with the agency, an exact duplicate, i.e. another copy of the original, must be filed with the common pleas court. Although *Hughes* held that a

copy of the original notice of appeal must be filed with the court of common pleas, it fell short of holding that the copy must be an *exact* photocopy of the original filed with the agency. See *Hughes*, second syllabus at 47.

This Court concludes that the original notice of appeal, the document that was filed **first** with the administrative agency, complied with R.C. 119.12. Upon review, the record shows that the Appellant filed three copies of the exact, same document, *i.e.* his notice of appeal. First, the record shows that he filed an original notice of appeal with the administrative agency which document bears the following time-stamp:

STATE MEDICAL BOARD
OF OHIO
2007 MAR 30 AM 11:20

Next, he filed an exact duplicate of that notice of appeal with this Court. That document, which also bears the common pleas court number in red ink, 07 CVF 03 04500, bears two time stamps:

STATE MEDICAL BOARD
OF OHIO
2007 MAR 30 AM 11:20

FILED
COMMON PLEAS COURT
FRANKLIN CO. OHIO
2007 MAR 30 PM 2:26
CLERK OF COURTS-CV

The third document, another exact duplicate of the original notice of appeal, *albeit* the second document filed with the Board, is imprinted with three time stamps. In addition to the same two time stamps that

appear on the notice of appeal with the Court, the second notice of appeal filed with the Board, is imprinted with a third time stamp as follows:

STATE MEDICL BOARD
OF OHIO
2007 APR 11 A 11:19

In summary, it appears that the original notice of appeal was received by the Board at 11:20 a.m. on March 30, 2007. It appears that an exact duplicate was then filed with the Common Pleas Court approximately three hours later at 2:26 p.m. on March 30, 2007. Additionally, it appears that a notice of appeal was received for a second time by the Board at 11:19 a.m. on April 11, 2007. Frequently, this is done at the request of the administrative agency and as a courtesy, since the document will then have the assigned common pleas court case number, allowing the agency conveniently to file the administrative record in accordance with the statutory mandate. Thus, the second notice of appeal Appellant filed with the Board also includes the Franklin County Common Pleas Court case number, 07 CVF 03 04500, printed in red ink. Although the signature lines on both the notice of appeal to the Board and the copy filed with this Court bear Appellant's original signature in blue ink, this Court finds that the time-stamp history on the three documents clearly demonstrates that Appellant first filed his original notice of appeal with the Board on March 30, 2007 at 11:20 a.m. and thus complied with R.C. 119.12.

Accordingly, in following the law set forth by the holdings in *Berus* and *Hughes*, this Court concludes that, as a matter of law, the Appellant has complied with the mandates of R.C. 119.12 by filing an exact duplicate of the notice of appeal with the Common Pleas Court that he originally filed with the Board. Consequently, this Court has jurisdiction to address this appeal on its merits. See *Berus, supra*; see also *Hughes, supra*.

FACTS AND PROCEDURAL HISTORY

In a January 12, 2005 letter, the Board notified Appellant that it had proposed to take disciplinary action against his license to practice medicine and surgery in Ohio. The Board based its proposed action upon allegations of Appellant's treatment of three patients. The Board alleged that Appellant's conduct constituted "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established." See R.C. 4731.22(B)(6); see also State's Exhibit 4A.

The evidence at the hearing focused on the documentation, treatment and care of three patients. Appellant treated Patient 1 for cosmetic issues in her neck area and performed three surgeries on her chin/neck area between December 14, 1995 and May 9, 1996. Among other things, the testimony at the hearing focused on whether Appellant failed to inform Patient 1 on multiple occasions as to appropriate

alternative treatment options, and failed to document her weight on April 26, 1996 when he performed a tumescent liposuction procedure and administered a total dose of 5000 mg of lidocaine.

Appellant operated on Patient 2's neck on August 3, 2000 and inappropriately indicated in the pre-operative diagnosis that she had malignant melanoma in situ. The testimony at the hearing focused on the fact that Appellant used the wrong template to record his treatment and care of Patient 2.

As to Patient 3, Appellant treated him for multiple skin lesions. In September 2000, Appellant identified the left posterior auricular zone of Patient 3 for possible "seb derm or another malignancy" and prescribed a mild cortisone cream treatment. However, after prescribing the cortisone treatment, he failed to re-evaluate this area over the next five-month period, when he was seeing Patient 3 and treating him for other smaller skin cancers. On February 2, 2001, Appellant performed a biopsy on Patient 3's left posterior auricular, which revealed "Bowen's disease with superficial squamous cell carcinoma." See State's Exhibit 3, p. 4.

Appellant referred Patient 3 to Dr. Ronald Siegle for Mohs surgery, which was performed on March 13, 2001. Dr. Siegel found Patient 3 to have an "extensive deeply spreading tumor requiring two large stages yielding a post op size of 6 x 5 cm." See State's Exhibit 3, p. 4, 33; Tr. 89-93, 654.

The Hearing Examiner issued his Report and Recommendation on January 19, 2007. On February 1, 2007, Appellant filed objections. On

March 14, 2007, the Board heard Appellant's matter, and Appellant's Counsel addressed the Board prior to its deliberations. The Board voted to approve the Report and Recommendation of the Hearing Examiner and voted to suspend Appellant's certificate to practice medicine and surgery in the State of Ohio for a period of 180 days. The suspension was stayed subject to Appellant's complying with the terms of a three-year probation set forth by the Board. See March 14, 2007 Entry of Order.

STANDARD OF REVIEW

R.C. 119.12 sets forth the standard of review a common pleas court must follow when reviewing an administrative appeal. R.C. 119.12 provides in pertinent part:

The court may affirm the order of the agency complained of in the appeal if it finds, upon consideration of the entire record and such additional evidence as the court has admitted, that the order is supported by reliable, probative and substantial evidence and is in accordance with law.

In *Our Place*, the Ohio Supreme Court provided the following definition of reliable, probative, and substantial evidence as:

(1) 'Reliable' evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) 'Probative' evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) 'Substantial' evidence is evidence with some weight; it must have importance and value.

Our Place, Inc. v. Ohio Liquor Comm. (1992), 63 Ohio St. 3d 570, 571.

Once the common pleas court has determined that the administrative agency's order is supported by reliable, probative, and substantial evidence, the court must then determine whether the order is

in accordance with law. See R.C. 119.12. The reviewing court cannot substitute its judgment for the agency's decision where there is some evidence supporting the decision. See *Harris v. Lewis* (1982), 69 Ohio St. 2d 577, 579; see also *University of Cincinnati v. Conrad* (1980), 63 Ohio St. 2d 108.

LAW AND ARGUMENT

Appellant has asserted the following five assignments of error:

First Assignment of Error:

The Board's Order Is Contrary to Law and Not Supported by Substantial, Reliable and Probative Evidence as It Was Based Upon Expert Testimony from an Expert with an Unavoidable and Prejudicial Conflict of Interest.

Second Assignment of Error:

The Board's Order Is Contrary to Law and Not Supported by Substantial, Reliable, and Probative Evidence as the Record Did Not Support the Finding that Dr. Parks' Failed to Obtain Informed Consent as to Patient 1.

Third Assignment of Error:

The Board's Order Is Contrary to Law and Not Supported by Substantial, Reliable, and Probative Evidence as the Board's Findings are unsupported as to Patient 1 and Exceeded the Scope of the Charge of the Cite Letter as to Patient 3.

Fourth Assignment of Error:

The Board's Order Is Contrary to Law and Not Supported by Substantial, Reliable, and Probative Evidence Because It is Based on Facts Not in the Record.

Fifth Assignment of Error:

The Board's Order is Contrary to Law because It Disciplined Dr. Parks for Not Performing a Metastatic Workup on Patient 2 when that Allegation Was Not Raised In the Cite Letter.

In his first assignment of error, Appellant contends that he was denied a fair and impartial hearing because the State's expert, Dr. Scarborough, had a conflict of interest and thus, should not have testified. Appellant asserts that Dr. Scarborough knew him personally, since he employed him 18 years prior in 1987. Appellant further argues that he and Dr. Scarborough directly compete with each other since they both advertise in the same magazine, *Columbus Monthly* and have advertisements on the same page in the local telephone directory.

The Hearing Officer found that these factors had a minimal effect on Dr. Scarborough's credibility. See Report and Recommendation, Findings of Fact ¶ 2: see also March 14, 2007 Board Minutes, Dr. Egner on p. 16572. The Board's policy on expert testimony is set forth in "The State Medical Board of Ohio Expectations of Experts." See Respondent's Exhibit BB. The Board's policy does not prohibit a physician from providing expert testimony if that expert is employed in the same field as the physician he or she is being asked to review. The policy requires that when an expert discovers a conflict of interest, he or she must notify the Board. Clearly, the conflict of interest was disclosed to the Board in this case, and the record demonstrates that at least one Board member, Dr. Robbins, was bothered by the fact that Appellant previously worked for Dr. Scarborough, although he did not see any issue of an economic conflict of interest in competing for patients between them. See March 14, 2007 Board Minutes, p. 16582. Consequently, the guidelines require disclosure, and the Board

has discretion to determine whether to hear the expert. The guidelines do not require the automatic exclusion of the expert.

This Court notes, as did some of the Board members, that the same logic could be applied to Appellant's expert witness, Dr. Siegle. It could be argued that the testimony of Appellant's expert witness, Dr. Siegle, is also influenced by an economic interest, since he stands to lose business from Dr. Parks' referrals if Dr. Parks is not able to practice in Ohio. March 14, 2007 Board Minutes, Dr. Egner on p. 16572, Dr. Steinbergh on p. 16573. Appellant testified that he has been referring patients to Dr. Siegle since 1987 and that the number of patients he refers to Dr. Siegle is too numerous to quantify. Tr. 90-91.

More importantly, the majority of the Board's members are experts in their own right since they are doctors and already possess the specialized knowledge needed to determine the acceptable standard of general medical practice. See *Arlen v. The State Medical Board of Ohio* (1980), 61 Ohio St. 2d 168; see also *In re Williams* (1991), 60 Ohio St. 3d 85, 87.² This Court concludes that a majority of the Board members themselves possess the expertise necessary to determine if the Appellant fell below the minimum standards of practice in failing properly to document his care in the treatment of Patients 1, 2, and 3. Accordingly, this Court concludes that there was reliable, probative, and substantial evidence that Appellant had a fair and impartial hearing, and that

² The Medical Board is comprised of twelve members: nine physicians and three non-physician public members. Each Board member is appointed by the Governor for a five-year term.

hearing was conducted in accordance with law. Thus, Appellant's first assignment of error is not well taken and is **OVERRULED**.

In his second assignment of error, Appellant asserts that the record does not support the Board's finding that he did not obtain informed consent from Patient 1. Apparently, the Appellant seems to assert that he did obtain informed consent from Patient 1 and that the record supports his contention, *i.e.* his own testimony asserting that he did it. Tr. 49, 753-754. The issue before this Court is not whether Appellant obtained informed consent from Patient 1, but rather whether he fell below acceptable medical standards by failing to *document* that he obtained informed consent from Patient 1. Tr. 69, 71, 255, 259, 262, 267, 307, 674. Also, missing from the record of Patient 1 is any documentation that Appellant discussed alternative options of face and neck lift surgery with her. Tr. 48-49, 757-760.

A review of the record indicates that there is reliable, substantial, and probative evidence to support the fact that Appellant did not document that he obtained informed consent from Patient 1. Tr. 69, 71, 255, 259, 262, 267, 307, 674. Moreover, Appellant admitted that he failed to document several facts about Patient 1, including her weight on April 26, 1996, the day that she underwent a tumescent liposuction procedure and was administered the drug lidocaine.³ Tr. 49, 54-57, 60-61, 285, 307, 500. The evidence demonstrated that Patient 1 had

³ Lidocaine is a local anesthetic solution. Tr. 37. The dosage amount of lidocaine is measured as milligrams of lidocaine per kilograms of body weight. Tr. 38.

experienced a recent fluctuation in her weight, and during the time from May to November of 1995, she lost 40 pounds as a result of taking an experimental drug. State's Exhibit 1A at 25; Tr. 108.

Appellant argued that in 1996, at the time that Patient 1 underwent this surgery, there was no standard of care for tumescent liposuction and the safe use of administering lidocaine to the patient undergoing that surgery. He argues that when the Medical Board later decreed that the safe use of lidocaine for tumescent liposuction was 50 mg per kg, he lowered the use of lidocaine to comply. If true, the fact that the standard of care had not yet been defined would suggest even more strongly that the treating physician should document his treatment and use of drug dosage based on the patient's weight, in order to protect both the patient and himself as to what was done. Clearly documenting a patient's weight immediately prior to any surgery is critical in calculating the total drug dosage given to that patient, and it would seem particularly critical for a patient that had recently experienced a significant fluctuation in weight. As in this case, Appellant administered lidocaine to Patient 1 and failed to document her weight and vital signs on the day of surgery.

Appellant testified that it was important to document the care of patients for two reasons: for billing purposes and for subsequent medical treatment. Tr. 33-34. He even agreed with the medical adage that if something is not charted, it was not done. Tr. 34. More

importantly, Appellant's own expert, Dr. Siegle, acknowledged that if Dr. Parks had failed to inform Patient 1 about alternative treatment options, such as a neck-lift, that failure would constitute a deviation from the standard of care. Tr. 37-39, 674.

Dr. Siegle, Appellant's own expert witness, testified that Appellant's medical records were "suboptimal" and "were not the optimal records that I like to see in a chart and they required additional information for clarification." See Tr. 631-632. Accordingly, there is reliable, probative, and substantial evidence to support the Board's conclusion that Appellant fell below the minimal standards of care by failing to document critical information as to his care and treatment of Patient 1. Therefore, Appellant's second assignment of error is not well taken and is hereby **OVERRULED.**

In his third assignment of error, Appellant asserts that the Board's Order is contrary to law and not supported by substantial, reliable and probative evidence since the Board's findings are unsupported as to Patient 1 and exceeded the scope of the January 12, 2005 Citation Letter with respect to Patient 3. This Court has already addressed these issues as to Patient 1, and overruled Appellant's second assignment of error, concluding that the Board's Order as it relates to Patient 1 is supported by reliable, substantial, and probative evidence and is in accordance with law.

Concerning Patient 3, the Hearing Examiner's January 19, 2007

Report and Recommendation, Finding of Fact 1g, is as follows:

On September 5, 2000, Dr. Parks treated Patient 3, a 62-year-old man, for skin lesions. Dr. Parks identified an area behind the patient's left ear as possibly "seb derm or another malignancy," and prescribed a mild cortisone cream, which normally would clear seborrheic dermatitis. However, Dr. Parks failed to further treat and/or diagnose the area for five months despite treating other skin cancers on Patient 3.

On February 2, 2001, Dr. Parks performed a biopsy on Patient 3's left posterior auricular sulcus, and prescribed another brand of cortisone cream "for seb derm behind [left] ear." The biopsy revealed "Bowen's disease with superficial squamous cell carcinoma." Dr. Parks referred Patient 3 to Dr. Siegle for Mohs surgery, which was performed on March 13, 2001. Dr. Siegle noted in his report that "[a] significant tumor occupied the left posterior ear, sulcus, and mastoid tissues[,] and that surgery revealed an "extensive deeply spreading tumor requiring two large stages yielding a post op size of 6x 5 cm."

The Hearing Examiner based his findings on the fact that when Appellant saw Patient 3 on September 5, 2000 he believed that the suspected seborrheic dermatitis behind Patient 3's left ear had been of sufficient importance to warrant attention and treatment and thus, he prescribed a cortisone cream. The Hearing Examiner concluded that Appellant should have followed up on that treatment in a timely manner, and he failed to do so. The Hearing Examiner also concluded that the tumor that was excised from behind Patient 3's left ear on March 13, 2001, occupied or overlapped the area that Appellant described on September 5, 2000 as possibly being seborrheic dermatitis. The conclusion was based upon (1) the large surface area of the tumor

removed; (2) evidence that the treatment prescribed by Appellant, the cortisone cream, had not succeeded in clearing the suspected seborrheic dermatitis, as it normally would be expected to do; and (3) the medical record contains no further documentation concerning the suspected seborrheic dermatitis following excision of the tumor on March 13, 2001. See Hearing Examiner's January 19, 2007 Report and Recommendation, Findings of Fact, 1g.

Appellant now asserts that the Board exceeded its scope and argues that his notations in the record of Patient 3 refer to a different area of the patient's neck. He asserts that the Board's January 12, 2005 Letter to him refers to Patient 3's left posterior auricular zone, whereas he wrote in Patient 3's record "behind the left ear."

In the transcript of the hearing before the Hearing Examiner, the Appellant admits that he did not specify in the patient record the exact location behind the left ear area to which he was referring. Tr. 82. Clearly, the confusion about the exact location of where Appellant treated Patient 3 is caused by the ambiguity in what the Appellant wrote in Patient 3's records. If Appellant had properly and accurately documented the exact location of Patient 3's treatment area, the issue would not have been presented to the Hearing Examiner and the Board, nor would the question be at issue before this Court.

Additionally, Appellant's own expert witness, Dr. Siegle, testified that in his initial review of Patient 3's records he was uncertain as to

what Appellant meant about the location when he wrote "back of" or "behind" the ear. Tr. 557-559. Dr. Siegle testified that based on the record alone, and without any clarification from the Appellant, it appeared that Appellant fell below the standard of care. Tr. 641-642. Dr. Siegle testified that he understood what Appellant meant only after Appellant drew a diagram for him and marked the spot with an "x." However, there was no chart or diagram in the record of Patient 3 specifying the exact location, and a physician rendering subsequent treatment based on Appellant's notations in the record of Patient 3 would have been uncertain and confused. Tr. 644-646.

Whether using the terminology "behind the left ear," "left posterior auricular area," or "left posterior sulcus" it is apparent that the general area Appellant is referring to, as documented in Patient 3's records, is the area behind the left ear from the sulcus to the hairline. More persuasive to this Court is the Hearing Examiner's finding that the tumor that was excised by Dr. Siegel on March 13, 2001 occupied or overlapped the area that Appellant described on September 5, 2000 as possibly being seborrheic dermatitis. Hearing Examiner's January 19, 2007 Report and Recommendation, Findings of Fact, 1g.

Clearly, the medical records demonstrate that Appellant failed to re-evaluate for over five months the area for which he prescribed a cortisone treatment for Patient 3, even though Appellant saw Patient 3 at subsequent office visits on October 20, 2000, October 31, 2000,

November 30, 2000, and December 12, 2000. See State's Exhibit 3; See also Tr. 86-88. On February 2, 2001, Patient 3's medical records indicate that, among other things, Appellant took a biopsy from the "(L) [left] post. auricular sulcus. Acolate [next word illegible] samples for seb derm behind (L) left ear." See State's Exhibit 3, p. 4. Appellant testified at the hearing that he had taken the biopsy from the sulcus, which he described as the crease behind Patient 3's left ear, where the ear meets the scalp. Tr. 88-89. The results from the pathology report that as recorded in Appellant's progress notes state, in part, "L/POSTERIOR EAR: BOWEN'S DISEASE W/ SUPERFICIAL SQUAMOUS CELL CARCINOMA." See State's Exhibit 3, p. 4.

The pathology report itself is not in Appellant's medical record for Patient 3. See Report and Recommendation, Findings of Fact ¶105; State's Exhibit 3 and 4; Tr. 88-89. Appellant referred Patient 3 to Dr. Siegle for Mohs surgery. Dr. Siegle removed Patient 3's tumor on March 13, 2001. See Report and Recommendation, Findings of Fact ¶105. Accordingly, there was reliable, probative, and substantial evidence to support the Board's March 14, 2007 Order as it relates to Patient 3, and the Board's inquiry, and findings of facts and conclusions of law were within the scope of the Board's January 12, 2005 Citation Letter sent to Appellant. See State's Exhibit 4A. Therefore, Appellant's third assignment of error is not well taken and is hereby **OVERRULED**.

Appellant asserts in his fourth assignment of error that the Board based its Order on facts that were not in the record. Appellant testified that he sees approximately 900 patients per month. Tr. 31. Appellant asserts that several comments made by members of the Board regarding the fact that Appellant sees over 900 patients per month made a significant impact and was the basis of the Board's decision. He asserts that this charge was not included in his January 12, 2005 Letter, and he was not afforded an adequate opportunity to defend this charge pursuant to R.C. 119.07.

A review of the record demonstrates that Dr. Enger, Dr. Kumar, Dr. Steinbergh, and Dr. Robbins, four members of those Board members present, made comments regarding the number of patients Appellant saw in a month. March 14, 2007 Order, pp. 16572-16574. Clearly, this was a fact in evidence. Tr. 31-32. Appellant has not demonstrated that a majority of the Board cast their vote based solely on the number of patients Appellant saw in a month.

Even if Appellant could point to evidence in the record that Board members relied on the fact that he saw 900 patients per month, it would be the Board's prerogative to infer that this high number of patients may have contributed to the Appellant's falling below minimal standards of care, since it was a fact in evidence. Tr. 31-32. By comparison, there was also evidence in the record that Dr. Scarborough sees 200-400 patients per month. Tr. 244.

As Dr. Egner, one of the Board members pointed out, in order to see 900 patients a month, you would have to work five days a week, see 45 patients a day giving each 10 minutes of time, and you would be working seven and half hours a day, Monday through Friday, without taking a day off. See March 14, 2007 Board Minutes, p. 16572.

Additionally, a practitioner would need time to follow-up with documenting each patient's chart. Moreover, this demanding schedule does not even factor in time for surgery procedures that may or may not take longer than ten minutes per patient.

As has been previously stated, the majority of the Board's members are experts in their own right since they are doctors and already possess the specialized knowledge needed to determine the acceptable standard of general medical practice. See *In re Williams* (1991), 60 Ohio St. 3d 85, 87; see also *Arlen v. The State Medical Board of Ohio* (1980), 61 Ohio St. 2d 168. Accordingly, Appellant's fourth assignment of error is not well taken and is **OVERRULED**.

Appellant asserts in his fifth assignment of error that he was disciplined for not performing a metastatic workup on Patient 2 when that allegation was not set forth in the January 12, 2005 Letter sent to him by the Board. Appellant takes issue with one of the member's comments at the March 14, 2007 Board meeting. Dr. Kumar made comments regarding Appellant's failure to perform a metastatic workup on Patient 2. See March 14, 2007 Board Minutes, pp. 16574, 16580-81.

The Board's Minutes from March 14, 2007 show that Dr. Kumar moved to amend the Proposed Order in the matter of the Appellant and impose upon him a more severe sanction. See March 14, Board Minutes, pp. 16574-16579. The motion died for a lack of a second, and thus Dr. Kumar's proposal for a more severe sanction was never considered by the Board. Clearly, this action by the Board indicates that the other members of the Board were not persuaded by Dr. Kumar to enhance the sanction set forth in the Proposed Order, even though a majority of the Board agreed that the Proposed Order was appropriate and voted in favor of it. See March 14, Board Minutes, p. 16582.

The record demonstrates that even Appellant's own expert witness acknowledged that based solely on Appellant's record of Patient 2, without further clarification, it appeared that Appellant had fallen below the minimal standard of care. Tr. 641-642. Some Board members made comments regarding Appellant's admitted use of the wrong template, a template that did not match the surgery he performed on Patient 2. See State's Exhibit 2; Tr. 67-69, 71; See March 14, Board Minutes pp. 16572, 16579, 16581.

Dr. Egner found it "abhorrent" that the operative template did not match the surgery of Patient 2. See March 14, Board Minutes 16572. Appellant admitted that Patient 2's records contained erroneous information as to the August 3, 2000 operative report because he had used the wrong template to create the report. See State's Exhibit 2; Tr.

67-69, 71. Clearly, the Board's evaluation of Appellant's care and treatment of Patient 2 focused upon his use of the wrong template to describe the surgery and the inaccuracies in his description of the procedure he performed. See State's Exhibit 2; see also Tr. 67-69, 71, 573-574, 657-658, 717-720, 728-729, 734-735, 749-751. Even Appellant's own expert witness, Dr. Siegle, found fault with Appellant having used the wrong operative template for Patient 2's August 3, 2000 excision. Tr. 573-574.

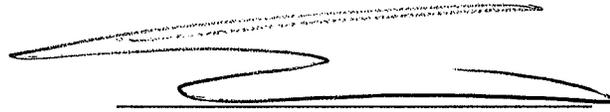
The evidence is overwhelming that Appellant was not disciplined for failing to perform a metastatic workup on Patient 2 and that the Board focused on other aspects of his care and treatment of Patient 2 when finding that he fell below the minimum standard of care in violation of R.C. 4731.22(B)(6). Appellant's fifth assignment of error is not well taken and is hereby **OVERRULED**.

Accordingly, this Court concludes that Appellant's conduct, as set forth in the Hearing Examiner's Findings of Fact 1.a-1.c, 1.e, and 1.g constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as set forth in R.C. 4731.22(B)(6). Therefore, Appellant's five assignments of error are hereby **OVERRULED**.

DECISION

Based on the foregoing, and upon a review of the record, this Court concludes that there is reliable, probative, and substantial evidence supporting the March 14, 2007 Order of the State Medical Board of Ohio. Moreover, this Court concludes that the Board's Order is in accordance with law. The Board's March 14, 2007 Order is hereby **AFFIRMED**.

It is so ordered.



JUDGE ERIC BROWN
28 Dec 2007

Copies to:

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BEFORE THE STATE MEDICAL BOARD OF OHIO

STATE MEDICAL BOARD OF OHIO

2007 APR 17 A 11:19

Alan J. Parks, M.D.
6222 Brooksong Way
Blacklick, OH 43004

Case No 07 CVF 03 04500
Judge _____

Appellant,

vs.

State Medical Board of Ohio
77 South High Street, 17th Floor
Columbus, OH 43215-6127

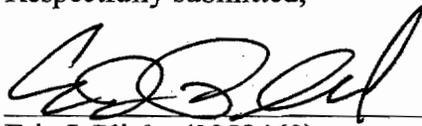
**Appeal from the Findings, Order,
and Journal Entry of March 14, 2007,
mailed March 16, 2007**

Appellee.

APPELLANT'S NOTICE OF APPEAL

Pursuant to Ohio Revised Code § 119.12, notice is hereby given that Appellant, Alan J. Parks, M.D., appeals the State Medical Board of Ohio's ("the Board") Findings, Order, and Journal Entry order dated March 14, 2007 and mailed March 16, 2007, a copy of which is attached as Exhibit A. The Board's Findings, Order, and Journal Entry is not supported by the requisite quantum of reliable, probative, and substantial evidence nor is it in accordance with law.

Respectfully submitted,



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2007 MAR 30 A 11:20
STATE MEDICAL BOARD OF OHIO

FILED
CLERK OF COURTS - CV
2007 MAR 30 PM 2:26
PORTER, WRIGHT, MORRIS & ARTHUR, LLP
COLUMBUS, OHIO

CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of March, 2007, the foregoing Notice of Appeal was filed via hand delivery with the State Medical Board of Ohio, was filed via hand delivery with the Court of Common Pleas, Franklin County, Ohio, and that a copy was served via ordinary U.S. Mail, postage prepaid, upon:

Barbara J. Pfeiffer, Esq.
Assistant Attorney General
Health & Human Services Section
Ohio Attorney General
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3428



Eric J. Plinke (0059463)



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

March 14, 2007

Alan J. Parks, M.D.
6222 Brooksong Way
Blacklick, OH 43004

Dear Doctor Parks:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on March 14, 2007, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3933 4658 8770
RETURN RECEIPT REQUESTED

CC: Eric J. Plinke, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3933 4658 8787
RETURN RECEIPT REQUESTED

Stanley B. Dritz, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3933 4658 8794
RETURN RECEIPT REQUESTED

Mailed 3-16-07

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on March 14, 2007, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Alan J. Parks, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Lance A. Talmage, M.D.
Secretary

(SEAL)

March 14, 2007
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

ALAN J. PARKS, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on March 14, 2007.

Upon the Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

- A. **SUSPENSION OF CERTIFICATE, STAYED; PROBATION:** The certificate of Alan J. Parks, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for a period of 180 days. Such suspension is STAYED, subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:
1. **Obey the Law:** Dr. Parks shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
 2. **Declarations of Compliance:** Dr. Parks shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances:** Dr. Parks shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Medical Records Course:** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Parks shall complete a course on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any course taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Parks submits the documentation of successful completion of the course on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **Monitoring Physician:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Parks shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Parks and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Parks and his medical practice, and shall review Dr. Parks' patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Parks and his medical practice, and on the review of Dr. Parks' patient charts. Dr. Parks shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Parks' quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Parks must immediately so notify the

Board in writing. In addition, Dr. Parks shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Parks shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

6. **Absence from Ohio:** In the event that Dr. Parks should leave Ohio for three continuous months, or reside or practice outside the State, Dr. Parks must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of the probationary period under this Order, unless otherwise determined by the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.

7. **Violation of Probation; Discretionary Sanction Imposed:** If Dr. Parks violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

B. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Parks' certificate will be fully restored.

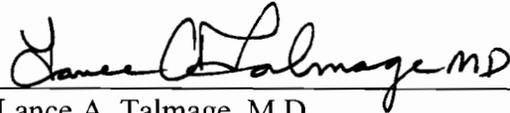
C. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Parks shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Parks shall provide a copy of this Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Parks receives from the Board written notification of his successful completion of probation.

D. **REQUIRED REPORTING TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Parks shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Parks shall also provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration or restoration of

any professional license. Further, Dr. Parks shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt, unless otherwise determined by the Board. This requirement shall continue until Dr. Parks receives from the Board written notification of his successful completion of probation.

This Order shall become effective immediately upon mailing of notification of approval by the Board.

(SEAL)



Lance A. Talmage, M.D.
Secretary

March 14, 2007

Date

2007 JAN 19 A 9:12

**REPORT AND RECOMMENDATION
IN THE MATTER OF ALAN J. PARKS, M.D.**

The Matter of Alan J. Parks, M.D., was heard by R. Gregory Porter, Esq., Hearing Examiner for the State Medical Board of Ohio, on August 29 through September 1, 2005.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated January 12, 2005, the State Medical Board of Ohio [Board] notified Alan J. Parks, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action upon allegations concerning Dr. Parks' treatment of three patients identified in a confidential Patient Key. Further, the Board alleged that Dr. Parks' conduct constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code." Accordingly, the Board advised Dr. Parks of his right to request a hearing in this matter. (State's Exhibits 4A and 4B)
- B. By document received by the Board on January 14, 2005, Stanley B. Dritz, Esq., requested a hearing on behalf of Dr. Parks. (State's Exhibit 4C)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Tara L. Berrien, Assistant Attorney General.
- B. On behalf of the Respondent: Eric J. Plinke and Stanley B. Dritz, Esqs.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
 - 1. Alan J. Parks, M.D., as upon cross examination
 - 2. Patient 1
 - 3. Dwight Scarborough, M.D.

B. Presented by the Respondent

1. David R. Barron, M.D.
2. Ronald J. Siegle, M.D.
3. Alan J. Parks, M.D.
4. Patrick J. Lillis, M.D., via videotaped deposition in lieu of live testimony

II. Exhibits Examined

A. Presented by the State

- * 1. State's Exhibits 1A through 1E, 2, and 3: Patient records for Patients 1 through 3.
2. State's Exhibits 4A, and 4C through 4FF: Procedural exhibits. Note that State's Exhibit 4S contains patient identifying information and has been sealed from public disclosure.
- * 3. State's Exhibit 4B: Patient Key.
4. State's Exhibit 5: Curriculum Vitae of Dwight Allen Scarborough, M.D.
5. State's Exhibit 6: Not admitted. See Proffered Material, below.
6. State's Exhibit 7: Ostad O, Kageyama N, Moy RL: "Tumescent Anesthesia with a Lidocaine Dose of 55 mg/kg Is Safe for Liposuction." *Dermatol Surg* 22:921-927, 1996.
7. State's Exhibit 8: Scarborough DA, Herron JB, Khan A, Bicaccia E: "Experience with More Than 5,000 Cases in Which Monitored Anesthesia Care Was Used for Liposuction Surgery." *Aesth Plast Surg* 27:474-480, 2004.
8. State's Exhibit 9: Klein JA: "Tumescent Technique Chronicles: Local Anesthesia, Liposuction, and Beyond." *Dermatol Surg* 21:449-457, 1995.
9. State's Exhibit 10: Printout of the American Academy of Dermatology Guidelines of Care for Liposuction, as published on the Internet at <www.aad.org/professionals/guidelines/Liposuction.htm> on February 18, 2005. [Note that the right margin of this printout cuts off portions of the text.]
10. State's Exhibit 11: Not presented.
11. State's Exhibit 12: Klein JA: "Tumescent Technique for Regional Anesthesia Permits Lidocaine Doses of 35 mg/kg for Liposuction." *J Dermatol Surg Oncol* 16:3, 1990.

B. Presented by the Respondent

1. Respondent's Exhibit A: Copy of April 22, 2005, letter to Stanley B. Dritz and James M. McGovern, Esqs., from Rebecca J. Albers, Assistant Attorney General.
2. Respondent's Exhibit B: Not admitted. See Proffered Material, below.
3. Respondent's Exhibit C: Curriculum Vitae of Patrick J. Lillis, M.D.
- * 4. Respondent's Exhibit D: Copy of January 19, 2005, letter to Dr. Parks from David R. Barron, M.D.
5. Respondent's Exhibit E: Curriculum Vitae of David Robert Barron, M.D.
6. Respondent's Exhibit F: Not presented.
7. Respondent's Exhibit G: Curriculum Vitae of Ronald J. Siegle, M.D.
8. Respondent's Exhibits H through K: Printouts of Dr. Parks' templates that he uses to prepare operative reports:
 - a. Respondent's Exhibit H: List of available templates.
 - b. Respondent's Exhibit I: Template for melanoma Breslow level.
 - c. Respondent's Exhibit J: Template for melanoma in situ.
 - * d. Respondent's Exhibit K: Example of what Dr. Parks argues his operative report for Patient 2 would look like if he had used the correct template.
- * 9. Respondent's Exhibit L: Copies of pathology reports for Dr. Parks' August 3, 2000, surgery on Patient 2: one report dated August 8, 2000, and a second addendum report dated January 26, 2005.
- * 10. Respondent's Exhibit L1: Copy of pathology report dated July 18, 2000, for Dr. Parks' July 13, 2000, surgery on Patient 2.
- * 11. Respondent's Exhibit M: Copy of the requisition form for the pathology report for Dr. Parks' August 3, 2000, surgery on Patient 2.
12. Respondent's Exhibit N: Not presented.
13. Respondent's Exhibit O: Not admitted. See Hearing Transcript at 860.
14. Respondent's Exhibit P: Not admitted. See Proffered Material, below.

15. Respondent's Exhibit Q: Callesen T, Bech K, Kehlet H: "One-Thousand Consecutive Inguinal Hernia Repairs Under Unmonitored Local Anesthesia." *Anesth Analg* 93:1373-1376, 2001.
16. Respondent's Exhibit R: Copy of bulletin published by the Tumescant Liposuction Council, Volume 3 Issue 1 (Summer 1995).
17. Respondent's Exhibit S: Lillis, J: "The Tumescant Technique for Liposuction Surgery." *Dermatologic Clinics* 8:439-450, 1990.
18. Respondent's Exhibit T: Not presented.
19. Respondent's Exhibit U: Scarborough DA, Herron JB, Khan A, Bicaccia E: "Experience with More Than 5,000 Cases in Which Monitored Anesthesia Care Was Used for Liposuction Surgery." *Aesth Plast Surg* 27:474-480, 2004. (Duplicate of State's Exhibit 8.)
20. Respondent's Exhibit V: Copy of excerpt from Tumescant Liposuction Council Bulletin. *Dermatol Surg* 23:213-214, 1997.
21. Respondent's Exhibit W: Coleman WP, et al: "Academy Guidelines: Guidelines of Care for Liposuction." *J Am Acad Dermatol* 45:438-447, 2001.
22. Respondent's Exhibit X: Not admitted. See Proffered Material, below.
23. Respondent's Exhibit Y: Printout of the American Academy of Dermatology Guidelines of Care for Local and Regional Anesthesia in Cutaneous Surgery, as published on the Internet at <www.aad.org/professionals/guidelines/Lcl-RgnlAnesthesiaCSurg.htm> on January 31, 2005. [Note that the right margin of this printout cuts off a portion of the text.]
24. Respondent's Exhibit Z: Sober AJ, et al: "Academy Guidelines: Guidelines of Care for Primary Cutaneous Melanoma." *J Am Acad Dermatol* 45:579-586, 2001.
25. Respondent's Exhibit AA: Not admitted. See Proffered Material, below.
26. Respondent's Exhibit BB: Copy of document entitled The State Medical Board of Ohio Expectations of Experts.
27. Respondent's Exhibit CC: Copies of excerpts from Columbus Monthly magazine that include advertisements for Dr. Scarborough's practice. (Note that this exhibit was presented in 11' x 17' format. Copies of these reduced to 8-1/2' x 11' will be distributed to Board members. The originals will be made available for Board member review at the Board's offices.)

28. Respondent's Exhibit DD: Excerpt from the 2003 Ameritech Yellow Pages, including page 1146, which features advertisements for Dr. Parks' practice and for Dr. Scarborough's practice.
29. Respondent's Exhibit EE: Copy of Dr. Parks' survey of Columbus, Ohio, dermatologists and plastic surgeons (redacted during hearing).
30. Respondent's Exhibit FF: Transcript of August 17, 2005, deposition in lieu of live testimony of Dr. Lillis, with attached exhibits:
 - a. Deposition Exhibit A: Curriculum Vitae of Dr. Lillis.
 - b. Deposition Exhibit B: Duplicate of State's Exhibit 6, which was held as proffered material for the State. Accordingly, this exhibit was removed by the Hearing Examiner post-hearing. See Proffered Exhibits, below.
 - * c. Deposition Exhibit C: Copy of Dr. Parks' medical records for Patient 1. (Duplicate of State's Exhibit 1A.)
 - d. Deposition Exhibit D: Duplicate of Respondent's Exhibit B, which was excluded but held as proffered material for the Respondent. Accordingly, this exhibit was removed by the Hearing Examiner post-hearing. See Proffered Exhibits, below.
 - * e. Deposition Exhibits E and F: Copies of photographs of Patient 1 from Dr. Parks' medical records.
 - f. Deposition Exhibit G: Copy of Tumescant Liposuction Council Bulletin featuring Lillis PJ: "Liposuction: How Aggressive Should It Be? and Coleman WP: How Much Is Too Much?" *Dermatol Surg* 22:973-978, 1996.
 - g. Deposition Exhibit H: Copy of excerpt from Tumescant Liposuction Council Bulletin. *Dermatol Surg* 23:213-214, 1997. (Duplicate of Respondent's Exhibit V.)
31. Respondent's Exhibits GG1 and GG2: Original videotapes of the August 17, 2005, deposition in lieu of live testimony of Dr. Lillis, Tape 1 and Tape 2, respectively. [Note: Copies of these videotapes will be distributed to Board members.]

* Note: Exhibits marked with an asterisk (*) have been sealed to protect patient confidentiality.

PROFFERED MATERIAL

The following documents were neither admitted to the record nor considered, but are being sealed and held as proffered material for the parties:

1. State's Exhibit 6: Expert report of Dr. Scarborough. See Hearing Transcript [Tr.] at 511-517
2. Respondent's Exhibit B: Copy of the expert report of Dr. Lillis. See Tr. at 858-860.

3. Respondent's Exhibit P: Butterwick KJ, Goldman MP, Sriprachya-Anunt S: "Lidocaine Levels During the First Two Hours of Infiltration of Dilute Anesthetic Solution for Tumescant Liposuction: Rapid Versus Slow Delivery." *Dermatol Surg* 25:681-685, 1999.
4. Respondent's Exhibit X: Gregory N, et al: "Shrinkage of Skin Excision Specimens and Downcoding." *Arch Dermatol* 139:542-543, 2003.
5. Respondent's Exhibit AA: Samdal F, Amland PF, Åbyholm, F: "Syringe-Assisted Microliposuction for Cervical Rejuvenation: A Five Year Experience." *Scand J Plast Reconstr Hand Surg* 29:1-8, 1995.
6. Deposition Exhibit B: Copy of the expert report of Dr. Scarborough that was attached to Respondent's Exhibit FF. (Duplicate of State's Exhibit 6.) This document was removed from Respondent's Exhibit FF by the Hearing Examiner post hearing.
7. Deposition Exhibit D: Copy of the expert report of Dr. Lillis that was attached to Respondent's Exhibit FF. (Duplicate of Respondent's Exhibit B.) This document was removed from Respondent's Exhibit FF by the Hearing Examiner post hearing.
8. Board Exhibit A: Original, unredacted pages from the Hearing Transcript that contain patient identifying information. See Procedural Matters 2, below.
9. Board Exhibits B through D: Excerpts from the Hearing Transcript that were stricken from the record.
10. Board Exhibit E: Proffered testimony from the State and the Respondent.

PROCEDURAL MATTERS

1. At the outset of the hearing, Assistant Attorney General Tara L. Berrien advised that the State would not pursue certain allegations contained in the Board's January 12, 2005, notice of opportunity for hearing [Notice]. Specifically, Ms. Berrien advised that the State would not present evidence or otherwise pursue the allegations made in the second paragraph of allegation 1(a). Further, Ms. Berrien advised that the State would not present evidence or otherwise pursue the allegations made in a phrase contained in the last sentence of allegation 1(b) that says "the volume and concentration of lidocaine used to anesthetize Patient 2, or an indication of whether epinephrine was used(.)" See Hearing Transcript at 16-17.
2. Patient identifying information was redacted from Hearing Transcript page 79, line 7, and from Hearing Transcript page 102, line 12. The original, unredacted pages have been marked Board Exhibit A and retained as proffered material.
3. Following discussion with counsel at hearing, all objections made during the deposition in lieu of live testimony of Patrick J. Lillis, M.D., are overruled. See Tr. at 836-850

4. Prior to the hearing on this matter, the Respondent moved to disqualify the State's expert witness, Dwight A. Scarborough, M.D., based upon a conflict of interest. The Hearing Examiner denied the Respondent's motion to disqualify Dr. Scarborough, but ruled that the parties may address that issue at hearing. See State's Exhibits 4S, 4Y, 4Z, and 4BB; Tr. at 5-6.

Evidence concerning the conflict of interest asserted by the Respondent is addressed in the Summary of the Evidence, below.

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background Information

Alan J. Parks, M.D.

1. Alan J. Parks, M.D., testified as an expert on his own behalf. Dr. Parks received his medical degree in 1983 from the State University of New York, Downstate Medical Center. He then completed a one-year internal medicine internship at Kings County, Brooklyn V.A. Medical Center in Brooklyn, New York, followed by a three-year dermatology residency at the Ohio State University Hospitals in Columbus, Ohio, which he completed in 1987. Dr. Parks noted that he had been chief resident during his final year. (Tr. at 29-30)

Dr. Parks testified that he currently practices dermatology on the east side of Columbus in a two-physician office, and that he has practiced in the Columbus/Franklin County area for approximately eighteen years. Dr. Parks is board certified in dermatology. Moreover, Dr. Parks holds hospital privileges at Mount Carmel East Hospital and at Children's Hospital, both of which are located in Columbus. Finally, Dr. Parks is licensed to practice medicine in Ohio, and does not hold medical licensure in any other state. (Tr. at 30-31, 707)

2. Dr. Parks testified that he sees approximately 900 patients per month. (Tr. at 31-32)

Dwight A. Scarborough, M.D.

3. Dwight A. Scarborough, M.D., testified as an expert on behalf of the State. Dr. Scarborough obtained his medical degree in 1979 from Loma Linda University in Loma Linda, California. From 1979 through 1980, he participated in an internship in internal medicine at Loma Linda University Hospital and, in 1982, completed a residency in dermatology at the Ohio State University Hospitals. Subsequently, from 1982 through 1983, Dr. Scarborough participated in a fellowship at the National Institutes of Health, National Cancer Institute, Division of Cancer Biology and Diagnosis in Bethesda, Maryland. Dr. Scarborough was certified as a diplomate of

the American Board of Dermatology in 1983. He holds active medical licenses in Ohio, New Jersey, and New York, and has an inactive license in Maryland. (St. Ex. 5; Tr. at 239-241)

Dr. Scarborough practices as a dermatologist in Dublin, Ohio. He also holds faculty appointments at the Ohio State University Hospitals and at Columbia University College of Physicians and Surgeons in New York City. Dr. Scarborough holds privileges at the Ohio State University Medical Center, Riverside Methodist Hospital, Grant Medical Center, and St. Ann's Hospital, all located in Columbus, and Grady Memorial Hospital in Delaware, Ohio. (St. Ex. 5; Tr. at 242)

Dr. Scarborough testified that more than eighty-five percent of his practice is devoted to clinical work. Dr. Scarborough further testified that he has had a special interest in dermatologic surgery throughout his career. Moreover, Dr. Scarborough testified that he does not see patients for general dermatology problems, such as rashes, warts, or eczema. Instead, he treats patients for such problems as growths and skin cancers, and he performs cosmetic procedures. (Tr. at 242-244)

4. Dr. Scarborough testified that he sees between 200 and 400 patients per month. (Tr. at 244)
5. Dr. Scarborough practices in an office that has as a subunit an ambulatory surgical center that is accredited by the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]. When asked if he performs his surgeries in the ambulatory surgical center, Dr. Scarborough replied, "A certain amount of them requiring a certain complexity, but not all of them." (Tr. at 248-249)

Ronald J. Siegle, M.D.

6. Ronald J. Siegle, M.D., testified as an expert on behalf of Dr. Parks, and also testified as a fact witness with regard to Dr. Parks' treatment of Patient 3. Dr. Siegle obtained his medical degree in 1979 from Upstate Medical College, State University of New York, in Syracuse, New York. From 1979 to 1980 Dr. Siegle participated in an internship at St. Joseph Mercy Hospital in Ypsilanti, Michigan; from 1980 through 1983 he participated in a dermatology residency at the University of Michigan in Ann Arbor, Michigan; and from 1983 through 1984 he participated in a fellowship in Mohs and dermatologic surgery at Duke University in Durham, North Carolina. Dr. Siegle was certified by the American Board of Dermatology in 1983. He obtained licensure to practice medicine in Ohio in 1984. (Resp. Ex. G; Tr. at 518-519)

Dr. Siegle joined the faculty at the Ohio State University College of Medicine in 1984 and eventually became a full professor. In 1999, Dr. Siegle went into private practice in Columbus, but remains a Clinical Professor of Dermatology and Otolaryngology at the Ohio State University. (Resp. Ex. G; Tr. at 519-520)

7. Dr. Siegle testified that he had been on the dermatology faculty at the Ohio State University at the time Dr. Parks had been a resident, and had been one of Dr. Parks' principal teachers. Dr. Siegle has since maintained both a professional relationship and personal friendship

with Dr. Parks, although he testified that the relationship is more professional than personal. Dr. Siegle further testified that Dr. Parks refers patients to him for Mohs procedures and that they have had discussions concerning Dr. Siegle's field of expertise. However, Dr. Siegle testified that those factors would not alter the truthfulness of his testimony. Finally, Dr. Siegle testified, "I have done expert testimony for years. And I know my obligation to the Board, to the residents of our state, and I will share with you the best of my knowledge truthfully how I see the case * * *." (Tr. at 537-538, 627-628)

8. Dr. Siegle testified that he is not being paid for his services in this matter. (Tr. at 626)

Patrick J. Lillis, M.D.

9. Patrick J. Lillis, M.D., testified as an expert on behalf of Dr. Parks concerning Dr. Parks' treatment of Patient 1. Dr. Lillis obtained his medical degree in 1975 from the University of Iowa. He participated in an internship at Good Samaritan Hospital in Los Angeles, California, and completed three years of residency in dermatology at the University of Iowa in 1979. Dr. Lillis testified that he then opened a dermatology practice in Loveland, Colorado, where he continues to practice. Dr. Lillis was board certified in dermatology in 1979. He holds medical licensure in Colorado. (Resp. Ex. C; Resp. Ex. FF at 5-7; Resp. Ex. GG1 at 00:02:10¹)

Dr. Lillis testified that he has performed between 8,000 and 9,000 tumescent liposuction procedures during his career. Dr. Lillis has trained approximately one thousand physicians in tumescent liposuction since 1988. Finally, Dr. Lillis' curriculum vitae indicates that he has published a number of articles on the subject of tumescent anesthesia and liposuction. (Resp. Ex. C; Resp. Ex. FF at 14, 17-18; Resp. Ex. GG1 at 10:22:28, 10:26:30)

David R. Barron, M.D.

10. David R. Barron, M.D., testified both as an expert witness and as a fact witness on behalf of Dr. Parks concerning Dr. Parks' treatment of Patient 2. Dr. Barron obtained his medical degree in 1979 from the George Washington University Medical School in Washington, D.C. From 1979 through 1980, he participated in an internship in internal medicine at Jackson Memorial Hospital in Miami, Florida, and, from 1980 through 1983, participated in a residency in dermatology at Cleveland Metropolitan General Hospital in Cleveland, Ohio. Subsequently, from 1983 through 1985, Dr. Barron participated in a fellowship in dermatopathology at the University of Cincinnati College of Medicine. Dr. Barron was board certified by the American Board of Dermatology in 1983, and by the American Board of Dermatopathology in 1984. Dr. Barron testified that he is licensed to practice medicine in Ohio, and that he has been so licensed for twenty-two years. (Resp. Ex. E; Tr. at 202-203)

Dr. Barron testified that one hundred percent of his practice is devoted to dermatopathology. (Tr. at 205)

¹ Note that references to the videotapes of Dr. Lillis' testimony identify the time noted on the videotape image when the referenced testimony began.

11. Dr. Barron has held faculty positions at the University of Cincinnati College of Medicine since 1985 and, since 1993, has been the Director of the Richfield Laboratory of Dermatopathology [Richfield Lab] in Cincinnati, Ohio. (Resp. Ex. E)

Dr. Barron stated that the Richfield Lab is one of the largest laboratories in the country, and that he sees “cases that people don’t see.” Moreover, Dr. Barron testified that Richfield Lab receives biopsies from about thirty states, “from California to Maine to Florida, all over.” Finally, Dr. Barron testified that ninety-five to ninety-eight percent of his business comes from dermatologists, with the remainder coming primarily from plastic surgeons and family practitioners. (Tr. at 205, 209-210)

12. Dr. Barron testified that he has known Dr. Parks for about eighteen years, and that Dr. Parks uses Richfield Lab for interpretation of skin biopsies and excisions. (Tr. at 211)

Evidence Concerning a Conflict of Interest Asserted by Dr. Parks against Dr. Scarborough

13. At hearing, the Respondent presented a copy of a document entitled “The State Medical Board of Ohio Expectations of Experts.” Under the heading, “Conflict of Interest,” the document states,

You must notify the Board immediately if you discover at any time that you have a conflict of interest. For example, you have a conflict of interest if: (1) you (or a member of your family) personally know the physician you have been asked to review; (2) you (or a member of your family) are in direct economic competition with the physician you have been asked to review; (3) you, a member of your family, or any of your practice partners have any financial dealings with the physician you have been asked to review; or (4) there are any other circumstances that may make it difficult for you to render an impartial judgment. Please contact the assigned Enforcement Attorney if you have any questions concerning possible conflict of interest situations.

(Resp. Ex. BB)

Dr. Scarborough testified that he recalls having seen and read that document. (Tr. at 346-347)

14. Dr. Scarborough’s office is located at 650 Shawan Falls Drive, Dublin, Ohio. Administrative notice is taken that this address is in the northwestern area of Franklin County. (Tr. at 239)

Dr. Parks’ office is located at 6275 East Broad Street, Columbus, Ohio. Administrative notice is taken that this address is in the eastern area of Franklin County. (Tr. at 30)

15. Both Dr. Scarborough and Dr. Parks advertise in *Columbus Monthly* magazine and in the yellow pages of the local telephone directory. (Resp. Exs. cc and DD; Tr. at 32-33, 244-245, 353-363)

When asked if these advertisements put him in competition with Dr. Parks, Dr. Scarborough replied, “I think practicing medicine, you’re in competition with whoever else is out there practicing medicine.” However, Dr. Scarborough further testified that those ads do not put him in direct economic competition with Dr. Parks. In addition, Dr. Scarborough testified that he does not believe that he and Dr. Parks compete geographically, stating, “[W]e are not in the same neighborhood.” Dr. Scarborough explained that he is no more in competition with Dr. Parks than he is with any other dermatologist who draws patients from “[w]ithin whatever referral base comes to Franklin County.” (Resp. Exs. cc and DD; Tr. at 244-245, 353-363, 472-473)

Dr. Scarborough testified that he would not expect to gain an economic benefit should Dr. Parks’ license be limited in any way. (Tr. at 472)

16. Dr. Scarborough testified that he knows Dr. Parks in a professional sense, but does not know him well personally. Dr. Scarborough testified that, “many years ago,” when Dr. Parks was a resident, Dr. Parks had been employed “[f]or a brief time, part time,” in Dr. Scarborough’s office. Dr. Scarborough further testified that in the past he and Dr. Parks “probably overlapped” in the same professional associations. (Tr. at 348-349)
17. Dr. Parks testified that he knows Dr. Scarborough, and that he knows him well enough to have addressed him on a first-name basis. (Tr. at 706-707)

Dr. Parks further testified that he had been employed by Dr. Scarborough while Dr. Parks had been a resident, and opined that it had seemed odd that Dr. Scarborough said that he did not know Dr. Parks personally, because Dr. Scarborough had employed Dr. Parks. Dr. Parks further testified, “I was hired by [Dr. Scarborough] to moonlight in his office; which meant that he was going to be out of town for a week or so, and I would take off time from my residency and spend time in his office, and see his patients, and care for his patients, and be on call for his patients if need be.” Moreover, Dr. Parks testified that he and Dr. Scarborough “had met and talked on a few occasions. And I came to his office and discussed what was expected of me and what he expected from me.” Finally, Dr. Parks testified that he has “seen [Dr. Scarborough] on multiple occasions at meetings. And I’ve gone to some workshops that he ran from his organization.” (Tr. at 707-709)

Evidence Concerning Patient 1: Tumescant Liposuction Surgery in General

18. Dr. Scarborough, Dr. Siegle, and Dr. Lillis all agreed that Jeffrey A. Klein, M.D., was an early pioneer of using tumescant anesthesia to perform liposuction surgery. Prior to that, liposuction had been performed under general anesthesia, and carried with it the complication of significant blood loss, often requiring transfusions, along with the usual complications that can arise from general anesthesia. This had resulted in a number of patient deaths. By contrast, beginning in the mid-1980s, Dr. Klein and other physicians developed a method of performing liposuction using only local anesthesia with minimal blood loss. (St. Exs. 9, 12; Resp. Ex. FF at 9-10, 13; Tr. at 40, 275-275, 286-287, 528-531, 534, 617-618, 795-796)

In an article published in 1990, Dr. Klein described in detail the methodology used to perform liposuction using tumescent anesthesia. Dr. Klein stated:

- A large volume of dilute anesthetic solution consisting of saline, lidocaine at a concentration of either 0.05% or 0.1%, and epinephrine at a concentration of 1:1,000,000 is infiltrated into the subcutaneous fat of the target area. The solution provides both local anesthesia and vasoconstriction.
- Fat is then extracted using a small-diameter cannula. For each liter of pure fat removed, patients lose about 12 ml of whole blood.
- Postoperatively, a large amount of anesthetic solution drains over a period of up to eighteen hours, and 300 ml of drainage contains less than 10 ml of whole blood.
- Local anesthesia persists for up to eighteen hours.
- Although the tumescent technique can be used in conjunction with general anesthesia or IV sedation, it permits liposuction of large volumes of fat using local anesthesia only.

(St. Ex. 12)

19. The term “tumescent liposuction” refers to liposuction performed using tumescent anesthesia as described above. The dosage of lidocaine administered to a patient during tumescent liposuction is described as the total amount of lidocaine in milligrams divided by the patient’s weight in kilograms, which is referred to as “milligrams per kilograms,” and written as “mg/kg.” (St. Ex. 12)

20. Dr. Siegle testified concerning the ease and safety of tumescent liposuction:

[A]s this tumescent technique evolved, we learned that we could literally just have you right now just step on the table, lie down on the table, and have surgery performed. It was that easy.

And I might say that when I took my course with [Dr. Lillis], there were around 20 physicians there. And actually while there, two of the physicians who were there for training actually volunteered to get on the table and have liposuction done and then to fly home the next day.

(Tr. at 533)

Medical Records for Patient 1

21. Patient 1 is a female born in 1940. She first came to see Dr. Parks on May 15, 1995, to consult with him concerning abdominal liposuction. Dr. Parks' progress note for that visit states, in part:

PE —> prominent lower abdomen overhanging extending out to flanks & back. Also an abdominal roll as well. No umbilical hernia. Skin tone fair.
See consult sheet for rest of discussion.

(St. Ex. 1A at 25) A May 15, 1995, Liposuction Consultation form indicates that Dr. Parks reviewed various aspects of abdominal tumescent liposuction surgery with Patient 1, including possible complications from the procedure. (St. Ex. 1A at 75)

22. Patient 1 testified that, during her first visit to Dr. Parks, she had told him that she was planning to go on a diet. She asked Dr. Parks whether it would be better to have the surgery done before or after she had dieted. Dr. Parks advised Patient 1 that she should wait until after her diet. (Tr. at 103-104)
23. Patient 1 next saw Dr. Parks on November 22, 1995. At that time, she consulted with Dr. Parks concerning having liposuction performed on her chin and neck rather than on her abdomen. Dr. Parks' progress note for that visit states:

Lipo consult – chin.
Has lost 40 lbs. since July and has about 10 more lbs. to lose.
PE – has some prominent fat in neck midline due to weight loss has lost some elasticity in skin there. Is just on Synthroid. No Tagamet.² [I]s on experimental drug to suppress appetite will get [illegible] info on it.
Discussed procedure that would need to do wedge excision to reduce redundant inelastic skin there but won't be perfect. She gets blood work regularly & can have results sent here.
[N]eeds CBC, SMAC, PT/PTT

(St. Ex. 1A at 25) Dr. Parks' medical records include the blood work he requested as well as Patient 1's diet medication information. (St. Ex. 1A at 27-29, 49-55)

24. A progress note dated December 4, 1995, indicates that Patient 1 had been scheduled for liposuction surgery on her chin, and that related instructions had been mailed to her. (St. Ex. 1A at 25)

² Note that Patient 1 had been taking Tagamet at the time of her first visit on May 15, 1995. (St. Ex. 1A at 25)

Patient 1's First Surgery – December 14, 1995

25. On December 14, 1995, prior to Patient 1's surgery, Dr. Parks took preoperative photographs of Patient 1. These photographs are included in Dr. Parks' medical record for Patient 1, and enlargements of these photographs were admitted to the hearing record as State's Exhibits 1C through 1E.
26. According to Dr. Parks' operative report, on December 14, 1995, Dr. Parks performed neck liposuction on Patient 1. He injected "[a] small amount of 1% lidocaine with epinephrine 1:100,000 * * * in the submental crease where the incision was going to be made." During the liposuction procedure, he infused into her neck 150 cc of the "Klein formula of tumescent anesthesia 0.05%" and removed 10 cc of fat. The report further states:

Because of the patient's age and the laxity of her skin in this area, [Dr. Parks] felt that she would gain maximum aesthetic improvement from her liposuction if a small wedge of skin was removed from her neck. This would remove any excess skin that would otherwise hang down. A small excision was done using a number 15 blade, in the submental crease. The tissue was then draped over the incision to see how much skin could be removed. The other side was then cut. The wound was then closed with (2) 4-0 daxon deep sutures and the skin edges approximated with 5-0 prolene simple interrupted sutures. The final length of the incision was 2.5 centimeters.

(St. Ex. 1A at 31)

27. Patient 1 saw Dr. Parks for postoperative checkups on December 15 and 20, 1995, and on January 10, 1996. In his progress note dated January 10, 1996, Dr. Parks wrote:

Re √ [Recheck] post-lipo chin. Doing well. No soreness. Minimal numbness. Has 1 small bump at site where suture was[,] can use gentle massage. Has good improvement but has not had good retraction of skin yet. Photos taken. Interested in having other parts of body done. Can set up time for another consultation.

(St. Ex. 1A at 25) The postoperative photos taken by Dr. Parks during this visit are included in his medical record for Patient 1. (St. Ex. 1A at 81, 99, 101)

28. Patient 1 next saw Dr. Parks on January 31, 1996, for a consultation concerning abdominal liposuction. His note for that visit states, in part:

[H]as protuberant lower abdomen & out onto flanks because of amount of weight loss. There is poor skin tone which might not all stretch back. Discussed this [with] patient.

Also needs to have some skin removed from neck to pull forward some sagging skin there. Patient aware of these limitations. Would be able to fix neck at same time we do abdomen.

(St. Ex. 1A at 25-26)

Patient 1's Second Surgery – April 26, 1996

29. On April 26, 1996, Dr. Parks performed on Patient 1 the following procedures, as described in his operative report: “Liposuction, abdomen, thighs and hips. Revision of mini neck lift.” With regard to liposuction on Patient 1’s abdomen, thighs, and hips, Dr. Parks’ operative report states that during the course of that procedure he infused a total of 10,000 cc of anesthetic solution at a concentration of 0.05% lidocaine: 6,450 cc into Patient 1’s abdomen, a total of 1,750 cc into her left hip and thigh, 1,700 cc into her right thigh, and 100 cc into her neck. (St. Ex. 1A at 35)

Dr. Parks then removed from Patient 1’s abdomen 1,575 cc of fat and 2,075 cc of anesthetic fluid. From her left hip and thigh he removed 450 cc of fat and 225 cc of fluid, and from her right thigh he removed 325 cc of fat and 150 cc of fluid.³ The total volume of fat removed was 2,350 cc, and the total volume of fluid removed was 2,450 cc. The report further states that “[e]xcess fluid was milked out of the openings.” (St. Ex. 1A at 35)

With regard to the neck procedure, Dr. Parks’ operative report states:

A small excision of excess skin on the neck was done with a number 15 scalpel. Redundant skin was then draped over the incision and excised. Undermining was then done and the area sutured with 5-0 dixon deep sutures and 5-0 prolene simple interrupted suture.

(St. Ex. 1A at 35)

30. Patient 1 saw Dr. Parks for postoperative checkups on April 29 and May 3, 1996. Dr. Parks’ progress note for May 3, 1996, states, in part, “Still not much improvement in neck. Will set up 45 [minutes] to re-do excision neck.” (St. Ex. 1A at 26)

Patient 1's Third Surgery – May 9, 1996

31. On May 9, 1996, Dr. Parks performed what he described in his operative report as “[n]eck revision post liposuction.” In his operative report, Dr. Parks indicated that, after

³ Dr. Parks stated in his operative report, “It was noticed when doing pre-operative measurements that the left thigh and hip were larger than the right.” (St. Ex. 1A at 35)

anesthetizing the area,

An excision was then carried out using a number 15 scalpel blade in an elliptical fashion on each side of the submental area to remove the dog ear from the liposuction repair and to alleviate the problem with redundant skin in the midline of the neck. Undermining was then done. Meticulous hemostasis was then obtained via spot electrodesiccation. The 2 areas were then closed in layers. First the deep dermis was closed with 4-0 dexion sutures and then the skin edges were then closed using a 5-0 prolene simple interrupted suture.

* * *

(St. Ex. 1A at 37)

32. A consent form signed by Patient 1 dated May 9, 1996, states, in Paragraph 2(d), that Dr. Parks had discussed “[p]ossible alternative treatments” with her. (St. Ex. 1A at 65)
33. Dr. Parks’ progress note for a follow-up visit on May 20, 1996, states that Patient 1 “[h]as a good improvement.” It further states “Re √ [Recheck] 1 mo.” However, there are no subsequent entries in Dr. Parks’ progress notes for Patient 1. (St. Ex. 1A at 26)

Medical Records for Patient 1 Maintained by Subsequent Treating Physician

34. Patient 1 first saw Steven L. Robinson, M.D., on August 8, 2001, with a complaint of “neck deformity after 3 operations by Dr. Parks & lower eyelid bags.” During that visit, Dr. Robinson found, among other things, “Neck [shows positive] platysmal banding, 2+ lax skin, 1+ fat, needs platysmaplasty and neck lift [illegible].” (St. Ex. 1B at 9)

On August 8, 2001, Dr. Robinson took photographs of Patient 1’s face and neck. These photographs were taken approximately five years after she had last seen Dr. Parks. There is no evidence that any intervening procedures had been performed on Patient 1’s neck after she stopped seeing Dr. Parks and prior to the August 8, 2001, photographs being taken. (St. Ex. 1B at 63)

Testimony Concerning the Chin/Neck Procedures that Dr. Parks performed on Patient 1

Testimony of Dr. Scarborough re: Patient 1 - Chin/Neck Procedures

35. Dr. Scarborough described Patient 1’s condition based upon the preoperative photographs taken by Dr. Parks. Dr. Scarborough stated that Patient 1 appears to have “significant laxity of skin in the neck and jaw area.” He further testified,

On the left-side view, there is no definition of a cervical mandibular angle. There’s prominent downward sloping. Both of the jowls and of the neck area.

And on the anterior view, there is a central web of skin with—that extends down to the—the manubrium from the chin.

* * *

The downward sloping is pretty clear down to where the thyroid area would be * * *. But she has significant webbing all the way down to, you know, basically down to her chest * * *.

(St. Ex. 1C through 1E; Tr. at 256-257)

36. Dr. Scarborough testified that, in his opinion, Patient 1 had not been a candidate for neck liposuction alone “[d]ue to recent history of a 40-pound weight loss, hanging skin, and very little fat” based upon the pre-operative photographs. Dr. Scarborough further testified that Patient 1’s neck had not had “a defined cervical mandibular angle.” (Tr. at 265) Moreover, Dr. Scarborough testified:

I found it difficult to conceive how [liposuction and a wedge excision] would address the downward sloping. It appeared to me that, if anything, it would further tighten and maybe exacerbate.

* * *

It would be more taut, I would say, perhaps. But it would be difficult for a wedge excision to pull the skin and drape it over the support structures.

(Tr. at 266)

Moreover, Dr. Scarborough testified that, if Patient 1 had wanted to resolve her hanging skin following a forty-pound weight loss, Dr. Parks “should have included as an option a more standard lifting procedure.” Finally, Dr. Scarborough testified, “I am of the opinion that liposuction alone or liposuction with or without what is described as a wedge excision was inappropriate.” (Tr. at 266-268)

37. Dr. Scarborough testified that Dr. Parks failed to recognize the basic underlying problem concerning Patient 1’s neck and chin. (Tr. at 307)
38. Dr. Scarborough testified that, when patients present with facial skin sagging away from the support structures, as had been the case with Patient 1, the standard of care requires the physician to discuss with the patient the different methods that can be used to obtain a satisfactory result. Dr. Scarborough further testified that the standard of care requires that the physician document that such a discussion took place. Moreover, Dr. Scarborough testified: “As physicians, we’re very aware of the requirements for charting when we deal with insurance companies, Medicare. It’s no different in cosmetic surgery. If something is not charted, it’s assumed it is not done.” (Tr. at 267)

Furthermore, Dr. Scarborough testified that it does not appear from Dr. Parks' medical records for Patient 1 that he had discussed, or documented any discussion, with Patient 1 concerning alternative treatment procedures prior to the December 14, 1995, or April 26, 1996, surgeries. Finally, Dr. Scarborough testified that it had been below the minimal standard of care for Dr. Parks to fail to inform Patient 1 concerning the appropriate alternative treatment options available. (St. Ex. 1A at 25-26; Tr. at 255, 259, 262, 307)

Testimony of Dr. Siegle re: Patient 1 - Chin/Neck Procedures

39. Dr. Siegle testified that the December 14, 1995, photographs of Patient 1 indicate that she had excess skin, and possibly some fat as well, around her throat and jowls. Dr. Siegle testified that the amount of fat and/or excess skin must be determined by physical examination. Dr. Siegle further testified that liposuction tightens the skin, and that he believes that Patient 1 could have benefited from liposuction, both to remove fat and to tighten her skin. (St. Exs. 1C - 1E; Tr. at 580-583)
40. With regard to the alternative treatment of neck-lift, Dr. Siegle testified that a neck-lift is much more extensive than liposuction. In contrast, liposuction is a brief procedure performed in an outpatient setting. Dr. Siegle further testified that a neck-lift requires removing and repositioning excesses of skin, and requires incisions higher up on the face, around the ear. Moreover, it involves placing instruments through the skin in areas where there are important, functional nerves. In addition, it is performed under general or twilight anesthesia. Finally, Dr. Siegle testified that "it's a higher-risk procedure, it's a bigger recovery procedure, and it's certainly a more costly procedure" than liposuction. (Tr. at 583-584)

When asked if he would have offered liposuction of the chin/neck to Patient 1, Dr. Siegle testified that he would have first examined her and graded her on the improvement that could be achieved with liposuction; Dr. Siegle testified, "I turn patients away who are not candidates; and I tell patients that, 'You are an excellent candidate'; and everything in between." (Tr. at 585) He would have discussed available treatment options along with her needs and expectations. (Tr. at 585-586) Dr. Siegle further testified:

I would have counseled [Patient 1] about having a neck-lift done because—and I haven't examined her. And I have seen other photos postop, so I know some of the improvements were achieved—but she has excess skin. I believe she also has excess fat.

And so I would tell her within the best of my ability—I don't do neck-lifts—the pros and cons of doing that procedure. Most patients don't want neck-lifts. Most patients don't want face-lifts. Liposuction is so much easier.

* * * We see a lot of people who may be an excellent candidate for a neck-lift but they don't want to go through with that, whereas I would consider them

only a fair candidate for liposuction. As long as I can present to them the outcome that I can achieve for them and they understand that, then as a rule, we have very happy patients.

(Tr. at 586) When asked whether he would have turned Patient 1 away, Dr. Siegle testified: "I haven't talked to her. I don't know. I can't answer that." (Tr. at 586-587)

41. Dr. Siegle acknowledged that, if Dr. Parks had failed to inform Patient 1 about alternative treatment options, such as neck-lift, that would be a deviation from the standard of care. (Tr. at 674)
42. Dr. Siegle testified that he believes that all three neck procedures performed by Dr. Parks on Patient 1 fell within the minimal standard of care. Further, Dr. Siegle testified that, in his opinion, based upon the outcome achieved as evidenced by the photographs taken by a subsequent treating physician, none of the three procedures performed by Dr. Parks had been inappropriate. (St. Exs. 1C through 1E; St. Ex. 1B at 57, 63, 67; Tr. at 597)

Testimony of Dr. Lillis re: Patient 1 - Chin/Neck Procedures

43. Dr. Lillis testified that, examining Dr. Parks' preoperative photographs of Patient 1, he believes that her underlying problem had been "both extra fat and skin laxity, primarily in the midline of the neck, but also, to some extent, in the jowls and the area on the lateral neck below the jowls." (St. Exs. 1C – 1E; Resp. Ex. FF at 49-50; Resp. Ex. GG1 at 11:09:00)
44. Dr. Lillis testified that he has performed approximately one thousand neck liposuction procedures. In reviewing Dr. Parks' preoperative photographs of Patient 1, Dr. Lillis believes that "a patient like this would be a candidate for neck liposuction if their expectations were that the final outcome would be not as good as a full face-lift." (St. Exs. 1C - 1E; Resp. Ex. FF at 39; Resp. Ex. GG1 at 10:48:15)

Dr. Lillis was asked whether, based upon the December 14, 1995, preoperative photographs, he would have performed neck liposuction on Patient 1. Dr. Lillis testified that, assuming that Patient 1 had determined not to have a face-lift, his decision would largely depend on whether he believed that Patient 1 would be happy with the results that he could deliver. (Tr. at 68-69; Resp. Ex. GG1 at 11:31:25)

45. Dr. Lillis testified that, in his opinion, Patient 1's problems with her chin and neck had been properly addressed by Dr. Parks in his three surgeries. Moreover, he does not believe that Dr. Parks had performed any unnecessary surgery on Patient 1. (Resp. Ex. FF at 50-51; Resp. Ex. GG1 at 11:10:00)

Dr. Lillis further testified that, in his opinion, Dr. Parks used appropriate care in the three procedures he had performed on Patient 1's chin and neck. (Resp. Ex. FF at 43; Resp. Ex. GG1 at 10:54:50)

46. Dr. Lillis acknowledged that he could find no documentation in Dr. Parks' medical record indicating that Dr. Parks had discussed a face-lift with Patient 1; however, Dr. Lillis testified that he does not usually document such discussions in his medical records, either. In his records, Dr. Lillis recites that the "[r]isks, benefits, and alternatives [had been] discussed" with the patient; however, Dr. Lillis acknowledged that he had not found a similar statement in Dr. Parks' medical record. (Tr. at 69-71; Resp. Ex. GG1 at 11:33:25)

Testimony of Dr. Parks re: Patient 1 - Chin/Neck Procedures

47. Dr. Parks testified that, in his opinion, Patient 1 had been an appropriate candidate for neck liposuction along with a wedge incision, and that he had used proper surgical judgment and a proper surgical approach in his treatment of Patient 1. (Tr. at 768-769)

When asked if the December 14, 1995, preoperative photographs of Patient 1 had revealed that the underlying problem with her neck had been excess skin and not excess fat, Dr. Parks replied,

Her problem consisted of excess skin and fat. And liposuction not only removes the fat, but it causes contraction of the skin, as well. And there are multiple documentations in the literature, some of which are exhibits that we have cited, that support that; that liposuction alone is significant in middle-aged to elderly people in not only removing fat, but also tightening the skin.

(Tr. at 49-50) Dr. Parks further testified that he had performed the wedge excision because Patient 1 had lost a significant amount of elasticity as a result of having lost a significant amount of weight in a very short time. (Tr. at 50-51)

48. Dr. Parks testified that Patient 1 had complained to him concerning the outcomes of her surgeries. Dr. Parks further testified that, as a result, he revisited her chin twice in an effort to give Patient 1 what she would consider to be a cosmetically acceptable result. Moreover, Dr. Parks testified that, in his opinion, all of the surgeries that he had performed on Patient 1 had been indicated and necessary, based upon the cosmetic purposes of the patient. (Tr. at 769-770)
49. Dr. Parks testified that, on November 22, 1995, prior to performing any procedures on Patient 1, he had discussed with her in detail the treatment options available, including face-lift and neck-lift. Dr. Parks further testified that she had not wanted those procedures due to the expense, recuperation time, and the risks associated with general anesthesia. Moreover, Dr. Parks testified that he had advised Patient 1 that the results of neck liposuction would not be perfect, and that that discussion is documented in his progress note. However, Dr. Parks acknowledged that he had not documented his discussion concerning the alternative treatment options of face- or neck-lift surgery. (St. Ex. 1A at 25; Tr. at 48-49, 757-760)

When asked if he can remember having discussed treatment options with Patient 1 ten years later and after having seen 900 patients per month in the interim, Dr. Parks replied, “Absolutely.” Dr. Parks testified that Patient 1 had been a very memorable patient. He further testified that Patient 1 had been unhappy with her results, sent him nasty letters, and sued him. Dr. Parks testified that he has been sued only one other time. Dr. Parks testified that, accordingly, he remembers his discussions with Patient 1 “like it’s yesterday.” (Tr. at 49, 753-754)

In addition, Dr. Parks testified that discussing treatment options is part of his standard informed consent discussion with his patients. Dr. Parks further testified that the first line in his operative reports state that informed consent had been obtained. Dr. Parks asserted that that statement therefore indicates that he had discussed treatment options with Patient 1. (St. Ex. 1A at 31, 35, 37; Tr. at 766-767)

Moreover, Dr. Parks noted that consent forms dated December 14, 1995, and April 26, 1996, support his testimony that he had discussed alternative treatment options with Patient 1. When asked to explain, Dr. Parks testified that the consent forms state that he had discussed the “nature of the proposed procedure(s) * * * [which] implies that alternatives were discussed with the patient.” Dr. Parks explained that this is so because “that’s part of the proposed procedure. I never propose doing a procedure on the patient unless I inform them of the alternatives, including doing nothing.” (St. Ex. 1A at 71, 79; Tr. at 762-763, 766)

Additional Testimony Concerning Photographs of Patient 1 taken by Dr. Parks and by Dr. Robinson

Testimony of Dr. Scarborough re: Photographs of Patient 1

50. Dr. Scarborough testified that he had reviewed Dr. Parks’ December 14, 1995, preoperative photographs of Patient 1’s neck, and compared them to Dr. Parks’ January 10, 1996, postoperative photographs taken after Patient 1’s first neck procedure. Dr. Scarborough testified that “it doesn’t look like there has been much difference.”⁴ (St. Ex. 1A at 93-101; Tr. at 255-258)

In addition, Dr. Scarborough testified that, comparing Dr. Parks’ preoperative photographs of Patient 1 to those taken by Dr. Robinson in August 2001,⁵ Dr. Scarborough has difficulty seeing a very good or successful surgical outcome having resulted from Dr. Parks’ surgeries. (St. Ex. 1A at 93-97; St. Ex. 1B at 63; Tr. at 263-265)

⁴ Dr. Scarborough testified that, in referring to the photographic evidence of Patient 1 and his assessment that Dr. Parks had achieved a poor result, he had taken into account that the postoperative photographs had been taken after only one month following the procedure. (Tr. at 500)

⁵ The Hearing Examiner will note that the August 2001 photographs taken by Dr. Robinson are somewhat grainy and indistinct, and no enlargements of those photographs were provided at hearing. (St. Ex. 1B at 63)

Testimony of Dr. Siegle re: Photographs of Patient 1

51. Dr. Siegle testified that it is not valid to assess postoperative improvement one month after a neck procedure. Dr. Siegle further testified that, at that time, the patient is still in the acute phase of healing. Moreover, Dr. Siegle testified: “There’s obligatory swelling that develops post liposuction of the neck, as well as other body sites. And the neck in particular, oftentimes we get a little fibrotic change that only through the maturation of the healing process, the completion of the healing process over three to six months, do we see that final tight, hopefully soft and smooth neck develop.” (Tr. at 599-600)
52. Dr. Siegle testified that, comparing Dr. Parks’ preoperative photographs with those taken by Dr. Robinson five years later, “there has been a fairly remarkable flattening of [a] broad excess of skin and fat that the patient had * * *. The angle is more acute and certainly sharper and not loose, flabby, turkey gobbler-like skin. And she’s got a pretty nice neck.” Moreover, Dr. Siegle testified that, in the five intervening years, in her age group, she would have experienced “further loosening of the skin and further draping.” Finally, Dr. Siegle testified that he wishes that his patients would turn out as well as Patient 1, and that Dr. Parks “has just a superb outcome here.” (St. Exs. 1C - 1D; St. Ex. 1B at 63; Tr. at 597-599)

Testimony of Dr. Lillis re: Photographs of Patient 1

53. Dr. Lillis testified that, in comparing the preoperative photographs taken by Dr. Parks with those taken by Dr. Robinson, he believes that Patient 1 had obtained a better-than-average result. (St. Ex. 1B at 63; St. Exs. 1C – 1E; Resp. Ex. FF at 47; Resp. Ex. GG1 at 10:59:10, 11:08:10)

Testimony of Dr. Parks re: Photographs of Patient 1

54. Dr. Parks testified that, based upon the postoperative photographs of Patient 1 taken on January 10, 1996, he believes that she had had good improvement as a result of her surgery, although he added that the final results of the surgery cannot be judged that soon after surgery. (St. Ex. 1A at 93-101; St. Exs. 1C through 1E; Tr. at 57, 767-768)

Testimony Concerning the April 26, 1996, Liposuction Procedure on Patient 1’s Abdomen, Hips, and Thighs: Dr. Parks’ Alleged Failure to Ascertain and/or Document Patient 1’s Weight Prior to the Procedure

Testimony of Dr. Scarborough re: Liposuction on Patient 1’s Abdomen, Hips, and Thighs - Dr. Parks’ Alleged Failure to Ascertain and/or Document Patient 1’s Weight

55. Dr. Scarborough stated that Dr. Parks’ medical records indicate that he had administered 5,000 mg of lidocaine as tumescent anesthesia during the April 26, 1996, liposuction on Patient 1’s abdomen, hips, and thighs. Dr. Scarborough further testified that Dr. Parks had failed to document Patient 1’s weight prior to that procedure. Moreover, Dr. Scarborough

testified that the omission is significant because lidocaine is toxic if an excessive amount is administered. (Tr. at 270-272)

Dr. Scarborough testified that it is below the minimal standard of care to give a patient a total dose of 5,000 mg of lidocaine as tumescent anesthesia without first documenting the patient's weight. Accordingly, Dr. Scarborough testified that Dr. Parks' failure to document Patient 1's weight on April 26, 1996, fell below the minimal standard of care. (Tr. at 285, 307, 500)

Testimony of Dr. Siegle re: Liposuction on Patient 1's Abdomen, Hips, and Thighs - Dr. Parks' Alleged Failure to Ascertain and/or Document Patient 1's Weight

56. Dr. Siegle testified that one can calculate an approximate dosage of lidocaine without taking the patient's weight. (Tr. at 676)

Testimony of Dr. Parks re: Liposuction on Patient 1's Abdomen, Hips, and Thighs - Dr. Parks' Alleged Failure to Ascertain and/or Document Patient 1's Weight

57. Dr. Parks acknowledged that, in order to calculate the dosage of lidocaine to be administered to a patient during tumescent liposuction, it is necessary to obtain the patient's weight. (Tr. at 37-39)
58. Early in the hearing, Dr. Parks testified that he had not documented Patient 1's weight on April 26, 1996. (Tr. at 60-61)

Subsequently, Dr. Parks testified that he had ascertained and documented Patient 1's weight and measurements prior to the April 26, 1996, procedure. Dr. Parks stated that an undated form in his medical record documents a weight of 175 pounds and contains other information, such as history of lidocaine exposure, that make it obvious that the form was filled out before surgery. In addition, Dr. Parks testified that the measurements of Patient 1's abdomen, hips, and thighs that were recorded on a different document would be consistent with a five-foot, three-inch tall female who had weighed 175 pounds. Moreover, Dr. Parks testified that, in his original medical record, the documents containing Patient 1's weight and measurements had been stapled to other documents relevant to the April 26, 1996, procedure. Finally, Dr. Parks testified that all of the documents had originally been placed in his chart in chronological order. (St. Ex. 1A at 69, 77; Tr. at 770-774)

59. Dr. Parks testified that, in his opinion, Patient 1's exact weight would not have been critical information prior to the April 26, 1996, procedure, and that "[a] ballpark range of her weight would have been sufficient." Dr. Parks stated that all of the weights referred to during the hearing concerning Patient 1, which ranged from 140 pounds to 182 pounds, would have placed the dosage of lidocaine that she received within a range that was considered at the time to be acceptable practice. Nevertheless, Dr. Parks testified that, today, an exact weight would be critical because a Board rule places a ceiling on lidocaine dosage. (Tr. at 775-777)

Testimony Concerning the April 26, 1996, Liposuction Procedure on Patient 1's Abdomen, Hips, and Thighs: Lidocaine Volume

Testimony of Dr. Scarborough re: Liposuction on Patient 1's Abdomen, Hips, and Thighs – Lidocaine Volume

60. Dr. Scarborough testified that, if one assumes that Patient 1 had weighed 182 pounds on April 26, 1996, administration of 5,000 mg of lidocaine via tumescent anesthesia would have amounted to a little over 60 mg/kg. Dr. Scarborough testified that 60 mg/kg exceeded all published safe limits at the time the surgery was performed. (Tr. at 272-274)

Dr. Scarborough testified that Patrick J. Lillis, M.D., one of Dr. Parks' expert witnesses, had reported that he did not consider lidocaine at a dosage of 63 mg/kg to be an unsafe amount. However, Dr. Scarborough referenced a 1990 article by Dr. Klein in which Dr. Klein had stated that 35 mg/kg "appeared to be a reasonably safe limit," although as much as 50 mg/kg had been used without problems. Moreover, Dr. Scarborough testified that 35 mg/kg was considered "the rule of thumb" during 1995 and 1996. (St. Ex. 9; Tr. at 274-278)

Finally, Dr. Scarborough testified that, although 35 mg/kg of lidocaine was not what he considered to be an absolute upper limit, if a physician stayed within 35 mg/kg, the odds of having lidocaine intoxication were very low. (Tr. at 443)

61. Dr. Scarborough testified that, if Dr. Parks had learned to perform liposuction from Dr. Lillis in 1996 and had been taught that it was okay to administer lidocaine at a dosage in excess of 63 mg/kg, it would not change Dr. Scarborough's opinion that such practice would fall below the minimal standard of care. (Tr. at 304)
62. Dr. Scarborough testified that, in 1996, the American Academy of Dermatology [AAD] had not yet established guidelines concerning the administration of tumescent anesthesia for liposuction. Moreover, Dr. Scarborough testified that the Board had not yet established any rule concerning that issue. (Tr. at 451-454)

Testimony of Dr. Siegle re: Liposuction on Patient 1's Abdomen, Hips, and Thighs – Lidocaine Volume

63. Dr. Siegle testified that, in 1995 and 1996, there had been no consensus or published standard concerning the dosage of lidocaine in tumescent liposuction. Dr. Siegle further testified that Dr. Lillis "was the most aggressive of our surgeons" who had commonly used as much as 80 to 110 mg/kg on his patients "and had been doing that for quite a while." Dr. Siegle further testified that, in 1995 and 1996, he himself had commonly used lidocaine up to a dosage of 75 mg/kg. (Tr. at 602-605)

Dr. Siegle testified that, at that time, Dr. Lillis and "the hundreds of people that he had trained" were performing the procedures in such fashion. Moreover, Dr. Siegle saw it

“discussed actively at the meetings at least two times per year. So there was nothing to have us not do that.” (Tr. at 605)

64. Dr. Siegle testified that, based upon Dr. Parks’ medical record for Patient 1, he believes that Dr. Parks’ care of Patient 1 had met the standard of care. (Tr. at 613)

Testimony of Dr. Lillis re: Liposuction on Patient 1’s Abdomen, Hips, and Thighs – Lidocaine Volume

65. Dr. Lillis testified that, in 1995 and 1996, each physician had had his or her own opinion concerning the dosage of lidocaine that was considered safe. Dr. Lillis further testified that there were no guidelines established at that time. Moreover, Dr. Lillis testified:

In my first article in 1988, I had used an average, I believe, if I remember correctly, of 66 milligrams per kilogram in that article.

Subsequently Klein, in 1990, published 35 milligrams per kilogram as a safe limit. I do remember that he initially had that as 55, and I was the reviewer for the article, and I was trying to get him to increase it from 55, and when [the article] finally came out, he had lowered it to 35.

But then subsequently, in 1996, [Dr. Ostad published] an article showing that 55 milligrams per kilogram was safe. And, in fact, a number of patients had more than that and still had very low blood levels, so that * * * became the unofficial standard.

(Resp. Ex. FF at 25-26; Resp. Ex. GG1 at 10:32:40) Dr. Lillis added that no commonly accepted standard had existed until 2000, when the AAD established a standard of 55 mg/kg as the maximum safe dosage of lidocaine. (Resp. Ex. FF at 26-27; Resp. Ex. GG1 at 10:34:50)

Dr. Lillis testified that, prior to 2000, he had used lidocaine at higher dosage levels without adverse effects, as had other physicians that he had trained. (Resp. Ex. FF at 27; Resp. Ex. GG1 at 10:35:15)

66. Dr. Lillis testified that, assuming Dr. Parks had used a dosage of 63 mg/kg during his April 26, 1996, procedure, he does not believe that Dr. Parks had jeopardized Patient 1’s health. Dr. Lillis testified that he [Dr. Lillis] had “done hundreds and hundreds of patients with significantly higher levels than that without any problems. * * *.” Accordingly, Dr. Lillis opined that 63 mg/kg had been “a very safe amount.” Further, Dr. Lillis testified that he does not believe that Dr. Parks had violated “any standard of care at that time.” (Resp. Ex. FF at 29-30; Resp. Ex. GG1 at 10:36:30)

Finally, Dr. Lillis testified that Dr. Parks had used a dosage that was less than what was being administered at that time by many other physicians. (Resp. Ex. FF at 30-31; Resp. Ex. GG1 at 10:39:50)

Patient 1 Additional Information

Testimony of Patient 1 Concerning Dr. Parks

67. Patient 1 testified that, in 1995, she had been thinking about having abdominal liposuction, but did not know any details about the procedure beyond what she had seen on television, and did not know any physicians who performed it. Patient 1 stated that, after having seen an advertisement for Dr. Parks in a local publication, she had made an appointment and consulted with him about the procedure. However, because Patient 1 had planned on going on a diet, Dr. Parks had advised her to delay having the procedure until after she had dieted. (Tr. at 102-103)

Patient 1 testified that she had worked overtime and on weekends to save enough money to pay for the liposuction. (Tr. at 104-105)

68. Patient 1 testified that, after going on a diet and losing about forty pounds, she returned to Dr. Parks concerning having liposuction performed on her chin rather than her abdomen. She testified concerning her chin that she had “felt like there was some fat in there.” Patient 1 further testified that she had wanted a “smooth chin.” She testified that Dr. Parks did not discuss with her either face-lift or neck-lift surgery. In December 1995 she underwent her first procedure. (Tr. at 104-105, 108, 112, 117)

At hearing, Patient 1 was asked to rate on a scale of one to ten, with ten being the highest, her level of certainty that Dr. Parks did not discuss other treatment options for her chin and neck. Patient 1 replied that her level of certainty is ten. (Tr. at 121)

69. Concerning the results of her first neck liposuction, Patient 1 testified:

Well, [three months following the procedure] the skin was still hanging on my chin. And so I called and I said, “You know, it’s not like you said it was going to be when the swelling and the skin tightened up. It’s not what you said.”

And so I went in for another appointment. And so he said, “Well, we can do it again. We’ll just make a wider incision to bring it up and make it tighter.”

(Tr. at 110-111)

Dr. Parks performed a second procedure on Patient 1’s neck in April 1996. She testified as follows concerning the results of that procedure:

It was literally worse than the first one because when he did it, he brought the skin up, and it looked like I had a small football right underneath my chin. I had a big ball of skin right here [beneath the chin]. And it really—I mean, every time somebody would look at me, “What happened?”, you know,

because it was a big ball. And, I mean, I was extremely upset with it because it was so noticeable.

* * *

After I started crying in his office, saying, “I can’t look like this. You can’t send me back to work with this big ball of skin here,” I said, “I—You’ve got to fix this. You’ve got to do something with it.”

And his nurse said, well, it would be—there again, I’m estimating—it would be a couple months or something before he would do it.

And I said, “No. I can’t go like this. It looks terrible.”

So then they got me in like a couple weeks later to do a third procedure.

(Tr. at 112-113)

Patient 1 testified that, after the third procedure, “It didn’t look any different. After—After it healed, it didn’t look any different that it did from the first time.” (Tr. at 113)

70. With regard to her weight at the time of the abdominal liposuction procedure, Patient 1 testified that she is absolutely certain that she had weighed about 141 to 145 pounds in April 1996. Patient 1 further testified that she is certain of her weight because, at that time, she had had a doctor’s appointment every week and had to weigh in. When asked at hearing to rate her level of certainty on a scale of one to ten, with ten being the highest, Patient 1 replied that her level of certainty is ten. (Tr. at 119-121)
71. When asked if she had had liposuction on her abdomen, hips, and thighs during the second procedure, Patient 1 denied that and stated that that had taken place during the first procedure. Patient 1 further testified that she would dispute Dr. Parks’ medical records if they indicated that she had had surgery on her chin, abdomen, hips, and thighs during the second procedure. Moreover, Patient 1 was asked to rate on a scale of one to ten her level of certainty that the first procedure had included liposuction on her abdomen, hips, and thighs. Patient 1 replied that her level of certainty is ten. (Tr. at 111-112, 175, 122)
72. Other evidence indicates that Patient 1’s recollection is incorrect. Dr. Parks’ medical records for Patient 1 clearly indicate that the first procedure included treatment of her neck only. The second procedure concerned liposuction on her abdomen, hips, and thighs, and a revision of what Dr. Parks referred to in his second operative report as a “mini neck lift.” (St. Ex. 1A at 25-26, 33, 35)
73. Patient 1 testified that, after she had stopped seeing Dr. Parks, she had filed a lawsuit against him, but later reconsidered and dropped it. When asked if the case had actually

been dismissed, Patient 1 replied, “We—I just dropped it. I didn’t go any further with it.” (Tr. at 114)

Patient 1 subsequently testified that she had been “convinced” to file a lawsuit against Dr. Parks by a lawyer friend. However, Patient 1 testified that, after having been questioned during a pre-trial discovery deposition, she had decided to withdraw the lawsuit. Patient 1 added that she had not at that time felt strong enough emotionally to go through with it. Patient 1 again testified that she dropped the lawsuit, and that it had not been dismissed. (Tr. at 136-138, 145-148)

When asked on cross-examination whether she had in fact dropped the lawsuit after Dr. Parks had filed a motion for summary judgment that was subsequently granted by the court, Patient 1 testified that she had been unaware of the case having been dismissed. Further, Patient 1 testified that, following the deposition, she “thought about it all night,” and decided the next day not to “go through with it.” Patient 1 further testified that she had asked her attorney to “dismiss it all.” (St. Ex. 4S; Tr. at 148-153)

Copies of documents maintained by the Franklin County Common Pleas Court indicate that Patient 1 filed a lawsuit against Dr. Parks on July 7, 1997. On October 17, 1997, Dr. Parks filed a notice of deposition, and the transcript of the deposition was filed with the court on December 2, 1997. Also on December 2, 1997, Dr. Parks filed a motion for summary judgment. On December 16, 1997, Patient 1 filed a memorandum contra Dr. Parks’ motion for summary judgment and, on December 24, 1997, Dr. Parks filed a reply memorandum in support of the motion for summary judgment. On August 18, 1998, the court filed an entry granting Dr. Parks’ motion for summary judgment and terminating the case. (St. Ex. 4S at 8-12)

Patient 1’s Testimony Concerning Subsequent Treating Physician

74. Patient 1 testified that, in 2001, she had consulted with Dr. Robinson and that Dr. Robinson performed a neck-lift that successfully corrected the problem. (Tr. at 115-116)

Patient 1 subsequently testified that she had been somewhat dissatisfied with the first procedure performed by Dr. Robinson, and had written a letter to Dr. Robinson expressing her dissatisfaction. She stated that Dr. Robinson then performed a second procedure on her chin. She testified that Dr. Robinson had also performed a third procedure around her eyes. (Tr. at 159-163)

75. In a November 2, 2002, letter to Dr. Robinson, Patient 1 complained concerning the outcome following the three procedures performed by Dr. Robinson. Among other things, Patient 1 wrote:

September 27th, 2001, you performed surgery on my chin & underneath my eyes. On the day of surgery my left eye was not right, it was not like my right eye. My daughter picked me up after surgery and she even noticed the difference in the two eyes. You assured me there was nothing wrong and that

it would clear up and be fine. In January you redid my left eye due to skin underneath & at the corner of the eye. Since the second surgery on my chin the skin is still not smooth under the chin, it is still hanging but now the skin on the right side is tighter than the left, now it looks worse as it does not hang even on both sides.

In June you redid the surgery on my chin due to the fact the skin was still hanging after surgery and I was definitely not satisfied.

* * * [During subsequent office visits] I voiced my dislike for my chin & the problem with my eyes still swelling in the morning. * * *

(St. Ex. 1B at 55)

76. Concerning her present state of satisfaction concerning her chin and neck, Patient 1 testified: "Am I satisfied right now? I still have some skin hanging. I am somewhat satisfied because I don't want to go through another surgery. I have to live with what I got. That's what I have to say." (Tr. at 167)

Patient 2

Dr. Parks' Medical Records for Patient 2

77. Patient 2 is a female born in 1925. Patient 2 first saw Dr. Parks on June 7, 2000. At that time, Dr. Parks found several lesions, including one on the left side of her neck that he described in his progress note as "3.4 x 1.4 dark irregularly colored patch [with] irregular edge on (L) [left] neck - lentigo, lentigo melanoma." Patient 2 was scheduled for biopsies. (St. Ex. 2 at 3)

78. On July 13, 2000, Dr. Parks performed biopsies on Patient 2 that included the lesion on the left side of her neck. (St. Ex. 2 at 3)

Pathology results concerning the biopsy, which are typed into Dr. Parks' progress notes, state, in part, as follows: "LENTIGO MALIGNA MELANOMA LEVEL TWO, MEASURING 0.31 MM IN DEPTH." The pathology report itself is not in Dr. Parks' medical record for Patient 2. (St. Ex. 2 at 3; Tr. at 69) (Emphasis in original)

79. On August 3, 2000, Dr. Parks performed an "Excision[] Intermediate repair" of the lesion on Patient 2's neck. The preoperative diagnosis noted on the operative report states, "Malignant melanoma in situ." Dr. Parks' description of the procedure states, in part, as follows:

After obtaining informed consent the area was prepped and draped in the usual sterile fashion. The area was anesthetized with one percent lidocaine with epinephrine via a field block. An excision was then done using a No. 15 scalpel blade, with a margin of 5 mm on all sides of the tumor. The tissue was

then removed with a gradle scissor. The tissue was then tagged and sent for histopathology. [Closing procedure described] The final length of the wound was 6.8 cm. The preoperative size of the lesion was 3.4 x 1.4 cm. The wound was cleansed with hydrogen peroxide and dressed with polysporin ointment and a pressure bandage was then applied. The patient was instructed in wound care and asked [to] return in 10-14 days for suture removal.

(St. Ex. 2 at 5)

Pathology results concerning the excision typed into Dr. Parks' progress notes state, "LENTIGO MALIGNA (MELANOMA-IN-SITU) COMPLETELY EXCISED." The pathology report itself is not in Dr. Parks' medical record for Patient 2. (St. Ex. 2 at 3) (Emphasis in original)

80. Dr. Parks' medical records for Patient 2 do not include documentation of any vital signs at the time of the surgery on August 3, 2000. (St. Ex. 2)
81. A copy of the original pathology report dated August 8, 2000, concerning the August 3, 2000, surgery on Patient 2's neck was presented at hearing. That report states, under the heading Microscopic Exam:

The epidermis is atrophic. There is a proliferation of atypical melanocytes dispersed within the basal layer. There is underlying solar elastosis and patchy lymphocytic inflammation. The lesion is completely excised.

(Resp. Ex. L at 1) The report further states, in part, under the heading Diagnosis: "Lentigo maligna, (melanoma in situ) completely excised." (Resp. Ex. L at 1)

82. After receiving the Board's notice of opportunity for hearing, Dr. Parks requested that the excision samples be reexamined and an updated pathology report prepared. (Tr. at 69-71) The new report, dated January 26, 2005, states, under the heading Microscopic Exam:

The epidermis is atrophic. There is a proliferation of atypical melanocytes dispersed within the basal layer. There is underlying solar elastosis and patchy lymphocytic inflammation. The lesion is completely excised.

Addendum of report originally dated 8/08/2000.

The review of the slides reveal an adequate margin for a thin, focally invasive level two, malignant melanoma. The depth of the excision extends deeper than the subcutis throughout the specimen.

Gross: skin tissue meas. 4.1 x 3.2 x 0.7cm plus 4 sm. dog ears.⁶

(Resp. Ex. L at 2) The diagnosis is the same as had been reported earlier. (Resp. Ex. L at 1-2)

Testimony of Dr. Scarborough re: Patient 2

83. Dr. Scarborough testified that he believes that Dr. Parks' treatment of Patient 2 departed from the minimal standard of care. (Tr. at 310)

84. With regard to the biopsy results recorded in Dr. Parks' progress notes, Dr. Scarborough testified that "lentigo maligna melanoma" refers to an invasive melanoma. Dr. Scarborough further testified that "Clark's Level II" described "malignant cells breaking through the basement membrane into the upper part of the dermis." Moreover, Dr. Scarborough testified that the measurement of "0.31 millimeters in depth" on the Breslow scale is "a measurement the pathologist makes to see the depth below the basement membrane zone of penetration of the malignant cells." (Tr. at 311)

Dr. Scarborough testified that, in contrast to a Clark's Level II lentigo maligna melanoma, a "melanoma in situ" is a lesion that "is on a cancerous track, but there's been no invasion." When asked whether a cancer can be both "in situ" and "Clark's Level II," Dr. Scarborough replied, "Within a melanoma, the maximum penetration is what—is what categorizes how aggressive it is, and the treatment is based on the maximum penetration." (Tr. at 312)

85. With regard to Dr. Parks' records concerning the August 3, 2000, excision, Dr. Scarborough testified that the operative report refers to a preoperative diagnosis of "malignant melanoma in situ" and describes an excision with a margin of 5 millimeters around the tumor. (Tr. at 313)

Dr. Scarborough testified that the volume of tissue removed as described in Dr. Parks' operative report would be inadequate for a Clark's Level II lesion with Breslow depth of 0.31 mm. Dr. Scarborough testified that the standard of care for a lesion of up to one millimeter in depth requires removal of one centimeter of tissue on all sides of the lesion. Moreover, Dr. Scarborough testified that, based upon the operative report, Dr. Parks' procedure did not meet the minimal standard of care. (Tr. at 313-314, 320-321)

Dr. Scarborough testified that the standard of care also requires that the medical record include a description of the depth of tissue removed. Moreover, he testified that it requires a description of the orientation of the ellipse, and that "[t]he elliptical orientation be oriented toward the draining lymph nodes." Dr. Scarborough further testified that Dr. Parks' medical record for Patient 2 contains neither of those descriptions. Finally,

⁶ Dr. Barron testified that "dog ears" are small pieces of tissue from around the intact excision that are taken by the surgeon to enhance the cosmetic result during closure of the surgical wound, and sometimes to obtain additional pathology information. (Tr. at 222)

Dr. Scarborough testified that the failure to document those items fell below the minimal standard of care. (Tr. at 314-315, 321)

86. Dr. Scarborough testified as follows concerning the pathology reports:

[The August 8, 2000, biopsy report indicating a final diagnosis of melanoma in situ] is curious because the initial lesion showed invasion. * * * The lab that I use and am familiar with is if you biopsy a lesion, send it for diagnosis, [and then] you reexcise it, that is considered one lesion. The biopsy and the reexcision, that was the lesion.

So to say at the bottom a final diagnosis on a reexcision is merely a melanoma in situ is a bit curious.

(Tr. at 389) Dr. Scarborough testified that, in any case, it appeared to him that the dermatopathologist had found no further invasion in the remainder of the lesion excised on August 3, 2000. (Tr. at 389-390)

Testimony of Dr. Parks re: Patient 2

87. Dr. Parks testified that his August 3, 2000, operative report contained erroneous information because he had used the wrong operative report template to create the report. Dr. Parks further testified that the report inaccurately describes the procedure that was performed. For example, Dr. Parks testified that, although the report states that the excision was made with a 5 mm margin around the lesion, he had actually made the excision with a one-centimeter margin. In addition, Dr. Parks testified that the depth of the tissue had not been included in the operative report because the wrong template was used. (St. Ex. 2 at 5; Tr. at 67-69, 71)

Dr. Parks further testified that a tissue depth of 0.7 cm is noted in the January 26, 2005, addendum to the original pathology report. (Resp. Ex. L; Tr. at 69-71)

Moreover, Dr. Parks testified that, elsewhere in his records, he had noted that he had excised an invasive melanoma rather than a melanoma in situ. He referred specifically to his progress notes dated July 13, 25, and August 3, 2000. He further testified that his July 25, 2000, note indicates that he had examined her cervical and supraclavicular lymph nodes, which he would not have done if he had believed that the cancer had been melanoma in situ. (St. Ex. 2 at 3; Tr. at 717-720)

88. Dr. Parks testified that the statement in the August 8, 2000, pathology report that indicated that the lesion had been “completely excised,” had meant to him that “the lesion [had been] completely removed with adequate margins.” Dr. Parks further testified that it had also meant that the margins had been within the standard of care. Moreover, Dr. Parks testified that Dr. Barron had prepared the August 8, 2000, pathology report, that Dr. Parks has sent “at least a thousand” samples to Dr. Barron, and that he trusts Dr. Barron’s judgment. (Tr. at 728-729, 734-735)

Dr. Parks further testified that he had not been confused by Dr. Barron's report stating that the excised tissue had been melanoma in situ. Dr. Parks testified that he had interpreted that to mean that there had been no more invasive melanoma remaining in the lesion following the biopsy, and that all that had remained had been melanoma in situ. (Tr. at 731)

89. Dr. Parks testified that he does not believe that he had violated the minimal standard of care by failing to document the depth of tissue removed. (Tr. at 749-751)

Dr. Parks further testified that he does not believe that he had violated the minimal standard of care by not documenting the orientation of the ellipse. Dr. Parks testified that, with a minimally invasive melanoma of Breslow level 0.31 mm he does not "believe that that was crucial to the outcome of this surgery to any degree." Moreover, Dr. Parks noted that the post-biopsy lesion had been in situ, which further minimizes concern for lymph node infiltration. (Tr. at 751)

Testimony of Dr. Siegle re: Patient 2

90. Dr. Siegle acknowledged that Dr. Parks' medical records indicate an insufficient 5 mm margin for the August 3, 2000, surgery. Dr. Siegle further acknowledged that a physician is responsible for the accuracy of his or her medical records. (Tr. at 657-658)

91. Dr. Siegle testified that, based upon the tissue measurements described in the updated, January 26, 2005, pathology report, he believes that it is feasible that the original excision had been one centimeter in depth. Although the depth is noted as 0.7 cm on the report, Dr. Siegle stated that tissue specimens contract after they have been removed. (Resp. Ex. L at 2; Tr. at 572-573)

92. Dr. Siegle testified that the standard of care in 2000 for excision of the lesion would have been "to take it through the fat to the fascia." Dr. Siegle testified that, in 2000 as now, the necessity of removing large volumes of tissue has been called into question, and that a more superficial resection is now, and was then, being done. (Tr. at 658)

Dr. Siegle further testified that, on certain areas of the body such as the face, deep removal of tissue is not always done "because then we would be removing critically important nerves." Dr. Siegle testified that physicians now have a better understanding of the biology of melanoma, and they have learned over the years that it is unnecessary to go to a depth of one centimeter. Finally, Dr. Siegle testified that excised tissue is always sent to a pathologist for confirmation that the diseased tissue was completely removed. (Tr. at 567-570)

93. Dr. Siegle testified that he finds fault with Dr. Parks for having used the wrong operative report for the August 3, 2000, excision. However, Dr. Siegle testified that, except for the operative report, he does not believe that Dr. Parks' care of Patient 2 deviated from the minimal standard of care. (St. Ex. 2 at 5; Tr. at 573-574)

Testimony of Dr. Barron re: Patient 2

94. Dr. Barron testified that his analysis of the excised tissue revealed that the malignant tissue had been completely removed, and that there had been no malignant cells at the margins of the tissue. Dr. Barron opined that the excision had been adequate and, had it not been adequate, he would have noted that in his report. (Resp. Ex. L at 1; Tr. at 219-220, 225)
95. Dr. Barron testified that, when examining an excision of cancerous tissue, he looks for several things. First, he inspects the tissue to see if there are any cancer cells remaining in the tissue and, if there are, where are they located. He then determines whether the margins were adequate for the diagnosis. (Tr. at 223)

Dr. Barron testified that, not only did Dr. Parks remove all the cancer, but he removed a quantity of tissue around the cancer that was adequate for the cancer diagnosed. Dr. Barron further testified, “If—If this cancer was on my neck, this is the type of treatment I would have—would have wanted on myself.” (Tr. at 223-225)

96. Dr. Barron testified that, to a reasonable degree of medical certainty, the tissue excised by Dr. Parks on August 3, 2000, was “[m]ore than adequate” with regard to having margins that were clear of cancer. (Tr. at 225-226)

Patient 2: Dr. Parks’ Alleged Failure to Perform or to Document Vital Signs for Patient 2 at the Time of Surgery

Testimony of Dr. Scarborough re: Patient 2 – Dr. Parks’ Alleged Failure to Perform or to Document Vital Signs

97. Dr. Scarborough testified that Patient 2 had been 75 years old at the time Dr. Parks had treated her, and had a history of heart problems, lung disease, hypertension, and skin cancer. Dr. Scarborough further testified that it had therefore been important for Dr. Parks to monitor Patient 2’s vital signs during the August 3, 2000, procedure. Moreover, Dr. Scarborough testified:

The location of the tumor is on the neck. We don’t know if this was a frail woman or a heavy woman, how thick is that area. You’re going through the fascia, you’re very close to the jugular vein. It is not a small lesion. And if an adequate margin was removed, it would require a certain volume of anesthetic administration.

Certainly depending on the patient’s hypertension, if she was actively hypertensive, [the] stress of surgery, with or without local anesthetics, may impact her significantly, her blood pressure.

(Tr. at 310, 315-316)

Dr. Scarborough testified that Dr. Parks' failure to monitor or to document Patient 2's vital signs during the August 3, 2000, procedure fell below the minimal standard of care.

Dr. Scarborough further testified that, had the lesion been closer to Patient 2's collarbone and not near the jugular vein, it would not change his opinion because Patient 2 would still have required the same volume of local anesthesia and would have had the same potential for cardiovascular problems. Moreover, Dr. Scarborough testified that the fact that Dr. Parks had been ACLS certified does not change his opinion because the procedure had been performed in an outpatient setting. (Tr. at 317-318)

98. Dr. Scarborough testified that he is not aware of any AAD guidelines that would have required the monitoring of Patient 2's vital signs during her August 3, 2000, surgery. (Tr. at 393)

Testimony of Dr. Siegle re: Patient 2 – Dr. Parks' Alleged Failure to Perform or to Document Vital Signs

99. Dr. Siegle testified that it had not been necessary for Dr. Parks to take Patient 2's vital signs at the time of surgery, even though Patient 2 had been 75 years old and hypertensive. Dr. Siegle stated that he would not have performed the procedure on a patient with "active cardiac disease" or who had complained of angina. However, Dr. Siegle testified: "I'm not really aware of healthy inventory patients in that setting with ambulatory patients, of any consequences of using our local anesthesia. It's safe." (Tr. at 576-577) Moreover, when asked if the standard of care requires that vital signs be taken, Dr. Siegle replied:

I've never seen that it is. It is in an ambulatory surgery center, it is in a hospital. There are different documentation rules that are necessary. So someone practicing in that setting may think, well, gee, you didn't do this. Well, in the office setting where the majority of outpatient surgeries in the United States of America are performed, it is not the standard to do vital sign examination.

(Tr. at 577-578) Finally, Dr. Siegle further testified,

This is a young patient in my practice. I do 80- and 90- and 100-year-old patients routinely in the same setting without vital signs, in the same location, with the same diagnoses. There is no indication to do vital signs if that patient is before me, talking, and doing well. That's the way it is.

(Tr. at 665)

Testimony of Dr. Parks re: Patient 2 – Dr. Parks' Alleged Failure to Perform or to Document Vital Signs

100. Dr. Parks acknowledged that, during Patient 2's surgery on August 3, 2000, he had not monitored her blood pressure, pulse, respiration rate, body temperature, or any other vital

signs. However, Dr. Parks testified that he had not violated the minimal standard of care. Dr. Parks further testified that the guidelines for such surgery that were first published by the AAD one year later, in August 2001, do not require such monitoring. (Resp. Ex. Z; Tr. at 78, 741-746) Moreover, Dr. Parks testified:

[I]n a stable person, there is very little, if any, fluctuation in vital signs. And we have people that we can monitor by talking to them.

Usually, if we're going to have any reaction to local anesthetic, it's going to be the patient's going to complain of palpitations. And at that point, we would start to take a pulse and blood pressure. But the patients are talking to us, we're—we're observing them, we're seeing that they're in no distress. And [the] standard of care in the community is that no vital signs are done for this type of surgery.

(Tr. at 746)

Finally, Dr. Parks testified that he had used only local anesthesia during Patient 2's surgery, and that she had not been under IV sedation. (Tr. at 745-746)

101. Dr. Parks testified that he had taken an informal survey of fourteen dermatologists in the central Ohio community and that "none of them took vital signs from their patients that were having excisional surgery done." However, Dr. Parks acknowledged that his informal survey did not address whether the dermatologists' patients had been elderly or hypertensive. (Resp. Ex. EE; Tr. at 746-748, 825)
102. Dr. Parks testified that Patient 2's lesion had been located on the left side of her neck, near the clavicle. Dr. Parks stated that it had not been near the jugular vein. (Tr. at 68)

Patient 3 – Dr. Parks' Medical Records for Patient 3

103. Patient 3 is a male born in 1937. Patient 3 began seeing Dr. Parks in March 1995, and Dr. Parks treated him for "multiple skin cancers and precancerous spots." (St. Ex. 3; Tr. at 79)
104. On September 5, 2000, Patient 3 saw Dr. Parks with a chief complaint of multiple skin lesions. Among other things, Dr. Parks stated in his progress note: "Tridesilon Oint [twice per day] * * * behind (L) [left] ear maybe seb derm or another malignancy." (St. Ex. 3 at 3)

Dr. Parks saw Patient 3 again on October 20, 2000, at which time he took biopsies of four areas on Patient 3's face and head, none of which were taken from behind Patient 3's left ear. Dr. Parks did not at that time document a recheck of the lesion behind Patient 3's left ear to see if the cortisone cream had been effective. (St. Ex. 3 at 3; Tr. at 86-87)

Dr. Parks saw Patient 3 again on October 31, 2000, to go over the results of the October 20 biopsies. The four biopsies revealed two basal cell carcinomas, one squamous cell carcinoma, and one melanoma in situ. Dr. Parks did not at that time document a recheck of the lesion behind Patient 3's left ear for the possible "seb derm or another malignancy" he had noted on September 5, 2000. (St. Ex. 3 at 4; Tr. at 87)

Dr. Parks also saw Patient 3 on November 30 and December 12, 2000. Dr. Parks did not document on either of those occasions that he had rechecked the lesion behind the left ear. (St. Ex. 3 at 4; Tr. at 87-88)

105. On February 2, 2001, Dr. Parks again saw Patient 3. Dr. Parks' medical records indicate that, among other things, he took a biopsy from the "(L) [left] post. auricular sulcus. Aclovate [next word illegible] samples for seb derm behind (L) [left] ear." At hearing, Dr. Parks testified that he had taken the biopsy from the sulcus, which he described as the crease behind Patient 3's left ear where the ear meets the scalp. (St. Ex. 3 at 4; Tr. at 88-89)

The results from the pathology report that are recorded in Dr. Parks' progress notes state, in part, "L/POSTERIOR EAR: BOWEN'S DISEASE W/ SUPERFICIAL SQUAMOUS CELL CARCINOMA." The pathology report itself is not in Dr. Parks' medical record for Patient 3. (St. Ex. 3 at 4) (Emphasis in original)

On February 23, 2001, Dr. Parks referred Patient 3 to Dr. Siegle for Mohs surgery. (St. Ex. 3 at 4; Tr. at 89-90)

106. In a report that he forwarded to Dr. Parks, Dr. Siegle indicated that he had seen Patient 3 on March 13, 2001, and that Patient 3 had "an extensive cancer behind his left ear." Dr. Siegle further reported:

Examination showed a heavily sun-damaged gentleman with multiple facial surgical scars and keratotic lesions. A significant tumor occupied the left posterior ear, sulcus, and mastoid tissues with estimated size at 5 x 2.3 cm. No adenopathy palpable today.

I/P—Bowen's disease with probable invasive SCC of the left ear. Biology discussed and the challenge of removing this extensive tumor. Options reviewed and today with consent we proceeded with Mohs and found extensive deeply spreading tumor. Two large stages were performed yielding a post op size of 6 x 5 cm. He was resurfaced with a STRG taken from his right anterior thigh. * * * Long-term active follow up mandatory with Dr. Parks for his numerous cancers.

(St. Ex. 3 at 33)

107. Following the March 13, 2001, Mohs surgery, Patient 3 continued to see Dr. Parks on a regular basis through December 27, 2001. During that period, Dr. Parks continued to

identify and treat Patient 3's skin problems. However, there is no further mention in the medical record concerning seborrheic dermatitis behind Patient 3's left ear. (St. Ex. 3 at 4-5)

Patient 3 – Evidence Concerning the Location of Suspected Seborrheic Dermatitis and the Location of Bowen's Disease

Dr. Parks' Medical Records for Patient 3 Concerning the Location of Suspected Seborrheic Dermatitis and the Location of Bowen's Disease

108. The Notice alleges that Patient 3's Bowen's disease was underneath the area that Dr. Parks examined and described as "seb derm or another malignancy." Thus, it is important to determine whether the location of the "seb derm or another malignancy noted in September 2000 was the same location as the Bowen's disease that was discovered and excised in February and March 2001. Dr. Parks' medical record for Patient 2 contains the following references:

- On September 5, 2000, Dr. Parks used "behind [left] ear" to describe the location of the "seb derm or another malignancy";
- On February 2, 2001, Dr. Parks used "[left] posterior auricular sulcus" to describe the February 2, 2001, biopsy site; and, for the same visit, used "behind [left] ear" to describe the location of the "seb derm";
- Dr. Parks or one of his staff members used "L/POSTERIOR EAR" regarding the results of the biopsy taken from the left posterior auricular sulcus on February 2, 2001;
- Dr. Parks' medical records include a copy of Dr. Siegle's report of his March 13, 2001, Mohs surgery on Patient 3 stated that Patient 3 had been referred by Dr. Parks "with an extensive cancer behind his left ear." Dr. Siegle further stated that, upon examination, he had found "[a] significant tumor [that] occupied the left posterior ear, sulcus, and mastoid tissues with estimated size at 5 x 2.3 cm."

(St. Ex. 3 at 3-4, 33)

Testimony of Dr. Scarborough Concerning the Location of Suspected Seborrheic Dermatitis and the Location of Bowen's Disease

109. Dr. Scarborough testified that the term used by Dr. Parks, "behind the left ear," is synonymous with the terms "left posterior auricular zone" and "left posterior auricular

area.”⁷ Dr. Scarborough opined that the term “behind the left ear was not a specific term:

It’s not an exact position because it could be when you’re looking behind the ear; it could be the back of the [ear lobe]; it could be the auricular sulcus; it could be the adjacent skin; even frontal occipital scalp. It’s all considered the post auricular zone * * *.

(Tr. at 327) Dr. Scarborough further opined that the term “behind the left ear” includes the back of the ear lobe, the left posterior auricular sulcus, the mastoid area,⁸ and the frontal occipital scalp. (327-328, 334, 473)

Testimony of Dr. Siegle Concerning the Location of Suspected Seborrheic Dermatitis and the Location of Bowen’s Disease

110. Dr. Siegle testified as follows concerning the terminology used to describe the area behind Patient 3’s left ear:

- Dr. Siegle commented on Dr. Parks’ progress note dated February 2, 2001, which states that Dr. Parks took a biopsy from the “[left] post auricular sulcus” and dispensed cortisone cream for “seb derm behind [left] ear.” Dr. Siegle testified that he does not believe that Dr. Parks was referring to the same anatomical location with those descriptions. Dr. Siegle testified: “It says one location and then it describes another location. If he was giving a cream for the area that he’s biopsying, he would say, ‘treating that area with the cream.’ He didn’t say that. He’s describing another site behind the ear.” (Tr. at 547-548)
- Dr. Siegle testified that it is difficult to be specific in describing the anatomy behind the ear because there is no common terminology. Moreover, Dr. Siegle testified that, since he reviewed the records in this case, he questioned associates concerning how they label various areas, and found that there is no common terminology. Dr. Siegle testified that, accordingly, there is no consensus regarding what “behind the ear” means. Finally, Dr. Siegle agreed that the areas around the nose and the ear are the most difficult for a physician to describe anatomically. (Tr. at 541-543)
- Dr. Siegle further testified that the term “sulcus” is descriptive of the groove where the ear meets the scalp and mastoid skin. (Tr. at 546-547)
- When asked if he would have documented Patient 3’s “seb derm” as “behind the left ear,” Dr. Siegle replied that, if there were multiple lesions and he needed to identify one particular spot, he would have been more specific in his description. (Tr. at 648-651)

⁷ Note that the terms “left posterior auricular area” and “left posterior auricular zone” were not used in the medical records for Patient 3. (St. Ex. 3)

⁸ Dr. Scarborough testified that the mastoid area includes an area behind the ear “[p]robably up to that area near the hairline.” (Tr. at 473)

Testimony of Dr. Parks Concerning the Location of Suspected Seborrheic Dermatitis and the Location of Bowen's Disease

111. Dr. Parks testified that the term "behind the left ear" refers to the back of the scalp. Dr. Parks further testified that the "sulcus" refers to "the groove [behind the ear] where the ear attaches to the scalp." Moreover, Dr. Parks testified he believes that the term "left posterior auricular zone," which was not a term he had used in Patient 3's medical record, refers to the back surface of the left ear. (Tr. at 81-83)
112. Dr. Parks testified that the seborrheic dermatitis he had treated on September 5, 2000, had not been the same condition or in the same location that he had biopsied on February 2, 2001. (Tr. at 714)

Patient 3: Expert Testimony Concerning Dr. Parks' Care and Treatment of Patient 3

Testimony of Dr. Scarborough Concerning Dr. Parks' Care and Treatment of Patient 3

113. Dr. Scarborough testified that Patient 3 had suffered from significant sun damage and multiple skin lesions. Dr. Scarborough further testified that Patient 3 had been a very difficult dermatologic patient, and that Dr. Parks treated numerous lesions that were both cancerous and precancerous. (Tr. at 322-323, 367-368)
114. Dr. Scarborough noted that the Tridesilon ointment that Dr. Parks prescribed on September 5, 2000, "is a mild cortisone [ointment] that is the treatment for seborrheic dermatitis[,] and can take from three to six weeks to clear up that condition depending on its severity. (St. Ex. 3 at 3; Tr. at 323)
115. Dr. Scarborough testified that "a six-centimeter width cannot be confined to the sulcus." Dr. Scarborough acknowledged that the entire tumor is not usually visible to the naked eye, which is why Mohs procedure is performed. However, Dr. Scarborough testified that "for a lesion of that size, though, to be described as a superficial squamous cell carcinoma by biopsy, there is something clinically present. It also apparently is deeply invading. And there are changes that are seen in the skin with that process." (Tr. at 335-337)
116. Dr. Scarborough testified that, in his opinion, Dr. Parks' care and treatment of Patient 3 fell below the minimal standard of care. (Tr. at 322)

Testimony of Dr. Siegle Concerning Dr. Parks' Care and Treatment of Patient 3

117. Dr. Siegle described Patient 3's skin, "[c]rudely, [as] a train wreck." Dr. Siegle testified that Patient 3 "was covered with growths of various types, as well as surgical scars and precancers." Dr. Siegle further testified that, in a patient such as Patient 3, whose skin had many cancerous and precancerous lesions, it had been necessary to triage the lesions, "prioritize [them] based on the clinical impression of [the] growths," and develop a plan. Dr. Siegle has many patients whose plans extend over a prolonged period of time, perhaps

years, due to their severe condition. In his practice, Dr. Siegle tries to identify and treat first those cancers that present the greatest threat to the patient, and afterward treat the next level of problems. (Tr. at 540-542)

Furthermore, Dr. Siegle testified that, based on the state of Patient 3's dermatological health, there had been no urgency for Dr. Parks to go back and check the "seb derm or other malignancy" because of all of the other more serious lesions the patient had had. If it had been cancer, Dr. Siegle said, it would have been a superficial basal cell carcinoma or another area of Bowen's disease. Dr. Siegle further testified: "So even if it was malignancy and it persisted, it's still just a superficial skin cancer. This is not a threat to the patient." Finally, Dr. Siegle testified that, "in light of the other problems and cancers being addressed," he does not believe that Dr. Parks' failure to document a follow-up falls below the minimal standard of care. He further testified that seborrheic dermatitis would have been the least of Patient 3's problems. (Tr. at 541-542, 699-702)

118. Dr. Siegle testified that Bowen's disease is known for "subclinical spread," and that it tends to spread "peripherally and not deeply. It's a cancer that cryptically spreads laterally." (Tr. at 552-553) With regard to Patient 3's Bowen's disease, and Dr. Siegle's report concerning the surgery, Dr. Siegle testified:

The biopsy had shown what we commonly see, which is Bowen's disease, which is a superficial cancer. And at least within the limits of the biopsy, it had started to become a squamous cell carcinoma. That means it now was leaving the epidermis and moving into the middle layer of the skin or the dermis.

When we actually removed his tumor, two things were of note as far as I'm concerned. The first was we use a—an instrument called a curette to debulk, to remove the obvious portion of the tumor. And in this case, when we did that debulking, it was obvious that there was thickness to the cancer[.]

* * *

And, thus, my ultimate comment that this was deeply spreading.

The other thing that we defined with that curette and ultimately with the microscope was that the cancer was, in fact, very significantly widely spreading so that my initial clinical impression of this, two things.

One is I wrote "estimated size", which means to me it's subtle. I don't know where it starts and stops.

And two is postop, we ended up being five centimeters wide. And so as is typical of [Bowen's disease], there was very significant subclinical spread of this cancer. So that we had trouble seeing it visually.

I can extrapolate, therefore, to Dr. Parks, the initial examiner, it wasn't so obvious what was cancer versus his normal sun-damaged skin. And that's a common scenario with Bowen's disease, to have that.

The other thing I did is I went back and I looked at my slides recently to see, in fact, what cancer we identified in the microscopic examination portion. And I did not have deep cancer within the skin itself.

We—All of our margin, all of our positivity was peripherally at the end of our first stage of removal with Bowen's disease, not a serious squamous cell carcinoma.

So probably, and I say this probably because I do not remember the actual removal, when we did the initial curetting and I felt that was going in deeply—There is a form of Bowen's disease which we call hyperplastic Bowen's and, basically, the cancer, instead of just being paper thin and spreading along, the epidermis itself thickens. The epidermis thickens and naturally raises up. It's not roots of a cancer growing deeply.

And when you curette that, instead of being just a fraction of a millimeter deep, the curette actually falls in, and it can be two or three millimeters deep, such that I'll go, "Whoa, what do we have here?" But then microscopically, when we actually looked at the tissue below that, I did not have serious squamous cell carcinoma.

(Tr. at 553-556)

119. Dr. Siegle testified that the sulcus normally has a smooth, growth-free texture and appearance. However, in Patient 3's case, "he had a rough patch; not a mass, not a lump or anything. This is Bowen's disease, which tends to be more of what we term a patch, just a broad area." Dr. Siegle further testified that it would have taken five or more years for the lesion to have reached that size. (Tr. at 551-552, 654)
120. Dr. Siegle testified that he does not believe that Dr. Parks failed to meet the minimal standard of care with regard to the "seb derm" and/or the lesion that was found in the sulcus. (Tr. at 558)

Testimony of Dr. Parks Concerning His Care and Treatment of Patient 3

121. When asked whether the seborrheic dermatitis he had treated on September 5, 2000, had required follow-up within five months, Dr. Parks testified:

With that kind of rash and his multitude of other problems, for the most part, I would follow up on that if the patient pointed it out.

There was no urgency to follow up on that. That was the least of his problems at the time in September. * * * I followed up with that five months later, and that's certainly within the realm of reasonability.

(Tr. at 713-714)

122. Dr. Parks testified that, in his opinion, his treatment of Patient 3's seborrheic dermatitis behind his left ear had been within the minimal standard of care. (Tr. at 713-714)

Testimony Concerning Medical Recordkeeping

Testimony of Dr. Parks Concerning Medical Recordkeeping, in General

123. Dr. Parks testified that it is important for a physician to keep accurate medical records for, among other things, billing purposes and for use by subsequent treating physicians. Dr. Parks further testified that it had been his responsibility to ensure that his medical records accurately reflected the care that he had provided to patients. (Tr. at 33-35)

Testimony of Dr. Siegle Concerning Dr. Parks' Medical Recordkeeping

124. Dr. Siegle acknowledged that he believes that Dr. Parks' medical records were "suboptimal" and "were not the optimal records that I like to see in a chart and they required additional information for clarification." (Tr. at 631-632)

Dr. Siegle testified that, after he had reviewed Dr. Parks' medical records in preparation for this case, he had required additional information "to better understand what had happened in terms of the patient care." One question that he had had concerned the operative report for Patient 2, wherein the report indicated that Dr. Parks had proceeded with excision for a melanoma in situ, which Dr. Siegle indicated would have been inadequate treatment. Dr. Siegle testified, "I needed to find out is that how it was treated or was it treated otherwise. And we did our work and identified the larger specimen; and he identified the template issue, and so there was really no issue there." However, Dr. Siegle acknowledged that, based on Dr. Parks' record alone, it appeared as though his treatment had fallen below the minimal standard of care. (Tr. at 641-642)

Dr. Siegle further testified that he had had questions concerning the anatomical terminology used to describe lesions around Patient 3's left ear. Dr. Siegle stated, "all I needed was clarification what his terms meant, and then it goes through very logically." Dr. Siegle further stated that Dr. Parks had used essentially lay terminology, "behind the ear," to describe the location of the seborrheic dermatitis. Moreover, Dr. Siegle testified that he had asked Dr. Parks to explain, and that Dr. Parks had drawn a diagram of its location indicating that it had been located in the "hair-bearing area" behind the ear. Dr. Siegle acknowledged that the diagram did not appear in the records he had been given to review. (Tr. at 643-646)

Finally, Dr. Siegle acknowledged that he had required clarification concerning Dr. Parks' treatment of Patients 2 and 3 because the medical records had been inadequate. (Tr. at 647)

Additional Information

125. Dr. Parks testified that, in his opinion, his care and treatment of Patients 1, 2, and 3 met or exceeded the minimal standard of care. (Tr. at 800)

FINDINGS OF FACT

1. In the course of his practice as a dermatologist, Alan J. Parks, M.D., undertook the care of Patients 1 through 3, as identified in a confidential Patient Key. In his care of these patients, Dr. Parks failed to appropriately evaluate, diagnose, manage, and/or treat these patients, and/or he performed inappropriate surgical procedures, and/or he failed to appropriately document his care of these patients, including, but not limited to, the following:

Patient 1

- a. On November 22, 1995, Patient 1 consulted with Dr. Parks regarding chin/neck liposuction. On December 14, 1995, Dr. Parks performed liposuction on Patient 1's chin/neck, and removed a "small wedge of skin" from her neck. Subsequently, on April 26, 1996, Dr. Parks performed what he described as a "[r]evision of mini neck lift" and liposuction on Patient 1's abdomen, hips, and thighs. Finally, on May 9, 1996, Dr. Parks performed a "[n]eck revision post liposuction."

Dwight Scarborough, M.D., the State's expert witness, testified convincingly that the cosmetic issue that had troubled Patient 1 had not resulted from excess fat; rather it had been the result of loose, hanging skin under her chin and on her neck following a recent loss of forty pounds. Further, although the evidence indicates that liposuction can tighten the skin as well as remove fat, liposuction and a wedge excision would not pull the loose skin in such a manner as to drape it over the underlying support structures and give Patient 1 a defined cervical mandibular angle. Such a result could be achieved only by a neck-lift or a face-lift. Dr. Scarborough's testimony to that effect was not refuted by Dr. Parks or his experts.

Moreover, although Ronald J. Siegle, M.D., and Patrick J. Lillis, M.D., two of Dr. Parks' expert witnesses, do not believe that Dr. Parks had practiced below the minimal standard of care by performing neck/chin liposuction on Patient 1, both experts testified that they would have performed chin/neck liposuction on Patient 1 only after Patient 1 had first determined not to have a neck-lift or face-lift. Dr. Lillis also testified that he would have performed chin/neck liposuction only if he had believed that Patient 1 would be happy with the results he could deliver. Further, Dr. Siegle testified that he would have counseled Patient 1 concerning having a neck-lift performed.

Moreover, Dr. Siegle testified to the effect that he could not rule out the possibility that he would have turned Patient 1 away as a candidate for chin/neck liposuction.

Dr. Parks documented in his November 22, 1995, progress note that he had advised Patient 1 that the results of her surgery would not be perfect. Further, Dr. Parks testified that he had discussed with Patient 1 the possibility of doing either a face-lift or neck-lift as an alternative to liposuction and a wedge excision. Moreover, Dr. Parks testified that Patient 1 had elected not to proceed with a face-lift or neck-lift based upon the greater cost and recuperation time required by those procedures, as well as the added risks associated with the general anesthesia that would have been required.⁹ Nevertheless, Dr. Parks failed to document in his medical record for Patient 1 any such discussions concerning appropriate treatment options prior to her first or second surgeries.

Accordingly, the evidence supports a finding that, throughout Dr. Parks' treatment of Patient 1 with regard to her chin/neck, he failed to recognize the basic problem, failed to inform the patient on two occasions as to appropriate alternative treatment options, and failed to use proper surgical judgment and/or approach, causing the patient to undergo inappropriate surgery under the circumstances on three separate occasions.

- b. With regard to the photographs of Patient 1 that were taken by Dr. Parks on December 14, 1995, and those taken by the subsequent treating physician on August 8, 2001, Dr. Scarborough testified that, comparing Dr. Parks' preoperative photographs with those taken five years later by the subsequent treating physician, he does not see any significant improvement. Conversely, both Dr. Siegle and Dr. Lillis testified that the later photographs reveal a substantial improvement in Patient 1's appearance from the earlier photographs.

In the Hearing Examiner's opinion, Patient 1's chin/neck in the August 2001 full-face photograph looks noticeably better than in the December 1995 full-face photograph. With regard to the photographs of Patient 1's right profile, the August 2001 photograph shows what appears to be some webbing of the skin beneath Patient 1's chin down to her thyroid area.¹⁰ Nevertheless, the skin does not appear to droop as much as it had in the earlier photo.

In any case, only limited evidentiary weight is given to comparisons of the photographs. The later photographs taken by the subsequent treating physician are too small, grainy, and indistinct to support any truly objective determination of the surgical result achieved by Dr. Parks. Further, there is no evidence that the earlier and later photographs were taken using similar lighting conditions, which lessens the weight to be accorded any comparison between the earlier and later photographs. Finally, following review of the

⁹ Patient 1 testified that Dr. Parks did not discuss treatment options with her. However, no weight is given to Patient 1's testimony because her memory is deemed unreliable.

¹⁰ No August 2001 photograph of Patient 1's left profile was included in the record.

- December 1995 and August 2001 full-face photographs, the Hearing Examiner believes that Patient 1 may have gained some weight between the time of the earlier photographs and the time of the later photographs, which further lessens the usefulness of any comparison between the earlier and later photographs.
- c. On April 26, 1996, Dr. Parks performed tumescent liposuction on Patient 1's abdomen, hips, and thighs during which he administered a total dose of 5,000 mg of lidocaine. However, he failed to ascertain and/or document Patient 1's weight, which is an omission of critical data necessary for patient safety in the calculation of total lidocaine dosage. Although a weight appears on a document in the medical record, the document is not dated and does not otherwise indicate that it relates to the April 26, 1996, procedure.
 - d. To the extent that the dosage of lidocaine administered to Patient 1 is relevant to this matter, there is insufficient evidence to support a finding that Dr. Parks had administered an excessive dose of lidocaine during the April 26, 1996, procedure. Journal articles and the testimony of Dr. Siegle and Dr. Lillis persuasively indicate that Dr. Parks did not exceed the lidocaine dosages being administered at that time by other physicians, and did not violate the minimal standard of care as it had existed at the time.

Patient 2

- e. Dr. Parks treated Patient 2 for malignant melanoma on her neck. He performed a biopsy on July 13, 2000, on a lesion that measured 3.4 cm x 1.4 cm, and the pathology result was charted as "lentigo maligna melanoma, [Clark's] level two, measuring [Breslow] 0.31 mm in depth." On August 3, 2000, Dr. Parks operated on Patient 2's neck and excised the remainder of the lesion. However, Dr. Parks' operative report for that surgery inappropriately indicates that the pre-operative diagnosis had been malignant melanoma in situ. Furthermore, the volume of tissue removed as recorded in the operative report—a margin of 5 mm on all sides of the lesion—would be inadequate treatment for a malignant melanoma, Clark's level II with a depth of 0.31 mm on the Breslow scale. Such a lesion normally requires a margin of 1 cm on all sides of the lesion.

An updated pathology report dated January 26, 2005, documents that the depth of the tissue sample submitted to the pathology lab had been 7 mm. Further, credible expert witness testimony indicates that tissue samples contract after removal. Accordingly, the evidence does not support a finding that Dr. Parks' surgery had been inadequate. Nevertheless, the evidence is clear that Dr. Parks failed to appropriately document his performance of that procedure. Moreover, Dr. Parks failed to document the depth of tissue removed, and failed to document the orientation of the surgical ellipse.

- f. The evidence is clear that Dr. Parks did not perform or document any vital signs for Patient 2 at the time of surgery. However, persuasive evidence was presented that, in

an office setting using only local anesthesia, with the patient fully conscious and communicating with the physician, the standard of care had not required him to do so.

Patient 3

- g. On September 5, 2000, Dr. Parks treated Patient 3, a 62-year-old man, for multiple skin lesions. Dr. Parks identified an area behind the patient's left ear as possibly "seb derm or another malignancy," and prescribed a mild cortisone cream, which normally would clear seborrheic dermatitis. However, Dr. Parks failed to re-evaluate the area subsequent to the cortisone treatment to determine if there was an underlying neoplasia. Moreover, Dr. Parks failed to further treat and/or diagnose the area for five months despite treating other skin cancers on Patient 3 during this five-month period.

On February 2, 2001, Dr. Parks performed a biopsy on Patient 3's left posterior auricular sulcus, and prescribed another brand of cortisone cream "for seb derm behind [left] ear." The biopsy revealed "Bowen's disease with superficial squamous cell carcinoma." Dr. Parks referred Patient 3 to Dr. Siegle for Mohs surgery, which was performed on March 13, 2001. Dr. Siegle noted in his report that "[a] significant tumor occupied the left posterior ear, sulcus, and mastoid tissues[,]" and that surgery revealed an "extensive deeply spreading tumor requiring two large stages yielding a post op size of 6 x 5 cm."

The evidence upon which these findings are based includes the following:

- Dr. Scarborough acknowledged that Patient 3 had been a very difficult dermatologic patient, and that Dr. Parks had treated Patient 3 for numerous precancerous and cancerous lesions. Further, Dr. Parks and Dr. Siegle provided testimony that, in a complex patient such as Patient 3, it is necessary to triage the patient's lesions and first address those that present the greatest threat to the patient. Moreover, Dr. Parks and Dr. Siegle testified that seborrheic dermatitis would have been a very low priority compared to Patient 3's other dermatologic problems. Nevertheless, the evidence is clear that, on September 5, 2000, Dr. Parks had believed that the suspected seborrheic dermatitis behind Patient 3's left ear had been of sufficient importance to warrant attention and treatment. Accordingly, the evidence supports a finding that Dr. Parks should have followed up on that treatment in a timely manner, and that he failed to do so.
- The evidence supports a finding that the tumor behind Patient 3's ear that was excised on March 13, 2001, occupied or overlapped the area that Dr. Parks described on September 5, 2000, as possibly being seborrheic dermatitis. This is based on the following:
 - the large surface area of the tumor removed;

- evidence that previous treatment with cortisone cream had not succeeded in clearing the suspected seborrheic dermatitis, as it would normally be expected to do; and
 - the medical record contains no further documentation concerning the suspected seborrheic dermatitis following excision of the tumor on March 13, 2001.
2. Dr. Parks presented evidence in support of his assertion that Dr. Scarborough has a conflict of interest in this matter, and that therefore his testimony should be accorded little or no weight. However, as will be explained more fully below, the Hearing Examiner concludes that, to the extent that there is a conflict of interest, it is minimal and does not require the Hearing Examiner to exclude Dr. Scarborough's testimony or to give it little or no weight.

First, the evidence Dr. Parks presented indicates that both Dr. Parks and Dr. Scarborough practice in the Columbus metropolitan area, and advertise in the same local magazine and telephone directory. On the other hand, administrative notice is taken that the Columbus metropolitan area includes more than seven hundred thousand residents and is served by at least two dozen dermatologists. Further, Dr. Parks' and Dr. Scarborough's offices are located in different parts of the county.

Second, Dr. Parks presented evidence that Dr. Scarborough personally knows him as a result of Dr. Parks' having worked for Dr. Scarborough, and that such knowledge presents a conflict of interest. The evidence indicates that, for a brief period of time while Dr. Parks was a resident, he had been employed in Dr. Scarborough's office to cover for Dr. Scarborough when Dr. Scarborough was out of town. However, the evidence also indicates that Dr. Parks had completed his residency in 1987, eighteen years prior to the hearing on this matter. In addition, no evidence was presented that Dr. Parks' period of employment by Dr. Scarborough had been eventful in any way, or would have given Dr. Scarborough any reason to harbor negative feelings toward Dr. Parks.

Third, Dr. Parks presented evidence that he knows Dr. Scarborough through membership in the same professional associations and attendance at the same medical seminars.

Based on all of the evidence, the Hearing Examiner finds that any extent to which Dr. Parks and Dr. Scarborough are in direct economic competition appears minimal. The Hearing Examiner believes that Dr. Scarborough's testimony was not influenced by a desire to eliminate or harm a competitor. Moreover, the Hearing Examiner believes that Dr. Scarborough's testimony was not influenced by personal knowledge of Dr. Parks through Dr. Parks' previous employment by Dr. Scarborough. Furthermore, there is no evidence that membership in the same professional association or attendance at the same medical seminars would qualify as a conflict of interest. Accordingly, the Hearing Examiner is convinced that Dr. Scarborough's testimony was not influenced by a conflict of interest. Dr. Scarborough appeared to be honest and forthright, and to have based his testimony solely on his medical opinion.

CONCLUSIONS OF LAW

The conduct of Alan J. Parks, M.D., as set forth in Finding of Fact 1.a through 1.c, 1.e, and 1.g constitutes “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

PROPOSED ORDER

It is hereby ORDERED that:

- A. **SUSPENSION OF CERTIFICATE, STAYED; PROBATION:** The certificate of Alan J. Parks, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for a period of 180 days. Such suspension is STAYED, subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:
1. **Obey the Law:** Dr. Parks shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
 2. **Declarations of Compliance:** Dr. Parks shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board’s offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board’s offices on or before the first day of every third month.
 3. **Personal Appearances:** Dr. Parks shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
 4. **Medical Records Course:** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Parks shall complete a course on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any course taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Parks submits the documentation of successful completion of the course on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **Monitoring Physician:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Parks shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Parks and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Parks and his medical practice, and shall review Dr. Parks' patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Parks and his medical practice, and on the review of Dr. Parks' patient charts. Dr. Parks shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Parks' quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Parks must immediately so notify the Board in writing. In addition, Dr. Parks shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Parks shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

6. **Absence from Ohio:** In the event that Dr. Parks should leave Ohio for three continuous months, or reside or practice outside the State, Dr. Parks must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of the probationary period under this Order, unless otherwise determined by the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.
7. **Violation of Probation; Discretionary Sanction Imposed:** If Dr. Parks violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

- B. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Parks' certificate will be fully restored.
- C. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Parks shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Parks shall provide a copy of this Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Parks receives from the Board written notification of his successful completion of probation.
- D. **REQUIRED REPORTING TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Parks shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Parks shall also provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration of any professional license. Further, Dr. Parks shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt, unless otherwise determined by the Board. This requirement shall continue until Dr. Parks receives from the Board written notification of his successful completion of probation.

This Order shall become effective immediately upon mailing of notification of approval by the Board.



R. Gregory Porter
Hearing Examiner



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF MARCH 14, 2007

REPORTS AND RECOMMENDATIONS

Dr. Kumar announced that the Board would now consider the Reports and Recommendations appearing on its agenda. He asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Paula Clark Adkins, M.D.; Thomas Leon Gemmer, P.A.; Jeffrey Michael Halter, M.D.; Jeffrey Vaughn Meyer, M.D.; Alan J. Parks, M.D.; Arthur Richard Schramm, M.D.; Philip L. Creps, D.O.; Mark Allen Davis, M.T.; Basma Ricaurte, M.D.; Albert W. Smith, III, M.D.; and Lovsho Phen, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Steinbergh	- aye
	Dr. Kumar	- aye

Dr. Kumar asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye

Ms. Sloan	- aye
Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Steinbergh	- aye
Dr. Kumar	- aye

Dr. Kumar noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. They may, however, participate in the matters of Dr. Halter and Dr. Ricourte, as those cases are not disciplinary in nature and concern only the doctors' qualifications for licensure. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....

ALAN J. PARKS, M.D.

.....

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS, AND PROPOSED ORDER IN THE MATTER OF ALAN J. PARKS, M.D. DR. MADIA SECONDED THE MOTION.

.....

A vote was taken on Dr. Steinbergh's motion to approve and confirm:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- nay
	Dr. Robbins	- aye
	Dr. Steinbergh	- aye

The motion carried.



State Medical Board of Ohio

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January 12, 2005

Alan J. Parks, M.D.
6222 Brooksong Way
Blacklick, Ohio 43004

Dear Doctor Parks:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) In the course of your practice as a dermatologist, you undertook the care of Patients 1 through 3, as identified on the attached confidential Patient Key. (Patient Key to be withheld from public disclosure.) In your care of these patients, you failed to appropriately evaluate, diagnose, manage, and/or treat these patients, and/or you performed inappropriate surgical procedures, and/or you failed to perform appropriate surgical procedures upon these patients, and/or you failed to appropriately document your care of these patients, including, but not limited to, the following:
 - (a) On or about November 22, 1995, you consulted with Patient 1 regarding a chin/neck liposuction. Between December 14, 1995 and May 9, 1996, you performed three surgeries on her chin/neck. Throughout this period of treatment, you failed to recognize the basic underlying problem, failed to inform the patient on multiple occasions as to appropriate alternative treatment options, and failed to use proper surgical judgment and/or approach, causing the patient to undergo inappropriate surgery on three separate occasions.

Furthermore, Patient 1 signed a consent form on or about December 14, 1995, giving you authorization to perform liposuction on her chin; however, the form did not authorize you to surgically remove excess skin. Despite failing to receive authorization, during this surgery, you performed a small excision, removing excess skin as described in the text of the operative report.

MAILED 1-13-05

Further on or about April 26, 1996, you performed an extensive liposuction procedure on Patient 1 and administered a total dose of 5000 mg of lidocaine. However you failed to ascertain and/or document Patient 1's weight, which is an omission of critical data necessary for patient safety in the calculation of total lidocaine dosage.

- (b) You treated Patient 2 for a malignant melanoma on her neck, performing a biopsy on July 13, 2000, with pathology charted as "lentigo maligna melanoma, [Clark's] level two, measuring [Breslow] 0.31 mm in depth." On or about August 3, 2000, you operated on Patient 2's neck, inappropriately indicating your pre-operative diagnosis to be malignant melanoma *in situ*. Furthermore, the removal you performed as described in the operative report was inadequate treatment for malignant melanoma Clark's level II, 0.31 mm depth. Further, you failed to document the depth of tissue removed and the orientation of the presumed ellipse. Additionally, you failed either to perform or to document any vital signs for Patient 2 at the time of surgery, the volume and concentration of lidocaine used to anesthetize Patient 2, or an indication of whether epinephrine was used, all of which is crucial data given Patient 2's hypertensive history and the size of the lesion.
- (c) On or about September 5, 2000, you treated Patient 3, a 63-year-old man, for multiple skin lesions. You identified the left posterior auricular zone as possibly "seb derm or another malignancy" and you prescribed a mild cortisone cream, which normally would clear seborrheic dermatitis. However, you failed to re-evaluate the area subsequent to the cortisone treatment to determine if there was an underlying neoplasia. Further, you failed to treat and/or diagnose the area for five months despite treating other much smaller skin cancers on Patient 3 during this five-month period. On or about February 2, 2001, you performed a biopsy on the left posterior auricular area, which revealed "Bowen's disease with superficial squamous cell carcinoma." Patient 3 was referred for surgery, performed on or about March 13, 2001, which identified an "extensive deeply spreading tumor requiring two large stages yielding a post op size of 6 x 5 cm."

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.”

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/blt

Enclosures

CERTIFIED MAIL # 7000 0600 0024 5143 0002
RETURN RECEIPT REQUESTED

CC: Stanley Dritz, Esq.
50 W. Broad Street
Columbus, Ohio 43215

CERTIFIED MAIL # 7000 0600 0024 5143 0019
RETURN RECEIPT REQUESTED