

THE COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss.

Division of Administrative Law Appeals

**Board of Registration in Medicine,**  
Petitioner

v.

Docket No. RM-18-0604

Dated: **JUN - 8 2020**

**Dave David, M.D.,**  
Respondent

**Appearance for Petitioner:**

Lisa L. Fuccione, Esq.  
Board of Registration in Medicine  
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**Appearance for Respondent:**

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**Administrative Magistrate**

James P. Rooney

**Summary of Decision**

The Board of Registration in Medicine charged a surgeon who performs liposuction with gross negligence in the treatment of one patient and failure to keep adequate medical records for two other patients. Although the first patient had a post-operative complication, the evidence fails to establish that this was the result of poor surgical technique. The pre-operative records of the other two patients are sparse, but the evidence does not establish a violation.

**RECOMMENDED DECISION**

On October 26, 2018, the Board of Registration in Medicine issued a Statement of Allegations charging Dave David, M.D. with negligence or gross negligence in his treatment of a patient on whom he performed liposuction and with failure to keep adequate medical records on this patient and three others. I held a hearing on November 18-20, 2019, which was transcribed. The Board proceeded on two of the medical records charges and a charge that the doctor had been grossly negligent in his treatment of Patient RN. The Board submitted twelve exhibits; the doctor submitted ten exhibits.<sup>1</sup> Dr. David and Patient RN testified, as did Michael Kaminer, M.D., a dermatologist who reported Dr. David to the Board, George Chatson, M.D., a plastic surgeon who served as the Board's expert witness, Luciano Sztulman, M.D., a cosmetic surgeon who served as Dr. David's expert witness, and Debbie David, Dr. David's wife and assistant. Both parties filed post-hearing briefs, which closed the record on March 11, 2020.

**Findings of Fact**

Based on the testimony and evidence presented, and the reasonable inferences drawn from them, I make the following findings of fact:

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<sup>1</sup> The doctor initially submitted five exhibits, then supplemented his exhibits with the curriculum vitae of himself and his expert. He introduced three exhibits at trial as well. During the hearing, I did not recall that he had already submitted exhibits 6 and 7, and thus I numbered those three new exhibits 6-8. For purpose of clarity, I now renumber them as exhibits 8-10. They are: Dr. Ex. 8 (a single page describing post-surgery men's bodysuits), Dr. Ex. 9 (a small men's bodysuit), and Dr. Ex. 10 (an extra-small men's bodysuit).

A. *Credentials*

1. Dr. David graduated with a degree in medicine from the University of Florida in 1978. He was a resident at Harvard and Tufts affiliated hospitals in internal medicine and obstetrics and gynecology, and then practiced obstetrics and gynecology in southern California for ten years. In 1998, he received training in liposuction in California and in Rome. He moved to Boston in the 1990s and, at first, continued to practice in obstetrics and gynecology. From 1998 on, he has been performing cosmetic surgery. He learned tumescent liposuction, which is a form of liposuction involving injection of liquid and a local anesthetic injected into the area where fat is to be removed. At first, he performed this type of liposuction with lasers used to break up fat. Later, he used a "Vaser" machine, which uses ultrasound to break up the fat. He opened his own office in 2009 and has been performing Vaser liposuction exclusively since then. He has performed over 1,000 Vaser procedures. (Dr. David testimony; Dr. Ex. 6.)

2. Dr. Kaminer obtained his medical degree from Tufts University School of Medicine. He was a general surgery resident at New York University and a dermatology resident at Tufts. He founded and practices at SkinCare Physicians in Chestnut Hill, Massachusetts. His practice involves mostly non-invasive cosmetic surgery. He has performed 40-50 Vaser liposuction procedures, but stopped in 2012 after he underwent shoulder surgery. (Kaminer testimony.)

3. Dr. Chatson's medical degree is from New York University. He was a general surgery resident at Hartford Hospital as part of the University of Connecticut residency program. He then was a plastic surgery resident at Rhode Island Hospital in the Brown

University resident program. He is certified by the American Board of Plastic Surgeons. He has been in private practice since 1995. He has performed liposuctions using ultrasound, but has not performed any with a Vaser machine or received any training on Vaser liposuction. (Chatson testimony.)

4. Dr. Sztulman obtained his medical degree in Brazil, and then was a resident in obstetrics and gynecology at the Sao Paulo Public Employees' State Hospital in Brazil and Maimonides Medical Center in Brooklyn, New York. His current practice involves both obstetrics and gynecology and cosmetic surgery. He has performed 1,000 liposuction procedures, including 300 Vaser procedures. He has received training in Vaser in both the United States and Brazil. (Sztulman testimony.)

B. *Vaser Liposuction*

5. According to its manufacturer, the "VASERlipo System is intended for the fragmentation, emulsification and aspiration of subcutaneous fatty tissue for aesthetic body contouring." (Bd. Ex. 11.) To perform Vaser liposuction, a doctor first creates a sterile field on the area of the body where the procedure is to be performed, anaesthetizes that area, and then makes a three millimeter incision and injects a solution that contains water, epinephrine, and lidocaine. The doctor waits ten minutes while the solution begins to break up the fat. The probe the doctor used to inject the solution will give the doctor an idea how firm the fat is, and this will guide him when choosing which ultrasound probe to use and at what energy level. Probes come in different sizes with one, two or three grooves (or rings). The 3.7 mm., two-groove probe is standard, but a one-groove probe would be called for with firmer fatty tissue. Grooves make a difference in which

direction the ultrasonic energy is directed. A one-groove probe directs 65% of its energy forward and 35% to the sides. A two groove probe directs 55% of its energy forward and 45% to the sides. (Dr. David and Sztulman testimony.)

6. When the doctor uses the ultrasonic probe, he moves it around in a fashion described by Dr. David as cross-hatching, by Dr. Sztulman as fan-like, or by the Vaser guidelines as “in and out like the spokes of a wheel.” The Vaser guidelines instruct doctors to “[k]eep the probe moving” and to “[l]ook for ‘loss of resistance’ to probe movement in all areas of the intended fragmentation volume as the primary indicator of the surgical endpoint.” The goal is to provide equal energy throughout the treatment area. (Dr. David, Chatson, and Sztulman testimony; Bd. Ex. 12..)

7. The ultrasonic energy emitted by the probe is taken up mostly by the fat cells, which break up and become emulsified in the liquid. The risk involved in the procedure is the possible exposure of the patient to excess heat energy, which can cause complications including “burns, sensory nerve dysesthesias, and collateral damage to the collagen tissue matrix.” (Dr. David, Chatson, and Sztulman testimony; Bd. Ex. 12.)

8. The Vaser machine has various safety features designed to prevent injury. The general safety guidance is that the probe should be used no longer than one minute per every 100 milliliters of fluid that has been injected into the patient. The probe will not work in the absence of liquid. The probe will beep if there is no liquid; it will also beep is the probe is stuck in one place. When the probe beeps, it stops working, and the doctor has to move on to a different location to continue the procedure. (Sztulman testimony; Bd. Ex. 12.)

*C. Doctor David's Office Procedure*

9. When an individual contacts Dr. David's office about liposuction, the doctor has him or her come into the office for a consultation. The prospective patient fills out a medical history and is interviewed by the Debbie David, the doctor's assistant, about which areas of the body the person wants to have undergo liposuction. The doctor then meets with the person, goes into more detail about his or her medical history, and explains that liposuction is not for weight loss and that there can be complications, such as loose skin. He tests the patient's skin for elasticity and estimates the amount of fat that can be removed. He makes notes as he is interviewing a prospective patient or immediately after a consultation. He typically notes skin elasticity, and whether the person has had any previous surgery or liposuction in the area of concern because the person is likely to have fibrosis in that area. (Dr. David testimony.)

10. After the doctor has seen the prospective patient, Mrs. David speaks to the person again, describes the cost of the procedure and schedules surgery. She also draws the patient's blood and goes over pre-operative instructions. Finally, she has the patient order a compression garment to be worn after the surgery. The garment selected must be one that completely covers the areas to be treated. The garment's purpose is to compress the skin to the underlying body tissue and thereby lead to a smooth result, avoid fluid accumulation, and prevent loose skin. (Debbie David and Dr. David testimony.)

11. On the day of surgery, the patient arrives with the compression garment. The patient then fills out a consent form and is weighed. The consent form is eleven pages long. The patient must sign a general consent for treatment, initial sixteen boxes that

describe specific risks of liposuction, and sign a Vaser liposuction consent form that describes what to expect from the procedure and the potential side effects and risks. The doctor performs a complete physical examination and calculates how much lidocaine to use. The doctor's pre-operative patient assessment is a preprinted form that lists the areas the doctor is to examine in the physical, provides a space to list the proposed procedures, and lists the cautions about expectations that the doctor intends to go over with the patient. He checks off the areas of the body he examined, notes any anomalies, lists the areas where he is to perform liposuction, and checks off whether he has gone over the listed cautions with the patient. The doctor marks the areas on the patient's body to be treated and shows the markings to the patient in a mirror. Mrs. David takes pictures of the marked areas to be treated. The doctor also discusses post-operative care with the patient. Even if the procedure goes well, there is a risk of scarring, uneven healing, or a seroma<sup>2</sup> thereafter if the patient moves about too soon. The doctor instructs the patient to lie flat on the day of the procedure and the next day. The patient is also told not to be active for a few days and not to resume exercise for two to three weeks. The patient is told to return to the doctor's office in one to two weeks, but in the meantime to expect some swelling. The patient is also told to schedule a followup appointment for three to six months after the procedure. (Dr. David testimony.)

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<sup>2</sup> "A seroma is an accumulation of fluid in a tissue or organ that can occur after surgery. . . . The fluid, called serum, leaks out of nearby damaged blood and lymphatic vessels. <https://www.healthgrades.com/right-care/symptoms-and-conditions/seroma>.

D. *Patient RN*

12. Patient RN, who is an orthopedic surgeon, consulted with Dr. David on November 22, 2013 about liposuction of his abdomen and lower flanks. Dr. David, in his consultation note, wrote that RN had good elasticity and was a good Vaser candidate. Mrs. David told RN not to schedule surgery the week of the procedure and to expect to wear the compression garment for three weeks. (RN, Dr. David, and Debbie David testimony; Bd. Ex. 3.)

13. RN's liposuction was performed on January 10, 2014. He signed a consent form and had pre-operative pictures taken, one set without markings and another set with markings. He brought a compression garment with him; it was a male small garment. (Debbie David testimony; Bd. Ex. 3, Dr. Ex. 9.)

14. Dr. David performed liposuction on both RN's abdomen and lower flanks. He injected 1,856 cubic centimeters of fluid into RN's abdomen. As is his general practice, he did not predetermine the volume of fluid to be injected. He used a 3.7 mm. probe with one ring because RN's stomach fat was relatively hard. The abdomen procedure took 14 minutes. The doctor extracted 650 cubic centimeters of aspirate. (Dr. David testimony; Bd. Ex. 3.) RN began wearing the compression garment immediately after the procedure and continued to wear a compression garment for the time recommended. (RN testimony.)

15. Three days after the liposuction, on January 13, 2014, RN came in for an office visit because he thought he might have developed a seroma. He could not come in until the end of the day because he had worked a full day. He had worked the night before as



well, because he had been retained by the Boston University hockey team and he was required to attend all home games. Dr. David examined him. He thought it would be unusual for a seroma to develop this quickly. He expected there to be fluid under the skin, and that is what he felt. His impression was that RN's abdomen was normal post-surgery. He aspirated 33 cubic centimeters of liquid from RN's abdomen and told him to return in two weeks. (Dr. David and Debbie David testimony.)

16. RN returned on January 27, 2014. He told Mrs. David that he was impatient about the swelling going down. He thought the compression garment was not small enough and said he intended to purchase an extra small garment. She told him that the male small garment was the right size and advised him not to buy a smaller size because it would dig in. He assured her that he would not, but later she learned from the manufacturer that, two weeks later, RN had returned the small size garment and ordered an extra-small garment. (Debbie David testimony.)

17. Dr. David met with the patient that day and had photographs taken of his progress. The pictures show that RN's belly was flat and that there was some lessening of belly size from the pre-operative photos. RN mentioned to the doctor that he was thinking of undergoing Coolsculpting, a non-invasive procedure that freezes fat. He complained of uneven skin, dimpling, fibrotic areas and pigmentation changes. Dr. David told him that he could not expect results this soon after liposuction. It would take six months before the final result would be known, and told him not to consider doing anything else before then. (Dr. David and RN testimony.)

18. RN did not return to see Dr. David again. At one point, he asked for his money back. Dr. David agreed to redo the procedure at no charge, but asked to see RN to determine what was needed. RN made an appointment for March 25, 2014, but did not show up for it. (Dr. David testimony; Bd. Ex. 10B.)

19. On March 21, 2014, Patient RN visited Dr. Kaminer. Photographs of RN's stomach taken that day show four small incisions at the edges of his upper and lower abdomen. Just above the incisions on the lower abdomen and below his bellybutton, there is a nearly horizontal bulge extending across much of his stomach. His skin is mostly white, but the underside of the bulge is dark. Dr. Kaminer stated that he observed "linear depressions with fibrosis and uneven contours that were tied into the fibrotic response." He added that between the two incision, he saw a "linear, fibrotic . . . adhesion, which is sort of bound down, scar type feel, with redundant or loose skin above that adhesion." (Kaminer testimony; Bd. Ex. 1.) Dr. Sztulman agreed with Dr. Kaminer's basic description of depression and bulge on RN's stomach. He opined that what RN had was a chronic seroma. (Sztulman testimony.)

20. Dr. Kaminer thought that because the linear depression was in between the two surgical incisions, it "indicated it was the path of treatment" during the Vaser procedure. In his opinion, "the treatment between those two scars resulted in an irregular contour and an over-treatment that caused the skin to change its surface texture."<sup>3</sup> He thought such a change might be seen within one or two weeks, but it could take two to four months after liposuction for this change to be observable. (Kaminer testimony.)

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<sup>3</sup> The Board did not offer Dr. Kaminer as an expert witness. I include his description of how he thought the injury occurred because it is the clearest in the record.

21. Dr. Chatson was later asked by the Board to review Dr. David's treatment of Patient RN. In a February 23, 2017 report he wrote:

The level of complications experienced by the patient indicates that the patient's treatment was outside the standard of care. . . . [Dr. Kaminer's pictures] show severe deformities of abdominal contour with extreme contour irregularities, concavity and skin scarring. This level of deformity indicates that excessive ultrasonic energy was applied to the subcutaneous fat and subdermal layers causing fat necrosis, subdermal lymphatic injury, contraction, and scarring. . . . The fact that Dr. David has been doing VASER liposuction for at least five years prior to this complication clearly indicates that he is not careful enough with this device. This extremely bad outcome in this patient should have been avoided.

(B. Ex. 9A.) At the hearing, he opined that although the 14 minutes it took to perform the procedure was not inappropriate, the results show that excessive energy was used and that Dr. David's performance of this procedure was "significantly outside" the standard of care. He thought the damage was possibly caused by the doctor going back and forth over the same area. (Chatson testimony.)

22. Dr. David does not believe RN's condition, when Dr. Kaminer observed it, was caused by a thermal injury. In his opinion, a thermal injury would cause an irregularity within two to three weeks. He has not seen a thermal injury in his practice, which he attributes to his being obsessive about monitoring thermal energy delivery. (Dr. David testimony.)

23. When the Board asked Dr. David to respond regarding his treatment of Patient RN, the doctor wrote a statement describing the course of his care and noted that he had not seen the patient after his two week followup appointment nor had he seen any pictures of the problem that RN had treated by another doctor. He concluded by observing that:

As any surgeon knows, post op care is as important as pre op care or the surgery itself, in determining the outcome. This is especially true with cosmetic surgery and even more so with liposuction. So often, the cosmetic result is not a function of how the surgery was performed, but rather the post op course. . . . Especially with liposuction, proper wearing of the garment and proper FITTING of the garment is vital and is up to the patient. If the patient does not come in for post op evaluation, the surgeon and his office staff doesn't have the opportunity to modify what the patient may or may not be doing, how the incisions are being cared for, how much activity the patient is doing in the immediate post op period or how the garment is fitting.

(Bd. Ex. 10b.) By the hearing, Dr. David had seen Dr. Kaminer's photographs. He did not think the deformity observable in them was caused by the surgery itself because that had been routine. Rather, he suspected that RN had engaged in too much activity too soon after the procedure, and that a garment had dug into RN's stomach creating a seroma.

24. Dr. Chatson reviewed Dr. David's response to the Board and noted that the doctor did not mention the time of energy delivery to the patient. He observed that:

Considering the time of energy delivery is a critically important aspect to using any energy-based delivery to any area, the more energy is delivered to that area, and the higher is the risk that excessive energy can result in tissue necrosis. When tissue necrosis occurs, it is followed by fibrosis, scarring, and contraction deformity. I believe that this is exactly what occurred in patient RN's case.

(Bd. Ex. 9B.) He was not surprised that Dr. David observed no problems in the two post-operation visits RN made to him because it would take several months for an injury of the sort that RN experienced to become evident. He did not think that RN's use of his compression garment was the likely cause of the deformity, because improper use of compression garments is rarely the cause of deformity and he would have expected to see such a problem to have surfaced in the post-operative photos. (Chatson testimony.)

25. Dr. Sztulman thought that RN's condition was not likely to have been caused by Dr. David's treatment itself. He opined that if excess energy caused harm to a patient, it would be observable in a few days, yet photographs of RN after 17 days showed no problems. The later developing problem he attributed to compression that prevented fluid from draining, thus causing a seroma. Over the next few months, the fluid in this encapsulated seroma was displaced by fibrotic tissue, which is what was present when RN saw Dr. Kaminer. (Sztulman testimony.)

E. *Medical Records*

1. *Patient OB*

26. Dr. David performed liposuction on Patient OB's thighs and knees in 2010. The doctor's consultation note mentions that he discussed the procedure in detail with the patient, including realistic expectations. His pre-operative note mentions that she is a candidate for liposuction, but does not mention her skin elasticity. He checked off in his pre-operative note that he provided various cautions to the patient about what to expect from liposuction. (Bd. Ex. 5.)

27. Dr. Chatson, in his report to the Board, thought these notes were lacking in detail and failed to mention the patient's skin tone. At the hearing, he added that the notes do not estimate the fat content of the areas to be treated and did not mention the loose skin on this patient's inner thighs. He opined that these details are pertinent to treatment, and therefore should have been documented, but, beyond that, it was important for the doctor to discuss them with the patient because then a determination of the suitability of the patient for liposuction could be made. He acknowledged that the pre-operative

photos of Patient OB were satisfactory, but stated that they do not replace written documentation. He did not object to the doctor having a pre-operative note form that he used to check off the areas of the body he examined. Thus, he did not object to Dr. David simply putting a check mark next to "general appearance." (Chatson testimony; Bd. Ex. 9A.)

28. Dr. David thought that he simply forgot to note Patient OB's skin elasticity, but would not have performed liposuction if he had not evaluated the patient's elasticity and found it to be acceptable. On that score, he crossed off some areas that he did not recommend be treated. (Dr. David testimony.) In his written response to the Board, Dr. David stated that on the day he performed liposuction, "I again recognized that in addition to having quite a bit of fat on her, that the contour of her thighs were quite irregular (see pre op pictures) and I told her that starting with irregularities like that, I especially couldn't guarantee a perfectly smooth outcome." (Bd. Ex. 10D.) His pre-operative note shows that he checked off that he discussed with the patient that liposuction was unlikely to address wrinkles, excess skin, or skin irregularities. (Bd. Ex. 5.) Dr. Sztulman thought Dr. David's pre-operative notes of Patient OB were adequate. (Sztulman testimony.)

2. *Patient JN*

29. Dr. David's consultation note for Patient JN stated that her skin had good elasticity and that she wanted liposuction in many areas, but that there was not much fat in any of these spots. His pre-operative note checked off that he had given the patient

cautions as to what liposuction does not do and that there may be complications such as skin irregularity. (Bd. Ex. 6.)

30. Dr. Chatson thought Dr. David's pre-operative notes on Patient JN lacked detail regarding skin tone, a description of what was to be done in each area to be treated, and expectations for the procedure. The notes mention that JN has "good elasticity," an evaluation with which Dr. Chatson disagreed. He thought the patient had moderate to poor elasticity. (Chatson testimony; Bd. Ex. 9A.)

31. Dr. David thought his pre-operative notes regarding Patient JN were adequate. They describe all the areas to be treated. He stated that he does not mention every last detail regarding the patient, just what he described as "pertinent positives," by which he meant findings (positive or negative) that were out of the ordinary. (Dr. David testimony.) Dr. Sztulman thought Dr. David's pre-operative notes of Patient JN were adequate. (Sztulman testimony.)

#### **Discussion**

The Board has charged Dr. David with two types of violations: gross negligence in the treatment of Patient RN and failure to keep adequate medical records regarding Patients OB and JN. Regarding Patient RN, the Statement of Allegations charged that the "energy level that [Dr. David] delivered to Patient RN's abdomen during the procedure was highly excessive and fell well outside the standard of care," and caused "severe deformities of abdominal contour." Regarding Patient OB, the Statement charged that Dr. David's pre-operative note did not contain "any detail or analysis regarding his plan for treating" the patient, "any information regarding his concern that

Patient OB had excessive fat in certain areas,” “any information that regarding his observation that the contour of Patient OB’s thighs was irregular,” and “any information regarding [his] assessment of Patient OB’s skin elasticity.” Regarding Patient JN, the Statement charged that Dr. David’s pre-operative note “does not contain any detail or analysis regarding his plan for treating Patient JN.”

Most of the testimony concerned the treatment of Patient RN. I turn to this first and consider whether the Board has proved that Dr. David was grossly negligent.

A. *Gross Negligence*

Physicians generally must meet the standard of care, which is "the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession." *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793,798 (1968). The standard of care is the level of care and skill that physicians in the same specialty commonly possess. *Palandijan v. Foster*, 446 Mass. 100, 104-05, 842 N.E.2d 916, 920-21 (2006); *McCarthy v. Boston City Hospital*, 358 Mass.639, 643, 266 N.E.2d 292, 295 (1971). The Board may discipline a physician who fails to meet the standard of care by practicing with gross negligence. M.G.L. c. 112, § 5, ¶ (8)(h) and 243 CMR 1.03(5)(a)3.<sup>4</sup>

Gross negligence is:

substantially and appreciably higher in magnitude than ordinary negligence. It is materially more want of care than constitutes simple inadvertence. It is an act or omission respecting legal duty of an aggravated character as distinguished from a mere failure to exercise ordinary care. It is very great negligence, or the absence

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<sup>4</sup> 243 CMR 1.03(5)(a)3 provides that a doctor may be disciplined for “gross negligence on a particular occasion or negligence on repeated occasions.” Because the Board alleges that Dr. David’s treatment of his patients fell below the standard of care as to only one patient, it could discipline him for negligence only if he was grossly negligent.



of slight diligence, or the want of even scant care. It amounts to indifference to present legal duty and to utter forgetfulness of legal obligations so far as other persons may be affected. It is a heedless and palpable violation of legal duty respecting the rights of others. The element of culpability which characterizes all negligence is in gross negligence magnified to a high degree as compared with that present in ordinary negligence.

*Altman v. Aronson*, 231 Mass. 588, 591-592, 121 N.E. 502, 506 (1919). Deliberate inattention and “persistence in a palpably negligent course of conduct over an appreciable period of time” can amount to gross negligence. *Parsons v. Ameri*, 97 Mass.App.Ct. 96, 109, 142 N.E.3d 628, 640 (2020).

Here, there is no dispute that a few months after his liposuction, Patient RN ended up with a wide, nearly horizontal bulge and associated depression on his stomach. What caused it is in considerable dispute. The Board and its expert witness, Dr. Chatson, assert that the skin deformity was caused by a burn during the liposuction. Dr. David and his expert witness, Dr. Sztulman, maintain that the deformity was caused following the surgery by the patient wearing too tight clothing, most likely a compression garment that was too small.

The evidence regarding Patient RN’s physical condition does not offer much help in determining which of these theories of causation is more likely to be correct. The doctors agreed that, when patient RN visited Dr. David three days and then seventeen days following liposuction, his stomach showed no signs of damage. But whether this means anything is disputed. In Dr. Chatson’s opinion, a burn injury that occurred during liposuction would not have manifested itself by then, while Drs. David and Sztulman assert that it would. The parties have offered no evidence that would back up either of these opinions.

The witnesses also do not disagree about the nature of RN's condition when he was treated by Dr. Kaminer, who described RN as having a "linear, fibrotic . . . adhesion, which is sort of bound down, scar type feel, with redundant or loose skin above that adhesion." Dr. Chatson views this condition as showing that RN has a burn injury that created scar tissue. Dr. Sztulman believes what Dr. Kaminer described was an encapsulated seroma caused by fluid pooling in a bulge created by a too tight garment, with the fluid later being replaced by fibrotic tissue. Neither party offered any evidence to that would tend to prove that one theory of causation or the other better fit Dr. Kaminer's description of Patient RN's condition.

There is however, other evidence that sheds some light on the question of causation. The surgical record itself shows that Dr. David had injected enough fluid into Patient RN's abdomen that he should have been able to perform 18 minutes of liposuction safely. RN's procedure lasted four minutes less, which shows that, at least as to the time limit, he performed the procedure within acceptable bounds. That by itself did not eliminate the burn risk, which the medical witnesses and the guidelines provided by the Vaser manufacturer agree is an inherent risk of the procedure. Dr. Chatson believes that this is exactly what happened: Dr. David applied too much energy in the areas that ended up being damaged. Presumably, this occurred in the manner described by Dr. Kaminer because the depression begins adjacent to one of the incisions Dr. David made, and therefore the depression represents overheating along a line of treatment. Dr. Chatson suspected that Dr. David had simply gone over this area repeatedly, thus causing damage.

There are two problems with this explanation. First, though the line extends from the incision, the method of treatment described respectively by Dr. David, Dr. Sztulman, and the Vaser guideline as cross-hatching, fan-like, or “in and out like the spokes of a wheel” would not suggest that Dr. David, when he operated on Patient RN, moved the probe not simply in straight lines from the point of incision, but rather moved it back and forth. Second, as explained by Dr. Sztulman, the Vaser machine has an important safety feature: it beeps and shuts off when the probe is in an area without liquid or it is simply stuck in one spot.<sup>5</sup> Given this safety feature, it would seem that, for Dr. David to have burned Patient RN in a long line across his stomach, he would have had to have repeatedly gotten stuck on a line between the two incision points, moved slightly along that line, gotten stuck again, and repeated this action time and again. This seems highly unlikely.

It is more likely that RN suffered post-operative complications. The evidence is that RN did not spend two days lying flat as he was told to do, but instead attended a hockey game as part of his job the day following his liposuction. He then went back to a full day of work the next day, rather than cancelling his surgeries that week as had been recommended. He was also anxious about his progress, seeing Dr. David three days after the liposuction because he was worried that he had developed a seroma. The doctor concluded he was experiencing normal post-operative swelling. Two weeks later, when he again saw Dr. David again, he remained concerned about his progress, telling the

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<sup>5</sup> Dr. Chatson was not asked about these safety features. Hence, there is no evidence in the record as to his opinion of whether they would have made a burn less likely.

doctor he was thinking about undergoing Coolsculpting and telling Mrs. David that his compression garment was not tight enough, and so he was thinking about purchasing a smaller one. Dr. and Mrs. David attempted to dissuade him from taking these steps, and were initially successful. Mrs. David's later conversation with the compression garment manufacturer suggests that RN went ahead with his wish to purchase an extra small garment and, having done so, presumably wore it.<sup>6</sup> RN's efforts to speed up the healing process faster than the months-long process he was told to expect is not definitive proof that any failure on his part to follow post-operative directions caused the ridge to develop on his stomach. Still, the long, nearly horizontal injury at his waistline would appear consistent with wearing clothes that were too tight, too soon after the procedure and could have caused a seroma by digging into his abdomen.

Ultimately, while the evidence does not show definitively how Patient RN suffered a postoperative complication, the Board had the burden to prove causation, and it did not prove by a preponderance of the credible evidence that poor surgical technique on the part of Dr. David caused the injury, let alone that he was grossly negligent in the way he conducted the liposuction.

B. *Medical Records*

The Board's Regulations provide that "[a] licensee shall maintain a medical record for each patient that is complete, timely, legible, and adequate to enable the licensee or any other health care provider to provide proper diagnosis and treatment." 243 CMR 2.07(13(a)). The issue here is whether Dr. David's records would have been

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<sup>6</sup> It can be no more than a presumption because Patient RN was not asked whether he purchased an extra small garment or wore it.

sufficient for another doctor to treat his patients subsequently. As noted at the outset, there is far less testimony on this topic than there is regarding the treatment of Patient RN.

Dr. Chatson had no objection to Dr. David's operative notes, his pre-operative pictures of the areas to be treated, or his consent forms. His only objections were to the doctor's pre-operative notes and their lack of detail. Regarding Patient OB, he objected that the doctor had failed to note the patient's skin tone or estimated the fat content of the areas to be treated, and failed to explain how he intended to approach the loose skin on the patient's thighs. As for Patient JN, he thought the doctor's notes lacked detail regarding skin tone, a description of what was to be done in each area to be treated, and expectations for the procedure. He also disagreed with Dr. David's description of JN's skin as having good elasticity.

Dr. David admitted that he did not note Patient OB's skin elasticity in his note, but said it was likely an oversight. There is no allegation that he failed to note skin elasticity in any other patient records the Board reviewed, which tends to confirm the doctor's testimony on this point. Dr. Chatson's objection to Dr. David's description of JN's skin elasticity is pertinent not to whether the doctor kept adequate medical records, but as to whether his evaluation was correct. Even if Dr. David was wrong in concluding that JN had good skin elasticity, a doctor following up with JN's treatment would know what Dr. David thought.

Dr. David noted that JN had very little fat in the areas to be treated. He did not note how much fat OB had, though in some of the areas he was to treat, he thought there

was considerable fat. Dr. David testified that he always estimates the amount of fat he will find in the areas to be treated. In the future, it might be useful for his pre-operative form to list skin elasticity and fat content as items he should describe when writing that note. But it is hard to see how any failure on Dr. David's part to list how much fat he estimated or how he intended to address that fat would be particularly useful to any doctor following up on his work. By the time he wrote the preoperative note, he was about to perform liposuction. Because the pre-operative note was written on the day the liposuction was to be performed, any doctor following up with one of Dr. David's patients would also be able to review his operative notes, and thus the adequacy of the pre-operative notes must be considered in that context. That is particularly so because Dr. David does not know until he injects the fluid how hard the fat is going to be and thus what instrument to use or how long the procedure will take. He figures out at that point what probe to use and how much fluid to inject. His decisions on these matters are written in his operative note. Whether the subcutaneous fat was negligible or considerable, it would seem obvious that he intended to remove it by Vaser liposuction, and how much he removed can be determined from the operative note. What more needed to be described for another doctor to understand his approach was not specified by Dr. Chatson.<sup>7</sup>

Dr. Chatson also objected to what he viewed as an overreliance by Dr. David on pre-operative photographs of his patients. I accept his point that photographs do not

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<sup>7</sup> Dr. Chatson observed, as well, that Dr. David failed to note anything about the skin tone of Patients OB and JN. There was little testimony about this, and no explanation as to how the lack of this notation would have affected the ability of any doctor following up with these patients to determine what Dr. David did.

eliminate the need to prepare an adequate pre-operative note, but here the preoperative photos were informative. His criticisms of Dr. David regarding OB's loose skin on her thighs and JN's skin elasticity appear to have been based on the photos he reviewed. Thus, the photos fill in gaps in Dr. David's pre-operative notes.

Finally, Dr. Chatson criticized Dr. David's notes for not mentioning in JN's case what to expect from liposuction and in OB's case what liposuction would or would not do to the loose skin on her thighs. These criticisms go not so much to what the doctor would do during the liposuction, but what patients could realistically expect from the procedure and whether the doctor discussed this with them. Dr. David handled this in two ways. He had patients sign a lengthy consent form that required them to check off numerous boxes presenting the risks and likely results of liposuction. His pre-operative note also lists the cautions he personally presented to each patient, and he had to check off which ones he discussed with a patient. This would appear to satisfy his recordkeeping obligation regarding the cautions he gave to these patients about what to expect from liposuction.

While Dr. David's pre-operative notes are sparse, the Board has not demonstrated that his medical records fail to meet the standard applicable to recordkeeping of liposuction procedures.

### **Conclusion**

For the reasons stated above, I therefore conclude that Dr. Dave David is not subject to discipline for his treatment of Patient RN or for the medical records he

prepared for Patients OB and JN and recommend that the Board dismiss the charges against him.

DIVISION OF ADMINISTRATIVE LAW APPEALS,

A handwritten signature in black ink that reads "James P. Rooney". The signature is written in a cursive style with a long, sweeping tail that extends downwards and to the right.

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James P. Rooney  
First Administrative Magistrate

Dated: **JUN - 8 2020**