

Public

NEW YORK STATE DEPARTMENT OF HEALTH  
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

PETER JAMES NORMANN, M.D.

CO-07-05-2897-A

COMMISSIONER'S

SUMMARY

ORDER

TO: PETER JAMES NORMANN, M.D.  
2915 W. Sousa Drive  
Anthem, AZ 85086-1786

PETER JAMES NORMANN, M.D.  
3624 W. Anthem Way  
Suite C-108  
Anthem, AZ 85086

The undersigned, Richard F. Daines, M.D., Commissioner of Health, pursuant to New York Public Health Law §230, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, has determined that the duly authorized professional disciplinary agency of another jurisdiction, the Arizona Medical Board, has made a finding substantially equivalent to a finding that the practice of medicine by **PETER JAMES NORMANN, M.D.**, New York license no. 212346, in that jurisdiction constitutes an imminent danger to the health of its people, as is more fully set forth in the Arizona Medical Board, Amended Interim Findings of Fact, Conclusions of Law and Order For Summary Suspension of License, dated July 12, 2007, attached, hereto, as Appendix "A" and made a part, hereof.

It is therefore:

ORDERED, pursuant to New York Public Health Law §230(12)(b), that effective immediately, Respondent shall not practice medicine in the State of New York.

Any practice of medicine in the State of New York in violation of this Order shall constitute Professional

Misconduct within the meaning of New York Education Law §6530(29) and may constitute unauthorized medical practice, a Felony defined by New York Education Law §6512.

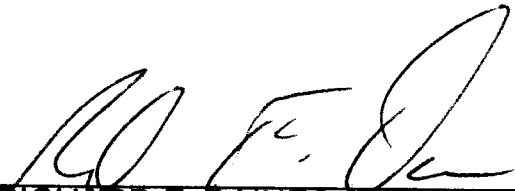
This Order shall remain in effect until the final conclusion of a hearing which shall commence within thirty days after the final conclusion of the disciplinary proceeding in the State of Arizona.

The hearing will be held pursuant to the provisions of New York Public Health Law §230 and New York State Administrative Procedure Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on a date and at a location to be set forth in a written Notice of Summary Hearing to be provided to the Respondent after the final conclusion of the proceeding. Said written Notice may be provided in person, by mail, or by other means. If Respondent wishes to be provided said written notice at an address other than that set forth above, Respondent shall so notify, in writing, both the attorney whose name is set forth in this Order and the Director of the Office of Professional Medical Conduct, at the addresses set forth below.

Respondent shall notify the Director of the Office of Professional Medical Conduct, New York State Department of Health, 433 River Street, Suite 303, Troy, NY 12180-2299 via Certified Mail, Return Receipt Requested, of the final conclusion of the Arizona proceeding immediately upon such conclusion.

These proceedings may result in a determination that your license to practice medicine in New York State be revoked or suspended and/or that you be fined or subject to other sanctions set forth in New York Public Health Law §230-a. You are urged to obtain an attorney to represent you in this matter.

DATED: Albany, New York  
August 27, 2007

  
RICHARD F. DAINES, M.D.  
Commissioner of Health  
New York State Health Department

Inquiries should be directed to:

Robert Bogan  
Associate Counsel  
N.Y.S. Department of Health  
Division of Legal Affairs  
433 River Street  
Suite 303  
Troy, NY 12180  
Telephone (518) 402-0828



1 female, were brought to a hospital's emergency department over a four month period after  
2 suffering cardiac arrest during liposuction procedures performed by Respondent at his office. Both  
3 patients died.

4 4. RG was an otherwise healthy male who presented to Respondent's office on March  
5 10, 2006 for an initial consultation for liposuction of the abdomen and waist. RG was seen again on  
6 May 3, 2006 for a pre-op visit. Respondent performed surgery in his office on May 16, 2006 under  
7 local (tumescent) anesthesia with minimal p.o. sedation except that Respondent gave Demerol 50  
8 mg and Phenergan 25 mg IM at the very end of the procedure. RG was discharged home  
9 approximately twenty-five minutes after the surgery ended. RG recovered uneventfully and  
10 subsequent follow-up was unremarkable. RG was again seen by Respondent on December 4,  
11 2006 and plans were made for repeat liposuction of the same areas treated on May 16, 2006. It is  
12 not clear from the records whether the indication for the repeat procedure was residual or re-  
13 accumulated fat.

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

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

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

12           8.       AS, an otherwise healthy female presented to Respondent's office on September 9,  
13 2006 and was seen by a licensed massage therapist ("LMT") employed by Respondent as a  
14 ~~medical assistant. Respondent was out of town attending a medical conference. AS next~~  
15 presented on September 25, 2006 and was seen by LMT in consultation for liposuction. The visit  
16 note is written and signed by LMT. AS's liposuction of the waist, abdomen, back and outer thighs  
17 was performed on September 27, 2006. LMT filled out and signed the intra-operative record. AS  
18 received eight liters of tumescent fluid, over six liters were aspirated and AS spent approximately  
19 twenty minutes in recovery before being sent home. AS received no resuscitative IV fluids and her  
20 urine output was not monitored. Respondent left for a trip to Germany two days after the surgery  
21 and all of the follow-up care was done by LMT. AS did not physically return for follow-up, but LMT  
22 placed calls to her. There is no operative note written by Respondent for AS's procedure and no  
23 documentation that Respondent ever participated in AS's pre-operative evaluation, surgery or  
24 follow-up.

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

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

23           11.       The "Liposuction Operative Note" from surgery indicates a plan to perform  
24 liposuction of the hips, revision of the right breast, and buttock augmentation. Review of the  
25 drawings on that sheet reveals all areas were injected with tumescent solution in anticipation of

1 surgery, including the buttocks. At the bottom of the sheet, there is a handwritten note that the  
2 buttock augmentation was not performed and AS coded after the breast revision and liposuction  
3 were performed. The "Conscious Sedation Record" shows the propofol drip was turned off at  
4 between 1735 and 1740 hours and AS coded some twenty or twenty-five minutes later at 1800.  
5 According to this record, the propofol drip was discontinued after the breast revision and  
6 liposuction was completed and well before AS arrested. The record is not consistent with a  
7 sequence of events in which the buttock augmentation was omitted as a result of the code, as  
8 implied by the handwritten note, and Respondent's account of the sequence of events (that AS  
9 arrested after the procedure had been completed) is not consistent with the records from surgery  
10 since all of planned procedures had not been completed. After AS arrested, 911 was called, and  
11 AS was intubated and ventilated and quickly went into asystole. CPR was begun, defibrillator pads  
12 were placed and she received epinephrine, atropine, flumazenil and narcan. AS was subsequently  
13 transported to the local hospital where a pulse and pressure were re-established, but she coded  
14 again and expired shortly after transfer to the OCU.

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

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



1 Respondent confirmed LMT sutured patients.

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

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

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

14 ~~17. Respondent was performing procedures involving laser equipment that was not~~  
15 ~~registered with the Arizona Radiation Regulatory Agency.~~

16 **MD-07-0589A**

17 18. On July 9, 2007 the Board was informed by a local fire department that on July 3,  
18 2007 they received a 911 call from Respondent's office requesting emergency response to a  
19 patient in cardiac arrest. This patient, LR, a fifty-three year-old female, later died at a local hospital.  
20 LR first presented to Respondent on May 22, 2007 for a consultation for a liposuction procedure.  
21 LR made three payments to Respondent, the last payment being made on July 3, 2007, the day of  
22 surgery.

23 19. Subsequent to signing the Interim Consent Agreement Respondent entered into an  
24 agreement with a licensed Homeopathic physician ("Homeopath"). Homeopath is not licensed by  
25 the Board as an allopathic physician. Respondent maintains: Homeopath evaluated LR the day of

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

14 Standard of Care

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

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

23 22. The standard of care requires a physician who is performing conscious sedation in  
24 the office using propofol to follow the American Society of Anesthesiologists ("ASA") Statement on  
25 Safe Use of Propofol, including employing certified and adequately trained personnel to monitor

1 the patients during surgery; being adequately educated and trained in the hours-long use of  
2 Propofol required for the liposuction procedures; being physically present while a patient is under  
3 conscious sedation; adequately monitor patients who are under conscious sedation; and  
4 demonstrate a complete understanding of propofol.

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

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

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

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

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

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

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

25 30. Three patients died.

1 Medical Records

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

8 Finding of Imminent Harm

9 32. The facts as presented demonstrate that the public health, safety or welfare  
10 imperatively requires emergency action.

11 INTERIM CONCLUSIONS OF LAW

12 1. The Board possesses jurisdiction over the subject matter hereof and over  
13 Respondent, holder of License No. 33254 for the practice of allopathic medicine in the State of  
14 Arizona.

15 2. The conduct and circumstances described above constitute unprofessional conduct  
16 pursuant to A.R.S. § 32-1401(27)(a) ("violating any federal or state laws or rules and regulations  
17 applicable to the practice of medicine,") specifically, A.R.S. § 30-672; A.R.S. § 32-1401(27)(e)  
18 ("failing or refusing to maintain adequate records on a patient;") A.R.S. § 32-1401(27)(q) ("any  
19 conduct or practice that is or might be harmful or dangerous to the health of the patient or the  
20 public;") A.R.S. § 32-1401(27)(t) ("knowingly making any false or fraudulent statement, written or  
21 oral, in connection with the practice of medicine or if applying for privileges or renewing an  
22 application for privileges at a health care institution;") A.R.S. § 32-1401(27)(cc) ("maintaining a  
23 professional connection with or lending one's name to enhance or continue the activities of an  
24 illegal practitioner of medicine;") A.R.S. § 32-1401(27)(jj) ("knowingly making a false or  
25 misleading statement to the board or on a form required by the board or in a written

1 correspondence, including attachments, with the board;") A.R.S. § 32-1401(27)(kk) ("failing to  
2 dispense drugs and devices in compliance with article 6 of this chapter;") and A.R.S. § 32-  
3 1401(27)(ll) ("conduct that the board determines is gross negligence, repeated negligence, or  
4 negligence resulting in harm to or the death of a patient.").

5 3. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public  
6 health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).

7 **ORDER**

8 Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above,  
9 **IT IS HEREBY ORDERED THAT:**

10 1. Respondent's license to practice allopathic medicine in the State of Arizona,  
11 License No. 33254, is summarily suspended pending a formal hearing before an Administrative  
12 Law Judge from the Office of Administrative Hearings.

13 2. The Interim Findings of Fact and Conclusions of Law constitute written notice to  
14 ~~Respondent of the charges of unprofessional conduct made by the Board against him.~~  
15 Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible  
16 after the issuance of this order.

17 3. The Board's Executive Director is instructed to refer this matter to the Office of  
18 Administrative Hearings for scheduling of an administrative hearing to be commenced as  
19 expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed  
20 otherwise by Respondent.

21  
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24  
25

1 DATED this 12 day of July 2007

ARIZONA MEDICAL BOARD

2  
3 [S]



4  
5  
6 By *Timothy C. Miller*  
Timothy C. Miller, J.D.  
Executive Director

7 ORIGINAL of the foregoing filed this  
8 12th day of July 2007, with:

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

10 EXECUTED COPY of the foregoing  
11 mailed by US Mail this 12th day of  
12 July 2007 to:

13 Peter James Normann, M.D.  
Address of Record

14 and

15 Dean Brekke  
16 Assistant Attorney General  
17 Arizona Attorney General's Office  
1275 West Washington, CIV/LES  
Phoenix, Arizona 85007

18 *Chris Damp*  
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