BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against TREVOR A. SCHMIDT, PA-C, Respondent.	)	**Case No. 14-36566-1**

FILED
OCT 14 2014
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

COMPLAINT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), composed of Beverly A. Neyland, M.D., Bashir Chowdhry, M.D., and Sandy Peltyn, by and through Erin L. Albright, Esq., General Counsel and Attorney for the IC, having a reasonable basis to believe that Trevor A. Schmidt, PA-C (Respondent), violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

A. Respondent's Medical License

1. Respondent is currently licensed as a certified physician assistant in active status (License No. PA1219), and has been so licensed by the Board since May 12, 2010, pursuant to the provisions of the Medical Practice Act.

2. At the times alleged herein, Respondent's supervising physician was Anil Patel, M.D.

3. At the times alleged herein, Dr. Patel was certified in tumescent liposuction and aesthetic procedures. He was not certified in fat injection procedures.

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4. Pursuant to NAC 630.360, a physician assistant is authorized to perform the medical services that are within the scope of practice of the supervising physician.

5. At all times alleged herein, Respondent was authorized to perform tumescent liposuction and aesthetic procedures. Respondent was not authorized to perform fat injection procedures.

B. Respondent's Practice

6. At all times alleged herein, Respondent was the owner of My Shape Lipo.

7. At all times alleged herein, Respondent was practicing medicine at My Shape Lipo under the supervision of Dr. Anil Patel.

8. While practicing medicine at My Shape Lipo, Respondent performed the following procedures at high volumes: tumescent liposuction, aesthetic procedures and/or fat injection procedures.

C. Health Department's Inspection of My Shape Lipo

9. On January 4, 2012, the state of Nevada Department of Health and Human Services (Health Department) conducted an onsite investigation at My Shape Lipo.

10. The Health Department noted that My Shape Lipo did not have IV catheters or monitoring equipment (i.e., oxygen saturation probe, cardiac monitor and fluid monitor) in the facility.

11. During this same visit from the Health Department, Respondent admitted that the instruments were not wrapped because liposuction procedures require clean, not sterile, environments.

12. The American Academy of Plastic Surgeons recommends that liposuction procedures performed at high volumes, like those procedures performed at My Shape Lipo, should be performed in a monitored, sterile environment, preferably a licensed surgical facility, due to the high risk of complication.

13. At all times alleged herein, Respondent violated the standard of care for high-volume liposuction procedures by not performing said procedures in a sterile, monitored environment.

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D. Respondent's Care and Treatment of Patients A and B

14. To protect the privacy of Patients A and B referenced herein, their true identities are not disclosed; however, their identities are disclosed in the Patient Designation served on Respondent contemporaneously with a copy of this Complaint.

a. Patient A

15. Patient A was a twenty-nine (29)-year-old female at the time the incidents in question commenced.

16. Patient A underwent three (3) high-volume liposuction procedures and one (1) fat injection procedure performed by Respondent at My Shape Lipo.

17. On or about October 13, 2011, Patient A presented to Respondent at My Shape Lipo for her initial evaluation for liposuction.

18. Patient A underwent her first liposuction procedure on or about October 14, 2011.

19. Patient A's first liposuction procedure was performed by Respondent on Patient A's abdomen, hips and lower back.

20. Patient A underwent her second liposuction procedure on or about October 17, 2011.

21. Patient A's second liposuction procedure was performed by Respondent on Patient A's thighs.

22. Patient A underwent her third liposuction procedure and a fat injection procedure on or about October 21, 2011.

23. Patient A's third liposuction procedure and fat injection procedure were performed by Respondent on Patient A's buttocks.

24. Prior to Patient A's third liposuction procedure and fat injection procedure, Patient A's pre-operative blood pressure was 73/44 with a pulse of 78.

25. Despite the fact that Patient A's pre-operative blood pressure was 73/44, Respondent administered two hundred (200) milligrams of Atenolol to Patient A.

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26. Respondent failed to recognize that Patient A required a blood pressure increase through the administration of IV fluids, not the administration of two hundred (200) milligrams of Atenolol.

27. It is a deviation in the standard of care to administer two hundred (200) milligrams of Atenolol to a patient whose blood pressure is 73/44.

28. Respondent violated the standard of care when he administered Atenolol to Patient A when Patient A's blood pressure was 73/44.

29. The standard of care for a patient who is undergoing multiple rounds of high-volume liposuction, like Patient A, requires at least a seven (7)-day recovery period before undergoing a subsequent round of high-volume liposuction.

30. Respondent also violated the standard of care for Patient A when he performed the second high-volume liposuction procedure only three (3) days after the first high-volume liposuction procedure.

31. Respondent further violated the standard of care for Patient A when he performed the third high-volume liposuction procedure only four (4) days after the second high-volume liposuction procedure.

32. At the time Respondent performed the fat injections on Patient A, Respondent was acting outside his scope of practice, as his supervising physician was not trained to perform fat injections.

33. Patient A's medical records demonstrate that Patient A did not consent to the fat injection procedure. The only consent forms contained and documented in Patient A's medical records are the forms for the liposuction procedures.

b. Patient B

34. Patient B was a sixty-six (66)-year-old female at the time the incidents in question commenced.

35. On or about October 24, 2011, Patient B presented to Respondent at My Shape Lipo to be evaluated for liposuction. That same day, Patient B underwent liposuction procedures performed by Respondent.

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36. Patient B's medical chart notes that she was to bring a list of current medications with her for Respondent's review prior to the performance of the high-volume liposuction procedures.

37. Patient B's medical chart lacks documentation demonstrating that Respondent was informed of the medications Patient B had taken prior to undergoing the high-volume liposuction procedures.

38. Patient B's medical chart lacks documentation demonstrating that Respondent questioned Patient B about the medications she ingested prior to undergoing the high-volume liposuction procedures.

39. Patient B's medical chart lacks documentation demonstrating that Patient B consented to the administration of medication.

40. Patient B's medical chart fails to designate the dose of lidocaine utilized in the high-volume liposuction procedures.

41. After the procedure, Patient B developed hypotension.

42. The standard of care for treating Patient B's hypotension was the immediate placement of an IV to administer fluid.

43. Patient B's medical chart lacks documentation demonstrating that Respondent immediately placed an IV to administer fluids to Patient B when she developed post-operative hypotension.

44. Patient B's medical chart lacks documentation demonstrating that Patient B's post-operative hypotension was addressed during her follow-up appointment, which was approximately two (2) days after Respondent performed liposuction procedures.

COUNT I

(Practicing Beyond the Scope Permitted by Law)

45. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

46. NRS 630.306(5) provides that practicing or offering to practice beyond the scope permitted by law or performing services that the licensee knows or has reason to know that he is

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not competent to perform or that are beyond the scope of his training is grounds for initiating disciplinary action against a physician assistant licensee.

47. NAC 630.380(m) states that a physician assistant is subject to disciplinary action by the Board if the Board finds the physician assistant violated NRS 630.306.

48. NAC 630.360 provides that a physician assistant is authorized to perform the medical services that are within the scope of practice of the supervising physician of the physician assistant.

49. Respondent's supervising physician was not trained to perform fat injections.

50. Since Respondent's supervising physician was not trained to perform fat injections, Respondent was operating beyond the scope permitted by law when he performed fat injections on Patient A.

51. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NAC 630.410.

COUNT II

(Malpractice)

52. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

53. NRS 630.301(4) provides that malpractice of a physician assistant is grounds for initiating disciplinary action against a licensee.

54. NAC 630.040 defines malpractice as the failure of a physician assistant, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

55. NAC 630.380(m) states that a physician assistant is subject to disciplinary action by the Board if the Board finds the physician assistant violated NRS 630.301.

56. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patients A and B by performing the high-volume liposuction procedures in a non-sterile environment that lacked IV catheters and monitoring equipment; failing to take measures to

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monitor the total input and output of patient fluids during the procedures; not providing high-volume liposuction patients with enough time to recover before undergoing a subsequent high-volume liposuction procedure; failing to treat patients' post-operative hypotension and failing to provide patients with enough time prior to the procedure to stop medications that could result in complications.

57. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NAC 630.410.

COUNT III

(Medical Records Violation)

58. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

59. NRS 630.3062(1) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating discipline against a licensee.

60. NAC 630.380(m) states that a physician assistant is subject to disciplinary action by the Board if the Board finds the physician assistant violated NRS 630.3062.

61. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patient A when he failed to document the patient's consent to the fat injection procedure in the patient's medical chart.

62. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patient B when he failed to document the dose of lidocaine utilized in the liposuction procedures and failed to document that he addressed the patient's post-operative complication of hypotension in the patient's medical chart.

63. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NAC 630.410.

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WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine the sanctions it will impose if it finds Respondent violated the Medical Practice Act;

4. That the Board make, issue and serve on Respondent, in writing, its findings of fact, conclusions of law and order, which shall include the sanctions imposed; and

5. That the Board take such other and further action as may be just and proper in these premises.

DATED this 14th day of October, 2014.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Erin L. Albright, Esq.
General Counsel
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Beverly A. Neyland, M.D., hereby deposes and states under penalty of perjury under the laws of the state of Nevada that she is the Chairwoman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the foregoing Complaint against the Respondent herein; that she has read the foregoing Complaint; and that based upon information discovered during the course of the investigation into a complaint against Respondent, she believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

Dated this 14th day of October, 2014.

Beverly A. Neyland MD

BEVERLY A. NELYAND, M.D.

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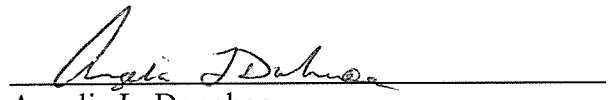
CERTIFICATE OF SERVICE

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 14th day of October 2014; I served a filed copy of COMPLAINT, PATIENT DESIGNATION and FINGERPRINT INFORMATION, USPS e-certified return receipt mail to the following:

Trevor A. Schmidt, PA-C
2610 Horizon Ridge Pkwy., #203
Henderson, NV 89052

Dated this 14th day of October, 2014.



Angelia L. Donohoe
Legal Assistant

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