State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

July 12, 2023

Katharine Roxanne Grawe, M.D.
3982 Powell Road, Suite 127
Powell, OH 43065

RE: Case No. 22-CRF-0220

Dear Dr. Grawe:

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 July 12, 2023, 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. Any such appeal must be filed in accordance with all requirements specified in Section 119.12, Ohio Revised Code, and must be filed with the State Medical Board of Ohio and the Franklin County Court of Common Pleas within (15) days after the date of mailing of this notice.

THE STATE MEDICAL BOARD OF OHIO

Kim G. Rothermel, MD/sme

Kim G. Rothermel, M.D.
Secretary

KGR:jlm
Enclosures

CERTIFIED MAIL NO 9402 8149 0315 2968 0270 99
RETURN RECEIPT REQUESTED

Cc: **Mailed USPS**
Sabrina S. Sellers, Esq.
Zachary R. Hoover, Esq.
POLING
300 East Broad Street, #350
Columbus, OH 43215

Mailed 7/13/23

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, Esq., State Medical Board Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 12, 2023, 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 Katharine Roxanne Grawe, M.D., Case No. 22-CRF-0220 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.

Kim G. Rothermel, M.D.
Secretary

(SEAL)

July 12, 2023
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 22-CRF-0220
Katharine Roxanne Grawe, M.D.	*	

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on July 12, 2023

Upon the Report and Recommendation of R. Gregory Porter, Esq., State Medical Board 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. **PERMANENT REVOCATION:** The license of Katharine Roxanne Grawe, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

B. **FINE**: Within thirty days of the effective date of this Order, Dr. Grawe shall remit payment in full of a fine of four thousand and five hundred dollars ($4,500.00). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

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

Kim G. Rothermel, MD/smc

Kim G. Rothermel, M.D.
Secretary

(SEAL)

July 12, 2023
Date

State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF JULY 12, 2023 IN THE MATTER OF KATHARINE ROXANNE GRAWE, M.D.

.....

REPORTS AND RECOMMENDATIONS

Dr. Johnson asked the Board to consider the Report and Recommendation appearing on the agenda: Katharine Roxanne Grawe, M.D.; Rudel Anton Saunders, M.D.; Jordan P. Fitzpatrick, L.M.T.; Mahogney Freeman; Jan. A. Pijanowski, M.D.; LaToya Marie Smith, M.T.; and Eric David Thomas, M.D.

Dr. Johnson asked all Board members the following questions:

1.) Has each member of the Board received, read and considered the Hearing Record; the Findings of Fact, Conclusions and Proposed Orders; and any objections filed in each of the Reports and Recommendations?

2.) Does each member of the Board understand that the Board's 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 or Permanent Denial?

3.) Does each member of the Board understand that in each matter eligible for a fine, the Board's fining guidelines allow for imposition of the range of civil penalties, from no fine to the statutory maximum amount of $20,000?

ROLL CALL:

Mr. Giacalone	- aye
Dr. Reddy	- aye
Dr. Lewis	- aye
Dr. Feibel	- aye
Mr. Gonidakis	- aye
Dr. Kakarala	- aye
Ms. Montgomery	- aye
Dr. Boyle	- aye
Dr. Bechtel	- aye
Dr. Johnson	- aye

In accordance with the provision in Ohio Revised Code 4731.22(F)(2), 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 any disciplinary matters. In the disciplinary matters before the Board today, Dr. Rothermel served as Secretary and Mr. Giacalone served as Supervising Member. In addition, Dr. Bechtel served as Secretary and/or Supervising Member in the matter of Dr. Grawe.

During these proceedings, no oral motions may be made by either party.

.....

Katharine Roxanne Grawe, M.D.

.....

Dr. Reddy moved to approve and confirm the Proposed Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Dr. Grawe. Dr. Kakarala seconded the motion.

.....

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

ROLL CALL:	Mr. Giacalone	- abstain
	Dr. Reddy	- aye
	Dr. Lewis	- aye
	Dr. Feibel	- aye
	Mr. Gonidakis	- aye
	Dr. Kakarala	- aye
	Ms. Montgomery	- aye
	Dr. Boyle	- aye
	Dr. Bechtel	- abstain
	Dr. Johnson	- aye

The motion to approve carried.

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 22-CRF-0220
Katharine Roxanne Grawe, M.D.,	*	
		Hearing Examiner Porter
Respondent.	*	

ERRATA FOR REPORT AND RECOMMENDATION

After filing the Report and Recommendation in this matter, errors were discovered in three paragraphs of the Summary of the Evidence which incorrectly identified a hospital. The corrected paragraphs are set forth below with the corrected information in **bold:**

SUMMARY OF THE EVIDENCE

274. With respect to the December 12, 2021, early morning telephone conversation between the **Riverside** plastic surgeon and Dr. Grawe, Dr. Surfield testified that the OSU physician had called Dr. Grawe to find out what has already been done with Patient 3. According to his notes, "[h]e was told that it was likely not related to the surgery at all because she had already had her implants removed and already had drains in place." (Tr. Vol II at 109, 112; St. Ex. 3a at 47-48)

    With respect to Dr. Grawe's testimony that anyone would have known that this patient's implants had not been removed, Dr. Surfield testified that the **Riverside** plastic surgeon's initial consultation with Dr. Grawe was over the phone before he had seen the patient himself." (Tr. Vol II at 110)

275. Dr. Surfield testified that he did not find documentation of Dr. Grawe's conversation with the **Riverside** plastic surgeon in Dr. Grawe's medical record for Patient 3. (Tr. Vol II at 113)

* * *

277. Dr. Surfield testified that the **Riverside** plastic surgeon "removed the implants on both sides, removed the mesh from both sides and then washed out the pocket and removed some non-viable tissue." (Tr. Vol II at 114)

R. Gregory Porter
Hearing Examiner

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 22-CRF-0220
Katharine Roxanne Grawe, M.D.,	*	
		Hearing Examiner Porter
Respondent.	*	

REPORT AND RECOMMENDATION

Basis for Hearing

In a Notice of Summary Suspension and Opportunity for Hearing dated November 18, 2022 ("Notice"), the State Medical Board of Ohio ("Board") notified Katharine Roxanne Grawe, M.D., that, pursuant to Ohio Revised Code Section ("R.C.") 4731.22(G), the Board had adopted an Entry of Order summarily suspending her license to practice medicine and surgery in the State of Ohio. In addition, the Board notified Dr. Grawe that it proposed to determine whether to take disciplinary action against her license based on allegations that, from in or around May 2020 through March 2022, Dr. Grawe provided care in the routine course of her practice at her office setting, Roxy Plastic Surgery, to three patients identified on a confidential Patient Key, and that she inappropriately treated and/or failed to properly treat and/or failed to appropriately document her treatment of these patients. The Board further alleged that such conduct, individually and/or collectively, constitutes one or more of the following:

- "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 R.C. 4731.22(B)(6).

- "[V]iolating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in R.C. 4731.22(B)(20), to wit:

    - Ohio Administrative Code ("Rule") 4731-25-02(H), Office-Based Surgery - General Provisions.

    - Rules 4731-25-05(B)(7), 4731-25-05(B)(8), 4731-25-05(C), and/or 4731-25-05(E), all concerning Liposuction in the Office Setting.

Accordingly, the Board advised Dr. Grawe of her right to request a hearing and received her written request on December 1, 2022. (State's Exhibits ("St. Exs.") 10a, 10b)

Appearances

Dave Yost, Ohio Attorney General, and Melinda R. Snyder and Kyle C. Wilcox, Assistant Attorneys General, for the State of Ohio. Sabrina S. Sellers and Zachary R. Hoover, Esqs., on behalf of Dr. Grawe.

Hearing Dates: May 15 through 19, 2023

PROCEDURAL MATTERS

1. Portions of Hearing Transcript Volume III at pages 6 and 7 were redacted to protect the identity of a patient. The original, unredacted transcript is sealed from public disclosure.

2. At the close of the hearing on this matter, the record was held open until May 22, 2023, to allow time to redact two State's exhibits that included protected and/or irrelevant information. Those exhibits were marked State's Exhibit 5 Redacted and State's Exhibit 8 Redacted and admitted to the record as public exhibits effective May 22, 2023. The hearing record closed at that time.

SUMMARY OF THE EVIDENCE

All exhibits and the transcript 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

1. Katharine Roxanne Grawe, M.D.,[1] obtained her medical degree in 2005 from the University of Texas Medical Branch in Galveston, Texas. From July 2005 through June 2010, Dr. Grawe completed a combined residency in general surgery and plastic surgery, general surgery from 2005 through 2008 and plastic and reconstructive surgery from 2008 through 2010. Dr. Grawe was certified by the American Board of Plastic Surgery from 2014 until her license was summarily suspended in November 2022. (Respondent's Exhibit ("Resp. Ex.") F; Hearing Transcript Volume I ("Tr. Vol I") at 41-47)

2. Dr. Grawe was first licensed to practice medicine and surgery in Ohio in November 2009. Her license is currently inactive as a result of the November 18, 2022 summary suspension of her license. (Ohio eLicense Center, https://elicense.ohio.gov/oh_verifylicense, search terms "Grawe" and "Katharine," accessed May 26, 2023)

---

[1] Dr. Grawe goes by her middle name, Roxanne. (Tr. Vol I at 39)

3. Dr. Grawe testified that she does not hold medical licensure in any other state but Ohio. (Tr. Vol I at 40)

4. Since completing her residency, Dr. Grawe has practiced in the following settings, all in the central Ohio area:

Practice Name	**Dates**
OSU Community Plastic Surgery Teaching Faculty	08/2010 – 08/2012
Medical Director – Breast Services, Mt. Carmel Health System	10/2011 – 2017
Midlevel Training Mentor • Provide Mentoring and Shadow Experience in Office and OR for PA Students, and High School Students	08/2011 – 11/2022
Roxy Plastic Surgery	09/2012 – 11/2022

(Resp. Ex. F)

In addition, Dr. Grawe noted in her curriculum vitae that she served as vice-president for the World Association of Gluteal Surgeons from January 2019 until November 2022. (Resp. Ex. F)

5. Dr. Grawe acknowledged that she did not complete a full general surgery residency. With respect to the combined residency program she completed, Dr. Grawe testified that that is a common track for medical school graduates to take in order to become plastic surgeons if they are already dedicated to doing plastic surgery. (Tr. Vol I at 43) Dr. Grawe further testified, "Typically the people who do [full] general surgery residencies don't know that they're going in to plastic surgery at first or they don't get into the combined programs, and that's their way to get into plastic surgery." (Tr. Vol I at 41)

6. Dr. Grawe testified that, earlier in her career, she had performed reconstructive surgery for breast reconstruction and maxillofacial reconstruction after trauma, and she served as the medical director of breast services at Mt. Carmel. She discontinued accepting insurance and focused on cosmetic surgery beginning in 2017. (Tr. Vol I at 45)

7. Dr. Grawe testified that she had started her own practice, Roxy Plastic Surgery, in Powell, Ohio, in 2012. (Tr. Vol I at 46-47) When asked why she started her own practice, Dr. Grawe testified:

> I had three really young kids. I had been on bedrest for a year. I had a four year old, a two year old, and a newborn, and I was driving all over the world, pumping breast milk while I drove, and I was not able to have the career or

> the family life that I thought I wanted, so I started Roxy Plastic Surgery in 2012 at a location that was very close to my house so that I could see my kids more and take control over my hours working and how the business was run.

(Tr. Vol I at 46)

8. Dr. Grawe testified that, until her license was summarily suspended, she had held hospital privileges at Mt. Carmel St. Ann's hospital ("St. Ann's"). (Tr. Vol I at 47)

Procedures Dr. Grawe Performs

9. Dr. Grawe testified that she practices plastic surgery primarily on the breast, abdomen, buttocks, thighs, and arms, including Brazilian butt lifts ("BBL"). Dr. Grawe testified that she does less face work, and she does not currently perform facelifts although she did them in the past. (Tr. Vol I at 48)

   Dr. Grawe testified that she also performs fat grafting on breasts as well as correcting contouring abnormalities from another surgeon's plastic surgery where there's a divot. Dr. Grawe described other procedures she performs such as breast augmentation, mastopexy, breast reductions, abdominoplasty, upper blepharoplasty, and labiaplasty. She also performs Renuvion J-Plasma procedures. Additionally, she performs minor office procedures such as earlobe repairs and administering injectables. (Tr. Vol I at 49, 57)

10. Dr. Grawe described Renuvion J-Plasma:

> That is a device that uses helium which is converted to plasma energy. So plasma is -- you know the states of matter are solid, liquid, gas. Plasma is another state of matter, and it both heats and cools the tissue at the same time below the skin, and so it helps with tissue contraction.

(Tr. Vol I at 147) Dr. Grawe further testified that, cosmetically, it contracts the tissue toward the patient's body. Dr. Grawe testified that she referred to tissue contraction rather than skin tightening "because you're not truly treating the skin. You're treating the subcutaneous tissue, and so we call it tissue contraction." (Tr. Vol I at 148) Dr. Grawe testified that, by "tissue," she is referring to "really anything below the skin; so it can include the fat, and there's connective tissue in that layer. There's something called Scarpa's fascia, which is a strong connective tissue." (Tr. Vol I at 148)

11. Dr. Grawe testified that she had likely performed procedures on about 5,500 patients in the preceding five years. (Tr. Vol I at 66) Dr. Grawe further testified that she typically performs two to five surgeries per day depending on the complexity of the procedures. (Tr. Vol I at 70)

12. When asked if there are criteria that would exclude a patient from having a procedure performed in her practice, Dr. Grawe testified:

> [S]ince we are doing only completely elective surgeries, I have some strict criteria before we'll even consider surgery in any way, and that is that patients are between 18 and 45. At one point it was 50, and we moved it down. Their BMI has to be -- and really, that is because as we get older, there are higher risks of heart or lung problems associated with anesthesia, and I just don't -- I'm trying to mitigate risks with these patients in elective surgeries. I want their BMI, which is the body mass index, to be 30 or below, and that is also based on the literature that doing an operation with a BMI above 30 greatly increases your risk of wound healing problems, infection, heart or lung complications, and specifically DVT, which can lead to a pulmonary embolism. We also do not operate on nicotine users. So we actually test people for nicotine the day of surgery, and if their test is positive, we'll just cancel their surgery right then, and that is because nicotine restricts your blood vessels so much that it does not allow the antibiotics to get that area, the healing itself to get to that area, and it greatly increases your risks of infection and wound healing problems. We don't operate on diabetics also because it's a high increase of wound healing problems and other complications from surgery. I'm trying to think of what the rest of my criteria is.
>
> Either way, we have all of our -- all of our patients also be evaluated by a primary care physician, because I also never want someone to think that I'm trying to do their surgery without -- like I'm trying to move them through the system and do more surgeries. I really want them to have the safest outcome, so those patients are always seen and cleared by a primary care surgeon -- or primary care physician who -- and they must be at a low risk for surgery, deemed at a low risk, or if they're at a higher risk or medium risk for surgery, then they need to do whatever it takes to be at a low risk or not do their surgery, meaning if somebody needed to control their blood pressure, we would get that under control before we would reevaluate them.
>
> I also have certain criteria for certain surgeries, so I get a hemoglobin level on anyone who is doing liposuction or is a massive weight loss patient and has had bariatric surgery because they might have a lower iron level, and I also do a prealbumin tests on patients who are having a lot of incisional surgery and/or a massive weight loss patient and can't absorb the protein, because that also lends itself to poor wound healing. Then the final look is the anesthesia provider on the day of surgery who does an evaluation and will cancel patients if they don't deem them good for this operation.

(Tr. Vol I at 71-73)

13. Dr. Grawe testified that she has a two-year wait list for her surgical practice. She further testified that she had been taking new patients up until the time her license was summarily suspended. However, Dr. Grawe noted that her practice had begun decreasing the number

of patients they would schedule out last summer "because it was getting difficult for me to go on a family trip two years from now or go take my daughter to college visits or whatnot, so we were slowing down how far out we were scheduling * * *." (Tr. Vol I at 98)

14. Dr. Grawe testified that she charges for each procedure she performs but that she has a flat fee for each procedure. (Tr. Vol I at 92-93)

Staff

15. Dr. Grawe testified that when she first opened her practice in 2012 her staff consisted of an office manager and patient coordinators, then she added a physician assistant a couple years later. In 2020 she added another physician, Dr. Carlos Domingo, to her staff to provide postoperative care while Dr. Grawe was in the operating room. Dr. Grawe further testified that Dr. Domingo has a background in general surgery and that she trained him on the specifics of her office. She added a licensed nurse practitioner to her staff as well, Tia Cela, who also provides postoperative care. (Tr. Vol I at 49-53) As of 2022, she had 20 people on staff. This included Dr. Domingo and the nurse practitioner, an office manager, front desk people, two patient coordinators, two individuals who worked in the med spa, an aesthetician, two social media staff, and then the surgical staff including a circulating nurse, director of nursing, and a recovery room nurse. (Tr. Vol I at 64-65, 95)

Dr. Grawe testified that she has never directly employed an anesthetist and that she always contracts for anesthesia care. (Tr. Vol I at 64)

Dr. Grawe's Facility

16. Dr. Grawe testified that she owns the building where she practices. She described the facility:

> When you walk through the front door there's the reception area and the waiting room, and then the first part of the office is the office where we have six patient rooms, and then there's the back office of -- the physician offices and the staff rooms, and then there is the surgery center, which has a two-bay recovery room and the actual operative suite.

(Tr. Vol I at 58-59) She also testified that she has a separate entrance in the back that allows patients to leave the recovery room into their car. (Tr. Vol I at 59)

17. Dr. Grawe testified that her facility has all the typical ambulatory surgery center equipment including "[t]he anesthesia machine, the anesthesia cart, of course all of our surgical instrumentation, as far as Bovies and liposuction machines." She further testified that she has "the SCD machine, Bair Huggers, fluid warmers, all those things." Moreover, when asked if she has any lifesaving equipment, Dr. Grawe testified, "We have all the typical things, the anesthesia machine, the Ambu bags. We have a malignant hypothermia cart.

We have a crash cart. We have a generator which keeps the electricity on in that area in case we should lose electricity." (Tr. Vol I at 60)

Expert Witnesses

Gregory A. Surfield, M.D.

18. Gregory A. Surfield, M.D., obtained his medical degree in 2001 from the Northeastern Ohio University College of Medicine. From 2001 through 2006, Dr. Surfield participated in and completed a residency in general surgery at SUMMA Health Systems in Akron, Ohio, and from 2006 through 2009, he participated in and completed a residency in plastic surgery at Loyola University Medical Center in Maywood, Illinois. (St. Ex. 5a; Tr. Vol II at 6-9)

    Dr. Surfield was first licensed to practice medicine and surgery in Ohio in 2005. His license is currently active. Dr. Surfield testified that he is currently licensed in no other states although he has a lapsed Illinois license from his earlier training at Loyola. (Tr. Vol II at 6, 11; Ohio eLicense Center, https://elicense.ohio.gov/oh_verifylicense, search terms "Surfield" and "Gregory," accessed June 4, 2023)

    Dr. Surfield testified that he is certified by the American Board of Surgery and by the American Board of Plastic Surgery. (Tr. Vol II at 12; St. Ex. 5a)

19. After completing his plastic surgery residency in 2009, Dr. Surfield was employed by the Firelands Physician Group which is associated with the Firelands Regional Medical Center in Sandusky, Ohio ("Firelands"). Starting out, he was the only plastic surgeon within a 30 or 40 mile radius. Dr. Surfield testified that, starting off after residency, "it was nice having that backup of having the hospital support for the administrative aspects of my practice." (Tr. Vol II at 16)

    Dr. Surfield testified that he continued practicing with Firelands Physician Group until January 2019 when he transitioned from being employed to private practice. Dr. Surfield testified that he did so to take more control over his practice and expand it. (Tr. Vol II at 17) Dr. Surfield further testified that he did not even change his practice location, he "just switched from being an employee to being a renter." (Tr. Vol II at 18) Dr. Surfield testified that he no longer performs hand surgery or microsurgery, but he does a lot of reconstructive surgery as well as cosmetic surgery. He estimated about a 50/50 split between reconstructive and cosmetic surgery. (Tr. Vol II at 18)

20. In his cosmetic surgery practice, he performs "cosmetic breast surgery, body contouring; so liposuction, abdominoplasty. I do cosmetic face surgery as well, rhinoplasty, face lifts, blepharoplasty, brow lifts. I mean, most aspects of plastic surgery I still perform." (Tr. Vol II at 19) Dr. Surfield testified that he does not perform large volume gluteal augmentation, but he performs fat grafting of breasts as well as small volume grafting of the buttocks. (Tr. Vol II at 19)

21. Dr. Surfield testified that he does not perform Brazilian butt lifts because he does not do the large volume fat grafting. Dr. Surfield defined "large volume" as 100 ccs or more. Dr. Surfield testified that Brazilian butt lift "was a surgery I decided the mortality rate was too high for me to, in good conscious, do on my own." (Tr. Vol II at 20)

22. Dr. Surfield testified that he is aware that BBL has a lower mortality rate than abdominoplasty as long as the grafted fat is not being placed into the muscle. However, "like I said, the task force has determined that a majority of people do not actually know where the fat is actually going and they've recommended people that use the ultrasound to determine where that fat is being grafted." (Tr. Vol II at 182)

23. Dr. Surfield testified that he has gone to lectures and received training concerning BBLs but no intraoperative training. (Tr. Vol II at 181)

24. Dr. Surfield further testified that he does not perform Renuvion J-plasma procedures because he does not have that technology. (Tr. Vol II at 120-121)

25. Dr. Surfield testified that he performs larger procedures either at the hospital or at Erie Shores Surgery Center ("Erie Shores"). Dr. Surfield testified that Erie Shores is licensed by the Ohio Department of Health ("ODH"). (Tr. Vol II at 22) Dr. Surfield testified that a majority of the surgeries he performs are done on an outpatient basis. (Tr. Vol II at 23)

26. Dr. Surfield testified that he has full privileges at Firelands, which is his primary hospital. He further testified that he also has courtesy privileges at Magruder Hospital and Fisher-Titus Medical Center. (Tr. Vol II at 23) Dr. Surfield testified that "courtesy privileges are not full-time staff. So I don't have to attend meetings or take call, but I'm allowed to operate there at a certain number of cases per year. I have limited admitting privileges as well." (Tr. Vol II at 23)

27. Dr. Surfield testified that he serves as an assistant professor for Ohio University. Medical students rotate through his practice, and family practice residents rotate through his practice as well. He also has ENT resident come for his head and neck cases. (Tr. Vol II at 24)

28. Dr. Surfield testified that medical charting is very important in the practice of surgery and plastic surgery:

> That's the official record of the patient. I mean, that documents everything that you've done, that documents the progress of the patient. You know, when it comes back to, you know, looking back at the patients -- you know, if they come back in three years, that's your record of what's -- of what happened, and that's, you know, the record that can be transferred out to other people to see what you did or what they -- or what other people have done with this patient in the past.

(Tr. Vol II at 27)

29. Dr. Surfield testified that he performs 50 to 75 abdominoplasties per year, around 30 to 50 mastopexies per year, 10 to 30 breast augmentation revisions per year, and from 50 to 75 breast reductions per year. In total, Dr. Surfield testified that he performs around 1,000 procedures per year, and about 500 of those are reconstructive rather than cosmetic procedures. (Tr. Vol II at 30-31, 121-122)

    Dr. Surfield acknowledged that, if Dr. Grawe is performing 1,000 breast augmentations per year, then her performs .02 percent of the breast augmentations that Dr. Grawe performs.[2] (Tr. Vol II at 122)

30. Dr. Surfield testified that the complications of liposuction include fluid shifts, lidocaine toxicity, blood clots including DVT and pulmonary embolism, damage to other structures including intra-abdominal injuries, as well as complications not specific to liposuction such as bleeding, infection, heart and lung issues, and anesthesia related issues. (Tr. Vol II at 27-28)

31. Dr. Surfield testified that he was informed by Board staff that Dr. Grawe performed the procedures he reviewed in an office-based setting rather than an ambulatory surgery center. Dr. Surfield testified that he has no independent knowledge of Dr. Grawe's practice setting. (Tr. Vol II at 125)

32. Dr. Surfield testified that his office is on the campus of the Firelands hospital, and that is where he performs most of his surgeries. He testified that he performs only a small percentage of his procedures—less than one percent—in an ambulatory surgery center. (Tr. Vol II at 125-126)

33. Dr. Surfield testified that he has never owned or operated an ambulatory surgical facility and has no knowledge of the technical requirements for licensure such a facility and vague knowledge concerning credentialing one. (Tr. Vol II at 126-127)

34. Dr. Surfield testified that, as a surgeon, he has experienced complications in his patients over time including infections and hematomas in the breasts and abdomens. (Tr. Vol II at 157)

Lloyd Krieger, M.D.

35. Lloyd Krieger, M.D., testified as an expert witness on behalf of Dr. Grawe. Dr. Krieger obtained his medical degree in 1994 from the University of Chicago Pritzker School of Medicine. While attending medical school, in 1992, Dr. Krieger obtained an MBA and a Certificate in Health Administration, both from the University of Chicago. From 1994 through 1998, Dr. Krieger participated in a general surgery residency at UCLA Medical

[2] According to the hearing examiner's math, 20 is actually 2 percent of 1,000.

Center, and from 1998 through 2001 he participated in a plastic surgery residency at the same institution. From 2001 until the present, Dr. Krieger has been engaged in the practice of plastic surgery in Beverly Hills, California. (Tr. Vol IV at 5, 12; Resp. Ex. G)

Dr. Krieger testified that his postgraduate training at UCLA was actually a combined, single-track program that took seven years to complete. He believes than most of the programs have moved to that model during the last 20 years. (Tr. Vol IV at 6)

36. Dr. Krieger is certified by the American Academy of Aesthetic Medicine. (Resp. Ex. G)

Dr. Krieger acknowledged that he is not certified by an ABMS member board. He testified:

> Well, the program I was in did not allow me to apply for general surgery because it was a combined single step program.
>
> Plastic surgery, I took the written test and I passed it, and then for the oral test they use a case list.
>
> My case list was found to be insufficient -- insufficiently diverse, I should say. And then I got busy. It seemed inconvenient to be flying to Houston for all those days. Got married. And there was a Board that was in California that seemed similar enough that I executed that one.

(Tr. Vol IV at 153-154)

Dr. Krieger testified that he was certified by the American Academy of Aesthetic Medicine. Dr. Krieger testified that, in his opinion, the is equivalent to the American Board of Surgery and the American Board of Plastic Surgery. (Tr. Vol IV at 154-157)

37. Dr. Krieger testified that he is licensed to practice medicine in California and New York. (Tr. Vol IV at 7)

38. Dr. Krieger testified that he is currently peer-reviewing for the Journal of Plastic and Reconstructive Surgery, and that he has also been asked to review papers for the Journal of the American Medical Association and the Journal of Bone and Joint. (Tr. Vol IV at 7)

39. Dr. Krieger described his practice location:

> It's called Rodeo Drive Plastic Surgery, and for about 17 years I had a big center on Rodeo Drive that, by our standards, was large.
>
> It was 5,500 square feet, it had an attached surgery center with two operating rooms. And in addition to my personal practice I had other surgeons using my outpatient surgery center for their surgeries, so it was a busy operation.

(Tr. Vol IV at 12)

Dr. Krieger testified that he no longer has the surgery center, "My lease was up about three years ago and I chose not to continue it, mostly because of the price increases of the real estate, and it just did not seem viable, and so now I use basically two outpatient surgery centers in Beverly Hills, and then sometimes a hospital." (Tr. Vol IV at 13) Dr. Krieger further testified that he is familiar with the credentialing, accreditation, and licensing of ambulatory surgical centers. (Tr. Vol IV at 14)

40. Dr. Krieger has hospital privileges at Cedars Sinai Medical Center and Northridge Hospital. (Tr. Vol IV at 13)

41. Dr. Krieger testified that Beverly Hills is the unofficial plastic surgery capital of the world, "for better and for worse." (Tr. Vol IV at 10) Dr. Krieger explained:

> Well, it's kind of like a Silicon Valley plastic surgery, there's a lot of innovation that goes on, mostly because there is a density of plastic surgeons that are in communication driving the specialty forward to a degree.
>
> For worse, it's a very competitive environment, and it's -- it's a bit of a magnet for people around California, and really around the world, which is good, but can also bring with it unrealistic expectations of miracles that simply can't be performed by the specialty.

(Tr. Vol IV at 10-11)

42. Dr. Krieger testified that it is important for plastic surgeons, and one of the larger challenges of their profession, to try to establish realistic expectations for outcomes among their patients. (Tr. Vol IV at 11-12)

43. Dr. Krieger testified that his practice focused on body contouring, including liposuction and tummy tucks. He further testified:

> I do a lot of breast surgery, whether it is augmentations or revisions to previous augmentations. And for many years that was really the main focus of my practice.
>
> As I've aged now I'm aging into a slightly different population of patients that might be getting facial surgery, which tends to skewed a little bit more now to my age group, so my practice has become a bit more diverse probably in the last five years, but it still skews towards body surgery, tummy tucks, liposuction, Brazilian Butt Lifts and breast surgery.

(Tr. Vol IV at 15)

Moreover, Dr. Krieger testified that he performs mastopexies and revision mastopexies. (Tr. Vol IV at 15-16)

44. Dr. Krieger testified that he performs approximately 80 BBLs per year. Dr. Krieger further testified that he does about 40 breast implant revisions or mastopexy per year. He testified that he performs approximately 150 liposuction procedures per year. (Tr. Vol IV at 17-18)

45. Dr. Krieger does not perform Renuvion J-plasma procedures himself but testified that he has observed it being used and is familiar with it. (Tr. Vol. IV at 17)

46. Dr. Krieger testified that he does perform reconstructive surgeries in his practice but 85 to 90 percent of his practice is cosmetic surgery. (Tr. Vol IV at 18)

47. Dr. Krieger testified that, when he reviewed the material in this case, he initially received only Dr. Grawe's medical records for Patients 1, 2, and 3. He did not at that time receive information concerning Dr. Surfield's opinion or the Board's allegations. Dr. Krieger testified that one can become somewhat biased otherwise. (Tr. Vol IV at 18-19) Dr. Krieger further testified:

> The task that you assigned me was to evaluate the standard of care and whether Dr. Grawe complied to it -- with it, and that is determined by the care that she delivered.
>
> People can have perfect care and have a very negative outcome, unfortunately. They can have -- they could have mediocre care and have a great outcome. So by not having any information except what Dr. Grawe did, there was no introduction of any sort of bias in my understanding of what Dr. Grawe did.

(Tr. Vol IV at 19-20)

Dr. Krieger further testified that, prior to learning about the allegations against Dr. Grawe, he had formed an opinion that Dr. Grawe's treatment of Patients 1, 2, and 3 complied with the standard of care. (Tr. Vol IV at 20) Dr. Krieger further testified that his opinion did not change after learning of Dr. Surfield's opinion and the Board's allegations. (Tr. Vol IV at 21)

48. Dr. Krieger testified that he eventually reviewed a number of items in preparing his written report. These include:

- Complete sets of the State's and Respondent's exhibits, including the patient records
- Dr. Grawe's AAASF and AAAHC certificates for the years she operated an ambulatory surgical facility
- Dr. Surfield's written report
- Dr. Grawe's written report and curriculum vitae

- Videos provided by the State and the Respondent

(Tr. Vol IV at 8-9)

49. Dr. Krieger testified that, prior to giving testimony in this matter, he had never met or spoken to Dr. Grawe. (Tr. Vol IV at 24)

50. Dr. Krieger testified that he has never practiced in Ohio. (Tr. Vol IV at 157)

51. Dr. Krieger testified that, in the last ten years, he has testified in two trials and about eight depositions. He further testified, however, that he has been hired around 35 to 40 times during that period. Dr. Krieger further acknowledged that his LinkedIn page indicates that he is a plaintiff and defense expert for malpractice, product liability, and nursing homes. (Tr. Vol IV at 159-160)

52. Dr. Krieger testified that he is familiar with the adage that if something was not documented in the medical record then it was not done. (Tr. Vol IV at 166)

53. Noting that prior testimony indicates that Dr. Grawe has performed 5,500 procedures over the last five years, or an average of 1,100 procedures per year, Dr. Krieger testified, "That is a busy practice. I would say unusually busy, but by no means unheard of. I have not done that many in a year since I was a resident." (Tr. Vol IV at 168-169)

Ambulatory Surgery Facility Licensure

54. Dr. Grawe testified that she did not know until she received the Board's Notice that she had needed an ambulatory surgery facility license issued by the ODH. (Tr. Vol I at 61, 118-119) She further testified:

> Actually, I did not know that I needed that, and I was under the understanding that the AAAASF accreditation was -- my certificate says," Ambulatory Surgery Center," and I believed at that point that I was doing everything correct to have the right things in place and the safety measures in place to act as an ambulatory surgery center, and I believed at that point that the office-based regulations were for truly people doing surgery in the office-based setting, in an office room, meaning -- in my residency we talked about this a lot, but there are non-plastic surgeons, Ob/Gyns, family practice doctors who do liposuction in their actual office, in an actual office room, and I believed that those regulations were based for that sort of setting. I in no way thought that I was operating in an office-based setting and was under those regulations, and if I ever had known at any point, I would have rectified that, because I wasn't trying to sneakily do cases in my office. I wasn't trying to save $300. I was trying to do everything the right way. I just actually didn't know about that one license.

(Tr. Vol I at 61-62)

55. Dr. Grawe testified that she is now aware that when you have an ambulatory surgical facility ("ASF") license from ODH, then ODH will perform an annual survey of the facility. She further testified that "we actually have a business that was helping us become accredited with AAAASF,[3] who does a quarterly assessment of us, and then of course we're evaluated by AAAASF every time we need to get reinstated. So, of course we would be happy to have that annual evaluation." (Tr. Vol I at 63, 118-119)

56. When asked if she has researched what is required to obtain the ODH license, Dr. Grawe testified:

> I actually have, and I've looked at what is needed, at the application, and I have everything in place that we need. I have the floor plan, the deed of occupancy. The fire marshal has been out to look at our location. There's one more thing -- oh, and a transfer agreement. We have a transfer agreement with Mount Carmel St. Ann's. So we actually had everything in place and just didn't know to get that license.

(Tr. Vol I at 62)

57. Dr. Grawe testified that, since receiving the Board's Notice, she has not applied for the ODH license because she is currently suspended. (Tr. Vol I at 62)

58. Dr. Grawe agreed that, because she did not have the ODH ASF license, she was working in an office-based facility. (Tr. Vol I at 119) Moreover, Dr. Grawe testified that she understands that she is responsible for maintaining the proper licensure for her practice. (Tr. Vol I at 120)

59. Dr. Surfield opined that not knowing that a particular license is necessary, such as an ASF license from ODH, is not an excuse to fail to obtain such licensure. (Tr. Vol II at 36)

60. Dr. Krieger testified that he was not asked to render an opinion concerning the ASF licensure status of Dr. Grawe's facility, but that he believes, based on a review of her report, she had appropriate third-party accreditation. He further testified that it is his understanding that Dr. Grawe admitted that she had not obtained the proper license from the State of Ohio. (Tr. Vol IV at 26-27)

Dr. Krieger testified that a facility goes through a rigorous review in order to obtain accreditation from the AAAASF and the Accreditation Association for Ambulatory Health Care ("AAAHC"). Moreover, based on a review of Dr. Grawe's accreditation documentation, he believes that Dr. Grawe's facility was accredited for the years 2018 through 2022. Dr. Krieger further opined that, although she lacked the appropriate State license, her facility was fully compliant with the requirements needed to be characterized

[3] The American Association for Accreditation of Ambulatory Surgical Facilities, Inc. (Resp. Ex. L at 2545)

as an ambulatory surgical center. (Tr. Vol IV at 27-35) Dr. Krieger added that he believes the accrediting authorities let Dr. Grawe down by not informing her of the requirement that her facility be licensed by the ODH because "[t]hat's one of the reasons you bring them in, is to cover you for loopholes and for technicalities." They should have been aware, and made Dr. Grawe aware, of the ODH licensure requirement. (Tr. Vol IV at 35-36)

61. Dr. Krieger opined that the lack of ODH licensure did not have any effect on Patient 1's or Patient 2's care or their outcomes. (Tr. Vol IV at 51)

Use of Social Media in Dr. Grawe's Practice

62. Dr. Grawe testified that she has used social media in her practice since 2010. Dr. Grawe further testified that she used it to produce educational videos and posted them mostly to YouTube, Facebook, and Instagram as all the other practitioners do "to show their work to patients and talk about these procedures. (Tr. Vol I at 74)

63. Dr. Grawe testified that she originally set up a Facebook account to educate people about how plastic surgery works and "really prep them on how recovery works." (Tr. Vol I at 79) Dr. Grawe further testified that patients watch television shows that lead them to be unrealistic about their recoveries and believe they can achieve miraculous results. Dr. Grawe testified that she wanted to educate patients that there is a lot involved in the process and that they need to be prepared for it mentally, emotionally, physically, and financially. She also wanted her patients to make choices for themselves and not what another person, such as a spouse, wants them to do. Moreover, Dr. Grawe testified that she wanted to demystify the process and give patients and their families a "peak behind the curtain to be able to see what was going on back there." (Tr. Vol I at 80) Dr. Grawe testified that the families loved being able to see their family member the entire time during the surgeries and to follow along during the procedure. (Tr. Vol I at 80-81)

64. Dr. Grawe testified that she actively tries to gain followers on social media "[j]ust by posting often and being there doing what we do." She further testified that she asks people to subscribe or "like" her channel and that she believes "that's a common thing to say on YouTube." (Tr. Vol I at 84)

65. When it was suggested that Dr. Grawe is not putting complications of procedures on social media, Dr. Grawe testified:

> That's not true. We definitely are. We talk about them, and I'll show on Snapchat a revision; here's a patient who her implant didn't fall despite we did a breast band to push the -- lift that muscle and help push her implant down and it didn't fall and this is what it looks like and this is what the procedure is to change it and here's how we go about doing that, and this is a real thing, you can typically wait up to six months and conservatively treat it with a breast band, but if that doesn't work, it's a very real possibility that you may require another surgery and here is how we do it and here's the cost to

> you and here is how it works and here's the recovery, or a hematoma or these things that happen in plastic surgery. I -- I just tell people. In fact, the YouTube channel is where we talk the most about all the details, and I have really long operations where I basically go through every single complication on the consent form, discuss what it means, what it's like for you, how we try to prevent it, how we treat it if it does happen, the things the patient can do, the things that we can do. I want people to know that stuff.

(Tr. Vol I at 82-83)

66. Dr. Grawe disagreed that she was trying to become "a social media influencer." she testified, "I was setting out to do exactly what I talked about with the education and the empowerment and the demystification." (Tr. Vol I at 85) When asked if she agreed that having more followers made her business more trustworthy, Dr. Grawe answered, "Maybe." (Tr. Vol I at 85) Further, when asked if having a lot of followers makes someone more likely to believe she is a credible surgeon, Dr. Grawe replied, "They might think that I'm a popular surgeon. I hope that I show them I'm an incredible surgeon by showing my work and the way that I educate the patients." (Tr. Vol I at 85-86)

67. When asked whether she thought of "Dr. Roxy" as a persona, Dr. Grawe testified that believes that she was just being herself. Further, when asked if she refers to her patients as "Roxy's Foxies," she testified that her patients "made that up themselves actually." (Tr. Vol I at 86) When asked if that persona led Dr. Grawe to make decisions about patient care that she may not otherwise have made, Dr. Grawe testified:

> Absolutely not. I think, like I said, I was portraying myself, and I am that person. I am outgoing and I am personable to patients, and I am an amazing, hard-working doctor who cares more than any other doctor that I've trained with about how much --how my patients are, how they do. I -- they help with me -- I care about their outcome. I do so many things to -- to provide safety for them, and I think -- I think that what you're asking about is the optics we were talking about. I can see how to people it would look like I was caring more about this or posting a TikTok rather than taking care of a patient, but it never was like that. I -- I go to the OR. I take care of the patient. After the day is done, we're filming something. On a Saturday we're filming something. I was doing it on top of being a surgeon, and I -- I wasn't trying to create some persona. I was being that person who is someone these women could talk to. You know, that is me. I'm not a -- I'm not a paternalistic, white coat, stingy doctor who tells you what you need to have done. I hear patients in my office all the time crying, saying doctor so-and-so down the street, you know, said I need to do all these things and it made me feel worse about myself and about all these things I didn't know I needed to get fixed and it felt like a man was telling me that I should do these things, and while that person was probably a great surgeon and has great ideas, but I -- I was just more

relatable to them being myself so that we could -- so we could discuss those intimate things about what they wanted to have done.

(Tr. Vol I at 86-87) Whereupon, Dr. Grawe was asked:

Q. [By Ms. Snyder] Can you see, looking back, when you look through your Instagram account or TikTok, that while you might have intended it to demystify, maybe you made these surgeries look like they do not have complications or that all of these before and after pictures that you're posting may lead people to believe that, you know, everybody walks out of your office looking like that?

A. I don't -- that was never my intent, and I don't think that I tried to make things look too good to be true, because always I was showing the reality. I mean, those people who have those before and afters are real people that I operated on, that made them look that way, you know, and it's true, not everybody -- there's risks. Things happen. Some of those people I showed might have had a scar that needed to be revised or something like that, but it -- it was never my intent to paint a picture that -- that it sounds like people think I was coercing people to have surgery, you know, or just to come to me and I was going to have this magic wand to make it perfect. I actually never acted like that on my social media.

(Tr. Vol I at 87-88)

68. When asked when she started livestreaming surgeries, Dr. Grawe replied, "We did surgery, which on Snapchat it's not truly livestreamed. It's realtime, so it's videotaped and then posted, but it's not one continuous livestream, and we started that back, like we talked about, maybe 2014 or right around then and have done that consistently. It was only with TikTok that we could livestream the actual surgery." (Tr. Vol I at 88-89)

Dr. Grawe testified that, when one of her surgeries is livestreamed, she performs the procedure as she always would. Another person is actually recording her. (Tr. Vol I at 89-90)

69. Dr. Grawe testified that when she livestreams surgeries on TikTok she interacts with people posting questions. Dr. Grawe testified that the person running it would read the questions or comments to her and she would respond. (Tr. Vol I at 155) When asked if she received a lot of criticism from people concerning the fact she was livestreaming procedures, Dr. Grawe testified, "I think in some of the livestreams we would have 300,000 people watching us, and there would be two people who would say why are you doing this, you know. So anything you do there are people who like it and people that are critical, and the critical people are louder." (Tr. Vol I at 56)

70. When asked if the considered the potential liability of livestreaming surgery and something going wrong, Dr. Grawe testified:

> Sure. I -- it is a liability, and that's why I felt like I was being the most transparent surgeon that ever existed, because I was showing what I just actually really do and not hiding anything, and so, I mean, clearly the liability got me here. You know, I never -- I never would have done that and lost my medical license and my ability to support my family and -- I was really just trying to do good and show the surgeries to people.

(Tr. Vol I at 90)

71. When asked if she had any sponsored posts, Dr. Grawe testified:

> We had -- we didn't have anything that we got paid for, but we did one time do like a -- we were trying to promote, like, a protein, patients to buy a protein, and so we, like, partnered with a company that made protein powder to -- to tell people, like, hey, you should buy protein powder, but we never were paid for any sponsorships or paid by social media or -- we weren't like an influencer who gets free sunglasses and there's the sunglasses to wear.

(Tr. Vol I at 90-91)

72. Dr. Grawe denied that she had any brand partnerships that paid her to use certain products, nor did she do any display advertising for certain products. Dr. Grawe acknowledged that she did sell merchandise associated with her practice such as T-shirts, and that she advertises those items on social media with a link to her practice's website to purchase those items. (Tr. Vol I at 91-92)

Caution Letters

73. Dr. Grawe testified that she had received a letter from the Board dated October 9, 2018. (St. Ex. 8 at 2) Dr. Grawe testified:

> This letter was notifying me that there was a complaint with a specific patient about her injectables, because she signed a consent that said her photos may only become part of her medical chart but said that they were published onto the social media platform, that the Board was not taking formal disciplinary action but cautioning me on the importance of patient privacy.

(Tr. Vol I at 100) Dr. Grawe testified concerning her response:

> I wrote a letter back to the Board explaining that we get that preliminary photo consent, but at that time in my practice we would verbally ask patients if they wanted their procedures filmed, and she said yes, and I explained to the Board

> that this wasn't a secret phone that we hid somewhere, that the patient was actually wanting her procedure filmed and looking at the camera and saying things like I'm so happy I found you guys and that we did not publish any of her photos.

(Tr. Vol I at 100-101) Further, in her November 11, 2018 response to the Board, Dr. Grawe stated, among other things:

> This case feels like a patient who came in for injectables and was upset when she bruised afterwards even though we specifically go over that risk of using needles in the (very vascular) face. She then lashed out against our practice in a very serious manner.
>
> If you or she can find any place that her photo is published that I am unaware of, I would like to be notified so that I can remove it immediately.

(St. Ex. 8 at 3)

74. In a letter to Dr. Grawe dated September 28, 2021, the Board expressed concern that an expert had reviewed videos relating to her treatment and surgeries of patients. (St. Ex. 8 at 6-7) The Board further stated, among other things:

> Following a review of some of the videos, specific matters noted by the expert included dancing to music in the operating room, the music being too loud and interfering with communication between essential operating room personnel, heart-shaped emojis and flame emojis superimposed over patients' genitalia and breasts in digital productions, and writing being imposed on the screen of a Brazilian buttock lift saying, "wake up and kick ass."

(St. Ex. 8 at 7)

The Board further noted that the expert determined that the videos "raised concerns primarily related to professionalism and referenced sections of the American Medical Association's Principles of Medical Ethics.[4] (St. Ex. 8 at 7)

75. Dr. Grawe understood the Board's concerns to be that some of the words and emojis used in the videos were unprofessional, and that the music was too loud in the operating room. Dr. Grawe believes that the Board had been unaware that the music in the videos was added later, after the surgery. Dr. Grawe further testified that she does play music in the OR but not at a volume that would interfere with communication among the surgical staff. Moreover, Dr. Grawe testified that she has never been in an operating room since she was a medical student that did not have music playing. (Tr. Vol I at 102-103)

---

[4] The Board's Notice that gave rise to this matter does not allege any ethical violations. (St. Ex. 10a)

Dr. Grawe testified that she changed her practice after receiving the Board's September 2021 letter. Dr. Grawe said that she began using a Social Media Consent Form so that she would be able to show that a patient had consented to that. (Tr. Vol I at 101) Dr. Grawe further testified that she took a course concerning ethics in social media and reported back to the Board what she had learned. (Tr. Vol I at 101-103) Dr. Grawe further testified that she provided more formal training for her social media staff:

> I have young people working for my social media that may not understand how it reflects on me professionally to use these certain emojis or say words on there, and I'm a little mixed on how I feel about it. So we did have a more formal training with the social media people about what is professional, even up to they would misspell things and that is a way that I don't look professional, because it's a medical word that I should know and things like that and some of these emojis and the things that we say, but a part of me also feels that we're also talking to a demographic who relates to those types of -- that type of language, which may not be what you and I -- how you and I would speak, but is how a 20 year old would understand what we were talking about.

(Tr. Vol I at 103-104)

With respect to the formal training she provided to her social media staff, Dr. Grawe testified:

> Well, we talked about how maybe flames are not an appropriate emoji to use. You have to use some -- we're trying to protect their privacy. We don't have to cover those private areas, but we're trying to, and on your phone you have -- on Snapchat you have certain things that you can use, and so we talked about maybe make a more bland object, so that it doesn't seem to mean anything else besides we're just covering that up, things like that. And we had -- you know, the new people that came in had to go under someone who had been formally trained by that and have things approved by the head of our social media before they were allowed to make decisions on their own. So we -- we tried to tighten up or pull in the reins. The hard part is I'm operating. I'm not approving every single post as it goes up.

(Tr. Vol I at 105)

76. When asked why professionalism is important in the medical profession, Dr. Grawe testified, "Well, I think that we have to be respected and trusted by the public to have them come to doctors and trust doctors." (Tr. Vol I at 106)

77. When asked if a physician might not receive the same level of respect if the physician does not uphold the level of professionalism that the public expects of a physician, Dr. Grawe testified:

> Yes and no, because I think that changes with the demographic. I think, you know, we all grew up without cell phones before, where the 25-year-olds can get instant information, and they're used to seeing these things come quickly and change and certain ways of talking, and they're more -- they more connect with that -- that more relaxed -- let's say it like this, people in the generation who are 80 and 90 wore a hat everywhere they went and wore a suit. Then my husband wore a tie when he first started working, but now nobody wears ties and everybody is more relaxed at a wedding, and things have become more casual, and that doesn't necessarily mean not professional, but it has become a more casual world, and the communication that we're making on social media -- and in no way am I trying to undermine my own authority or professionalism, but it is a method of a more casual conversation, and I think in that way makes it easier for patients, certain patients, not all of them, to communicate with me and be more intimate with me about those medical concerns.

(Tr. Vol I at 106-107)

Roxy Recovery House

78. Dr. Grawe testified that the Roxy Recovery House is a house that patients can use to stay for a few days following surgery away from children and home responsibilities. She testified that it is about a mile and a half away from her practice so patients "can get to us easily if they have any concerns." She has had that or a similar facility since around 2017 although she did not purchase the house until 2018 or 2019. Dr. Grawe further testified that there are two caretakers who staff the house who can assist patients. They at not licensed medical professionals; however, Dr. Grawe testified that they are trained to take care of her patients such as going over postoperative instructions, when to call the office about something, help take them to the bathroom and shower, do their laundry, and cook for them. (Tr. Vol I at 109)

    Dr. Grawe testified that the Roxy Recovery House has three rooms that can accommodate two patients apiece. (Tr. Vol I at 109-110)

79. Dr. Grawe testified that she charges around $300 per night for the Roxy Recovery House. (Tr. Vol I at 110)

80. Dr. Grawe testified that if there is a medical concern, either she or Dr. Domingo will have the patient come to the office. (Tr. Vol I at 111)

Description of Liposuction

Testimony of Dr. Grawe

81. Dr. Grawe testified that liposuction is a procedure to suction out fat to create the contour you're looking for using a cannula, which is a blunt-tipped instrument that has holes in it.

The cannula is inserted underneath the skin through a small incision. Dr. Grawe further testified that liposuction requires tumescent fluid which helps to decrease bleeding and withdraw the fat. Dr. Grawe testified that physicians can use different tools such as laser, ultrasound, or other devices to help liquify the fat for removal. Dr. Grawe testified that she does not use either laser or ultrasound. She uses a MicroAire cannula that has a tip that can vibrate to help withdraw the fat. (Tr. Vol I at 111-114)

82. Dr. Grawe testified that the tumescent fluid infiltrates the fat cells like a sponge and the fat is then extracted out along with the tumescent fluid. (Tr. Vol I at 115)

83. Dr. Grawe testified that, for her tumescent fluid, she uses a gram of Thromboxane, also called TxA, and an "amp" of epinephrine per liter of fluid. Dr. Grawe testified that there are other medications that could be included in tumescent fluid. Dr. Grawe acknowledged that most physicians would record what they use. (Tr. Vol I at 115-116)

84. Dr. Grawe testified that when a patient comes to her asking for liposuction she does a full history and physical examination in her office. Dr. Grawe further testified:

> So we go through their past medical history, their medications, their social history, all those details, and then ask them what they are looking for. Sometimes they'll bring photos, which I like because it helps me know what they're talking about than words, and then I do -- I have them get into a gown, and I look at the body parts that we are operating on, and then we discuss how that operation could go and what we can do and the risks and the benefits and all the alternatives and the plan and the postop care.

(Tr. Vol I at 116-117)

85. When asked if more risks are presented when more fat is taken out, Dr. Grawe testified:

> I don't think so. So in general we talk about staying around 5 liters as an outpatient, because over 5 liters of aspirate tends to be when there are some risks of hemodynamic instability, which means that they can have low blood pressure or require blood products, and that's generally the number plastic surgeons use as an outpatient. The number 4500 to 5 liters. I don't know that there's ever been anything written about increased risks with those numbers.

(Tr. Vol I at 117)

86. Dr. Grawe testified that a fluid imbalance can be caused by liposuction:

> There is something called third spacing. So when you remove -- liposuction, let's say in their abdomen, then you have these broken capillaries from doing surgery and your veins actually put fluid into that area. This happens with any trauma. So when you sprain your ankle and it gets bigger, that's third spacing

> because fluid is going into that area to help heal it, and the same thing happens here. That's how your body heals it, by putting fluid in the area, and so it's -- you can get dehydrated from it, and so, therefore, we have our patients drink actually a gallon of water every day for three days before surgery, because when you come more primed and your gas tank is full, then you have less -- you have less chance of having that instability hemodynamically.

(Tr. Vol I at 118)

87. Dr. Grawe testified that liposuction is a blind procedure, meaning that the surgeon cannot see the exact area she is operating on because it's below the skin. However, the surgeon can palpate the location of the cannula tip. (Tr. Vol I at 120-121) She testified:

> Traditionally, in all plastic surgery residencies we're taught two different techniques to do liposuction, and one is pulling up on the skin so that you have kind of two layers of skin below and doing the cannula through this area,[5] and the other is to put pressure down this way [with her hand laying flat on the patient in the path of the cannula] and have the cannula go below your hand (indicating).

(Tr. Vol I at 121)

88. Dr. Grawe agreed that the standard of care requires the surgeon to maintain awareness of where the cannula tip is. (Tr. Vol I at 122)

89. When asked if there are ever occasions where she feels comfortable pushing the cannula tip through fat without palpating the tip, Dr. Grawe testified that one might be a very thin patient where she can physically see the tip. (Tr. Vol I at 122-123) Another would be "on an area of your body where there's no anatomic structures that you're worried about, so you might just kind of go around that corner." (Tr. Vol. I at 123) Such an area would include the flank/hip area of the side, "you're kind of going around the corner, and you can feel it here and you can see it there, and you're not near large blood vessels, nerves, organs." (Tr. Vol I at 123)

Patient 1

90. Dr. Grawe was asked about the medical records she provided to the Board pursuant to the Board's subpoena, and that it contains 40 fewer pages than the same chart that she provided as a respondent's exhibit for the hearing. (St. Ex. 1b; Resp. Exs. A-1 through A-3) Dr. Grawe testified that she was uncertain whether her office had supplied the Board with the complete record for Patient 1. Dr. Grawe said she is uncertain if she had reviewed the records before they were produced to the Board. Dr. Grawe testified that the task of

[5] Dr. Grawe testified that that technique is referred to as tenting the skin. (Tr. Vol I at 121)

answering the Board's subpoena was delegated to her office manager. (Tr. Vol I at 128-133)

91. Patient 1, a female, first saw Dr. Grawe in February 2018 requesting a Brazilian butt lift, abdominoplasty, and liposuction. She was 47 years old at that time. Dr. Grawe testified that that had been a consultation visit. (St. Ex. 1b at 8-11; Tr. Vol I at 133-134)

92. Patient 1 saw Dr. Grawe again on June 17, 2020, concerning the same procedures. (St. Ex. 1b at 12-16) Dr. Grawe acknowledged that, among the preoperative discussions documented on her progress note for that visit, Dr. Grawe documented, "We discussed that with surgery that is extensive, it is safer to stay in the Recovery House with caregiving help. I require that for my patient's safety. We have arranged for a stay at The Recovery House near our office." (St. Ex. 1b at 15; Tr. Vol I at 135-136) Dr. Grawe testified that staying at the Recovery House is mandatory for some patients as determined by Dr. Grawe on a case-by-case basis. (Tr. Vol I at 136) Dr. Grawe further testified:

> [T]ypically for Brazilian butt lifts, liposuction, combination cases, those are procedures that make people less mobile and less able to take care for themselves and more difficult to be around your family and your kids and so laundry and things like that; so for those I require, if they want to have surgery with me, that they would stay at the recovery house.

(Tr. Vol I at 136)

Dr. Grawe testified that, by the term "extensive" surgery in Patient 1's case, she meant "we're doing surgery on multiple parts of her body, and it reaches a level where I like them to stay at the recovery house." (Tr. Vol I at 136)

July 9, 2020 Surgery ("First Surgery")

93. On July 9, 2020, Dr. Grawe performed liposuction of the upper and lower back, Brazilian butt lift, and abdominoplasty on Patient 1 under general endotracheal anesthesia at Roxy Plastic Surgery. (St. Ex. 1b at 67-68)

94. With respect to the July 9, 2020 pre-op questionnaire for Patient 1's first surgery, Dr. Grawe testified that, on the day of the surgery, a nurse filled out the questions on the left side of the form and the anesthesia provider, in this case a certified registered nurse anesthetist ("CRNA"), filled out the anesthesia evaluation on the right side of the form. The CRNA noted Patient 1's ASA Class to be "3." (Tr. Vol I at 137; St. Ex. 1b at 77)

Dr. Grawe testified that, as a CRNA, the anesthetist worked under Dr. Grawe's supervision. Dr. Grawe noted that, as a midlevel practitioner, a CRNA can work independently, but the physician is ultimately responsible for their performance. (Tr. Vol I at 139) Moreover, Dr. Grawe noted that her signature appears on the preoperative questionnaire below that of the CRNA. (Tr. Vol I at 140; St. Ex. 1b at 77)

95. When asked if, because Patient 1 was an ASA 3, Dr. Grawe could not perform surgery on her in an office-based setting, Dr. Grawe testified, "Two things. One, I was under the impression that I was operating within an ambulatory surgery center, and, two, she, looking at her medical record, does not meet the qualifications to be an ASA 3." (Tr. Vol I at 140)

    Dr. Grawe testified that the ASA class guides the anesthetist and ultimately guides her as well. She further testified that, if the anesthetist had concerns about the patient, then they would tell Dr. Grawe and she would cancel the patient. (Tr. Vol I at 141)

96. On the first page of the anesthesia record an ASA value of "3" is recorded. "Co-Morbidities – diagnosis" listed are "Amlodipine" and "HTN / [illegible - anxiety?]." In addition, the anesthesia medications include Lidocaine. (St. Ex. 1b at 81) Dr. Grawe further testified that she believes that Amlodipine is a blood pressure medication, and that the co-morbid conditions listed are hypertension and anxiety. Moreover, Dr. Grawe testified that neither hypertension nor anxiety would necessitate an ASA level of 3. (Tr. Vol I at 142-144; St. Ex. 1b at 81) However, Dr. Grawe acknowledged that she did not document her disagreement with the ASA level 3 in the medical record, and believes that had been an oversight on her part. (Tr. Vol I at 145) When asked whether the standard of care required her to document that in the medical record, Dr. Grawe testified, "I would never -- never had any intention of doing something against the standard of care or tricking anybody or trying to do surgery on someone who had a higher ASA than we were comfortable with. I think she mistakenly was put as a three. I believe she was a two, and it was a human error, and it didn't affect how we treated her." (Tr. Vol I at 145)

97. With respect to the July 9, 2020 nurse's operative record, Dr. Grawe noted that it identifies the staff who were present in the operating room. Dr. Grawe further testified that it should also include the medications she used in the tumescent fluid; however, in this case, it does not. (Tr. Vol I at 141-142; St. Ex. 1b at 79)

98. Dr. Grawe testified that the Lidocaine identified on the anesthesia record was administered intravenously by the anesthetist. It was not part of the tumescent fluid that she used for the liposuction. (Tr. Vol I at 142-143)

March 21, 2022 Surgery ("Second Surgery")

99. On December 17, 2021, Patient 1 returned to Dr. Grawe to discuss additional surgery. Dr. Grawe's progress note states, in part, "The patient is interested in discussing liposuction. She is almost 1.5 years s/p TT, lipo u/l back, BBL and her and her husband are extremely happy with her results. She would like to discuss liposuction of the abdomen now that she is healed." (St. Ex. 1b at 40)

    Dr. Grawe testified, "In this case if someone has an abdominoplasty, I typically like to wait six months to a year to allow the scar tissue below her abdominal skin to soften before we do liposuction." (Tr. Vol I at 146)

100. On March 21, 2022, Dr. Grawe performed liposuction of the abdomen and arms, Brazilian butt lift – round 2, and Renuvion J-plasma of the abdomen and arms on Patient 1 under general endotracheal anesthesia at Roxy Plastic Surgery. (St. Ex. 1b at 123-124) According to Dr. Grawe's March 21, 2022 operative report, she removed 3,700 cc of liposuction aspirate. (St. Ex. 1b at 123) Dr. Grawe testified that the liposuction aspirate includes both tumescent fluid and fat. (Tr. Vol I at 149) Dr. Grawe testified how she performs the fat graft for the Brazilian butt lift:

> First I have the canister that has the fat in it, and it's on a vibrating plate. So actually fat is lighter than fluid, so it vibrates to separate those layers, and the fluid is, like you said, from the tumescent, some of the bodily fluids, and then the fat -- and it's never completely pure fat cells, but it's more concentrated fat cells. So we remove the fluid layer, and then there's a closed system, so it's already connected to that canister. It connects back to that liposuction cannula, and then through a small incision I go into that subcutaneous space above the muscle, below the skin, and then graft it into that area, laying small amounts in multiple areas so that those fat cells can then obtain a blood supply, and whichever fat cells obtain a blood supply will live there forever, similar to a skin graft or a hair transplant.

(Tr. Vol I at 149-150)

Dr. Grawe further testified that she uses the cannula to create a tunnel in the subcutaneous space above the muscle and then deposit the fat as she withdraws the cannula. (Tr. Vol I at 150)

101. When asked if a physician can be too aggressive with the cannula during liposuction and devascularize the skin, Dr. Grawe testified, "There is a way that you can do that. It's -- you would have to be up close to the subcutaneous dermal -- what's called the dermal plexus of veins, and those would have to be injured to denude that area of its blood supply." (Tr. Vol I at 150) Dr. Grawe further testified that the result could be skin necrosis. Dr. Grawe testified that that is one of the risks of liposuction that she includes on her consent forms. (Tr. Vol I at 150-151)

102. Dr. Grawe testified that the second surgery she performed on Patient 1 lasted for about three-and-one-half hours. Dr. Grawe further testified that this surgery was recorded, and the nurse's operative report identified the individual who recorded the surgery on Snapchat. (Tr. Vol I at 153-154; St. Ex. 1b at 133-134)

103. Dr. Grawe's medical record for Patient 1 includes a Social Media Consent Form signed by Patient 1 granting consent to have her procedure featured on Dr. Grawe's social media outlets, including Snapchat. (St. Ex. 1b at 126; Tr. Vol I at 154-155)

104. Dr. Grawe testified that the Snapchat video was not livestreamed but was recorded and then posted to the application. (Tr. Vol I at 154)

Video Viewing

105. During the following testimony, the hearing participants viewed State's Exhibit 6, the Snapchat video of Patient 1's March 21, 2022 surgery. Dr. Grawe testified that she does not keep such videos as part of the patient's record. Dr. Grawe further testified that Snapchat videos disappear after 24 hours unless someone records the video on their own device, as happened in this case. (Tr. Vol I at 156-159)

106. The video of Dr. Grawe's March 21, 2022 procedure on Patient 1 is not a single, continuous recording of the surgery from start to finish; rather, it consists of multiple snippets of the surgery along with other content such as photographs. (St. Ex. 6)

Dr. Grawe testified that she had her left hand flat on the patient during the procedure to palpate the location of the cannula tip, and "to create enough pressure in that area to help the liposuction aspirated out." (Tr. Vol I at 161; St. Ex. 6 at 1:15 – 1:21, 1:55 – 2:10, 3:22 – 3:40; and 4:53 – 4:57)

At other times, Dr. Grawe did not appear to be palpating the tip while maneuvering the cannula. (Periodically throughout St. Ex. 6 at 1:55 – 2:30) Dr. Grawe testified, "I can see, as I'm looking at this video here, I can see the tip of the cannula, and I can see that I'm looking at it also. See, I feel, and then there I can see the tip. And it's above the rib, so I can feel that I'm above the rib as well. I can feel it with my right hand." (Tr. Vol I at 163)

Dr. Grawe was also questioned concerning some footage that shows Dr. Grawe maneuvering the cannula on the patient's left side without her hand on the patient. Ms. Snyder asked about the video where Dr. Grawe talks about pushing through the tissue she makes two passes with the cannula without having her left hand on the patient. (Tr. Vol. I at 164; St. Ex. 6 at 1:50 – 1:52) However, Dr. Grawe testified that she can see the tip of the cannula on the video and she indicated where tip was. (Tr. Vol I at 164-165)

Post-op Complications

107. Referring to Chart Notes from Dr. Grawe's medical record for Patient , Dr. Grawe testified that these notes are used to document information that "wouldn't require an entire encounter," such as lab results. In this case her staff also documented telephone communications with Patient 1's husband after the surgery. Following are a series of notes from Ms. Cela, the nurse practitioner, relevant to those communications:

> [Husband of Patient 1] called the emergency line on Friday 3/25 with concerns of dizziness, sleepiness. He also reported that [Patient 1] was forgetful. He reported that she was trying to remember her password to log in into her work email but could not remember it. He also expressed frustration with caring for

her. He reported it was too much for him. I asked to speak with the patient [Patient 1] states I don't have any pain, I just feel very sleepy and I feel very tired , I asked her if she has been forgetful. When asked patient was alert to name, DOB, Month, date and year. She was able to tell me what procedure she had and when. Her husband also stated that she gets more sleepy when she take them pain pills. I suggested she spaced out the Percocet to every 6 hour instead of every 4. I also suggested she skips the morning Gabapentin to prevent sleepiness during the day. Patient and her husband agreed and denied any questions or concerns at this time. We also discussed fluid and protein intake. We discussed abdominal binder and post-surgical swelling. I recommended patient came in to our office for an in person evaluation. I also offered them to come in to the recovery house where trained caregivers can care for her. [Husband] said he will think about and let us know

3/26 at 0500. [Husband] called the emergency line. He reported that the medics were at his house checking the patients vitals signs and getting her back to bed. He stated he had called 911 due to the patient falling while going to the bathroom. I stayed on the phone and asked [Husband] with the medics said. He reported that they got her back in the bed and they said her blood pressure and stuff is alright . He said she was going to rest for a while and call if he had any further questions or concerns. I again recommended that she come In and be seen. He reported that he would likely bring her in tonight but did not. A couple hours later I attempted to call [Husband] x2 to follow up if he was on the way. I was not able to get a hold of him.

3/27 at 0800. [Husband] called the emergency line. He reported that [Patient 1] was not doing well again. She was having a hard time standing up going to the bathroom and she was very drowsy. At this time I asked for him to come in for an evaluation. When seen patient was disoriented. She was in her original surgery dressing and likely has not showered for 6 days. She was incontinent in diapers. Her abdomen was soft and nontender, nondistended. I immediately called the squad to transfer her to the ER for evaluation.

She was evaluated in the ED and found to have Hepatic encephalopathy and free air in her abdomen. They transferred her to OSU for surgical intervention. Dr. Grawe notified frequently with updates.

(St. Ex. 1b at 6)

108. Dr. Grawe testified that Patient 1's husband had called her office each day following surgery but not all of his calls were documented. (Tr. Vol. I at 171-172) When asked if it is alarming to have a spouse or caregiver call the office every day with concerns, Dr. Grawe replied:

> In general there are patients who call every day with concerns, and we always offer to see them in our office every single day, and oftentimes it's not alarming and they just want to talk to us every single day. In this case, when he called with concerns, we told him that he should bring the patient in every time that he called us, which he didn't.

(Tr. Vol I at 172-173) Whereupon the following exchange took place:

Q. What other types of concerns did he call in with?
A. Every -- most of his concerns were this feels like too much for me to take care of, I can't take care of her, I don't know what she needs, and then that she started to feel too sleepy or dizzy, these same kinds of things.
Q. Okay. When a patient is saying that they are dizzy and forgetful, do you always expect that patient to be able to come into the office to see you? I mean, is there ever a point at which their condition -- they are in no condition to come in to see you?
A. Of course. That would mean, if they're -- if they were in a condition to come see us, like she had been for five days, then we would want the patient to come see us. If they were not in a condition to leave, we would want them to call 911.
Q. And how do you know she was in a condition that she could come see you for those five days?
A. We don't know because we can't evaluate her at her house.
Q. Okay.
A. We have to rely on what the husband tells us and what we can do.

(Tr. Vol I at 173-174)

109. Dr. Grawe testified that the series of notes identified above were recorded on March 30, 2022. Further Ms. Cela made the notes and talked to Patient 1's husband. (Tr. Vol I at 174)

110. Dr. Grawe testified that each day Patient 1's husband called the office, her staff asked that Patient 1 to be seen at the office but she did not come in until March 27. (Tr. Vol I at 175) When asked if she knows why, Dr. Grawe testified, "It seems like she was doing better, doing worse, doing better, doing worse, in her husband's point of view. Maybe that's why." (Tr. Vol I at 175)

111. Dr. Grawe testified that she discussed the husband's calls with Ms. Cela and that she had been concerned:

> I was unable to evaluate her and he was unable to care for her, and it was impossible for me to know what was going on with her. She called the -- she called 911, and the squad evaluated her and found no medical reason for her

> to go to the hospital, but I was still unable to assess her and wanted her to come in.

(Tr. Vol I at 176)

112. Dr. Grawe testified that March 27, 2022, had been a Sunday, and Patient 1 had come to the Recovery House to be evaluated and she was sent to the ER immediately by Ms. Cela who called 911. (Tr. Vol I at 177) Dr. Grawe testified that Ms. Cela did not contact Dr. Grawe until after the patient had been sent to the ER, and Dr. Grawe testified that it was appropriate for Ms. Cela to take care of the patient first and then call her. Dr. Grawe testified that Patient 1 was taken to the ER at St. Ann's. (Tr. Vol I at 178)

St. Ann's

113. Physicians at St. Ann's ordered a CT scan of Patient 1's abdomen and pelvis. The findings include:

> Evaluation of the abdominal/pelvic organs and vasculature is limited due to the lack of IV contrast material. Normal liver and spleen sizes. No peripancreatic inflammatory changes. Normal adrenal glands. Moderate bilateral ureteropyelocaliectasis. Marked distension of the urinary bladder. Mild gallbladder distention.
>
> * * *
>
> There is a mottled collection of air bubbles within the left anterior pelvis adjacent to multiple thick-walled small bowel loops.
>
> * * *
>
> Air bubbles are located within the posterior lateral right chest wall. There are multiple collections of air within the anterior and lateral aspects of the abdominal and pelvic walls, extending into the inguinal regions and mons pubis. There are air bubbles within the right flank subcutaneous tissues. Air bubbles are located within the midline anterior upper pelvis. These are probably both intraperitoneal and properitoneal. Air bubbles are located within the lateral abdomen near the descending colon, probably retroperitoneal.
>
> The abdominal and pelvic walls are edematous. A surgical drain is located within the anterior left lower quadrant abdominal wall.

(St. Ex. 1c at 77)

114. The CT scan report also includes the following impressions:

1. The constellation of findings, including a partial small bowel obstruction, small bowel wall thickening, and air bubbles within the adjacent anterior intraperitoneal/properitoneal space suggest a small bowel injury.
2. There is a mottled collection of air within the left lower quadrant. It is unclear if this is contained within a thick walled small bowel loop versus an extraluminal collection. Further evaluation of the above findings with a CT scan to include oral and IV contrast may be useful.
3. Multiple collections of air within the chest, abdominal, and pelvic walls.
4. Small amount of left retroperitoneal air.
5. Extensive subcutaneous edema and unorganized fluid involving the abdominal/pelvic walls.
6. Marked distension of the urinary bladder with associated bilateral ureteropyelocaliectasis.

(St. Ex. 1c at 77)

115. Among other things, Patient 1's caregivers at St. Ann's indicated under the heading "MDM": "Her ammonia level was markedly elevated at 163. Consistent with her jaundice, bilirubin level elevated to 15, with direct bilirubin of 9.1 and indirect of 5.9. AST, ALT, alkaline phosphatase were more modestly elevated." In addition, the note states that the "[c]ase was discussed with general surgery as well as plastic surgeon who performed liposuction/BBL." Finally, the note states, "Given concern for acute liver failure, we opted to transfer the patient where hepatology consultation would be available. Discussed case with OSU via transfer center. Patient was accepted for transfer there by Dr. Ho. (St. Ex. 1c at 17)

116. Dr. Grawe testified that she considers the standard of care to require her to follow her patient's status as the patient progresses through hospitalization. She testified that it is easy for her to follow her patients at St. Ann's because she has privileges there. (Tr. Vol I at 189-190) However,

> [w]hen people go to outside hospitals, we can call in and try to follow their care, but not being -- having privileges there, we are not -- I guess we're not in as good of communication with them. They don't communicate with us as well on what's going on with the patient. But would we like to know every second? Yes.

(Tr. Vol I at 190)

OSU Wexner Medical Center

117. In the medical records from OSU Wexner Medical Center ("OSU"), the SICU physician documented on March 30, 2022, that she personally saw and examined Patient 1 on March 29, 2022, and stated, among other things, "At the time of the evaluation, patient

remained critically ill. I have spent 40 minutes providing critical care for the following critical conditions with risk for acute decompensation: acute respiratory failure, necrotizing fasciitis, open abdomen." (St. Ex. 1a at 126)

118. Dr. Grawe testified that she is aware that Patient 1 had been hospitalized for a total of about 60 days and underwent multiple surgeries. (Tr. Vol I at 193)

119. In an office visit note dated June 13, 2022, the record documents the surgeries that Patient 1 underwent during her stay at OSU. It states:

> [Patient 1] is a 51 y.o. female with a past medical history of HTN, Abdominoplasty, brazilian butt lift (2021) and repeat BBL+ Liposuction done 3/21/2022 who presented to OSH with AMS, Acute renal failure, and septic shock. A CTAP was concerning for possible small bowel injury and free air. She was subsequently transferred to The Ohio State University Wexner Medical Center for further evaluation.
>
> She underwent the following surgical procedures:
>
> 3/28: sharp debridement of NSTI wound including fat, skin, muscle of lower abdomen wall/upper left thigh as well as 1. Exploratory laparotomy 2. Sharp debridement of the abdominal wall to include skin, subcutaneous tissue, fascia and a portion of the bilateral rectus abdominus muscles bilaterally 3. Primary repair of small bowel injury 4. Cholecystectomy 5. Incision and drainage of bilateral hips
>
> 3/29: Abdominal incision and debridement (16X6X3cm skin, subcutaneous tissue), washout and wound vac placement.
>
> 4/1: Reopening of recent laparotomy, Two-layer repair of small bowel perforation, Small bowel resection with primary handsewn end-to-end small bowel anastomosis (two-layer repair), Liver biopsy, Peritoneal lavage, Placement of negative pressure wound therapy for temporary abdominal closure (ABThera)
>
> 4/2: exploratory laparotomy, washout, placement of vicryl mesh
>
> 4/16: Abdominal wall wound bed preparation, Engraftment of abdominal wound wound with Xenograft-Kerecis, NPWT to abdominal wound, Complex closure of bilateral thighs wounds with AT, NPIWT to bilateral thighs.
>
> 5/4: STSG to abdomen

(St. Ex. 1a at 64-65)

120. Dr. Grawe testified that she had reviewed the OSU medical records, and she was asked to describe what happened to Patient 1, whereupon the following exchange took place:

> A. So she had a necrotizing fasciitis, which means that the infection was eating away at tissues and, therefore, involved her good skin of her trunk and I believe part of her thigh, which required skin grafting.
> Q. [By Ms. Snyder] So they literally had to cut away all of the dead skin; right?
> A. The infected tissue.
> Q. The infected tissue and the dead skin.
> So is it your understanding with this particular patient they had to remove everything down to basically her intestines?
> A. I believe that she had involvement of her abdominal wall.
> Q. And so does that mean everything down to the intestine?
> A. Yes.
> Q. Okay. And so when they skin grafted it back, she actually had to be referred to the burn unit. Is that your understanding as well from the record?
> A. Those are the surgeons that do skin grafting at OSU.
> Q. Okay.
> A. At least during my residency.

(Tr. Vol I at 195-196)

Dr. Grawe was also asked to review a photograph from the OSU medical records. Taken on April 22, 2022, it shows Patient 1's abdomen at its then-current state of healing. (St. Ex. 1a at 734) Dr. Grawe testified:

> When a skin graft is placed, and hers is mesh to cover more area, then the skin lives for the first few days by something called imbibition, which means by the fluids that are around it, and then the blood supply starts growing in, and when that skin graft gets a blood supply, then it lives there, and those meshed areas with skin in between the open areas comes across and forms skin.

(Tr. Vol I at 197)

121. Dr. Grawe acknowledged the surgeon at OSU found, among other things, a bowel perforation. (Tr. Vol I at 166-167) When asked whether a bowel perforation is a known complication of liposuction, Dr. Grawe disputed that she caused the bowel perforation:

> I would think that it would be almost impossible to use the force needed to do liposuction, go through the abdominal wall, and the bowel sits with many loops of bowel; so to me it would feel almost impossible to go through those -- the force going through the abdominal wall and scar tissue from her tummy tuck, go into the abdomen, with many loops, but somehow hit one side of the bowel and not go through it or go through four loops of bowel.

(Tr. Vol I at 167)

Dr. Grawe also testified that they found a necrotic gallbladder. Dr. Grawe testified that she could not have reached the gallbladder with her cannula because her cannula was not long enough. She further testified that "you would go through the liver and the patient would likely bleed to death on your table while you did that." (Tr. Vol I at 166) Dr. Grawe also testified that Patient 1 has deserosalization of the small intestine, meaning that the outside surface of the small intestine was wearing away, somewhat analogous to a rug burn on the skin. Dr. Grawe further testified that "during the first procedure at OSU they found one perforation on one side of the intestine, and then at a later operation, when they went back, because their anastomosis started leaking, they found a new perforation that was not there two days prior." (Tr. Vol I at 166)

122. When asked whether one of Dr. Grawe's theories is that Patient 1 had an infection that came in from the outside, Dr. Grawe replied:

> I think it's -- this is a very complicated case, so it's hard to know where the infection started. One theory could be that she had this gangrenous gallbladder that was possibly an underlying condition that no one had any idea about prior to surgery, which became infected and infected the abdominal wall out. The other theory is that, you know, on exam at the time that Tia saw her, the NP, and also the ED saw her, she had no signs of infection. She had no erythema on the outside. She had no -- any sign -- no pus, any sign of any infection at all, but the other idea is that she had been sitting in her own stool with these open incisions for five days -- or we don't know how long because we didn't get to see her, and that --possibly that stool could have caused the infection.

(Tr. Vol I at 184)

Dr. Grawe agreed that, if stool had caused Patient 1's infection it would have entered from the outside in through an incision or drain but acknowledged that Ms. Cela did not see any external infection at the incision site, nor did St. Ann's ER staff, at that time. When asked whether she had ever seen any indication that Patient 1 had some kind of internal infection that could have traveled inward, Dr. Grawe noted that at one point Patient 1 had necrotizing fasciitis of her skin. When asked if that started from the inside and traveled out or vice versa, Dr. Grawe replied that she does not think anyone can know. (Tr. Vol I at 185)

123. Dr. Grawe testified that it is not possible to regrow muscle. (Tr. Vol I at 198)

Patient 1 – Testimony of Dr. Surfield

124. Dr. Surfield agreed that Patient 1 went through an extensive informed consent discussion with Dr. Grawe and her staff and gave her consent for, among other things, social media, risks and complications of surgery and, specifically, for liposuction. He also agreed that

the liposuction consent included the risks of infection, damage to other structures, patient compliance, and that additional surgery could become necessary. (Tr. Vol II at 155-156)

First Surgery - July 9, 2020

125. Dr. Surfield noted that on July 9, 2020, Dr. Grawe performed liposuction of the upper and lower back, Brazilian butt lift, and abdominoplasty. (Tr. Vol II at 37; St. Ex. 1b at 67)

126. Dr. Surfield described abdominoplasty, "Abdominoplasty is removing of excess skin of the lower abdomen, generally involves transposing the umbilicus or the belly button, and usually also involves repairing the fascia of the abdominal wall." (Tr. Vol II at 38)

127. Dr. Surfield described the anesthesia classification system of the American Society of Anesthesiology ("ASA"):

> So the American Society of Anesthesiology has developed a classification system for patients, and it's broken down into different tiers. So one is a normal, healthy patient without any medical conditions. Two is a patient that has a systemic illness of moderate severity. Three is when that illness has now become a more severe illness. So it could be something simple like blood pressure that is just not well controlled or diabetes that is not well controlled. Number four is a systemic illness that is a constant threat to life. So if someone has had a recent heart attack or stroke or something like that. Five is a patient that's going to die without surgery.

(Tr. Vol II at 40-41)

128. Dr. Surfield noted that Patient 1 had been classified as an ASA 3 on the preop Anesthesia Evaluation prior to her July 9, 2020 surgery, and on the Anesthesia Record of the surgery. The anesthesia evaluation is signed by the CRNA and Dr. Grawe. (Tr. Vol II at 40-42; St. Ex. 1b at 77, 81)

Dr. Surfield testified that the ASA 3 classification is significant because "only ASA Class 1 and 2 are supposed to be performed in an office-based setting." (Tr. Vol II at 42)

129. Dr. Surfield testified that, if Dr. Grawe had performed the first surgery on Patient 1, who had a documented ASA score of 3, in a licensed ambulatory surgery facility, that would have been within the standard of care. (Tr. Vol II at 132)

130. Dr. Surfield testified that he reviewed Patient 1's records to see if she was properly classified as an ASA 3 and found her to be taking medication for hypertension, so she could be an ASA 2 or 3 depending on how well-controlled her blood pressure was. Dr. Surfield further testified that he did not see any information concerning how well it was controlled. (Tr. Vol II at 132-133)

131. Reviewing the medical records provided by the respondent, which includes documentation that was not provided to the State pursuant to the State's investigatory subpoena, Dr. Surfield was directed to Respondent's Exhibit A-1, page 188. This is a progress note dated June 12, 2020, from an internal medicine physician concerning Patient 1's preoperative testing. It indicated among other things that Patient 1 has hypertension which is "Stable," and that Patient 1 was "cleared medically for surgery." (Resp. Ex. A-1 at 188)

    Dr. Surfield testified that he had not previously seen that note. (Tr. Vol II at 134) However, based on that information, he does not know the reason why Patient 1 was classified as ASA 3. (Tr. Vol II at 136)

    Dr. Surfield testified that, based upon Patient 1's record and an ASA scale that Dr. Grawe included in her expert report, Patient 1 did not have any of the maladies identified as meriting an ASA score of 3. (Tr. Vol II at 140)

132. Dr. Surfield testified that Patient 1 experienced no adverse outcome from the July 9, 2020 surgery and that Patient 1 had been happy with the results. (Tr. Vol II at 42, 140, 152)

Second Surgery – March 21, 2022

133. Dr. Surfield noted that a physical examination was performed by Dr. Grawe prior to Patient 1's second surgery; however, Dr. Surfield opined that more information could have been obtained. (Tr. Vol II at 152-153)

    Reviewing the medical records provided by Dr. Grawe, which includes documentation that was not provided to the State pursuant to the State's investigatory subpoena, Dr. Surfield was directed to Respondent's Exhibit A-1, page 196. This is a February 23, 2022 note from an advanced practice nurse clearing Patient 1 for surgery. The physical examination notes continue through page 207. (Resp. Ex. A-1 at 196-207) Dr. Surfield agreed that that is a thorough history and physical examination completed prior to Patient 1 undergoing her second procedure. (Tr. Vol II at 154)

134. Dr. Surfield noted that on March 21, 2022, Dr. Grawe performed liposuction of the abdomen and arms, Brazilian butt lift – round 2, and Renuvion J-plasma of the abdomen and arms. (Tr. Vol II at 42; St. Ex. 1b at 123) Dr. Surfield testified that these are multiple procedures including liposuction in an office-based setting which violates a Board rule that liposuction cannot be combined with additional procedures in an office setting. (Tr. Vol II at 42-43) Dr. Surfield believes the reason for the rule "is mainly just because liposuction can have some significant post-operative fluid shifts and becomes a little bit more difficult to manage as you have -- if you start adding more and more procedures onto it." (Tr. Vol II at 43) Dr. Surfield further testified that complications can increase if you add more procedures onto liposuction. (Tr. Vol II at 43)

135. Dr. Surfield testified that, even though liposuction is typically an outpatient procedure, is not a minor procedure. Dr. Surfield testified, "I would consider it just as a major

procedure, as a large open surgery. Just because the incision sites are small, doesn't mean that the surgery itself is a small surgery." (Tr. Vol II at 43) Dr. Surfield testified that liposuction is "a significant surgery that carries considerable risk with it as well." These include "[b]leeding, infection, damage to deeper structures, nerve injury, you know, blood clots, DVT, PE, heart and lung issues." (Tr. Vol II at 44)

136. Referring to the medication record on the nurse's note for the March 21, 2022 surgery, Dr. Surfield noted that it lists tumescent fluid as among the other medications but does not define the composition of the tumescent fluid. Dr. Surfield further testified, "It says there is 3,000 CCs of tumescent solution that was used, but there is not a definition of what is in the tumescent solution, which is -- which should be documented as a medication. (Tr. Vol II at 48, 52)

    Dr. Surfield further testified that there was no record concerning whether or not Dr. Grawe used lidocaine in her tumescent fluid in July 2022. (Tr. Vol II at 53) However, records from Patient 1's 2020 surgery indicated that Dr. Grawe had used Marcaine in her tumescent fluid on that occasion. Dr. Surfield testified that Marcaine is a local anesthetic like lidocaine but has a longer duration of effect. (Tr. Vol II at 53-54; St. Ex. 1b at 79)

137. Patient 1 was determined to be an ASA 2 prior to the July 9, 2020, surgery. (St. Ex. 1b at 131)

138. Patient 1 was discharged home following the surgery. (St. Ex. 1b at 125)

139. Dr. Surfield testified that none of the notes of post-operative calls from Patient 1 or her husband reflect that Dr. Grawe herself had spoken to the caller. (Tr. Vol II at 46)

140. Dr. Surfield testified that Patient 1 returned Dr. Grawe's office on March 27, 2022. When Patient 1 arrived, Ms. Cela immediately called an ambulance to take her to the ER. When she arrived at the St. Ann's ER she was found to have volume resuscitation issues and electrolyte abnormalities, abnormal liver enzymes, and a CT scan that was "highly suspicious for some intra-abdominal air." Later that day, St. Ann's providers determined that Patient 1 should be transferred to OSU where a hepatology consultation would be available. Arrangements were made and Patient 1 arrived at OSU at 12:20 a.m. on March 28. (Tr. Vol II at 54-56; St. Ex. 1a at 100; St. Ex. 1b at 6; St. Ex. 1c at 16-17, 19)

141. On March 28 at 8:30 a.m., Patient 1 underwent an exploratory laparotomy. Dr. Surfield noted that pneumoperitoneum, which is free air outside the bowel but inside the abdominal cavity, had previously been found on a CT scan. (Tr. Vol II at 57) Dr. Surfield further testified:

    > So she was found to have a large amount of necrotizing soft tissue infection of the abdominal wall that required a large amount of debridement of the abdomen wall. There was also a perforation of the small bowel, and there was

> a --there was areas of gangrenous tissue of inter-abdominal, as well that involved the omentum[6] and the gall bladder.

(Tr. Vol II at 58)

142. The operative report states, in part, that Patient 1 "was noted to have violaceous changes of her lower abdomen with some superficial sloughing of the skin. A generous midline incision was created. On entering the subcutaneous tissue, we were met with a rush of foul purulence." (St. Ex. 1c at 782) Dr. Surfield testified, "So this is just a really bad infection at this point. It's actually just the bacteria eating pretty much everything and turning it into mush. So, you know, there's the abdominal tissue, the -- all the fat and all the fascia are all being broken down by the bacteria because it's a very aggressive bacteria." (Tr. Vol II at 59) Dr. Surfield further testified that the surgeon found two different areas where the small bowel had been injured—a partial thickness injury involving the serosa at 50 cm, which the surgeon repaired, and "[a]t 150 centimeters from the ileocecal valve, [the surgical team] identified a punctate wound expressing frank succus." (Tr. Vol II at 59-60) The operative report indicates that the surgeon repaired the puncture. (St. Ex. 1c at 782)

Dr. Surfield testified concerning debridement:

> So with this, she's got a very aggressive bacterial infection. And so you have to remove all the dead tissue. You have to try to get ahead of this so it doesn't continue to eat away. This is a life-threatening infection. So this first surgery was pretty much trying to get this patient to be stable enough to live. So you're debriding a lot of this tissue. You know you're coming back at the end of this surgery. And she was in pretty critical condition. She was now on blood pressure elevating medications because she was that sick.

(Tr. Vol II at 61)

143. Dr. Surfield testified that, by the time Patient 1 had undergone skin grafting, "[p]retty much all of her skin between her rib cage to her pelvis was removed, and that included the -- almost the entirety of the anterior abdominal wall. So pretty much from lateral flank to lateral flank between rib cage and pubic bone." (Tr. Vol II at 61; St. Ex. 1c at 758)

144. Dr. Surfield described a photo of Patient 1 prior to the exploratory laparotomy,[7] "This shows that she has a severe infection of her abdominal wall. You see a lot of inflammation. It doesn't -- you can't see it on this black-and-white photo, but the color photos you can see that she's got some mottling of her abdominal wall skin. That's threatened skin. That's -- you know, that's undergoing necrosis. So she's got a severe infection of her abdomen. (Tr. Vol II at 65)

---

[6] Dr. Surfield testified that omentum is "kind of a protective fatty layer that kind of makes a protective layer on the top -- very top of the bowel. It kind of drapes over from the inferior aspect of the stomach and the colon and kind of covers the -- kind of the top half of the abdominal viscera." (Tr. Vol II at 58)

[7] St. Ex. 1c at 3008.

145. Referring to a photograph of Patient 1's surgical wound taken on March 28 at 3:20 p.m., Dr. Surfield testified, "That's after initial debridement, it's showing that all of her abdomen wall skin, pretty much from the bottom of her breast all the way down to her mons pubis, has been removed. A large portion of the abdominal musculature has been removed as well. She's got a trauma bag covering her bowel to protect the bowel from drying out." (Tr. Vol II at 62-63; St. Ex. 1c at 3002)

146. Dr. Surfield was asked whether the infection suffered by Patient 1 could have been caused by a gangrenous gallbladder and not a perforation of the bowel leaking contents into the body cavity. Dr. Surfield responded, "I don't believe that's accurate based on everything that we see here. This looks like a case of abdominal perforation after liposuction and the enterococcus causing the infection, which causes all the subsequent infections of the abdominal wall tissues, the infection of the omentum, the infection of the gall bladder." (Tr. Vol II at 64)

147. Regarding whether Patient 1's infection could have entered her body through fecal soiling from the outside, Dr. Surfield testified:

> I mean, an infection is a risk with any surgery. The fecal soilage, you know, could be a risk factor. Generally you'd see more inflammation that would start around these incision sites. And, again, you have all this intra-abdominal injury as well. So the most likely scenario is that this is from an abdominal injury from liposuction and the cannula injuring the bowel. That explains everything with this case.

(Tr. Vol II at 66)

148. Referring to the video of Patient 1's March 21, 2022 surgery, Dr. Surfield testified:

> [T]his is a blind procedure, so there's several ways that you have to try to figure out where the tip of your cannula is at all times because, I mean, this can go quite a different amount of areas because, again, these cannulas are long and you're not being able to see it. So a little bit of variation in the angle of your wrist can change where this tip goes.
>
> These cannulas also are very long so they tend to bend with time too. And so you can see that it may not be exactly where you thought it was on insertion, just with scar tissue and things like that that may deflect the tip of cannula

(Tr. Vol II at 69-70)

149. Dr. Surfield testified concerning where you want to be in the body when performing liposuction:

> You want to be in the fat layer. So you want to be above the fascia and you want to be below the skin and you want to be below the subdermal fat as well. Because if you're in the superficial fat, you can cause some contour irregularities. So there's a smaller area that you want to be in that's just not all the skin area -- or all the area underneath the skin. So you want to be above the fascia and below that subdermal fat.

(Tr. Vol II at 70-71) Dr. Surfield further testified that the layer of fat you want to be in is generally a centimeter thick but can be three or four centimeters in bigger patients. (Tr. Vol II at 71)

Dr. Surfield further testified with respect to awareness of the location of the cannula tip:

> Because like I said, you know, you're working kind of a long ways away from where the actual tip of the cannula is. And so, you know, there's a lot of variability in that angulation of that cannula. As it goes through the body, it can change significantly from where you put it in at and where it ends up over time. And just -- as this is a very physically demanding procedure as well, and so just over time you get some fatigue, things like that where you can actually end up changing that angle and you may not necessarily feel that in your power hand.
>
> So generally it's kind of described as you have a smart hand and a power hand. So your smart hand is kind of feeling where the cannula tip is and your power hand is the one that's actually doing the motion of the -- pushing the cannula in and adding the power to it.

(Tr. Vol II at 71-72)

150. Dr. Surfield agreed that there are times during liposuction procedures when the cannula tip can be seen underneath the skin. However, he testified that visualizing the cannula does not mean that you can tell if the cannula tip is in the appropriate area "[b]ecause you can lift that muscle up with the cannula tip." He testified that you would still be able to see the cannula tip if you lifted up the muscle with it. (Tr. Vol II at 157-158)

151. With respect to the video of Patient 1's surgery, Dr. Surfield pointed out that, at one point, "she's looking down around the -- you can see that actually here too, the hand is up off the patient. You know, back there a couple seconds ago, there was several strokes where she's putting in with no real awareness to where the tip of the cannula is." (Tr. Vol II at 73) When apprised of Dr. Grawe's testimony that she could visualize the tip of the cannula under the skin, Dr. Surfield testified, "I mean, her head is turned away. So it's hard to really say that that's in the line of sight." (Tr. Vol II at 73; St. Ex. 6 at 1:26 – 2:00)

A bit further into the video (St. Ex. 6 at 2:10 – 2:15) Dr. Surfield testified:

> Yeah. So those are very forceful insertions. I mean, you -- and she's actually talking about the scar tissue and making it more difficult to penetrate through there. You know, putting the cannula in there like that is pretty reckless because you don't have any awareness of where that cannula is. And that's a very forceful insertion. So that's -- you know, and the abdominal fascia layer is not going to stop that cannula from going through.

(Tr. Vol II at 73-74) When asked what that means, Dr. Surfield testified, "That means there's a risk of entering the abdomen." (Tr. Vol II at 74)

152. Dr. Surfield concluded with respect to the video:

> I mean, that's just -- you know, when I watch this video, you can just see there's several times where the focus is taken off the patient. And some of it is to explain what's being done. You can see that there's times where she's pointing at the abdomen scar when the cannula -- and the abdominal scar is in the lower abdomen and the cannula is in the upper abdomen.[8] So it's -- you know, the focus is clearly away from the cannula. There's no palpation of the tip. There's no direct visualization of the tip. Those are all things that put the patient at risk of a bowel perforation.

(Tr. Vol II at 75)

153. Dr. Surfield was then asked how this differs from a scenario where a plastic surgeon is demonstrating liposuction techniques to plastic surgery students in the operating room. He testified:

> Yeah. So for the most part, you know, a lot of times they're scrubbed in. So they're standing directly across from me. Probably less than a foot away from my face because they're, you know, face-to-face with me. You know, and, again, even with that, you're not supposed to make direct eye contact. I mean, it's not all this stuff that you learn, as far as, you know, eye contact.
>
> You're still focused on the patient. You're still looking at what you're doing. You're still paying attention. And it's a little bit easier for them just because, you know, they're supposed to be looking at the same thing that you're looking at. You know, both of you are focused on the same procedure. They're watching what you're doing. You're watching what you're doing.

[8] St. Ex. 6 at 1:57 - 2:00, 2:04 - 2:05

> You know, and like I said, you're right next to each other. So it's not -- you don't really have to worry about turning your head to project your voice over to them or anything like that. They're right there.

(Tr. Vol II at 76)

154. When asked to comment on the opinion of Dr. Grawe's expert witness, Lloyd Krieger, M.D., that "[s]pecifically, at all times Dr. Grawe displayed complete regulation of the cannula tip." (Resp. Ex. E at 9) Dr. Surfield testified, "He -- well, he says during this video there's no time where she's not identifying where the cannula tip is. And I see several instances of where that is inaccurate." (Tr. Vol II at 77) He was further asked to comment on Dr. Krieger's opinion that "Throughout the video, Dr. Grawe's liposuction techniques were flawless." (Resp. Ex. E at 9) Dr. Surfield testified, "There's several instances where there's no awareness of where the cannula tip is, which is not flawless." (Tr. Vol II at 77)

When asked if the standard of care in liposuction requires awareness of the tip of the cannula, Dr. Surfield testified, "Over the abdomen, yes, for sure." (Tr. Vol II at 77)

155. Dr. Surfield acknowledged that, even when a surgeon uses appropriate technique, infection, injury, bleeding, or injury to other structures can occur, and that these can occur in the absence of negligence, absence of social media, and regardless of whether the surgery was performed in an office, ambulatory surgery facility, or a hospital. Moreover, Dr. Surfield acknowledged that the fact that an adverse event occurred is not evidence of a deviation from the standard of care. (Tr. Vol II at 151)

156. Dr. Surfield agreed that patients bear some responsibility for their care, such as following post-operative instructions and attending follow-up visits. (Tr. Vol II at 151-152) Dr. Surfield also agreed that it is important for patients to comply with discharge instructions, including the instructions for post-op wound care, showering, and follow-up. (Tr. Vol II at 160)

157. Dr. Surfield testified that he does not know if Dr. Grawe's staff made her aware of Patient 1's husband's calls to the office following her second surgery. However, he agreed that the husband called on multiple occasions and was asked by Dr. Grawe's staff to bring Patient 1 to the office but did not. He acknowledged that on one occasion EMS was called to her home because she had fallen but she was not taken to the hospital. Dr. Surfield further acknowledged that they would have transported her to the hospital if they had believed it was medically necessary. Moreover, Dr. Surfield acknowledged that Dr. Grawe's staff called Patient 1's house twice to check on her when she did not come to the office and received no response. (Tr. Vol II at 161-163)

158. Dr. Surfield testified that, on post-op day 6, Patient 1's husband called again and Dr. Grawe's staff asked that Patient 1 be brought in, and she was. Dr. Surfield further testified that they documented that Patient 1 was wearing the same clothing she had been

wearing the day of her surgery, had not showered, and was sitting in a diaper in her own incontinence. He further acknowledged that Dr. Grawe's staff immediately contacted EMS. (Tr. Vol II at 163)

Dr. Surfield further agreed that Dr. Grawe's instructions for Patient 1 had included to take a shower 48 hours after her surgery to allow water to run over her surgical wounds to clean them, and that that was not done. Moreover, Dr. Surfield agreed that Dr. Grawe had instructed her to remove the bandage and change it and that that too was not done. Also, Dr. Surfield agreed that sitting in a diaper incontinent can cause a patient's wounds to become infected. (Tr. Vol II at 164-165)

159. Dr. Surfield was asked whether he would expect any of his patients to still be wearing the same clothes they wore the day of a surgery that occurred a week earlier not having showered or changed and sitting in their own incontinence in a diaper. Dr. Surfield testified, "Showering, that doesn't always happen just because, you know, if there's garments or anything else like that, sometimes it's difficult for people. The incontinence, yes, that's, you know, not something that you want to see." (Tr. Vol II at 164)

160. Dr. Surfield testified that bacteria were cultured at St. Ann's ER that can be found in feces. (Tr. Vol II at 165-169)

161. Dr. Surfield agreed that the gangrenous gallbladder had been found at the time she presented to the OR at OSU. He also agreed that pathology found acute and chronic cholecystitis with necrosis of Patient 1's gallbladder, meaning it had been present for a while but there was also an acute event. (Tr. Vol II at 170) When asked if he would agree that that had nothing to do with Dr. Grawe's surgery, Dr. Surfield testified, "The acute has -- is due to the inflammation inside the abdomen." (Tr. Vol II at 170)

When asked of the chronic cholecystitis would have had nothing to do with Dr. Grawe's surgery, Dr. Surfield replied, "The chronic cholecystitis is hard to really quantify what they mean by chronic. It just means that there's been something that's -- you know, there's different cells that are present, as well as the acute inflammatory cells." (Tr. Vol II at 171)

Dr. Surfield agreed that the gangrenous gallbladder could have led to Patient 1's necrotizing fasciitis and that "[a]ny sort of infection can cause necrotizing fasciitis." He also agreed that external pathogens from fecal material could also cause necrotizing fasciitis. (Tr. Vol II at 171)

162. Dr. Surfield testified that the initial procedure performed at OSU found two perforations of the bowel, one a partial thickness serosal injury and the other a full thickness perforation. (Tr. Vol II at 172) Dr. Surfield also testified that the surgeon ran the whole bowel from one end to the other looking for perforations and found only the serosal injury and one full perforation. (Tr. Vol II at 173-174)

Dr. Surfield agreed that Patient 1 went through a second surgery because the anastomosis of the bowel performed during the first surgery was leaking. During that surgery, they found three additional areas that were actively leaking. Dr. Surfield acknowledged that these were new areas of holes that had nothing to do with Dr. Grawe's second surgery on Patient 1. (Tr. Vol II at 173-177; Resp. Ex. A-3 at 1342, 1345)

163. Dr. Surfield testified that Dr. Grawe's treatment of Patient 1 constituted "a failure to maintain minimal standards of care of similar practitioners under similar circumstances." (Tr. Vol II at 78)

164. Dr. Surfield testified that he had opined that Dr. Grawe's failure to provide Patient 1 with discharge instructions concerning lidocaine toxicity deviated from the standard of care. He further testified that Dr. Grawe's report states that she used TXA and epinephrine in her tumescent solution which Dr. Surfield believes is an appropriate solution to use for that procedure. When asked whether, if a physician does not use lidocaine in their tumescent solution, there is no need to give discharge instructions for lidocaine toxicity, Dr. Surfield testified that, per the rule, lidocaine toxicity instructions have to be given regardless of the medications used in the tumescent solution.[9] (Tr. Vol II at 143-149)

165. In his report, Dr. Surfield opined that Dr. Grawe violated ORC Section 4731.22(B)(6), and Rules 4731-25-02 (H), 4731-25-05 (B)(7), 4731-25-05 (B)(8), 4731-25-05 (E), in her care of Patient 1. (St. Ex. 5 at 2)

Patient 1 – Testimony of Dr. Krieger

166. Dr. Krieger testified that if a surgeon is using a CRNA to administer anesthesia, even though the physician is ultimately in charge of the CRNA, it is the CRNAs obligation to advise the surgeon that the patient is not an appropriate risk for the surgery. (Tr. Vol IV at 38-39)

Dr. Krieger testified that, based on his review of the record, he did not believe that Patient 1 rated an ASA classification of 3 at the time of her first surgery. (Tr. Vol IV at 39-45)

167. Dr. Krieger testified that infection, injury, injury to structures, and bleeding can occur in the absence of negligence, and when not being filmed on social media. Moreover, Dr. Krieger testified that the presence of those outcomes does not, by itself, mean that there had been a deviation of the standard of care. (Tr. Vol IV at 82, 92)

168. When asked if patients are also responsible for following their physician's orders for postoperative care, Dr. Krieger testified: "Well, you know, healthcare is a collaborative

[9] Rule 4731-25-05(E) states, "The written discharge instructions given to the patient shall include specific information concerning the symptoms of lidocaine toxicity, the period of time during which such symptoms might appear and specific instructions for the patient to follow should the patient experience such symptoms."

process, and at a minimum, the more that patients follow instructions, the better. But certainly, if there is a lapse in following instructions, it can lead to negative outcomes." (Tr. Vol IV at 82-83)

169. Dr. Krieger opined concerning the cause of Patient 1's postoperative infection:

> My opinion is that the patient had chronic cholecystitis, which is blockage and infection of the gallbladder, that then had superimposed on that chronic problem, an acute infection, as revealed in the operative notes and pathology reports, and that this gangrenous gallbladder was the source rather than the secondary site of infection -- of the infection.

(Tr. Vol IV at 93)

When asked whether Patient 1's hygiene contributed to her infection, Dr. Krieger testified:

> Well, the records indicate that there were hygiene issues, specifically that the dressings weren't changed as instructed, and that a shower to clean the skin was not done as instructed.
>
> And also that the organisms that were cultured were not what we would call skin flora or naturally occurring bacteria that's on the skin, but rather they are -- were from poop. And a lack of cleanliness can allow that type of organism to track up into the body, including into wounds or incisions.

(Tr. Vol IV at 93-94) Dr. Krieger opined that Patient 1's presentation post-surgery could have allowed for infection and could have been the source for the organisms that infected her. (Tr. Vol IV at 97)

Dr. Krieger further testified that, following Patient 1's second surgery, there were several calls from Patient 1's husband where Dr. Grawe's staff asked that Patient 1 be brought to the office which he did not do. Staff also offered to have Patient 1 brought to the recovery house for care to relieve the husband of some responsibilities. Dr. Krieger further testified that EMS had been called on one occasion but did not transport Patient 1 to the hospital. (Tr. Vol IV at 94-96)

170. Dr. Krieger also testified that the surgeon found a single perforation of the small intestine and an area of the serosa that was damaged. Dr. Krieger testified that a single wound on one side of the bowel is unusual for a cannula injury. He testified that, more typically, the cannula passes through and through the bowel and more often includes additional injury to the adjacent loops of bowel. (Tr. Vol IV at 99-100)

Dr. Krieger testified that the surgeon fixed the damaged bowel, ran the bowel, and found no other perforations. (Tr. Vol IV at 100-101)

171. Dr. Krieger testified that Patient 1 was taken back two days later for additional surgery at which time additional holes in the bowel were found. Dr. Krieger noted that those additional holes had to have occurred following Patient 1's first surgery at OSU. (Tr. Vol IV at 101-102)

172. Dr. Krieger testified that liposuction can be safely combined with other procedures such as Brazilian butt lifts and that "[l]iposuction is part and parcel of a Brazilian butt lift." He further testified that "you cannot do a Brazilian Butt Lift without obtaining the fat through liposuction." (Tr. Vol IV at 45-46)

Dr. Krieger further testified that liposuction can be safely combined with abdominoplasty, breast augmentation, mastopexy, breast revision. Dr. Krieger further testified that liposuction would be safe to perform in conjunction with a Renuvion J-plasma procedure. (Tr. Vol IV at 46, 49)

173. Dr. Krieger acknowledged that the Board's rules do require that, for all liposuction patients, discharge instructions related to Lidocaine toxicity must be given regardless of whether that medication was used in the tumescent fluid. (Tr. Vol IV at 52) However, Dr. Krieger testified that there is no medical reason to provide lidocaine toxicity instructions to patients when lidocaine was not included in the tumescent fluid used during their procedures. Further, Dr. Krieger testified that there are medical reasons not to include that information when lidocaine was not part of the fluid because it creates confusion. (Tr. Vol IV at 52-53, 58)

174. Dr. Krieger testified that he has viewed some of Dr. Grawe's social media posts that were produced by both the State and Dr. Grawe and that were included in the exhibits in this matter. He believes that the videos reflected very positively on her and believes that they were helpful to patients. (Tr. Vol IV at 65-66)

175. Reviewing Patient 1's Social Media Consent Form that she signed for her March 21, 2022 surgery, Dr. Krieger opined that the form Dr. Grawe used was excellent and "is better than what we used to use" when Dr. Krieger had his ambulatory surgery facility. (Tr. Vol IV at 70-71) He further opined, "These are as clear and thorough as I believe is possible, and I think I have seen some, but they are unusually complete and clear." (Tr. Vol IV at 84-92)

176. Dr. Krieger testified that he had had an opportunity to review the video of Patient 1's second surgery prior to his testimony. Dr. Krieger further testified that, in his opinion, Dr. Grawe maintained complete control of the cannula tip throughout the video. (Tr. Vol IV at 73) He further testified that Dr. Grawe used the cannula at the appropriate angles: "The cannula needs to be kept parallel to the patient's body, to the patient's skin, and the fat layer as opposed to an acute angle that points downward towards the internal structures of the body. And she maintained that parallel positioning at every point in the video." (Tr. Vol IV at 73)

177. Dr. Krieger testified that he observed Dr. Grawe's use of the cannula, her hand placement, and the angle of the cannula to the body. At approximately 1:15 to 1:22 into the video, Dr. Krieger testified that the cannula "is completely straight and flush parallel to the body, and is not an angle downward or inward towards the internal structures of the body." Also, he testified that "she's using her left hand to assess the position of the tip as --which is in some ways redundant, because the tip is in the right place based upon her right operating hand, keeping the cannula completely parallel." (Tr. Vol IV at 77; St. Ex. 6 at 1:15 – 1:22)

    At approximately 1:50 to 1:52 in the video, Dr. Grawe testified that he is able to see the tip of the cannula when Dr. Grawe inserts the cannula into the umbilical incision and makes three passes with the cannula. (Tr. Vol IV at 78-79; St. Ex. 6 at 1:50 – 1:52)

178. Dr. Krieger testified that there is no standard of care that you have to have your left hand in any particular place. (Tr. Vol IV at 79) Dr. Krieger further testified:

> The standard of care is to have knowledge and control of where the tip of the cannula is traveling.
>
> The first way of doing that is with your right -- with her right -- if you're right-handed, your right operating hand, keeping it parallel as it is here to the body, rather than an angle pointing downward into the body, that's the first way of having control and understanding of where the cannula is going.
>
> The second way is to monitor where the tip is. That could be visually, it can be by your hand palpating it. I think those are really the only ways.
>
> But it's -- your right hand is where the action is, because the right hand is moving the cannula. So the control begins and ends with your right hand.
>
> The others are confirmatory that you're doing it correctly, and that you're keeping control correctly.
>
> And I don't mean to dismiss them when I say redundant, I don't say meaningless, but they are confirming what your right hand is doing, and your right hand drives the action and your right hand also provides feedback to the surgeon about where the cannula is headed, because you know -- you know if you bend your wrist or not that you are taking a cannula out of that parallel safe position.

    (Tr. Vol IV at 79-80)

179. At approximately 2:04 to 2:10 into the video, Dr. Krieger testified that he is able to "very clearly" see the tip of the cannula as it reaches the midline of her abdomen. (Tr. Vol IV at 80; St. Ex. 6 at 2:04 – 2:10)

180. At approximately 2:12 to 2:15 into the video, when Dr. Grawe is demonstrating the amount of force needed to push through scar tissue, Dr. Krieger testified that "this was not in any way an undue amount of force, and the tip was still visible. * * * And the right hand was holding it in that safe parallel zone." (Tr. Vol IV at 80-81; St. Ex. 6 at 2:12 – 2:15)

181. When asked if there was anything in the video that caused concern, Dr. Krieger testified that Dr. Grawe demonstrated adequate control at all times and that she met the standard of care. (Tr. Vol IV at 81)

182. Dr. Krieger testified that he does not participate in social media and that he "wouldn't know where to begin." (Tr. Vol IV at 61) Dr. Krieger further testified that the internet has never been part of his personal or professional life although his practice does have a website. Dr. Krieger believes that that makes him the exception because a lot of physicians do use social media. Dr. Krieger further testified that he had colleagues who livestream their surgeries. Moreover, Dr. Krieger testified that, when he had his surgical facility, he approved the use of social media subject to some parameters such as immaculate patient consent. (Tr. Vol IV at 62-63)

183. With respect to Dr. Grawe's use of social media to post videos of procedures on the internet, Dr. Krieger acknowledged that he does not post his procedures on social media and lacks familiarity with that technology. (Tr. Vol IV at 170-171) With respect to the colorful emojis and the words "Let's get this party started" that can be seen on the video of Patient 1's second procedure, Dr. Krieger testified, "I do know from my daughter that there's a language that's used with these little doodle popup phrases that I don't understand, and that's why I haven't chosen to participate. But as far as I have seen, it would not be a respectable quote, unquote, SnapChat without these little icons and quotes that seems universally part of it." (Tr. Vol IV at 171-172)

    Dr. Krieger acknowledged that such embellishments do not serve an educational purpose. (Tr. Vol IV at 172)

184. Dr. Krieger agreed that livestreaming videos of surgery could potentially divert the surgeon's attention away from the patient. He further agreed that the surgeon needs to be focused on the patient during procedures. (Tr. Vol IV at 175)

185. Dr. Krieger testified concerning his opinion the Dr. Grawe's preoperative care of Patient 1 met the standard of care:

> Well, what preoperative care ideally should include is evaluating the patient as an individual, and that's their goals, their expectations, their current anatomy and appearance, and evaluating whether the proposed surgical intervention can work towards meeting the patient's goals, and then individualizing it for things like their age, their health status, and things like that.

> And then having -- creating a situation where the patient is educated enough to make an informed decision about whether -- taking into account the likely outcomes, but the definite risks that they are in a position to make an informed decision.
>
> And the -- what makes the decision informed is almost completely what and how the doctor explains these things to them, and I felt that Dr. Grawe did all that in a thorough and commendable way.

(Tr. Vol IV at 21-22)

Dr. Krieger further testified that Dr. Grawe's intraoperative care of Patients 1, 2, and 3 met the standard of care:

> Well, this was an unusual situation in which there was video, and that added the ability to actually see some of what was going on.
>
> But the -- the procedures as performed were done in a completely professional -- we talk about indications, and it matched the indications for surgery, meaning that what was the goal, and her technical maneuvers were aligned to achieving that goal. And it was clearly done in a professional and safe environment.

(Tr. Vol IV at 22-23)

Moreover, Dr. Krieger testified that Dr. Grawe's postoperative care of the three patients met the standard of care:

> Well, most importantly, Dr. Grawe and her staff were immensely accessible at all times to be involved with these -- I assume all patients that she has, but in these cases, certainly in terms of answering questions, being available for unscheduled visits, and having a constant or semi-constant interaction so that it's not a -- it's less of a mechanical process of doing the surgery and then sending the person out to be on their way. It's a continuous process of care, and that was evident in the records.

(Tr. Vol IV at 23)

Testimony of Patient 1

186. Patient 1 testified that she is familiar with Dr. Grawe and that Dr. Grawe performed two procedures on her. She lives in the Dayton area. (Tr. Vol III at 5, 8) Patient 1 described how she became aware of Dr. Grawe:

> Well, back in 2018 is when I started researching trying to -- you know, I wanted -- I was looking at doing a BBL. So in 2018, I started looking around. I think I found her on RealSelf, and then I found her on Instagram. And that's when I found out that she had like a lot of before and after pictures. I did have my research dealing with other doctors, but I kind of was looking more local so I wouldn't have to travel as much.
>
> And I looked at and I liked her work, you know, her before and after pictures. And, you know, her procedure, her BBL seemed to be more natural looking versus, you know, out of the -- you know, just fake.
>
> * * *
>
> So that's what drew me to her.

(Tr. Vol III at 8)

When asked if other physicians she researched had the same level of social media presence as Dr. Grawe, Patient 1 testified, "No, they did not. There were some that had before and after pictures, but she had Snapchat. So, you know, that's what really drew me, that I can actually look at the procedures, what's being done and stuff like that." (Tr. Vol III at 9) Patient 1 also testified that Dr. Grawe had posted videos of actual surgical procedures. It enabled Patient 1 to see the types of procedures she was doing and the results. Patient 1 further testified that she watched Dr. Grawe's videos daily. Patient 1 felt that was "a big plus" for her because she would be able see her actual procedure being performed and what Dr. Grawe did or did not do. (Tr. Vol III at 9)

187. When asked if she had had any concerns about complications, Patient 1 testified:

> Well, there's -- you know, with surgery I feel there's always complications. I've had three c-sections. So, you know, that in itself, I was kind of a little leery. You know, I wanted a tummy tuck and a BBL the first procedure. And I knew it was a risk, especially with the tummy tuck. But, you know, with the social media presence that she had and Snapchat videos, you know, I felt pretty confident.

(Tr. Vol III at 10)

188. Patient 1 testified that she found that watching Dr. Grawe on social media was educational because people would ask her questions and have their questions answered in live stream while the video was going on. (Tr. Vol III at 10)

189. Patient 1 testified that she first reached out to Dr. Grawe around 2019 after she had followed her on social media. Patient 1 testified that she had considered other doctors and

read their reviews and, at that time, Dr. Grawe had had good reviews. Patient 1 also noted that Dr. Grawe was local. (Tr. Vol III at 11)

190. Patient 1 noted that the surgery was expensive, and that she used her savings and withdrew money from her 401k to pay for it. (Tr. Vol III at 12)

191. Patient 1 acknowledged that she had found Dr. Grawe to be knowledgeable and someone she could relate to. She felt comfortable asking Dr. Grawe questions and discussing personal, intimate issues with her. She also acknowledged that she had a good relationship with Dr. Grawe throughout the time leading up to her second surgery. (Tr. Vol III at 46-48)

Patient 1's July 2020 First Surgery

192. Patient 1 testified that she had a consultation appointment with Dr. Grawe and her surgery was scheduled. There was some delay that resulted from the Covid pandemic and she eventually had her first surgery in July 2020. She had a tummy tuck, liposuction of the flanks, and a BBL. (Tr. Vol III at 13)

193. Patient 1 was asked how she felt about Dr. Grawe's office when she had her first surgery: "Oh, it was great. The energy matched my energy. I mean, I'm very -- she was outgoing. I'm very outgoing. It was just a pleasant environment that -- you know, one that you wanted to be there. She made you feel comfortable." Patient 1 further testified that her office did not feel like other physicians' offices because of "[h]er vibe. Even her employees, you know, they were just -- the way they greeted you from the door, the one that took pictures, it was just like everybody in the office just had this very unique excitement about them." (Tr. Vol III at 14) Patient 1 further testified that it felt more personal than other physicians she has seen. (Tr. Vol III at 14)

194. Patient 1 testified that Dr. Grawe asked for her consent to being featured on social media and that she consented. (Tr. Vol III at 15)

195. Patient 1 testified that she stayed at the Recovery House following her first surgery because it was a requirement. Patient 1 testified that she was required to stay there because it had been her first surgery. (Tr. Vol III at 17)

196. Patient 1 testified that she did well following her first surgery and "didn't have any issues at all. I was fine." (Tr. Vol III at 18)

Patient 1's March 2022 Second Surgery

197. Patient 1 testified that she ultimately decided to go back to Dr. Grawe for a second surgery. She testified:

> So on my follow-up surgeries, I did end up getting -- did end up having dog -- what they call dog ears. So I needed that fixed. So that was an

> additional fee. And also there was like a stitch that poked out of my incision that they took out when they did the dog ears revision.
>
> So once the revision was finished, about a couple weeks later -- I know I was still in the healing process, I started noticing that my tummy tuck scar was hard, and it wasn't flat. So that was a concern of mine. So I reached out to her. I think it was maybe Dr. Carlos, and he was like, well, give it time. You know, he was telling me techniques to do, you know, get a massager and maybe try to do that. Well, I was doing everything that he said and it still -- still was like a lump, like a lump all through my scar. Like it wasn't straight. It was just like a heel, just heels, you know, on the scar.
>
> And so I brought that to her concern, and she was like, oh, that's scar tissue. Liposuction can get rid of that. So that's when I decided to do the second one.

(Tr. Vol III at 19-20)

198. Patient 1 acknowledged that she had understood prior to her second surgery that one of the complications could be an infection, and that complications can occur even if the doctor does everything right. (Tr. Vol III at 45-46)

199. Patient 1 testified that she had consented to her second surgery being shown on social media. She further testified that her daughter had recorded it on video, as she had done for Patient 1's first surgery, because the video would be posted on social media for only 24 hours and Patient 1 wanted to be sure she could see it. (Tr. Vol III at 23)

200. Patient 1 testified that she was discharged home following her second surgery, where she was cared for by her husband and her daughter. (Tr. Vol III at 24)

201. Patient 1 testified that her post-operative experience following her second surgery was very different from her first. The day following the surgery she "wasn't feeling up to par." Her energy level was low and she just "didn't feel the same." (Tr. Vol III at 24-25)

Patient 1 testified that she slept in her granddaughter's room because the bed was lower, and her husband and daughter brought her the medications and "[m]ade sure I was doing my dressing changes and fed me." When asked if she had taken a shower after she got home, she replied that she did not, and that she had been instructed not to take one for the first 24 hours after surgery. Patient 1 also recalled that she had been told by her husband and daughter that she could not take a shower. However, she testified that she did take a shower within the first five days following her surgery. She further testified that she or her husband cleaned her wounds. (Tr. Vol III at 26-27) Moreover, she testified, "my husband is very, very particular about care. So I had all the paperwork. I mean, so the first -- the first time he helped me -- the first surgery he helped, you know, with the drains and the wounds. So he pretty much knew what to do." (Tr. Vol III at 27)

202. On March 22, 2022, a member of Dr. Grawe's staff called Patient 1 to check on her. Among other things, Patient 1 had indicated that she had not yet had a bowel movement. The note states, in part, that Patient 1 will purchase a bottle of magnesium citrate if she has not had a bowel movement by the end of the next day. (Resp. Ex. A-1 at 48-49) Patient 1 did not recall being constipated following her second surgery and that the magnesium citrate was one of the medications she was supposed to take. (Tr. Vol III at 67)

203. Patient 1 testified that her husband became concerned about her condition on Wednesday, which was two days following her surgery.[10] Patient 1 testified that she had been "kind of going in and out." (Tr. Vol III at 27) Her husband called either Dr. Grawe's office or the Recovery House and asked what he should do. They told him that it was normal and advised that he cut back on Patient 1's medication, which he did. However, Patient 1 testified that it didn't make a difference, she was still lethargic and not nearly as functional as after her first surgery. (Tr. Vol III at 27-28)

Patient 1 testified that at some point her husband called EMS. They came, checked her out, and told them everything appeared to be okay. (Tr. Vol. III at 29)

Patient 1 described her condition at that time, "So I just remember -- like I'll be --I'll be up, you know, and alert and, you know, looking; and they ask me a question I might say it, and then the next minute I'm out and I don't remember." (Tr. Vol III at 30)

204. Patient 1 testified that at some point her husband took her to the Roxy House to be seen. From there, she went to the OSU Wexner Medical Center. (Tr. Vol III at 32)

205. Patient 1 testified that she has no memory of that event or of being taken to the hospital. She testified that her first memory is "waking up in the hospital with constraints." (Tr. Vol III at 32-33) Patient 1 further testified, "I was told I was in a medically induced coma for 10 days. So when I finally woke up, I was tied to the bed and I didn't know why. So for me not remembering anything, to be waking up, being tied to the bed, I went crazy. I didn't know what happened." (Tr. Vol III at 33) Patient 1 testified that she was delirious and thought everyone was trying to hurt her. She did not recall going through surgery at the hospital, did not know why she was in constraints, and "going crazy because I didn't understand why I was there." (Tr. Vol III at 34)

Patient 1 testified that she learned that she was in constraints for her own safety because they did not want her to touch her abdominal area or remove the coverings that were place there. (Tr. Vol III at 34-35)

206. Patient 1 testified that, she woke up in the intensive care unit and remained there for about two weeks, "[a]nd it wasn't until toward the end of the week that I actually -- my brain started actually working again, that I'm realizing, oh, my God. I'm here as a result of

[10] Administrative notice is taken that Wednesday was March 23, 2022, two days following the March 21, 2022 surgery.

surgery. So that's --that's what I was realizing. Then after that, I know I did have a fish skin graft. And -- and then I had a skin graft of my head and my -- area of my thigh." (Tr. Vol III at 36) Patient 1 testified that "So they took the skin from my entire head and placed it over my abdomen, as well as my thigh." She testified that those were the major ones. She believes there were other grafts as well "but those were the ones that I totally remember the most because they were so painful." (Tr. Vol III at 36)

207. Patient 1 testified concerning the pain she suffered as she underwent multiple skin grafts and bandage changes. She testified that the bandage changes, which occurred twice a day, were excruciatingly painful. Patient 1 further testified that it was so bad and her anxiety level was so high that she had to take anti-anxiety medication as well as pain medication to get through it. She also had to undergo debridement as the skin regenerated, which was painful also. (Tr. Vol III at 36-38)

208. Patient 1 testified that she was in the hospital for about 60 days, and then taken to a rehabilitation facility for three weeks. Following that, she was discharged home and was having daily nurse visits for wound care. Patient 1 testified that the nurse visits lasted for about a month with decreasing frequency over that time. They stopped when Patient 1 was able to provide her own wound care. (Tr. Vol III at 36-39)

209. Patient 1 testified concerning her current condition. The following exchange took place:

A. Well, I -- I have to constantly wear a protector. Kind of the medical grade binder is just -- doesn't -- it doesn't really work. It's too bulky. So I kind of did a makeshift type thing. So I take an ace bandage, and I wrap it around to bring up my stomach because everything is drooped down. And then I take another -- like this waist trainer that is kind of flexible, and I wrap it around my stomach. And then I have another like support garment that lifts up that goes above my breast that I wear as, you know, a protectant and to try to hold it in.
Q. [By Ms. Snyder] Okay. And when you say "as a protectant," what are you protecting with those garments?
A. Well, my stomach because the only thing is -- I have is just skin graft and -- well, thin layer of skin graft and then my insides.
Q. Okay. So you no longer have any abdominal muscles?
A. None.
Q. Okay. And how has this affected you on a daily basis, your physical condition?
A. Oh, just as far as even sneezing or coughing, you know, I always have to hold my stomach, even walking for periods. I'm not as active. I was very active with my grandkids. I worked out a lot. I can't do any of that just because it's a -- it's a hazard. It's a hazard.
I'm just scared of just getting in a car accident and, you know, just -- God forbid if somebody stabbed me, you know, straight to my insides. So I'm

> very cautious and careful of my daily activities. I'm totally not the same. I'm not the energetic person that I was. I'm kind of, you know, closed off.

(Tr. Vol III at 39-40)

Patient 1 further testified:

> I was in a very, very dark place. When I was in the hospital, I couldn't under -- like when I said earlier, I couldn't understand why this happened to me. I just wish -- there were times that I wished that I didn't even make it because I didn't know how I would survive. I've never heard of somebody actually living with no -- with the loss of domain, with no stomach muscles and I'm trying --and I'm saying, oh, my God, this is a disability, just because I chose to have this surgery. So I beat myself up a lot. I was in a very dark place.
>
> So with that being said, coming home I didn't want to do anything. I was embarrassed. I was angry. I was just -- I just wanted to stay at home. So my activities were very, very limited because, I mean, this changed my life. I'll never be the same.

(Tr. Vol III at 41)

When asked what her future looks like, Patient 1 testified:

> There is an option of me having a surgery to help, not fix, to provide me more support. And that would be to take skin and muscle from one or both legs. And it's called a free flap transfer. And transfer it over my stomach. But with that, I would have to have a mesh and then the free flap. So there's all type of risk involved with that. But, I mean, what I do I can't -- I can't go on living like this with that loss of muscle. You know, I just --so that's one thing that I'm trying to consider.
>
> Ohio State never seen anything like that, so they couldn't touch it. They wouldn't touch it. One of the doctors at Ohio State found me somebody at Cleveland who said that they can do it. They can make -- try to make the quality of my life better, but this could be up to a 15-hour surgery, and there are major risks. So I'm kind of struggling with that.

(Tr. Vol III at 41-42)

210. Patient 1 concluded:

> Well, I just -- I didn't know how --there was a point in time that I -- I just wish I wasn't here. You know, I just was embarrassed. I didn't know how I would

> go on living because I would never be the same. This is considered a disability, but I can't go out on disability because I still have a family to support.
>
> You know, so it's just – it changed -- it doesn't change my outlook on cosmetic procedures, it changes my outlook on how doctors should focus more on their patients other than social media. I think with Dr. Roxy I think social media got the best of her, and she was worried about -- in my opinion, she was worried about quantity, not quality. And being -- you know, the more surgeries she had, the more money she'd make, not the quality care of the patient.
>
> Because hindsight, I'm not a medical expert, but she was performing a lot of surgeries in one day. And that could be, you know, tiring. And then being on social media, it's just I don't think that she properly cared for the patients like she should have. And it just bothers me. I mean, that's what drew me to her.
>
> But then, you know, once you think about it, you know, the people that she had affected, it's -- they're saying the same thing. And it's just -- it's just a horrible experience to experience.

(Tr. Vol III at 43-44)

211. Patient 1 acknowledged that she testified at the hearing pursuant to a subpoena. (Tr. Vol III at 71)

Patient 2

212. Patient 2, a female, first saw Dr. Grawe on November 17, 2020, to discuss liposuction. She was 36 years old at the time. (St. Ex. 2a at 57-60)

213. According to Dr. Grawe's Operative Note, on December 10, 2020, Dr. Grawe performed the following procedures on Patient 2 under general endotracheal anesthesia at Roxy Plastic Surgery:

    1. Liposuction 360
    2. Brazilian Butt Lift
    3. Umbilical Hernia Repair
    4. Renuvion J-plasma of the abdomen and flanks

    (St. Ex. 2a at 36)

    Dr. Grawe testified that Liposuction 360 "means we do liposuction 360 degrees around the trunk, so it's the abdomen and back." (Tr. Vol I at 201) Dr. Grawe further testified that the umbilical hernia had not been diagnosed prior to the surgery. (Tr. Vol I at 201) Moreover,

Dr. Grawe testified, "On exam I didn't see it and nor did the COPC physician, but a lot of times when people undergo anesthesia, their abdominal wall becomes more relaxed, and then it was apparent to me." (Tr. Vol I at 202) Dr. Grawe further testified that she had to fix the hernia before she could do liposuction:

> There's a medical reason, because a hernia means that there's a hole in the fascia. So you have your abdominal organs, the fascia, the muscle, another layer of fascia, and then the subcutaneous fat, and if there is something coming through from the intra-abdominal region through that muscle and you can see that, you don't know what that is. You don't know if it's just omental fat or if it is a loop of small bowel, so it has to be reduced back into its place, close that fascia, before you do the liposuction.

(Tr. Vol I at 202-203)

214. Dr. Grawe acknowledged that she had removed 4,900 cc of aspirate during the procedure. Dr. Grawe testified that she had believed that she was operating in an ASF and was following the rules applicable to that sort of facility. (Tr. Vol I at 203; St. Ex. 2a at 36)

215. Patient 2 granted consent to being featured on Roxy Plastic Surgery's social media outlet on Snapchat only. (St. Ex. 2a at 40; Tr. Vol I at 203-204)

216. Dr. Grawe testified that Provider Notes chronicle the patient's progress after surgery. (St. Ex. 2a at 54; Tr. Vol I at 204) Dr. Grawe testified that, following surgery, Patient 2 went to the Recovery House. (Tr. Vol I at 204) According to a provider note by Dr. Grawe's director of nursing, Patient 2 called their emergency line on December 11 at 1:05 a.m. complaining of "diffuse abd cramping and burning 10/10." She told the nurse that she had previously had rhabdomyolysis after engaging in crossfit and that this pain felt similar. (St. Ex. 2a at 54) The note further states:

> Per the house aide, patient started to feel bad a few hours ago. I had the aid assess drainage from LLQ penrose and covering dressings, which was stated to be serosanguineous and without odor. Her abd appeared to be swollen but WNL. HR 90's and normal. Foley catheter with 2,000mL of dark yellow urine over past 4 hours without sediment per picture sent per this RN request. Patient did not seem to be in distress when we talked. I educated her on pain expectations after a long liposuction surgery. I instructed her and the aide to give her zofran for the nausea and let it start working, followed with a light meal and then to start neurontin and 2 percocet instead of 1 (per. Dr. Domigo's orders). Encouraged increased fluid intake and rest. I told her we would be rounding first thing in the morning. If she starts to feel worse or is unable to manage pain with these interventions, she is to call back. Patient and aide verbalized understanding and seemed on board with this plan.

(St. Ex. 2a at 54)

Dr. Grawe testified that the house aide was not an STNA but was a caretaker whom Dr. Grawe had trained. She further testified, "So this would be the same as if she was at home and the nurse was asking the husband what does the color of the drainage look like, what does the smell smell like. They're trying to gather more information." (Tr. Vol I at 205)

217. The next provider note documents a call from the house aide received by Dr. Grawe's director of nursing on December 11 at 1:45 a.m. The note states:

> Received a call from the house aide, patient decided to call 911 to be assessed. I offered to have Dr. Domingo come to the house to assess the situation, but the patient was adamant and preferred to be seen in the ER. Per EMS, patient stable but will take her to Dublin Methodist or Riverside to be evaluated. Dr. Domingo aware, will follow up with patient.

(St. Ex. 2a at 54)

218. Patient 2 was taken to Dublin Methodist Hospital ("Dublin Methodist"). A hospital note concerning Patient 2, which appears to be dated December 12, 2020, states:

> -With liposuction and fat transfer 12/10/20 with Garwe (sic)
> -Developed abdominal muscle cramping and dark urine (has indwelling foley from surgery) 12 hours after surgery
> -Was to stay at "recovery house" for 5 days post procedure
> -Has multiple incision sites per patient, abdominal binder in place
> **-Discussed with her on call surgeon Dr Domingo, her pain and abdominal swelling is to be expected, he recommended getting her OOB and starting aggressive bowel regimen if no BM today. No need for dressing changes, ok to shower and get incisions wet, they do not have privileges here at DMH, if needed, we would need to consult general surgery**
> -Continue oxycodone and IV dilaudid for breakthrough, gabapentin and IV Toradol added overnight

(St. Ex. 2 at 26) (Emphasis in original)

219. A hospital progress note dated December 13, 2020, states in part, under Assessment and Plan:

> **Intraperitoneal abscess**
> **Perforated small bowel**
> **Pneumoperitoneum**
> -Patient presented with increasing abdominal pain s/p liposuction. CT was obtained showing free air and patient underwent emergent surgery on 12/12 with Dr. Shoemaker

-Continue post op mgmt and antibiotic therapy directed by surgery
-Follow OR cultures

Anemia, acute blood loss
-Secondary to recent surgery and aggressive fluid administration
-Monitor, transfuse < 7

Hyponatremia
-Possibly pain mediated/SIADH
-Continue to monitor with fluid resuscitation

Rhabdomyolysis
-Secondary to abdominal surgery
-Hx of rhabdomyolysis 4 years ago secondary to Cross Fit
-Continue to trend CPK levels
-Continue NS at 200cc/hr, q 6 BMP and CK

(St. Ex. 2 at 28-29) (Emphasis in original)

220. Dr. Grawe acknowledged that she had spoken to Dr. Shoemaker, the surgeon who repaired Patient 2's bowel at Dublin Methodist hospital. Dr. Grawe further testified that she spoke to Dr. Shoemaker after he saw the CT scan results to tell her that he was taking her to surgery, and again following the surgery to tell her what he had found. Dr. Grawe testified that he found and repaired six bowel perforations. (Tr. Vol I at 211-212)

Dr. Grawe acknowledged that she did not document her two phone calls from Dr. Shoemaker in the medical record, other than in an email to Patient 2. When asked why, Dr. Grawe testified:

> Because it really would be very difficult to put in the patient record every time you talked to anybody on the weekends and evenings when you're not at your computer at the office, and so I have to look, but a lot of times when we come back on on Monday we'll write some chart notes about what happened over the weekend, but we don't record every single phone call with everybody.

(Tr. Vol I at 211-212)

When asked if Patient 2's emergency surgery impacted her care of Patient 2 going forward, Dr. Grawe testified, "I would mostly manage the plastic surgery component of what she was still healing from, and Dr. Shoemaker would manage the general surgery component." (Tr. Vol I at 212)

221. Patient 2 returned to Dr. Grawe's office on December 21, 2022, following her release from the hospital. At that time, she was seen by both Dr. Domingo and Dr. Grawe. (Tr. Vol I at 210-211; St. Ex. 2a at 61-63)

Patient 2 – Testimony of Dr. Surfield

222. Dr. Surfield testified concerning Patient 2, "So this patient underwent a procedure where she had liposuction, umbilical hernia repair. And she ended up subsequently having a bowel perforation that was identified at the hospital afterwards after she was admitted for rhabdomyolysis." (Tr. Vol II at 79)

223. With respect to the umbilical hernia repair, Dr. Surfield testified, "The main reason why you worry about hernia is -- during liposuction is that there is --that's a weakening in the abdominal wall. So that safe space that you think that you're in that's between the fascia and the skin can now have intra-abdominal contents into it. So that's a concern with a hernia during liposuction." (Tr. Vol II at 82)

224. Dr. Surfield testified that the amount of aspirate identified in Dr. Grawe's operative report is 4,900 ccs. Dr. Surfield testified that the maximum amount of aspirate allowed under the Board rules for office-based surgery is 4,500 ccs. (Tr. Vol II at 83; St. Ex. 2a at 36)

    Dr. Surfield testified that the removal of 4,900 ccs of liposuction aspirate, and the performance of other procedures along with liposuction, would have met the standard of care if her ambulatory surgical facility had been appropriately licensed. (Tr. Vol II at 141-142; St. Ex. 2a at 36)

225. Dr. Surfield testified that Patient 2's medical record does not document the makeup of Dr. Grawe's tumescent fluid she used for the liposuction. (Tr. Vol II at 83-85)

226. Dr. Surfield testified that Dr. Grawe performed multiple procedures on Patient 2 along with liposuction which violated the Board's rules concerning office-based surgery. (Tr. Vol II at 86)

227. Dr. Surfield noted that, the day following her surgery, while staying at the Recovery House, Patient 2 developed abdominal pain that she compared to a previous bout of rhabdomyolysis. She asked to be transferred to a hospital and was taken to Dublin Methodist Hospital. (Tr. Vol II at 86-87)

    Dr. Surfield testified among other things that Patient 2 had labs drawn at the hospital and was found among other things to have an elevated CPK level of almost 12,000.[11] Because of that the hospital admitted her and started her on aggressive fluid resuscitation. (Tr. Vol II at 87; St. Ex. 2 at 12, 17, 76) Dr. Surfield testified concerning CPK and its significance, "So with CPK, that's a -- that's an enzyme that's found in muscle, and it's a specific enzyme for muscles. So it indicates some sort of trauma or breakdown of that

[11] The transcript states that the CPK level was near 1,200; however, it is clear from the medical record that the level taken on December 11, 2020, was actually near 12,000 U/L with a reference range of 40 – 170 U/L. (St. Ex. 2 at 76)

muscle. And so she was found to be in rhabdomyolysis with this very elevated level of the creatine kinase or the CPK." (Tr. Vol II at 88)

Dr. Surfield further testified that rhabdomyolysis is "a trauma to the muscle that causes breakdown and release of the enzyme. That enzyme can then end up causing some issues due to toxicity to the kidneys. And so that's why they are bringing her in to be admitted with aggressive fluid resuscitation." (Tr. Vol II at 88)

228. Dr. Surfield testified that a CT scan was performed that revealed pneumoperitoneum, or free air inside the abdomen and outside the bowel. Based on that finding, Patient 2 underwent an exploratory laparotomy on December 12, 2020. (Tr. Vol II at 88-89) The procedures performed are listed on the operative report as:

1. Exploratory laparotomy with drainage intraperitoneal abscess
2. Small bowel resection with primary anastomosis
3. Repair of small bowel enterotomy x 2
4. Partial omentectomy

(St. Ex. 2 at 62)

Dr. Surfield testified that the operative diagnoses were an abdominal abscess, six perforations of the small bowel, and pneumoperitoneum. (Tr. Vol II at 90) Dr. Surfield further testified that the abdominal abscess was "likely due to the spillage of the intraluminal contents of the bowel." (Tr. Vol II at 90)

229. Dr. Surfield testified that, following surgery, Patient 2 recovered and was discharged home. (Tr. Vol. II at 91)

230. Dr. Surfield opined that Patient 2's rhabdomyolysis resulted from significant injury to the abdominal muscle caused by the liposuction cannula skimming along the muscle. (Tr. Vol II at 91) When that happens, "this is sucking the muscle up into the cannula, and it's causing injury all along the length of the muscle. And that's happening multiple times." (Tr. Vol II at 92) Dr. Surfield further testified that this would not have been caused by just one "small pop through" with the cannula, like from a stab wound. Dr. Surfield testified that the cannula would have been rubbing along the muscle tissue at a very small angle, causing "a large amount of trauma because a large amount of the contact area." (Tr. Vol II at 92-93)

Dr. Surfield further testified that damage to the abdominal muscles as described above was most likely the cause of Patient 2's. He also testified that there are two other less likely causes. The first could have been damage to the gluteal muscle during the fat grafting. Dr. Surfield doubted that was the case, however, due to the large amount of intra-abdominal injury. The third possibility could have been the patient's positioning during the surgery, but he doubted that was the cause in Patient 2's case. (Tr. Vol II at 93-94)

231. Dr. Surfield testified that, theoretically, the cannula tip can go below the abdominal wall in the absence of negligence and catch multiple loops in one pass and could, theoretically, caused the six holes in Patient 2's bowel without repeatedly going under the muscle. (Tr. Vol. II at 185-186)

232. Dr. Surfield testified that he had opined that Dr. Grawe's failure to provide Patient 2 with discharge instructions concerning lidocaine toxicity deviated from the standard of care. He further testified that, even if Dr. Grawe did not use lidocaine in her tumescent fluid, per the rule, lidocaine toxicity instructions have to be given regardless of the medications used in the tumescent solution. (Tr. Vol II at 143-149)

233. In his report, Dr. Surfield opined that Dr. Grawe violated R.C. 4731.22(B)(6), and Rules 4731-25-05 (B)(8), 4731-25-05(C), and 4731-25-05 (E), in her care of Patient 2. (St. Ex. 5 at 4)

Patient 2 – Testimony of Dr. Krieger

234. Dr. Krieger agreed that a cannula can go below the abdominal wall in the absence of negligence, and that it is unpredictable how many loops of bowel might be pierced by the cannula. (Tr. Vol IV at 109-110)

235. Dr. Krieger also testified that it is safe to perform liposuction in conjunction with a BBL and a hernia repair. Dr. Krieger further opined that removing 4,900 ccs of liposuction aspirate during Patient 2's procedure did not affect the outcome. (Tr. Vol IV at 49-50)

236. Dr. Krieger testified that Patient 2 had a complete history and physical examination performed by another provider prior to her surgery. However, that provider did not find the hernia that was later found by Dr. Grawe during Patient 2's procedure. (Tr. Vol IV at 102)

237. Dr. Krieger testified that Dr. Grawe's repair of Patient 2's hernia decreased Patient 2's risk profile for liposuction back to what it was as if she had no hernia. (Tr. Vol IV at 105)

238. Dr. Krieger testified that in performing Brazilian butt lifts, Dr. Grawe placed the fat grafts under the skin and nowhere near the muscle. (Tr. Vol IV at 108)

239. Dr. Krieger opined that Dr. Grawe's surgical technique for Patient 2's surgery met the standard of care. (Tr. Vol IV at 108)

240. Dr. Krieger criticized Dr. Surfield's three possibilities for Patient 2'rhabdomyoslysis. He testified that they were not based on literature and were like hypotheticals and not based on medical facts. He testified that they are not based on any recognized sourcing for that condition. (Tr. Vol IV at 108-109, 110) Dr. Krieger further disagreed with Dr. Surfield's opinion that Dr. Grawe must have spent considerable time in the abdomen to create

rhabdomyolysis. Dr. Krieger testified that "surgeons work in the abdomen all the time and patients don't get rhabdomyolysis." (Tr. Vol IV at 109)

241. Dr. Krieger testified that there is no evidence that Dr. Grawe repeatedly traumatized Patient 2's muscle. (Tr. Vol IV at 113)

242. Dr. Krieger testified that Patient 2 followed up with Dr. Grawe after her hospitalization. (Tr. Vol IV at 152)

243. Dr. Krieger testified concerning his opinion the Dr. Grawe's treatment of Patient 2 met the standard of care for the same reasons discussed with regard to Patient 1. (Tr. Vol IV at 21-23)

Patient 3

244. Patient 3 is a female who first saw Dr. Grawe on September 13, 2018. She was 45 years old at that time. (St. Ex. 3b at 3-6)

245. On December 1, 2021, Dr. Grawe performed a breast augmentation mastopexy revision with an internal bra (Galaflex) under general endotracheal anesthesia at Roxy Plastic Surgery. (St. Ex. 3b at 1) In her operative report, Dr. Grawe described Patient 3's previous history of breast surgery:

> [Patient 3] is a 48-year-old female with an unacceptable cosmetic appearance for which she would like to undergo the above procedures. She has a complicated history starting with a breast reduction as a teenager. She then underwent breast augmentation with submuscular saline implants by another surgeon. She didn't like how big she was and underwent a revision with another surgeon for 300cc silicone implants. She complains of her breasts looking wide, the implant falling to the side, and still being much larger than she would like to be. She would like to be a C cup at the largest even though she understands we cannot guarantee a certain bra size.

(St. Ex. 3b at 1)

Dr. Grawe testified that this had been Patient 3's fourth breast surgery, having had three previous surgeries performed by other physicians. Dr. Grawe testified that her history made Patient 3 a complicated case. (Tr. Vol I at 214) Dr. Grawe testified, "Having multiple surgeries of the breast and specifically the breast reduction and augmentation combination can compromise the blood supply to the skin and also the nipple when you're doing this operation." (Tr. Vol I at 215)

246. Dr. Grawe explained the difference between a mastopexy and an augmentation, "A mastopexy is a breast lift, and that involves lifting the breast skin up, removing -- or moving the breast tissue higher onto the chest and then bringing it altogether and then

sewing it in an anchor fashion, where an augmentation is placing the implants." (Tr. Vol I at 215) When asked if augmentation means larger just by definition, Dr. Grawe replied, "It doesn't mean larger than you are, but it means you're augmenting the breast, typically with an implant, but it could also be with fat grafting." (Tr. Vol I at 215-216)

Dr. Grawe further testified that an internal bra

> is almost like a mesh. It's a synthetic material that gets incorporated into the tissues, and it's specifically made for this purpose in the breast, because her implants were falling to the side. If your the -- have the type of tissue that needs a breast lift, that means your tissues are much more ptotic or stretchy, and the inside tissues are the same. They're not as tight, so if you put an implant in, they can easily fall to the side with gravity, down and out, and compromise how things cosmetically appear, and that was in her case, and, therefore, we decided to do something called an internal bra, which takes that mesh and closes down the bottom and the side of the breast in order to hold that implant more centrally.

(Tr. Vol I at 216)

December 6, 2021 visit

247. On December 6, 2021, Patient 3 returned to Dr. Grawe's office for a postop visit. The progress note indicated that she was seen by a "midlevel independently." (St. Ex. 3b at 20) Dr. Grawe believes Patient 3 was seen by the nurse practitioner and did not know why the NP's name did not appear on the note. (Tr. Vol I at 217)

The HPI for that visit states:

> She has undergone breast augmentation revision. The scar pattern is wise. Patient reports with nausea since surgery with no relief from Zofran. She reports she stopped taking her antibiotic she was prescribed. She states her antibiotics and Percocet made her stomach feel a lot worse. She denies any other symptoms or discomfort. She is here for an evaluation.
>
> OF NOTE: Patient states she has been feeling nauseous and "ill" about a week prior to surgery. She states she was in the hospital with her daughter and is concerned she might have been exposed to covid. She also shared "I wish would of waited on the surgery until I started feeling better". States she took a home COVID test which she tested negative.

(St. Ex. 3b at 20)

Under the physical examination section, the comment for NAC[12] states, "left nipple slightly purple in color with sluggish cap refill." (St. Ex. 3b at 21)

When asked whether it is normal for a nipple to look like that at this stage in her recovery, Dr. Grawe testified:

A. [W]hat it means is that there is something going on with that nipple that's not perfect, but it is what we saw.
Q. [By Ms. Snyder] It's not supposed to be purple?
A. It's supposed to be perfect after.
Q. Okay.
A. But it happens.

(Tr. Vol I at 220-221)

December 8, 2021 Visit

248. On December 8, 2021, Patient 3 returned to Dr. Grawe's office. The HPI indicates, "She has undergone augmentation/mastopexy. The scar pattern is vertical. The patient is concerned with bleeding, noticed dark blood draining from left breast incision (bottom); no pain. The patient has good pain control. The patient has been wearing the surgical bra." (St. Ex. 3b at 23)

Dr. Grawe testified that Patient 3 was seen by both Dr. Domingo and Dr. Grawe at this visit. (Tr. Vol I at 221-222)

In the physical examination section of the note, it indicates with respect to the incision that steri strips and dermabond were in place, and the comment states, "left, expressible serosanguinous drainage from horizontal incision; evidence of hematoma; no signs of infection." For NAC, the comment states, "left NAC – slow cap refill, 'poke test' shows bleeding." For fluid collection, the comment states, "suspect hematoma." (St. Ex. 3b at 24)

249. Dr. Grawe testified that a hematoma "means that there was some bleeding in that subcutaneous plane sometime after surgery, which had stopped and then formed clotted blood." (Tr. Vol I at 223) Dr. Grawe further testified that Dr. Domingo evacuated the hematoma at this visit. (Tr. Vol. I at 223) When asked if she would have been the best person to perform the procedure because she had inserted the implants, Dr. Grawe testified that the hematoma did not in any way involve the implant. Further, "This is something that you remove a couple stitches and it's directly underneath the skin, and he's trained to evacuate hematomas extensively in his residency and with me." (Tr. Vol I at 224) When asked if the hematoma could have been anywhere in the capsule, Dr. Grawe testified:

[12] Dr. Grawe testified that NAC means nipple-areolar complex. (Tr. Vol I at 218-219)

> It wasn't in the capsule at all. It was -- there's the -- there's the implant, the capsule, then breast tissue, then skin, and in order to do the breast lift, you move the skin, lift it up this way, and the breast tissue is there. So the only part that is connecting to the capsule is a small area at the bottom of the breast in this midregion, and the hematoma was above that, many layers above that. So could it involve -- could there be some involvement or a problem with that implant cavity? Yes, but under sterile evaluation you would likely be able to see that, and that would be a different story. So then that person would go to the operating room to evaluate the implants.

(Tr. Vol I at 224)

Dr. Grawe testified that Dr. Domingo removed two to three stitches from the bottom of the breast and used his gloved finger to evacuate the hematoma, "basically sweeping out those blood clots." (Tr. Vol I at 224-225)

Dr. Grawe testified that they did not do any imaging prior to evacuating the hematoma "because it's directly under the skin." She further testified:

> It's not uncommon that you can get a hematoma underneath the skin after surgery, and because she presented with dark blood draining from her left breast incision at the bottom, so I think it's entirely common, in my training and with other plastic surgeons in town and in my practice, to remove a few stitches under sterile technique to evaluate that area, and you can remove -- if you see it in the subcutaneous plane, you can remove it. If it's something that's deeper, then you can prep her and decide to go to the operating room, but it's a way to evaluate it without putting her under anesthesia again for possibly no reason.

(Tr. Vol I at 225-226)

December 10, 2021 Visit

250. On December 10, 2021, Patient 3 returned to Dr. Grawe's office. Dr. Grawe testified that Patient 3 was seen at this visit by nurse practitioner Ms. Cela and Dr. Grawe. (Tr. Vol I at 226-227) The HPI states:

> [Patient 1] is 10 days s/p BAM revision with cohesive implants and Internal bra. She developed a left sided hematoma which was evacuated 3 days ago by Dr. Domingo. Her nipple was dusky and improved somewhat after this. Today she presents with Malaise. She denies any fever at home. She reports she has been feeling nauseous and fatigue with right arm pain. She reports she stopped taking the nausea and pain medicine due to the medications making her nausea worse. She states she initially thought she had COVID,

> but she reports that her home test COVID was negative. Today she denies any shortness of breath. She denies any changes in urinary or bowel changes.

(St. Ex. 3b at 26)

In the physical examination section of the note, the comments state with regard to the right breast, "Right nipple darker in color with bleeding to pin prick." For the left breast, "eschar to middle of nipple, surround nipple area with sluggish cap refill, tender to light palpation-axillary region. Patient with good range of motion." Finally, with respect to the incision, "Ecchymosis to bilateral breast. Both breast are equal in size, nipples symmetrical. No redness or induration present. Hematoma present to bilateral breast axillary region." (St. Ex. 3b at 27)

Dr. Grawe testified that eschar refers to a scab, which is dead tissue. Dr. Grawe further testified that ecchymosis refers to bruising. (Tr. Vol I at 228)

251. Dr. Grawe testified that Patient 3 was taken to recovery so that they could evaluate Patient 3 for a longer period. Dr. Grawe further testified that Ms. Cela evacuated the hematoma with Dr. Grawe present. (Tr. Vol I at 228-229) When asked why she did not do that herself, Dr. Grawe testified that she was talking to Patient 3's husband and was becoming more concerned about her condition. Dr. Grawe testified:

> [Patient 3] was tachycardiac. I began to worry that she was having left-sided chest pain, she was describing, and on exam -- typically, if you have an infection, I --it's almost never heard of that you wouldn't have draining from the incision. I don't know if I can think of another time. So typically if you have an implant infection, there's draining, and when you touch that tissue where the previous incision was, it just melts away underneath your finger and fluid comes out because the infected tissue can't heal well together, but she wasn't. She was very well healed, and she's bilaterally symmetric, which is also very strange, because typically you build up fluid around the implant if you have an infection, so one side typically gets much bigger than the other one, but since she was symmetric and she had no redness, no fever, she -- I was -- I didn't know if she had an infection or not at that point, but what I did know was that her heart rate was in the mid-120s to 130s, and we were hooking her up to all the monitors while she was doing all the -- getting set up for the evacuation of her hematoma, and she began to talk about her left-sided chest pain which was not getting better, and I started thinking that this patient might have a myocardial infarction or a pulmonary embolism, which are two life-threatening problems; so regardless of what's going on with her breasts, I think she needs to be evaluated in the hospital.

(Tr. Vol I at 229-230)

252. When asked if evacuating a hematoma is a surgical procedure, Dr. Grawe testified, "There can be evacuations of hematoma that are deeper that we do in the operating room, but if something is removing sutures and pushing out old clot, then I wouldn't necessarily call that surgery." (Tr. Vol I at 232) Dr. Grawe testified that the procedure was documented in the progress note and Ms. Cela's record. There is no operative report for the procedure; however, Dr. Grawe testified that Ms. Cela's note is like an operative report. (Tr. Vol I at 232; St. Ex. 3b at 27, 30)

253. When asked if it is important to locate the implant when evacuating a hematoma, Dr. Grawe testified, "No. You should always assess if there's any communication to the implant cavity, but you hope to not locate the implant." (Tr. Vol I at 233-234) When asked how they knew the hematoma didn't involve the implant, Dr. Grawe testified that the location of the hematoma was directly under the skin and very superficial. (Tr. Vol I at 234)

254. Dr. Grawe testified that she or Tia called for an ambulance. (Tr. Vol I at 230) The progress note for that visit states, among other things:

> Over the next hour, she continued to be tachycardic to the 120-130s. She continued to be in pain which was treated with 0.25mg Dilaudid IV. She fell asleep but continued to be tachycardic. When she became more alert, she complained of 10/10 left sided chest pain radiating to her left arm which was becoming numb. We began to worry that there may be a cardiac etiology and called an ambulance to bring her to the hospital for evaluation. We first called Mt. Carmel St. Ann's but they were diverting patients and so we sent her to Riverside. Her husband was updated.

(St. Ex. 3b at 30)

Treatment at Riverside Methodist Hospital

255. Notes from the Riverside Methodist Hospital ("Riverside") ER physician assistant who examined Patient 3 state, "Comments: Surgical incisions intact she has some seepage from the left lateral incision. Ecchymosis and edema noted to both breasts left greater than right. Patient noted to have necrotic nipples which she has been placing Nitropaste on does complain of a lot of discomfort to the left nipple." (St. Ex. 3a at 14)

The physician assistant's notes also record the results of a CT scan:

1. No evidence of pulmonary arterial embolism.
2. Dependent atelectasis bilaterally.
3. Status post bilateral breast prosthesis placement. Small intramuscular hematoma within the left pectoralis minor muscle is noted.

(St. Ex. 3a at 17)

256. With respect to the small intramuscular hematoma in the left pectoralis muscle, Dr. Grawe noted that it was within the muscle and not within the implant cavity, "[a]nd doesn't need to be evacuated because it was small and likely happened with the breast augmentation. That's not of clinical concern." (Tr. Vol I at 239)

257. An HPI note dated December 12, 2021, by an on-call plastic surgeon at Riverside documents, among other things, the history he garnered from Patient 3, including that Patient 3 had told him, "Towards the end of last week she went back to Dr. Grawe's office and states that she told them they were either removing the implants or she was going to the emergency department." (St. Ex. 3a at 36)

When Dr. Grawe was asked if she recalls the patient saying that, Dr. Grawe replied, "I never heard anything close to that," "That's not in my patient record because she never said that to me," and "We never had a discussion like that at all." (Tr. Vol I at 243)

The HPI note then goes on to say:

> I eventually was able to get a hold of Dr. Grawe and we discussed the case. Dr. Grawe did not feel there was much for plastics to do because the patient's implants were out and she already had a drain in place. She felt she just needed supportive care. We discussed possibly transferring the patient to Saint Annes where Dr. Grawe has privileges. Dr. Grawe informed me that there was a significant wait list to get transferred to Saint Annes due to the ongoing Covid pandemic and they were on diversion so she felt it was best for the patient to stay at Riverside. This morning on my evaluation of the patient I was a little surprised to see that the patient actually still has her implants in place and in fact does not have a drain in place. The patient appeared to be in some distress and her incisions are beginning to open and drain. Her nipples show signs of partial necrosis. The case was discussed with Dr. Zilioli from infectious disease and we both feel strongly that the patient needs to go to the operating room for removal of the implants, washout, and drain placement.

(St. Ex. 3a at 36)

258. Dr. Grawe testified that the conversation did not happen the way it was documented in the Riverside records. Dr. Grawe testified:

> I honestly have no idea why this is written like this. I can see some things that I said that he got switched around a little bit, but I'm also confused because in looking at this, it appears that he writes this note in the middle of the night, possibly from home, and then later comes to see the patient; so it's just a little confusing to me about where -- where he was when he was -- you know, what part of his evaluation he was at when he wrote this, but when I talked to him, what I did relay to him is that he asked me why I didn't have her transferred to

> St. Ann's where I have privileges, and the reason was it was during the COVID pandemic and we called to transfer the patient to St. Ann's and they were diverting patients away from their ER, so we could not get her into the ER. At that time again we were trying to evaluate her for an MI or a PE, so I needed to get her to the closest ER, evaluate those things, and then, of course, if there was some reason why she had a surgical problem, then we could deal with that, but I wanted to look at her life-threatening issues first; so that's the part about the diversion, not that there was a wait list to transfer over there, because that's different. When you have a patient that is your surgical patient and you need to transfer them over to where you operate for a surgery reason, you can easily transfer that patient. It was the ER that was closed to patients.
>
> Also, I would never imply that the patient's implants were out and she had a drain in place. I don't know why I would ever do that.
>
> * * *
>
> * * * So I have no idea why he would say that because I would never imply that the patient's implants were out. The patient knew her implants were out. He had a CAT scan that showed that she had implants and a chest x-ray; so I actually have no idea why he would think that I said that her implants were out.

(Tr. Vol I at 244-246)

Dr. Grawe testified that she did offer to have Patient 3 transferred to St. Ann's where she has privileges. She further testified that, if the records from Riverside state that they offered to send the patient to St. Ann's for Dr. Grawe to treat but she refused, that is "[a]bsolutely" inaccurate. (Tr. Vol I at 241)

Moreover Dr. Grawe testified that she does not recall that she was difficult to get ahold of that evening. Dr. Grawe testified that the Riverside plastic surgeon "called the emergency line, which Dr. Domingo answered and he talked to Dr. Domingo, and then he said I only want to talk to her surgeon, and Dr. Domingo called me and gave me his number and I called him back." (Tr. Vol I at 246-247)

259. On December 12, 2021, Patient 3 underwent surgery at OSU. The preoperative and postoperative diagnoses were:

    1. Infected right breast implant and mesh.
    2. Right breast hematoma.
    3. Infected left breast implant and mesh.
    4. Left breast hematoma.

(St. Ex. 3a at 99) She underwent the following procedures:

1. Removal of right infected breast implant. (CPT 19328)
2. Removal of right infected breast mesh. (CPT 10121)
3. Debridement of right breast. (CPT 11042)
4. Evacuation and washout of right breast hematoma and fluid collection. (CPT 10140)
5. Removal of left infected breast implant. (CPT 19328)
6. Removal of left infected breast mesh. (CPT 10121)
7. Debridement of left breast. (CPT 11042)
8. Evacuation and washout of left breast hematoma and fluid collection. (CPT 10140)

(St. Ex. 3a at 99)

260. Dr. Grawe testified that her last record for Patient 3 was the December 10 progress note. Dr. Grawe further testified that she did not document the December 12 conversation because it was the weekend, and Patient 3 never followed up with her. (Tr. Vol I at 247)

Patient 3 – Testimony of Dr. Surfield

261. Dr. Surfield testified that a hematoma is a collection of blood that usually signifies bleeding beneath the surface. (Tr. Vol II at 30) Dr. Surfield testified that he considers a hematoma to be a significant complication in breast augmentation surgery:

> So with a breast augmentation, we worry about having an implant in there. And blood can be very inflammatory, so there's a few different things that you worry about with a hematoma with breast augmentation. The immediate concerns are ongoing bleeding. So you have an ongoing blood loss coming that's uncontrolled. So that pocket can get quite large. You can lose quite a bit of blood. So you can have this ongoing blood loss.
>
> You also worry about is this going to put too much tension on the skin. So now you have to worry about the overlying skin envelope and breakdown of that skin and, you know, loss of nipple sensation, loss of nipple tissue itself. You worry about, you know, having that wound open up because now it's under too much tension.
>
> Blood is also an excellent medium for bacteria to grow, so you worry about infection later. Blood is also very inflammatory. And with breast augmentation specifically, you worry about capsular contractors. So with breast implants -- a capsule forms around every foreign object in the body, whether it's a tooth implant or a hip implant or a breast implant. And, you know, your body recognizes that that's not a part of it, and so it puts a capsule around it.

> If you have a lot of inflammatory responses, the chances of that capsule turning hard and firm over time are greater. So blood can lead to a higher risk of capsular contractor afterwards, which may not show up immediately, but it can be a delayed response sometimes happening months to years down the road.

(Tr. Vol II at 28-30)

Dr. Surfield testified that a hematoma "generally requires a return to the operating room for most patients * * * [t]o evacuate the hematoma, assess for any ongoing bleeding, you know, try to wash that pocket out, try to decrease the risk of capsular contracture." (Tr. Vol II at 30)

262. When asked if hematomas are a common complication of breast augmentation, Dr. Surfield testified that "complications aren't very common, but it's one of the more common complications." (Tr. Vol II at 112-113) When asked if it is rare to see that on multiple occasions with one patient, Dr. Surfield testified, "The presentation is a little abnormal. Generally you see a hematoma usually at that first post-operative visit. Most of the time bleeding will happen within that first 48 hours or so. So her showing up with just the one side and then both sides at a later date is a little bit unusual." (Tr. Vol II at 113)

263. Dr. Surfield briefly described Dr. Grawe's treatment of Patient 3:

> So Patient 3 was a patient that underwent a breast revisional surgery. She had previously underwent a breast reduction and subsequent breast augmentation and then a revision of her augmentation. And then she underwent a breast augmentation mastopexy revision with placement of an internal bra with GalaFLEX. Subsequently she developed hematomas of one and then both breasts, which required evacuation, and then ended up going to the -- being transferred to the hospital where ultimately the implants and the GalaFLEX were all removed.

(Tr. Vol II at 97-98)

Dr. Surfield further testified that a "breast augmentation mastopexy would be placing an implant in addition to having a breast lift to reshape the breast around it. It's a revision because it's previously been performed before by somebody else." (Tr. Vol II at 98) Dr. Surfield further testified that an internal bra with GalaFLEX, Dr. Surfield testified, "So GalaFLEX is a type of resorbable mesh. And so it's placed on the inside to help support the implant and to help correct any implant malposition that has occurred over time due to loss of control of the implant capsule." (Tr. Vol II at 98) Dr. Surfield noted that he performs both procedures in his own practice. (Tr. Vol II at 98) Dr. Surfield added that "there was a significant amount of breast tissue removed as well." (Tr. Vol II at 100)

264. Dr. Surfield explained why he opined that Patient 3 had a complex history:

> Well, she previously had a breast reduction. So she's already had her nipple areolar complex moved at one point. So you always worry about blood supply to the nipple areolar complex because, you know, not always do you have availability to previous operative reports. There's multiple different pedical[13] types that you can use to keep that nipple areolar complex alive. And so when you don't have access to the reports or, you know, you're not the same surgeon that has done it because a superior medial pedical that may be performed by one surgeon, it may be different than what a different surgeon defines that as. And so there's multiple different things that make this difficult coming in as a secondary surgeon.

(Tr. Vol II at 98-99)

265. Dr. Surfield agreed that the multiple surgeries Patient 3 had had prior to coming to Dr. Grawe placed her at higher risk for healing issues which were appropriately discussed between Patient 3 and Dr. Grawe. (Tr. Vol II at 193)

266. Patient 3 returned to Dr. Grawe's office on December 6, 2021, one week following surgery, and there were no complications at that time. (Tr. Vol II at 101; St. Ex. 3b at 20-22)

Dr. Surfield agreed that at Patient 3's initial post-op visit she reported that she had stopped taking her antibiotics. Dr. Surfield further agreed that antibiotics are provided to patients specifically to prevent infection. He further agreed that failure to take the antibiotics prescribed could place the patient at higher risk of a post-op infection. (Tr. Vol II at 193-194)

267. Patient 3 returned to Dr. Grawe's office on December 8, 2021. Dr. Surfield testified, "So there she was noted to have some dark blood coming from the left breast incision and a slow refill of the nipple areolar complex." (Tr. Vol II at 101) When asked what he meant, Dr. Surfield testified, "So generally you talk about capillary refill is show of blood flow into the nipple. If you're pushing on the skin, and you're seeing how quickly the blood returns to that skin. So if it's less than 2 seconds, then you worry about compromised blood flow to that nipple." (Tr. Vol II at 101-102)

Dr. Surfield testified that Patient 3 was taken to the OR and Dr. Domingo evacuated the hematoma. (Tr. Vol II at 103)

268. Patient 3 returned to Dr. Grawe's office on December 10, 2021. Dr. Surfield testified, "So on this day, she was identified to have a hematoma of both breasts. And so she was taken back for a hematoma evacuation by the nurse practitioner." (Tr. Vol II at 104) Dr. Surfield agreed that the nurse practitioner discussed the matter with Dr. Grawe and that Dr. Grawe

[13] Dr. Surfield defined "pedical," "So the pedical -- when you move the nipple areolar complex on the breast, you know, it has to have a blood supply to it. And so, you know, the pedical is an area of tissue that should contain the blood vessels that keep the nipple areolar complex alive." (Tr. Vol II at 99)

testified that she was present when the evacuation occurred. (Tr. Vol II at 104-105) However, Dr. Surfield testified, "This was not a task that should have been delegated to a nurse practitioner." (Tr. Vol II at 105) Dr. Surfield explained:

> This is a patient that's now presented twice for evacuation of her hematoma. You know, so this -- the first time it was either inadequately addressed or the patient has ongoing bleeding. This is a very complex patient. You know, she's got a lot of moving pieces and parts with this breast reduction or breast augmentation and mastopexy.
>
> You know, this is not an easy case to, you know, evaluate. Even as a board certified plastic surgeon, if this patient came to my office from somebody else that has performed the procedure, it's very difficult to identify where everything is, where all the pieces came from. You know, you're moving this nipple areolar complex up and over. You're taking flaps from both sides. You've got a second pocket that's now underneath the muscle that's now walled off with this GalaFLEX.
>
> You know, you're worried about ongoing bleeding because this is the second time that the patient has presented with more bleeding. So you're worried that this bleeding is still ongoing somewhere and it wasn't identified last time. So, you know, identifying all that stuff, trying to identify where all the bleeding is coming from, what parts go where, it's a very complex surgery. And that nurse practitioner is just not trained in any way for that.

(Tr. Vol II at 105-106)

269. When asked if he amended his report after learning that Dr. Grawe was present for the second hematoma removal on December 20, 2021, Dr. Surfield testified that he did not. Dr. Surfield further testified, "Again, this procedure was done by the nurse practitioner. This was delegated to an untrained professional. She's not trained in surgery. This is a patient that has developed a second hematoma or inadequate treatment of the first hematoma." (Tr. Vol II at 196; St. Ex. 3b at 30; Resp. Ex. C at 2081)

Dr. Surfield testified that he did not know what the nurse practitioner's background was, or whether she had received advanced training as a first assistant, but that "[t]here is no nurse practitioner program for plastic surgery." (Tr. Vol II at 198)

270. When it was suggested that hematoma removal is not surgery, Dr. Surfield disagreed. He testified that "she's doing it in the PACU, they're giving her IV fluids. They're giving her IV medications. You know, this is a procedure or surgery that's done under sterile technique." (Tr. Vol II at 198-199) Dr. Surfield further testified that opening up two stitches is a surgical procedure, and that "[e]xploring this wound for bleeding is a surgical procedure." (Tr. Vol II at 199) Whereupon the following exchange took place:

Q. [By Ms. Sellers] And, Doctor, where does it say that she explored the area?
A. So it says that she opened up the incision and evacuated hematomas.
Q. And where does it say she explored the area.
A. So there's no communication with the implant cavity,[14] so that means that she's looking for the implant cavity.
Q. Okay. And are you aware that Dr. Grawe also documented that this was a subcutaneous hematoma with no communication with the implant cavity, which was well healed?
A. Yes. She documented that.
Q. All right. Do you know if Dr. Grawe explored the implant cavity?
A. It does not say it was explored by her.

(Tr. Vol II at 200)

271. Dr. Surfield testified that Dr. Grawe's delegation of the hematoma evacuations to the nurse practitioner was below the standard of care whether Dr. Grawe was in the office or not. (Tr. Vol II at 106)

272. Dr. Surfield agreed that Dr. Grawe acted appropriately by addressing Patient 3's tachycardia and left arm pain before addressing any other issues as those symptoms could indicate a life-threatening condition. Dr. Surfield also agreed that it was appropriate for Dr. Grawe to ask to have Patient 3 taken to St. Ann's where Dr. Grawe has privileges. Nevertheless, she was taken to Riverside where Dr. Grawe does not have privileges because St. Ann's was diverting patients due to Covid. Moreover, Dr. Surfield agreed that, if a physician does not have privileges at a hospital, then the physician cannot be involved in that patient's medical care while she is at that facility. (Tr. Vol II at 208-210)

273. At about 2:00 p.m. on December 10, 2021, Patient 3 arrived at the ER at Riverside. Dr. Surfield testified that it took a while to determine what was wrong with Patient 3. (Tr. Vol II at 107) Dr. Surfield further testified:

> So the patient was seen -- it was discussed that, you know, after she had a -- she had a significant workup for the chest pain, it was more concern with cardiac and pulmonary origin. And eventually they saw on a CT scan I think it was for a PE study that she had significant fluid accumulations around both implants. At that point, they decided that it was likely infectious etiology that was causing all the issues. And then the patient was taken back to surgery for removal of the implants and the GalaFLEX.

(Tr. Vol II at 108)

274. With respect to the December 12, 2021, early morning telephone conversation between the OSU plastic surgeon and Dr. Grawe, Dr. Surfield testified that the OSU physician had

[14] St. Ex. 3b at 30; Resp. Ex. C at 2081.

called Dr. Grawe to find out what has already been done with Patient 3. According to his notes, "[h]e was told that it was likely not related to the surgery at all because she had already had her implants removed and already had drains in place." (Tr. Vol II at 109, 112; St. Ex. 3a at 47-48)

With respect to Dr. Grawe's testimony that anyone would have known that this patient's implants had not been removed, Dr. Surfield testified that the OSU plastic surgeon's initial consultation with Dr. Grawe was over the phone before he had seen the patient himself." (Tr. Vol II at 110)

275. Dr. Surfield testified that he did not find documentation of Dr. Grawe's conversation with the OSU plastic surgeon in Dr. Grawe's medical record for Patient 3. (Tr. Vol II at 113)

276. Reviewing a photo of Patient 3's right breast, Dr. Surfield testified, "So you can see that she's got threatened skin of her nipple areolar complex. There's already eschar forming on the inferior portion of the nipple areolar complex. There is some questionable viability along the inframammary incision line. There's some of that purple mottled skin that's along the inferior aspect." (Tr. Vol II at 115-116; St. Ex. 3a at 39)

Reviewing a photo of Patient 3's right breast, Dr. Surfield testified, "So Page 40 also shows some mottled skin along the inframammary fold incision. Looks like that incision is still open. There's a significant amount of drainage that you can see on the -- on the bandage. Again, there's some questionable viability of the nipple areolar complex specifically on the central and inferior portions." (Tr. Vol II at 116; St. Ex. 3a at 40)

277. Dr. Surfield testified that the OSU plastic surgeon "removed the implants on both sides, removed the mesh from both sides and then washed out the pocket and removed some non-viable tissue." (Tr. Vol II at 114)

278. Dr. Surfield testified that Dr. Grawe's treatment of Patient 3 fell below the minimal standard of care because delegating the second hematoma evacuation to a nurse practitioner was improper. (Tr. Vol II at 118) Dr. Surfield further testified:

> [T]his should have been explored by Dr. Grawe. I mean, this was not something that should have been done by a nurse practitioner. It should have been done by a surgeon that's an expert in the field to be able to control this bleeding. You know, this is a patient that has now presented twice. So you worry about ongoing bleeding, was it done properly the last time. You know, it was a very small incision that was done. There's no way to really assess that pocket.
>
> A nurse practitioner was just not prepared to do that surgery at all. And this is something that, you know, if that nurse practitioner was -- you know, found the implant, is she able to remove an implant. And, you know, she's not even skilled enough to figure out where the implant pocket should be. Making that

> whole decision tree along -- you know, not only identifying the surgical pocket and not only identifying the bleeding, which are above her scope of practice, but then trying to do any definitive surgery or procedures afterwards are well beyond her scope of practice.

(Tr. Vol II at 118-119)

279. In his report, Dr. Surfield opined that Dr. Grawe violated R.C. 4731.22(B)(6) in her care of Patient 3. (St. Ex. 5 at 6)

Patient 3 – Testimony of Dr. Krieger

280. Dr. Krieger testified that it is his understanding that Patient 3 discontinued taking her antibiotics following the surgery. Dr. Krieger testified that is problematic because "[a]ntibiotics are mandatory with any implant, but particularly with a longstanding implant that's being exchanged." (Tr. Vol IV at 132)

281. Dr. Krieger testified that Patient 3's multiple prior breast surgeries placed her in a higher risk category because the tissues have already been traumatized and had to heal, and there is scarring. (Tr. Vol IV at 120) Dr. Krieger further testified:

> This is particularly the case with the breasts because the -- both the skin, and particularly areolas and the nipples are very ultra dependent on perfect or near perfect blood flow.
>
> And every time the breasts have been traumatized by a procedure there is a direct or indirect effect on that blood flow.
>
> And so we're very concerned for any --well, any first mastopexy, which is a breast lift which cuts around areola, but certainly on a revision we're concerned that the blood flow might not be robust enough to heal a wound.

(Tr. Vol IV at 120-121)

Further, Dr. Krieger testified that, if the blood flow is not sufficient to heal the wound or reach the nipple:

> The nipple could die, the areola can die, and some skin can die. That's the worst case scenario.
>
> The incisions might not have enough blood flow to heal and they might separate, and those are -- or less blood flow means that there's a high risk of infection because there's not enough fresh nutrient-rich blood to keep the tissues at their peak to resist infection.

(Tr. Vol IV at 121)

282. Dr. Krieger testified that he has experienced in his patients, and that hematomas do not mean that something was done improperly during the surgery. Dr. Krieger also testified that it is appropriate for someone other than the plastic surgeon to remove a hematoma. Moreover, Dr. Krieger testified that it was okay for another general surgeon to remove Patient 3's first hematoma. Further, Dr. Krieger testified that it was within the standard of care for Dr. Grawe to have a nurse practitioner with whom she had had a long supervisory relationship to remove the hematoma under Dr. Grawe's supervision. (Tr. Vol IV at 132-135)

283. Dr. Krieger disputed that the fact that the second hematoma removal was done under sterile conditions made it a surgical procedure. Dr. Krieger testified that nurses draw blood and place IVs under sterile conditions. (Tr. Vol IV at 134)

284. Dr. Krieger testified that, in a revision breast augmentation, a capsule has already been created from the original augmentation:

> A capsule is a scar that forms around an implant. It always develops a hundred percent of the time. That's the body's reaction to having an implant.
>
> Sometimes it is harder or softer depending upon the person and how they heal. When it becomes harder than we like, that's unfavorable because the breasts could become hard and even painful, and that occurs certainly at least five percent of the time when the people will need a revision just because of the hardness of the capsule.
>
> But even leaving that out, everyone develops a capsule. It starts to develop at about a month or six weeks, develops over the next year, and that forms a natural shell around the implant.

(Tr. Vol IV at 16)

285. Dr. Krieger testified that the capsules that form around breast implants are made up of scar tissue. Dr. Krieger further testified that Patient 3 already had capsules from her previous breast implants prior to Dr. Grawe's procedure. Dr. Krieger testified that Dr. Grawe had to open the capsules to remove the old implants. She then inserted the new implants into the empty capsule spaces and tightly sealed the incisions she made in the capsules. During the course of the surgery, she also placed the mesh to provide support for the new implants. (Tr. Vol IV at 127-130)

Dr. Krieger further testified:

> The incision in the capsule was closed by Dr. Grawe. And this is tough inert tissue. The body developed it, but it no longer has blood supply or anything, it's like scar. And scar doesn't have its own blood supply.

> And so this is a reasonably thick and water impermeable fluid, impermeable tissue that she then did a tight closure of.

(Tr. Vol IV at 130)

When asked if it's not like a screen that fluid can pass through, Dr. Krieger testified:

> Well, there's -- there's always a little microscopic fluid everywhere in the body, but in terms of bleeding, right, blood cannot pass through a capsule, okay?
>
> And also within the capsule there's no source for bleeding because it's -- all directions are covered up by this blood free scar, so there's nothing to bleed into the capsule.
>
> Any blood that's right on the implant would have to come from outside of the capsule, and that's not possible. So there's no bleeding possible or that occurred into the capsule.

(Tr. Vol IV at 130-131)

286. The note of the second hematoma removal indicates "Under sterile techniques, Tia, NP, opened the IMF incision and evacuated both subcutaneous hematomas. There was no communication with the implant cavity which was well healed. The patient felt immediate relief and there was no sign of active bleeding." (Resp. Ex. C at 2081) Dr. Krieger testified that "the key point is what she's saying here is that that fully surrounding capsule was intact, and therefore there was no exposed implant and no ability for blood to communicate into that cavity." (Tr. Vol IV at 136)

287. Reviewing pictures of Patient 3's breasts upon her arrival at the hospital, Dr. Krieger testified that they both appear to have implants still in place and there are no visible signs of infection. (Tr. Vol IV at 141; Resp. Ex. C at 2308-2309) Dr. Krieger described how he would expect an infected mastopexy or an implant would appear, "Redness of the skin, swelling of skin, what we call streaking of the skin, which is redness but in streaks. And these were fresh incisions, literally hours old. I would express -- if it's infected I'd expect some infected fluid to be coming out that's either murky, which is dusky, or frankly pus, and that's clearly not here." (Tr. Vol IV at 142)

Dr. Krieger further testified that the nipples show duskiness which is "an indication that the blood flow actually out is not as robust as we would like. And this was noted not even just this, but several days before, and judging from this it looks like it was successfully treated, because while it's dusky, it's days after the treatment began and if the treatment was unsuccessful this would be dead, and this is clearly not dead." (Tr. Vol IV at 143)

Overall, Dr. Krieger testified that the breasts present with what appears to be recent hematoma incisions and normal postoperative healing. (Tr. Vol IV at 143)

288. In a note dated December 12, 2021, at 1:55 a.m., the on-call surgeon at Riverside documented, among other things, "Patient appeared on my list late tonight. I never received a phone call about her being sent to the ER by her plastic surgeon or that a consult was placed." (Resp. Ex. C at 2207) Dr. Krieger testified, "I don't know who he's thinking should have called him there. Certainly Dr. Grawe was not in a position to call him, she doesn't know who is on call. I think he's saying that the ER didn't call him maybe." (Tr. Vol. IV at 145-146) Dr. Krieger noted that he also wrote that he was not contacted when the consult was placed. (Tr. Vol IV at 146)

289. With respect to the on-call plastic surgeon's note that Dr. Grawe had told him that the patient "required a return to the OR for evacuation of a hematoma and implant removal by Dr. Grawe," Dr. Krieger testified that there is nothing in the medical record prior to that note that indicates that Patient 3 had had her implants removed. Dr. Krieger further testified that a review of Patient 3's records from the ER visit would have revealed that the patient still had her implants. (Tr. Vol IV at 146-149; Resp. Ex. C at 2207-2208)

290. Dr. Krieger agreed that if, while out of the office, he receives a call from another surgeon to discuss one of Dr. Krieger's patients, at some point he would want to document that conversation. (Tr. Vol IV at 191)

291. Dr. Krieger opined based on his review of Dr. Grawe's operative note and surgical technique that she met the standard of care in her treatment of Patient 3. (Tr. Vol IV at 131, 150)

292. Dr. Krieger testified that Dr. Grawe's treatment of Patient 3 met the standard of care for the same reasons discussed with regard to Patient 1. (Tr. Vol IV at 21-23)

Additional Information

293. Information from the Ohio Board of Nursing indicated that Luftie Cela is an actively licensed certified nurse practitioner whose specialty is identified as "Family" and whose focus is identified as "Family/Individual Across Lifespan." (St. Ex. 11) (All-caps omitted)

SELECTED STATUTES AND RULES

R.C. 4723.43(C) states, in pertinent part:

> (C) A nurse authorized to practice as a certified nurse practitioner, in collaboration with one or more physicians or podiatrists, may provide preventive and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the nurse's nursing specialty, consistent with

the nurse's education and certification, and in accordance with rules adopted by the [nursing] board. * * *

Rule 4731-25-02(H) states:

(H) Special procedures or surgery utilizing moderate sedation/analgesia or anesthesia services shall be performed in the office setting only on patients who are evaluated as level P1 or P2 according to the American society of anesthesiologists physical status classification system current at the effective date of this rule.

Rule 4731-25-05 is titled Liposuction in the Office Setting.

Rule 4731-25-05(B)(7) and (8) state:

(B) Liposuction in the office setting shall be performed in compliance with rules 4731-25-03 and 4731-25-04 of the Administrative Code as appropriate to the level of sedation being administered and in compliance with the following standards:

* * *

(7) Liposuction in the office setting shall be performed only on patients who are evaluated as level P1 or P2 according to the version of the American society of anesthesiologists physical status classification system current at the effective date of this rule;

(8) Liposuction shall not be performed in an office setting in combination with other procedures except as specifically authorized in paragraph (F) of this rule.

Rule 4731-25-05(C) states:

(C) Liposuction performed in an office setting shall not exceed four thousand five hundred milliliters of total aspirate.

Rule 4731-25-05(E) states:

(E) The written discharge instructions given to the patient shall include specific information concerning the symptoms of lidocaine toxicity, the period of time during which such symptoms might appear and specific instructions for the patient to follow should the patient experience such symptoms.

FINDINGS OF FACT

1. In a letter dated October 9, 2018, the Secretary of the Board cautioned Katharine Roxanne Grawe, M.D., regarding the need to maintain patient privacy when sharing photos or video via social media. Dr. Grawe responded via letter dated November 11, 2018, that she had remediated these concerns by instituting an updated patient consent form.

   In a letter dated September 28, 2021, the Secretary of the Board cautioned Dr. Grawe a second time. The letter articulated multi-faceted issues with her care of patients, including ethical concerns related to privacy and social media. Based upon these concerns, the Secretary of the Board strongly recommended you undertake remedial education courses related to professionalism/ethics, and requested you provide the Board with certificates of completion along with summaries of what you learned and how you would apply it to your future practice. On or about December 20, 2021, you provided the Board with information documenting your completion of remedial education in "Ethical Social Media."

2. From in or around May 2020 through March 2022, Dr. Grawe provided care and treatment in the routine course of her practice at her office setting, Roxy Plastic Surgery, to Patients 1 through 3, as identified in a confidential Patient Key. Dr. Grawe inappropriately treated and/or failed to appropriately treat and/or failed to appropriately document her treatment of these patients.

3. Examples of such care and treatment identified in Finding of Fact 2 included the following:

   a. On or about February 2018 through March 2022 Dr. Grawe provided care and treatment to Patient 1. On or about July 9, 2020, she performed an abdominoplasty, Brazilian butt lift, and liposuction of Patient 1's upper and lower back under general endotracheal anesthesia at Roxy Plastic Surgery, her office setting. The CRNA who administered anesthesia on the case evaluated Patient 1 using the American Society of Anesthesiologists (ASA) Physical Status Classification System and evaluated her as ASA 3, and Dr. Grawe undersigned the anesthesia evaluation. Dr. Grawe collected a total aspirate of 4300 cc. Further, although Dr. Grawe did not utilize lidocaine in her tumescent fluid, she nevertheless was required by the rules governing liposuction in an office setting to provide written discharge instructions to Patient 1 concerning specific information about lidocaine toxicity, but failed to do so.

      On or about March 21, 2022, Dr. Grawe performed liposuction of the abdomen and arms, a Brazilian butt lift, and Renuvion J-plasma procedure on abdomen and arms, under general endotracheal anesthesia at Roxy Plastic Surgery. At this time Patient 1 was evaluated as ASA 2. Dr. Grawe collected a total aspirate of 3700 cc. The procedure was recorded and was posted to SnapChat. There are moments when Dr. Grawe can be seen looking at the camera and speaking to the camera while engaged in liposuction of Patient 1's abdomen. Despite liposuction being a blind surgery that requires awareness of the tip of the cannula to avoid injury, her attention

to the camera meant at those moments that she was not looking at the patient or palpating the location of the tip of the cannula. Further, Dr. Grawe failed to provide written discharge instructions to Patient 1 concerning specific information about lidocaine toxicity as required by Board rules despite not utilizing lidocaine during the procedure.

In determining these findings, the hearing examiner found the testimony of Dr. Surfield, the State's expert witness, to be more credible than that of Dr. Krieger. Dr. Surfield identified several times during the video when Dr. Grawe was not focused on the abdomen and the patient. She took her eyes off the patient and looked at the camera but was not palpating the cannula with her left hand. There was no medical reason for her to do that. Dr. Surfield identified another moment when Dr. Grawe made what Dr. Surfield referred to as very forceful insertions of the cannula. She did this for no medical reason but for the edification of her social media audience to demonstrate the force needed to penetrate scar tissue.

Dr. Krieger, on the other hand, did not criticize any aspect of Dr. Grawe's conduct on the video.

The hearing examiner is not medically trained. However, viewing the video, it appeared to him that, at times, Dr. Grawe did not have her full attention on the abdominal liposuction she was performing, and the insertions that Dr. Surfield identified as forceful were, to the hearing examiner, frightening to watch and completely unnecessary from a medical standpoint. Accordingly, Dr. Krieger's opinion on this issue is not found to be credible. The hearing examiner invites the Board, as a panel of experts, to amend this finding if it disagrees.

On March 25, 2022, Patient 1's husband called Dr. Grawe's emergency line and spoke to a nurse practitioner with concern about Patient 1's drowsiness and forgetfulness. Among other things, the nurse practitioner offered that Patient 1 be brought to the Recovery House for care; however, Patient 1 or her husband elected not to do that. On March 26, 2022, Patient 1's husband called to report that emergency medical personnel were checking on her at their house. The nurse practitioner answered the call and asked that Patient 1 come in and be seen but she was not brought in. On or about March 27, 2022, Patient 1's husband called and advised that Patient 1 was not doing well. Patient 1 was brought in and the nurse practitioner saw Patient 1 and sent her to the emergency room for evaluation. The nurse practitioner documented that the patient's hygiene at that time was poor. At the emergency room Patient 1 was found to have free air in her abdomen and hepatic encephalopathy. On or about March 28, 2022, Patient 1 was transferred to another hospital for further evaluation and definitive treatment. Patient 1 underwent surgery for exploratory laparotomy and was found to have a gangrenous gallbladder, a perforated small bowel, and necrotizing soft tissue infection. Patient 1 required a prolonged stay with multiple debridements, open abdomen, and skin grafting.

Dr. Surfield opined that Patient 1's infection resulted from an abdominal perforation that occurred during liposuction and enterococcus bacteria from inside the bowel causing infection, leading to the subsequent infections of the abdominal wall and omentum, and acute infection of the gallbladder. However, Dr. Grawe and Dr. Krieger attribute the infection to the patient's chronic cholecystitis and gangrenous gallbladder, as well as to bacteria entering from outside via the surgical wounds. The hearing examiner believes that the timing of the infection to be very coincidental if not caused by the punctured bowel, but the defense noted that that bowel puncture was unusual for one caused by liposuction in that only one side of the bowel had a hole and not the other side. Nevertheless, it is possible that the cannula stopped before passing through the entire width of the bowel. Accordingly, the hearing examiner finds Dr. Surfield's opinion to be credible.

b. On or about May 20, 2020 through December 21, 2020, Dr. Grawe provided care and treatment to Patient 2. On or about On December 10, 2020, she performed "Liposuction 360," a Brazilian butt lift, an umbilical hernia repair, and Renuvion J-plasma of the abdomen and flanks under general endotracheal anesthesia at Roxy Plastic Surgery. Dr. Grawe collected a total aspirate of 4900 cc from Patient 2. Patient 2 was discharged to the recovery house. Further, although Dr. Grawe did not utilize lidocaine in her tumescent fluid, she nevertheless was required by the rules governing liposuction in an office setting to provide written discharge instructions to Patient 2 concerning specific information about lidocaine toxicity, but failed to do so.

On or about December 11, 2020, Patient 2 called the emergency line due to cramping and severe abdominal pain. Patient 2 had produced 2000 cc of dark yellow urine over the previous four hours. After that phone call, Patient 2 called 911, was transferred to the emergency room, and admitted to the hospital with rhabdomyolysis. Patient 2's creatine kinase level on admission was 11,900. The following day, Patient 2 developed an acute abdomen with pneumoperitoneum. She underwent exploratory laparotomy and was found to have six enterotomies and multiple serosal tears that were not full thickness. Patient 2 required small bowel resection, two repairs of the small bowel, and partial omentectomy.

The hearing examiner does not attribute the cause of Patient 2'a rhabdomyolysis to Dr. Grawe because there is no evidence of muscle injury caused by Dr. Grawe in the record.

However, and although bowel punctures are a known complication of liposuction, Patient 2 had six bowel punctures and multiple serosal tears. Although Dr. Grawe posits that all six bowel punctures could have happened from a single errant insertion of the cannula, this seems highly unlikely, and does not account for the multiple serosal tears. Accordingly, the evidence supports a finding that this constitutes a minimal standard of care violation.

c. On or about September 13, 2018 through December 10, 2021 Dr. Grawe provided care and treatment to Patient 3. On or about December 1, 2021, she performed breast augmentation with silicone implants and mastopexy revision with internal bra (GalaFLEX), under general anesthesia at Roxy Plastic Surgery. On or about December 6, 2021, Patient 3 complained of nausea since her surgery. Her left nipple appeared dusky on exam. On or about December 8, 2021, Patient 3 complained of bleeding from the breast. A general surgeon in Dr. Grawe's employ opened Patient 3's left breast and evacuated a hematoma at Dr. Grawe's office and no implant was visualized. On or about December 10, 2021, Patient 3 complained of malaise, nausea, and pain in her arm. Patient 3's right nipple was dark, and her left nipple showed eschar. Despite Patient 3's complex surgical history and her prior hematoma, Dr. Grawe delegated bilateral breast exploration and hematoma evacuation to her nurse practitioner whose specialty is family medicine. No implant was visualized. Patient 3 was tachycardic and had pain in her left arm. She was transferred to the hospital for treatment of a possible cardiac event. Dr. Grawe communicated to the plastic surgeon who assumed care at the hospital that she believed her condition was not infectious in origin, and, according to the plastic surgeon's note, erroneously indicated that Patient 3's implants had been removed. This was credibly disputed by Dr. Grawe at the hearing, and the hearing examiner is convinced that it resulted from a miscommunication. Once at the hospital, Patient 3 was found to have developed infection requiring removal of bilateral implants, removal of the mesh bra bilaterally, and debridement bilaterally of both breasts.

In making these findings, the hearing examiner finds Dr. Surfield's opinion that bilateral breast exploration and hematoma evacuation is a surgical procedure to be credible. However, the hearing examiner does not find that Dr. Grawe is responsible for the postoperative infection suffered by Patient 3 because the evidence establishes that Patient 3 discontinued taking her prescribed antibiotics shortly after the surgery.

4. The evidence is undisputed that, at all times relevant to this matter, Roxy Plastic Surgery did not hold a license as an ambulatory surgical facility issued by the Ohio Department of Health.

CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of Katharine Roxanne Grawe, M.D., as set forth in Findings of Fact 2, 3.a, and 3.b, 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 R.C. 4731.22(B)(6).

Further, Dr. Grawe's delegation of bilateral breast exploration and hematoma evacuation to an unqualified individual, as set forth in Findings of Fact 2 and 3.c, 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 R.C. 4731.22(B)(6).

1.a. Pursuant to R.C 4731.225, the Board is authorized to impose a civil penalty for this violation. The Board's guidelines provide as follows:

Maximum Fine: $20,000
Minimum Fine: $3,500

2. Because Roxy Plastic Surgery did not hold a license as an ambulatory surgical facility from the Ohio Department of Health, it is subject to the Board's rules governing office-based surgery. Accordingly, Dr. Grawe's acts, conduct, and/or omissions in performing office-based surgery on a patient classified as ASA 3, as set forth in Finding of Fact 3.a, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in R.C. 4731.22(B)(20), to wit: Rule 4731-25-02(H), Office-Based Surgery - General Provisions.

2.a. Pursuant to R.C 4731.225, the Board is authorized to impose a civil penalty for this violation. The Board's guidelines provide as follows:

Maximum Fine: $20,000
Minimum Fine: $4,500

3. Dr. Grawe's acts, conduct, and/or omissions in performing office-based surgery on a patient classified as ASA 3, as set forth in Finding of Fact 3.a, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in R.C. 4731.22(B)(20), to wit: Rule 4731-25-05(B)(7), Liposuction in the Office Setting.

3.a. Pursuant to R.C 4731.225, the Board is authorized to impose a civil penalty for this violation. The Board's guidelines provide as follows:

Maximum Fine: $20,000
Minimum Fine: $4,500

4. Further, Dr. Grawe's acts, conduct, and/or omissions in performing liposuction in combination with other procedures, as set forth in Findings of Fact 3.a and 3.b, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in R.C. 4731.22(B)(20), to wit: Rule 4731-25-05(B)(8), Liposuction in the Office Setting.

4.a. Pursuant to R.C 4731.225, the Board is authorized to impose a civil penalty for this violation. The Board's guidelines provide as follows:

Maximum Fine: $20,000
Minimum Fine: $4,500

5. Further, Dr. Grawe's acts, conduct, and/or omissions in exceeding four thousand five hundred milliliters of total aspirate in Patient 2's surgery, as set forth in Finding of Fact 3.b, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in R.C. 4731.22(B)(20), to wit: Rule 4731-25-05(C), Liposuction in the Office Setting.

5.a. Pursuant to R.C 4731.225, the Board is authorized to impose a civil penalty for this violation. The Board's guidelines provide as follows:

Maximum Fine: $20,000
Minimum Fine: $4,500

6. Further, Dr. Grawe's acts, conduct, and/or omissions in failing to provide discharge instructions that included information concerning lidocaine toxicity to Patients 1 and 2, as set forth in Findings of Fact 3.a and 3.b, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in R.C. 4731.22(B)(20), to wit: Rule 4731-25-05(E), Liposuction in the Office Setting.

6.a. Pursuant to R.C 4731.225, the Board is authorized to impose a civil penalty for this violation. The Board's guidelines provide as follows:

Maximum Fine: $20,000
Minimum Fine: $4,500

RATIONALE FOR THE PROPOSED ORDER

The evidence establishes that Dr. Grawe violated the minimal standards of care in her treatment of three patients. Particularly with respect to Patient 1 whose surgery was videorecorded, there were times when Dr. Grawe's attention appeared to be drawn away from the surgery she was performing to talk directly to the camera. The impression the hearing examiner received from Dr. Surfield's very credible testimony was that liposuction is a major surgery that demands the surgeon's full and complete attention. During moments when Dr. Grawe was looking at the camera, she did not have her full attention on the surgery. There was no medical reason for this.

In addition, Dr. Grawe performed these procedures in an office setting that was not licensed as an ambulatory surgical facility by the Ohio Department of Health. It is somewhat mitigating that it was a very well-equipped office setting and was accredited by a national third-party accrediting body. However, Dr. Grawe not having the $300 license, or even being aware of its necessity, is just mystifying. Moreover, Dr. Grawe's inappropriate delegation of bilateral breast exploration and hematoma evacuation to an unqualified individual is difficult to understand. Her lack of knowledge of the laws and rules governing her medical practice, especially after prior contact from the Board, is also difficult to understand, and does not bode well for future rehabilitation efforts.

The proposed order would permanently revoke Dr. Grawe's medical license and levy a fine of $4,500.

PROPOSED ORDER

It is hereby ORDERED that:

A. **PERMANENT REVOCATION:** The license of Katharine Roxanne Grawe, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

B. **FINE**: Within thirty days of the effective date of this Order, Dr. Grawe shall remit payment in full of a fine of four thousand and five hundred dollars ($4,500.00). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

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

R. Gregory Porter
Hearing Examiner

State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

November 18, 2022

Case number: 22-CRF- 0220

Katharine Roxanne Grawe, M.D.
3982 Powell Rd., Suite 127
Powell, OH 43065

Dear Doctor Grawe:

Enclosed please find certified copies of the Entry of Order, the Notice of Summary Suspension and Opportunity for Hearing, and an excerpt of the Minutes of the State Medical Board made at a conference call on November 18, 2022, scheduled pursuant to Section 4731.22(G), Ohio Revised Code, including a Motion adopting the Order of Summary Suspension and issuing the Notice of Summary Suspension and Opportunity for Hearing.

You are advised that continued practice after receipt of this Order shall be considered practicing without a certificate, in violation of Section 4731.41, Ohio Revised Code.

Pursuant to Chapter 119, Ohio Revised Code, you are hereby advised that you are entitled to a hearing on the matters set forth in the Notice of Summary Suspension and Opportunity for Hearing. If you wish to request such hearing, that request must be made in writing and be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice. Further information concerning such hearing is contained within the Notice of Summary Suspension and Opportunity for Hearing.

THE STATE MEDICAL BOARD OF OHIO

Kim G. Rothermel, MD/smc
Kim G. Rothermel, M.D.
Secretary

KGR/TCN/LV
Enclosures

Mailed 11-18-2022

CERTIFICATION

I hereby certify that the attached copies of the Entry of Order of the State Medical Board of Ohio and the Motion by the State Medical Board, meeting in in a conference call on November 18, 2022, scheduled pursuant to Section 4731.22(G), Ohio Revised Code, to Adopt the Order of Summary Suspension and to Issue the Notice of Summary Suspension and Opportunity for Hearing, constitute true and complete copies of the Motion and Order in the Matter of Katharine Roxanne Grawe, M.D., Case number: 22-CRF-0220 as they appear in the Journal of the State Medical Board of Ohio.

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

Kim G. Rothermel, MD/smc
Kim G. Rothermel, M.D., Secretary

(SEAL)

November 18, 2022
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	:
	:
KATHARINE ROXANNE GRAWE, M.D.	:
	:
CASE NUMBER: 22-CRF- 0220	:

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio the 18th day of November 2022.

Pursuant to Section 4731.22(G), Ohio Revised Code, and upon recommendation of Kim G. Rothermel, M.D., Secretary, and Bruce R. Saferin, D.P.M., Supervising Member; and

Pursuant to their determination, based upon their review of the information supporting the allegations as set forth in the Notice of Summary Suspension and Opportunity for Hearing, that there is clear and convincing evidence that Dr. Grawe has violated Sections 4731.22(B)(6) and 4731.22(B)(20), Ohio Revised Code, as alleged in the Notice of Summary Suspension and Opportunity for Hearing that is enclosed herewith and fully incorporated herein; and,

Pursuant to their further determination, based upon their review of the information supporting the allegations as set forth in the Notice of Summary Suspension and Opportunity for Hearing, that Dr. Grawe's continued practice presents a danger of immediate and serious harm to the public;

The following Order is hereby entered on the Journal of the State Medical Board of Ohio for the 18th day of November 2022:

It is hereby ORDERED that the certificate of Katharine Roxanne Grawe, M.D., to practice medicine and surgery in the State of Ohio be summarily suspended.

It is hereby ORDERED that Dr. Grawe, shall immediately cease the practice of medicine and surgery in Ohio and immediately refer all active patients to other appropriate physicians.

This Order shall become effective immediately.

Kim G. Rothermel, MD/smk
Kim G. Rothermel, M.D.
Secretary

(SEAL)

November 18, 2022
Date

State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

EXCERPT FROM TELECONFERENCE OF NOVEMBER 18, 2022

VIDEO CONFERENCE CALL OF NOVEMBER 18, 2022 TO CONSIDER THE SUMMARY SUSPENSION OF A CERTIFICATE

KATHARINE ROXANNE GRAW, M.D. – ORDER OF SUMMARY SUSPENSION AND NOTICE OF OPPORTUNITY FOR HEARING

.....

Dr. Reddy moved to enter an Order of Summary Suspension in the matter of Kaharine Roxanne Grawe, M.D., in accordance with Section 4731.22(G), Ohio Revised Code, and to issue the Notice of Summary Suspension and Opportunity for Hearing to Dr. Grawe. Dr. Johnson seconded the motion. A vote was taken:

ROLL CALL:	Dr. Rothermel	- abstain
	Dr. Saferin	- abstain
	Dr. Schottenstein	- aye
	Dr. Soin	- aye
	Dr. Johnson	- aye
	Mr. Gonidakis	- aye
	Dr. Feibel	- aye
	Dr. Reddy	- aye
	Dr. Bechtel	- abstain
	Ms. Montgomery	- aye

The motion carried.

State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

NOTICE OF SUMMARY SUSPENSION
AND
OPPORTUNITY FOR HEARING

November 18, 2022

Case number: 22-CRF- 0220

Katharine Roxanne Grawe, M.D.
3982 Powell Rd., Suite 127
Powell, OH 43065

Dear Doctor Grawe:

The Secretary and the Supervising Member of the State Medical Board of Ohio [Board] have determined that there is clear and convincing evidence that you have violated Sections 4731.22(B)(6) and 4731.22(B)(20), Ohio Revised Code, and have further determined that your continued practice presents a danger of immediate and serious harm to the public, as set forth in paragraphs (1) through (3), below.

Therefore, pursuant to Section 4731.22(G), Ohio Revised Code, and upon recommendation of Kim G. Rothermel, M.D., Secretary, and Bruce R. Saferin, D.P.M., Supervising Member, you are hereby notified that, as set forth in the attached Entry of Order, your license or certificate to practice medicine and surgery in the State of Ohio is summarily suspended. Accordingly, at this time, you are no longer authorized to practice medicine and surgery in Ohio.

Furthermore, in accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the Board intends to determine whether or not to limit, revoke, permanently revoke or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or 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 a letter dated October 9, 2018, the Secretary of the Board cautioned you regarding the need to maintain patient privacy when sharing photos or video via social media. You responded via letter dated November 11, 2018, that you had remediated these concerns by instituting an updated patient consent form.

In a letter dated September 28, 2021, the Secretary of the Board cautioned you a second time. The letter articulated multi-faceted issues with your care of these patients, including concerns regarding the lack of informed consent, ethical concerns related to privacy and social media, and avoidable complications that required surgical revision. Based upon these concerns, the Secretary of the Board strongly recommended you

undertake remedial education courses related to complications of plastic surgery and professionalism/ethics, and requested you provide the Board with certificates of completion along with summaries of what you learned and how you would apply it to your future practice. On or about December 20, 2021, you provided the Board with information documenting your completion of remedial education in "Ethical Social Media" and "Finesse in Mastopexy and Augmentation Mastopexy."

After your completion of these remedial education courses, you continued to video produce and live broadcast medical procedures of some patients, at least through on or about October 14, 2022. Aspects of these productions include, but are not limited to, pre-operative photos, pre-operative interviews with patients about their bodies, live-streams of their procedures, post-operative still images of patients taken in the operating room, and the cost of the procedure. During some videos/live-streams you engage in dialogue to respond to viewers' online questions while the surgical procedure remains actively ongoing.

(2) From in or around May 2020 through March 2022, you provided care and treatment in the routine course of your practice at your office setting, Roxy Plastic Surgery, to Patients 1 through 3, as identified in the attached Patient Key (Key is confidential and to be withheld from public disclosure). You inappropriately treated and/or failed to appropriately treat and/or you failed to appropriately document your treatment of these patients.

(3) Examples of such care and treatment identified in paragraph (2) include, but are not limited to, the following:

(a) On or about February 2018 through March 2022 you provided care and treatment to Patient 1. On or about July 9, 2020, you performed an abdominoplasty, "Brazilian Butt Lift," and liposuction of Patient 1's upper and lower back under general endotracheal anesthesia at Roxy Plastic Surgery, your office setting. You evaluated Patient 1 using the American Society of Anesthesiologists (ASA) Physical Status Classification System and evaluated her as ASA/P3. You collected a total aspirate of 4300 cc. Further, you failed to provide or failed to document providing written discharge instructions to Patient 1 concerning specific information about lidocaine toxicity.

On or about March 21, 2022, you performed liposuction of the abdomen and arms, a "Brazilian Butt Lift", and Renuvion J-plasma procedure on abdomen and arms, under general endotracheal anesthesia at Roxy Plastic Surgery, your office setting. At this time you evaluated Patient 1 as ASA/P2. You collected a total aspirate of 3700 cc. During the procedure, you broadcast on social media. While looking at the camera and speaking to the camera, you were engaged in liposuction of Patient 1's abdomen. Despite liposuction being a blind surgery that requires awareness of the tip of the cannula to avoid injury, your attention to the camera meant at those moments you were not looking at the patient or palpating the location of the tip of the cannula. Further, you failed to provide or failed to document providing written discharge instructions to Patient 1 concerning specific information about lidocaine toxicity.

On March 26, 2022, Patient 1's husband called to report that emergency medical personnel were checking on her at their house. On or about March 27, 2022, a nurse practitioner in your practice saw Patient 1 and sent her to the emergency room for evaluation, where she was found to have free air in her abdomen and hepatic encephalopathy. On or about March 28, 2022, Patient 1 was transferred to another hospital for further evaluation and definitive treatment. Patient 1 underwent surgery for exploratory laparotomy and was found to have perforated small bowel and necrotizing soft tissue infection. Patient 1 required a prolonged stay with multiple debridements, open abdomen, and skin grafting.

(b) On or about May 20, 2020 through December 21, 2020, you provided care and treatment to Patient 2. On or about On December 10, 2020, you performed "Liposuction 360," "Brazilian Butt Lift, an umbilical hernia repair, and Renuvion J-plasma of the abdomen and flanks under general endotracheal anesthesia at Roxy Plastic Surgery, your office setting. You collected a total aspirate of 4900 cc from Patient 2. Patient 2 was discharged to the "recovery house." You failed to provide or failed to document providing written discharge instructions to Patient 2 concerning specific information about lidocaine toxicity.

On or about December 11, 2020, Patient 2 called the emergency line due to cramping and severe abdominal pain. Patient 2 had produced 2000 cc of dark yellow urine over the previous four hours. After that phone call, Patient 2 called 911, was transferred to the emergency room, and admitted to the hospital with rhabdomylosis. Patient 2's creatine kinase level on admission was 11,900. The following day, Patient 2 developed an acute abdomen with pneumoperitoneum. She underwent exploratory laparotomy and was found to have six enterotomies and multiple serosal tears that were not full thickness. Patient 2 required small bowel resection, two repairs of the small bowel and partial omentectomy.

(c) On or about September 13, 2018 through December 10, 2021 you provided care and treatment to Patient 3. On or about December 1, 2021, you performed breast augmentation with silicone implants, mastopexy revision with internal bra (Galaflex), under general anesthesia at Roxy Plastic Surgery, your office setting. On or about December 6, 2021, Patient 3 complained of nausea since her surgery. Her left nipple appeared dusky on exam. On or about December 8, 2021, Patient 3 complained of bleeding from the breast. A general surgeon opened her left breast and evacuated a hematoma at your office and no implant was visualized. On or about December 10, 2021, Patient 3 complained of malaise, nausea and pain in her arm. Patient 3's right nipple was dark, and her left nipple with eschar. Despite Patient 3's complex surgical history and her prior hematoma, you delegated bilateral breast exploration and hematoma evacuation to your nurse practitioner. No implant was visualized. Patient 3 was tachycardic and was transferred to the hospital for treatment. You communicated to the plastic surgeon who assumed care at the hospital that you believed her condition was not infectious in origin, and erroneously indicated that Patient 3's implants had been removed. Once at the hospital, Patient 3 was found to have developed infection requiring removal of bilateral implants, removal of the mesh bra bilaterally, and debridement bilaterally of both breasts.

Your acts, conduct, and/or omissions as alleged in paragraphs (2), and (3)(a) through (3)(c) 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.

Further, your acts, conduct, and/or omissions as alleged in paragraph (3)(a) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-25-02(H), Ohio Administrative Code, Office-Based Surgery - General Provisions.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (3)(a) and (3)(b) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-25-05(B)(7), Ohio Administrative Code, Liposuction in the Office Setting.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (3)(a) and (3)(b) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-25-05(B)(8), Ohio Administrative Code, Liposuction in the Office Setting.

Further, your acts, conduct, and/or omissions as alleged in paragraph (3)(b) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-25-05(C), Ohio Administrative Code, Liposuction in the Office Setting.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (3)(a) and (3)(b) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in the or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-25-05(E), Ohio Administrative Code, Liposuction in the Office Setting.

Furthermore, for any violations that occurred on or after September 29, 2015, the Board may impose a civil penalty in an amount that shall not exceed twenty thousand dollars, pursuant to Section 4731.225, Ohio Revised Code. The civil penalty may be in addition to any other action the Board may take under section 4731.22, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, and Chapter 4731., Ohio Revised Code, you are hereby advised that you are entitled to a hearing concerning these matters. 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 or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice, 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 or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or 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 license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Kim G. Rothermel, MD/smc

Kim G. Rothermel, M.D.
Secretary

KGR/TCN/LV
Enclosures

CERTIFIED MAIL # 9414 8149 0315 2968 0129 15
RETURN RECEIPT REQUESTED

cc: BY PERSONAL DELIVERY

cc: Sabrina Sellers, counsel for Dr. Grawe
300 East Broad St.
Suite 350
Columbus, OH 43215

CERTIFIED MAIL # 9414 8149 0315 2968 0129 22
RETURN RECEIPT REQUESTED

IN THE MATTER OF KATHARINE ROXANNE GRAWE, MD

22-CRF-0220

NOVEMBER 18, 2022, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.