NEVADA STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF CHARGES AND COMPLAINT AGAINST

GEORGE PETER CHAMBERS, JR., M.D.

ADJUDICATION

Case No: 22-27891-1

Date: September 15, 2023

PUBLIC COPY

INDEX

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, M.D.** **Respondent.**	**Case No. 22-27891-1**

FILED
SEP 21 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
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COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Brandee Mooneyhan, J.D., Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that George Peter Chambers, M.D., (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:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 10476). Respondent was originally licensed by the Board on April 30, 2003, and specializes in obstetrics and gynecology.

2. As noted by the Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG), the "relationship between obstetrician-gynecologists and their patients . . . requires a high level of trust and professional responsibility," because the practice of this medical specialty "includes interactions in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences." *See* AGOC Committee Opinion No. 796, *Sexual Misconduct* (January 2020).

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Victor M. Muro, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Ms. Pamela J. Beal.

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3. Physician behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient constitute sexual impropriety, and are a form of physician sexual misconduct. *Id.*

4. In professional settings, "obstetrician-gynecologists should strictly avoid sexual innuendo, sexually suggestive humor, and sexually provocative remarks," and even in nonclinical communication with current patients, should maintain professional boundaries. *Id.*

PATIENT A

5. Patient A[2] was a thirty-six (36) year-old female at the time of the events at issue.

6. Patient A sought surgical repair of a damaged perineum, and Patient A's regular gynecologist referred Patient A to Respondent for consultation. Patient A presented to Respondent's medical office on November 17, 2020, for the desired consultation.

7. After telling Patient A to undress for a physical examination, Respondent told Patient A to keep her personal cellular phone nearby, as he would be using it to take pictures during the examination.

8. During the course of Patient A's examination, Respondent used Patient A's cellular phone to take approximately twelve (12) photographs of Patient A's vaginal and anal areas.

9. Among the photographs taken by Respondent on November 17, 2020, is a photograph of him inserting four (4) fingers in Patient A's vagina.

10. Of the approximately twelve (12) photographs he took of Patient A on November 17, 2020, Respondent directed her to send two (2) of the photos, which showed her vulva, to his cellular phone via text message.

11. The photograph of Respondent inserting four (4) fingers into Patient A's vagina was not one of the photographs he asked her to text to him.

12. Patient A was uncomfortable texting the pictures to Respondent's cellular phone, in part because she had no assurances that the data was being exchanged securely, how the pictures might be used, or who might have access to them once they were sent.

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[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

Nonetheless, Patient A did as Respondent directed and sent the two (2) photographs via text message to the phone number Respondent provided.

13. In his medical record of the November 17, 2020, encounter, Respondent indicated that he inserted two (2) fingers in Patient A's vagina, stating: "On sizing the introital opening with my two examining fingers, the vagina opened to a width of 7cm horizontally and vertically."

14. In his response to a request for information in the IC's investigation of this matter, Respondent repeated his assertion that he inserted only two (2) fingers in Patient A's vagina during the November 17, 2020, encounter, stating that he "inserted one finger into her vagina" in his evaluation of her pelvic floor muscles, and "then inserted [his] two examining fingers to check the tonicity of her pubococcygeus muscles by asking her to squeeze her vagina."

15. Respondent did not document in the medical record, nor inform the IC during its investigation, that during the November 17, 2020, encounter with Patient A, he inserted four (4) fingers into her vagina.

16. After his physical examination of Patient A, Respondent informed Patient A that during the examination, he had attempted to "fist" her, that is, insert his entire hand into her vagina, *see Artemie v. State*, No. A-10463, 2011 WL 5904452, at *8 (Alaska Ct. App. Nov. 23, 2011), but had been unable to insert his entire hand, and he showed her how much of his hand he had been able to insert.

17. Respondent also showed Patient A the two (2) photographs that she had texted him, which he had printed following the physical examination, and used them to explain the procedures he proposed to perform on her. Respondent included the two (2) photographs in Patient A's medical record.

18. After her encounter with Respondent on November 17, 2020, Patient A suffered pain and tenderness in her genital area.

19. The other approximately ten (10) photographs Respondent took of Patient A's vaginal and rectal area, which he did not direct her to send to him, were not for purposes of medical examination or treatment.

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20. Respondent's action in taking numerous pictures of Patient A's vaginal and rectal areas that were not for purposes of medical examination or treatment, as well as using the nonmedical term "fisting" and informing Patient A that he had attempted to do so, humiliated and sexually demeaned Patient A.

21. Respondent's action in taking numerous photographs of Patient A's vaginal and rectal areas on an unsecured cellular telephone and directing Patient A to text some of those photographs to him, in the absence of any assurance of how the photographs would be protected from improper access, was disrespectful of Patient A's privacy.

COUNT I

NRS 630.301(6) – Disruptive Behavior

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

23. NRS 630.301(6) provides that disruptive behavior with patients that interferes with patient care or has an adverse impact on the quality of care rendered to a patient is grounds for initiating disciplinary action against a physician.

24. Respondent's behavior in taking approximately ten (10) photographs of Patient A's vaginal and rectal areas that were not for purposes of medical examination or treatment was humiliating and sexually demeaning to Patient A and thus adversely affected the quality of care rendered to her.

25. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.301(6) – Disruptive Behavior

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

27. NRS 630.301(6) provides that disruptive behavior with patients that interferes with patient care or has an adverse impact on the quality of care rendered to a patient is grounds for initiating disciplinary action against a physician.

28. Respondent's behavior in telling Patient A that he had attempted to "fist" her was humiliating and sexually demeaning to Patient A and thus adversely affected the quality of care rendered to her.

29. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT III

NRS 630.306(1)(b)(1) – Engaging in Conduct Intended to Deceive

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

31. NRS 630.306(1)(b)(1) provides that "engaging in any conduct, which is intended to deceive" constitutes grounds for initiating disciplinary action against a physician.

32. Respondent's statement in the medical record of his encounter with Patient A on November 17, 2020, that he measured Patient A's introital opening with "two examining fingers" and his failure to otherwise document that he had inserted four (4) fingers into Patient A's vagina during that encounter was calculated to conceal that he had inserted four (4) fingers into Patient A's vagina.

33. Respondent's statement in his response to the IC's investigative inquiry that he had inserted no more than two (2) fingers into Patient A's vagina during the November 17, 2020, encounter was calculated to conceal that Respondent had inserted four (4) fingers into Patient A's vagina.

34. By knowingly making statements designed to conceal that he had inserted four (4) fingers into Patient A's vagina during his November 17, 2020, encounter with her, Respondent engaged in conduct intended to deceive the Board or any other authority examining his record of the encounter.

35. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

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COUNT IV

NRS 630.3062(1)(a) – Failure to Maintain Accurate Medical Records

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

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

38. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient A when he failed to document in the record of his November 17, 2020, encounter with her that he had inserted four (4) fingers into her vagina during the encounter.

39. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

PATIENT B

40. Patient B[3] was a thirty-five (35) year-old female at the time of the events at issue.

41. Patient B was a patient of Respondent for several years, and had an appointment with him on October 29, 2018.

42. During his October 29, 2018, encounter with Patient B, Respondent explained that he would pay her or other patients one thousand dollars ($1,000) to allow him to take, or arrange for the taking of, nude photographs of the patient(s), ostensibly to use in an advertisement for his services.

43. The nude photographs for which Respondent offered to pay Patient B or other patients were not for purposes of medical examination or treatment.

44. Telling Patient B during a medical encounter that he would pay her or other patients one thousand dollars ($1,000) to pose for nude photographs that were not for purposes of medical examination or treatment was sexually suggestive and/or sexually demeaning to Patient B and violated the professional boundaries of a medical encounter between a doctor and a patient.

[3] Patient B's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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COUNT V

NRS 630.301(7) – Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship With the Patient for Financial or Other Personal Gain

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

46. NRS 630.307(7) provides that "engaging in conduct that violates the trust of the patient and exploits the relationship between the physician and the patient for financial or other personal gain" constitutes grounds for initiating discipline against a physician.

47. In expressing to Patient B in the midst of a medical encounter that he would pay her or other patients one thousand dollars ($1,000) to pose for nude photographs for Respondent to use for purposes other than for medical examination or treatment, Respondent violated Patient B's trust and exploited his relationship with her in order to realize financial or other personal gain for himself.

48. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

PATIENT C

49. Patient C[4] was a twenty-seven (27) year-old female at the time of the events at issue.

50. Patient C visited Respondent's practice in 2019 for routine gynecological care and to address dysmenorrhea and pelvic pain.

51. At an encounter on or about October 15, 2019, Patient C mentioned to Respondent that she was struggling financially.

52. After the October 15, 2019, encounter, Respondent told Patient C he was seeking models to participate in a photography session in which photos would be taken of the model's vaginal area and nude body, ostensibly for inclusion in Respondent's "portfolio" of work and/or an advertisement. Respondent offered to pay Patient C one thousand dollars ($1,000) to

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[4] Patient C's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

participate in such a photography session, as well as give her a thumb drive with the "boudoir" photos resulting from the session.

53. Patient C thought it was odd that Respondent was soliciting photographs of her vaginal area as representative of his work because he had never performed any cosmetic procedure on her genitals.

54. The nude photographs for which Respondent offered to pay Patient C were not for purposes of medical examination or treatment.

55. Offering to pay Patient C one thousand dollars ($1,000) to pose for nude photographs that were not for purposes of medical examination or treatment was sexually suggestive and/or sexually demeaning to Patient C and violated the professional boundaries of a medical encounter between a doctor and a patient.

COUNT VI

NRS 630.301(7) – Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship With the Patient for Financial or Other Personal Gain

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

57. NRS 630.307(7) provides that "engaging in conduct that violates the trust of the patient and exploits the relationship between the physician and the patient for financial or other personal gain" constitutes grounds for initiating discipline against a physician.

58. In offering to pay Patient C one thousand dollars ($1,000) to pose for nude photographs for Respondent to use for purposes other than for appropriate medical examination or treatment, Respondent violated Patient C's trust and exploited his relationship with her in order to realize financial or other personal gain for himself.

59. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

PATIENTS A, B, AND C

60. As set forth by the above-outlined facts, Respondent has demonstrated a pattern of failing to use the reasonable care, skill, or knowledge ordinarily used by obstetrician-

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gynecologists in good standing by repeatedly engaging in sexual improprieties with more than one patient.

61. As set forth by the above-outlined facts, Respondent repeatedly exploited his relationships with patients and violated patients' trust by engaging in sexual improprieties that constitute sexual misconduct.

62. Respondent's repeated acts of sexual misconduct and violations of the Medical Practice Act as set forth above undermine the public's trust and respect for the medical profession and thereby bring the medical profession into disrepute.

COUNT VII

NRS 630.306(1)(g) – Continual Failure to Practice Medicine Properly

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

64. NRS 630.306(1)(g) provides that "continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field" constitutes grounds for initiating discipline against a physician.

65. By repeatedly engaging in sexual misconduct with Patients A, B, and C, as set forth above, Respondent has continually failed to exercise the skill and diligence and use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in his field of obstetrics and gynecology.

66. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT VIII

NRS 630.301(9) – Disreputable Conduct

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

68. NRS 630.301(9) provides that engaging in conduct that brings the medical profession into disrepute constitutes grounds for initiating discipline against a physician.

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69. As demonstrated by the above-outlined facts, by repeatedly engaging in sexual misconduct and by repeatedly violating his patients' trust and exploiting his relationship with them, Respondent engaged in conduct that brings the medical profession into disrepute.

70. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

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 what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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

DATED this 21st day of September, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

BRANDEE MOONEYHAN, J.D.
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Victor M. Muro, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 21 day of September, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
VICTOR M. MURO, M.D.
Chairman of the Investigative Committee

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

GEORGE PETER CHAMBERS, M.D.,

Respondent.

Case No. 22-27891-1

FILED
AUG 21 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

FINDINGS AND RECOMMENDATIONS/SYNOPSIS OF RECORD[1]

Introduction and History

This matter was heard on May 2, May 3, June 1, and June 2, 2023. This Hearing Officer was present in the Reno office of the Nevada State Board of Medical Examiners (the "Board") along with Donald White, J.D. on behalf of the Investigative Committee (the "IC"). Appearing and present in the Las Vegas office of the Nevada Board of Medical Examiners Respondent, George Peter Chambers, M.D. ("Respondent" or "Dr. Chambers") and co-counsel for the IC, Brandee Mooneyhan, J.D.

Patients A and B, and witnesses for the Board, were present and appeared from the Las Vegas office of the Board. The remaining witnesses were present and appeared in the Board's Reno office, except for the IC's witnesses Patient C and Ms. Casey Carden, and Respondent's expert witness, Michael Goodman, M.D., all of which appeared by *Zoom* videoconference.

The Complaint in this matter was filed by the IC on September 21, 2022, with the Answer and Notice of Defense filed by Respondent's former counsel on October 18, 2022. Both an Early Case Conference and a Prehearing Conference were held. Attorneys for Respondent withdrew as counsel of record on January 18, 2023, and requested a continuance of the hearing on behalf of the

[1] Incorporated herein by reference is the full Transcript of the Hearing Proceedings of the above dates, which is provided herewith as **Exhibit A** and referred to herein under the designation "TR," as well as the exhibits admitted at the hearing, which are indexed and provided herewith as numbers for the IC Exhibits and letters for Respondent's Exhibits.

Respondent, which was granted by the undersigned Hearing Officer, and, in the interest of due process, additional time was allowed for Respondent to retain counsel and to determine whether his Errors and Omissions/Malpractice Insurance would cover his representation. Respondent ultimately chose to represent himself in this proceeding.

Motions: Although other motions were filed in this matter, some were abandoned when Respondent's former counsel withdrew from representation. The motions of note that did reach decision were as follows: (1) IC's Motion to Protect Patient Likenesses, which was decided in the IC's favor. Exhibits 12, 19, 24, 26, and 28; and (2) Respondent's Motion to Exclude Testimony of Peer Reviewer Witness, which was decided in the IC's favor. Exhibits 13, 16, 25, 29. Also of note is the Stipulation and Order filed on February 22, 2023, addressing Pre-Hearing issues, such as the requirement for chaperones to be present, when the hearing was continued. Exhibit 22.

Media: The undersigned Hearing Officer is aware that this matter has garnered media attention but represents that she has no knowledge of the contents of any media reports outside any statements made by those involved with these proceedings. In addition, the media attended these hearings and was informed at the beginning of each session of Exhibit 28, the Order Granting Investigative Committee's Motion to Protect Patient Likenesses. The undersigned hearing officer was also contacted twice regarding dates for hearings and these Findings.

Approach: Given the scope of this matter, including approximately 22 hours of hearing over three days and 750 pages of hearing transcript, emphasis will be given to the summary of the testimony. Also of note, some of the witnesses were taken out-of-order or witness direct and cross-examination were broken up in order to be as efficient as possible and to accommodate witnesses' schedules.

All witnesses were sworn. The rule of exclusion was invoked.

Allegations

The Complaint alleges, charges and are premised upon as follows:

Count I, NRS 630.301(6), Disruptive Behavior, premised upon the taking photographs of Patient A;

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Count II, NRS 630.301(6), Disruptive Behavior, premised upon the allegation that Respondent told Patient A that he attempted to "fist" her;

Count III, NRS 630.306(1)(b)(1), Engaging in Conduct Intended to Deceive, premised upon the allegation that the Respondent used four fingers to examine Patient A but documented that he used only two fingers in the medical record;

Count IV, NRS 630.3062(1)(a), Failure to Maintain Proper Medical Records, premised upon the allegation that the Respondent used four fingers to examine Patient A but documented that he used only two fingers in the medical record;

Count V, NRS 630.301(7), Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship of a Patient for Financial or Other Personal Gain, premised upon the allegation that the Respondent offered to pay Patient B $1000 if she would pose as a nude model while she was still in the examining room;

Count VI, NRS 630.301(7), Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship of a Patient for Financial or Other Personal Gain, premised upon the allegation that the Respondent offered to pay Patient C $1000 if she would pose as a nude model while she was still in the examining room;

Count VII, NRS 630.306(1)(g), Continual Failure to Practice Medicine Properly, premised upon the allegation that "[b]y repeatedly engaging in sexual misconduct with Patients A, B, and C, as set forth above, Respondent has continually failed to exercise the skill and diligence and use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in his field of obstetrics and gynecology." *Complaint, p. 9, ll. 17-20*; and

Count VIII, NRS 630.301(9), Disreputable Conduct, premised upon the allegation that "by repeatedly engaging in sexual misconduct and by repeatedly violating his patients' trust and exploiting his relationship with them Respondent engaged in conduct that brings the medical profession into disrepute." *Complaint, p. 10, ll1-3.*

Witnesses and Testimony

In relation to the IC's case, the undersigned hearing officer heard from the following witnesses:

Johnna LaRue, Deputy Chief of Investigations and Compliance Officer of the Nevada State Board of Medical Examiners (Vol. I, TR 39-54; Recalled Vol. III, 174-195);

Respondent George Peter Chambers, M.D. (Vol. I, TR 56-97; Vol. II, 198-207;

Patient A (Vol. I, TR 100-154);

Patient B (Vol. II, 9-44);

IC's Expert Witness Richard Rafael, M.D. (Vol. II, 44-164);

Patient C (Vol 3, TR 163-172)

Casey Carden (Vol. 3, TR 128-160).

In relation to Respondent Dr. Chambers' case, the undersigned hearing officer heard from the following witnesses:

Respondent's Expert Witness Michael Goodman, M.D. (Vol. 3, TR 74-120; TR 197-254);

Brittany Turner (Vol. II, TR 188-197);

Respondent George P. Chambers, M.D. (Vol.2, TR 198-207; Vol. 3, TR 11-71; Vol. IV, TR 33-53).

MAY 2, 2023 HEARING

IC's Witnesses

NSBME Deputy Chief of Investigations Johnna LaRue

The first witness called by the IC was Johnna LaRue, the Deputy Chief of Investigations of the Nevada State Board of Medical Examiners, who the IC called to authenticate exhibits one through ten. Vol. I, TR 27-31.

Cross-examination of Investigator LaRue was utilized primarily to demonstrate her limited knowledge of the phrase "fisting," at issue in the case, although Ms. LaRue stated that she knew what it meant and based her answer on review of a photograph supplied by Patient A and her own personal opinion. Vol. I, TR 53-54.

Investigator LaRue was called later in the proceedings as a rebuttal witness with regard to Respondent's testimony about producing advertisements in Adult Video Network (AVN) publications. Vol. III, TR174-197.

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Respondent George Peter Chambers, M.D.

The second witness called and questioned by counsel Ms. Mooneyhan for the IC was Respondent Dr. Chambers himself. Vol. I TR 56-97.

Respondent was questioned and testified as to his professional credentials, i.e., that he was previously licensed in Colorado and New York in addition to being licensed in Nevada, but that he allowed those licenses to lapse as he did not intend to practice in those states again. Vol. I TR 57. Respondent also testified that he is both a fellow and Diplomat of the American College of Obstetricians and Gynecologists and described the process of his certification in sexual health and treatment by the American Academy of Antiaging, which training consisted of four to five days on each module in four different cities. Vol. I TR 59-61. In addition, Respondent answered questions about his professional affiliation and training with the National Society of Cosmetic Physicians. Vol. I TR 62.

Respondent described his current medical practice as encompassing the whole scope of OB-GYN including sexual health medicine which includes cosmetic gynecology. Vol. I TR 62-64. He also described the differences in how an exam by a sexual health specialist may differ from a general OB-GYN. Vol. I TR 64- 66.

When questioned about his encounter with Patient A, Respondent testified that she was referred by another physician and arrived with pages of questions. Vol. I TR 66. He believed that Patient A was there to be seen for cosmetic gynecological surgery. Vol. I TR 66, 69. He typed the records the same day or within a few days of the exam, as he types notes if it's a consult for another provider but will generally handwrite exam notes that remain in his office. Vol. I TR 69-70.

Respondent testified that he did conduct a physical examination of Patient A, and took photos of her examination, using her cell phone. He did so because he has always used illustrations to help his patients understand what was happening, sometimes images he drew himself or prepared illustrations. But when a patient suggested that he take a photo, he thought it was a good idea. If a patient was just in for a consultation and had not decided about surgery, he would suggest using the patient's own phone camera so that she could do what she wanted with the photos, whether the

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patient would discard the photos or share with another physician. Vol. I TR71-72. He took twelve photos of Patient A to get a good picture and then the others could be discarded. Vol. I TR72-73.

The initial meeting involves only verbal consent to take the photos during the exam. The Respondent testified that if a patient returns, he has her complete six written consents which include a consent for photography. Vol. I TR 73-74. He does not require written consent if the patient takes the photos with her, and/or is shopping for a cosmetic surgeon, but only if he's doing a procedure on the patient and keeps the photos in his office. Vol. I TR 74.

The Respondent and Counsel for the IC engaged in a discussion about the security of the photos of his patients and internet system as he does not trust technology and doesn't upload photos to "the cloud," but he uses secured office Wi-Fi to send the photos to the printer. Vol. I TR 74-76. Respondent has a policy of deleting the photos, usually the same day, that patients text to him if they aren't going to be used for surgery. Vol. I TR 76-78.

Respondent reviewed Exhibit 3, Patient A's medical records, and agreed that he sized Patient A's vagina with two fingers although he agrees that the photos show that he used four fingers. Vol. I TR78-79. He testified that he would sometimes use slang terms depending upon her vernacular as he thought it would be inappropriate and condescending to correct the patient's terminology. Vol. I TR 79-80. He would usually use the type of anatomical terminology the patient used. Vol. I TR 80. He would use slang terms with patients when describing sexual acts. Vol. I TR 80-81. The Respondent stated that he would not use the term "fisting" unless the patient engages in that activity. Vol. I TR 81.

Regarding the presence of a chaperone at Patient A's visit, Respondent testified that his office manager, Casey, stood in the doorway of the exam room and would move back to her reception desk where the exam table was still in sight. Vol. I TR 82-83; Exhibit 6. That was Patient A's only visit and he did not perform gynecological cosmetic surgery on her. *Id.*

Patient B was a regular patient of the Respondent for seven or eight years, and Respondent never performed gynecological surgery on her. Vol. I TR 84. According to Exhibit 7, Patient B saw the Respondent in October of 2018 for blood and nipple discharge. *Id.* He testified that he

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"probably did" offer Patient B money to pose in a nude photograph for an ad but does not know when. *Id.*

Regarding placing ads in the Adult Video Network (AVN) ads, Respondent placed ads in the AVN awards ceremony program three times beginning in 2012 with the last ad placed in 2020, and he also placed ads in the industry magazine approximately twelve times. Vol. I TR 85; Exhibit 6. There were two ads that were used for both publications. One was a profile photo of a nude woman in a prone position; the other was a profile of a (different) nude woman with her face shielded. The second woman was a patient. Vol. I TR 86-88.

Respondent took the first photograph, and a professional photographer took the second of a friend of a patient at Respondent's office although Respondent was not present. Vol. I TR 88. Respondent was trying to get an ad ready for the 2019 AVN ceremony but, although his office was in contact with AVN, he was too late to get it in the program. Vol. I TR 89. Respondent has taken photographs approximately five times and has had a professional photographer take photos approximately twelve times of patients in his office for ads that have not been used. Vol. I TR 89-90.

These photos were taken in Respondent's office, stored on the same air cam iPad and locked away, since approximately 2013 when he was trained in medical photography. Vol. I TR 91. Respondent considers the vaginal photos, which are on the walls in the restroom and one in the exam room, so he doesn't bring up the topic directly with patients, to be medical photography. *Id.*

Although the professional photographer who took these photos did not have training in medical photography, Respondent explained to her what he wanted. *Id* at 92. Everyone who posed for these photos had to sign a written consent, and they were paid $1000, usually in cash. *Id.* The nude photos are called "boudoir" photos, some of which included photos of genitals, some with lingerie. *Id. at 93.* Respondent had the ads professionally done, and the ads for AVN were designed by a company that Respondent was directed to use by AVN. *Id. at 94.*

With respect to Patient C, she had been a regular patient, but Respondent could not remember but thinks for approximately two or three times. *Id.* Respondent was aware that Patient C was having financial issues and offered her the same arrangement for posing for photos for $1000.

Id. Clarification that Exhibit 10, page 144 is a photo he took of a model who was not a patient for an advertisement. *Id. at 95-96.*

PATIENT A

Direct Examination

Initially, Ms. Mooneyhan, counsel for the IC, established the identity of Patient A without revealing her true name. Vol. I TR 99-101.

Patient A testified that she was referred to Respondent Dr. Chambers by her regular OB-GYN for perineum discomfort and possible repair and had just one appointment with him on November 17, 2020. *Id. at 103-104.* Patient A thinks that although her regular gynecologist did perform perineoplasty surgery, she referred Patient A because Patient A had also asked about labiaplasty. *Id. at 105.*

Patient A was well-prepared for her appointment and had researched and had looked at Respondent's website and thus knew that he performed all the procedures that could possibly help with her issues. *Id.* Because she is a very thorough person and tends to get nervous at medical appointments, she prepared notes with symptoms and questions. *Id.* Patient A didn't remember exactly how long the appointment was as it was two and a half years ago but estimates that both she and Dr. Chambers were thorough, and it probably took 15 or 20 minutes. *Id. at 107.*

After the initial discussion, Respondent, Dr. Chambers, asked Patient A to wait to ask her questions until after the exam when he gave her his opinion. *Id.* Respondent then asked Patient A to keep her phone nearby and, although she wasn't surprised about the photos, she thought it was unusual and odd that he would be using her phone, but that is what he needed to address her health. *Id. at 108.*

Patient A expressed hesitation when Respondent then asked if could leave the door ajar, but he reassured her that no one else was in the office and that the doors were locked. Vol. I TR 109. Patient A testified that no one else was in the room and that she was aware of only the "office girl", who came to the room at one point to see if Respondent would be able to see another patient. *Id.*

Patient A testified that the Respondent did not take her weight or blood pressure or any other vital signs. *Id. at 110.* She then described the exam, testifying that Dr. Chambers explained that

he would be feeling around and assessing for nerve damage to try to determine if that was the cause of her pain and discomfort, and she gave him her phone. *Id.* Patient A does not remember Q-tips on a nearby tray but recalls that he did not use a speculum. *Id. at 111.* Patient A again states that since it has been two- and one-half years, she does not remember the sequence of events exactly with respect to the exam and the taking of photos. *Id.*

She recalled that he did feel around with his fingers and asked her if she felt any pain and that he took photos of her vulva from different angles with his fingers inserted. *Id.* She did not feel "zinger" pain but felt a great deal of pressure and discomfort. *Id. at 112.* Patient A testified that "I felt his knuckles inserted into my vagina," and when she told him that it was very uncomfortable, he pulled his hand out, and that Respondent also did a rectal exam. *Id.*

At that point, the exam was over, and the Respondent asked Patient A to show him the photos, and he asked her to text two of them to him. Vol. I TR 113. Patient A was uncomfortable with this as she was concerned that it may not be secure and the photos could be texted to someone else, but that he was doing it for her medical care. *Id. at 112-113.*

Patient A testified that Respondent said to be very careful with the phone number and told her a story about photos mistakenly sent to the wrong person. *Id. at 113.* When the Respondent left the room so she could dress, she texted her husband that it was "weird" and her husband told her that it was probably okay but that she could ask if she was worried about it, but she was too embarrassed to do so and also still trusting that she was receiving medical care. *Id. at 113-115.*

Patient A testified that when Dr. Chambers returned to the exam room, he told her and demonstrated that he engaged in "fisting" during the exam and indicated that he used his hand up to between his knuckles and his fist, but that he indicated with two fingers the size of a man's penis. *Id. at 115.* This information had a profound negative effect on Patient A's sexual confidence, leaving her humiliated and embarrassed, and she did not want to share the information with what she perceived was wrong with her body with her husband. *Id. at 116.* Patient A also testified that Dr. Chambers used the term "lips" when referring to the labia when discussing labiaplasty, although she uses only anatomically correct terms. *Id. at 117.*

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Patient A testified that the Respondent to keep the remaining ten photos of the exam in a secure folder on her phone and not to let her husband see them or "they would mess with his head." *Id.*; *see,* Exhibit 4.

After the examination, Patient A described that she was in pain and that there was swelling, and she felt like she had small tears and lumps around her vaginal opening. *Id. at 118.* Patient A stated that the pain and discomfort lasted a couple of weeks. *Id.* Because of her discomfort after the exam with Dr. Chambers, she made an appointment with her regular gynecologist, Dr. Lewis, four days later which was scheduled for approximately a week after the appointment with the Respondent, although she felt better at the time of the follow-up appointment with Dr. Lewis. *Id.*

At the appointment with Dr. Lewis, she asked about the term "fisting," and Dr. Lewis told her that she had never heard of the term. *Id. at 119.* Patient A also asked Dr. Lewis about Respondent's statement that he would be stimulating her clitoris during the surgery and "not to hold back" because he wanted to make sure that he was not cutting any nerves. *Id.* Patient A related to Dr. Lewis that she asked him about it because he had previously assured her that the surgery would not lead to any loss of clitoral sensation, but that he brushed off her question. *Id.* Patient A testified that Dr. Lewis told her that "[t]here was no reason to ever do that during surgery." *Id.*

Patient A related that the Respondent proposed to perform a perineoplasty, vaginoplasty, rectocele, vaginal reduction, and labiaplasty. *Id. at 119.* She confirmed that she did not make an appointment for cosmetic reasons but just to address the discomfort she was experiencing, but that she had asked about labiaplasty. *Id.* She was concerned about the risk of losing sensation, however, and decided against labiaplasty. *Id. at 120.* Patient A testified that she had no concerns about her clitoris, but that the Respondent commented that "[w]omen would kill for a clitoris like yours." *Id.* She also testified that her "labia [is] bent on one side," and she "thinks that [she] remembers" that the Respondent proposed excising some tissue from one side of her labia to make it perfectly symmetrical. *Id. at 120-121.*

Psychologically, Patient A stated that she "knew what had happened was wrong", was sexual assault and not for her medical care. *Id. at 121.* This had a profound effect on her in that she believed that something was wrong with her vagina and that she was disgusting. *Id.* She stated

that she suffers from PTSD and anxiety, and that she had counseling through the Rape Crisis Center. *Id. at 122.* Due to this event, Patient A testified, she still hasn't had any surgery to address her perennial pain, but she hasn't been able to go through with it although she has found a good doctor at UCLA and will pursue it at some point. *Id.*

Cross-Examination of Patient A by Respondent

On cross-examination, the Respondent tried to ask what Patient A said to the media and to the police, over objection by counsel for the IC, which was overruled, but the Respondent did not follow-through with the question. However, with respect to a question from the Respondent about possible contradictory statements to the media and/or law enforcement, Patient A did state "I'm just trying to remember what I said to the police." Vol. I TR 125.

The Respondent then asked Patient A, in respect to the allegation of "fisting," whether she screamed, whether she saw how he prepared his hands for her examination, or whether she saw how many gloves he put on for her examination. *Id. at 125-126.* Patient A answered "No" to each of these questions. *Id.* There was then some discussion about the amount of lubrication needed to "fist" that was not resolved and the undersigned hearing officer explained that the testimony was more appropriate and would be permitted in the Respondent's case-in-chief. *Id. at 127-128.*

When the Respondent asked Patient A whether she had heard of the term "lips" when referring to the labia, she replied, "probably." *Id. at 129.*

Patient A confirmed that Exhibit 3 NSBME 0024 entitled "Vagina Repair Consultation" was the document of questions and information she prepared for and gave to the Respondent at her appointment, which addressed many matters including her history, pain, and sexual issues. *Id. at 131.* A discussion, objections and rulings occurred thereafter regarding the allowable scope of the Respondent's cross-examination. *Id. 132-134.*

The Respondent questioned whether a discussion of Patient A's sexual function was not unexpected considering the list of questions and statements Patient A supplied to him, and Patient A replied that "discussing sexual matters wasn't a problem for me." *Id. at 135; Exhibit 3 NSBME 0024.* The Respondent then questioned Patient A whether she asked him about Dr. Red Alinsod, whether she had heard of Dr. Alinsod's techniques, and how many of these procedures the

Respondent had himself performed, and Patient A responded that she did not recall, she may have, she probably did since she wrote it down, she assumed she looked at Dr. Alinsod's website, and she didn't know if she had looked at Dr. Alinsod's photo gallery on his website. *Id. at 136-137.* When Dr. Chambers asked whether he could introduce photos from Dr. Alinsod's website to compare to the photos taken of Patient A, all agreed that it would be more appropriate to introduce said photos in Respondent's case-in-chief and with his expert witness. *Id. at 139-140.*

Upon further questioning and review of the photographs, Patient A agreed that the photo showed that his fingers were only partially inside her vagina. *Id. at 141.* Although Patient A does not recall a Q-Tip being used during the examination, she recalls that the Respondent asked her if she felt pain. *Id.* She also recalls that he did an exam that included a finger in her anus. *Id. at 142.*

The Respondent questioned Patient A about whether she remembered that he referred her to a urogynecologist, and Patient A testified that she remembered, she did have an appointment with urogynecologist Dr. Wasserman, that Dr. Wasserman examined her and recommended surgery for perineal and posterior repair. Patient A recalled that the Respondent made the referral so that Patient A's insurance would cover the procedures, although Dr. Chambers recalled that Patient A would return for the "outer stuff" and Patient A recalled that she didn't want to have the labiaplasty of she was going to lose sensation. Again, Patient A responded that "I'm trying to remember. I haven't' thought about this in—it was over two years ago." *Id. at 143-144.*

Finally, Respondent asked Patient A about what happened after the appointment, and Patient A testified that she did not immediately depart but talked with Casey, the receptionist about Dr. Chambers, and recalls Dr. Chambers being present, didn't say anything about pain except she did about the discomfort during the exam itself, and agreed that the conversation between the three of them was "probably" jovial. *Id. at 145.*

Re-Direct, Re-Cross, and Follow-up Questions of Patient A

Upon re-direct by Ms. Mooneyhan, counsel for the IC, Patient A clarified that she believed that her discomfort was separate from the insertion of Respondent's fingers during the examination to be two separate events. *Id. at 146-147.* Patient A also answered that they discussed the questions that she brought to the exam with her after the exam and when the Respondent told her his diagnosis

and treatment recommendations. *Id. at 147.* When asked whether they had discussed questions about lubrication and sex, Patient A stated three more times that she couldn't remember. *Id. at 147-148.*

Upon re-cross by the Respondent, Patient A clarified that she gave him the form of questions at the very beginning of the appointment. *Id. at 149.*

In response to questioning by the undersigned Hearing Officer and follow-up questions by the Dr. Chambers and Ms. Mooneyhan, Patient A stated that she returned to her regular gynecologist Dr. Lewis about six days after her appointment with Dr. Chambers because of her pain but does not recall the date that she saw Dr. Wasserman. *Id. at 150.* Patient A further explained that she saw Dr. Wasserman on Dr. Chambers' recommendation, that she questioned Dr. Chambers about the referral if it was the exact same procedure and that Dr. Chambers replied that her insurance wouldn't cover it because he, Dr. Chambers, did the procedure in-office. *Id. at 150-151.* Patient A further clarified that Dr. Wasserman could do the rectocele and perineal repairs but not the cosmetic portions, and that her intention was not to seek a cosmetic procedure. *Id. at 152.* However, Patient A recalls, and the Respondent directed her attention to her own list of questions, that a labiaplasty procedure could help with her discomfort. *Id. at 152-154.*

MAY 3, 2023 CONTINUED HEARING

PATIENT B

Direct Examination

Dr. Chambers was Patient B's physician for over seven years for her yearly exams and when she was pregnant and after she had her son, with her last appointment in 2018. Vol. II, TR 10. Patient B was aware that Dr. Chambers did cosmetic gynecological surgery as there were posters in his office, although she never inquired about it. *Id. at 11.*

Patient B testified that she discontinued seeing Dr. Chambers as her primary gynecologist after her last appointment with him in 2018 for a couple of reasons, including that she felt that she had trusted him with her personal history, and he had shared that information with medical students. *Id. at 11-12.*

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In addition, she had made the appointment for a second opinion about a lump in her breast and need scans to be ordered. *Id. at 13.* The nurse also had her undress from the waist down, and the nurse and the two students, both women, were in the exam room. *Id.*.

Patient B had had breast implants since her last appointment with Dr. Chambers, and he asked her to sit up so that he could look and asked her about them. *Id.* He then asked the students to leave, and Patient B thought he wanted to talk to her about something privately, and she still trusted him although she felt it was awkward as she was still exposed from the waist up. *Id. at 14.* At that point, the Respondent asked Patient B if she had ever posed nude before and that some of his patients were models for him for his ads. *Id. at 15.* She knew immediately "that it was incredibly inappropriate. It was crossing so many ethical boundaries", and it was a very uncomfortable situation to be in. *Id.*

Patient B stated that the Respondent went on and told her how he wanted real women and that it would be empowering for her to do this because of her history. *Id. at 15-16.* He showed her a photo on his phone that was filtered and that he said was one of his patients. *Id. at 16.* The Respondent also told Patient B that if she did pose for him, that she couldn't tell her husband. *Id. at 16-17.* Patient B also testified that she told him that she had had laser hair removal in her genital area and that he asked to see, stating that was even more perfect. *Id. at 17.* The conversation continued, and Patient B testified how the Respondent described how his other patients who posed as models enjoyed the process and became seductive with the camera, that he is the photographer and paid $1000. *Id. at 17-18.* Patient B testified that it was a fairly short conversation, that she was still naked, that she was nervous and uncomfortable and just kind of laughed, and that the conversation ended, and he left the room when the Respondent told her and they agreed that she would just to text a simple "yes" or "no" regarding the project without any details. *Id. at 18-19.* Patient B then left the office, and it was a friendly goodbye, and she realized that was inappropriate because he was her doctor that she trusted with personal details of her sex life and other personal details. *Id. at 19-20.*

Patient B later discussed the incident with her sisters, friends, and her therapist, who agreed that it was inappropriate and violating, and she texted her answer to the Respondent from her

therapist's office, which said that the project would be highly unethical and that she would be seeing another gynecologist. *Id. at 20, 21.* Patient B stated that Dr. Chambers texted back that he did not think that it crossed patient boundaries and that it was the only way he could recruit models, he was worried that he may lose some patients because of this, and that he wished her well. *Id. at 21.* Patient B added that she and Dr. Chambers had previously texted about medical matters and voting for him for Top Doctor Awards, which she did. *Id. at 21, 22.* Subsequent to the incident there were texts only about Patient B's scans. *Id. at 22.*

Cross-Examination of Patient B by Respondent

Respondent asked which of them initiated the discussion about the photos, and Patient B replied that Dr. Chambers asked, and she also implied that there may not have been ads for which he was taking photographs. Vol. II TR 22-23.

During Patient B's testimony, there was a great deal of interrupting each other, some confusion and contradiction while the Respondent was attempting to ask Patient B about why he was asking her about sexual matters, with Patient B stating that she never raised the issue but would answer Dr. Chambers' questions during appointments. *Id. at 23-24.* The Respondent attempted to demonstrate that she contradicted herself as his exam notes on the date of one of her appointments show that Patient B did in fact raise concerns about her sexual life. *Id. at 24-32; NSBME Exhibit 7, p. 105;* typewritten in NSBME Case File Pleadings 27, p. 3.

Upon being given some latitude, and although she was reluctant to agree or to answer in the affirmative, Patient B testified that with respect to the statement and information recorded by Dr. Chambers in his exam notes, "it was a long time ago, but I can't say there's not truth to this," and "there isn't any untruth to this," and "[i]t looks like something that I would have said, because when I read it, it's the truth," and "I know that this is how I feel…about my sexual struggles," and "I would have not said any of this, just like I'm saying this now. So, this is the truth I trusted you with." *Id. 30-32.*

The cross-examination continued back-and-forth between the Respondent and Patient B, and Patient B testified that she did discuss with others about her discussions with Dr. Chambers

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about her sexual life, and that he did not wait for her to ask the questions, but he asked very personal questions which made her feel awkward. *Id. at 34-35.*

When the Respondent asked that, based on the notes and history, whether he had had a basis for asking detailed questions about her sexual life, Patient B had difficulty answering. *Id. at 36-39.*

Because of Respondent's difficulty in asking and getting responses from Patient B during her testimony, and because Respondent stated that he felt that it had become argumentative and that he was in a detrimental "he said she said" position, he declined to cross-examine Patient B further. *Id. at 38-39.*

On re-direct, IC counsel asked, and Patient B clarified that she had never seen the medical record of Dr. Chambers' notes and that she had no control about how he characterized her visit. *Id. at 39-40.* On re-cross examination, Respondent asked, and Patient B testified that she had read physician notes at the end of a medical appointment but did not look at any of Dr. Chambers' notes about her. *Id. at 40.*

IC'S EXPERT WITNESS RICHARD RAFAEL, MD

Direct Examination

Dr. Richard Rafael was called as the IC's expert witness. Dr. Rafael was initially questioned and testified about his education, training, practice, expertise, experience, professional affiliations and descriptions of the organizations, current professional activities, and education and position as chief resident, and affiliations to remain current in his chosen specialty. Vol. II, TR 44-58. Dr. Rafael's CV can be found at IC's Exhibit 16. Dr. Rafael also described his work for ProAssurance Indemnity Company claims underwriting committee, and a list of CMEs he had taken throughout his career, and how he chose OB-GYN as his specialty. TR 58-61.

Dr. Rafael was asked about and discussed a series of hypothetical scenarios related to a patient's sexual health. TR 62-65. Dr. Rafael then testified about a sub-specialty and training in sexual health, and whether an OB-GYN would be able to perform female genital plastic surgery or whether that would require a specialty in plastic surgery. TR 65-67.

Regarding marketing, Dr. Rafael testified that his practice was marketed by word of mouth and that he did not have models or use ads in his office. TR 67.

Dr. Rafael further testified about the recommended use of chaperones, how that changed over time, and his use of chaperones, how at times a chaperone wasn't present and how that declination was documented. TR 68-71; IC Exhibit 11, p. 160.

Dr. Rafael testified that the ACOG's opinions and guidance are the accepted standard of care in OB-GYN. *Id. at 72-72.* After reviewing the paragraph entitled "sexual impropriety" in Exhibit 11, Dr. Rafael opined that he believed that there was sexual impropriety in the cases of Patients A, B, and C. TR 72; IC Exhibit 11, p. 160.

Dr. Rafael was then asked about IC's Exhibit 3, which is Respondent Dr. Chambers' medical records and notes for Patient A, which he reviewed in preparation for testifying in the instant matter. TR 74. When asked about his review of the records, Dr. Rafael responded, "Well, first I'd like to state that this is a thorough history and physical performed by Dr. Chambers." TR 74.

Dr. Rafael was further questioned and discussed Patient A's presentation, history, questions, and concerns when she saw Dr. Chambers. *Id. at 74-76.* Dr. Rafael testified that he had done two labiaplasties during his career, and he did them with a colleague who had taken courses from Dr. Red Alinsod, and he did them for functional rather than cosmetic purposes. TR 76.

Dr. Rafael was then asked about and testified about instances when labiaplasty could be beneficial for a patient, and that insurance should cover the procedure. TR 77. He also was asked, based on Patient A's medical records, to analyze her case based on his review of the records and how else he might have treated her, and gave a significant statement, which should be reviewed. TR 77-83.

In his assessment, Dr. Rafael shared a generally positive impression of Dr. Chambers' evaluation of Patient A. *Id.*

The questions and testimony then turned to Respondent Dr. Chambers' use of Patient A's cell phone to photograph her vulva. TR 83-84. Dr. Rafael testified that he personally would never do that, and that, without being an authority on this, he believes that the ACOG's rules are, first, to de-identify the patient and, second, that the phone is encrypted. TR at 84. He opined that the patient's cell phone was not encrypted and that was a way to identify someone. *Id.* In Dr. Rafael's

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career, he would not use photos of his patients in preparation for surgery, but just his notes, and he would use illustrations in his practice to inform patients. TR 85-86.

Dr. Rafael commented on the medical notes of Dr. Wasserman (to whom Dr. Chambers referred Patient A following their appointment). After reviewing Dr. Wasserman's notes, Dr. Rafael testified that it appeared that Dr. Wasserman did not believe that Patient A needed labiaplasty or a clitoral hood reduction. TR86-88; Exhibit 3, p. 26.

When asked to review IC's Exhibit 4, a photo of Patient A's vulva taken, Dr. Rafael states that there appears to be a small hematoma, which could have been caused during an examination, and compares the photo to an earlier photo taken four minutes earlier that did not show a hematoma. TR 88-90; Exhibit 4, pp. 33, 38.

Regarding ten of the twelve photos that Respondent Dr. Chambers did not choose to keep if Patient A proceeded with the surgeries, Dr. Rafael stated that "I want to be fair. Dr. Chambers has taken a course from Dr. Red Alinsod, who's a renowned—I don't know if he's a urogynecologist, but he's held in esteem within the cosmetic surgery community. And Dr. Alinsod teaches medical photography, and Dr. Chambers has taken courses to improve his surgical technique and surgery in this sexual gynecological female genital cosmesis. And in that course, Dr. Alinsod has papers and recommendations to take photos." TR 91.

When asked if it's acceptable to use four fingers in a pelvic exam, Dr. Rafael testified, "Yes." *Id.*

When asked his opinion about the Respondent noting that he used two fingers in Patient A's pelvic exam but the photo using four fingers, Dr. Rafael responded that he would not have documented using four fingers, and that "[c]ertain things are done on an everyday basis" and "this exam, in my opinion, is a perfectly normal exam" and also "I don't see anything abnormal with his exam" and sometimes "these things are so common", such as using a speculum, that not everything is dictated into the notes. TR92-93.

Regarding the use of non-medical terms, Dr. Rafael testified that patients do use non-medical terms, and he was trained not to use big words that could be confusing to patients. TR 94.

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Dr. Rafael would never use the term "fisting" or ever discuss his personal intimate life, nor show photos of other patients. *Id.* Dr. Rafael testified that using four fingers is not referred to as "fisting" in ACOG or anywhere else and he believes would be demeaning to a patient. TR 95.

Regarding labiaplasty, Dr. Rafael testified that it is useful to reduce pain and discomfort for different patients, and that since the 1990's, "there's been a dramatic increase in interest and demand" for cosmetic labiaplasty and it's a matter of choice. TR 95-96. Dr. Rafael also discussed an "O-shot". *Id.* at 96.

Dr. Rafael testified that he did have a problem with the apparent lack of identification encryption by using the patient's phone and thought that could put the patient at risk. TR 98.

Dr. Rafael testified that he "is aware of the fact that in her allegation that he (sic) states that Dr. Chambers talks about fisting or—it's not clear whether—exactly what he said." TR 98. Dr. Rafael added, "[b]ut she does mention the word 'fisting,' and the way I read it was that, perhaps, somehow he said, well, this isn't fisting, because she was in pain during the time of exam. TR 98.

Dr. Rafael agreed that "fisting" would be an inappropriate term to use. TR 98-99. When asked whether he thought that using the term "fisting" could lead to disruptive behavior by the doctor or a disruptive exam, Dr. Rafael did not either agree or disagree but defined his concept of "disruptive behavior" is whether it interferes with the patient-physician relationship or whether it affects the patient's perception of the physician's integrity. TR 99.

Dr. Rafael was asked about "sexual impropriety" per ACOG Opinion 796, IC's Exhibit 11, and he agrees with counsel for the IC, again, that using the term "fisting" would be an inappropriate comment and could be construed as making sexual comments and could be sexually demeaning; and that taking photos of the patient's cell phone and texting to her could be disrespectful of her privacy. TR 99-100.

It is unclear whether he believes that they happened during the visit when asked specifically. TR 100, ll. 9-13.

Additional IC Exhibits 14 and 15 that Dr. Rafael relied upon for review were then introduced and admitted into evidence. TR101-102.

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The questions then turned to Exhibit 7 relating to Patient B and Dr. Rafael had difficulty reading Respondent's medical notes. Dr. Rafael answered questions that he has never used models, would never offer to pay somebody to model for him, and would not post an advertisement in his practice advertising for models as he thought it would be disrespectful and inappropriate, bring disrepute to medicine, would be demeaning and violate the trust that a patient would have in him as an ethical physician. TR 104-105.

Dr. Rafael stated that offering to pay Patient B $1000 for photos was "[u]nprofessional, unethical, against the Code of Conduct, against society's rules, in my opinion" and violate the trust of a patient. TR 107-108; Exhibit 5. Dr. Rafael reviewed IC Exhibit 6, Respondent's response letter addressed to NSBME, and testified that there was no doubt that Respondent had offered to pay $1000 for photos for an advertisement. TR 108; Exhibit 6.

Likewise, Dr. Rafael testified that there was no question that the Respondent offered Patient C $1000 to model for an advertisement and that husbands and boyfriends were not allowed at a photo shoot. TR108-109; Exhibits 8 and 9.

Finally, Dr. Rafael questioned whether NSBME's allegation letter was exactly what Patient A had stated, but he opined that it isn't "particularly appropriate" or "particularly professional" to tell Patient A that her vagina was too big for a man's penis. TR 111-112.

In wrapping up direct examination, Dr. Rafael testified that he did not believe that Dr. Chambers committed sexual violence, but that Dr. Chambers committed sexual impropriety with all three patients because he fulfilled the criteria laid out in section 158 of the ACOG's definition. TR. 112-113.

Cross-Examination of Dr. Rafael by Respondent

In answering questions posed by Respondent Dr. Chambers, Dr. Rafael testified that his knowledge of sexual health was acquired post-residency and very little time was spent on it. Vol. II, TR 115-116.

Dr. Rafael testified that a physician discussing sexual desires and fantasy is not a form or sexual misconduct except under certain circumstances, and additional questions are appropriate if a patient seemed to have persistent and recurrent sexual dysfunction. TR 116.

Dr. Rafael also stated that he was aware that Patient A went to the urogynecologist that Respondent Dr. Chambers referred her to, despite Patient A's allegation that Respondent abused her. TR 116-117.

Regarding chaperones, Dr. Rafael agreed with Dr. Chambers that ACOG opinion was a recommendation rather than a mandate and that at times, such as an emergency or with the patient's permission, it is acceptable to examine a patient without the presence of a chaperone. TR119-120; IC Exhibit 11, p. 160.

Dr. Rafael stated that he believed that a chaperone should be in the examination room despite the risk of COVID-19 and Respondent Dr. Chambers' safety protocols at the time of Patient A's examination. TR 120-125.

Regarding labiaplasties, Dr. Rafael answered that, as he had previously testified, he had done just one labiaplasty and worked with an assistant/colleague who had trained with Dr. Red Alinsod. *Id. at 125.* Dr. Rafael agreed that his colleague was appropriately trained because she had taken courses offered by Dr. Alinsod. TR 125-126.

Regarding examinations and the Respondent's question of being trained to look at aesthetics or for pathology, Dr. Rafael responded that the first thing is to look for aesthetics of the vulva, note if something seems wrong and move to a functional evaluation. TR 126. Dr. Rafael agreed with Dr. Chambers that there are many variations of a normal vulva and that a plastic surgeon and a gynecologist looking at the same photo would probably not have the same impression. TR 126-127.

Regarding the possible bruising in the photos of Patient A, Dr. Rafael only observed and commented that it was not in a photograph from four minutes earlier and would not offer conjecture about how much force would be required during an exam to create that bruising and agreed that pain is not the same as discomfort. TR 129-130.

Dr. Rafael agreed that it is acceptable for plastic surgeons to have before and after photos and that Dr. Chambers had taken courses in medical photography "and that I thought it was acceptable for the photos that you took before and after" and that it is acceptable to use photos of a patient's vulva to teach and explain. TR 131.

Dr. Rafael has sized his patients' genitalia, and described the process, as an OB-GYN, and thought that Dr. Chambers "did a thorough history and physical, and I thought your pelvic exam was certainly appropriate." TR 132-133.

Regarding the allegation of "fisting," Dr. Rafael noted and agreed that Patient A made an allegation of "fisting" but that there was no proof within the records. TR134-135.

Regarding the "Q-Tip test", Dr. Rafael agreed that it is possible for a patient with chronic pelvic pain, etc., to feel something and couldn't identify exactly what it was, such as Respondent's four fingers, and using four fingers can be appropriate. TR 135.

Redirect, Recross, and Further Questions

On redirect, Dr. Rafael was asked and answered questions already covered in earlier testimony, and there was redundancy, including the following:

Dr. Rafael would discuss sexual fantasies if raised by the patient. TR136;

Dr. Rafael agrees that a chaperone should be in the exam room and that the ACOG does not mandate, and it is a good idea for both patient and physician to have a chaperone in the room. TR 136-137;

Dr. Rafael would document if there wasn't a chaperone in the room in an emergency situation and did not see that documented in the Respondent's medical notes. TR 137; Exhibit 3;

There is a range of normal in female genitalia. TR 138;

Dr. Rafael believed that the photos on Patient A's phone could put her at risk and the potential for abuse and could be disrespectful to patient privacy. TR 139;

Dr. Rafael stated that using the term "fisting" "in and of itself is lewd language." *Id.*

On recross, Dr. Rafael defined his understanding of "fisting" and agreed that a great deal of lubrication would be needed and a standard pack of lubrication that OB-GYN's usually use during an exam would not be enough. TR 140-141;

Dr. Rafael states that, based upon the definition of fisting and the amount of lubrication needed, stated that, although it is speculation, "I would say, sir, do think it's likely that you fisted her? No, I don't think it's likely you fisted her." TR 142;

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In answering questions from the undersigned hearing officer, Dr. Rafael reiterated his earlier testimony and, in addition, stated that his greatest concerns were about "integrity, the code of conduct, boundaries and unprofessional language, suggestive sexual language" and believes that this behavior fulfills the requirements of "disruptive behavior" found in NRS 630.301(6). TR 147-148.

Dr. Rafael again reiterated that he did not think that the four finger/two finger issue was a problem as time is always a concern when seeing patients. TR 154-155. And, when invited by the Hearing Officer to state his conclusions, Dr. Rafael stated the following:

1. Dr. Chambers did not commit medical malpractice (although that was not an allegation). TR 156;

2. Dr. Chambers actions met the definition of sexual misconduct and sexual inappropriateness. TR 157;

3. Dr. Chambers did not commit sexual violence, although that is not alleged in the complaint. TR 157-158.

Dr. Rafael clarified that he did not think that Patient A was traumatized, but that Patient A *felt* that she was traumatized. TR 159. Dr. Rafael's opinion is that the Respondent's treatment of Patients A, B, and C brings the medical profession to disrepute and meets the definition of "disruptive behavior." TR 159-160. Dr. Rafael was more ambivalent about Count IV, Continual Failure to Practice Medicine Properly, but stated that "I think each of these patients did not feel that they were treated in a professional manner," so agreed that Count IV was fulfilled. TR 160-161. In response to the Respondent's question, Dr. Rafael stated that it would not surprise him that Dr. Chambers noted that he used two fingers in the exam because that was the photo that was in front of him when he was charting his notes. TR162.

RESPONDENT'S EXPERT WITNESS MICHAEL GOODMAN, M.D.

Over IC's objections that the offer of Dr. Goodman's CV was untimely, this Hearing Officer admitted Dr. Goodman's CV. As counsel for the IC wished for additional time to review the CV, and the complication of less-than-optimal video and audio connection, Dr. Goodman's testimony was rescheduled to June 1, 2023, a date already set aside for another witness.

RESPONDENT'S WITNESS MS. BRITTANY TURNER

Ms. Turner is a patient of Respondent Dr. Chambers and is an adult film actress. TR 188. Ms. Turner testified that Dr. Chambers has always used proper medical terminology at her appointments. TR 189-190.

Ms. Turner is familiar with "fisting," has fisted but has never been fisted herself and is "an expert" with the practice. TR 190-191. Ms. Turner stated with conviction that the amount of lubrication used in a normal pelvic exam is "no way" near enough to fist someone. TR 191. Respondent Dr. Chambers then asks Ms. Turner to describe the practice of "fisting", which was allowed over objection that Dr. Chambers wasn't actually accused of fisting, but that he was accused of saying that he had "fisted" Patient A. In response, Respondent stated that "I'm trying to show that, while I haven't' been accused, I have been accused of saying that I attempted to fist. So I'm trying to be respectful and not say that it's ridiculous--a ridiculous accusation. I'm trying to show that it makes no sense that I would say something like that, if I didn't attempt to do it or did it." TR 192. Ms. Turner proceeded to answer Respondent's questions and described the process of "fisting", including her testimony regarding lubrication. TR 193.

Regarding posing nude, Ms. Turner agreed that partners or husbands are not allowed on the set because "they overstep boundaries or the model may not be comfortable doing certain things, so it's a closed set." TR 193-194. Ms. Turner further testified that how she is paid for modeling nude depends on the job, and models could be on payroll for larger companies, but smaller companies may pay a model by check or cash. TR at 194.

IC's Cross-Examination

On cross-examination, Ms. Turner acknowledged that she wasn't present at any of the appointments of the patients in this matter and does not consider herself an expert in the ethical behaviors of OB-GYNs. TR at 194. Ms. Turner was cross-examined and testified that she had been a patient of Dr. Chambers since 2016 and she had had a good experience with his care-that he had experience and knowledge treating her as an adult film actress. TR 195. Other than being his patient, she has no other personal or financial relationship with the Respondent. *Id.*

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Respondent Dr. Chambers delivered Ms. Turner's daughter in 2017, did not perform any surgeries on Ms. Turner, has never taken any photos of her, only used medical terms to describe body parts. TR 196-197.

RESPONDENT DR. CHAMBERS' SELF DIRECT EXAMINATION

Note: As Dr. Chambers did not have legal representation, he chose to give a statement as his direct testimony at the end of the day on May 3, 2023 at approximately 4:35 p.m., with knowledge that the hearing needed to conclude before 5:00 p.m. This statement/testimony is very brief and should be reviewed as a whole by the Decision Makers/Board rather than summarized. TR 198-207.

Dr. Chambers explained that the reason that he had his chaperone, receptionist Casey Cardin, at the entry of the exam room was trying to protect his patients, his family, and himself because he was very fearful of getting COVID-19 at the beginning of the pandemic;

At the time, his son was a year and a half, and his daughter was three; and

Dr. Chambers worked in the hospital at the beginning of the pandemic.

JUNE 1, 2023 (CONTINUED) ADMINISTRATIVE HEARING (via *Zoom*)

RESPONDENT DR. CHAMBERS (Continued Testimony)

IC's Cross Examination

Respondent did not ask patients to take photos of their own genitalia but asked to use their phones and he would take the photos if they were seeing him for a consultation (unless international patients had to leave Las Vegas, then he would have them send post-operative photos to check healing). TR 11-12.

Dr. Chambers typed his consultation notes if he knew they were going to other providers, such as a referral. TR 12. Respondent Dr. Chambers' practice is to have a patient text certain, not all, photos to him to send to another provider without identifying them but without knowing if they're encrypted. TR 13-14. He testified that it could be difficult to trace the photos back to a patient because they could also be downloaded and edited photos and has considered how bad it could be if such photos ended up in the wrong hands. TR 14-15. Dr. Chambers does not recall

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having the conversation with Patient A that one of his patients had texted their pictures to the wrong person. *Id.* Respondent has thought about how the photos could fall into the wrong hands. TR 15.

Respondent testified that spouses or boyfriends are excluded at nude photo shoots because they could cause a disruption for the photographer and the models may be less relaxed, so closed set, but at Respondent's office. TR15-16. Respondent also stated that the only way he solicits patients to be models is by posting an ad on the lavatory door and the patient herself inquires. TR 16.

Dr. Chambers testified that outside of the pandemic, family members were allowed in the office for a consultation but that he was very careful during COVID-19 as no one knew what was going on and so he, along with hospitals, made up their own rules in response. TR 17.

Dr. Chambers understood that he wasn't being accused of "fisting" but of telling Patient A that he tried to do something called "fisting" and that it made her uncomfortable, but questions Patient A's testimony that she had never previously heard that term. TR 18.

Dr. Chambers practices the full scope of OB-GYN with added sexual health medicine and cosmetic gynecologist surgery. TR 19. A labiaplasty would have alleviated some of Patient A's pain and discomfort but not her perineal pain. TR 20. Dr. Chambers would have done the perineal surgery. TR 21.

Reviewing Respondent's Exhibit Q/17, ACOG Opinion 795 regarding consent, Dr. Chambers testified that he went over the risks of cosmetic surgery with his patients on their second visit, when they filled out three consent forms. TR24.

Patients of Dr. Chambers who choose to proceed with the surgery would receive the amount of the consultation fee deducted from the surgery fee. TR 26. Most patients are well informed about a cosmetic procedure when they arrive for their first consultation. TR 26-27. Reviewing page 105 of Exhibit Q, Respondent Dr. Chambers agrees that the ACOG encourages OB-GYNs to warn their patients that there may not be any benefits that outweigh the risks of cosmetic surgery. TR 28.

Respondent answered the question that was he aware that his completion of the Master's course in 2013 "did not even qualify for CME's for this board" by saying that the course was not

meant to be a CME. TR 30-31; Exhibit 2. Dr. Chambers' next training was "Sexual Health and Treatment" with Dr. Jennifer Landa is not recognized by the American Board of Medical Specialty by the Antiaging Board. TR 31; Exhibit C. Dr. Chambers also confirmed that he was a member and received CMEs from the National Society of Cosmetic Physicians. TR 32-33; Exhibit D. Respondent has not taken any more CMEs related to female genital cosmetic surgery since 2014. TR 33.

Respondent Dr. Chambers joined the National Society of Cosmetic Physicians—a society of doctors from different specialties-- to learn, educate, and to advance the field of cosmetic OB-GYN surgery, and "to learn things that were already within my scope of practice of gynecology," rather than the other areas that were offered, such as Botox or liposuction, lip fillers, etc. TR 33-34. It does not concern him that that society does not have a website as there are very reputable and well-esteemed physicians that are a part of that group. *Id.* He didn't join other organizations because "we would be spending $50,000 a year" in fees, and he didn't want to just join organizations to them on his CV. TR 35.

Returning to the subject of chaperones, Dr. Chambers maintains that, with respect to Patient A, he had a chaperone who stood in the doorway, and "I was not alone in a locked room with a patient", and "I've always used a chaperone…I deviated during the onset of COVID-19, and when everybody got immunized via vaccine or natural immunity for the protection of people who are in my office including myself." TR 36. Dr. Chambers is very much aware that the ACOG recommends that you have a chaperone present for all breast, genital and rectal examinations. TR 37; Exhibit 11, p. 156.

Respondent Dr. Chambers explained that he received his certification in sexual health from the American Academy of Antiaging Medicine from attending four modules over a one-year period at four different times for a total of 16 days. TR 37-38. However, he does not purport to be a sexual health therapist, although he does in the matters in which he "was trained as a clinical sexual health expert treating hormonal diseases of female sexual health, surgical treatment, counseling of sexual health problems, and giving certain advice that's within the scope of my training. Anything else

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gets referred out." TR 38-39. He testified that he did it to help his patients and, although it has been approximately ten years since his training, there have been very few changes. TR 39.

Upon questioning, Dr. Chambers explained his professional background with a group and call groups and why he left. TR 39-42.

Upon additional questioning regarding the appointment with Patient A, Dr. Chambers testified that he most definitely addressed her pain and again detailed how he did so, and her records were again discussed. Dr. Chambers was asked why this wasn't documented, and Dr. Chambers replied that "no OB-GYN writes that down" and writing every exam process and discussion is unrealistic. We just do our work and write our findings down. [There is extensive discussion about Patient A's appointment and his general approach to exams that should be reviewed]. TR42-49.

Regarding his office assistant, Ms. Cardin, Dr. Chambers testified that he gave her time off, that she would test herself, she came down with COVID-19 more than once because of her daughter. TR 50.

Regarding Patient B, Dr. Chambers testified that she saw the ad on the lavatory door, inquired, and he told her how much it paid. TR 50-51. Dr. Chambers wouldn't have done it if it were illegal, and if a patient inquired while there were students in the room, he would answer her question. TR 51-52. Dr. Chambers did not have a copy of the ad but described it. TR 52-53. Dr. Chambers explained that he was "livid" by Patient B's text in which she was angry that her boyfriend couldn't be present and that the Respondent might be up to no good. TR 54. In his response to the letter from the NSBME about the ad and this text from Patient B's, he testified that she did not have to inquire or pose and most of his patients never even inquired about the ad. TR 54-55; Exhibit 6, pp. 45-46.

With respect to his response to the IC's investigator Ms. LaRue, Dr. Chambers does not want to change his accusation of Patient C of being a liar because he did not call her but tried to leave a written message but did not call. TR 57-58. Dr. Chambers testified that, at the end of the visit, Patient C asked him about being paid to pose nude after she saw the ad in the bathroom. TR 58-59.

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On Respondent Dr. Chambers re-direct of himself, he made a brief statement addressing his skills and training should be reviewed. TR 62-63.

The undersigned Hearing Officer then asked some questions of Dr. Chambers, who answered as follows:

During the first six months to a year of COVID-19, Dr. Chambers lost much of his staff because he could not compete with the payments from the government, so Ms. Cardin was his only remaining staff member. When Ms. Cardin became ill, there was a nurse practitioner who sublet a space in his office who filled in as a chaperone when Ms. Cardin wasn't available. The nurse practitioner also stood in the doorway during that time. When the nurse practitioner was not available to assist him as a chaperone, Dr. Chambers would close his office and reschedule patients. TR 63-64.

The nurse practitioner did aesthetic work such as facials, but she sometimes assisted Dr. Chambers with certain procedures. The nurse practitioner was braver about COVID-19 and not as strict about masks as Dr. Chambers. TR 64-65.

During COVID-19, his doors were locked and there would be at most two patients in his office at a time and the person acting as chaperone. Prior to COVID-19, Dr. Chambers would have all six exam rooms filled and would go room-to-room with his chaperone. TR 65.

Dr. Chambers eased his restrictions "once there was sufficient evidence from the CDC that people were getting immunized, when I was confident and comfortable that most of my patients were getting the vaccines." TR 66. He started allowing chaperones back into the exam room after Ms. Cardin left the practice but does not remember when that was. TR 67.

Because of the way his office was designed, a chaperone was able to see into the exam rooms if the doors were open from up to 15 feet away and from the receptionist's desk. TR 67-68.

The ACOG recommends that a chaperone is in the room; Dr. Chambers does not believe that a chaperone must be in a certain position in relation to the patient, but he prefers them to be at "the business end" in the event that there is an allegation. TR 69-70.

Everyone-doctor, patient, chaperones-were required to be masked in his office, and patients were not seen if they did not mask. TR 69.

Dr. Chamber of course took other CMEs to meet licensing requirements and also to satisfy his curiosity, and although there were not courses in the areas that he was looking to learn, he had plenty of CMEs and did not care. TR 71.

RESPONDENT'S EXPERT WITNESS DR. MICHAEL GOODMAN

Direct Examination by Respondent Dr. Chambers

Dr. Goodman's education and training are explored, he is still practicing part-time, he is board certified by the ABOG and a fellow of the ACOG; he's a certified menopause clinician by the North America Menopause Society; affiliate of the American Academy of Cosmetic Surgery, an elected fellow of the International Society of the Study of Women's Sexual Health; a published author in peer-reviewed publications and gives examples of the publications, edited and contributed to textbooks. Vol. II, TR 75-78.

Dr. Goodman's trained specialty is obstetrics and gynecology, special training in endoscopic surgery. TR 79.

Dr. Goodman reviewed cases for the California Medical Board for approximately ten years in the '80s and '90s, presented in approximately 80 local and national medical conferences, taught and proctored many gynecologists in advanced operative laparoscopy; received several professional awards; and is considered to be one of the pioneers in cosmetic GYN surgery. TR 79-81.

Dr. Goodman testified that a cosmetic gynecologist is a general gynecologist who has undergone additional training in the specific area of cosmetic gynecology. TR 81.

Dr. Goodman responded that cosmetic gynecology is not recognized by the American Medical Boards because there are many boards that exist to regulate their subspecialties, and this is one of them that is self-policing and training board. TR 81-82.

Dr. Goodman stated that it was his pleasure to train Dr. Chambers in cosmetic GYN surgery. TR 82.

Dr. Goodman described at length the training that plastic and gynecologic surgeons receive in his formal courses and what is covered. TR 82-87.

These procedures are done in the office under local anesthesia because they're safer, it can be a better procedure and be more cost effective. TR 86.

Dr. Goodman describes his understanding of Dr. Chambers' medical practice. TR 91.

Dr. Goodman believes that the training Dr. Chambers received from him was sufficient to do cosmetic gynecology work and complemented Dr. Chambers as having good hands, intellect, understanding and training, although he hasn't seen Dr. Chambers' recent work. TR 92.

Dr. Goodman describes how GYNs measure vaginas with their fingers in gynecology and in cosmetic gynecology. TR 92-94.

Dr. Goodman states that it is standard for GYNs and cosmetic GYNs to ask a patient to do Kegel exercises while the physician's fingers are inside the vagina. TR 94.

Dr. Goodman states that the term "fisting" is used in cosmetic GYN as it applies to measurement, and he could see a trainee might use the term, but he doesn't deal with a patient population that engages in fisting so does not expound further. TR 95.

Regarding preoperative and postoperative photos that are necessary in cosmetic GYN surgery, Dr. Goodman states that he will note operate on women who do not allow photos, and that is the case with most experienced cosmetic surgeons as preoperative photos are very important both medically and legally as part of documentation and part of the medical record like office notes. TR 96.

Dr. Goodman testified that with permission, a signed disclaimer, it is appropriate to show these photographs of other people as part of a gallery of the physician's work as part of an initial consultation, although some patients do not give permission to share the photos. TR 96-97.

Dr. Goodman sees nothing wrong with physicians marketing their services, although if may differ depending on the type of practice or specialty. TR 98.

Regarding marketing of a traditional GYN practice versus a cosmetic GYN practice, Dr. Goodman testified that sometimes the nature of the practice and how medicine has changed requires a physician to market their services. TR 99-100.

Dr. Goodman, trained in sexual health medicine, discusses the term "sexual medicine" and its place in GYN care and in medicine in general, how it has been stigmatized but is "creeping" into mainstream medicine, and that is why he is a member and fellow of a multi-specialty organization, "International Society for the Study of Women's Sexual Health". TR 100-101.

Dr. Goodman testified about how physicians and patients rarely discuss sexual dysfunction treatment and how he addresses it in his practice, and how he opens the door to discussion. TR 103-104.

Dr. Goodman explained the purpose of the cosmetic organizations that connect physicians from different medical specialties including OB-GYN. TR 104-105.

Dr. Goodman assessed and was impressed and complimentary about Respondent Dr. Chambers' consultation notes of Patient A. TR 106.

Dr. Goodman discusses the use of fingers for measuring vaginas and how it varies and is not exact and opines that much has been made of Dr. Chambers using two versus four fingers in his exam and notes of Patient A is "a red herring, to be honest with you." TR 106-107.

Dr. Goodman discusses the O-shot, platelet-rich plasma, and urinary incontinence. TR108-114.

Dr. Goodman discussed his transition from general OB-GYN to cosmetic gynecologist and the difference in how cosmetic GYNs view female genitals. TR 14-117.

Insurance doesn't cover cosmetic gynecology so cosmetic GYNs do not accept insurance unless there's a functional issue, and Dr. Goodman thinks that is wrong. TR 117-119.

Dr. Goodman believes that Respondent Dr. Chambers should be judged as a general OB-GYN but also as a sub-specialist who has made the effort to obtain additional training as a cosmetic GYN that general OB-GYNs do not have just as a GYN Oncologist has additional training. "And a general OB-GYN, as intelligent and well-meaning as well-trained as that individual may be, is ill-suited to judge you in those areas in my opinion." TR 119-120.

IC'S WITNESS/DIRECT EXAMINATION OF CASEY CARDEN

Respondent Dr. Chambers was Ms. Carden's doctor for approximately eight to ten years, until last year, and then she worked for him as a receptionist for less than a year, although she does not remember the exact timeframe. TR 128-129.

Ms. Carden remembers wearing a mask during COVID-19; she spoke to Dr. Chambers in the last few weeks to let him know that she would be a witness for the IC so he wouldn't be blindsided.

Ms. Carden left her job with Dr. Chambers because she felt like she didn't get paid consistently and "it was just time." TR 129-130.

Ms. Carden remembers acting as a chaperon for Dr. Chambers' practice not every day, "but I'd say like it was like semi-consistent like I don't know. Not like terribly often, but not like, you know, only like once a month. I'd say it was irregular, but I don't know. Maybe like a couple of times a month if there was like an underage patient or someone like he just wanted me to be in the room." TR 130-131.

Ms. Carden testified that she didn't act as a chaperone with every patient as she was a receptionist; that there was also someone "doing insurance stuff"; that there was another nurse doing "her own plastic surgery practice" that was there towards the end of Ms. Carden's employment; that she worked "like—it was more part-time. Like maybe 30 hours a week…it varied because, you know, he would leave if he got called to the hospital…."; that she didn't have any training about acting as a chaperone. TR 131-132.

Ms. Carden had COVID-19 multiple times but doesn't remember whether she got it while working for Dr. Chambers but "I think the first time I got it was after I was done working for him, I think, but I'm—honestly, I don't think so." TR 132. Ms. Carden remembers a written COVID-19 policy in the office, and "I remember he was strict about patients wearing masks, but I don't—I don't know." *Id.*

When she did act as a chaperone, she stood in the doorway or behind Dr. Chambers or off to the side. *Id.*

Ms. Carden testified that when she chaperoned from the doorway, she had a view of what was going on as if she were in the room—she would be inside the doorway. TR 133.

Ms. Carden remembers Patient A's appointment but was doing charts and didn't chaperone during her appointment, and "I think the door was closed. I don't recall seeing into the room, but--" [here Ms. Carden's answer was cut off by IC counsel's next question about whether she could hear the conversation in the room]. TR 134. Ms. Carden could hear voices but not what they were discussing. TR 133-134.

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Ms. Carden had conversations with Patient A both before and after Patient A's appointment and testified that after her exam, Patient A was very excited about doing the surgery and that "she was finally going to do something for herself". Ms. Carden does not believe that Dr. Chambers was present during that conversation. TR 135-136.

Ms. Carden was surprised that she was not able to get in touch with Patient A after that and thought it was "weird because she was so—she was like overly excited about the surgery and she seemed really, you know, like she wanted to do it...." TR 136.

Dr. Chambers asked Ms. Carden if she would be interested in posing nude for pictures, she thought for an adult porn convention, and she declined. TR 137.

Ms. Carden did see a couple of photos of patient's genitals and the results of vaginal reconstructive surgeries, but not that many. TR 137-138.

Cross-Examination of Casey Carden by Respondent Dr. Chambers

Ms. Carden read her email to Dr. Chambers about her conversation with Patient A after the appointment and still could not recall whether Dr. Chambers was somewhere in the room or not- "I mean, I think you were in the back area, but like you were always kind of underfoot...I can't say for certain if you were like there or you weren't there...." TR 144-145; Exhibit 3, p. 28.

Regarding her recollection of dates, Ms. Carden did not have a text she purportedly sent to Dr. Chambers about having COVID-19 and she had difficulty remembering dates that she was employed by him and dates that she or her daughter had COVID-19, testifying that "to be very, very honest with you, I don't have a great memory, and like I am unsure about the dates that I worked for Dr. Chambers. That's the honest truth. So, the fact that I don't recall, it doesn't mean it wasn't sent." TR 146-150.

Ms. Carden recalls having to reschedule patients because they had COVID-19; she does not recall Respondent Dr. Chambers having to close the office because of COVID-19; she does not recall Dr. Chambers having COVID-19; Ms. Carden recalls that not all patients needed an exam.

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Follow-Up Questions/Redirect Examination

Questions from the undersigned Hearing Officer attempting to narrow down date ranges were only somewhat successful as Ms. Carden still seemed not to recall and was speculating. TR 152-153.

Ms. Carden was comfortable being a patient of Dr. Chambers. She did not recall why she stopped being his patient and speculated as to the reasons, such as she had to wait and also that she heard of another good doctor. TR 154.

Ms. Carden remembers that there was always a chaperone-his medical assistant or receptionist- while she was Dr. Chambers' patient for approximately nine years and doesn't recall if there was a time when there wasn't a chaperone present at her exams. TR 155-156.

Ms. Carden testified again that both she and her daughter have had COVID-19 multiple times but could not recall the dates. TR 157-158.

On Redirect examination, Ms. Carden testified that Dr. Chambers initiated the discussion, and it was by text message, as many of their communications were even after she quit, as he gave his number out to patients to text him if they had any medical issues. TR 159.

IC'S DIRECT EXAMINATION OF PATIENT C

Patient C's name and identity was first authenticated.

Patient C testified that she was not sure but believes that Respondent Dr. Chambers was her OB-GYN for approximately four to five visits, and reviews Exhibit 10, her medical records, which show her visits between September and November of 2019. TR 163-164; Exhibit 10.

Patient C testified that she made an appointment with Dr. Chambers because she was having extremely painful periods and chose him because she had looked online, and his reviews were excellent, and he took her insurance. TR 165.

Patient C testified that Dr. Chambers always had a chaperone present during her visits with him, was aware that he did cosmetic gynecological surgery but that she never inquired about it. TR 165. She believes that there was an ad in the bathroom but doesn't remember anything specific, but she did not see an ad about modeling for photos. TR 166.

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Dr. Chambers called her at home once offering her $1000 to model for photos although he did not say what kind of photos. She was concerned that they were for nude photos, but "I don't know exactly what was said, but I know that I was uncomfortable with it being somewhat implied that it would be nude because I was worried about distribution and how I could protect myself...." TR 167.

Patient C recalls that the phone call took ten to 15 minutes and occurred during the late afternoon, and that afterwards she told her partner and a friend to whom she had recommended Dr. Chambers and "I wanted her to be aware of his character as well." TR 168.

Patient C described how Respondent Dr. Chambers' call affected her at that time, especially since she was struggling financially, which Dr. Chambers was aware of, and how it affected her over time, including how her lack of trust in physicians has changed since then. TR 169-170.

RESPONDENT DR. CHAMBERS' CROSS EXAMINATION OF PATIENT C

Patient C testified that she has never had any contact with Patient A or B. TR 171.

IC'S RECALL OF WITNESS MS. LARUE AS A REBUTTAL WITNESS

IC Counsel recalled their first witness, IC Investigator Ms. Janna LaRue, as a rebuttal witness, offering it as evidence to possibly contradict Respondent Dr. Chambers testimony regarding taking photos for ads to be placed in the Adult Video Network (AVN) program. Vol III, TR 181.

Note: there was an abundance of discussion and argument regarding the admissibility of IC Exhibit 17 and Ms. LaRue's testimony. TR 173-195. However, the crux of the matter is the following:

Ms. LaRue's testified that she inquired in June of 2022, first, on AVN's portal and sent a request for public information about their publications, and then she received an email back from the vice-president of the AVN Media Network that more information was needed for AVN to provide information about Dr. Chambers ads, which Ms. LaRue sent. TR 181-182.

Ms. LaRue testified that AVN's VP, Ms. Newman, responded that Dr. Chambers had inquired once in 2016 about an expo with AVN but never submitted any artwork. The email

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exchange is IC's Exhibit 17. TR 182; Exhibit 17. Ms. LaRue inquired again in April of 2023 and received the same response. *Id.*

Respondent Dr. Chambers objected but was informed and chose to raise the information behind his objections during his re-direct that would occur later in the proceeding. TR 183.

CROSS-EXAMINATION OF RESPONDENT'S EXPERT WITNESS, DR. MICHAEL GOODMAN

Dr. Goodman completely agrees and does not like that his training was referred to as a mini-fellowship was previously referred to on an earlier version of his website. Vol. III, TR 200.

However, Dr. Goodman testified that he—and other experts agree-that a two-to-three course would work for someone who is already savvy in this field if they aren't in over their heads. TR 200-201. The master's course is AMA category one accredited for 14.5 hours and they worked hard to get that accreditation. TR 201-202.

Dr. Goodman has mixed feelings that these procedures are not and would like to see some covered by insurance, but they are cosmetic and are not. TR 204-205.

A cash-only business is more profitable, and Dr. Goodman does not accept insurance. TR 205.

Dr. Goodman agrees that he hopes those he trains to be properly trained, successful, safe, competent, etc., but also stated that different types of words may be used in sexual medicine for the patient's understanding, including the word "fisting" and other phrases that he describes as "semantics" and understands that there are such allegations against the Respondent. TR206-209.

Counsel for the IC continued to ask questions about the appropriate use of fisting which Dr. Goodman could not answer. TR 210-212.

Dr. Goodman wasn't aware one way or another whether Dr. Chambers performed surgery on any of the three patients in this case, and he never checked to see if Dr. Chambers knows how to do labiaplasty or any of Dr. Chambers' charts or records at his office, just what he was provided to review for this case, the same way someone who trains a resident or educates doesn't follow that person into their practice and look over their shoulder. TR 212.

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Dr. Goodman testified that he was a member of ACOG until approximately two years ago when he went inactive and agrees that it is the preeminent organization that provides guidelines for general OB-GYNs but not at all for cosmetic gynecology. TR 215.

Dr. Goodman agrees with ACOG committee opinion 795 discussing risks, etc., with and making sure women considering cosmetic gynecology are properly informed, but Dr. Goodman got into research and publishing because "ACOG has their head in the sand." TR 215-217; Exhibit Q.

Dr. Goodman's testimony on pages 216-217 regarding why he quit paying dues should be read in full. TR 216-217.

Dr. Goodman testified that he does not agree with the ACOG's continuing statement in its opinion regarding cosmetic gynecological procedures and should likewise be read in full. TR 218-219.

Dr. Goodman's published work is cited in ACOG Opinion 795, "Effective Female Genital Cosmetic Surgery," TR 220; Chambers Exhibit Q.

Discussion with Dr. Goodman testified that an opinion published by the ACOG critical of one of his studies misstated and editorialized, and he "a hundred percent disagree[s] with that because it did have a control group," another reason he stopped paying dues to the ACOG. TR 222-224.

Dr. Goodman believes that it is wonderful and exemplary when a physician continues medical education, and he encourages it. TR 224.

Dr. Goodman offers "brush up" training, and only three—not including Dr. Goodman—have returned. Dr. Goodman himself went back for extra training after learning these procedures. TR 224-226.

Dr. Goodman testified that it would concern him if any doctor might propagate body dysmorphia by telling vulnerable patients that see them for medical advice and possibly surgery that they have a problem, but that he sees no evidence that Dr. Chambers acted in such a way. TR 229-230.

Regarding the taking of preoperative photos, Dr. Goodman testified that some physicians, including experts in the field such as Dr. Alinsod, take as many as 20 photos with a black velvet

background, but Dr. Goodman takes a minimum number of photos unless, with the patient's consent, he's taking more for teaching or publishing purposes, he codes them, and he takes them himself most of the time, and now uses his cell phone and transfers them to his computer, but he likes Dr. Chambers' approach and thinks it may be more secure. TR 232-233. Dr. Goodman discusses whether there's a right or better approach to taking photos, and surmises that there may be some literature on the subject, possibly with plastic surgeons, but he does not know what is right and proper. TR 234.

Dr. Goodman testified that he wouldn't solicit patients to pose nude while they're still gowned, but that doesn't necessarily mean it's inappropriate, nor would he use a poster in the bathroom to solicit models for nude photos because that is not his patient population nor his style. He would not do it, but that doesn't mean it's improper. TR 236.

Dr. Goodman agrees that most doctors don't have the same kind of knowledge as a sexual therapist, and he testified that he does indeed refer patients to a sexual therapist. TR238-239.

Dr. Goodman agrees that his courses are nowhere like a hand fellowship for an orthopedic surgeon, a comparison he used earlier in his testimony, but he educates his trainees in many areas related to sexual medicine, and it's "the best we can do in the circumstances. It's better than nothing. TR 240-241.

Dr. Goodman has never practiced in Nevada and is not familiar with the statutes and regulations. TR 241.

Respondent Dr. Chambers' Redirect of Expert Witness Dr. Goodman

Dr. Goodman does not know how many OB-GYNs have been dual trained in sexual health medicine and cosmetic GYN surgery, but he doesn't believe that there are many. TR242.

Dr. Goodman describes his practice of treating patients that come from a distance to see him, including using photos, telephone calls, videoconferencing, local physicians to see if there's a problem. TR 243-244.

Hearing Officer's Questions

With acknowledgement that Dr. Goodman did not hear testimony from any of the patients and is not a Nevada physician, and over objection, Dr. Goodman was afforded the same opportunity

as IC's expert witness to render his opinion of the instant matter after his review of the allegations and the records. His statement, like Dr. Rafael's, with follow-up questions from the IC's counsel, should be reviewed in its totality. TR 247-254.

RESPONDENT DR. CHAMBERS' REDIRECT EXAMINATION

In response to rebuttal testimony about Respondent Dr. Chambers' interactions with AVN, Dr. Chambers testified that he never dealt with Ms. Beth Noonan, AVN VP in his other dealings with AVN. Vol. IV; TR 26.

Dr. Chambers testified that there was "a plethora of communication between me and AVN dating back to 2013." *Id.*

Dr. Chambers testified regarding emails exchanged with representatives of AVN, including the following: dated January 4 and 5, 2016, from Ms. Jessie Dena, graphic designer for the AVN, regarding a copy of the ad to be used; a January 29, 2016, that he exchanged with Ms. Sara Harter, AVN Media director of sales, regarding sending Dr. Chambers his copy of the 2016 show guide featuring his ad; a contract he signed for the AVN adult entertainment expo dated December 30, 2015; a photo of his ad of the 2014 awards show program; and more. TR 26-28.

Responding to earlier questions about the National Society of Cosmetic Physicians not having a website, Dr. Chambers testified that he had not been a member since 2015; that he met Drs. Goodman, Alinsod, and Plastic, founders of and highly published in their subspecialty of cosmetic GYN surgery, at the 7th Annual Congress on Aesthetic Vaginal Surgery in 2012, sponsored by the National Society of Cosmetic Physicians, so their lack of a website was of no importance to him. TR 28-29.

Dr. Chambers testified that his staff has seen his gallery of work, before and after photos, that have been de-identified. TR 29.

Dr. Chambers testified that he has not gone back for a repeat course in cosmetic GYN surgery, as he has not gone back for a review course in how to perform a hysterectomy, a Caesarian section, or advanced operative laparoscopic surgeries because he is competent in those areas, and he's not inventing a surgical technique. *Id.*

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In response to the IC's previous questions about whether Dr. Chambers promoted body dysmorphia with the suggestion that Patient A gave Dr. Chambers her list of questions at the end of her exam, Dr. Chambers clarified that Patient A gave him the list of questions at the very beginning of her appointment and does not promote body dysmorphia. Vol. IV, TR 33; Vol. I, TR149.

Dr. Chambers restated and summarized Patient A's physical complaints and opines that it caused her significant physical and psychological trauma, which is why she was referred to him, stating "I turn away more patients than I operate on because they do not need surgery or they're depressed or they're, in fact, having body dysphoria, given the numerous cosmetic surgeries they have yet still dissatisfied with their body image. I stay clear of those people…this is the reason for my multiple office visits before the actual surgery…." Vol. IV, TR34.

Dr. Chambers testified that he is proud that he was elected to the Alpha Omega Alpha Honor Medical Society as he believes that there are not too many of such physicians working in Nevada. TR 35.

During COVID-19 in 2020 and 2021, Dr. Chamber experienced the impact on his practice, but he did not take money from the government to support his business, suffered through it and survived, making payroll even if it was difficult, even affecting his receptionist, Casey Cardin, and that is why she left. TR 35.

IC's Recross-Examination of Respondent Dr. Chambers

Counsel for the IC had questions about the timing of AVN ads in relation to the appointments of Patients A, B and C, regarding communication between Respondent Dr. Chambers and representatives of AVN, and Dr. Chambers responded to questions about the ads, testifying that he had contact with AVN, particularly emails with Sara Harter, regarding submitting ads almost every year. He responded to an ad from AVN for program submissions in 2020, but he testified that by the time he had the money and do the things to get his ad in, it was too late for the 2020 program. TR 38-40.

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Dr. Chambers testified that everyone that used the lavatory would have seen his ad offering $1000 for nude models but that he does not remember how many people talked to him about it. TR 40-41.

Counsel for the IC and the Respondent engage in discussion about Respondent Dr. Chambers' preparation of ads for various AVN publications and communications regarding the same. TR 41-47.

FINDINGS and VERACITY OF WITNESSES

It is noted that, clearly, the very nature of the facts surrounding this proceeding could indeed be upsetting and inflammatory. However, these same facts could also be interpreted differently by reasonable minds, as the experts in this matter did, and still give the utmost respect and sensitivity to the facts as described by Patients A, B, and C.

However, this must be balanced with the requirement that the facts gleaned from these proceedings are viewed without an inflammatory lens in order for all to experience a fair hearing without bias despite the nature of the allegations.

With that observation, the undersigned finds that Respondent gave credible and factual testimony and explanations for the actions leading to the allegations in the IC's Complaint.

Likewise, regarding the credibility of the expert witnesses, the undersigned found both experts to be informative and surprisingly in concert in some of their testimony, although, not surprisingly, each came to different conclusions as to Respondent's culpability as to some of his actions leading to the current allegations, as discussed in more detail below.

Regarding Patient's A, B, and C's testimony, the undersigned found each witness to be credible and compelling, yet it is noted that some of their testimony was affected by the passage of time and each witnesses' unique circumstance and subjective perception of her own experience. Indeed, and as noted before, the IC's expert witness, Dr. Rafael, clearly stated that he did not believe that Patient A had been traumatized, but that she *felt* (emphasis added) that she had been traumatized. Vol. II, TR 159.

The undersigned will make the following findings about the core issues with references to the record to be found in the transcript summary, above:

Chaperones: Much of the testimony and evidence dealt with whether the Respondent's use of a chaperone was lacking and/or insufficient. After hearing a great deal of testimony and reviewing the exhibits, the undersigned finds that, although not ideal, Respondent's use of a chaperone was adequate. Indeed, I found Respondent's testimony about the circumstances surrounding his office practice during the early days of the pandemic to be compelling and convincing in that he attempted to thread the needle to keep his patients, staff, and family -via himself- as safe as possible while adhering to a practice of having a chaperone present, or he would reschedule his patients. IC's witness Patient C testified that the Respondent always had a chaperone present during her exams. IC's witness Ms. Carden was the only witness other than the Respondent who was familiar with the regular operation of Respondent's medical practice, and, although she had difficulty remembering many things she was asked about, her testimony was mostly consistent with his. She did remember, among other things, that there were COVID-19 policies in place; that patients were rescheduled if ill; that, although not trained as a chaperone, she stood in the doorway or in the exam room; that a nurse practitioner was present toward the end of her employment as a receptionist; and that there was always a chaperone present when she had exams as a patient.

Photographs for Ads: The IC offered evidence to prove as untrue Respondent's position that he used models for nude photos to create ads for various AVN publications. To that end, evidence was offered that he hardly had contact with representatives of AVN that could lead to the conclusion that the solicitation of models for nude photos was for other reasons. However, in light of Respondent's testimony of ongoing contact with AVN throughout an approximate seven-year period that was corroborated by evidence of ads, drafts of ads, and email communication, the undersigned cannot reach the conclusion that Respondent's pursuit of models for nude photos was for nefarious purposes other than for ads promoting his practice in AVN publications, although reasonable minds can differ whether that is appropriate or not.

Solicitation of Patients B and C for nude photographs: The testimony is consistent that Respondent placed ads in the bathroom at his practice informing those who read them about his cosmetic GYN practice and procedures and his offer to pay $1000 for a nude photo shoot. The testimony is inconsistent about who raised the modeling question, with Respondent testifying that

he put the posters up in the bathroom and answered questions if posed by his patients. In contrast, Patients B and C's both testified that Respondent raised the issue of modeling for nude photos. In Patient B's case, she testified that she was still in the exam room in an examination gown and partially disrobed. There is no question that any patient in this position would feel vulnerable and exposed, both literally and figuratively. In Patient C's case, she testified that Respondent posed the question of modeling nude during a later phone call. In either case, any patient would find this to be highly unexpected and inappropriate in a regular exam situation that would undermine her trust and confidence in her physician. Although Respondent's expert Dr. Goodman stopped short of calling this practice inappropriate, stating that it depended upon how it was presented, he did testify that he would not do it in his own practice. Once again, these are "he-said-she-said" situations. However, regarding this specific issue, the undersigned found that the testimony of both Patient B and C was clear, unequivocal, and convincing.

"Fisting": There was an abundance of testimony and evidence offered on the issue of "fisting", the likelihood of fisting, and in numerous instances there was clarification that Respondent was not accused of "fisting" but of saying to Patient A that he "fisted" her, as set forth in the summary, above. The undersigned agrees with IC's expert witness Dr. Rafael, that he is aware of Patient A's allegation that she "states that Dr. Chambers talks about fisting or—it's not clear whether—exactly what he said....[b]ut she does mention the word 'fisting,' and the way I read it was that, perhaps, somehow he said, well, this isn't fisting, because she was in pain during the time of exam." Vol. II, TR 98.

Photos Taken During Exams: Neither expert, Dr. Rafael nor Dr. Goodman, were too concerned with the taking of "before-and-after" photographs, with consent. Both testified that it has become common in many specialties, but especially in cosmetic practices. Dr. Rafael testified that he did not use photos when he had an active practice. However, both experts testified about the risk of personal photos being misused or inadvertently shared and the importance of proper encryption and safeguarding of such personal photos. Dr. Goodman testified that taking multiple photos and choosing a few was accepted practice in his field.

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Thus, based on the credibility of the witnesses and the testimony rendered, I find as follows:

Count I, NRS 630.301(6), Disruptive Behavior, premised upon the taking photographs of Patient A: Based on the evidence and testimony given, the undersigned finds that the IC did not meet its burden of proof by a preponderance of the evidence that Respondent's taking of photographs for purposes of establishing documentation of before and after patient conditions amounts to Disruptive Behavior as described in NRS 630.301(6).

Count II, NRS 630.301(6), Disruptive Behavior, premised upon the allegation that Respondent told Patient A that he attempted to "fist" her: As stated above, Patient A's testimony was compelling, yet there was a great deal of conflicting testimony—a classic "he-said-she-said" situation—regarding this issue. As such, with the IC having the burden of proof, the undersigned finds that with the elements of this allegation have not been met by a preponderance of the evidence.

Count III, NRS 630.306(1)(b)(1), Engaging in Conduct Intended to Deceive, premised upon the allegation that the Respondent used four fingers to examine Patient A but documented that he used only two fingers in the medical record; both expert witnesses Dr. Rafael and Dr. Goodman agreed separately that the Respondent's medical notes were thorough, and that physicians generally do not document everything during a busy day seeing patients, this appears to be a non-issue, thus the burden of proof demonstrating that Respondent engaged in conduct that intended to deceive that would violate NRS 630.306(1)(b)(1) is not met.

Count IV, NRS 630.3062(1)(a), Failure to Maintain Proper Medical Records, premised upon the allegation that the Respondent used four fingers to examine Patient A but documented that he used only two fingers in the medical record: likewise, for the same reasons stated above in Count IV, the testimony did not support a finding that Respondent failed to maintain proper medical records by a preponderance of the evidence that would violate NRS 630.3062(1)(a).

Count V, NRS 630.301(7), Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship of a Patient for Financial or Other Personal Gain, premised upon the allegation that the Respondent offered to pay Patient B $1000 if she would pose as a nude model while she was still in the examining room; based on the evidence and testimony presented, the

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undersigned finds that the IC met its burden of proof and meets the requirements of NRS 630.301(7).

Count VI, NRS 630.301(7), Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship of a Patient for Financial or Other Personal Gain, premised upon the allegation that the Respondent offered to pay Patient C $1000 if she would pose as a nude model while she was still in the examining room: based on the evidence and testimony presented, the undersigned finds that the IC met its burden of proof and meets the requirements of NRS 630.301(7).

Count VII, NRS 630.306(1)(g), Continual Failure to Practice Medicine Properly, premised upon the allegation that "[b]y repeatedly engaging in sexual misconduct with Patients A, B, and C, as set forth above, Respondent has continually failed to exercise the skill and diligence and use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in his field of obstetrics and gynecology." *Complaint, p. 9, ll. 17-20.*

Initially, the undersigned hearing officer notes that there is not a separate allegation of "sexual misconduct." The question becomes, then, even if the basis of "sexual misconduct" is removed from consideration, did the IC prove by a preponderance of the evidence that Respondent's actions in offering $1000 to Patients A, and B while at their appointments, some still in an examination gown and partially disrobed, and Patient C later by telephone, enough to demonstrate that his "continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field"? Respondent's expert witness, Dr. Goodman, testified in the affirmative and, although he did not believe it violated the standard of practice, he would not have engaged in that practice himself. That is enough to tip the scales to find that the burden of proof has been met as to Count VII.

Count VIII, NRS 630.301(9), Disreputable Conduct, premised upon the allegation that "by repeatedly engaging in sexual misconduct and by repeatedly violating his patients' trust and exploiting his relationship with them Respondent engaged in conduct that brings the medical profession into disrepute." *Complaint, p. 10, ll1-3.*

A similar analysis is appropriate regarding Count VIII, and the result is likewise that the IC has met its burden of proof.

CONCLUSION

As required of a hearing officer, I have provided a synopsis of the testimony and have made recommendations on the veracity of witnesses if there is conflicting evidence, or the credibility of a witness is a determining factor. Accordingly, I submit that it is within the purview of the Board to determine if the charges have been established by a preponderance of the evidence. To the extent my authority allows me to weigh in on that via a determination of credibility, I submit such a burden has not been met in this matter as to Counts I-IV but has been met in Counts V-VIII alleged in the Complaint against Respondent for the reasons set forth herein.

RESPECTFULLY SUBMITTED this 21st day of August 2023.

Nancy Moss Ghusn, Esq.
Hearing Officer for the
Nevada State Board of Medical Examiners
675 West Moana Lane Ste. 170.
Reno, NV 89509

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

In the Matter of Charges and Complaint Against: Case No. 22-27891-1

GEORGE PETER CHAMBERS, M.D.,

Respondent.
_____/

TRANSCRIPT OF HEARING PROCEEDINGS

VOLUME I

Held at the Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, Nevada

Tuesday, May 2, 2023

Reported by: Brandi Ann Vianney Smith

Job Number: 974172

A P P E A R A N C E S:

THE HEARING OFFICER:	NANCY GHUSIN, ESQ. nmg416@gmail.com
FOR THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS:	BRANDEE MOONEYHAN, ESQ. DONALD K. WHITE, ESQ. Deputies General Counsel Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 mooneyhandb@medboard.nv.gov dwhite@medboard.nv.gov
FOR THE RESPONDENT:	GEORGE PETER CHAMBERS, M.D., In Pro Se
ALSO PRESENT:	MERCEDES FUENTES Legal Assistant Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 fuentesm@medboard.nv.gov

I N D E X

E X H I B I T S

RENO, NEVADA -- MAY 2, 2023 -- 1:00 P.M.

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HEARING OFFICER GHUSIN: We're on the record. And for those of you who don't know me, I'm Administrative Hearing Officer Nancy Ghusin, and this is the time and place --

THE REPORTER: I'm sorry, ma'am. I'm going to get a little closer to you. The road noise is too distracting for me.

HEARING OFFICER GHUSIN: Well, we can close it if you'd like. I'd prefer to leave it open.

We're trying to get some fresh air in here. So, we'll make some adjustments.

MR. WHITE: We can trying closing this one and opening this door.

HEARING OFFICER GHUSIN: Thank you.

All right. So, mostly for your benefit, Dr. Chambers, I know Ms. Mooneyhan has been through this numerous times, in an administrative hearing, we have relaxed rules of evidence, and I'll get to that in just a moment.

We were just having a discussion on how to swear the witness. We have witnesses siting in the back; that is correct, Ms. Mooneyhan?

MS. MOONEYHAN: We do.

HEARING OFFICER GHUSIN: Okay. We could swear every one at once. How would you prefer? Or one at a time?

MS. MOONEYHAN: I do have a plan for addressing -- one at a time. I do have a plan for having them verify their identity on the record using the patient designation that was filed under seal.

HEARING OFFICER GHUSIN: Okay. All right.

Then just a few preliminary matters, I won't worry about swearing. As I was mentioning up here, sometimes in hearings, we sware all at once.

Is anyone invoking the rule of exclusion?

MS. MOONEYHAN: Yes, Your Honor. The IC does invoke the rule.

HEARING OFFICER GHUSIN: Okay. Thank you.

A couple other matters, Dr. Chambers, since clearly you're not represented, if you have any questions, if technology's ever a problem, if you cannot understand any of the witnesses as well, please feel free to interrupt and let me know.

I'd rather stop any questioning than plow ahead and have to go back and start over again.

Do you understand, Dr. Chambers?

DR. CHAMBERS: I do.

HEARING OFFICER GHUSIN: Okay. Thank you.

Also, I don't know if this has been explained to you, but as the IC has the burden of proof by a preponderance of the evidence, the IC gets to go first and gets to go last. And so the first and last bite of the apple in questioning and in opening and closing statements.

Do you understand that, Dr. Chambers?

DR. CHAMBERS: I do.

HEARING OFFICER GHUSIN: Okay. Perfect.

You will have the opportunity to make an opening statement at the conclusion of Ms. Mooneyhan's opening statement.

Ms. Mooneyhan, I am pronouncing it correctly -- right? -- after all of our status conferences.

MS. MOONEYHAN: Yes. Thank you very much.

HEARING OFFICER GHUSIN: Okay.

She will make her opening statement on behalf of the IC. At that point, you have the opportunity either to make on opening statement at that time or reserve the right to make an opening statement before your case the chief. That will be your call.

Do you understand, Dr. Chambers?

DR. CHAMBERS: I do.

HEARING OFFICER GHUSIN: Okay. Do you have any

questions at this point, Dr. Chambers?

DR. CHAMBERS: I do not.

HEARING OFFICER GHUSIN: Okay.

Ms. Mooneyhan, any questions?

MS. MOONEYHAN: I would like to make a couple of points of order, Your Honor.

First of all, I wanted to know for the record that -- well, also I want to bring attention to your record, protecting patient likenesses.

You have some cameras in the hearing office in the south, so I just wanted to make a point -- point it out that that is in effect, and our general counsel, Deonne Contine, is here to ensure clients maintain order and maintain decorum in the hearing --

HEARING OFFICER GHUSIN: And that --

MS. MOONEYHAN: -- room.

HEARING OFFICER GHUSIN: And that -- excuse me -- order has been shared?

MS. MOONEYHAN: Yes.

HEARING OFFICER GHUSIN: So -- and the media is aware of the existence of the order; is that correct? Everyone's nodding I see. Okay. Perfect.

All right. Go ahead, Ms. Mooneyhan.

MS. MOONEYHAN: Also, a second point or order, one of our designated witnesses, Dr. Richard Rafael, he

let us know that he believes he may, very tangentially, maybe, have met you, maybe knows a family member of yours, Ms. Ghusin, and --

HEARING OFFICER GHUSIN: And I wanted to -- yeah, thank you for brining that to my attention. I think I brought that up early on. I don't know him. I recognize his name.

Yeah, I though about it, and I thought maybe it's because of Reno, and people you know.

And also for full disclosure, my brother is a retired physician, and he may know my brother.

So, I don't know if I'd recognize him. I do recognize his name, and I do remember brining that up early on in the case.

MS. MOONEYHAN: I just want to make a record of that.

HEARING OFFICER GHUSIN: Yes. Right.

MS. MOONEYHAN: We do not have any objection to you continuing, but we wanted to put it on the record.

HEARING OFFICER GHUSIN: Well, I'd want to know if Dr. Chambers -- should be aware of that.

DR. CHAMBERS: I have no objection.

HEARING OFFICER GHUSIN: Okay. And, again, I recognize his name, and I think that's all. But there may be a mutual friend, patient, family member because of

physicians in my family. Okay? I think we're all clear.

Okay, Ms. Mooneyhan, next order?

MS. MOONEYHAN: I think that's it. Although this exchange does highlight the fact that, for the sake of the court reporter, we should probably all take a pause after each statement that we make. I'm as guilty of violating that as anybody, but I just wanted to remind all of us that we need to --

HEARING OFFICER GHUSIN: Thank you.

MS. MOONEYHAN: -- wait a second --

HEARING OFFICER GHUSIN: Yes.

MS. MOONEYHAN: -- before --

HEARING OFFICER GHUSIN: And I agree. Let me know if we start speaking too quickly. I know I don't have the loudest voice also. I think I'm going to do a lot of listening.

So, Dr. Chambers, how it's going to go is Ms. Mooneyhan --

And possibly you too, Mr. White.

MR. WHITE: Yes.

HEARING OFFICER GHUSIN: -- will have questions for the witnesses.

Dr. Chambers, you'll have an opportunity to cross-examine at the conclusion of their questioning. And it'll go back and forth like that. Okay?

Objections, we may hear some. Like I said, we have the relaxed rules of evidence. You may hear me asking some questions.

My purpose here is to gather information, and I need -- I need what I need as far as writing decisions and making recommendations.

So I'll probably ask some questions too. Both the IC, and you, Dr. Chambers, will have the opportunity to follow up any of questions as well.

Do you understand, Dr. Chambers?

DR. CHAMBERS: I do.

HEARING OFFICER GHUSIN: Okay.

Ms. Mooneyhan, anything?

MS. MOONEYHAN: Nothing further. Thank you.

HEARING OFFICER GHUSIN: Okay. Did we decide to swear one at a time?

MS. MOONEYHAN: Yes. And are we going to make opening remarks before --

HEARING OFFICER GHUSIN: I was going to also ask Mr. White -- I'm sorry.

Do you have anything else to add?

MR. WHITE: I don't. Thank you.

HEARING OFFICER GHUSIN: Thank you.

Yes, please go ahead.

MS. MOONEYHAN: Thank you.

OPENING STATEMENTS

BY MS. MOONEYHAN: Keep your cell phone nearby so I could take photos of your body during your gynecological exam. During your gynecological exam, I try to do something called "fisting." Would you allow me take photos of your nude body for $1,000?

In this hearing, three patients will explain how they heard statements like this from the respondent, Dr. Chambers. All three patients were receiving gynecological care from Dr. Chambers. A situation that necessarily engenders trust and vulnerable on the part of the patients.

You will hear the affect that Dr. Chambers' behavior had on these patients and their medical care, and how such behavior reflects on the medical profession.

You will also hear how Dr. Chambers maintained his records of one of those encounters in a way that was designed to conceal his misconduct.

Johnna LaRue, the Deputy Chief of Investigations for the Board of Medical Examiners, conducted an investigation of the three patients' encounters with Dr. Chambers.

Patient A, who needed a physical to help her address uncomfortable changes to her body arising from childbirth, primarily perineal pain, will explain that

her normal gynecologist referred her to Dr. Chambers, and what happened at the resulting visit.

Patient A was nervous about meeting with the doctor regarding potentially having surgery. She was worried that she might forget the questions that she had that arose from the extensive research that she did.

She didn't want to forget them, so she carefully wrote out those questions so she would remember to ask them during her meeting with Dr. Chambers.

She was primarily there to address pain, not anything cosmetic.

After some discussion about her pain, Dr. Chambers told her to undress for a physical exam and to keep her cell phone nearby so that he could use it to take pictures of her body with it.

She wondered why he didn't have his own camera for such purposes, but she deferred to him because he's a doctor.

So she did so.

He returned to the room. Even though he was going to be performing a pelvic examination on Patient A, Dr. Chambers did not close the door to the examining room.

When patient A questioned him about this, Dr. Chambers assured her that the exam would be private.

He proceeded to perform the exam and use the patient's cell phone to take twelve photos of her vaginal and rectal areas. One of those pictures shows him inserting four fingers into her vagina.

By itself, a gynecologist inserted four fingers during a pelvic exam may be appropriate; however, this detail's important in this case because it's closely related to comments Dr. Chambers made after he examined her, which we will get to.

But first, addressing the taking of photos.

You know Dr. Chambers took twelve photos of Patient A's vaginal and rectal areas. He asked her to text him only two pictures of her vulva so that he could show her the surgery he proposed to perform on her.

She was somewhat hesitant to text the photos because they were extraordinarily intimate pictures, and Dr. Chambers did not explain any measures he was taking to ensure that they would remain secure and confidential.

He simply said, "Text these two pictures to this number, and be careful when you do, because I had another patient misdirect such photos once."

It begs the question what the other ten photos were for?

The investigator, Ms. LaRue, wrote Dr. Chambers a letter inquiring about this encounter with Patient A.

In his response to that letter, Dr. Chambers stated, in part, that his examination of Patient A showed that she had a rectocele and used his left hand to take a picture of it so, quote: "I could explain what it was and how it could be repaired."

However, this was not one of the photos he had her text him. He did not use the other ten photos or ask for that, and it's quite clear that the other ten photos were not for purposes of diagnosis for treatment.

Again, Patient A initially thought that Dr. Chambers had to take these photos for her treatment, but when it later dawned on her that he never used the other ten photos, Patient A was humiliated and felt sexually demeaned that he took them for no apparent reason, related to her medical care, and they were left on her phone.

After he was done taking photos and her physical exam was complete, Dr. Chambers left the room while Patient A dressed and then returned for more discussion.

Upon his return, he informed Patient A that during her exam, he had attempted to do something called "fisting."

Fisting is a non-medical term for a sexual act in which a person inserts and entire hand into a person's

vagina.

Patient A did not know what fisting meant, but Dr. Chambers said, "That's what I tried to do," and explained that he was only able to get his hand, quote, this far, and he showed her with his hand how he was able to insert a significant part of his hand into her vagina.

He followed up his extremely inappropriate commentary by stating that a man's penis is approximately two fingers wide, leaving Patient A feeling that her vagina was abnormally large.

She walked in believing that the pain in her perineum might be addressed, and all of a sudden, she was worried that her vagina was too large for a man's penis.

In her letter to Dr. Chambers about this matter, Ms. LaRue asked if Dr. Chambers had made these comments about fisting to Patient A.

In his response, Dr. Chambers ignored that precise question and instead misdirected by vehemently denying that he had fisted Patient A.

We trust that you will carefully look at elevations of the complaint. The IC does not accuse Dr. Chambers of fisting Patient A; it accuses him of using the sexual term in a way that humiliated and demeaned her, and interfered with the care she was there to received.

Careful review of his responses to Ms. LaRue's letter also shows that Dr. Chambers repeatedly notes the number of fingers inserted into Patient A's body, and he repeatedly states that it was one or two.

He stated that during his exam of Patient A, he inserted one finger into her vagina while palpating parts of her anatomy and asking her whether she felt pain or pressure, then inserted a second finger to check her muscle tone.

He also states that prior to her examination, he used a single packet of lubricating jelly to, quote, lubricate my two fingers.

Similarly in his record of the encounter, Dr. Chambers stated that he sized Patient A's introital opening with, quote, my two examining fingers.

Dr. Chambers stated repeatedly, again, had inserted one or two fingers into Patient A's vagina during the encounter. He never mentioned that he inserted four fingers.

However, the photos he took with Patient A's cell phone show that he did, indeed, insert four fingers. This is consistent with what he told Patient A when he brought up trying to fist her, but only being able to insert part of his hand into her vagina.

There would be no reason for a gynecologist to

have to hide the insertion of four fingers if such insertion was part of a normal pelvic examination.

However, there may, indeed, be a reason to hide it if doing so coincides to an extremely inappropriate comment to a patient that the doctor had tried to fist her.

Dr. Chambers's record of the encounter and this explanation to Ms. LaRue were inaccurate and deceptive and in order to conceal the highly unprofessional part of the encounter.

Just like with the unnecessary pictures or her cell phone, Patient A was humiliated and sexually demeaned at being told the doctor had tried to fist her and was able to insert a significant part of his hand to her vagina.

She felt embarrassed and demeaned by what he told her.

Another notable element of Dr. Chambers' response to Ms. LaRue was him mentioning the presence of a chaperone. He alleged that a chaperone was present and that she could refute Patient A's description of the encounter.

However, the alleged chaperone will testify that she not in the room during the exam while she was nearby working on files, and, again, he did leave the

door open during the exam.

The alleged chaperone did not hear the particulars of the conversation between Dr. Chambers and Patient A.

You'll also hear from Patient B, who was a patient of Dr. Chambers for several years until their last encounter in October of 2018.

Patient B will explain that after that exam with Dr. Chambers, he asked other staff there that were present to leave the room, leaving just she and Dr. Chambers in the room.

While it was just two of them, Dr. Chambers asked her if she would model nude for photos to be taken by him, and that he would pay her $1,000 if she did so.

He offered to give her a copy of the photos, but that she should not tell her husband that he was the one that took the photos.

While Dr. Chambers refutes the details of how this offer was presented to Patient B, he does not dispute that he offered $1,000 to a patient to model for an ad he allegedly hoped to create.

Patient C will explain a very similar encounter when Dr. Chambers also offered her $1,000 to model for one of his ads.

Again, Dr. Chambers refutes the details, but,

again, he does not dispute the key fact that he offered the patient $1,000 to model nude for an ad.

Making such offers in the middle of medical encounters violated the patient relationship with these patients, it violated these patients' trust in their doctor, and it was done in order to realize a personal gain for himself.

Finally on behalf of the IC, you will hear from Dr. Richard Rafael, who has been a licensed gynecologist in Nevada since 1985, and who will testify about his review of the records in these cases and his familiarity with what is appropriate in a patient encounter with a gynecologist, as well as his study of authorities on sexual misconduct by physicians in general and gynecologists in particular, and the conclusions that he draws when applying that knowledge to what happened to these three patients.

As an OB-GYN, Dr. Chambers encounters patients in an especially vulnerable position. Doctors and patients have a special relationship. Patients trust physicians with their health. They are dependent on doctors to use their extensive education and experience to keep them healthy or help address any threats to their health. There is an inherent imbalance of power.

ACOG, which is the American College of

Gynecologists, is the prestigious, professional association for OB-GYNs. Both Dr. Chambers and Dr. Rafael are members.

ACOG has issued a formal opinion stating that the relationship between OB-GYNs and their patients requires a high level of trust and responsibility because the practice of gynecology, quote:

> "Includes interactions in times of intense emotion and vulnerability for patients, involves sensitive physical examination, and medically necessary disclosure of private information about sexual experience."

In that same opinion, ACOG explains that sexual improprieties, such as behavior, gestures, or expressions that are sexually suggestive, disrespectful of patient privacy, or sexually demeaning are a form of sexual misconduct.

Dr. Chambers' behavior with Patient A, Patient B, and Patient C was sexually suggestive, disrespectful of their privacy, and sexually demeaning, and he therefore engaged in sexual misconduct as defined by ACOG.

In so doing, he also violated several of the patients under Nevada's Medical Practice Act.

Dr. Chambers identified his witnesses as Dr. Michael Goodman, who was designated in part as being expected to testify as an expert in female genital plastic and cosmetic surgery.

Notably, none of these patients in these matters has genital plastic or cosmetic surgery, and that is not what we're talking about in this case.

Dr. Goodman is also going to apparently testify about Dr. Chambers' training and his character.

Dr. Chambers also identified three patients who apparently had better experiences with him than did Patient A, Patient B, and Patient C.

However, these patients were not present during his encounters with Patient A, Patient B, and Patient C, and they likely cannot shed much light on those encounters.

The evidence will show that Dr. Chambers fundamentally disregarded the boundaries between a physician and patient that are required. Not suggested, not strongly encouraged, but required by his profession.

We are confident that the evidence in this matter will support an eventual finding that Dr. Chambers violated the Medical Practice Act in each of the ways

alleged in the formal complaint.

Thank you.

HEARING OFFICER GHUSIN: Thank you.

Dr. Chambers, do you choose to make an opening statement at this time, or do you reserve it until later?

DR. CHAMBERS: Now.

HEARING OFFICER GHUSIN: Okay. Thank you.

BY DR. CHAMBERS: Good afternoon, Ms. Ghusin, members of Board, and counsel for the Board.

The complaint filed against me by the Board on September 21, 2022, contains allegations of rape. Although it may read as if facts have established, they have not.

Please consider that I'm innocent until proven guilty, and just like any other American, I deserve the benefit of the doubt until proven otherwise.

Vagina whisperer OB-GYN accused of sexual misconduct by the medical field.

This is what media wants people on the world-wide web to believe about me. The nickname "vagina whisperer" was given to me 16 years ago by a well-respected, local perinatologist in response to a nurse who jokingly complained that I had taken two hours to repair my patient's extensive obstetrical laceration.

My response to the nurse was that the time I

took was to ensure that there would be no scarring or sexual disfunction.

Although the complaint did not charge me with any sexual misconduct, it incriminated me in having been seductive, sexually aggressive, and sexually demeaning toward Patients A, B, and C.

In the eyes of the Investigative Committee, my role as a cosmetic gynecological surgeon was seen as a depraved means to allegedly sexually victimize women.

Sexual deviance just don't form over night.

I have served the women of this community for over two decades. In all those years, the main complaint about me was the long wait time in my office, with those same patients complimenting my skills as an OB-GYN.

The Investigative Committee order me to go for psychiatric evaluation. The psychiatrist, who was chosen by the Board said, quote:

> "It is my professional opinion to a reasonable degree of psychiatric probably that Dr. Chambers does not suffer from a psychiatric condition which would impair his ability to reasonably and safely practice medicine within his specialty of

choice."

I am not the monster that they want you to believe I am. I am George Peter Chambers, Jr., medical doctor, fellow of the American College of Obstetrician and Gynecologists.

I am here to proclaim my innocence so that I may continue to work as physician in my chosen specialties. So I may continue to give my children the life and education that promised them on the day of their birth.

I'm here to clear my name, which was given to me by my late father, and whose name I passed on to my son.

I received the calling to become a physician when I was ten years old. I'm a board-certified OB-GYN, with a quarter century of experience. And for almost a decade, I've been a certified sexual health clinician, as well a trained cosmetic GYN surgeon.

I am not an abuser of women.

I am the doctor who picked up a patient who started having a miscarriage in my office and still hemorrhaging with a liter of blood whilst in my bathroom, my office lavatory.

After the 911 operator told me that an ambulance would arrive in ten minutes, I thought that was

absurd, as there were ambulances in the parking lot below my office window. Ten minutes would be long, too long, for an actively hemorrhaging patient.

In front of my former employer, Dr. Nader Abdelsayed, I picked up my patient into my arms, carried her down a flight of stairs, then ran with her in my arms across the parking lot into the ER at North Vista Hospital, where she stabilized. I then performed an emergent dilation and curettage.

I am the doctor who persuaded paramedics who had brought in a laboring, pregnant woman who was 25 weeks pregnant into North Vista Hospital to take her to Valley Hospital Medical Center for a higher level of prenatal care.

They were afraid, but I promised to drive behind the ambulance and that I would pull over with them on the side of the freeway to deliver the baby if necessary. Dr. Ravi Krishnan, neonatologist, agreed to follow behind me. We delivered her baby safely at Valley Hospital an hour after we had arrived.

I am the doctor who rescued a pregnant patient who came into my office freshly battered and bruised. I protected her from an abusive partner by escorting her out of my office private entrance, took her to the hospital where her labor was induced. I then helped her

to make arrangements to return to her family in Puerto Rico.

I am the man who has sponsored the Cup Cake Girls. This is a local group that helps individuals in all rounds of the sex industry, including those who have been sex trafficked.

I am the doctor who, after delivering my patient's baby, I was we getting into my car at 0200 house one night, when I noticed the labor nurse running towards me in the parking lot whilst yelling out my name. Apparently, I was in only OB-GYN in the hospital at said hour of the night, another OB-GYN's patient that experienced an umbilical cord prolapse, there was no anesthesiologist in house, and the patient's OB-GYN was 20 minutes away, I performed an emergency cesarean section, using local anesthesia. The baby was saved.

I didn't do it for the money or glory; I did it because it was the right thing to do. And I did it without fear.

There are countless examples of my good deeds as a physician.

Dedicating my life to the service of women's health was my way of honoring my heros. They are my late great grandmother who taught me courage, my 99-year-old grandmother who continues to teach me perseverance, my

mother who continues to teach me about the power of forgiveness and generosity, as well as my undergraduate adviser, Dr. (indubible), chair of the chemistry department at the American University in Washington DC, who opened many doors of opportunity for me.

At a certain points during my tenure here in Las Vegas, I started getting patients who wanted their vagina restored to their pre-childbirth status.

My research showed that this was becoming a world-wide trend. These patients reported sexual dysfunction from their sensation of having vaginal laxity or a lifelong problem with enlarged or asymmetric labia minora.

I even had patients who were requesting hymenal restoration for cultural reasons. And for some, it was a matter of life or death.

There's a plethora of data that shows that a woman's comfort with the appearance of her breasts, vulva, vagina, and buttocks directly correlates with her comfort with sexual intercourse.

I saw the link between cosmetic GYN surgery and sexual health. I decided I would pursue a subspeciality in this niche market.

As a board-certified OB-GYN, I was already trained in pelvic neuroanatomy and surgery. But I

realized in residency training, OB-GYNs got little to no training in plastic surgery techniques or female sexual health.

The American College of Obstetricians and Gynecologists, in its practice bulletin number 213, published July, 2019, stated, quote:

> "Although female sexual dysfunction is relatively prevalent, women are unlikely to discuss it with their healthcare providers unless asked, and many healthcare providers are uncomfortable asking for a variety of reasons, including lack of knowledge and training."

At great financial expense, I went for post-residency training. Firstly, I attended the Seventh Congress on aesthetics of vaginal surgery, sponsored by Dr. Red Alinsod, one of the pioneers in cosmetic GYN surgery, and the National Society of Cosmetic Physicians on October 20 and 21 of 2012.

I attended lectures by Dr. Alinsod and Dr. Michael Goodman, my expert witness and another pioneer in cosmetic GYN surgery.

Secondly, I enrolled in the sexual health

certification program through the American Academy of Antiaging Medicine, on July 2nd, 2012. The training concluded on December 14, 2013.

Thirdly, in November of 2013, I enrolled in Dr. Goodman's female genital plastic cosmetic surgery masters course to learn plastic surgery techniques to close the skin, options in labiaplasty, safe ways to perform clitoral reduction, appropriate suture selection, and how to do these surgeries under local anesthesia.

Dr. Goodman has edited one of the two -- or the only two available textbooks in cosmetic GYN surgery. He has written many articles in peer review journals on the topic, and has written two chapters in a plastic surgery textbook.

He will describe his training course, the fundamental differences between cosmetic GYN surgery and general gynecological surgery, as well different ways in which we size or measure patients in the two fields.

It has been alleged that had I attempted to fist Patient A. Fisting is a sexual kink in which a person inserts his or her entire hand in a woman's vagina.

I don't do this in my personal life. I'm in the business of vaginal restoration and preservation. Fisting has the potential of harming a woman's pelvic

floor.

In fact, in my 25 years as an OB-GYN, the only time that I've ever inserted by entire hand in a woman's vagina professionally is to remove or retain placenta after vaginal delivery of a baby.

The procedure is a one that I absolutely detest because failing is not an option. Failure could be catastrophic. Failure could lead down a path to an emergency hysterectomy or maternal death due to postpartum hemorrhage.

My notes, which were handwritten in shorthand during the consultation with Patient A, were typed either later that day or a couple of days after the consultation.

When I typed the consultation note, I used the two photographs that Patient A had texted me to describe the examination and my findings.

When I appeared before the Investigation Committee, well over a year after the consultation, I was asked if I had inserted four fingers into Patient A's vagina. I said, "No." Not because I was willingly misleading the IC, but because I genuinely could not recall doing so.

I should have taken some time to think about the question before answering. But I said "no" because

attempted fisting was the accusation against me.

I only had two photographs, one of which showed my fingers separating her vaginal introitus or opening. It wasn't until the discovery phase of this case that I saw the photograph showing my four fingers in Patient A's vaginal introitus that I recalled doing so.

It was alleged that I took 12 photographs for self-serving reasons. I took those photos the way I take pictures of my family, that is, I pressed the shutter release button in rapid succession, thereafter, I look at the photos, and keep the best ones. And I take the pictures while moving my hand from side to side across the targeted area.

My second witness, Ms. Brittany Turner, who's an adult entertainer, will address this kink. I will show through her testimony that I did not attempt to fist Patient A, had I tried to do so, my chaperone would have seen and heard her scream in pain.

Ms. Mooneyhan and her cocounsel will tell you that my examination of Patient A was not chaperoned. My examination was chaperoned. The chaperone might not have been standing inside the room, but the examination was chaperoned.

Historically, it has been taboo for an OB-GYN to market his or her medical practice while I also

subspecialize in cosmetic GYN surgery.

If it is legal or ethical for a plastic surgeon to market his or her practice, why is it that the same privilege is not afforded a cosmetic GYN surgeon in Nevada?

If you walk into a plastic surgeon's office, you will see a gallery of before and after surgical photographs. Yet the IC made it appear as if the photographs that I have taken were pornographic.

Pre- and post-operative photographs are necessary for medical, legal, educational, and marketing purposes. This was not pornography, as the public has been led to believe. The photographs were taken after consent is obtained.

It is not illegal or unethical to pay a woman or models to pose for my marketing materials. I did not hire modeling for my marketing photos with exchange for any medical favors.

Sex is at the core of our existence. Sex is at the core of our evolution. Sex is necessary for us having good emotional, mental, and physical health. Therefore, when there is a sexual health problem, it is significant.

The questions that must be asked of a patient seeking consultation for sexual dysfunction and sexual

pain may be perceived as intrusive. They may be seen as taboo, especially when asked by a male OB-GYN.

But these patients are referred to me because their OB-GYNs are not trained to treat these problems.

According to the textbook, Female Genital Plastic and Cosmetic Surgery, published in 2016 and edited by Dr. Goodman, quote:

"Proper preoperative evaluation is a vital process for a patient who presents with an interest in surgery to repair what she conceives is a loose or relaxed vagina, and would like it tightened for sexual enhancement and to correct the feeling of having a wide-open vagina.

"This includes proper medical history, psychosocial evaluation for sexual dysfunction and overall sexual satisfactions prior to any of the anatomical changes she may have noted since childbirth.

"Marital or relationship issues or concerns and an evaluation of

her expectations of surgery and a reason why she's interested in the procedure should be discussed as well.

"An adequate urogynecological history and physical examination must be completed."

Am I allowed to give you an exhibit at this time during the opening --

HEARING OFFICER GHUSIN: Dr. Chambers --

DR. CHAMBERS: -- statement?

HEARING OFFICER GHUSIN: Dr. Chambers, this is just the opening.

So it will be IC's turn to put on their case in chief. And then it will be your turn, and you can introduce exhibits then.

DR. CHAMBERS: Thank you.

HEARING OFFICER GHUSIN: Anything to add, Ms. Mooneyhan?

MS. MOONEYHAN: No. Thank you.

BY DR. CHAMBERS: I do not ask these questions for my personal pleasure. They are asked so that I may develop proper differential diagnoses and treatment plans.

Likewise, the pelvic examination that is done

to examine a patient with sexual dysfunction and pelvic pain is more thorough than the usual pelvic examination done at a gynecological visit for an annual.

In general, I talk to my patients before I touch them to avoid any surprise reaction. I educate them about why I'm doing what I do.

I should not be penalized nor have my name and character besmirched for doing what I am supposed to do to help my patients.

In 2014, after A four M had made the online training an option for sexual health certification program, I tried to convince a couple female OB-GYNs to do the program because not every woman would be comfortable seeing a male sexual health clinician.

One, whom I will not name, had a nervous laughter. The other, Dr. Joana Folayan, expressed interest, and I gave her the A four M contact information. I don't know if she did the course.

It is my hope that you'll see that this has been one big misunderstanding, one that has tarnished my once-stellar reputation, and has cost my dearly.

My medical practice has been decimated. I was fired from a lucrative nighttime laborious job with Intermountain Healthcare.

One local media outlet even has a TikTok video

on its website, soliciting my patients to come forth to say I sexually abused them.

I have been interviewed by detectives from the Las Vegas Metropolitan Police Department, yet I have not been arrested.

I've been the subject of a grand jury subpoena, yet I've not been indicted.

My life has been hell for the past seven months. I believe in the American justice system. I believe in this Board. Before for these proceedings are over, and after all the facts in this case are known, I believe that you will see that I'm innocent of charges against me.

Thank you for your time and attention.

HEARING OFFICER GHUSIN: Thank you.

Ms. Mooneyhan?

MS. MOONEYHAN: Thank you. The IC would call Johnna LaRue.

HEARING OFFICER GHUSIN: And we had spoken previously about the rule of exclusion, and I should explain that to Dr. Chambers.

Ms. Mooneyhan, do you have any comments on that?

MS. MOONEYHAN: No. Ms. LaRue is not currently in the room. So we will need a second for somebody to go

get her.

Just so Dr. Chambers knows, if any his witnesses are in the room, they should --

HEARING OFFICER GHUSIN: I don't know who's in room. Are there any witnesses in the room?

MS. MOONEYHAN: None of the IC's witnesses are in the room.

DR. CHAMBERS: None of mine are here.

HEARING OFFICER GHUSIN: Okay. Let's go ahead and get your first witness, then.

MS. MOONEYHAN: Thank you.

MS. FUENTES: Can you hear okay? I know there's a lot of planes.

THE REPORTER: When the planes go over, it's difficult.

MS. FUENTES: Just let us know if it's too much.

HEARING OFFICER GHUSIN: Is it okay?

THE REPORTER:

Not when the planes go over.

MS. FUENTES: I worried when the ambulance went by.

THE REPORTER: Yes. That was difficult.

MS. FUENTES: Well, just let us know, because we need our record.

HEARING OFFICER GHUSIN: Do you need it closed?

THE REPORTER: I would prefer for it to be closed, yes.

HEARING OFFICER GHUSIN: I will have to wear a mask if that's the case.

MS. MOONEYHAN: Ms. LaRue's here, Your Honor.

Ms. Ghusin, can you hear us?

HEARING OFFICER GHUSIN: Yes.

MS. MOONEYHAN: Okay. Ms. LaRue is here and ready to be sworn in.

HEARING OFFICER GHUSIN: Okay. She's in the room?

MS. MOONEYHAN: Yes. At the end of the table.

HEARING OFFICER GHUSIN: Okay. Thank you.

(The oath was administered.)

THE WITNESS: I do.

DIRECT EXAMINATION

BY MS. MOONEYHAN:

Q. Ms. LaRue, for the record, will you please state and spell your first and last name.

A. Johnna LaRue. J-O-H-N-N-A L-A capital R-U-E.

Q. Ms. LaRue, how are you employed?

A. By the Nevada State Board of Medical Examiners.

Q. What is your title at the Nevada State Board of Medical Examiners?

A. Deputy Chief of Investigations and Compliance Officer.

Q. How long have you worked for the Board of Medical Examiners?

A. Seventeen years.

Q. Can you describe, in general, the process when an investigation, how it lands on your desk?

A. We get complaints either in paper or through our website. They come in. As deputy chief, I'm one of the people that reviews those complains to determine violations. Then they get assigned to an investigator where we go through process of reviewing the allegations, sending out a letter to the physician of the allegations that were based in the complaint, we require a response.

If medical record are required based on whatever the allegations are in the complaint, then we gather the medical records.

We get all the information and then put that forward for our Investigative Committee to make a decision.

There's a lot more to it, but that's in general.

Q. Are you familiar in the formal complaint that was filed in this matter regarding Dr. Chambers?

A. Yes.

Q. Did you conduct the underlying investigation with respect to Patient A?

A. Yes.

Q. I'm going ask you to turn to Exhibit 1 in that binder in front of you.

A. (Witness complied).

Q. Do you recognize that document?

A. Yes.

Q. Can you describe what it is?

A. This is the allegation letter that I prepared based on the complaint that I received.

Q. Just is to clarify, with respect to Patient A?

A. With respect to Patient A, yes.

Q. What is the date of that document?

A. September 2nd, 2021.

Q. And who signed the document?

A. I did.

Q. Is this document that's in your binder a true and correct copy of the letter sent?

A. Yes.

MS. MOONEYHAN: Your Honor, I move to admit Exhibit 1.

HEARING OFFICER GHUSIN: Thank you.

Dr. Chambers, any objection?

DR. CHAMBERS: None.

HEARING OFFICER GHUSIN: IC's Exhibit 1 will be admitted into evidence.

(IC's Exhibit 1 was admitted.)

BY MS. MOONEYHAN:

Q. On page NSBME 2, will you please review -- and you don't need to read it out loud, will you please review items that you noted on that page 13 and 14.

A. Yes.

Q. Did you ask Dr. Chambers -- accuse Dr. Chambers of fisting Patient A?

A. Yes.

Q. Did you accuse him of using the term "fisting"?

A. Yes.

Q. And that -- it appears that -- did that appear to have actually happened or something less than that that he was accused of that day?

A. Based on the evidence that we gathered, it appears that that's the case.

Q. Can you turn to Exhibit 2, please?

A. (Witness complied).

Q. Do you recognize that document?

A. Yes.

Q. What is it?

A. This is a response to my letter.

Q. What is the date of this document?

A. January 20, 2022.

Q. Is that a document on letterhead?

A. Yes.

Q. And what does the letterhead say?

A. Chambers and Associates. Do you want me to read the rest?

Q. No. Who sign the document?

A. George Chambers, MD.

Q. Is that a true and complete copy of the letter you received regarding the allegations?

A. Yes.

MS. MOONEYHAN: I move to admit Exhibit 2.

HEARING OFFICER GHUSIN: Dr. Chambers, any objection?

DR. CHAMBERS: No objections.

HEARING OFFICER GHUSIN: IC's Exhibit 2 is admitted into evidence.

(IC's Exhibit 2 was admitted.)

BY MS. MOONEYHAN:

Q. Ms. LaRue, in this letter, did Dr. Chambers admit to taking more photographs of Patient A than he actually printed out that day?

A. Yes.

Q. And how many photographs did -- do you believe that Dr. Chambers took of Patient A's vaginal rectal area

that day?

A. Twelve.

Q. And how many did he ask her to text, according to his letter?

A. Two.

Q. Will you please turn to Exhibit 3.

A. (Witness complied).

Q. Do you recognize Exhibit 3?

A. Yes.

Q. What does Exhibit 3 appear to be?

A. These are Patient A's medical records.

Q. And how did you become familiar with these records?

A. They were submitted with Exhibit 2 from Dr. Chambers.

Q. And does this appear to be a complete copy of what you received from Dr. Chambers regarding Patient A?

A. This is a complete copy of what I received from Dr. Chambers, yes.

MS. MOONEYHAN: Move to admit Exhibit 3.

HEARING OFFICER GHUSIN: Dr. Chambers, any objection?

DR. CHAMBERS: I have no objection.

HEARING OFFICER GHUSIN: Okay. IC's Exhibit 3 is admitted into evidence.

Thank you.

(IC's Exhibit 3 was admitted.)

BY MS. MOONEYHAN:

Q. I ask you to turn to Exhibit 4.

A. (Witness complied).

Q. Do you recognize what Exhibit 4 is?

A. Yes.

Q. And can you briefly describe what Exhibit 4 is?

A. These are the 12 photographs that were taken.

Q. That were taken?

A. On the patient's cell phone by Dr. Chambers.

Q. How did you come into this evidence?

A. Patient A sent them to me directly.

Q. Do those appear to be true and correct copies of the photos that she provided to you as part of this investigation?

A. Yes.

MS. MOONEYHAN: Move to admit Exhibit 4.

HEARING OFFICER GHUSIN: Dr. Chambers, same question, any objection to the --

DR. CHAMBERS: I have no objection.

HEARING OFFICER GHUSIN: IC's Exhibit 4 is admitted into evidence.

(IC's Exhibit 4 was admitted.)

BY MS. MOONEYHAN:

Q. Ms. LaRue, are you familiar with Dr. Chambers' ex-wife?

A. Well, "familiar" wouldn't be the appropriate word.

Q. Are you -- have you ever spoken to her?

A. Once.

Q. Did you speak to her about our investigation of his encounter -- Dr. Chambers' encounter with Patient A?

A. No.

Q. Did she have any input at all into your investigation of Patient A?

A. No.

Q. Did you also conduct the underlying investigation with respect to Patient B?

A. Yes.

Q. Please turn to Exhibit 5.

A. (Witness complied).

Q. Do you recognize Exhibit 5?

A. Yes.

Q. What does it appear to be to you?

A. This is the allegation letter that I compiled based on the complaint that I received from Patient B.

Q. And what is the -- on that document, what is the date?

A. February 3rd, 2022.

Q. And who signed this document?

A. I did.

Q. Does this appear to be a true and complete copy of the letter to Dr. Chambers regarding the investigation with respect to Patient B?

A. Yes.

MS. MOONEYHAN: Move to admit Exhibit 5.

HEARING OFFICER GHUSIN: Any objection, Dr. Chambers?

DR. CHAMBERS: None.

HEARING OFFICER GHUSIN: Thank you.

IC's Exhibit 5 is admitted into evidence.

(IC's Exhibit 5 was admitted.)

BY MS. MOONEYHAN:

Q. Let's turn to Exhibit 6.

A. (Witness complied).

Q. Do you recognize that document?

A. Yes.

Q. What is Exhibit 6?

A. This is Dr. Chambers' response to Exhibit 5 in regards to Patient B.

Q. And what is that date of that response?

A. March 17th, 2022.

Q. And what indicia do you have that it came from

Dr. Chambers?

A. It's letterhead is Chambers and Associates, and Dr. Chambers' signature is on it.

Q. Does this letter appear to be true and complete copy of the letter you received from Dr. Chambers regarding -- in response to your letter about Patient B?

A. Yes.

MS. MOONEYHAN: Move to admit Exhibit 6.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: I have no objection.

HEARING OFFICER GHUSIN: IC's Exhibit 6 is admitted into evidence.

(IC's Exhibit 6 was admitted.)

BY MS. MOONEYHAN:

Q. Ms. LaRue, in Exhibit 6, does Dr. Chambers admit to offering Patient B money for nude photographs?

A. Yes.

Q. Did you ever speak to Dr. Chambers' ex-wife about your investigation of his encounter with Patient B?

A. No.

Q. Did she have any input at all into that investigation?

A. No.

Q. Please turn to Exhibit 7.

A. (Witness complied).

Q. Do you recognize Exhibit 7?

A. Yes.

Q. And what does it appear to be?

A. These are Patient B's medical records.

Q. Just to clarify, are those Patient B's medical records from Dr. Chambers?

A. Yes.

Q. How did you come into possession of those records?

A. Dr. Chambers sent them to me with his response in regards to Patient B.

Q. And what in Exhibit 7 -- does that appear to be a correct and complete copy of the records you received from Dr. Chambers regarding Patient B?

A. Yes.

MS. MOONEYHAN: Move to admit Exhibit 7.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: I have no objections.

HEARING OFFICER GHUSIN: IC's Exhibit 7 is admitted into evidence.

(IC's Exhibit 7 was admitted.)

BY MS. MOONEYHAN:

Q. Ms. LaRue, did you also conduct the investigation -- the underlying investigation with respect to Patient C?

A. Yes.

Q. Will you please turn to Exhibit 8.

A. (Witness complied).

Q. Do you recognize that document?

A. Yes.

Q. And what is it?

A. This is the allegation letter that I compiled based on the complaint that was received in regards to Patient C.

Q. And what is the date of letter?

A. February 17th, 2022.

Q. And does this appear to be a true and correct copy of the letter you sent to Dr. Chambers regarding the investigation of Patient C?

A. Yes.

MS. MOONEYHAN: Move to admit Exhibit 8.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: I have no objections.

HEARING OFFICER GHUSIN: Okay. IC's Exhibit 8 is admitted into evidence.

(IC's Exhibit 8 was admitted.)

BY MS. MOONEYHAN:

Q. I'll ask you now to turn to Exhibit 9.

A. (Witness complied).

Q. Do you recognize Exhibit 9?

A. Yes.

Q. And what is Exhibit 9?

A. Exhibit 9 is Dr. Chambers' response to my letter in regards to Patient C.

Q. What is the date of letter?

A. March 17th, 2022.

Q. And what makes you believe it is from Dr. Chambers?

A. It's on Chambers and Associates letterhead, and it's signed by Dr. Chambers.

Q. And that, Exhibit 9, is a true and complete copy of the letter you received?

A. Yes.

MS. MOONEYHAN: Move to admit Exhibit 9.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: I have no objections.

HEARING OFFICER GHUSIN: IC's Exhibit 9 is admitted into evidence.

(IC's Exhibit 9 was admitted.)

BY MS. MOONEYHAN:

Q. Ms. LaRue, in Exhibit 9, in Dr. Chambers' response, did he admit to offering Patient C $1,000 to take nude paragraphs of her?

A. Yes.

Q. Could you turn to exhibit 10?

A. (Witness complied).

Q. Do you recognize Exhibit 10?

A. Yes.

Q. And what is it Exhibit 10?

A. These are Patient C's medical records.

Q. How did you come into possession of those records?

A. Dr. Chambers included them with his response in regards to Patient C.

Q. That appears to be a true and complete copy of the records that Dr. Chambers sent to you?

A. Yes.

MS. MOONEYHAN: Move to admit Exhibit 10.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: I have no objections.

HEARING OFFICER GHUSIN: IC's Exhibit 10 is admitted into evidence.

(IC's Exhibit 10 was admitted.)

BY MS. MOONEYHAN:

Q. Ms. LaRue, did Dr. Chambers' ex-wife have any input into your investigation of Patient C?

A. No.

MS. MOONEYHAN: May I have a moment, Your Honor?

HEARING OFFICER GHUSIN: Yes. Thank you.

MS. MOONEYHAN: Thank you.

HEARING OFFICER GHUSIN: Maybe I'll take a quick moment too.

Mr. White, I checked into those in the room in the south end, but in the north end, anybody here that is a witness?

MR. WHITE: No, they're not.

HEARING OFFICER GHUSIN: Okay. Thank you.

MS. MOONEYHAN: I have no further questions of Ms. LaRue at this time.

HEARING OFFICER GHUSIN: Thank you, Ms. Mooneyhan.

Dr. Chambers, any questions for Ms. LaRue?

DR. CHAMBERS: I do.

CROSS-EXAMINATION

BY DR. CHAMBERS:

Q. Ms. LaRue, good afternoon. You said that, in questioning, that it appears that I fisted Patient A?

MS. MOONEYHAN: Objection. Your Honor, that is not what Ms. LaRue testified to. She said that it appeared.

HEARING OFFICER GHUSIN: If you rephrase your question, Dr. Chambers.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

Q. You said that it appeared that I fisted Patient A. What makes you draw that conclusion?

A. The photographs that I received from the patient.

Q. Okay. Do you know what fisting is?

A. Yes, I do.

Q. What is the definition of fisting to you?

A. Putting one's hand inside of another's -- inside a woman's vagina.

Q. Part of the hand? All of the hand?

A. Part of the hand -- well, most of the hand, I would say. I mean, I don't know if you can do a gesture, but four fingers or more would be considered -- what I would -- what I would consider personally as fisting.

Q. Okay. Thank you.

DR. CHAMBERS: I have no further questions.

HEARING OFFICER GHUSIN: Ms. Mooneyhan?

MS. MOONEYHAN: No redirect, Your Honor.

HEARING OFFICER GHUSIN: Okay.

Thank you, Ms. LaRue.

Is she subject to recall, Ms. Mooneyhan?

MS. MOONEYHAN: Yes, Your Honor.

HEARING OFFICER GHUSIN: Okay. Thank you.

Next witness, please.

MS. MOONEYHAN: I would like to call Dr. Chambers.

HEARING OFFICER GHUSIN: Would you like him up at the table?

MS. MOONEYHAN: Yes. Please.

HEARING OFFICER GHUSIN: Okay. Dr. Chambers, please.

And let's take a quick look at the time. It's 2 o'clock straight up. Does anyone need a break when we're an hour into it or can you go a little bit farther?

MS. MOONEYHAN: I think we're okay down here.

HEARING OFFICER GHUSIN: Are you good?

THE REPORTER: I wouldn't mind taking five minutes.

HEARING OFFICER GHUSIN: Okay. Let's take a quick break. Thank you.

MS. MOONEYHAN: Five to ten minutes, Your Honor?

HEARING OFFICER GHUSIN: Yes. No more.

(Recess from 2:02 P.M. to 2:11 P.M.)

HEARING OFFICER GHUSIN: Back on the record. Mr. Mooneyhan, Dr. Chambers, can you hear me?

DR. CHAMBERS: I can.

HEARING OFFICER GHUSIN: Okay. Perfect.

We're back on the record in the matter of

Dr. Chambers, who is ready to testify at this point.

Just that -- we were just talking up here about what it looked like the rest of afternoon, Ms. Mooneyhan. And the first thing is I would probably like a break every hour at an opportune moment, not in the middle of testimony or anything.

And if we're good to go to 5:00 to help us out tomorrow, great, even if -- we'll take a look when you're finishing up with your witness. We may just clearly go to 5 o'clock at this point. Okay?

MS. MOONEYHAN: Okay. Thank you.

HEARING OFFICER GHUSIN: Thank you.

MS. MOONEYHAN: May I proceed, Your Honor?

HEARING OFFICER GHUSIN: Dr. Chambers, you haven't been sworn in yet?

DR. CHAMBERS: I have not.

(The oath was administered.)

THE WITNESS: I do.

HEARING OFFICER GHUSIN: Thank you.

Ms. Mooneyhan?

DIRECT EXAMINATION

BY MS. MOONEYHAN:

Q. Sir, can you please state your full name and spell your last name for the record?

A. George Peter Chambers, Jr., C-H-A-M-B-E-R-S.

Q. And are you a licensee of the Nevada State Board of Medical Examiners?

A. I am.

Q. How long have you been so licensed?

A. Since April of 2003.

Q. Have you ever been licensed in another jurisdiction?

A. Yes.

Q. And where was that?

A. Colorado and New York.

Q. When were you licensed Colorado?

A. I believe 2003 to 2008. I might be off by a year or two.

Q. Why are you no longer licensed in Colorado?

A. I decided that I was not going to live in Colorado, so I didn't continue paying for the membership -- the license.

Q. And when were you licensed New York?

A. 1998 through, I believe, 2008 or '10.

Q. And why are you no longer licensed in New York?

A. I decided I was not going to move back to New York, so there was no point in maintaining the license.

Q. Can you please turn to Exhibit A. It's marked as number 1 behind the blue sheet of paper.

A. Yes.

Q. Is this your CV?

A. It is a portion of my CV. I do have a current version if you'd like a copy.

Q. Is this the version that you submitted as an exhibit?

A. Yes, it is.

Q. What has changed since this CV?

A. I was fired from Intermountain Healthcare. It's not listed here as former -- I don't think it's on here. It was not listed on here that I worked for them, in this version.

Q. So is this a current version?

A. The current version I have. It feels like it.

Q. Okay. You said you submitted this version?

A. Correct.

Q. The only thing that's different --

A. Intermountain is not listed.

Q. And you said it's not listed --

A. Here.

Q. This is not --

A. It's not the current version. It's accurate with the exception of Intermountain.

Q. Who you no longer work for?

A. Correct.

Q. In this document, on the first page, Chamber's

page 1, you listed your board certifications under one heading; correct?

A. Correct.

Q. Is says you're a fellow of the American College of Obstetricians and Gynecologists. Can you explain what that means?

A. It means that after you complete a written examination as well as an oral examination after the completion of four years of training, you get the take those examinations, and if you passed, you're certified -- you're board certified.

And it has to be maintained every year through a continuing medical education.

Q. Okay. And you've been a fellow since July of 2008?

A. No. I've been a fellow -- yes. Yes. Yes.

Q. Okay. It also lists that you're a diplomate of the American Board of Obstetrics and Gynecology?

A. Yes.

Q. Can you explain what this means?

A. Once you take the test and you've passed -- the test is administered by the American Board of Obstetrics and Gynecology, and once you pass that test, you're a diplomate, which also means you are a fellow.

You cannot become a fellow without being a

diplomate.

Q. Okay. You're currently a diplomate?

A. Yes.

Q. To your knowledge, is the American Board of Obstetrics and Gynecology a member of the American Board of Medical Specialties?

A. It is.

Q. Your CV has a separate section above your board certification with a heading "Post-residency Training." The first item there said that you were certified in sexual health and treatment by the American Academy of Antiaging.

Does this correspond with the certificate and information that you submitted as Exhibit C, which is behind tab 3?

A. Yes.

Q. Was that training completed online?

A. No. They started the online course in 2014.

Q. How did you complete the course?

A. Went to four different locations during the training. I believe San Diego; Atlanta, Georgia; December of 2013 was here in Vegas; and I can't remember where the fourth location was.

But there are four modules, four locations.

Q. Four modules?

A. Yes.

Q. And how long was each module in terms of time?

A. I believe there were four to five days each.

Q. That certificate represents 16 to 20 days of training?

A. Correct.

Q. Is the American Academy of Antiaging recognized by the American Board of Medical Specialties?

A. I cannot speak to that. I'm not sure.

Q. Is the American Academy of Antiaging recognized by the American Medical Association?

A. It probably is.

Q. Do you know if it is?

A. No.

Q. Also under your heading of post-residency training, you've listed certificate of completion, female genital plastic cosmetic surgery master's course.

Does that correspond with your certificate of completion behind tab 2, Exhibit B?

A. Yes.

Q. And how many hours of training does that certificate represent?

A. Sixteen hours.

Q. And was it -- the certificate was awarded by the person who taught the 16-hour course?

A. Yes.

Q. On page 3 of your CV, you have another heading "Professional Affiliations." It says you're affiliated with the National Society of Cosmetic Physicians from 2012 to 2015.

A. Correct.

Q. Are you board certified in plastic surgery?

A. No.

Q. How would you describe the National Society of Cosmetic Physicians?

A. It's for doctors who do cosmetic procedures. It includes plastic surgeons as well. One of the pioneers in cosmetic GYN, he's on that --

Q. Thank you. I just had a question about what it represents. Thank you.

Can you describe your current medical practice?

A. Well, I practice the whole scope of obstetrics and gynecology. I also practice cosmetic GYN surgery, as I said, for almost ten years. And I also practice sexual health medicine for almost ten years, as they go hand in hand.

Q. How do you describe sexual health medicine?

A. Sexual health medicine is for women who are having problems with any form of sexual dysfunctions. Anorgasmia, for example, meaning inability to achieve an

orgasm. Women with painful sexual experiences. Women who are in the hormonal problem leading to sexual dysfunction. Women who have had history of psychiatric problems leading to a condition known as --

Q. Do you have training in psychiatry?

A. No. But we all -- all doctors --

Q. Thank you, sir. I just asked if you had psychiatric training.

A. Okay.

Q. Is sexual health medicine recognized by the American Board of Medical Specialties?

A. I do not know.

Q. What training do you have do you think that qualifies you to say that you practice in sexual health medicine?

A. The training that I just mentioned through the American Academy of Antiaging Medicine, which supplemented what we were not taught in medical school nor in OB-GYN residency training.

Q. So to clarify, the four-module class, you believe qualifies to call yourself certified in sexual health medicine?

A. Correct. I received a certification.

Q. Could you describe your practice in terms of where you practice?

A. I now sublease. Is that what you mean?

Q. Yes, where the location is.

A. I now sublease from another OB-GYN.

Q. And what is that OB-GYN's name?

A. His name is Dr. Craig Hartman. H-A-R-T-M-A-N.

Q. You're not partners with Dr. Hartman?

A. I am not.

Q. In your words, how does cosmetic gynecology differ than regular gynecology?

A. Well, it differs in the sense that, in general, gynecology, when we do surgery for, let's say, incontinence, we're taught to reduce bulk in the hernia and restore function.

Cosmetic gynecology teaches us to sculp, to make the tissue aesthetically pleasing, while reducing the barrel of the vagina so that it's not just functional, but enhances the woman's sexual function.

It allows us to address things like anorgasmia. It allows us to address things like sexual pain. How to examine the patient properly and how to treat her.

For example, when you see a general OB-GYN regarding pelvic pain or sexual pain, everything is lumped. The exam consists of two fingers in the vagina, you go by manual exam, you might send for ultrasound.

When you see someone that does sexual health

medicine and cosmetic gynecology, you use a Q-Tip to palpate areas around the patient's external genitalia, specific points to see if you could elicit pain. If there's a little lump, the diagnosis, we break it up. Is it penetration or pain? So, this Q-Tip will help.

Then you want to know is pain in the vagina, so you palpate different areas inside of vagina.

Q. Is it your testimony that a licensed gynecologist cannot find the area of pain in the patient's vaginal area?

A. That is not my testimony.

My testimony is that as a general OB-GYN, we're not trained to discern pain in different levels, penetration, vagina, or deep, the way that someone who does cosmetic gynecology and sexual health is trained to do. And it's not by fault of our own. It's we weren't taught that.

And, in fact, when I did the training, I was appalled at how much I didn't know about female sexual health.

We were not taught it in medical school. We had a one-hour lecture, and in residency, it was just blown over. So none of us were practicing.

We trained, at the time -- I did or before knows anything about sexual medicine or -- and how you go

about eliciting a diagnosis of pain on patients with those problems.

Q. Let's talk about your encounter with Patient A. Why did you believe that Patient A was consulting you?

A. Was consulting me for what?

Q. Yes. Why was Patient A consulting with you?

A. Well, she came in with -- she came in with a two-page paper saying she was referred by Dr. Michelle Lewis to address certain problems.

And on the list, it was a list of sexual pain disorders, as well as problems with sexuality, and she had concerns about the way her vagina looked and felt.

Q. Before Patient A showed up with her list of questions, what did you believe she was there to consult with you regarding?

A. For cosmetic gynecological surgery.

Q. And what do you mean by "cosmetic gynecological surgery"?

A. Well, the surgery was -- the appointment was scheduled to address --

DR. CHAMBERS: I have a question for Ms. Ghusin. How tight of rope am I walking with a HIPAA violation depending on my answer? I want to be as transparent as possible without violating the HIPAA laws.

HEARING OFFICER GHUSIN: And, Dr. Chambers, I

can't advise you. I don't know if Mr. White or Ms. Mooneyhan want to weigh in here. That would be your own choice.

DR. CHAMBERS: In other words, if I answer the questions, will the Board come after me for a HIPAA violation, considering that this is a public hearing?

MR. WHITE: That's a federal law.

MS. MOONEYHAN: Yeah, the Board doesn't enforce HIPAA.

MR. WHITE: Yeah.

MS. MOONEYHAN: And, to my knowledge, an exception to HIPAA is participating in state proceedings and a medical board proceeding. That's one of the exceptions to HIPAA.

DR. CHAMBERS: Okay.

MS. MOONEYHAN: Obviously, we want to protect the patient's privacy and not use her name.

DR. CHAMBERS: Gotcha.

HEARING OFFICER GHUSIN: So your testimony here, if your concern is would it lead to another complaint being filed, it doesn't sound like that's the case.

But let's also mention, since you brought it up earlier in your opening, that there are not any criminal matters pending; is that correct?

DR. CHAMBERS: Correct.

HEARING OFFICER GHUSIN: Okay. But your testimony here, if there had been or might be, could be used in any criminal proceeding. Do you understand that?

DR. CHAMBERS: I understand that.

HEARING OFFICER GHUSIN: Okay. Thank you, Dr. Chambers.

DR. CHAMBERS: Thank you.

HEARING OFFICER GHUSIN: So you got a question that you were answering?

DR. CHAMBERS: Yeah.

BY MS. MOONEYHAN:

Q. Do you remember the question?

A. I do.

So, I bring your attention to your Exhibit number 3, NSBME 0023.

Q. Sir, that is the list of questions that Patient A came to your office with.

A. Correct.

Q. And my question to you was if you know what the issues was she was being referred by Dr. Lewis for, and you said cosmetic gynecological surgery.

So before you saw this document that Patient A came in with, I want to know what you thought she was there to do?

A. I thought she was there for a vaginal rejuvenation consultation.

Q. And why did you think that?

A. That's how it was scheduled, and she paid the fee that was charged for that, so that was my understanding.

So if that's your question, I don't need to refer to this document yet.

Q. In Exhibit 3 -- I'm glad you turned to that -- on page 16. Let's just talk about page 16.

A. Okay.

Q. Is that your handwriting?

A. It is.

Q. The next few pages, 17, 18, 19, are typewritten?

A. Yes.

Q. Do you have electronic recordkeeping?

A. I did.

Q. You don't any longer?

A. I do not.

Q. All these pages got typed?

A. Yes. No. These were typed separately.

By the time I saw her, I got rid of my electronic health records.

Q. When did you quit using electronic health

records?

A. Probably 20- -- 2015, I'm guessing. I don't know for sure.

Q. How did these get typed?

A. I typed them.

Q. You typed them?

A. Yes.

Q. When?

A. Either that afternoon or a couple days after.

Q. You don't recall exactly?

A. No.

Q. Why did you type some and write others?

A. Well, this was a consultation. She is sent by Dr. Michelle Lewis.

So, consultations, surgical procedures, anything that require a document to be sent out to another provider, I type.

Documents that are mainly in the office, like annual exams, problem visits, those are handwritten because they're faster.

Q. Did you conduct a physical examination of Patient A during your encounter with her?

A. I did.

Q. Did you tell her to keep her personal cell phone nearby so you could use it to take pictures?

A. I did.

Q. Did you, indeed, use her cell phone to take pictures of her body during the examination?

A. I did.

Q. Why did you take photos with her cell phone?

A. Well, since medical school, I use illustrations to get patients to understand what I'm about to do. Doesn't matter if it's doing a leak procedure in the office, discussing abnormal Pap smears, or doing a hysterectomy, I use illustrations.

And I was doing a colposcopy one day, and a patient said to me, "Why don't you take a picture of my cervix so I can see what it looked like."

And I thought, traditional gynecology use a mirror so the patient can see. Because this was in the back of the vagina and the light would not reflect there, I thought, oh, this is a good idea. Why not?

So I held a phone, and it was my phone and I didn't really know how to use it since I was an Android person. My medical assistant said, "If you tap the screen, it will focus."

And so it focused, and I said, "Well, this is great."

So I used it to teach her, and after I thought, why am I wasting my time drawing a vulva when I can take

a picture?

And then for some point in time, I was using the atlas that we used in medical school, but the patient just didn't grasp it. And I thought it would grasp what needed to be done if we used their photographs.

Now, generally if I'm going to do the surgical procedure, they will come for a second visit. We'll to consents, a psychiatric evaluation, a depression screen, the one they use in the hospital, and then I take a picture with my camera after they've been consented to reasons for photography.

But if they're just coming for a consultation, and I needed to use their picture, I would say, since you don't know if I'm going to do the surgery, you haven't decided, why don't I take the picture with your camera, you be in control of the pictures, you can discard it if you wish, or you can use it if you consult another cosmetic surgeon or plastic surgeon, you have these pictures, you can show them.

That's why I made her do it.

Q. With respect to Patient A specifically, why did you take twelve photos that day?

A. As I discussed in my opening statement, if I were to take a picture of you right now, I would do this with the camera (indicating), and then afterwards we'll

look, we'll take a picture with your eyes wide open, smiling, take the best picture, and we discard the rest. That was my intention.

Q. Okay. You've said if the patient comes back, you have them execute consents?

A. Correct.

Q. What does that mean? What are these consents?

A. So, initially, I received a verbal consent to use her camera. If she had come back, like other patients, I have six pages of consents that has to be read. The first one is preop counseling, about what needs to be done before surgery, what she needs to get before, what I will provide her --

Q. I'm sorry. I'm going to interrupt you.

My question is directly related to your taking photos of patients intimate areas --

A. Correct.

Q. -- what consents do -- is it that six page --

A. This is the six pages. It involves a preop counseling, postop counseling, and the consent for photography.

So, that's only given to patients who actually complete the surgery with me.

Q. So you took pictures of the patient's vagina before she actually executed this written consent?

A. I had a verbal consent to do this.

Q. But you did it before she executed a written consent?

A. Correct. And that's typically done with pictures that are kept in my office.

Pictures that they walk out the door with does not get this six-page consent, especially if they're shopping for a cosmetic surgeon.

Q. What kind of steps did you take to ensure the security of these photos?

A. Well, there's no identifying marks on them or names or date of birth.

Q. Did you have the patient text some of the photos to you?

A. Two photos to me, correct.

Q. And those came from her phone number?

A. Correct. And they were immediately printed and erased from my phone.

Q. Do you take any other steps? For example, is your phone encrypted?

A. It is not.

Q. So you don't use any software to make sure that your phone is --

A. I don't. My phone does not upload to the -- what do you call it? The -- not the sky, the -- I

blocked that. I'm very -- I don't trust technology a lot, so my phone does not upload to the --

Q. Are you looking for the word "cloud"?

A. The cloud. To the cloud, like everyone else's phone. I turn all those off so it remains on my phone, or so I believe, until I erase it, but nothing is a uploaded.

Q. Does that phone ever leave your office?

A. Yes.

Q. Is that the phone that you also make personal phone calls on?

A. No. I carry two phones at a time.

Q. Were you familiar with Patient A's telephone?

A. What do you mean?

Q. Were you familiar with what network she was using or if her phone ever had any encryption?

A. No.

Q. What did you do with the two photos she texted to you?

A. I printed them, and they were put in her chart.

Q. How did they get from your phone to the printer?

A. It went through my office Wi-Fi, which is secured on own its own server, and then on to the printer.

Q. Do you have a company that you use to help you ensure that the Wi-Fi's secure?

A. Yes.

Q. What is the name of that company?

A. The company was known as Agiletcit, A-G-I-L-E-T-C-I-T.

Q. How often do they come and service your Wi-Fi?

A. They were there whenever I needed them or would be there every four months.

Q. So you used Wi-Fi to send the photos to your printer?

A. Correct.

Q. Do you have a written policy about deleting photos that you have patients text you?

A. Yes.

Q. And where is that policy kept?

A. Well, it's my office in the -- you have -- we have a practice guideline, it tends to deal with the computers, confidentiality, nondisclosure clauses, and stuff like that.

Q. And it includes policy about not keeping photos?

A. Correct.

Q. And what does it say about dealing --

A. It basically has that if a picture is not going

to be kept in the office, it needs to come off the phone. And typically, that's the only time it's used.

Otherwise, it's done with a Cannon camera, which is hooked up to what I call an "air cam" iPad, it's never been online, and it's stored there under the patient's name.

Q. It's stored in the iPad?

A. Stored and secured. It's kept in a safe.

Q. And who has the combination to the safe?

A. I'm the only one who has access because it's a safe with a -- my VIP patients and celebrity patients. So it's kept in a safe that no one else can access.

Q. I'm sorry. I didn't understand what you said. If the photos are not kept in the office, they need to come off the phone?

A. Meaning that if they're not going to be used to do a surgery, they have to be deleted.

Q. So with respect to Patient A, at that point, you didn't know whether she was going to have the surgery or not?

A. Well, I printed the pictures because she gave the impression she was going to have the surgery. So I printed them, and they're included in her chart.

Q. And so, per your policy, were they deleted off your phone?

A. Yes.

Q. When?

A. The same day. The minute they popped up on the printer, I had no more use of the pictures.

Q. Do you still have Exhibit 3 opened?

A. Yes.

Q. Page 18, NSBME 0018.

A. Yes.

Q. About half way down the page, there's a heading called "Physical Examination."

A. Yes.

Q. And there's a subheading "pelvic."

A. Yes.

Q. And then a few more subheadings underneath that, there's one called "vagina," do you see that?

A. I do.

Q. Now, here you state that you sized the patient's introital opening with your two examining fingers; is that correct?

A. Correct.

Q. And the vagina opened to a width of seven centimeters horizontally and vertically?

A. Correct.

Q. According to your record, is it correct to say that you sized Patient A's opening with two fingers?

A. Correct.

Q. Can you please turn to Exhibit 2, page 9?

A. I'm there.

Q. If you would, the second paragraph there, if you want to read that yourself. Take a minute to read that.

A. To myself. Okay.

Q. So, according to that paragraph, how many fingers did you insert to Patient A's vagina during her examination?

A. Two fingers.

Q. During Patient A's examination, did you ever insert more than two fingers into her vagina?

A. From the photographs that got that discovery, yes.

Q. Did you discuss the width of Patient A's vagina with her?

A. Yes.

Q. Did you tell her that man's penis is about two fingers wide?

A. I probably did.

Q. Do you ever use non-medical or slang terms with patients when describing parts of their body?

A. Yes.

Q. Such as?

A. It depends on patient's vernacular. I have some patients who come in and refer to the vagina as "cooch" or "coochie" or "pussy," and I don't think it's appropriate for me to look at a 35-year-old woman and say the proper term is "vagina."

So, I roll with it, because the idea is to get her trust so she listens to what you have to say to her without being -- feeling that you're being condescending correcting her.

Q. Do you ever use a non-medical slang term if the patient hasn't used it first? Will you use those terms?

A. No. I tend to feel the patient out, and depending on if the patient is speaking proper, anatomical terms and using them, then I use proper anatomical terms.

I tend to feel out the patient first before I give my advice.

Q. Did you ever use non-medical or slang terms with your patients when you're describing sexual acts?

A. Well, yes.

Q. For example?

A. There's some patients who, when they're trying to explain positions where they have pain, most patients will not tell you that they have pain when they're in the rear entry position, which is doggie. They won't tell

you that they're spooning when their partner's laying behind them. They won't tell you that they're practicing yawning when their legs are over the partner's shoulders and they're bent in half.

They don't have that terminology, but whatever terms they use, I use those terms, and then I tell them what it is.

Q. Did you use the term "fisting" with her?

A. I really cannot recall because it's not part of my language.

Q. Have you ever used the term "fisting" with any other patient?

A. If the patient does fisting, yes.

Q. Would you use that term if the patient didn't use it first?

A. No. Because it's not something I do in my private life, and it's not something that -- it makes no sense to me, so it's not something that I would use.

Can I ask, am I allowed to ask for a Zyrtec? My allergies are kicking in.

MS. MOONEYHAN: Can we take a two-minute break, Your Honor?

HEARING OFFICER GHUSIN: Yes. We can take a five-minute break.

(Recess 2:51 P.M. to 3:07 P.M.)

HEARING OFFICER GHUSIN: Back on the record in the matter of Dr. Chambers. We have everybody here.

Would you like to continue, Ms. Mooneyhan?

I would like to also note for the record that we have new visiters in the south who are not witnesses; correct? We did a check here, and I just want to put it on the record.

MS. MOONEYHAN: None of the IC's witnesses are in the crowd.

HEARING OFFICER GHUSIN: Okay.

Dr. Chambers, are you ready to go forward?

DR. CHAMBERS: Thank you.

HEARING OFFICER GHUSIN: Thank you.

BY MS. MOONEYHAN:

Q. Dr. Chambers, would you please turn to Exhibit 2 in the IC's exhibits.

A. I'm there.

Q. Thank you. On page NSBME 6, the very first page of your letter, about six lines down, it says that Patient A's visit was chaperoned by your office manager, Casey. Do you see that?

A. I do.

Q. Would please describe Casey's participation in Patient A's visit.

A. Casey was present. She spoke with her before

and after I saw her. She maintained a presence at the door and outside of the room during the examination in which the door was kept open, and that was the extent of participation.

Q. Was Casey in the room while you were performing your physical examination of Patient A?

A. No.

Q. Was she standing in the doorway when you were performing your physical examination of Patient A?

A. Part of the time.

Q. Approximately how long?

A. That, I can't estimate.

Q. Why -- do you know why only part of the time?

A. Well, she moved back to the desk, what was in plain view of the exam table and me.

Q. So, your testimony is from the desk, she could see into the examination room?

A. Correct.

Q. Approximately how far from the examination room was the desk?

A. Probably ten feet, twelve feet.

Q. Did you have any other medical encounters with Patient A after her visit in November of 2020?

A. No.

Q. Did you ever perform cosmetic gynecological

surgery on Patient A?

A. No.

Q. Turning to Patient B, was Patient B a regular patient of your practice?

A. Yes.

Q. Approximately long was Patient B a patient of yours?

A. Seven or eight years.

Q. Did you ever perform cosmetic gynecological surgery on Patient B?

A. No.

Q. I'm going to ask you to turn to IC's exhibit book, specifically NSBME 107, Exhibit 7.

Are you there, Dr. Chambers?

A. I am.

Q. Is that a record of your encounter with Patient B in October of 2018?

A. It is.

Q. What, in your words, was the reason for Patient B's visit to you in October of 2018?

A. She had blood and nipple discharge.

Q. During Patient B's visit in October of 2018, did you offer her money to pose nude for photographs for an ad?

A. I probably did. I don't know the exact date.

Q. Will you please turn to Exhibit 6, NSBME page 45.

A. (Witness complied).

Q. You can go ahead and read the second paragraph to yourself, beginning in 2012.

A. Okay.

Q. So, did you place advertisements for your practice in the Adult Video Network awards ceremony program?

A. I did.

Q. How many times?

A. I did it three times.

Q. Which years did you place an ad in the AVN program?

A. It was in the '13 or '14, '15, and then we were looking at '20.

Q. So you placed ads in the AVN program?

A. Correct. In the awards program.

Q. At least three times?

A. Correct.

Q. And the last in 2020?

A. Correct. And then we also did the magazine that the people in the industry would read. And that was over a series of some time as well. I don't remember the dates.

So, in addition to the awards program, there was also the industry magazine that ran ads.

Q. Do you know the name of that magazine?

A. Not off the top of my head, no.

Q. Do you know approximately how many times you advertised in that magazine?

A. Probably twelve times.

Q. Is it a monthly magazine?

A. Yes.

Q. Do you remember how much it cost to run an ad in that magazine?

A. No.

Q. Were the ads for the AVN program and the magazine the same ad? Similar to one ad?

A. We interchanged them, yes.

Q. How many ads have you created over the years for these two publications?

A. Two.

Q. Can you describe the first one?

A. Well, the first one is right here in Patient B or C's record. I just saw it.

It's of a women, nude, laying on a flat surface in a prone position.

Q. Can you see the woman's face?

A. You can see a profile of her face, yes.

Q. Can you see her breasts?

A. No. Well, you can see the profile of her breasts, but you cannot see nipple.

Q. And what about the second ad that you referred to? Can you describe that ad?

A. It's with her hands up like this (indicating) in her hair, with her head titted back, standing up, with her nipples shaded out.

Q. Is it a picture of the woman?

A. Profile.

Q. Did you use the same model for both of those photos?

A. No.

Q. Do you remember the model for either one of them?

A. Yes, I do.

Q. Okay. Where either of them former patients?

A. One of them was.

Q. And which ad was the former patient the model for?

A. The second one.

Q. The second with -- where the one standing with her hands in her hair?

A. Correct. With her face shielded.

Q. You cannot see her face?

A. Correct.

Q. And who took the photographs for each of those ads?

A. The first one, I took, and the second one was taken by a professional photographer.

Q. So you took the photo of the woman lying down?

A. Correct.

Q. And the woman with the hands in her hair was by a professional photographer?

A. Correct.

Q. What is that professional photographer's name?

A. I don't have it with me.

Q. How did you find her?

A. A patient of mine knew I was looking for models, and she said that she was about to do pictures for her partner and she had a friend who did modeling, pictures, and would be willing to work for me to do it.

Q. Were you present during that photo shoot?

A. No. I opened the office, but I was not there.

Q. The photos were taken at your office?

A. Correct.

Q. The first ad that you took the photos for, were those photos taken at your office?

A. Yes.

Q. Who was your contact in the Adult Video Network

for placing these ads?

A. I can't remember her name.

Q. So in Exhibit 6, regarding Patient B, that paragraph -- that second paragraph there says that in the fall of 2018, you were getting ready for your ad in the 2019 AVN award ceremony?

A. Yes.

Q. Did you do an ad in the 2019 AVN ceremony?

A. Did we? We did not. We were a little bit too late.

Q. You called the AVN to inquire?

A. Correct. I was back and forth with the contact, and she said there were no space left.

Q. Have you either taken photographs -- well, have you take any photographs for anybody else for any ads that you have not used?

A. Yes.

Q. How many times would you say that has happened?

A. It would be a guess. I don't know.

Q. Five?

A. Probably.

Q. More than ten?

A. Five is more like it.

Q. And have you had a professional photographer take pictures of models that you have not used?

A. Yes.

Q. And what how many times would you say that has occurred?

A. Trying to visualize the ad that was in my office. There are probably 12 pictures on that ad, so probably 12 times.

Q. Those are of 12 different --

A. Patients, correct.

Q. They're patients?

A. Correct.

Q. And that's in your office?

A. Correct.

Q. And those were taken by a professional photographer?

A. Correct.

Q. Is it the same professional photographer that took the pictures for the ad that you described with the hands in the hair?

A. Yes.

Q. And you don't remember her name?

A. I don't. Not off the top of my head.

Q. Where do you store the photos that were taken for these ads?

A. Those are kept on the same air cam iPad and locked away.

Q. Those 12 pictures that are in your office, those taken by a professional photographer, were those also taken in your office?

A. Yes.

Q. Over what time period would you say these photo shoots occurred? What years?

A. 2013 was when I was trained. So the training included lectures on medical photography, so 2013 to about 2018.

Q. Your training included lectures on medical photography?

A. Correct.

Q. Do you consider the pictures in these ads medical photography?

A. Well, the vaginal pictures are.

Q. Do some of these photos include vaginal pictures?

A. Correct. They're depicting different types of labia minora that patients may choose to augment, and they were put in my office so that I would not have to bring up the topic directly with the patients.

Q. So, when you say they're in your office, they're on the wall?

A. They are on the wall in the lavatory, the patient's lavatory, and they -- one was in the room where

the consultation is done, behind the door.

Q. Did the professional photographer that you engaged have training in medical photography?

A. No. I explained to her what I wanted her to take.

Q. And do you have written consents from the patients in the -- with respect to the 12 photographs on the walls in your office?

A. Everyone who posed had to sign a consent, yes.

Q. Did you pay the subjects of those photos?

A. I did.

Q. And how much did you pay them?

A. One thousand dollars.

Q. Each patient or each subject receive $1,000?

A. Yes.

Q. You never paid any less than that or any more than that?

A. I never paid any less than that, no. So, 1,000.

Q. How did you make that payment?

A. It depends. I think the vast majority were paid in cash.

Q. Of these patient that posed for the ads within your office and/or the AVN magazine, did you take boudoir photography?

A. Well, that's what it is. I call it boudoir, but it's the nude pics.

Q. Okay. So how do you define boudoir photography? Does that include the patient's genitals?

A. Well, yes. Some, like in one of the ads, might have partial lingerie.

Q. Did all of those patients who did pose for you ads, did they receive a copy of the photos?

A. Yes.

Q. Do you use an advertising agency to help you put these ads together?

A. No.

Q. In terms of compiling the ads, though, do you do that yourself?

A. No. I used -- professionally done. It was professionally done by a young woman who helped design my website, the company that I've used to design any website before.

Q. What's the name of that company?

A. I'd have to look it up and tell you.

Q. Do you remember the woman's name?

A. No.

Q. And just to clarify, that woman put together the ad for the AVN program?

A. That one was done through AVN. They directed

me to the company that designed the ads for their pages because they had to meet certain specifications.

So she did the ones that were in the office.

Q. She did the ones in the office?

A. Yes.

Q. What about the magazine?

A. The ad people.

Q. Regarding Patient C, was she a regular patient of your practice?

A. Yes. She had been there, I think, two or three times. I can't remember.

Q. Did patient C ever receive cosmetic gynecological surgery from you?

A. No.

Q. Did you offer Patient C an arrangement similar to what you offered to Patient B in terms of posing for an ad?

A. I did.

Q. Were you familiar with Patient C's financial situation.

A. I was.

Q. How so?

A. She told me she was having financial problems. I -- I don't know if was in relation to something I needed to do, if it was regarding the tests I had to

order on her and she couldn't do it.

I don't recall how the conversation came up.

MS. MOONEYHAN: Your Honor, if may I have a moment?

HEARING OFFICER GHUSIN: Go ahead.

MS. MOONEYHAN: I have no further questions for Dr. Chambers at this time.

HEARING OFFICER GHUSIN: Thank you, Ms. Mooneyhan.

Dr. Chambers, it's a little unusual, as you're representing yourself. Since you're going to have your case in chief, you can testify as cross-examination with respect to Ms. Mooneyhan's questions, or you can just wait until your own case in chief. It's your call.

Do you have any questions for me about that?

DR. CHAMBERS: No. But I'll wait.

May I point Ms. Mooneyhan's attention to something in her exhibit?

HEARING OFFICER GHUSIN: Well, you can't ask questions of Ms. Mooneyhan. You can -- I know you can't cross-examine yourself, but you can clarify something.

DR. CHAMBERS: Okay. It's the one of the advertisement, if you look in the section ten, Exhibit 10, NSBME's 0144, that's one of the ads.

MS. MOONEYHAN: Your Honor, may I redirect?

HEARING OFFICER GHUSIN: Are you done, Dr. Chambers?

DR. CHAMBERS: I am. I am.

HEARING OFFICER GHUSIN: Okay. I'm sorry. Will you tell me -- oh, the picture. Okay.

And let me correct myself. That wouldn't be cross-examination, since that would be later on.

Okay. Go ahead, Ms. Mooneyhan.

MS. MOONEYHAN: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MS. MOONEYHAN:

Q. Dr. Chambers, just to clarify, this is the first photo that you described?

A. Correct.

Q. And this is the photo that you took?

A. Correct.

Q. And this model is not a former patient?

A. Correct.

MS. MOONEYHAN: Thank you, Your Honor. No further questions.

HEARING OFFICER GHUSIN: I have a quick question, Dr. Chambers.

DR. CHAMBERS: Yes.

EXAMINATION BY THE HEARING OFFICER

HEARING OFFICER GHUSIN:

Q. Why did you pay in cash?

A. I had cash, and a lot of patients wanted cash, so I just did it.

Q. Okay.

A. I wanted to do checks for my tax write off, --

Q. That was my question.

A. -- but they insisted on cash payments, so I just did it.

Q. Okay. Yeah. That crossed my mind about the deduction, if you had a record of it.

So, thank you for answering my question.

HEARING OFFICER GHUSIN: Any follow-up, Ms. Mooneyhan?

MS. MOONEYHAN: Yes.

FOLLOW-UP EXAMINATION

BY MS. MOONEYHAN:

Q. Dr. Chambers, did you keep records of those payments to the patients?

A. Yes.

Q. Okay. Thank you.

MS. MOONEYHAN: No further questions.

HEARING OFFICER GHUSIN: Thank you, Dr. Chambers. You may go back to your seat.

So, Ms. Mooneyhan, we have time for your next witnesses.

MS. MOONEYHAN: Yes.

HEARING OFFICER GHUSIN: And let me throw in here while we're waiting is we need to wrap it up by five o'clock up here. We can't go over.

So if there's a natural -- I'm fine going to five o'clock, but if there's a natural stopping point a little bit before that, we'll take it. Okay?

MS. MOONEYHAN: Okay. Thank you, Your Honor.

HEARING OFFICER GHUSIN: Thank you.

MS. MOONEYHAN: I'd like to call Patient A.

HEARING OFFICER GHUSIN: Is someone bringing her in?

MS. MOONEYHAN: Yes. Someone will get her.

HEARING OFFICER GHUSIN: Thank you.

And you understand, Dr. Chambers, that you can cross-examine the IC's witnesses; correct?

DR. CHAMBERS: I do. Thank you.

HEARING OFFICER GHUSIN: Okay. Thank you. Do you have any other questions about the process?

DR. CHAMBERS: I do not.

HEARING OFFICER GHUSIN: Okay. Thank you.

DR. CHAMBERS: Thank you.

MS. MOONEYHAN: And, your Honor, before Patient

A is sworn in -- I'll wait until she gets into the room, but I wanted to -- I have a representation to make before she's sworn in.

HEARING OFFICER GHUSIN: Okay. Thank you for the heads-up.

And a reminder about the order that's in effect; correct?

MS. MOONEYHAN: Thank you.

(The witness was seated.)

HEARING OFFICER GHUSIN: Good afternoon.

THE WITNESS: Good afternoon.

MS. MOONEYHAN: Your Honor, before Patient A is sworn in, as you just noted of course, we have the -- your order protecting the patient likenesses and identity.

So, as an officer of the court, I would like to represent that I know the person sitting here testifying as Patient A is the person identified as Patient A in the patient designation filed under seal on September 21st, 2022.

Based on that representation, I would ask that she be sworn in on the record as Patient A, and that my first few questions will establish her identity by using that patient designation.

HEARING OFFICER GHUSIN: Okay. Thank you very

much.

Dr. Chambers, do you understand the representation?

DR. CHAMBERS: I do.

HEARING OFFICER GHUSIN: Okay. Do you have any objections?

DR. CHAMBERS: I don't.

HEARING OFFICER GHUSIN: Okay.

In that case, we're ready to swear her in as Patient A.

(The oath was administered.)

THE WITNESS: Yes.

HEARING OFFICER GHUSIN: Thank you. Are you comfortable there? Do you have some water?

THE WITNESS: Yes.

HEARING OFFICER GHUSIN: Okay. So we all have allergies. The Kleenex is there.

Ms. Mooneyhan, go ahead.

MS. MOONEYHAN: Your Honor, I'm handing Patient A the patient designation that was filed on September 21st, 2022. The other patients names have been redacted, but Patient A's name is not redacted, and I'm going to give Dr. Chambers a copy as well.

DR. CHAMBERS: Thank you.

DIRECT EXAMINATION

BY MS. MOONEYHAN:

Q. Ma'am, if you'll look at the patient designation in front of you, it shows the true patient identity of Patient A in this matter. Is that your name?

A. Yes.

Q. And is that your date of birth?

A. Yes.

Q. Thank you.

MS. MOONEYHAN: Can the court reporter hear the patient?

THE REPORTER: I'm okay right now. Yes.

HEARING OFFICER GHUSIN: Yes. Thank you.

MS. MOONEYHAN: Thank you.

BY MS. MOONEYHAN:

Q. Thank you, Patient A.

Ma'am, did you ever interact with the respondent, Dr. George Chambers, as a patient?

A. Yes.

Q. Approximately how many times?

A. (Inaudible).

THE REPORTER: I can't hear her.

HEARING OFFICER GHUSIN: Excuse me. I'm going to interrupt because we cannot hear up here, Patient A. If you could speak up a little bit, please.

MS. MOONEYHAN: Look --

HEARING OFFICER GHUSIN: Yeah, let's look --

MS. MOONEYHAN: Can you move closer?

HEARING OFFICER GHUSIN: Okay. I'm going to wave. Can you see me?

THE WITNESS: Yeah, I can see you.

HEARING OFFICER GHUSIN: Okay. I'm the hearing officer. Okay?

THE WITNESS: Okay.

HEARING OFFICER GHUSIN: Nice to meet you. And we have a court reporter here who's taking down what is happening in it is hearing. Okay? And we just need to hear what you're saying.

If you have any questions, I want to make sure you're comfortable. Ms. Mooneyhan is right there to answer any questions, but we need to hear so we could get this transcribed. Okay?

THE WITNESS: Okay.

HEARING OFFICER GHUSIN: Okay. So, that's who we are up here.

THE WITNESS: Okay.

HEARING OFFICER GHUSIN: Just a little bit louder. Okay?

THE WITNESS: I will try.

HEARING OFFICER GHUSIN: Okay. Thank you.

MS. MOONEYHAN: Thank you, Patient A.

I just learned the microphones are towards the camera, so speak up as loud as you can so that they can hear in Reno.

Did you hear those first few questions, Ms. Ghusin?

HEARING OFFICER GHUSIN: Let's go ahead and repeat them, please.

MS. MOONEYHAN: Okay.

BY MS. MOONEYHAN:

Q. Patient A, did you ever interact with the respondent, Dr. George Chambers, as a patient?

A. Yes.

Q. And how many times?

A. One.

Q. Do you remember approximately when?

A. November 17th, 2020.

Q. And what was that purpose of your appointment with Dr. Chambers on that day?

A. I was referred to Dr. Chambers by my long-time OB-GYN, Dr. Michelle Lewis, for a repair of my perineum.

Q. And was your primary concern regarding your perineum cosmetic?

A. No.

Q. What was your primary concern regarding your

perineum?

A. Pain and discomfort in the area and just having it repaired properly.

Q. When you say "repaired properly," had it been repaired improperly in the past?

A. Yeah. It had been torn open from childbirth and was not repaired properly.

And I had had discomfort and pain from that for 12 years until that time.

Q. Okay. And you discussed that perineal pain with your regular gynecologist, Dr. Lewis?

A. Yes.

Q. And what was her recommendation?

A. Having a perineoplasty.

Q. And she wasn't able to perform that?

A. She could.

Q. Do you know why she referred her to Dr. Chambers?

THE REPORTER: I'm struggling to hear her.

HEARING OFFICER GHUSIN: Excuse me, Ms. Mooneyhan. I think we didn't catch a word or two.

THE REPORTER: When she faces this way I can hear her, but when she turns around, I can't hear what she's saying.

THE WITNESS: Okay. So, Dr. Lewis does do

perineoplasty. I had called her office to schedule the surgery, and she had -- her office person told me that she was referring me to Dr. Chambers or Dr. Shae, who was a urogynecologist, as they were more specialized in that kind of surgery.

I think also part of reason that they didn't do it was because I had asked her if, like, having labiaplasty would help with the discomfort I was having. And she knew that that wasn't her specialty, I guess.

HEARING OFFICER GHUSIN: Thank you.

BY MS. MOONEYHAN:

Q. Did you prepare for your appointment with Dr. Chambers in any way?

A. Yes, I did. I'm a very thorough person.

I researched -- I looked on his website. I researched. I was also concerned I might have something called a "rectocele," which I had researched online.

I saw on Dr. Chambers' website that he does vaginoplasty, perineoplasty, labiaplasty, all of which would help with these issues I was concerned about.

And I'm, like, a super-thorough person, and I also tend to get very, very nervous at the doctor and forget what I'm coming in for, so I took notes with, like, my symptoms and any questions I had for the doctor with me to the exam.

Q. Thank you. Do you recall if you were seen at your scheduled appointment time?

A. No. I mean, you never really are. When I got there, they said that Dr. Chambers was at the hospital delivering a baby.

My appointment was in the morning, sometime around 9:00, and he arrived sometime around 10:30ish.

Q. And after Dr. Chambers arrived, were you called back for your appointment?

A. Yeah. Well, I heard him come in the office. There was only one other person in the office that worked there, and he called me up to the desk, and she said, "Even though you aren't the first scheduled patient, Dr. Chambers wants to see you first."

And I uncomfortable -- I felt bad because I didn't want someone else to wait longer.

Q. When you went back, did you have a conversation with Dr. Chambers?

A. Yes. He -- I mean, I remember he was kind of still trying to get sorted because he just arrived at the office for the day, I'm assuming.

And, you know, he had -- I don't know. He was wrestling around a little bit in the back, and I sat in the exam room in the chair next to the counter and he sat also in a chair next to the counter. We had a

conversation regarding my symptoms and the reason I was there.

Q. You described your symptoms, do you remember approximately how long that conversation took?

A. This was two-and-a-half years ago, so, I think I probably was thorough, as I usually am, and Dr. Chambers was thorough, and it probably took 15, 20 minutes.

Q. Okay. After your initial conversation, did Dr. Chambers perform a physical exam?

A. After our initial -- you know, went over my symptoms and the reason I was there, and then I said -- I got to, like, my notes, the questions I had. He said to wait for me to ask questions until after the diagnosis and treatment, like, what he thought I should have, and then I would know which questions to ask from whatever he told me.

So, did I answer your question?

Q. Yeah, you did.

Did Dr. Chambers ask you to undress?

A. He rolled over -- he had, like, a rolling stool that he was sitting on, he went to pull out a paper gown, and he said, "Because I'm a gynecologist, I always do a breast exam."

And I reminded him that just seen my regular

OB-GYN, so I didn't need a breast exam or anything.

Q. Okay. Did he tell you keep anything nearby after you changed?

A. Yes. He just told me to keep my phone nearby because he would use it to take photos.

Q. And what did you think about him asking you to keep your phone nearby?

A. I thought it was unusual. I wasn't surprised about photos; I was surprised that he used my phone to take photos. I just thought it was unusual.

Q. Okay. But you did what he said, kept your phone nearby?

A. Yeah.

Q. Okay.

A. I mean, he was a doctor, and I didn't realize at the time that it was -- I thought, I met the doctor, I'm here for health care, and this is what he needs to do to take care of my health, even though it's odd.

Q. So, you changed into the paper gown and kept your phone nearby, and then Dr. Chambers returned; is that right?

A. I went -- you know, sat on the examining table, he came back in. He said, "Is it okay if I leave the door open?"

I expressed some hesitation, and he said,

"Don't worry. Nobody else is back here and the doors are locked."

So, I conceded to leave the door ajar.

Q. Was he accompanied by anybody?

A. No.

Q. Was anybody else in the room at any time during your exam?

A. No one else was in the room at any time, other than the office girl, the one and only employee that I knew of that was there, at one point came to the room and said that another patient has to leave in -- I don't know if she said 30, 40 minutes, and is wondering if he'll be done in time to see her.

And Dr. Chambers acted irritated and said, "Well, what is she here for?"

And the office girl said, "An issue."

And he said, "Tell her she'll be seen."

And that's all. That was the only time I saw any other person in the exam room.

Q. Did Dr. Chambers take your blood pressure?

A. (Inaudible).

THE REPORTER: Was that a no? Blood pressure -- I'm sorry.

BY MS. MOONEYHAN:

Q. Did he weigh you?

HEARING OFFICER GHUSIN: Hold on just one moment, please.

THE REPORTER: Did Dr. Chambers take your blood pressure, what was the response?

THE WITNESS: No, he did not take my blood pressure.

THE REPORTER: Thank you.

THE WITNESS: Or weigh me. Or take any vitals.

BY MS. MOONEYHAN:

Q. So, how did the exam begin?

A. He asked me to, you know, lay down. He asked me to -- he told me he was going to -- well, before, you know, I was undressed, he told me the exam was -- during the exam, he would assess for nerve damage because -- I could have sustained nerve damage and that's what could be causing the problem.

When I was undressed, he asked me to lay down. He told me that he was going to be feeling around for nerve damage, trying to assess where the pain and discomfort was coming from. And he, you know, told me to, like, put my feet together, spread my legs as far as I can.

And I gave him my phone to take photos, that he said he would be taking photos.

Q. Did you see Q-Tips or something similar to

Q-Tips on a tray nearby?

A. No, not that I remember.

Q. Did Dr. Chambers use a speculum at all?

A. No.

Q. Okay. Do you recall whether -- so he said he was feeling around for the pain. Do you remember if he did that first or took photos first?

A. I think he did feel around, you know, and asked me you know, if things were -- where the pain was.

I couldn't say, I mean, it's been two-and-a-half years, so I'm not going to say definitely that happened first and then the photos, but that's the best of my recollection.

Q. So you do remember that he did --

A. He did feel around --

Q. -- palpate?

A. -- a little bit with his fingers.

Q. Okay. And asked you if there was pain?

A. Um-hum.

Q. And then at some point -- and you're not sure of the order, but he also took photos of your vaginal rectal area with your phone?

A. Yes. He took photos just of my vulva from different angles and took photos with fingers inserted.

Q. When he was asking you about the pain -- did

you feel pain while he was palpating different parts of your vulva?

A. No.

Q. Did you feel any pressure or anything unusual during the exam?

A. When he began to do a vaginal exam, yes, I felt a lot of pressure, a lot of stretching. I felt as though I was being stretched as far as I could be stretched and beyond.

He was asking me if it was painful. I said, "It was uncomfortable."

You know, I'm thinking nerve pain, it's going to be like a zinger pain. It was not a zinger pain; it was pressure and stretching.

Then at one point, I felt his knuckles inserted into my vagina, and I told him, I said, "This is very uncomfortable." And then he pulled his hand out.

Q. Did he touch anywhere besides your vulva and vagina?

A. He did a rectal exam where he put a finger into my rectum and tried -- like, pushed the rectum through the vagina and took a photograph of that.

When he took that photograph, he asked me to remove the soiled glove off of his hand so that he could use the same hand to hold the phone to take a photograph,

which I did.

Q. Just to clarify, that was soiled from your exam to that point?

A. I don't know. Whatever he had done up to that point.

Q. Okay. Thank you.

After that rectal exam, was the physical examination over?

A. Yes.

Q. Did Dr. Chambers leave you alone to dress?

A. He asked me to show him the photos which he had taken, and selected two of the photos and asked me to text them to his phone.

Q. And how did you feel when he asked you to text him the two photos?

A. I thought it was unusual. I was not really comfortable with it.

But, again, I thought I was here for medical care, and I believed that what he was doing was for my medical care, so I did it.

Q. Why -- if you can just explain, why were you uncomfortable. Were you concerned --

A. I mean, I didn't know who would see the photos. I mean, being on a phone, I didn't know if it was a personal phone. I didn't know who would see the photos.

If I was texting them, could they, like, be texted to somebody else. I didn't feel like it was a very secure way to exchange, like, something really personal to me and humiliating.

Q. Did Dr. Chambers give any reassurances that the photos would be confidential?

A. I don't think I asked.

Q. So, did he give you a phone number to text them to?

A. Yes. He told me to be careful to put in the number exactly because he had another patient who put in number in wrong, and she got a text back saying, "What bitch is sending my husband pictures," or something like that.

Q. Okay. So you texted him the two photos to the number he told you to. Then did he leave you alone to dress?

A. Yes, I believe so.

Q. And did he return to the room after you were dressed?

A. Yes. And while he was gone, on I texted my husband, I said, "This is weird. The doctor took pictures on my phone and asked me to text them to him."

"Probably okay, but," you know, "you could ask him if you're worried about it."

I was too embarrassed to bring it up.

I still trusted that I was there for my medical care and getting medical care.

Q. When Dr. Chambers returned to the room, did he speak to you?

A. The first that thing happened when he came back to the room, I was just sitting back in the chair next to the counter, and he was standing in front of here (indicating), he said, "What happened during the exam is called fisting, and that's where I try to insert my entire first into your vagina. I was only able to get it this far."

He showed me with his hand (indicating) how far he got his fist in, and then he said -- he said, "A man's penis is only this big." And he showed me two fingers about the size of two fingers.

I took that to mean my vagina was too large for a penis.

Q. I'm sorry, Patient A, but for clarification, when Dr. Chambers said that he was only able get his hand this far, you touched your hand at -- approximately where on his hand was he pointing to? Did it include four fingers?

A. Above his knuckles and below his wrist.

Q. Between his knuckles and his wrist?

A. Yes.

Q. Then he immediately followed it with a comment about a man's penis being approximately two fingers wide?

A. Yes.

Q. What affect did that exchange have on you?

A. The affect was very profound, and, you know, I had never considered what had been told to me. I was humiliated and embarrassed.

I didn't want my husband to know. Like, I just -- I didn't know what to tell my husband about what had happened because I didn't want him to know about my body, what was supposedly wrong with it.

And, you know, it had a profound affect on my confidence and my sexual confidence and . . .

Q. Thank you.

Have you ever heard the term "fisting" before that?

A. No.

Q. Did Dr. Chambers use any other non-medical terms during your meeting?

A. I mean, he tends to speak in lay terms, and he -- sorry. Can you say it again?

Q. Yes.

I was curious if during your experience with Dr. Chambers if he used any other non-medical, slang

terms similar to fisting or something else to describe --

A. Generally, yeah. I just -- I remember him calling labia "lips." He said that when he does labiaplasty, he "kisses the lips together."

And just used, like, I mean, he's just very unformal, used other -- I don't remember specifically.

Q. Do you remember if you had referred to labia as lips before that?

A. No. I only use anatomical terms for everything.

Q. Okay. Can you please turn to Exhibit 4?

A. (Witness complied).

Q. Can you confirm that those are the photos that Dr. Chambers took of you on your cell phone?

A. Yes.

Q. Okay. Would those -- what did Dr. Chambers tell you to do with the ten photos that you did not text him?

A. He told he would need them -- you know, if we did the surgery, he would need them later on, so keep them in a secured folder in my phone.

He also told me to make sure they're secure so my husband wouldn't see them because if he did, they would mess with his head.

Q. How did you feel after the examination

physically?

A. I was in a lot of pain. I had swelling. I had what felt like my micro tears all around my vaginal opening.

I mean, I had some, like, hard lumps in my labia, and I remember my husband going to the store to get me Epsom salts so I can soak for the pain. It was painful.

Q. Approximately how long did that pain last?

A. Pain, you know, I mean, if you're saying pain, swelling, discomfort, a couple of weeks, honestly.

You know, by the time I -- I was worried about the pain. I was worried about if there was damage, so I made an appointment with my OB-GYN, Dr. Lewis. I think called her, like, four days after, and she got me in six days after the exam with Dr. Chambers.

And I remember we took a trip for Thanksgiving so that I could go see her. At the time when I went in to see her, I remember feeling better than I did at the time I made the appointment.

Q. Did you ever talk to Dr. Lewis about the fisting comment?

A. I was concerned that it wasn't a medical term. I had never heard it before, so I was hoping she would verify, yeah, that's a medical term. This is a normal

thing.

She said, "No, I've never heard that term before."

And I also asked her -- Dr. Chambers was discussing surgery with me. He had said during surgery, he doesn't do the surgery under a local -- or a general anesthetic, he does a local anesthetic.

And he said during the surgery, he would be stimulating my clitoris, and that he wanted me to not hold back and it would okay if I come, and I was concerned about that.

I had asked Dr. Chambers about it, "Why would you need to do that? I don't understand why that's necessary."

He said, "It's to make sure that I'm not cutting any of nerve fibers attached to the clitoris."

And I had said, "But you already assured me that there would be no clitoral sensation lost with the surgery."

He just brushed it off. So I brought it up with Dr. Lewis, and she said, "There was no reason to ever do that during surgery."

Q. What -- if you remember, what surgery did he propose to perform on you?

A. I mean, the perineoplasty, the vaginoplasty,

the rectocele, and also he believed that my vagina needed to be smaller. And labiaplasty.

Q. When you -- just to confirm, when you first met with him, it was not for cosmetic reasons at all?

A. No. I did ask about labiaplasty. It was in relation to the discomfort and -- that I was experiencing.

I asked him if that would help. He said, "It could."

And asked him what were the chances of losing any, like, feeling or sexual sensation, and I can't remember for sure, I know it was a high incidence that you -- I think said, like, 50/50 percent you could lose feeling.

And at that time, I was like, not doing labiaplasty. Not worth the risk.

Q. Did he also propose to you doing surgery of your clitoral hood?

A. Honestly, I just remember him saying your clitoris -- I didn't express any concern about my clitoris. Never had any concern about it. I just remember him showing me the picture and saying, "Women would kill for a clitoris like yours."

I do have, kind of like, my labia bent on one side. I think I remember him saying that he would excise

that so that it was, like, perfectly symmetrical.

Q. How did you feel after this encounter psychologically?

A. It was kind of an unfolding -- honestly, really embarrassing and humiliating. I didn't want to tell my husband everything, what happened.

I didn't fully -- how did I feel after when? Like, right after? The day after?

Q. How would you describe the affect? You know, you said it was unfolding, so a couple of months later, how did you feel about what had happened that day?

A. Well, it was -- I mean, I knew what had happened was wrong. I knew what had happened was sexual assault. I knew what had happened was not for my medical care.

I had profound affect. I believed -- despite all reason and despite everything in my real life, I believed something was wrong with my vagina. I believed my body was disgusting. I believed -- I remember feeling for the longest time like I cannot exist in this body, it's too disgusting.

I suffer from post-traumatic stress disorder. I mean, the effects have been profound.

I have four little kids. Living with anxiety, just the post-traumatic stress, I mean, it didn't feel

good.

Q. Did you seek assistance from a mental health professional?

A. I did. I had counseling through the Rape Crisis Center.

Q. You -- since this encounter in November of 2020, have you had any surgery to address your perennial pain?

A. No.

Q. And is the delay in that care a result of this encounter with Dr. Chambers?

A. Absolutely. I mean, I was ready to have it repaired as soon as possible. I was very anxious to have it repaired.

And, you know, afterwards, I thought I have to get this surgery. I have to -- need surgery to repair my body so I can heal. If I heal physically, I can heal emotionally.

But I haven't been able to go through with surgery. I did find a really good doctor at UCLA, and at some point, I will have the surgery.

Q. You never went back to Dr. Chambers after this encounter in November of 2020?

A. No.

Q. Do you know Dr. Chambers ex-wife?

A. No.

Q. Thank you very much, Patient A. I have no further questions.

HEARING OFFICER GHUSIN: All right. Let's take a quick look at our time and what's next.

And that would be, Dr. Chambers, do you intend to cross-examine Patient A?

DR. CHAMBERS: I do.

HEARING OFFICER GHUSIN: Okay. Not going to hold you to -- how long do you think it would take? Should we call it a day now, or are we good to go until five o'clock?

DR. CHAMBERS: I would like to continue, if that's possible.

HEARING OFFICER GHUSIN: Let me ask Patient A. Are you willing to --

THE WITNESS: Yes. Thank you.

HEARING OFFICER GHUSIN: You'd like to continue today?

THE WITNESS: Yes.

HEARING OFFICER GHUSIN: It may spill over until tomorrow anyway. Do you understand that?

MS. MOONEYHAN: I --

HEARING OFFICER GHUSIN:

Do you understand that?

THE WITNESS: Yes. That's okay.

HEARING OFFICER GHUSIN: Okay.

Everyone good? We don't need another break.

MS. MOONEYHAN: No, Your Honor.

HEARING OFFICER GHUSIN: Okay. I think we're good to go until 5:00. Thank you, everyone.

Okay, Dr. Chambers.

DR. CHAMBERS: Would you like to take a minute, Patient A?

HEARING OFFICER GHUSIN: Yes.

THE WITNESS: No.

CROSS-EXAMINATION

BY DR. CHAMBERS:

Q. I'm going to start with something said. You did an interview with the Daily Beast --

MS. MOONEYHAN: Objection. Relevance.

DR. CHAMBERS: It points to something she said here that contradicted what said in the article.

HEARING OFFICER GHUSIN: Do you have that interview?

DR. CHAMBERS: I have it on my phone. I don't have it printed with me.

HEARING OFFICER GHUSIN: Because that's something you should probably offer that into evidence if you intend to cross-examine her about it.

DR. CHAMBERS: Okay. All right. I'll try another way.

HEARING OFFICER GHUSIN: Okay. Thank you.

BY DR. CHAMBERS:

Q. At any point after the examination, did you say to anyone, including the police, that you did not know what I inserted into your vagina?

A. Did I say that to anybody?

Q. Yes. Or to the police?

A. I -- I (inaudible) what I said to the police.

THE REPORTER:

I can't hear her.

HEARING OFFICER GHUSIN: Patient A, I'm going to ask you to speak up again. The court reporter's having a little bit of trouble.

Thank you.

THE WITNESS: I'm just trying to remember what I said to the police.

MS. MOONEYHAN: Your Honor, I have a question -- I have an objection, really.

I'm not sure that Patient A, on direct, testified that she did know. She said she felt stretching, then what he told her.

I don't think she ever said she knew what was inserted into her.

DR. CHAMBERS: Your Honor, she said, "I felt his knuckles."

HEARING OFFICER GHUSIN: Overrule it.

DR. CHAMBERS: You're overruling the question or --

HEARING OFFICER GHUSIN: Overrule the objection.

DR. CHAMBERS: Thank you, Your Honor.

THE WITNESS: I felt his knuckles during -- at the time exactly during the exam, I couldn't imagine -- you know, during the exam, I couldn't imagine what he could be -- I never -- had no concept that he would be inserting his hand into my vagina.

When he came and told me he had put his fist in the vagina, that's exactly what it felt like. I didn't see it with my eyes.

BY DR. CHAMBERS:

Q. Did you scream during the examination?

A. No.

Q. Did you see how I prepared my hands to examine you?

A. No.

Q. Did you see how many gloves I put on to examine you?

A. No.

Q. Did you see how many packets of lubrication I used to examine you?

A. No.

DR. CHAMBERS: Your Honor, I'd like to introduce Exhibit A -- or 1, the packet of lubrication I used.

MS. MOONEYHAN: Your Honor, exhibit -- what's emerged as Exhibit A is Dr. Chambers' CV, and there are exhibits behind that. I believe he's trying to introduce a packet of lubrication that is not the exact one that you used that day.

DR. CHAMBERS: Well, it came from the same packet I used.

HEARING OFFICER GHUSIN: Where are --

DR. CHAMBERS: And this is --

HEARING OFFICER GHUSIN: I'm sorry. Where are we as far as his exhibits?

MS. MOONEYHAN: He's trying to introduce it now as an exhibit. None admitted, but they have been labeled --

HEARING OFFICER GHUSIN: Okay.

MS. MOONEYHAN: -- A through T.

DR. CHAMBERS: Your Honor, in preparing this case, I realized that we're talking about fisting, and as my witness tomorrow will testify, when you fist someone,

you need a ton of lubrications.

And the purpose of this introduction is to show the only packet of lubrication that I use on every single patient I examine, to show that there's no possible way to lubricate my entire fist --

MS. MOONEYHAN: Your Honor, I would submit that Dr. Chambers is currently testifying.

HEARING OFFICER GHUSIN: I agree.

Dr. Chambers, you can testify on your case in chief about this.

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSIN: You could ask her --

MS. MOONEYHAN: Your Honor, the witness has answered the question that she did not see what lubrication had been used.

HEARING OFFICER GHUSIN: Did she answer that question, counsel?

DR. CHAMBERS: She did. She did.

HEARING OFFICER GHUSIN: Okay. Then let's move on, Dr. Chambers. You'll have an opportunity to discuss that.

DR. CHAMBERS: Okay. All right.

BY DR. CHAMBERS:

Q. You said used the term "lips" instead of labia; is that correct?

A. Yes.

Q. Are you aware that in multiple medical textbooks, journals, also seen in medical writings on the internet, labia minora is often referred to as the inner lips the labia majora --

MS. MOONEYHAN: Your Honor, I'm going to object. I would say that this question is argumentative, but if the witness has stated --

HEARING OFFICER GHUSIN: Overrulled, counsel.

Counsel, ask a simple question of the witness, please.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

Q. Have you ever heard the term "inner labia minora" referred to as inner lip?

A. Probably.

Q. You also --

HEARING OFFICER GHUSIN: And I'm sorry to interrupt again, and I know this is difficult for Patient A.

I'm going to ask you to answer audibly so the court reporter can pick it up.

THE WITNESS: I said probably.

HEARING OFFICER GHUSIN: Thank you very much.

BY DR. CHAMBERS:

Q. You also mentioned that I said "kissing the lips." When I -- do you remember when I did or said when I mentioned the term "kissing the lips"?

A. You put the labia together so that you can excise or cut them to match.

Q. Okay. Thank you.

You complained to the Medical Board and later repeated the same statement that I asked you about intimate moments with your husband --

MS. MOONEYHAN: Objection. Beyond the scope of direct examination.

HEARING OFFICER GHUSIN: It is allowed in administrative hearings under the relaxed rules of evidence.

But keep it simple, please, Dr. Chambers. I'm not going to allow you to go too far afield. She's absolutely right. That was outside the scope of direct, but we're not in a courtroom either.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

Q. You said you came to the office for pain in your perineal. But during the consultation, you handed me -- Exhibit number 2, if you turn to that please. You see a 2 on the tab.

A. (Witness complied).

Q. If you go to NSBME 0023, then 24.

HEARING OFFICER GHUSIN: I'm sorry, Dr. Chambers. Will you repeat that? What?

DR. CHAMBERS: Exhibit 2, pages NSBME 0024.

MS. MOONEYHAN: That's in exhibit 3.

DR. CHAMBERS: Exhibit 3. Sorry.

BY DR. CHAMBERS:

Q. Other than my writing your first initial, your last name, my signature, the word "noted," as well as the date, is everything else on that form what it was when you gave it to me?

A. I'm assuming so. I didn't have time to read the whole thing.

Q. Is that your handwriting on both pages?

A. Yes.

Q. Okay. What is title of that document?

A. "Vagina Repair Consultation."

Q. Okay. If you go down to where it says "sentence" on page 23, can you read what it said, the first thing that it says there, starting with pain?

A. It says:

"Pain and discomfort around the opening of my vagina for almost 12 years."

Q. Okay. And if you go down to the last subsection of that paragraph, where it starts with "sex can be," would you please read that for me?

A. It says:

"It can be painful if not lubricated. My husband has learned some areas not to touch. Lubricant is used to be an occasional thing that we didn't use very often. Now it's necessary."

Q. Okay. Keep going, please.

MS. MOONEYHAN: I'm just wondering what the point of the --

DR. CHAMBERS: The point of this question is, part of the complaint was that I discussed sexual matters with her.

THE WITNESS: I never complained that you discussed matters with me.

HEARING OFFICER GHUSIN: Okay. Hold on Patient A, let us settle this.

THE WITNESS: In general.

HEARING OFFICER GHUSIN: Hold on.

DR. CHAMBERS: Am I not allowed to discuss her complaint to the Board?

HEARING OFFICER GHUSIN: Yes, sir, you are.

DR. CHAMBERS: Okay. Thank you.

HEARING OFFICER GHUSIN: Ms. Mooneyhan, did you have a response?

MS. MOONEYHAN: Yeah. Your Honor, I would just like to point out that that was not a part of the complaint as filed by the Investigative Committee.

The Investigative Committee is focused on the taking of the photographs and the using of the term "fisting." It did not --

HEARING OFFICER GHUSIN: Correct.

MS. MOONEYHAN: -- (inaudible) any issues related to discussing the patient's sex life, questions that she had about her sex life.

DR. CHAMBERS: Was it not the basis for that complaint?

HEARING OFFICER GHUSIN: Yeah, Ms. Mooneyhan, is that correct? Isn't that the basis for everything is the examination and what she came to see him for?

MS. MOONEYHAN: Correct.

And I believe the patient stated that the main reason she was there was for pain.

DR. CHAMBERS: Yes. She said she inquired about cosmetic gynecologic procedures.

HEARING OFFICER GHUSIN: Okay. Again, I'm

going to allow this to go forward.

Let's keep it very simple, Dr. Chambers.

I believe he has the right to question on the basis of her coming to see him, and --

MS. MOONEYHAN: Your Honor, just --

HEARING OFFICER GHUSIN: -- the communication between them.

MS. MOONEYHAN: Just -- Your Honor, just maybe to forestall any other further objections, maybe Dr. Chambers can focus on asking non-compound questions, one question at that time?

HEARING OFFICER GHUSIN: Okay. And as I said, let's keep it simple.

And it is challenging, Dr. Chambers, I know, as you're not represented by counsel, and this is not your wheelhouse, but let's keep the questions simple. Again, I agree with Ms. Mooneyhan. Okay?

And although I have some latitude in an administrative hearing regarding the admissibility of evidence, anything that might actually help me or -- but let's not go too afield, please.

DR. CHAMBERS: We'll do.

HEARING OFFICER GHUSIN: Thank you.

DR. CHAMBERS: I know what I'll do. I'll have her read the statements to herself, as to not create any

embarrassment.

BY DR. CHAMBERS:

Q. Would you please read the following section that says "feels like" to yourself, please.

A. (Witness complied).

Q. Okay. Continue on to page 24, the next sentence.

A. (Witness complied).

Q. And if you go down to four more dots where it says "it takes more."

A. Um-hum.

Q. And if we go down to the questions about surgery, if you go down six dots down where it says "how will this change," and if you go to the second from bottom of that section "I saw," and then "okay."

When given those questions, which I addressed individually with you, do you think it was fair that you complained to the Board that I asked you about sexual matters?

A. I don't recall complaining that you asked about sexual matters in general. I've always been very open about the fact that I came in with some questions about sexual matters, and there may have been specific things that I wasn't comfortable with, but, in general, discussing sexual matters wasn't a problem for me.

I had seen on your website that you are a certified sexual health doctor, and that's the reason that I even thought to discuss it with you.

And I was hoping to get help. I was hoping that -- like, what I was hoping for was we could check my hormones, see if everything was good. I mean, things had changed since my last childbirth, and that was what I came in -- those were the expectations I came in with.

Q. Okay. Well, the public was made to believe that I was making inappropriate inquiries, and so I wanted to clear that, that I didn't just out of the blue ask you about that.

MS. MOONEYHAN: Your Honor, does Dr. Chambers have a question or is he testifying?

DR. CHAMBERS: I'm moving on to my question.

BY DR. CHAMBERS:

Q. Did you expect me to address any sexual dysfunctions you mentioned during the conclusion?

A. I wouldn't call it "sexual dysfunction," but, yes, I expected you to address questions that I had about sexual function.

Q. Okay. Did you ask me about Dr. Red Alinsod during the consultation?

A. I -- I don't remember, honestly, but what I do remember is that we didn't -- I didn't ask you any of my

questions until after the examination because I didn't want -- I didn't know if I had a rectocele, so I didn't even want to discuss surgery for a rectocele since I hadn't been diagnosed with it.

Q. Can you recall when you, as written here on page 24, when you asked me how many of these procedures I've done, if I have heard of Red Alisod's technique that you listed on that same page on the questions about surgery?

A. I don't recall. I may have.

Q. Okay.

A. I wrote I down here, so I probably did if I was still concerned about it.

Q. How did you learn of Dr. Alinsod?

A. Just a Google search about vaginoplasty, rectocele repair.

Q. Did you visit his website?

A. I'm assuming I did because I had a question about what he called "the surgery."

Q. Okay. Do you recall looking at his photo gallery of before and after photos?

A. I don't know.

DR. CHAMBERS: Your Honor, is it appropriate for me to introduce an exhibit that I'd like for her to compare what's on Dr. Alinsod's website with the pictures

I took of her?

HEARING OFFICER GHUSIN: Ms. Mooneyhan?

MS. MOONEYHAN: Well, Your Honor, my question is if it's appropriate for Patient A to testify on comparing photos of different vagina -- pictures of vaginal areas.

If Dr. Chambers wants to attempt to admit such evidence later for Your Honor to do, but I don't think Patient A has testified about the photos that were on her phone. That's what she had knowledge about, and I don't think she should be asked to compare that to --

HEARING OFFICER GHUSIN: Let me ask you, Dr. Chambers, I tend to agree with Ms. Mooneyhan.

DR. CHAMBERS: But I thought --

HEARING OFFICER GHUSIN: What is the purpose of this?

DR. CHAMBERS: I'm not asking her to compare vaginas.

The purpose of the comparison is to show how the doctor who taught cosmetic GYN surgeons how to size a patient's vagina, how his website displays pictures of him sizing patients vaginas using two, three, and four fingers.

It's not meant for her to critique the vagina, how they look; it's about the measuring technique that he

tells us and teaches all of us to --

HEARING OFFICER GHUSIN: Okay. Let me jump in here, and, again, since you're not represented, we all have to be careful here.

But I will make a suggestion. Perhaps, might it be more appropriate -- I could see where you're going with this and that it may be relevant, but this may not be the right list of questions about it.

Perhaps, if it's something you want to argue in your case, you should talk to your expert about it.

DR. CHAMBERS: Okay. That's fair.

HEARING OFFICER GHUSIN: Ms. Mooneyhan, what do you think?

MS. MOONEYHAN: That's it exactly it, Your Honor. I believe there may be other --

HEARING OFFICER GHUSIN: Yeah.

MS. MOONEYHAN: Dr. Chambers will have the opportunity to put on his case in chief and/or there may be other witnesses, even in the IC's case, that he can discuss this with if his witness is not qualified to now to measure --

HEARING OFFICER GHUSIN: I agree that.

MS. MOONEYHAN: -- the opening of a patient.

DR. CHAMBERS: Okay. May I continue, Your Honor?

HEARING OFFICER GHUSIN: Please.

BY DR. CHAMBERS:

Q. Patient A, I point you to Exhibit 4, page 0030.

A. (Witness complied).

Q. Is it my fingers or fist that is in your vagina in that photograph?

A. Your fingers.

Q. If you look at my hand, can you say how far my fingers are inserted when you compare it to the gloves?

MS. MOONEYHAN: Your Honor, she already answered this question.

HEARING OFFICER GHUSIN: Okay. And I'm sorry. I actually didn't hear that answer.

THE WITNESS: His fingers.

HEARING OFFICER GHUSIN: Okay. Thank you.

DR. CHAMBERS: Okay. And I showed her my hand to see if she was able to discern from that photograph how far was my finger was inserted by looking at my hand in the pictures to discern --

HEARING OFFICER GHUSIN: If you could ask a question, Dr. Chambers, do you remember, don't testify, please.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

Q. From the photograph, can you see whether or not

my entire fingers were inside your vagina or just partially inside the vagina? Are you able to tell?

A. How much of your fingers are in my vagina?

Q. Yes.

A. Yesish. I mean, you had a glove on.

Q. Okay. Is it partial or the full length of my fingers?

A. It's partial.

Q. Thank you.

After I have done the Q-Tip testing on the outside of your vagina, I then proceed to insert two fingers into your vagina.

Do you recall what I asked you as I touched each points inside the vagina?

I first pushed up against your bladder, then I pushed on each side wall, and then I pushed down on the rectum. Do you recall what I asked and what your response was?

A. I don't recall a Q-Tip being inserted.

Q. Okay. For the record --

A. I recall you asking if there was pain.

Q. Okay. Thank you.

For the record, the Q-Tip test, which is done by some OB-GYNs, is part of the standard workup for pain.

I then did a rectal vaginal exam in which I

inserted one finger into your vagina and one into your rectum; is that correct?

MS. MOONEYHAN: Your Honor, I don't have an objection, but the patient has testified she couldn't see what was going on --

HEARING OFFICER GHUSIN: Okay.

MS. MOONEYHAN: -- things going on. She saw photos, and she testified as to what she was told.

DR. CHAMBERS: She could not feel my finger in her anus?

HEARING OFFICER GHUSIN: Okay. I'm going to sustain the objection.

And, Dr. Chambers, again, question, answer, question, answer.

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSIN: No testimony.

BY DR. CHAMBERS:

Q. Were you able to discern whether or not I had one finger in your vagina and one in your anus?

A. I definitely discerned your finger in my anus.

Q. Okay. Thank you.

For the record, a rectal vaginal exam --

MS. MOONEYHAN: Your Honor --

DR. CHAMBERS: Okay. I get it. It's not a question. I get it.

BY DR. CHAMBERS:

Q. Did I refer you to a urogynecologist?

A. Yes. Dr. Wasserman.

Q. Did you go?

A. Yes.

Q. A minute ago, you said you went to Dr. Lewis, but you've not gone to deal with these issues because of your alleged PTSD from my exam.

So you did go to Dr. Wasserman --

A. I said --

Q. Did he examine you?

A. -- (inaudible) surgery because --

HEARING OFFICER GHUSIN: Okay. I'm doing to jump in here, folks. I'm sorry. Just to keep it clean, and we're going to try not speak over each other as the court reporter has difficulty getting it down. Okay?

Please, try to wait until someone finishes before you start to answer.

Thank you.

BY DR. CHAMBERS:

Q. Did he examine you?

A. Yes.

Q. And what did he recommend?

A. Same. Surgery. Only he doesn't do labiaplasty, so he recommended the perineal repair and a

posterior repair -- I'm trying to remember. I haven't thought about this in -- it was over two years ago.

Q. Do you remember why I recommend that you see Dr. Wasserman?

A. So that I could have insurance pay for the procedures.

Q. Okay. And then the plan was that you would return to me for outer stuff; is that correct?

A. No. Because I didn't want to have -- I didn't want to have labiaplasty if I was going to lose sensation.

Q. Okay. At the end of the consultation, after you paid, did you leave right away?

A. No. I talked to the front-desk person. I believe her name was Casey.

Q. How long were you there?

A. I don't recall how long. How long did I talk to Casey?

Q. Yes.

A. I don't recall. I remember asking her if people were happy with the surgery, if she thought you were a good surgeon. I don't remember.

Q. Was I standing there with the two of you during this?

A. When I was asking if you were a good surgeon?

Q. Yes.

A. I don't think so.

Q. When we were standing at the back desk, did you see me standing next to you at the back desk, the patient desk, after the procedure? After the procedure?

A. The after exam, yes, we were standing near the back desk. Yes.

Q. Did you at any time say to me that you were in pain from the exam I just performed on you?

A. Well, other than when I told it was very uncomfortable, that's the only thing I ever said to you.

Q. Was the conversation between the three of us jovial?

A. Probably.

Q. Did you express your excitement to do the procedure?

A. I don't remember.

Q. Okay.

DR. CHAMBERS: I have no further questions for Patient A, Your Honor.

Thank you very much.

HEARING OFFICER GHUSIN: Thank you, Dr. Chambers.

Ms. Mooneyhan, any redirect?

MS. MOONEYHAN: Yes. Thank you. I have a few

questions.

REDIRECT EXAMINATION

BY MS. MOONEYHAN:

Q. Thank you, Patient A.

Just now, Dr. Chambers asked about a photograph with four fingers inserted. Just to clarify, the photo -- when he took the photos of the exam, when he (inaudible).

THE REPORTER: I didn't understand her.

HEARING OFFICER GHUSIN: I'm sorry, Ms. Mooneyhan. We're having some connectivity issues, so we didn't hear the question and answer. And we're probably going to go -- I don't know if -- it looks like we're going to wrap this up. Let's do ten more minutes anyway, and let's try it again.

And I'm sorry if I have to interrupt again, everybody.

MS. MOONEYHAN: Can you hear me now?

HEARING OFFICER GHUSIN: I can now. If you could ask that question again. I didn't get it either.

MS. MOONEYHAN: Sure.

BY MS. MOONEYHAN:

Q. Dr. Chambers asked you about the photo with his four fingers inserted in your vagina, and just to clarify, the series of photographs at the exam, you said

you were incredibly uncomfortable, were those the same event or were those separate --

A. It was two separate events.

Q. Those were two separate instances during that encounter?

A. Yes.

Q. You also stated that this -- the list, the two-page list that you had typed before you went in, you discussed all of those questions after your exam?

A. Yeah. We discussed the questions, which I felt were still relevant, after the exam and after he had told me his diagnosis and treatment recommendations.

Q. So, some of these questions about, you know, changes to your sex life and those questions he had you read, you hadn't discussed those before he performed the exam; is that correct?

A. Which questions? Like about my sex life?

Q. Yeah. Had you mentioned any questions about, you know, lubrication, sex, that sort of thing, before the exam?

A. I don't remember, honestly. I'm trying to think. If you give me a minute.

MR. WHITE: She said had or had not discussed before the exam? Was it clear for you?

HEARING OFFICER GHUSIN: I'm going to jump

quickly. Did you say had or had not discussed before the exam, Ms. Mooneyhan?

MS. MOONEYHAN: Well, that's -- I was asking if they had -- had discussed these questions before the exam. If there had been any mention of these questions before the exam.

HEARING OFFICER GHUSIN: Okay. Thank you.

THE WITNESS: I can't remember. I can't say for sure yes or no.

But I would expect, that, yes, if I had a symptom or a concern, that would have been discussed before the exam.

HEARING OFFICER GHUSIN: And you don't have to speculate. If you don't remember, it's okay.

THE WITNESS: I don't.

HEARING OFFICER GHUSIN: It's okay. It's fine. I think everyone's getting a little tired too. If you don't remember, it's okay.

THE WITNESS: Okay.

MS. MOONEYHAN: I have no further questions. Thank you.

HEARING OFFICER GHUSIN: Any recross, Dr. Chambers?

DR. CHAMBERS: Yes. Please. I just one question.

RECROSS-EXAMINATION

BY DR. CHAMBERS:

Q. At what point during the encounter did you give me this form?

A. At the very beginning.

DR. CHAMBERS: Thank you very much.

HEARING OFFICER GHUSIN: One moment.

DR. CHAMBERS: I'm finished, Your Honor.

HEARING OFFICER GHUSIN: Thank you.

Ms. Mooneyhan, any followup?

MS. MOONEYHAN: No, Your Honor.

HEARING OFFICER GHUSIN: Okay. Give me just a moment.

First, Patient A, I just want to thank you for -- I know this is difficult, but I would like a little clarification.

EXAMINATION BY THE HEARING OFFICER

HEARING OFFICER GHUSIN:

Q. I'm a little fuzzy about when you went back to your own GYN, Dr. Lewis, and you went to Dr. Wasserman, in the scope of time, did you go to them for different things?

I know those are two questions.

A. I went to Dr. Lewis because of the pain I was experiencing from the exam with Dr. Chambers.

Q. And that was soon after --

A. That was six days after the exam --

Q. Thank you.

A. -- with Dr. Chambers.

I don't recall the exact date of my visit to Dr. Wasserman, but that was just for -- not concerning the pain, it was concerning my initial gynecological issues.

Q. So you are still seeking some treatment for original your concerns?

A. Right.

Q. Okay. And you went to Dr. Wasserman on Dr. Chambers' recommendation. Did I get that right?

A. Yes.

Q. Okay. And to make sure I understand, my notes say because he recommended the same surgery, but he does not perform that surgery.

So, he recommended the same surgery that Dr. Chambers recommended; is that right?

A. Yes. I said to Dr. Chambers, "Why won't my insurance pay for this procedure?"

And he said, "It's because I do it in my office. There's no way for me to bill insurance, but if you go see Dr. Wasserman, he'll do the exact" --

And I remember I said, "Is it the exact same

surgery?"

He said, "Yes, it's the exact same surgery, only he'll bill your insurance."

So, Dr. Wasserman is partnered -- I mean same practice as Dr. Shae, who was the other doctor Dr. Lewis had originally recommended that I go see.

Q. Okay. So, Dr. Chambers said to go to Dr. Wasserman, he'll do the same surgery and insurance would cover it.

But Dr. Wasserman said, "I don't do that surgery"; is that right?

A. No. Wasserman does do the surgery.

HEARING OFFICER GHUSIN: Oh, okay. See my notes are wrong then.

MS. MOONEYHAN: Your Honor --

HEARING OFFICER GHUSIN: Go ahead, Ms. Mooneyhan.

MS. MOONEYHAN: Can I ask a follow-up? I --

HEARING OFFICER GHUSIN: Please.

FOLLOW-UP EXAMINATION

BY MS. MOONEYHAN:

Q. Patient A, when you're talking about the surgery that Dr. Chambers recommended and what Dr. Wasserman was going to do, you said he did something to other parts. Were you talking about the rectocele

repair?

A. Right. So, the only thing -- from what I remember, the only thing Dr. Wasserman didn't do would be a labiaplasty.

If I wanted to to have a labiaplasty, that would need to be Dr. Chambers.

Q. So Dr. Wasserman didn't do the cosmetic portions, but he would do the rectocele repair and the perineal repair?

A. Correct.

Which, just to clarify, I did actually discuss also -- I did -- like the labiaplasty, I never went -- you say "cosmetic," my intention wasn't to have a cosmetic fix to my labia; my intention was to deal whatever was causing discomfort and pain.

I had asked Dr. Chambers if a labiaplasty would help with that.

HEARING OFFICER GHUSIN: Thank you for the clarification.

Any follow-up, Ms. Mooneyhan? Any more?

MS. MOONEYHAN: No. Thank you.

HEARING OFFICER GHUSIN: Dr. Chambers, any follow-up?

DR. CHAMBERS: Yes.

BY DR. CHAMBERS:

Q. We go back to --

HEARING OFFICER GHUSIN: And I'm just going to forewarn you that we have to wrap this up in five minutes today.

DR. CHAMBERS: Correct. Correct.

BY DR. CHAMBERS:

Q. If we go back to the documents that you gave me on page 23 and 24, section 3.

HEARING OFFICER GHUSIN: Which exhibit?

DR. CHAMBERS: Section 3, Exhibit 23 and 24. So document entitled "Vagina Repair Consultation."

I'll try not to say it out loud, Your Honor.

BY DR. CHAMBERS:

Q. Go on to page 24, the top of the page where it says "the inner," can you read that statement, the three-line statement to yourself.

A. Okay.

Q. With specific attention to the word "often I have," to the end of sentence, and then the next sentence.

A. (Witness complied).

Q. Do you recall us discussing how labiaplasty might prevent that problem?

A. I don't recall a lot about that, but, yes, I'm

sure we discussed it.

And that's -- I just said that the concerns I had for my labia were for pain and discomfort. That's what we addressed. Yes.

DR. CHAMBERS: Thank you. No further questions.

HEARING OFFICER GHUSIN: Thank you.

Ms. Mooneyhan?

MS. MOONEYHAN: No more questions, Your Honor.

HEARING OFFICER GHUSIN: Okay. Are you going to keep this witness on recall for tomorrow, or is she excused?

MS. MOONEYHAN: She's excused.

HEARING OFFICER GHUSIN: Thank you, Patient A, for being here today. Okay?

THE WITNESS: Yes.

HEARING OFFICER GHUSIN: And good luck.

All right. So, looking ahead, I assume, Ms. Mooneyhan, Patient B tomorrow morning?

MS. MOONEYHAN: Yes, Your Honor. We intend to call Patient B and Dr. Rafael tomorrow.

HEARING OFFICER GHUSIN: In that order?

MS. MOONEYHAN: Yes.

HEARING OFFICER GHUSIN: Okay. At 9 o'clock?

MS. MOONEYHAN: Yes, ma'am.

HEARING OFFICER GHUSIN: Okay. And Dr. Rafael is here?

MR. WHITE: He's in Reno.

HEARING OFFICER GHUSIN: Okay. He's going to be in Reno. All right.

Any other matters?

DR. CHAMBERS: Ms. Ghusin, I have a question.

HEARING OFFICER GHUSIN: Yes.

DR. CHAMBERS: I told my expert witness we wouldn't need him until the afternoon. Should I adjust that time?

HEARING OFFICER GHUSIN: I think we're probably going to stick to it.

I guess if there's a chance that we're done early and he's available, we could address it at that time. Right now, I don't know.

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSIN: I mean, we have a time, it's a certain time, we could stick with that time.

But if we're done at, say, ten o'clock or 10:30 and he's available and we're willing to do that, we could talk about it then.

DR. CHAMBERS: Okay. Thank you very much.

HEARING OFFICER GHUSIN: Any objection to that, Ms. Mooneyhan?

MS. MOONEYHAN: No, Your Honor.

HEARING OFFICER GHUSIN: Okay. Otherwise we may have -- what? -- like a three-hour break in the middle, possibly.

So, let's just deal with it when comes up. Okay? Perfect. All right.

Thank you all. See you in the morning.

(Proceedings ended at 4:55 P.M.)

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

I, BRANDI ANN VIANNEY SMITH, do hereby certify:

That I was present on May 2, 2023, at the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada, and took stenotype notes of the proceedings entitled herein, and thereafter transcribed the same into typewriting as herein appears.

That the foregoing transcript is a full, true, and correct transcription of my stenotype notes of said proceedings consisting of 157 pages.

DATED: At Reno, Nevada, this 10th day of May, 2023.

/s/ Brandi Ann Vianney Smith

_____
BRANDI ANN VIANNEY SMITH

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

In the Matter of Charges and Complaint Against: Case No. 22-27891-1

GEORGE PETER CHAMBERS, M.D.,

Respondent.
_____/

TRANSCRIPT OF HEARING PROCEEDINGS

VOLUME II

Held at the Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, Nevada

and videoconference

Wednesday, May 3, 2023

Reported by: Brandi Ann Vianney Smith

Job Number: 974172

A P P E A R A N C E S:

THE HEARING OFFICER:	NANCY GHUSIN, ESQ. nmg416@gmail.com
FOR THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS:	BRANDEE MOONEYHAN, ESQ. (by video) DONALD K. WHITE, ESQ. Deputies General Counsel Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 mooneyhandb@medboard.nv.gov dwhite@medboard.nv.gov
FOR THE RESPONDENT:	GEORGE PETER CHAMBERS, M.D., In Pro Se (by video)
ALSO PRESENT:	MERCEDES FUENTES Legal Assistant Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 fuentesm@medboard.nv.gov

I N D E X

E X H I B I T S

(Admitted but not attached) PAGE

On behalf of the Investigative Committee:

RENO, NEVADA -- MAY 3, 2023 -- 9:00 A.M.

-o0o-

HEARING OFFICER GHUSIN: Back on the record in the matter of Dr. George Chambers. This is day two of the administrative hearing.

We have a couple housekeeping matters that we'd like to put on the record. Dr. Chambers had requested a sidebar discussion, and we discussed a couple of other items also.

Let me start with the first item regarding public spectators and the entrances, and I'll ask Ms. Mooneyhan to address that matter, please.

MS. MOONEYHAN: Thank you, Your Honor.

Yes, as we discussed, there is the door that I believe I just can see on the video behind me, that's the primary entrance for the public. In, also, the corner of the room is a door that Medical Board personnel used to access the back offices.

I'm not sure you were aware that yesterday, Patient A came through that door, and today Patient B will come through that door, through that staff door.

They're at a conference table in the back area for their comfort.

And Dr. Chambers expressed a concern that a

member of public had accessed to that door, and we were going to ensure today that the only persons going through that door are Board staff members or witnesses, IC witness.

And as an officer of the court, I make a representation that a member of public that did access that door had no affect on the prosecution of this matter or on the witness testimony.

HEARING OFFICER GHUSIN: Okay.

And, Dr. Chambers, as I had expressed, we cannot even see that door from up here, so I was not even aware of that.

Are you satisfied with this a result, sir?

DR. CHAMBERS: I am.

HEARING OFFICER GHUSIN: Okay. Thank you very much for bringing it to our attention.

The next item, again -- good morning, media, and just a reminder again that that order is in affect. And welcome, good morning, and just a reminder.

And I also mentioned in your sidebar, and I'd like to put it on the record, I am aware that there is press on this matter, and there has been for sometime. I had divulged that I had not read anything, so what I know is what I hear in the hearing.

And if people around me have read anything, I

have asked them not to discuss what they read with me to protect the integrity of this hearing process and the rights of all those involved. And I just wanted to put that on the record.

The third item is with respect to our court reporter up here. She will interrupt if she needs to have something that we stated, that she doesn't catch something.

A few of us up here were exchanging glances if we didn't get something. She's just going to speak up and interrupt today if she needs to get something so we have a pristine record.

And I think you just heard that too, Dr. Chambers -- correct? -- and Ms. Mooneyhan.

DR. CHAMBERS: I did.

MS. MOONEYHAN: Yes.

HEARING OFFICER GHUSIN: All right. We've discussed it here, and she's just going do it on her own. So she's not going to wait for me, I'm not going to look at Mr. White, she's just going to speak up, and I will too if I don't get something. All right?

Any other preliminary matters before we dive in this morning?

MS. MOONEYHAN: I just wanted to confirm, Your Honor, that any rebuttal witnesses will be testifying on

July 1st, the third day of the hearing.

HEARING OFFICER GHUSIN: And we all agreed to that as well in our sidebar. So, yeah, it's on the record, and we'll just how it comes out at the end of the day.

MS. MOONEYHAN: Thank you.

HEARING OFFICER GHUSIN: Anything else, Ms. Mooneyhan?

MS. MOONEYHAN: Nothing from me. Thank you.

HEARING OFFICER GHUSIN: Dr. Chambers, anything else?

DR. CHAMBERS: Nothing from me too.

HEARING OFFICER GHUSIN: Okay. Perfect. All right.

So, Ms. Mooneyhan, you're up.

MS. MOONEYHAN: Thank you. I'd like to call Patient B.

HEARING OFFICER GHUSIN: Thank you.

MS. MOONEYHAN: Your Honor, like yesterday, before Patient B is sworn in, I would like to take a moment just -- in order to protect her identity, I represent that Patient B that's identified in the patient designation filed on of September 1st, 2022, under seal, so I'd ask that she be sworn in as Patient B, and then my first few questions will address her establishing that

she is Patient B.

HEARING OFFICER GHUSIN: Thank you, Ms. Mooneyhan. That's what we'll do. Go ahead.

(The oath was administered.)

THE WITNESS: Yes.

HEARING OFFICER GHUSIN: Thank you.

DIRECT EXAMINATION

BY MS. MOONEYHAN:

Q. Patient B, preliminarily, I just want to let you know that they are having trouble a little bit with hearing in the Reno office.

So, when you -- it is going a little awkward, but when I ask you a question, when you answer it, if you could look at that camera on the wall, that seems to help them hear a little bit better. Because the court reporter is reporting --

HEARING OFFICER GHUSIN: We'll will you know if we can't hear. If you need to adjust.

THE WITNESS: Okay.

HEARING OFFICER GHUSIN: Thank you.

BY MS. MOONEYHAN:

Q. Thank you. I'd like the record to reflect that I've handed Patient B the patient designation with all the patient names redacted, except for her name.

I've also given Dr. Chambers a copy.

Item two on that document, Patient B, it states Patient B, the name of Patient B. Is that your name?

A. Yes.

Q. Is that your date of birth?

A. Yes.

Q. Thank you.

Do you know the respondent, Dr. Chambers?

A. Yes. He was my doctor for over seven years.

Q. In that -- in those seven years, do you remember approximately how many times you saw Dr. Chambers?

A. Not really. I saw him for my yearly exams. I did see him a lot when I was pregnant with my son. I saw him a couple of times after I delivered my son. That was about it.

Q. And what time span did your relationship with Dr. Chambers cover?

A. Over seven years.

Q. Do you know the time span, like, when it began and when it approximately ended?

A. I think I began when -- I think he was born in 2013, and I had seen him before I got pregnant.

Q. And when was your last visit with him?

A. October of 2018.

Q. Were you aware that Dr. Chambers does cosmetic

gynecological surgery?

A. Yes, I was aware because there were posters in his office.

Q. Did you ever inquire about having cosmetic gynecological surgery?

A. Absolutely not.

Q. Did Dr. Chambers perform any other surgeries on you?

A. No.

Q. Why did you stop seeing him? Why was your last visit in October of 2018? Why did you discontinue using him as your primary gynecologist?

A. I discontinued using Dr. Chambers because I believed that over the seven years that we had a doctor-patient relationship, he had tried very hard to earn my trust. He had asked me a lot of questions about my childhood, about my past experiences, about any sexual abuse, rape, things like that.

And because he was my doctor, and such an intimate one, I did feel that it was important for me to answer those questions, as uncomfortable as it was to answer them.

And so -- but it was the last visit that I did see him for a second opinion on a breast lump. I needed some scans ordered, and he was friendly as usual, he greeted me when he first came in, he had a nurse with him, he had two

student doctors.

His introduction was him telling that I was his patient who was ganged raped. I definitely did not feel okay about that because these were student doctors that I had never met and that was something that I had told him in confidence, and I told him about that in detail too.

It had been years ago, but it was something that I had trusted him thinking that it was important for him to know for my sexual health, but also because he asked.

And then in the exam, I was asked to undress completely, even though that I knew that I was only there for a breast exam, I was told to undress from the waist down as well.

So I just assumed that maybe it was -- that maybe I was due for my Pap smear. I wasn't really sure, but this was a doctor's office, and I tried to comply as much as I always do when I see a doctor.

So, I undressed, I had a paper gown over my waist, my legs, and then I had another one of those paper-gown-shirt things that went over my chest.

Q. Let me stop you there just to clarify a few things. Who told you to get undressed?

A. The nurse. The nurse told me to undress.

Q. And that visit in October of 2018, your primary reason for visiting was because you had concerns about a

breast lump?

A. Yes. And I needed a second opinion -- I needed scans to be ordered.

Q. And there were -- so you undressed, you put on paper gowns, you were alone when you undressed and put on the paper gowns; is that correct?

A. Yes.

Q. And then Dr. Chambers entered the room with -- being accompanied by three other people?

A. A nurse and two student doctors, all female.

Q. Okay. And then how did the exam proceed? Did you explain to him why you were there?

A. Yes. And so he did a breast exam. He did a breast exam, and he was just his, you know, usual friendly, chatty self. I don't remember exactly what he was talking about during the exam.

When he was giving me the exam, he had asked about -- I had had implants since the last I saw him, so he was asking me who was my doctor, how do I like them, and I told him some of concerns that I had about them.

He said, "Sit up so I can see them."

And the two student doctors were definitely in the room. At this point, I don't remember if the nurse had already left, but the two student doctors were still there.

And he sat on the chair. He had me sit up. I was

naked under the paper gown, and he was giving me his opinion on my breasts, what he thought about them.

And after that, he asked -- so by this time, there were only the two student doctors remaining, and he specifically said, "Could you leave so I could speak with Angela privately."

So they left. And I didn't object in that moment because, you know, this was my doctor. I truly did trust him, and I thought that he always had my best interest in mind.

They left and I thought just maybe he wanted to talk to me about something that was more private, maybe something that did have to do with my past. Unlike how he, you know, immediately told them that I was raped, I thought that maybe this time he wanted to, you know, keep my confidence and talk to me in private.

So, it was awkward being naked, but I just went with it. It was -- it's a very awkward situation to be in.

Q. Patient B, let me interrupt. So the gown had not been pulled back down at this point when he asked the student doctors to leave the room; is that correct?

A. The waist, yeah, the gown that was over my waist. I was exposed from the waist up, but the waist -- I still had the paper gown from my waist covering the lower part of my body.

Q. Okay. Thank you.

A. And after the student doctors left, he asked me if I had ever posed nude before. I told him that I hadn't and was wondering why he would ask such a question like that.

And then he told me about his patients, him asking some of his patients to be models for him, and that this was for his ads. He said that I wouldn't need to show my face, that was up to me.

And I knew right off the bat that it was incredibly inappropriate. It was crossing so many ethical boundaries.

But, you know, when you're in that situation, it's very -- it's very difficult to find the right words. And also, I was naked. It's a very uncomfortable situation to be in.

And he told me that he could pay $25 per stock photo. You could do that for his ads. But why wouldn't you do that because he wants a real woman. He wanted women who had been through so much, just like I had been.

He knew that I had some childhood trauma, he knew that I had been raped as a teenager, he knew that I had struggled sexually in my own intimate life because of the rape, because of the trauma, because of the PTSD.

He knew all of that, and he proceeded to tell

me -- to actually go on and on how, because of my past, this would be very empowering for me. This would be the thing that could heal me because so many men have treated me a certain way growing up, and then, of course, the rape.

So this, with him, would be empowering for me to do.

I tried to steer the conversation away. I don't remember everything I said, but I just remember how uncomfortable I felt.

He pulled out his phone, he showed me a picture of a model that he claims was one of his patients. It was filtered, the image that he showed me, much like the ones that he has on his Instagram, and --

Q. Patient B, what was -- do you remember what the picture was of? Was it --

A. It was a woman who was naked, she was in a squatting position, and kind of looking back like that (indicating), but she was naked and she was squatting and, you know, that's the best way I can describe it.

Q. Okay. Thank you.

A. And he told me that if I do this project, that I could not tell my husband. He said I -- he would give me copies of photos, because he said, "What woman wouldn't want to have professional nude photos to give to their husband. But you cannot tell your husband who was

the photographer. You cannot tell him where it was taken," and reminded me of that quite a few times.

And, you know, again, it was just a very -- you know, I knew since I had seen him last -- I mean, here he was saying he wanted real woman, and I knew that since I had seen him last, he did not know that I had laser hair removal, and somehow that just popped in my head as to kind of, you know, I had laser hair removal down there anyway.

And he said, "Stand up. Let me see."

So, I stood up and the gown that was covering my waist dropped, and I just stood there like this (indicating). And he sat right there in the chair (indicating), his little black chair, and he looked my body up and down. He looked right there at my vagina, but from that view, and he said, "Perfect. Even more perfect."

And the conversation went on, it went on about the empowerment, and again about how I couldn't tell my husband. And, you know, I never repeated everything he was saying.

And then he told me that his other patients really enjoy it, and they get very seductive when he tells them to fuck the camera.

I remember at this point, he was not sitting. I was sitting on the bed, he was standing right here (indicating), and I remember him doing the motions of fuck the camera. You know, I really felt that his point was, you

know, other women have done this, and this has been empowering for them, therefore, it should be empowering for you because you have been through so much.

Q. Patient B, you said that part of -- he told you that you can't tell your husband who the photographer is. And I believe you may have answered this question, but did he tell you who the photographer would be?

A. He told me that he was the photographer. He told me that he took the pictures of patients. He told me he tells them to fuck the camera, and he said they get really into it, which is fine, if other patients want to do it, but not for me.

Q. Did he offer you anything in exchange for participating in this project?

A. Yes. He did say, "The gig pays $1,000."

Q. What did you tell him about -- how did you respond to this offer?

A. I just remember responding in the way that I respond when I'm nervous and uncomfortable, just kind of trying to -- I didn't know what to do. I was naked. I certainly didn't say yes. I just kept saying ha, ha, ha, you know.

I just wanted it to be over, and the only way the conversation finally ended -- and I would say this was a fairly long conversation. The way it ended was he told me

to text him with my answer, but he made it very clear, he said, "Do not text me with any details. Just say, yes, I'm interested in doing the project, or, no, I am not interested in doing the project." And again made it very clear, do not put any details in the text.

Q. So when the conversation was through, did Dr. Chambers leave the room?

A. The conversation was through after we agreed that I would text him my answer. He left the room.

Q. And did -- so what happened then? Did you dress?

A. Then I got dressed, and I remember leaving -- walking out of the room. I saw Chambers on my right, standing at the counter in the back of the medical office. He was -- I would assume he was making notes in my chart. And it was a very friendly goodbye. I left.

And going down the elevator and out to my car, I knew exactly what happened. I knew what happened while the conversation was going on. And there's so many things I wish I would have done or said instead.

But it's a situation that's very hard to deal with, even for myself, as a 35-year-old woman at that time, knowing that it was inappropriate.

This was my doctor that I trusted. I mean, I shared some of the most intimate details with him. I talked

to him about my sex life -- I answered questions about my sex life, more like, but, you know, and just talking to him about things that I've gone through as a child. I did. I trusted him with a lot.

Q. Did you subsequently text him your decision?

A. Yes. I was so disturbed that, not only did I call my sisters and a couple good friends right after it happened, I was in shock, I couldn't -- and it was disappointing to me too because I felt incredibly betrayed and violated, and I did feel that, you know, this was my doctor of seven years.

Now not only did I have to find another doctor, I -- who can I trust, there were a lot of feelings going through my head.

So, I saw my therapist, I and discussed it with her. And, of course, we discussed, and she agreed, that it was incredibly inappropriate. It was violating. It was -- and I while I was in the therapist's office, I sent him the text that I sent him, while I was in her office.

And as I was leaving and going back out to my car is when I received his response.

Q. And what did your text to him say, if you can remember or paraphrase?

A. Something about how doing -- I feel that doing this project would be highly unethical and that I'm not

interested and that I would be seeing another gynecologist.

Q. And do you remember -- can you summarize his response?

A. He said something along the lines that he didn't feel that it crossed patient boundaries, and that this is his only way that recruit models for his ads. Something along the lines of that. And then he wished for continued good health and best wishes.

He said that he was worried that he would lose some patients over this.

Q. Have you had other text discussions with Dr. Chambers since then or prior?

A. Yeah. Prior, yes.

The reason I got that number from him was because there was an appointment -- I don't remember if it was for birth control or my yearly Pap exam. I don't remember, but it wasn't a sexual consultation.

But in that appointment, in response to questions that he had asked, I was honest about having low libido, and he prescribed some medicine for me.

And he did message me -- or I don't remember if it was that day or the next day, but just -- it only had to do with the medication. There was nothing inappropriate.

And then he messaged me on another occasion before

this last experience with him asking me to vote for him for the top doctor awards, which I did, and this was before all of that happened.

And then after -- after his last message to me where he said that he didn't think it was violating the professional boundaries, I did receive a message shortly after that when my scans came back, and he told me that he received my scans and he told me the results of them and asked me what I wanted him to do with them.

And I responded, basically, just saying something along the lines of, I picked up my scans, and I'm seeing a different gynecologist.

Q. Thank you. Are you -- do you -- have you ever met Dr. Chambers's ex-wife?

A. I've never met Dr. Chamber's ex-wife.

Q. Thank you.

MS. MOONEYHAN: I have no further questions.

HEARING OFFICER GHUSIN: Thank you.

Dr. Chambers?

CROSS-EXAMINATION

BY DR. CHAMBERS:

Q. Good morning. You said I asked you to take pictures for my ad. Did I ask you or did you ask me about the ad yourself?

A. Oh, you asked me, and you know that. If there

ever was such an ad.

Q. You said I repeatedly asked you about sexual issues, your childhood, and rape. Was there a basis for that?

A. You didn't ask it -- in that particular exam, you were asking me about my orgasms, how strong they were, favorite sex positions, were my orgasms clitoral, were they vaginal, but --

Q. Why would I --

A. -- prior to that, years back, yes, you did ask me about my past, and I answered thinking that maybe this was important for you to know because you were taking care of such an intimate, you know, part of me, I guess.

Q. Why would I, just out of blue, ask you that? Did you see me or --

MS. MOONEYHAN: Objection, Your Honor. Calls for speculation.

HEARING OFFICER GHUSIN: Let him finish asking the question.

BY DR. CHAMBERS:

Q. Was there a reason why I asked that question?

A. Which question?

Q. About you orgasms and --

HEARING OFFICER GHUSIN: Okay. Dr. Chambers, I'm going to sustain the objection. It does call for

speculation.

Unless Patient B knows the answer to that, it's not speculation.

DR. CHAMBERS: Okay. I'll try it another way.

BY DR. CHAMBERS:

Q. Did you ever see me for a sexual health consultation?

A. Never.

Q. Never?

A. No. Was it brought up in exams? Yes. You would bring it up.

And when you would ask me, how about this, how about that, I would respond honestly because I trusted you and would tell you. I would give you answers to it.

And that's -- there was a cream that was prescribed to me, for my sex life.

Q. Would you please turn to section 7.

MS. MOONEYHAN: Patient B, there's the binder.

BY DR. CHAMBERS:

Q. There's a binder, section 7, NSBME 0105. Section 7, page number 0105.

A. (Witness complied).

Q. Can you read the date on that page?

A. April (inaudible), 2015.

Q. And what does the chief complaint say?

THE REPORTER: I'm sorry, Ms. Witness. I didn't catch your answer.

THE WITNESS: April 27th, 2015.

THE REPORTER: Thank you.

BY DR. CHAMBERS:

Q. And what does the chief complaint say?

A. Well, you wrote "sexual health," but I'm not saying that wasn't discussed, but I never made an appointment just for sexual health.

That doesn't mean that I -- that you hadn't run some blood work or things like that.

Why would I make an appointment for sexual health?

Q. All right.

DR. CHAMBERS: Ms. Ghusin, is it okay if I read the history of present illness from this visit?

MS. MOONEYHAN: Your Honor, I just question the relevance.

DR. CHAMBERS: The relevance is she has accused me of some salacious things. She's denied seeing me for sexual health consultation, and there's a note here that clearly shows that.

HEARING OFFICER GHUSIN: I'm going to allow it.

DR. CHAMBERS: Thank you. Okay.

MS. MOONEYHAN: So just to clarify, he's going to read this into the record? Is that --

HEARING OFFICER GHUSIN: Okay. In fact, Dr. Chambers, why don't you have Patient B read to herself, and then you could question her about that.

BY DR. CHAMBERS:

Q. You able to read it? My writing?

A. Your handwriting is atrocious. No.

Q. Okay.

DR. CHAMBERS: Do you have a copy of motion where I objected to their identities being kept confidential?

MS. MOONEYHAN: I do not.

DR. CHAMBERS: Because that was submitted in that motion, this entire paragraph. It was typed, and she would be able to read it more clearly.

HEARING OFFICER GHUSIN: Ms. Mooneyhan --

THE WITNESS: I don't mind --

HEARING OFFICER GHUSIN: -- do you see a way around this?

MS. MOONEYHAN: I can get a copy of the motion.

HEARING OFFICER GHUSIN: Let me see if I have it here.

MS. FUENTES: It should be in the pleadings binder.

HEARING OFFICER GHUSIN: Okay.

THE WITNESS: Whatever this is, I'm not denying

this. You would always talk to me about my sexual health. You would talk to me about all those things. And in response, I was honest with you.

BY DR. CHAMBERS:

Q. Well, don't deny it. I want you to read it and fully understand it to show the --

HEARING OFFICER GHUSIN: Okay. Hold on, everyone.

Okay, Patient B, you don't have to read it out loud. Let's see if we could get this to work. Did you already read the whole thing out loud, Patient B?

THE WITNESS: Did I read what he wrote?

HEARING OFFICER GHUSIN: Yeah. Because we're trying to keep it confidential.

DR. CHAMBERS: She read what she could identify, but didn't read everything.

THE WITNESS: Um --

HEARING OFFICER GHUSIN: Okay. Hold on.

MR. WHITE: She's trying to refresh her recollection; right?

HEARING OFFICER GHUSIN: Okay. And he's not familiar, of course, with the rules of evidence.

MR. WHITE: Yeah.

HEARING OFFICER GHUSIN: Dr. Chambers, we're having a little discussion about the purpose of your

questioning, and are you just trying to refresh her recollection?

DR. CHAMBERS: Correct.

HEARING OFFICER GHUSIN: Okay. Let's see if we could find it just so she can take a quick look at it, and you can ask questions about it. Okay?

DR. CHAMBERS: Thank you.

HEARING OFFICER GHUSIN: Okay. One moment.

Dr. Chambers, do you specifically remember where we may find it?

DR. CHAMBERS: I'm actually looking right now.

HEARING OFFICER GHUSIN: Okay.

DR. CHAMBERS: It was in the motion to -- the motion that I wrote to suppress maintaining their confidentiality, as they were giving media interviews, one of them, with their real first name and last initial.

HEARING OFFICER GHUSIN: Okay.

MS. MOONEYHAN: Will you state the date that that was filed?

DR. CHAMBERS: It was the last one before Ms. Ghusin rendered her decision.

HEARING OFFICER GHUSIN: It's right here. It's 27, page 3 of the case file pleadings. Tab 27, page 3.

If we could put that in front of Patient B.

MS. MOONEYHAN: We don't a copy of all the

pleadings, but I believe Dr. Chambers has a copy.

DR. CHAMBERS: I can't find it.

MS. MOONEYHAN: Can we take a five-minute break, and I can access the document?

HEARING OFFICER GHUSIN: Sound good. Thank you.

(Recess from 10:17 A.M. to 10:26 A.M.)

HEARING OFFICER GHUSIN: Back on the record in the matter of Dr. George Chambers. We took a brief break.

Ms. Mooneyhan?

MS. MOONEYHAN: Thank you, Your Honor.

I believe that Dr. Chambers was referring to a document that was filed in this matter on April 17th, 2023, that was titled "Reply to the IC's Opposition to Respondent's Motion" --

HEARING OFFICER GHUSIN: Agree.

MS. MOONEYHAN: -- and the Investigative Committee's Motion to Protect Patient Likenesses.

I printed a copy, and Dr. Chambers did look at it. It does appear to be the document that he was talking about.

I'm going to hand it to Patient B, but I would ask -- I would just like to make it clear for the record that Patient B -- I believe she can read this to herself

and --

HEARING OFFICER GHUSIN: Yes.

MS. MOONEYHAN: -- not loud, and we -- he can ask her if it refreshes her recollection.

HEARING OFFICER GHUSIN: I totally agree. That's why -- the whole purpose of this exercise.

BY DR. CHAMBERS:

Q. Please look at page 3, line number 9, and read that paragraph, please, to yourself.

A. Page 3, number 9?

Q. Yes. Line 9.

A. I can read it.

Q. Okay. Is that what we discussed?

A. You know, it was a long time ago, but I can't say there's not truth to this.

We would discuss a lot of things about my sexual health, and I would answer honestly.

Q. Okay.

A. And I don't think there's anything wrong with that. I was your patient.

Q. Okay. Your memory is very good a minute ago, but you're telling me you don't remember making these statements?

A. I'm not --

MS. MOONEYHAN: Your Honor --

THE WITNESS: -- I just said --

HEARING OFFICER GHUSIN: One at a time please.

THE WITNESS: -- there isn't any untruth to this.

HEARING OFFICER GHUSIN: Okay. Hold on, please.

Ms. Mooneyhan, did you say something?

MS. MOONEYHAN: Yes. I believe that misstates the patient's testimony.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

Q. You had a vivid memory about ten minutes ago, but you're saying you cannot look at this statement and say that we had this discussion?

MS. MOONEYHAN: Same objection, Your Honor. She answer the question to the extent --

HEARING OFFICER GHUSIN: Okay. I'm going to sustain it.

I'm going to allow a little latitude. Patient B seems willing to have this discussion. It's up to Patient B.

Ms. Mooneyhan, I know you've tried to run interference little bit.

Patient B, if you could just answer the question. I know it sounds like you have things to say.

That's your personal choice. Okay?

Dr. Chambers, I know you're not an attorney, do the best you can with phrasing the question.

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSIN: And we'll try to get through this, Ms. Mooneyhan. Okay?

BY DR. CHAMBERS:

Q. Does that look like an accurate assessment of what we had talked about?

A. It looks like something that I would have said, because when I read it, it's the truth.

Q. Okay.

A. I know that this is how I feel. This is how I feel about my sexual struggles.

Q. Okay.

A. This is not -- there's -- I would have not not said any of this, just like I'm saying this now. So, this is the truth I trusted you with.

Q. So, you said you didn't have a sexual health consult, yet on that date, I reported an entire paragraph full of those statements.

You were diagnosed. I prescribed medications, which you subsequently took.

You talk about the concept of mindfulness, self-esteem, and acknowledgement of your strong sense of

sexuality.

Do you disagree with that?

A. I agree that a woman should have a strong sense of her sexuality and high self-esteem, and you made it all worse.

Q. Okay. You did a -- you did a video interview for a media outlet, which I ran across on TikTok, and you said something to the effect that other doctors would ask about your libido, but that was not good enough for Dr. Chambers. What do you mean by that?

MS. MOONEYHAN: Objection, Your Honor. This is beyond the scope of what we're talking about in this proceeding.

We are were talking about the treatment this patient received from Dr. Chambers, not her alleged participation in any media.

DR. CHAMBERS: Well, it goes to ability and what we are discussing. She stated that other doctors would not go into what was discussed or wouldn't ask more details.

She saw me for a sexual health consultation --

HEARING OFFICER GHUSIN: Okay. I'm going to sustain the objection. I will allow you to ask limited question/answer without in-depth discussion about this. Okay?

DR. CHAMBERS: Can I rephrase the question?

HEARING OFFICER GHUSIN: Yes.

BY DR. CHAMBERS:

Q. Have you discussed with anyone my questioning about your libido in a detailed fashion?

A. What do you mean have I discussed it with anyone?

Q. Have you had a discussion with anybody about me asking about you about your libido?

A. About how you would ask what my favorite position was?

Q. Correct.

A. About you would ask if I preferred clitoral or vaginal orgasms?

Q. Correct.

A. All of that?

Q. Correct.

A. Have I discussed that with anyone else? Absolutely. It's the truth.

Q. Okay. So when you -- did you make any attempts to say that I questioned you about your sexuality without basis?

A. You would not wait until I asked a question. You were just firing these questions -- I remember how awkward I felt sitting there, feeling like I had to

answer these questions.

They were not just simple questions, such as how's your sex life? How's your libido? They were very, very detailed questions.

And, again, that -- at the end of the day, isn't that why you wanted me to pose nude for you to empower me?

Q. You're making assertions and you're making speculations.

On April 27th, 2015, when we talked about your sexual health, what was the reason for me to go into your sex life in details the way I did?

MS. MOONEYHAN: Objection, Your Honor. I believe the patient as already answered this question, repeatedly.

DR. CHAMBERS: Your Honor, she's --

HEARING OFFICER GHUSIN: Let's ask a yes or no question and move on.

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSIN: So I'm going to overrule it.

And Patient B, go ahead and just answer yes or no, and we can get on to the next question.

BY DR. CHAMBERS:

Q. Did I have a reason to ask you those detailed questions?

A. In that --

Q. In reference to why you saw me? Yes or no.

A. I believe that you asked me those questions because --

DR. CHAMBERS: Your Honor, wound you please advise her to answer yes or no --

HEARING OFFICER GHUSIN: Ms. Mooneyhan --

DR. CHAMBERS: -- instead of speculating.

HEARING OFFICER GHUSIN: Ms. Mooneyhan, do you have anything to add?

MS. MOONEYHAN: Well, Your Honor, she's trying to answer his question, and --

HEARING OFFICER GHUSIN: I know. She is expounding on it, and it is a tenuious situation because Patient B has more to offer.

MS. MOONEYHAN: And it wasn't a yes or no question; he's asking her to speculate on his reason for why he did something.

HEARING OFFICER GHUSIN: Dr. Chambers, go ahead and ask your question again, please.

BY DR. CHAMBERS:

Q. Did I have a reason to ask you more about your sexual preferences and your sex life and your libido on April 27, 2015?

A. Did you? What was the reason?

DR. CHAMBERS: Your Honor --

HEARING OFFICER GHUSIN: Okay. Patient B, that is a yes or no question.

THE WITNESS: I mean, I don't know what his reason would have been.

HEARING OFFICER GHUSIN: Okay. Okay.

DR. CHAMBERS: Okay.

THE WITNESS: I mean, I could tell you what I think his reason was.

HEARING OFFICER GHUSIN: Okay. Hold on. So we're at a disadvantage since he's not represented.

Ms. Mooneyhan, your witness wants to volunteer more; correct?

MS. MOONEYHAN: Well, --

DR. CHAMBERS: Well, the problem here is she cannot publicly read that paragraph, and I am trying my best to respect her privacy and pose a question, but instead of answering, she's grandstanding and --

HEARING OFFICER GHUSIN: Okay. Let's not characterize, Dr. Chambers. Okay?

DR. CHAMBERS: Yeah, but it seems like that is what she's doing, to me.

And I understand I'm walking a very fine line. She's woman. I'm man. I cannot appear aggressive. I'm walking a very tight rope here.

HEARING OFFICER GHUSIN: Let's just move ahead, Dr. Chambers.

Ms. Mooneyhan, let's see what we can do moving forward. And if Patient B, she seems uncomfortable in answering a question, you make an objection.

Let's keep it within the scope of this hearing, not what's out there, beyond the scope of this hearing. Okay?

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSIN: I think we're starting to slob through right now.

So, Dr. Chambers, you need to be able to put your case on, and I want you to do that. Go ahead and ask your question, and let's try to get through this.

DR. CHAMBERS: Tell you what. This is going to be an adversarial witness, and I don't want to argue with her. It's going to become a he said/she said situation.

HEARING OFFICER GHUSIN: Dr. Chambers, you could make your argument later about this. This let's go ahead and question Patient B.

DR. CHAMBERS: Okay. So with that said, I have no further questions for this witness.

HEARING OFFICER GHUSIN: At this point?

DR. CHAMBERS: At this point.

HEARING OFFICER GHUSIN: Okay. Are you --

DR. CHAMBERS: But I would like her back on June 1st, if necessary. If that's okay with, Ms. Mooneyhan.

HEARING OFFICER GHUSIN: Dr. Chambers, I'm going to ask you if you're sure. You don't have any more questions?

DR. CHAMBERS: I'm going to rest the questions of her at this point, because it's becoming argumentative and, again, it's going into a he said/she said, and given the tight rope I have to walk, I don't want to walk that rope today.

HEARING OFFICER GHUSIN: Ms. Mooneyhan?

MS. MOONEYHAN: May I ask questions on redirect, Your Honor?

HEARING OFFICER GHUSIN: Of course.

REDIRECT EXAMINATION

BY MS. MOONEYHAN:

Q. Patient B, with respect to the record that the respondent asked you to look at of a visit on April 27th, 2015, have you ever seen that record before today?

A. No.

Q. Did Dr. Chambers ask you to read it and verify at that time?

A. At the time of my appointment, no.

Q. Did you have any control about how he

characterized your visit?

A. No control.

MS. MOONEYHAN: No further questions, Your Honor.

DR. CHAMBERS: I'd like to redirect.

HEARING OFFICER GHUSIN: You may.

RECROSS-EXAMINATION

BY DR. CHAMBERS:

Q. Have you been to any physician's office where they let your read the notes at the end of the visit?

A. A couple. A couple notes, but I'm not sure if those notes are their personal notes or -- do you mean with the diagnosis and --

Q. Yes.

A. Yes.

Q. I have never seen that.

A. I could list --

Q. Number two, of all the visits that you had with me, have you ever looked at any of the documents I've made about you at the end?

A. No.

DR. CHAMBERS: Thank you very much.

HEARING OFFICER GHUSIN: Just one moment.

For clarification, Ms. Mooneyhan, as far as the complaint goes with respect to Patient B. It seems very

limited.

NRS 630.301, sub 7, engaging in conduct that violates the trust of a patient -- and correct me if I'm wrong -- it's limited to the alleged solicitation of photographs for money?

MS. MOONEYHAN: That's correct, Your Honor.

HEARING OFFICER GHUSIN: And that's it for Patient B?

MS. MOONEYHAN: Correct.

Your Honor, I would point out that there's also a charge -- Count VII also regards a continual failure to practice medicine properly, and Count VIII is regarding engaging in disreputable conduct, and those do encompass --

HEARING OFFICER GHUSIN: A, B, and C.

MS. MOONEYHAN: -- the counts alleged with all three patients. So --

HEARING OFFICER GHUSIN: Right.

MS. MOONEYHAN: -- Patient B is encompassed in that.

HEARING OFFICER GHUSIN: Thank you.

In considering the scope of the question. Just hang in there. I may ask a couple of questions.

I'm good.

Thank you very much for your time, Patient B.

THE WITNESS: Thank you.

HEARING OFFICER GHUSIN: Okay. And, Ms. Mooneyhan, you heard Dr. Chambers's request that she be available for recall on June 1st; correct?

MS. MOONEYHAN: I did hear that, and I would just like to -- if you would, you know, if we could make it clear to Dr. Chambers that any rebuttal evidence needs to rebut evidence that was presented today. No new matters may be explored on June 1st with this patient.

DR. CHAMBERS: That's correct.

HEARING OFFICER GHUSIN: Perfect. Thank you all.

You're excused and have a good rest of your day, Patient B.

THE WITNESS: Thank you. Is it okay if I just add something?

HEARING OFFICER GHUSIN: Ms. Mooneyhan and Dr. Chambers --

Hold on a second.

-- you may need a sidebar.

In the context of what? You have more to say?

THE WITNESS: Because --

MS. MOONEYHAN: If you have any clarification of the areas that we've explored today, what area do you look explore?

THE WITNESS: Well, it's because Dr. Chambers, I know wants me to read this out loud, and what this is discussing is that -- is my issues with having sex.

HEARING OFFICER GHUSIN: Patient B, I'm going to cut you off here, because if there are any other questions and answers, that would be acceptable.

But just to have Patient B discuss the situation or testify without any questions is not appropriate.

MS. MOONEYHAN: Understood. Thank you.

HEARING OFFICER GHUSIN: Okay.

Thank you, Patient B.

All right. I know we just took a break. It's a quarter to eleven, are we good to move forward with the next witness or would you like a break at this time?

MS. MOONEYHAN: I'm okay to continue. I defer to Mr. White, who will be questioning our next witness.

MR. WHITE: I'm ready to go.

(Sotto voce discussion between Hearing Officer Ghusin and Dr. Rafael.)

HEARING OFFICER GHUSIN: As discussed before, Dr. Rafael indicated that he may know me, and I indicated that I recognized his name, as I think expressed earlier in this case, possibly because we live in Reno, possibly because of mutual friends, and possibly because of my

family.

And it is because of that. It was many years ago.

And, Dr. Chambers, you had indicated that you are fine with that and that is divulged?

DR. CHAMBERS: I am.

HEARING OFFICER GHUSIN: Do you waive -- I don't believe there is any conflict, but do you waive any potential conflict?

DR. CHAMBERS: I do.

HEARING OFFICER GHUSIN: Okay. Thank you very much.

MR. WHITE: Thank you.

(The oath was administered.)

THE WITNESS: I do.

DIRECT EXAMINATION

BY MR. WHITE:

Q. Please state your first and last name and spell --

A. Richard Rafael, R-A-F-A-E-L.

Q. Okay. I'm just going to ask you to let me finish my question, and then you can answer. The court reporter can only --

A. Yes, sir.

Q. -- take down one of us at time. Or take down

one of our voices. Make sense?

A. Absolutely.

Q. Thanks. Are you currently employed?

A. I am currently employed, yes.

Q. Okay. What do you do?

A. I am a -- I review charts for peer review for the Nevada State Board of Medical Examiners. I also volunteer, for which I'm not paid, at the Student Outreach Clinic at UNR, so I teach medical students.

Q. I'm going to stop you there. What do you teach them?

A. I am a clinical professor of obstetrics and gynecological. We see patients in clinical studies, so I review their cases with them, review the write-ups.

Q. Are you retired now also?

A. Yes, I am retired from 32 years of practice of an OB-GYN.

Q. Okay. When did you retire?

A. I retired in December 31st, 2018.

Q. Is that when you started working for UNR Medical?

A. It was approximately six months later, I believe, I started working for them.

Q. And what was your profession when you had your practice?

A. I am a board-certified obstetrician-gynecologist. I'm a member of ACOG, American College of Obstetricians and Gynecologists. I had my own private solo practice for the 32 years. Previous to that, I did my residency in New England, at Mount Sinai Hospital in Hartford, Connecticut.

Q. Are you licensed in Nevada?

A. Yes, sir.

Q. How long have been licensed in Nevada?

A. I was licensed from 1986 until 2018, which I believe is 32 years.

Q. Are you still currently licensed?

A. Yes, sir.

Q. Okay. So you didn't let your license go in 2018?

A. No, sir.

Q. Okay. You just mentioned that you're certified also by the American Board of -- and that's the American Board of Obstetrics and Gynecological?

A. Yes, sir.

Q. Okay. Is that what we also refer to as ABOG?

A. Correct.

Q. What is the difference between ABOG and ACOG, which is the American College?

A. Correct. They changed their name. But the

American College is the probably premiere congress of obstetricians and gynecologists and principally used for teaching and up-to-date information.

Q. Okay. Is it fair to say that is the prestigious professional association?

A. Yes.

Q. And it contains members?

A. Yes, sir.

Q. So ACOG -- are you a member of ACOG?

A. Yes, sir.

Q. Okay. Now, do you have other important certifications or qualifications related to practice of gynecological?

A. Well, you if you review my CV, you'll see that I have approximately 190 various courses that I've taken.

Q. We will get to that. Are you a fellow?

A. Yes, I'm a fellow in the American Congress of Obstetricians and Gynecologists.

Q. Prior to your retirement, describe your practice.

A. I initiated my practice in 1986. I did obstetrics and gynecological. I was part of the community here in Reno.

I delivered babies both at St. Mary's and at Washoe, and did major and minor surgeries at both St. Mary's

and Washoe, which became Renown.

During that time, I was the president of Washoe County Medical Society, and served in a number of aspects with the Washoe County Medical Society.

I also sat on the board of HAWC, which became the Community Health Alliance, in various committees on HAWC.

Q. Just for clarification, HAWC is H-A-W-C?

A. Yes. Correct.

Q. Okay.

A. Health Access Washoe County, federally funded and, it's mission is to serve underserved patients in the area.

Q. How long did you work with HAWC?

A. Good question. I'd have to check that, but I'm sure it was for a number of years. I started their main charity and that continues throughout today.

Q. Did you work with other OB-GYNs, and in what aspect?

A. Well, I would say the obstetrics and gynecological community, it's a very collegial community.

So, during those 32 years, you have call groups, some were large, some were small, some would change. So we would see each other at meetings, college meetings. We would review charts. I had good, collegial acquaintances. I valued my fellow OB-GYNs. We helped each other.

When I started, if someone came in labor and delivery, each one of us was on call every night, we would do deliveries without pay. That was part of our community duty.

So all in all, I valued my relationship with my fellow OB-GYNs. We had a good maternal fetal medicine specialists. We had wonderful, fantastic GYN oncologists. We had terrific reproductive endocrinologists, so we all work closely together, help each other out. If you're walking down the halls in labor and delivery, you would do that for free, which would be not charged, we were there to take care of patients to the best of our abilities.

Q. Did you have -- you were in a group -- or you said a "call group," let me specify.

Were you part of a group or did you have a solo practice?

A. I had a solo practice. I started my practice solo, and I ended my practice solo.

Q. And how did you become -- describe to us what a call group is and how did you become a part of it?

A. Well, for example, the first call you might have with two other OB-GYNs, and we had similar practices, we would deliver approximately 15 to 20 patients.

Obviously, you need some time off or you need to

go out of town to a meeting, so we would share weekend calls. I would be on one weekend; the other two would be on other weekends. We would call each other for C-sections or GYN assistance.

Q. How did you become a member of the call group?

A. I think it's just you are obviously attracted to other people that have similar practices, and over time, some people would retire, so you would pick up new individuals. Or someone would retire from obstetrics, so, you know, generally people you enjoyed working with and had similar philosophies.

Q. Was there some trust involved too?

A. Absolutely.

Q. Can you briefly describe what a typical work week might look like when you were practicing?

A. Okay. I would probably be up at six o'clock, you know, and at seven o'clock, do rounds.

Often Mondays and Tuesdays are general surgery, so you would book surgery, say, at 7:30.

Prior to that, you would do a thorough history and physical, that would be dictated to the hospital.

You would meet your patient in preop, go over any questions they had, confirmed informed consent, identify the surgery, see if there there's anything that has changed since the time you had seen them last.

You take the patient into surgery, perform the surgery, take the chart, dictate the chart, check with them in post-op care.

Then if you had a second surgery or third surgery, that would generally follow. If not, you would be over at the office seeing scheduled patients. And those patients could be obstetrics.

On a real busy day, you might see 30 obstetrics patients. That's a big day -- was a big day for me. You would see cases for GYN, gynecology surgery, some annuals.

And my practice, it included adolescence, ladies in their midlife, pre-menopausal, post-menopausal, and elderly patients.

I accepted TRICARE, I accepted all government insurances, I accepted Medicaid, as well as private insurances.

Q. Thank you. Do you keep up to date with all the materials out there regarding obstetrics and gynecology?

A. Yes, I do. I find retirement pretty boring. My usual day is to get up at 6:30 or 7:00, have breakfast, and this has afforded me a great time to read.

So, when you're practicing all the time, it's difficult to keep up with literature. So I enjoy reading.

When you're doing a peer review, you're also learning in --

Q. Where do you get your information from? Is it ACOG mainly?

A. Mostly it's ACOG.

Q. Online?

A. Online. Yeah. Plus they have the Green Journal. So, ACOG clinical prologue, I do the prologue, which is a book, maybe, 180 questions. They have clinical questions, and it covers obstetrics, gynecology, endocrinology. I've done all the prologues for them. I'm doing one in obstetrics in order to teach students at UNR Medical School.

I have to keep up with family practice issues, and an obstetrician gynecologist is a family practitioner, in a sense, for women, so we're reading about thyroid disease, hypertension, diabetes.

Q. Okay. Prologue, I'm not familiar with that. Do you read about something and then take an exam that tests you on clinical issues?

A. Correct. You do, and it's generally worth about 25 CMEs.

So, they'll have a scenario, a clinical scenario, you know, hormonal replacement therapy, you will read the case history, then will have five choices, you make the choice.

And it can be an open book test or closed book,

whatever you prefer, and then that is sent in for CME credit.

Q. And you said about 25?

A. Twenty-five, yeah. About 180 questions.

Q. I'd like you to take a look at what's been marked as Exhibit 16, please.

A. (Witness complied).

Q. Are you familiar with what Exhibit 16 represents?

A. Yes. This is my CV.

Q. You've seen it?

A. Yes, sir.

Q. And are you the one who sent us this?

A. Yes, I did.

Q. To the IC?

A. Yes.

Q. Okay. Now, you had -- is this a true and correct copy of your CV that you provided to the Board?

A. Let me take a look.

HEARING OFFICER GHUSIN: Counsel, I might be in the wrong place. Exhibit 16?

MR. WHITE: Oh, unfortunately, we don't have letters for Dr. Chambers' part of the binder. So it's the first number 16 that we have.

MS. FUENTES: Yeah. Where the blue slip is,

that goes into the respondent's. Unfortunately, I didn't have exhibits tabs that were A, B, and C.

HEARING OFFICER GHUSIN: That's okay. Thank you.

THE WITNESS: This is not complete, and I did update this with a number of more CMEs, which I did send.

BY MR. WHITE:

Q. Okay. I'm going to I show you what you've sent in.

A. Correct. So there is -- in addition -- this stops at 185, and there's an addition of 186 through 192, if I may --

Q. And the other stuff hasn't changed as far as awards?

A. I'm sorry, sir?

Q. The awards has not changed -- right? -- those are the same.

A. Well, there's one more addition to that.

Q. Okay.

A. And I don't think it's in there. Do you want me to tell you about it?

Q. Sure. What is your extra award that you received?

A. So, in three days, I'm going to be honored as outstanding clinical community physician for the

University of Nevada, Reno.

Q. Congratulations.

A. And if I can say two things about this?

Q. What I've handed you?

A. Yes, sir.

Q. Let me ask a question first. So, you said it extends from 185?

A. Correct.

Q. Which was where it ended before. And now we have -- it goes up to 192; is that correct?

A. Yes, sir.

Q. Okay. What else changed, possibly, that you may able to help us with?

A. Well, I think it's interesting to note that I recently have taken medical ethics for physicians, updated that, sexual assault through Med CE, sexual harassment prevention, California law.

Q. This is the last page I handed you?

A. It's actually -- this page? Yes. Yes. That's a confirmation that those were taken.

Q. Okay.

MS. MOONEYHAN: I hate to interrupt, Your Honor, but I wanted to note for the record, I want it to reflect that I handed Dr. Chambers those additional pages.

HEARING OFFICER GHUSIN: Thank you, Ms. Mooneyhan.

DR. CHAMBERS: Thank you.

MR. WHITE: Thank you, Ms. Mooneyhan.

Dr. Chambers, have you had a moment to review those?

DR. CHAMBERS: I have.

MR. WHITE: Thank you.

I'm going to move to admit Exhibit 16, including the addendum that we just received a few days ago.

HEARING OFFICER GHUSIN: Dr. Chambers, any objection?

DR. CHAMBERS: I have none.

MR. WHITE: Thank you.

HEARING OFFICER GHUSIN: Exhibit -- IC's Exhibit 16, with the additional three pages -- three pages addendum will be admitted into evidence.

(IC's Exhibit 16 was admitted.)

BY MR. WHITE:

Q. Dr. Rafael, I think you already kind of went over your education, and underneath the heading "Summary of Experience," also I'd like to highlight -- did you say -- did you mention you were chief resident in residency?

A. I don't believe we have gone over my education.

Q. Okay. Let's do that a little bit.

Why don't you explain to us about -- where did you go to medical school?

A. I went to St. George's University School of Medicine.

Q. And then where did you do your residency?

A. I did my residency at the Mount Sinai Hospital in Hartford, Connecticut.

Q. And for that entire time, you weren't chief resident, but you did become chief resident at one point, did you?

A. That last six months I did. Yep, it would have been the last six months from June to December of -- I can't remember what year -- '86, I think it is.

Q. Yes.

HEARING OFFICER GHUSIN: Let me just interject as far as what year. A quick correction here. Your eduction here, 1892 to 1986?

THE WITNESS: Typo. 1982. I think I corrected that and sent another copy, so I think you've got the old copy.

BY MR. WHITE:

Q. So do I.

When you became chief resident, did you take that

as a pretty high honor and take it seriously?

A. Absolutely.

Q. Now, you also have listed here that you're a member of ProAssurance Indemnity Co. claims underwriting committee. Describe a little bit what that entails.

A. Just as a little background, in Nevada, we were undergoing a medical malpractice crisis, and at that time, I was working with the Washoe County Medical Society, I believe in 2000, 2001.

And everyone was leaving the state. All medical malpractice companies were leaving the state. And I recall we had a meeting with Saint Paul's and they promised, we will never leave you, and two months later, they were gone.

So the medical state insurance came to Mr. Bob Berg, who had a medical malpractice company, Nevada Medical Liability, and they asked him if he could create a Nevada liability company, which was called MLN. So, I became -- he asked me to join the board.

And subsequently, that company grew -- I was not reimbursed for this, it was purely voluntary.

Q. Let me stop up you for a second. What did you do there?

A. I was on the board and just offered opinions as far as need. I wasn't particularly involved in any marketing. But they would ask, what do physicians in

Nevada need in order to stay in Nevada?

So, the idea was to keep physicians in Nevada, not leave because of lack of medical malpractice, starting, actually, in Las Vegas when the trauma surgeons refused to see patients that were in motor vehicle accidents because the cost of medical malpractice was so high.

So the company grew and kind of became the main medical malpractice for the State of Nevada. And we were at a certain point where we either had to be sold or we needed to grow.

So we were approached by Mr. Berg from ProAssurance, and ProAssurance bought the company.

They then asked me to stay on a committee, which met quarterly in Las Vegas, still the underwriting committee, and we reviewed malpractice cases.

It was a fabulous committee. Fabulous doctors from Las Vegas. Topnotch doctors from the north.

We would fly out on a quarterly basis, day in day out. In other words, flew in and out that night.

We would review six to eight malpractice cases. Initially, it started from looking at Nevada cases, but it grew to reviewing malpractice cases from the West Coast and the western states.

Then in June of 2020, that indemnity claims understood writing committee was disbanded.

So I had been with them for seven years, and probably reviewed, conservatively, 165 to 200 cases.

Q. Thank you. You have a list here of continuing medical education, CMEs, it looks like they go back to 1984.

Is this a fair and accurate depiction of what you've done for CMEs over the year?

A. Yes, it's a fairly thorough CME.

As you can see, I took courses at Boston University, Johns Hopkins, Chicago, Mayo, University of California, which is a common thing for obstetricians and gynecologists.

Q. Are there any that stand out to you that you want to talk about?

A. I recall that a conference at the University of Chicago with reconstructive gynecological pelvic surgery. Also top names, Brewbaker, Delancey; Dr Chambers would be aware of all these people.

And there's a fabulous course every year in Las Vegas called PAGS, pelvic gynecological anatomy -- pelvic and gynecological, and that was started by my chief, a gentleman by the name of Mickey Baggish, who subsequently went to SUNY Upstate, and he may actually had been the chief at SUNY Upstate when Dr. Chambers was up there.

DR. CHAMBERS: He had left when I arrived.

THE WITNESS: Fabulous man.

DR. CHAMBERS: Yes, he was.

BY MR. WHITE:

Q. So in medical school, as you're going through and you've decided your specialty was going to be OB-GYN, do you learn certain surgeries there that you must keep up with in CMEs?

A. Well, when you're going -- the first two years of medical school is general theoretical. The third and fourth years of medical school is more clinical.

So, during the third and fourth year, you really get an idea, are you a medical personality or surgical personality?

I was attracted to obstetrics and gynecology because I enjoyed family practice, and you are a family practitioner for ladies, but I also enjoyed doing surgery, so there's limited surgery in a sense.

So it was really the combination of those two things that appealed to me, plus endocrinology, infertility, and, you know, what's better than delivering a healthy baby? That gets me charged.

Q. In your practice -- I'm going to kind of move away from your CV now.

In your practice, did patients ever ask you questions related to their sexual health?

A. Yes, sir.

Q. Okay. What would you typically do if a patient complained about, say, decreased libido?

A. Well, I would take a thorough history and physical. I would ask her what medications she was taking because medications will affect the libido. I would ask her about her relationship with her husband, because decreased libido is a very complex situation.

Human sexuality was promoted -- I think the first researchers were Masters and Johnson into human sexuality in the 1960s. So they talked about a continuum at that time, but subsequently, it's become even more complex.

So, things that affect human sexuality, certainly your relationship with your spouse, physiologically, infectious problems, and neurological problems, psychiatric problems, in an elderly lady, hormonal replacement therapy.

So, it's a very complex, interrelated situation.

Q. So, very much on a case-by-case basis, is that fair to say?

A. Yes, I would say that's a true statement.

Q. So if I were to ask you what would be a proper treatment, in your opinion, for decreased libido, that could be anything based on the patient?

A. Well, once again, I would do a thorough history and physical.

So, if this lady was elderly, she may be post-menopausal. We would have a discussion of hormonal replacement therapy, whether or not she had her uterus or no uterus.

If one has a uterus and you wanted to place her on hormonal replacement therapy, you could do it orally, transdermally by available hormones, rings, patches. If one has a uterus, you must -- you should use both estrogen and progesterone.

The Women's Health Initiative, which I believe was in 2001, was a study that came out. In those days, principally Premarin, which was an equine estrogen, was used.

Subsequently, we've learned that Estradiol is probably a better estrogen to use. Micronized progesterone is probably better to use than hydroxyprogesterone.

So a with woman with a uterus, you would use estrogen and progesterone, and a woman without a uterus, you would use estrogen alone, and again, I can tell you various forms.

With the Women's Health Initiative, originally and previous to that, we thought that it was -- hormones were beneficial in a cardiac situation.

And subsequent to that study, it was suggested no. There have been changes as those studies have been looked

at. Some people would consider a short dose of testosterone for libido.

Again, it's age related. Usually if you initiate hormonal replacement therapy at age 50 -- I feel very comfortable treating from 50 to 55 -- you discuss the risk benefits of hormone replacement. It would increase risk which include potential increase in breast cancer, potential deepening thrombosis, and that depends on what type of hormone you're doing and how you're giving it also.

We would talk about her relationship with her partner. If she's on any particular medications that would be deleterious to the libido, we would try to get her off those medications.

If she had lichen sclerosus et atrophicus or a vaginal infection, we would treat the vaginal infection and appropriately treat whatever secondary medical problems, neurological problems, refer her for psychology or psychiatry, and talk about things, such as her sexual desire, her fantasies, her -- if those have changed, and there's a chart that you check off those various things. If she has any body dysmorphic problems.

So it's a very complex evaluation.

Q. Is it fair to say that sexual health, as it's been somewhat defined, is not a new field?

A. No. It goes back 2,000 years.

Q. You had mentioned partner's spouses. If a patient came in and started asking questions or telling you about decreased libido or other sexual health issues, would you ask them if they wanted to have their partner at the appointment?

A. Partners are always welcome at an appointment.

Q. Always welcome?

A. Always welcome.

Q. Do you feel that having a specialty of some sort in sexual health, if it can be defined that way, does that require any kind of certification?

A. Well, it's interesting because the American College of Obstetrics and Gynecology does not have a specialty in sexual health.

Q. Okay. Do you feel it be sufficient to attend some two-day courses to get some CMEs and now you're certified in that?

A. The American Board of Specialties Societies also has no special specialized certification.

So, I think if you do this surgery, yes, it's important to attend courses, conferences in order to increase your skill with that -- those particular surgeries.

Q. Which particular surgeries are you referring to?

A. Well, I think we went through this case, it

would be labiaplasty, clitoral reduction, clitoral hood reduction, vaginoplasty.

DR. CHAMBERS: Ms. Ghusin?

HEARING OFFICER GHUSIN: Yes, Dr. Chambers.

DR. CHAMBERS: I don't really want to offer an objection, but he's not answering the question that was asked.

He's -- the question was about sexual health. He's answering cosmetic gynecologic surgery questions.

HEARING OFFICER GHUSIN: Mr. White?

MR. WHITE: Okay. I'll rephrase.

HEARING OFFICER GHUSIN: Thank you.

BY MR. WHITE:

Q. Is there a -- I think your answered that, but let's just clarify it for the record, is there a specific specialty recognized by the American Board of Medical Specialties called sexual health?

A. The only -- no.

Q. Okay.

A. No. Can I say something? If you're going to be a sexual therapist, it's usually a two-years master's degree at various universities.

Q. Would you -- in your practice, did you ever refer someone to a sexual therapist because you felt it was outside your scope?

A. Yes.

Q. I'm going to ask you a question about female genital plastic surgery, labiaplasty, vaginoplasty. Is that something that can be done by a gynecologist, or would it be something that would be more suited to someone's who's got -- their specialty is plastic surgery?

A. Well, I think, certainly, a gynecologist or OB-GYN or reconstructive surgeon or a urogynecologist can absolutely do these things if they're appropriately trained.

Q. Let's talk a little bit about how you marketed your practice. How did you do that?

A. Well, I didn't -- my practice was marketed, principally, by word of mouth.

My philosophy was the needs of a patient come first. If I take good care of the patient, one patient will talk to eight other patients, and that would promote my practice.

I did have a website after a number years. Mostly that website stated my philosophy, my training, and what services I offered.

Q. Did you ever have any models in there?

A. No, sir.

Q. Did you ever put ads on bathroom doors?

A. No, sir.

Q. I do want to talk about chaperons for a moment. Did you have chaperons?

A. Yes.

Q. How many did you have?

A. I would have one chaperone in the room. When I began my practice, the American College had kind of an opt-in, opt-out situation. In other words, they recommended that a chaperone be present.

As time went on, they then said, we think you -- we believe you should have a chaperon in the room at all times when you're doing a physical exam. Not necessarily during the history. You're taking part -- you took their history in the room. But their recommendation was to have a chaperon all the time in the room at the bedside.

Q. Let me stop you for one moment. I might have missed it. You said "they recommended," who was that?

A. That would be the American College of Obstetrics and Gynecology.

Q. ACOG. And you just mentioned you had a chaperon?

A. Yes, sir.

Q. Were there any times when you did not have a chaperon?

A. Well, I had three people in my office: front

desk, medical assistant, and an insurance person.

There are times where, say, someone was sick or became ill and went out, so if that situation occurred, I would ask a patient -- and I would pick my patients. If it's a young patient, if it's somebody in their 80s, I might not have a chaperon in the room. But only after I said, "I'm sorry, but my assistant has gone home ill, it is acceptable to you not to have someone? And we can also always rescheduled this visit if you feel uncomfortable in any way."

Q. If they were okay with no chaperon present, was it documented?

A. Yes. And some people -- I recall a lady who was a lesbian, and she did not wish a female in the room. So I would have her sign an informed declination that she did not wish to have a chaperone in the room.

Q. I want you to take a look at what's, just at this point, been marked as Exhibit 11.

A. (Witness complied).

Q. Are you -- what is that we're looking at?

A. This is an ACOG Committee Opinion, Number 373, August 2007, Committee on Ethics and Sexual Misconduct.

Q. Actually, does it replace something that was done in August of 2007?

A. Oh, excuse me. You're correct. It does say

"replaces the Committee Opinion of 2007." This is January of 2020.

Q. Okay. I see at the bottom left-hand side of page 3. Okay. Have you seen this before?

A. Yes.

Q. Is this something -- this opinion, did you rely on this when you were reviewing this matter?

A. Yes. This was part of my bibliography in my peer review.

Q. And is this a fair and accurate depiction of what you sent to the Board?

A. Yes.

Q. Or what you used to review the case?

A. Yes.

MR. WHITE: I'd move to admit Exhibit 11.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: I have no problems.

HEARING OFFICER GHUSIN: IC's Exhibit 11 is admitted into evidence.

(IC's Exhibit 11 was admitted.)

BY MR. WHITE:

Q. I'd like you to take a look at page 160.

A. Um-hum.

Q. If you look at the top-right paragraph. I do want you to start where it says "exceptions being made,"

and just read that to yourself. I'll ask you questions when you're done.

A. (Witness reviewing document).

HEARING OFFICER GHUSIN: Dr. Chambers, you have this exhibit in front of you?

DR. CHAMBERS: I do. I have my own copy of it and the one in the book, yes.

HEARING OFFICER GHUSIN: Thank you.

THE WITNESS: Yes.

BY MR. WHITE:

Q. Thank you.

Does that kind of sum up what we talked about? If somebody doesn't want a chaperon, somebody needs to document it, and they need to sign something?

A. Correct. I believe that's an accurate accounting.

Q. Okay. Thank you.

I also want you to take a look at the box on page 158?

A. There are two boxes there.

Q. Yeah. The one on the top left.

A. Um-hum.

Q. Would you read "sexual impropriety" to yourself.

A. Yes.

Q. Now, you have reviewed all three matters, all three cases for Patients A, B, and C?

A. Correct, I did.

Q. I'm going to ask you again later, but as you sit here now with what you remember, do you feel -- it is your opinion from what you saw -- we're going to go through taking the pictures, we're going to go through Patient A's, their treatment during the visit.

Do you feel, in your opinion, that there was sexuality impropriety in all three matters?

A. In my professional opinion to reasonable degree of medical certainty, I do feel that there was impropriety --

Q. And we'll go through it all. I just wanted to get that --

A. -- in those three cases.

Q. Is this -- again, this comes from ACOG, so is this something that just about every OB-GYN in the United States is going to adhere to?

A. I don't understand your question.

Q. Is this -- does this opinion -- along with the other opinions that we're going to get to, does this opinion from ACOG, does this set the rules that you should abide by as an OB-GYN?

A. I would say this would be accepted and is

standard of care regarding this subject.

Q. I'd like you to turn to Exhibit 12.

A. (Witness complied).

Q. What is that?

A. This is an ACOG Practice Bulletin regarding pelvic organ prolapse, put out by the American College of Obstetrics and Gynecologists, dated November of 2019.

Q. Same question as before, is this something you relied on when doing your review of this case?

A. Yes, it was.

Q. And does it appear to be a fair and accurate representation of what you looked at when you were reviewing this case?

A. Yes, it is.

MR. WHITE: I'd move to admit Exhibit 12.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: I have no objections.

THE HEARING OFFICER: IC's exhibit 12 is admitted into evidence.

(IC's Exhibit 12 was admitted.)

BY MR. WHITE:

Q. Okay. I'm going to ask you to take a look at what's marked and admitted as Exhibit 3.

A. Exhibit 3?

Q. Three.

A. Yes, sir.

Q. Okay. Have you seen these records before?

A. Yes, I have.

Q. Without saying the patient's name, do you remember what patient this is for?

A. This is Patient A.

Q. Did you review these records as part of your review of this matter?

A. Yes, I did.

Q. Do you recall what your review of those record showed regarding Patient A's interaction with Dr. Chambers?

A. Well, first I'd like to state that this is a thorough history and physical performed by Dr. Chambers.

Do you wish me to summarize this? Is that your question.

Q. I'll stop you and ask you questions, but if you could just answer that one.

A. Okay. Well, fundamentally, Patient A is a 36-year-old, married, white female whose last menstrual period was two weeks prior to seeing Dr. Chambers.

Her chief complaint was pain, dyspareunia, and she noted that 12 years prior to seeing Dr. Chambers, she had a third-degree perineal laceration during the delivery of her first baby, which it stated was eight pounds, and another

was seven pounds, eight ounces, but, certainly, eight pounds is a large infant.

She came in with a two-page questionnaire, she gave it to Dr. Chambers. She had noted she had seen three previous physicians, I think, Dr. Parker, Dr. Wilson, and Dr. Michelle Lewis.

Dr. Lewis was her OB-GYN, and she referred Patient A to Dr. Chambers because he was more specialized in this particular surgery than Dr. Lewis was.

Q. Let me stop you. Some of the things she complained about were discomfort wearing tight clothes?

A. Correct.

Q. Perineal pain?

A. Correct.

Q. Okay. What do some of -- in looking at those records, what does those indicate to you?

A. Perineal pain is most likely secondary to her traumatic delivery. So she probably has some scar tissue, which also makes sexual intercourse painful.

What was the first part of your question?

Q. What does -- also discomfort from wearing tight clothes?

A. Yes. That would speak to the labial situation. In other words, with extended labia -- or enlarged, Dr. Chambers, I believe, noted hypertrophy vulva, and I

what he's suggesting is that the labia are a little bit enlarged, and therefore one of his recommendations was to do a labiaplasty.

She said that she was uncomfortable and didn't wear pants, didn't wear a thong, she had to buy underwear that was two sizes too big, and she also had -- she was uncomfortable in a bathing suit, so she would buy a bathing suit that was two sizes to large.

Q. Now, have you done labiaplasty in your career?

A. Yes, I have.

Q. How many, do you think?

A. Very few, actually, I did no labiaplasties in my residency. I had two cases with people who wanted it.

The first case, I referred to my one of my colleagues, who was a big fan of Red Alisod, she had taken many of his courses. We did that together.

The second one, she assisted. We did a labiaplasty in which the patient was satisfied.

But I did not have labiaplasty -- not too many people thought -- came to me for that who wished that.

Q. When you did the few you did, did you do them for cosmetic purposes or for other reasons?

A. No. They were because patients had abnormal symptoms. So, it wasn't for cosmesis; it was for functional reason.

Q. Did you ever do a labiaplasty for, say, an athlete or somebody like that who needed it?

A. No. There were a few that I thought that could benefit from it, but they weren't interested.

Q. Would a -- would a labiaplasty that is -- providing it is giving a patient discomfort, if you do a labiaplasty, can you ease some of that discomfort?

A. Yes.

Q. If pain is involved in a -- if pain is their reason to do a labiaplasty surgery, if you know the answer to this question, would that more than likely be covered by insurance?

A. Yes, it would.

Q. Okay. What about cosmetic labiaplasty?

A. I don't think I'm qualified to answer that. I don't know.

Q. Are there any other things from reading this, Patient A's records, that you would have done for her other than labiaplasty possibly?

A. Well, I think I would have talked to her about spironolactone, in that I'm not sure why she was taking the diphenhydramine or hyaluronic acid, magnesium, minoxidil, and spironolactone.

Spironolactone is a potassium-sparing diuretic. It has feminizing results, it decreases testosterone, so

possibly some of her complaints were associated with that.

So that's something I would have talked to her about.

I don't know how expansive you wish me to be on this.

Q. Well, would you have done any other surgeries, possibly, or suggested them?

A. Well, as I take a look at this case, let's look on the -- take a look at "Impression."

Q. Yeah. Would it be helpful if you turn to page 19, or is it impression that you want?

A. I would start with page 18.

Q. Impression, okay.

A. Hypertrophy of the vulva, rectocele, stretching or incontinence, dyspareunia, female orgasm dysfunction, and pelvic and perineal pain.

So, if we -- and his recommendations for hypertrophy of the vulva, he discussed various ways to do the labiaplasty. He felt she would benefit most from a sculpted linear resection of labia minora. He recommends a clitoral hood reduction, which would be done at the same time.

In terms of the rectocele and cystocele, he referred to Dr. Richard Wasserman, who is a urogynecologist at the Women's Cancer Center.

In terms of the dyspareunia and pelvic pain, he correctly said no one can guarantee hundred-percent pain relief because the pain is multi-factorial. I concur with that.

He states that may be significantly reduced after the posterior colporrhaphy, and he would also include a perineorrhaphy. I would concur with that because I think most of her pain is from scar tissue, as described in the six o'clock position. Dr. Wasserman says from five to six o'clock not on the posterior vagina.

So, if pain persists postop, there might be a hormonal component to the pain, and he would recommend compounded and combined topical estrogen and testosterone cream. Gabapentin can also be used for pain or vaginal Valium suppository. I am personally not familiar with vaginal Valium suppository. Psychology counseling might also help, given the long history of pain and physical response when she is touched or penetrated vaginally.

Q. Okay. Do any of these things involve surgery?

A. Yes.

Q. Okay.

A. Yes. The hypertrophy of the vulva, which would be a labioplasty surgery, repair of the rectocele, a surgery, repair of stress urinary incontinence, a surgery and/or something like a transvaginal tape. The posterior

colporrhaphy would address the rectocele.

One of the things that I probably would have done is a vaginal pro ultrasound to see if there was any rectal sphincter tear, and to confirm or deny that, because your approach to surgery maybe a little bit different.

It's interesting because various physicians who have seen Patient A will state that this is type two cystocele. If you take a look at in the pelvic prolapse, it appears to be -- excuse me-- not a type two, but a stage two. It could well be a stage one, according to Dr. Wasserman's description.

It is interesting that Dr. Wasserman, when he's discussing his vaginal exam or history or physical, he states that he believes that the cosmesis is normal. In other words, his statement suggests that, perhaps, this lady does not need labiaplasty.

As far as incontinence, generally, a stretch urinary incontinence evaluation is with a urologist is done if you have a stage two cystocele. In my opinion, this is a stage one.

You can do some conservative things at your examination. So, Q-Tip test, put in the urethra about that far (indicating), have her bear down, once she's in the dorsal position, if the Q-Tip goes up greater than 20 degrees, that could suggest that she has genuine stress

urinary incontinence.

Most of what she's speaking about is not urgent incontinence. It appears to be stress incontinence, possibly from her obstetrical delivery or her tissue.

So I don't think a hundred percent you have to do a full urodynamic workup. You can fill her bladder with 500 ccs of saline and have her cough and then have her pee and then you would catheterize the bladder and see how much residual there is. Usually the cutoff is 200 ccs of residual urine. And that's suggestive of the problem.

He's got -- Dr. Chambers did a very thorough evaluation.

So to answer your question, what would I have done? I would have discussed with her whether or not she was interested in a transvaginal tape surgery. And the risk and the benefits to that, if you did a cystocele alone, the statistics are that 68.5 percent of repair of cystoceles will take care of the problem at this, what I would call it, stage one.

Now you can add to that polypropylene mesh or porcine mesh. Most studies suggest that the porcine mesh does not increase your benefit. In other words, if you're unsuccessful, you might have to go back for another attempt.

But there is some data that suggests that polypropylene mesh can -- it has better outcomes, but you have to discuss with the patient the risk, and there is an increased risk of morbidity when you put polypropylene mesh in there, to include erosion of pain and potential infection.

So, if I was operating, I would probably would suggest just a cystocele repair, which is the anterior space, a posterior colporrhaphy and perineorrhaphy.

Now, no one has suggested that her cervix comes down or her uterus comes down. Everyone's saying, in examination of this lady, she has a seven centimeter sized uterus, so she doesn't have that uterus come down, and there is no suggestion that she has any index or masses or variances.

One surgeon suggested a sacrospinous suspension using the da Vinci. I don't think that that is a worthwhile recommendation.

Q. Thank you.

HEARING OFFICER GHUSIN: Counsel, it is noon. Do you want to --

MR. WHITE: Do you want to take a break?

THE WITNESS: Can I add one bit to that.

HEARING OFFICER GHUSIN: Oh, let's get to a stopping point. I want to check with them down south.

THE WITNESS: Just one sentence, in fairness. If the patient did want a labiaplasty, certainly that could be done too.

HEARING OFFICER GHUSIN: Need a break in the south? Yes. It's been awhile. Let's do a five- to ten-minute break.

Ms. Mooneyhan, are you good?

MS. MOONEYHAN: Yes. Thank you.

HEARING OFFICER GHUSIN: Thank you.

(Recess from 12:03 P.M. to 12:22 P.M.)

HEARING OFFICER GHUSIN: Back on the record in the matter of Dr. George Chambers. Can you hear me down there?

MS. MOONEYHAN: Yes, Your Honor. Can you hear us?

HEARING OFFICER GHUSIN: Yes. Thank you.

Dr. Chambers?

DR. CHAMBERS: Yes, I can.

HEARING OFFICER GHUSIN: Perfect. All right.

Mr. White?

MR. WHITE: Thank you.

BY MR. WHITE:

Q. Dr. Rafael, I'd like to refer you to page 18 of Exhibit 3. IC's Exhibit 3, page 18. I want you to read to yourself where it says "Data."

A. Yes.

Q. What does that refer to?

A. Dr. Chambers had asked Patient A if he can -- he took photographs of her vulva with Patient A's personal mobile telephone.

Q. Okay. Would you do that or is that something that ACOG would recommend?

A. Well, to answer you first question, personally, no, I would never do that.

Q. Okay. Would ACOG recommend doing it that way?

A. ACOG has rules. There are two rules, and I believe these are also HIPAA rules. I'm not an authority on it, though.

Two the rules are, number one, you de-identified the patient, and, number two, that the phone is encrypted.

So I don't think -- you know, I'm not a tech genius, but I'm not sure that the patient's phone was encrypted nor when she sends that telephone message to Dr. Chambers, I would assume that her name would be on there, and therefore deem her identified.

Q. And de-identified could mean many things; right? You can't see their face, but it also could mean not identify to a phone number; is that correct?

A. To a phone number as well as a name.

Q. Did he have her -- from what you read there,

and it's his records, did he have her text the pictures to him?

A. "I asked her to text the photographs to me on my work mobile phone, should she decide to have me perform the recommended surgery." And, indeed, she did text two photos to him of a -- I believe, twelve photos taken.

Q. If -- and that's correct. If you were about to do surgery on a patient during -- when you practiced, would you take digital photos? How did you do that?

A. No. I took no photos. I didn't want photos ever to be misconstrued. Also you need to get rid of photos if photos are taken for teaching purposes, you'd take them for clinical purposes, or you write a paper.

But, no, I would not take photos of patients.

Q. What did you use?

A. I would use my notes and my recollection. But you know, generally, just from my notes, I know what surgery I need to do.

Q. Did you have pictures at your office?

A. No. Oh, do you mean --

Q. I'm sorry. Illustrations to show patients?

A. Yes. Yes. We had illustrations, and I had illustrations on my desk, pamphlets you could go through with illustrations. So that is helpful.

Q. Is that how you went about describing to the patient what the surgery might be?

A. I would describe the surgery, I would use illustrations to help them with the anatomy.

You know, you want your patient to be informed, and I think that's part of the informing side of the process.

Q. And I think missed it. Did you ever take photos of a patient?

A. No. Let me take that back.

In my day, I don't know if they do it now, we would have photos of babies, and those photos would be on the wall. That, now, is a HIPAA violation.

So all those photos of babies on the wall are considered non, de-identified patients.

Q. On what wall? Renown or Sr. Mary's?

A. Well, again, when I was practicing, it was a very common, joyful event. You may have two or three or a hundred fifty babies, and moms would come in, here's my child, and it was just a joyful thing.

Q. I'm going to ask you to turn to page 26 of the same exhibit, please.

A. (Witness complied).

Q. Would you read "general examination." Well, actually, first of all, what does this say at the top?

And please don't say that patient's name.

A. Yes. I won't. Consultation notes, PCP George Chambers, dated 11/30/2020. And I believe this is Dr. Wasserman's consultation, who is a urogynecologist.

Q. And so if you look, like, almost right in the middle of page, it says "general examination."

A. General appearance?

Q. And then general appearance, yep.

What does it say about -- how does it rate, I guess, for lack of a better term, the pelvic exam right in the middle there?

A. Okay. Pelvic, normal; external genitalia, non-tender, no masses; small midline uterus and cervix, seven centimeters, and it's referring to the uterus; inside hymen -- oh, and cervix seven centimeters inside hymen, so that means that this lady does not have uterine prolapse; rectocele, two centimeters inside hymen, so, if this is the hymen, he's saying that were two centimeters above the hymen.

Q. Okay. Let me stop you for a second.

A. Cystocele.

Q. You've talk about that before, possible cystocele, rectocele; right?

A. Correct.

Q. And then jumping down just a little bit it says

"I spoke to patient," and then if you skip down to the paragraph that says "her external vaginal," what does that say?

A. It says, "Her external vaginal has normal cosmetics at this time."

Q. Okay. Thank you. I'm going to ask you to -- so, what does that say? According to Dr. Wasserman, her -- everything looked normal from the outside?

A. Well, I think what he's saying, normal cosmetics, he is not terribly impressed with -- that he thinks the cosmesis of her clitoral hood and labia majora and minora appear to him to be within normal range.

Q. Would that also suggest that Dr. Wasserman doesn't agree that she needs any kind of cosmetic surgery?

A. I think what it suggests is that he doesn't believe she needs labiaplasty or a clitoral hood reduction, that that is, in his opinion, normal.

Q. Now I'd like you to take a look at what's been marked and admitted as Exhibit 4, and specifically page 33?

A. Yes.

Q. Have you seen these photos?

A. Yes, I have.

Q. Okay. I'd ask you to, in your opinion, tell us

what see on the lower left of the picture there?

A. On the patient's right-hand side?

Q. Okay. Yes.

A. Okay. Well, obviously this is --

Q. Well, what are we seeing right here, first of all?

A. Well, you're seeing a photography of the vulva with the clitoris and clitoral hood framing on the urethra, the vagina, and her labia, on the right-hand side, there's a small hematoma, it looks like it's about two centimeters, that bluish area.

Q. What could cause that? Let me ask I this way: Can that happen during an examination?

DR. CHAMBERS: Objection. Leading the witness.

HEARING OFFICER GHUSIN: I'm sorry. I didn't catch that.

DR. CHAMBERS: Objection. He's leading the witness.

MR. WHITE: It's a yes or no question.

HEARING OFFICER GHUSIN: Overrulled.

BY MR. WHITE:

Q. Can that happen during an examination?

A. Yes.

Q. Would it be an examination that is rougher than normal or rougher than it should be?

A. Well, potentially. If you look -- you go to page 0038.

Q. Which one? 38?

A. Yes. Okay. November 17th, 2020, 11:17 A.M., I do not see a hematoma on that. Or on page 37, I see no hematoma. Page 36, no hematoma. Page 35, no hematoma. 34, no hematoma. 33, November 17th, 2020, 11:21, four minutes later, hematoma.

Q. Thank you.

So how many photos do we see here -- and as you reviewed it before, how many photos do we see here in Exhibit 4?

A. Twelve.

Q. And how many are included in her records on pages 20 and 21 of Exhibit 3?

A. Two.

Q. So, in your opinion, would the taking of ten photographs that weren't used to illustrate the procedure that may be done indicate that they were not for purposes of medical examination for treatment?

A. No. So just a correction, a total of fourteen.

Q. Fourteen photos?

A. Yeah. One, two, and twelve on the other page. I don't know if two of them are the same.

Q. I think two of them are the same.

Okay. In other words, were those other ten photos used for medical purposes?

A. I wish to be fair. Dr. Chambers has taken a course from Dr. Red Alinsod, who's a renowned -- I don't know if he's a urogynecologist, but he's held in esteem within the cosmetic surgery community.

And Dr. Alinsod teaches medical photography, and Dr. Chambers has taken courses to improve his surgical technique and surgery in this sexual gynecological female genital cosmesis.

And in that course, Dr. Alinsod has papers and recommendations to take photos.

Q. He doesn't recommend that they take photos with the patient's cell phone, does he?

A. I do not know. I would be speculating if I said anything other.

Q. I'm going to ask your opinion on something: Is it suitable -- it is acceptable to use four fingers in a pelvic exam?

A. Yes.

Q. I'd like you to turn to page 18 of Exhibit 3, about two-thirds of the way down the page, there's a heading "vagina." Read that first sentence to yourself.

A. Um-hum.

Q. Okay. Thank you.

Did he say four fingers or two fingers in his medical records there?

A. He states:

"On sizing the introital opening with my two fingers, the vagina opened to a width of seven centimeters horizontal and vertically."

Q. And then if we turn the Exhibit 4, page 30 --

A. Number 4, page 30?

Q. Yes.

A. Um-hum.

Q. How many fingers is he using there?

A. There are four fingers in the vagina.

Q. Would you have documented that you used four fingers?

A. No, I would not have.

Q. You would not have?

A. I would not have.

Q. You would have documented you only used two?

A. I wouldn't document how many fingers.

Certain things are done on an everyday basis as a gynecologist. He's checking her pelvic floor, seeing if there's -- sometimes we use the words "gaping vagina."

He knows how far that is. Somewhere I recall using size 8 gloves, so he knows that that's four

centimeters, and this is actually abnormal.

So, this exam, in my opinion, is a perfectly normal exam. You put four fingers into the posterior floor and push down because he's trying to evaluate the size of the introitus. And a lot of her complaints are in this area.

Q. So, in your opinion, was it sort of -- was it sort of abnormal to put in here that there were -- that he used two fingers to specify that?

A. Well, I think he dictates a little bit differently.

A normal exam is done with two fingers in the vagina, and if you're sizing the uterus, your left hand is on the top of the uterus, and you're touching with your right hand, the cervix, and you're examining the sides, if there's any tenderness on the uterus.

But, generally, we don't -- you know, perhaps, some people use one finger. So, l don't see anything abnormal with his exam.

Q. Okay. And I'm not saying there's anything abnormal with the exam, I'm saying why would somebody specify that they used two fingers when they used four, at least in one picture.

A. I would just say that that's what he typically does. And, you know, I when I do a Pap smear, I use a

speculum, but I don't say -- well, sometimes I say I placed the speculum, but I don't always dictate that I use a speculum.

Some these things are so common. For us to think, well, I have to document how many fingers I used in the vagina, that's the way I do an exam.

Q. In general terms, do patients ever use non-medical terms when speaking?

A. Non-medical terms, yes.

Q. And how would you approach that when they do that?

A. Well, if they use -- you know, one of the things we're taught is that not to use big words that are going to be confusing to the patient. So, I have no problem if they use non-medical terms.

Q. Would you or had you ever -- have you ever used the term "fisting"?

A. No, sir.

Q. Would you discuss your own sex life with them?

A. Never.

Q. Would you show other patients pictures or videos, even though you never took them?

A. No.

MR. WHITE: Just a moment.

BY MR. WHITE:

Q. Nowhere in ACOG or anywhere else is using four fingers for examination is referred to as fisting, is it?

A. No.

Q. Let me ask, in your opinion, would that be demeaning to a patient?

A. Yes.

Q. Ask your opinion of -- what is your -- briefly, what is your opinion of labiaplasty for cosmetic purposes?

A. To to reduce pain. To reduce discomfort. To -- often young female athletes will have difficulties, if they're runners. Patients could have a tear during their delivery.

Q. But how effective is it just to change the look of the labia for cosmetic purposes?

A. Talking about cosmesis?

Q. Yes.

A. Well, I would say since the 1990s and since direct marketing, there's been a dramatic increase in interest and demand.

You know, there are a lot of normals, and just because one side is a little bit larger, doesn't mean that is abnormal.

But within that advertising, I think there's a

push towards a vagina that looks younger or idealized.

So, it's purely, I suppose, a patient's choice if she wishes to have that.

Q. Are you familiar with what's called the "O-Shot," Exhibit 3, page 18?

A. O-Shot, yeah.

Q. Is that PRP also?

A. It's an injection of plasma-rich protein into the G spot. And some people think that tissue is similar to kind of a spongy tissue that males have.

So you take the patient's blood, you spin it down within the office, and I don't know what OSHA rules are regarding this plasma, you take the supernatant of the plasma and you inject approximately three centimeters in the interior of the vulva.

And, theoretically, it is used to increase angiogenesis, which means increased blood supply. And I would say critical to orgasm is blood supply.

So, as patients age, they may have less intense orgasms.

Q. Have you ever done one?

A. No, sir.

Q. What is your opinion of the effectiveness?

A. Well, I don't believe there's a great deal of solid evidence that it increases satisfaction, or I just

don't think there's much solid science behind it.

Q. So you take into account, Patient A took -- was asked to provide her cell phone for twelve pictures, and then was asked something along the lines of what fisting is during this visit. Would you agree, in your opinion, that this was --

DR. CHAMBERS: Objection. Objection, Ms. Ghusin.

HEARING OFFICER GHUSIN: Yes?

DR. CHAMBERS: There's nothing in the record that stated that the patient was asked what fisting is.

HEARING OFFICER GHUSIN: Mr. White?

MR. WHITE: It's -- she's already --

DR. CHAMBERS: Your question was worded as such.

HEARING OFFICER GHUSIN: Would you like to rephrase it?

MR. WHITE: Yeah.

HEARING OFFICER GHUSIN: Okay.

BY MR. WHITE:

Q. The pictures -- being asked while you were in a paper gown to provide your cell phone to take pictures, would that be considered -- would you consider that a visit that you would or the ACOG recommends?

A. Well, again I have a problem with the

identification encryption of using the patient's phone. I think, in a sense, that's putting the patient at risk.

Patient A describes a situation that says -- or alleges that Dr. Chambers stated to her that one of his patients was trying to send the picture to him, got a digit wrong, and ended up getting a reply from an irate woman that said, "What bitch is sending me these photos to my husband?"

I thought, suppose Patient A misplaces a digit and sent it to an adolescent, is Patient A going to be in trouble? I think so.

Q. Are you aware if Patient A was ever asked about fisting?

A. In her --

Q. In your review of this case?

A. Yes. Yes, she was.

Excuse me. Can I restate that, please? I'm aware of the fact that in her allegation that he states that Dr. Chambers talks about fisting or -- it's not clear whether -- exactly what he said.

But she does mention the word "fisting," and the way I read it was that, perhaps, somehow he said, well, this isn't fisting, because she was in pain during the time of exam.

Q. Would using a non-medical term -- we talked about it before, would you use the term "fisting"?

A. Well, I think it's inappropriate to use the term "fisting."

Q. Would you agree that that could lead to disruptive behavior by the doctor or a disruptive exam?

A. My concept of disruptive behavior is whether it interferes with the patient-physician relationship, and whether or not the patient believes in the physician's integrity.

Q. Let's go back to page 158, which I believe is Exhibit 11.

A. I have 156.

Q. I want you to look at box on 158, left box.

A. Okay.

Q. And specifically sexual impropriety.

A. Do you want me to read that to myself?

Q. I do.

A. Yes.

Q. Okay. Again, I want to state that this is an ACOG Committee Opinion from January 2020.

Would using the term "fisting" be inappropriate comments?

A. Yes.

Q. Could it be construed as sexual comments?

A. Yes.

Q. Are you making -- could it be construed as

making sexualized or sexually demeaning comments to a patient?

A. Yes.

Q. Would -- possibly -- would the -- is there a possibly of taking photos on her own cell phone and texting them to him be disrespectful of patient privacy?

A. Yes.

Q. Okay. So, would you agree that this -- some of the terms here that define sexual impropriety by ACOG that they happened during this visit?

A. I believe all of them suggest sexual impropriety, and I believe that is true of each one of those.

Q. I'd ask you to go to Exhibit 13, please.

A. (Witness complied).

Q. Have you seen this exhibit before?

A. Yes.

Q. And what is it?

A. This is produced by the Federation of State Medical Boards, entitled "Physician Sexual Misconduct, Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct, Adopted as policy by the Federation of State Medical Boards, May 2020."

Q. Is this one of the reports that you relied upon in drawing your opinion in this matter?

A. Yes, it is.

MR. WHITE: I'd move to have 13 -- NSBME Exhibit 13 admitted, please.

HEARING OFFICER GHUSIN: Thank you.

Dr. Chambers, any objection?

DR. CHAMBERS: None.

HEARING OFFICER GHUSIN: Okay. IC's Exhibit 13's admitted into evidence.

(IC's Exhibit 13 was admitted.)

BY MR. WHITE:

Q. Please turn to Exhibit 14.

A. (Witness complied).

Q. Have you seen this exhibit?

A. Yes, I have.

Q. What is it?

A. It's an article, "Part 1 - Special from Missouri Physicians Health Program, Sexual Misconduct by Professionals: A New Paradigm of Understanding."

Q. And I'll ask the same question: Did you rely upon this in drawing your opinion in this matter?

A. Yes, I did, sir.

MR. WHITE: I have move to admit Exhibit 14.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: I have no objection.

HEARING OFFICER GHUSIN: Thank you. IC's

Exhibit 14 is admitted into evidence.

(IC's Exhibit 14 was admitted.)

BY MR. WHITE:

Q. And then please turn to Exhibit 15.

A. (Witness complied).

Q. Have you seen this exhibit?

A. Yes, I have.

Q. And what is it?

A. Code of Professional Ethics of the American College of Obstetricians and Gynecologists.

Q. And did you rely upon this to draw your opinion in this matter?

A. Yes, I did.

MR. WHITE: I would move to admit Exhibit 15, please.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: I have objections.

HEARING OFFICER GHUSIN: IC's Exhibit 15 is admitted into evidence.

(IC's Exhibit 15 was admitted.)

BY MR. WHITE:

Q. I'd like you to turn to Exhibit 10, please.

A. (Witness complied).

Q. Have you seen this exhibit before?

A. Yes.

Q. Okay. Without saying the name of patient, do you know what patient this is?

A. I do not know which patient this is.

Q. Okay.

MR. WHITE: I represent that this has already been admitted. It is for Patient B.

DR. CHAMBERS: Objection, Your Honor.

MS. MOONEYHAN: That's incorrect. That's actually Patient C.

MR. WHITE: I'm sorry. Did I say -- okay.

DR. CHAMBERS: Objection, Your Honor. That is neither Patient B or C.

MR. WHITE: I'm sorry.

HEARING OFFICER GHUSIN: Okay. Let's clarify. Are we talking about Exhibit 10?

MR. WHITE: Yeah. I think I had the wrong --

DR. CHAMBERS: Ten.

MR. WHITE: Let's go to Exhibit 7, please.

HEARING OFFICER GHUSIN: Are we skipping over Exhibit 10 now?

MR. WHITE: Yes.

HEARING OFFICER GHUSIN: Okay. Okay.

Dr. Chambers, objection withdrawn then?

We're skipping over to Exhibit 10?

MR. WHITE: Yes. For now.

DR. CHAMBERS: That's fine, Your Honor.

HEARING OFFICER GHUSIN: Thank you.

THE WITNESS: I'm sorry. What exhibit?

BY MR. WHITE:

Q. Seven. Please turn to page 0107.

A. Yes.

Q. From this, can you determine what the reason for the visit is?

A. Bloody nipple discharge.

Q. Okay. Is there any indication that he discussed surgery from this? If you can read it.

A. I'm looking at assessment, plan, it says: nipple discharge.

I'm having difficulty reading the second line. I think, is it something -- has nipple. Something about libido. Return in two weeks.

So, I am having some difficulty reading all this.

Q. Okay.

A. But I don't see anything about surgery.

Q. Okay. Are you aware of the patient's assertion regarding photographs or a photograph?

A. This is Patient B?

Q. Yes.

A. No, I'm not aware of any photograph.

Q. Have you ever used models?

A. No, sir.

Q. When I mean "models," I mean human models, female models?

A. No.

Q. Okay. Have you ever paid somebody for that?

A. No.

Q. Have you ever offered to pay somebody to model for you?

A. I would never do that.

Q. Would you do that at your practice?

A. No.

Q. I asked this before: Would you ever put an advertisement on, say, a wall or a bathroom door, soliciting models for your practice for advertising?

A. No.

Q. Why not?

A. I'm sorry, why not?

Q. Why not?

A. I think it would be disrespectful, certainly, to any patient I had. I think it would be inappropriate. I think it would bring disrepute to medicine. I think that it would be slap in the face of any patient if I offered to do that. I think it would be demeaning.

And I think it would violate the trust that she had in me as an ethical physician.

Q. I'd like you to turn to Exhibit 5, please.

A. (Witness complied).

Q. Have you seen that before?

A. Yes.

Q. Okay. Do you know what patient this -- which patient this represents?

A. I'm not sure whether this is B or C.

Q. Okay. We haven't gotten to C yet.

HEARING OFFICER GHUSIN: Counsel, may I interrupt for moment --

MR. WHITE: Yeah.

HEARING OFFICER GHUSIN: -- just to see where we are in the scheme of things, seeing -- it looks like we're probably going to go -- we need more than another 15 minutes; right?

MR. WHITE: Yeah.

HEARING OFFICER GHUSIN: Dr. Goodman's coming in at 1:30?

MR. WHITE: Yeah.

HEARING OFFICER GHUSIN: Why don't we let Dr. Rafael take a break, and get a little energy.

I don't know what the schedule -- she's not going to make it down until 1:30; right?

MR. WHITE: Yeah.

MS. MOONEYHAN: Your Honor?

HEARING OFFICER GHUSIN: Yes.

MS. MOONEYHAN: Your Honor, I believe we agreed that Dr. Goodman would be on standby --

DR. CHAMBERS: Correct.

MR. WHITE: -- for Dr. Chambers. Requesting --

HEARING OFFICER GHUSIN: So, 1:30's not --

MS. MOONEYHAN: He didn't want to break up his testimony, so he's going to be on call this afternoon, when Dr. Rafael's finished.

MR. WHITE: I can probably wrap up in the next 15 to 20 minutes.

THE WITNESS: I'm ready to go.

HEARING OFFICER GHUSIN: Are you good?

THE WITNESS: Yeah.

HEARING OFFICER GHUSIN: Okay. Thank you.

BY MR. WHITE:

Q. Have you -- did you review those allegations as part of your review of this matter.

A. Yes, I did.

Q. Okay. And you can see where he offered -- Dr. Chambers's offered to pay Patient B $1,000 for photos?

A. Yes.

Q. Does your opinion still stand that this would be unprofessional?

A. Unprofessional, unethical, against the Code of Conduct, against society's rules, in my opinion.

Q. Okay. You also think it would violate the trust of a patient?

A. Absolutely.

Q. I'd ask you to look at Exhibit 6.

A. (Witness complied).

Q. I just want you to read, to yourself, the second paragraph, about half way through, it starts "in fall of 2018."

A. Yeah.

Q. Is there any doubt that he offered to pay her $1,000 for an advertisement?

A. No, it's clear.

Q. And this is -- have you seen this -- let me back up the little bit -- have you seen this response from Dr. Chambers before?

A. Yes, I have.

Q. Okay. I'd ask you to turn to Exhibit 8.

A. Um-hum.

Q. Have you seen Exhibit 8 before?

A. Yes, I have.

Q. Okay.

MR. WHITE: I'll represent, this has already been marked and admitted as the allegation letter for

Patient C.

HEARING OFFICER GHUSIN: Thank you.

BY MR. WHITE:

Q. And you've reviewed these allegations before?

A. Yes.

Q. Did you review these in drawing your opinion in this matter?

A. Yes.

Q. Turn to Exhibit 9, please.

MR. WHITE: It's already been marked and admitted, and it is Dr. Chambers's response.

BY MR. WHITE:

Q. And third paragraph down on page 141, "I offered." It's near the bottom of that paragraph.

A. Yes.

Q. Any doubt that he offered Patient C $1,000 to model for an ad?

A. Correct.

Q. Also I'd ask you to take a look at page 142, second paragraph. If you read that to yourself and look up when you're finished.

A. Yes.

Q. Thank you.

Is there any doubt that boyfriends and husbands were prohibited from being at that photo shoot?

A. There's no doubt.

Q. I want you to turn to Exhibit 1, please.

A. Exhibit 1?

Q. Yes.

A. (Witness complied).

Q. Have you seen Exhibit 1 before?

A. Yes, I have.

Q. Did you review these allegations and rely on them to draw your opinion in this matter?

A. I'm a little bit confused because I would receive from the Board certain questions, and I would answer from each one of those questions.

Q. Did you see this before?

A. I have reviewed this, yes.

Q. Okay. So, on page 2 of this exhibit --

A. Um-hum.

Q. -- can you see where it says -- I'd like, actually, just read 13 and 14 on page 2 to yourself.

A. Okay.

Q. Thirteen refers to the word "fisting"; correct?

A. Correct.

Q. And does 14 address fingers being compared to the size of a man's penis?

A. I'm sorry. Can you rephrase that?

Q. Does 14 address comparing the size of -- I

guess, a fist to the size of a man's penis?

A. I don't think that is exactly how it went down.

Q. Okay. There's --

A. What I recall in her allegation was that Dr. Chambers had said the size of a man's penis is about the size of two fingers. And --

Q. On the very end of number 14, was it appropriate to tell Patient A that her vagina's too big for a man's penis?

A. Yes.

Q. It was appropriate?

A. I don't think it's appropriate.

Q. Oh, you don't think it's appropriate?

A. I do not think it's particularly appropriate.

Q. Was it professional?

A. I don't believe it's particularly professional.

Q. Does it bring on any sexual connotations?

A. I'm sorry because I'm not sure that exactly the way that it's written down is exactly what her allegations is. If that's fair.

HEARING OFFICER GHUSIN: Can you go to the source, Mr. White, rather than the investigator's summary of what she said?

MR. WHITE: Let's see.

BY MR. WHITE:

Q. Would it be considered an inappropriate comment about the patient --

A. To say fisting?

Q. -- to say that her vagina's too big for a man's penis?

A. I think it's demeaning. There are other ways to say it.

Q. Okay.

MR. WHITE: I have no further questions.

HEARING OFFICER GHUSIN: Thank you.

MR. WHITE: Actually, I do have one.

BY MR. WHITE:

Q. Taken together all of this, all of the things we've talked about for Patient A, Patient B, Patient C, would you consider this sexual impropriety?

A. In my professional opinion --

Q. If you take them individually --

A. -- within --

Q. And I'll put some context on there too: Per ACOG's definition on page 158.

A. So, I'm going to make a statement, and that is with sexual misconduct, it's broken into sexual impropriety and sexual violence.

I do not believe Dr. Chambers committed violence.

I do believe Dr. Chambers committed sexual impropriety, which is, quote, sexual misconduct with Patient A, Patient B, and Patient C, because he fulfilled every one of those of the definition, inappropriate language, inappropriate gestures, sexual innuendo. I'd have to look at the other --

Q. 158.

HEARING OFFICER GHUSIN: 158 of --

MR. WHITE: Your Honor, it's Exhibit 11.

THE WITNESS: Exhibit 11. So:

"Sexual impropriety may compromise behavior, gestures or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient that may include, but not limited to the following:"

And it talks about disrobing and draping.

BY MR. WHITE:

Q. If you skip down to number 6 of the bullet points.

A. I would say in that section, in that paragraph, he fulfilled that. The behavior, he fulfilled each one of those.

Q. Okay. Thank you.

MR. WHITE: Now I have no further questions.

HEARING OFFICER GHUSIN: Just one moment.

THE WITNESS: Can we take a quick break now?

HEARING OFFICER GHUSIN: In a moment.

Do you have questions of Dr. Rafael?

DR. CHAMBERS: I do.

HEARING OFFICER GHUSIN: All right. Let's take a quick break. No more than five to ten minutes.

(Recess 1:25 P.M. to 1:42 P.M.)

HEARING OFFICER GHUSIN: Back on the record in the matter of Dr. Chambers. I think we have everyone back in the room in the south as well as north.

We just finished up with Dr. Rafael's direct by Mr. White.

Dr. Chambers, you would like to cross-examine Dr. Rafael?

DR. CHAMBERS: Yes. Please.

HEARING OFFICER GHUSIN: Okay. And hopefully it all goes smoothly.

CROSS-EXAMINATION

BY DR. CHAMBERS:

Q. Good afternoon, Dr. Rafael.

A. Good afternoon, sir.

Q. I have a bunch of questions for you.

A. Okay.

Q. And I, too, hope it goes smoothly.

A. Thank you.

THE WITNESS: Can we turn the volume up a little bit?

MS. FUENTES: I can.

THE WITNESS: Thank you.

BY DR. CHAMBERS:

Q. You mentioned Masters and Johnson in one of your answers?

A. Yes, sir.

Q. How were they viewed by the medical community when they were first doing their research?

A. Well, that's an interesting question. I assume that there was some skepticism because, perhaps, this was a taboo subject at the time.

But I think they became known as more or less the earliest solid scientific researchers.

Q. Okay. Your knowledge of sexual health, you said sexual health to one of the questions, went back 2,000 years, which I will agree.

Your knowledge of sexual health, was it acquired during medical school, OB-GYN residency, or post residency?

A. I'm having the little bit of trouble with your accent, sir. I apologize.

Q. Your knowledge of sexual health, was it acquired in medical school, residency, or post residency?

A. I would say residency or more post residency.

Q. Okay. How much time was spent in residency when you went through training on sexual health matters?

A. Very little time, sir.

Q. Okay. In answering one of the questions, you talked about a patient's sexual desires and fantasy, that it was important to ask those questions in relation to some of her concerns.

Is discussing sexual desires and fantasy a form of sexual misconduct?

A. No, sir.

Well, let me clarify that. It depends on the degree of the interview. In other words, for a physician -- and I'm not suggesting you did, but for a physician to talk about his sexual fantasies is inappropriate, and I think you would agree that in certain problems where a patient seemed to have persistent and recurrent sexual dysfunction, that more questions along those lines is reasonable.

But when someone doesn't particularly have serious problems, it could be unreasonable.

Q. Okay. Were you aware that Patient A went to see the male urogynecologist that I referred her to, despite the fact that allegedly abused her?

MR. WHITE: Objection. Relevance.

HEARING OFFICER GHUSIN: Dr. Chambers?

DR. CHAMBERS: The relevance is I sent her to a urogynecologist, and he concurred with my recommendation. So, I'd like to know if Dr. Rafael realized that I was the one who sent her to Dr. Wasserman.

HEARING OFFICER GHUSIN: That's a fair question.

THE WITNESS: Yes, I was aware you that you had referred her.

BY DR. CHAMBERS:

Q. Did you notice that he concurred with my recommendation?

A. I apologize because I have a little hearing deficiency.

HEARING OFFICER GHUSIN: Okay. This is what we're going to do, and, perhaps, Mr. White could help also.

I'm going to try to state your question for you, and we could check each other to make sure it is right just so we can get through this, unless you have some other suggestion.

DR. CHAMBERS: Okay. That's fine. That's fine.

THE WITNESS: Perhaps if we put a speaker here (indicating). I apologize for the disruption.

HEARING OFFICER GHUSIN: Not at all.

(Speaker moved.)

THE WITNESS: Okay. I'm ready.

BY DR. CHAMBERS:

Q. I'm not trained to evaluate the anal sphincter using an ultrasound, are you?

A. No. I do not personally do the anal ultrasound. I refer that to radiology and have, say, it done at the hospital.

Q. Were you aware that down here in Las Vegas, we really have to send patients to a colorectal surgeon to have them do that?

A. No, I wasn't aware of that.

Q. Yeah. A lot of the radiologist aren't able to do that.

In the Sexual Misconduct Committee Opinion, did the opinion state that a chaperon needed to be in the room or in your own opinion?

MR. WHITE: Ask him which one he's referring to, Ms. Hearing Officer.

HEARING OFFICER GHUSIN: Okay.

Dr. Chambers, which patient are you referring to?

DR. CHAMBERS: It's no particular patient. I'm just asking a general question regarding chaperons.

THE WITNESS: Within the ACOG --

MR. WHITE: Hold on.

HEARING OFFICER GHUSIN: Hold on.

MR. WHITE: Well, he's referring to a committee opinion or something like that. I was just wondering which one it was. That's all.

HEARING OFFICER GHUSIN: Dr. Chambers, I'm going to ask you to be more specific with your questions.

DR. CHAMBERS: It's Exhibit 11.

MR. WHITE: Okay.

BY DR. CHAMBERS:

Q. The committee opinion on sexual misconduct where it discussed chaperon, was it recommendation or a mandate?

A. I'm looking at page 160.

HEARING OFFICER GHUSIN: Do you have a page -- here it is. Page 160, Dr. Chambers, is that what you're referring to?

DR. CHAMBERS: Correct.

HEARING OFFICER GHUSIN: Okay.

THE WITNESS: So down at the end of 160, on the left-hand side:

> "ACOG now believes that the routine use of chaperons is needed for the protection of patients and obstetricians-gynecologists. Therefore, it is recommend that a chaperon

be present for all breast, genital, and rectal examinations. The need for chaperon is irrespective of sex or gender of the person performing the examination, and applies to examinations performed in the outpatient and inpatient settings, including labor and delivery, as well as diagnostic studies, such as transvaginal ultrasonography and urodynamic testing."

Q. Okay. So, this is a recommendation or a mandate?

A. They stated that it's recommended.

Q. Okay. And most of us do do that; correct?

A. Correct.

Q. And you stated in your own experience that you have actually examined patients without a chaperon; correct?

A. With their permission.

Q. Okay. In emergency cases, you would actually examine a patient if there's no chaperone?

A. Correct. In the case of emergency, yes, it's acceptable to examine without a chaperon.

Q. In the case of Patient A, when I examined her the chaperon was not in inside the room. The chaperone was outside of the room because of COVID policies that I

implemented.

In your opinion, if she's able to see and hear the examination, is that being chaperoned or not?

MR. WHITE: Objection. You're asking him to speculate on what's the size of your room, what's the size of the room, and where she's standing. He has no --

DR. CHAMBERS: I didn't mention the size of the room.

MR. WHITE: Yeah, but he has no spacial recognition of where she was.

DR. CHAMBERS: Can I --

HEARING OFFICER GHUSIN: Okay.

DR. CHAMBERS: -- introduce --

HEARING OFFICER GHUSIN: Just a moment.

MR. WHITE: Calls for speculation.

HEARING OFFICER GHUSIN: Okay.

DR. CHAMBERS: May I introduce --

HEARING OFFICER GHUSIN: Just a moment. Let's try not to speak over one another. All right?

Let me rule on an objection if we get it. Okay?

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSIN: All right. What do you have there, Dr. Chambers?

DR. CHAMBERS: May I introduce a new exhibit of

my office, photographs?

MR. WHITE: Objection. No. Because, I mean, on the basis of it's -- there's no good cause. It should have been done at the prehearing conference.

HEARING OFFICER GHUSIN: This is true, Dr. Chambers.

Would there be an acceptable way for the description of his office if he would ask the question?

MR. WHITE: No. I mean, it's too late to bring that exhibit now.

HEARING OFFICER GHUSIN: He could ask a hypothetical question.

MR. WHITE: Well, hypothetical might -- well, he can.

HEARING OFFICER GHUSIN: Um-hum. And we are in an administrative hearing.

So what I am going to do is sustain the objections as far as the exhibit, and direct Dr. Chambers to rephrase the question into a hypothetical that Dr. Rafael would be able to address.

Any objection to that?

DR. CHAMBERS: Thank you.

MR. WHITE: Not yet.

HEARING OFFICER GHUSIN: Again, with the relaxed rules of evidence, if it's relevant, material,

and probative, it will help the Hearing Officer make recommendations, it's coming in. Just -- let's get through that because that's what I'm going to say every time. Okay?

All right. Go ahead.

MR. WHITE: Understood.

DR. CHAMBERS: Thank you.

BY DR. CHAMBERS:

Q. With the examination room opened, if she's standing at the door, outside the examination room, is that being chaperoned?

A. I don't think that's an acceptable chaperon, sir.

My idea of an acceptable chaperone is that the chaperone is at the examining room table or at the bedside. And I say this based on another case that I have reviewed where there was --

MR. WHITE: Let's not get into it.

BY DR. CHAMBERS:

Q. Okay. The committee opinion did not state where a chaperon should be inside the room, did it?

A. It didn't, but I think it's an assumption.

MR. WHITE: Objection. Calls for facts not in evidence. Actually, it does say that.

DR. CHAMBERS: Where does it say it?

MR. WHITE: It says right under "chaperones" on 160.

HEARING OFFICER GHUSIN: Withdraw the objection, and --

DR. CHAMBERS: Could you point me to it?

THE WITNESS: It says:

"The presence of a third party or chaperon in the examination can" --

DR. CHAMBERS: Can I --

THE WITNESS: It doesn't say outside the examination room.

BY DR. CHAMBERS:

Q. Now, considering we were in the middle of COVID, and there were no vaccines, where one person just had COVID, do you think --

MR. WHITE: Objection.

DR. CHAMBERS: -- it would be appropriate --

MR. WHITE: Objection. Again, it calls for facts not in evidence.

THE WITNESS: Okay.

DR. CHAMBERS: Okay.

MR. WHITE: We don't know about your COVID policies or that anybody had COVID.

BY DR. CHAMBERS:

Q. Is it appropriate that given a situation where

there is possible -- possibility of spread of disease, that the chaperon could stand outside the room to protect everyone?

A. I still think that's unacceptable. With COVID, it was considered six feet to be acceptable.

For someone to be outside doing charts, possibly, not within hearing range, not to hear exactly what was going on is --

Q. She was ten to 12 feet away.

A. I think that's -- even with COVID, I would expect my chaperone to be in the room where she can see and hear everything that's going on.

Q. All right. I'm going to change my line of questioning.

You said you did some labiaplasties?

A. I did one labiaplasty, sir.

Q. Okay. Where did you train to do that?

A. Well, I think we could agree that labiaplasty is not a difficult operation. So, like with any residency, see one, do one, teach one.

And I relied on my assistant, who I noted was trained by Red Alinsod and had gone to many of Dr. Alinsod's conferences, just as you did.

Q. So you find it acceptable that your colleague who went to the courses offered by Dr. Alinsod was

appropriately trained to do this?

A. She was appropriately trained to perform labiaplasty.

But as you know in residency, you will see one, then you would work with you senior resident, and then perform the operation.

Q. Okay. I agree.

When a traditional OB-GYN or urogynecologist examine a patient, are we trained to look at the aesthetics of the vulva, or do we just go into the vagina?

A. Well, I think the first thing you do is an inspection of the vulva, and --

Q. Are we looking for aesthetics or are we looking for pathology?

A. Well, I think you look for aesthetics. If there was something significantly wrong, you would note that, and then you are more, as you suggest, doing a functional evaluation.

Q. Okay. That contradicted what you said earlier regarding -- well, didn't really contradict.

Dr. Wasserman said that her vulva was normal in appearance?

A. Correct.

Q. We all know that the vulva has different variations of normality in each one?

A. In each --

MR. WHITE: I'm going object to --

HEARING OFFICER GHUSIN: Okay. Hold on.

MR. WHITE: He is testifying now.

HEARING OFFICER GHUSIN: I'm going to sustain it.

Dr. Chambers, try to ask a question.

DR. CHAMBERS: I'll rephrase.

BY DR. CHAMBERS:

Q. Each woman has different variations of her labia -- of the labia.

MR. WHITE: Is that a question?

BY DR. CHAMBERS:

Q. The question follows: Are gynecologist and urogynecologist trained to look through the lens of a cosmetic surgeon or plastic surgeon when you look at the anatomy?

A. There are many variations of normal.

Q. Are we trained as traditional OB-GYN or urogynecologist to look through the lens of a cosmetic surgeon?

In other words, if you're showing me a picture, and you're showing me --

HEARING OFFICER GHUSIN: I'm going to interrupt. I'm sorry, Dr. Chambers.

I see some motioning in the background, and anyone who is going to remain in the room as an audience member, please refrain from making gestures. I would appreciate that.

Thank you.

BY DR. CHAMBERS:

Q. In other words, if you're showing a plastic surgeon and a gynecologist -- so you're a gynecologist -- the same picture of the vulva, or a cosmetic surgeon, would they all have the same impression?

A. Probably not.

Q. Okay. You said -- if we go to the pictures of Patient A. I think they were -- well, I can't find them.

On the pictures where you said there were bruising --

A. That would be Exhibit 4.

Q. Exhibit 4. Thank you. Could that possibly be the copying machine? Could it possibly be the way the picture was printed?

MR. WHITE: Objection. I think it's outside of his expertise. He doesn't know --

HEARING OFFICER GHUSIN: Sustained.

BY DR. CHAMBERS:

Q. You testified to the fact that it appears to be bruising. She has other bluish colors on her vulva.

A. Well, this wasn't there four minutes before. It appears to be similar to a hematoma. So, there are other bluish areas, but not to this degree.

So, my assumption is -- potentially, this is a hematoma.

Q. How much force would be required during an exam to create that?

MR. WHITE: Repeat the question, please. He didn't hear.

BY DR. CHAMBERS:

Q. How much force would one be required to inflict during an exam to bruise a patient?

A. I don't think any studies have been done on that. I would not know. All I'm saying is it wasn't there before and now it's there following the exam.

Q. Okay. Would it surprise you to learn that Patient A did not complain that that exam was painful? She reported discomfort.

A. That would surprise me because in her allegation, she noted that she had pain.

Q. But testified differently to that yesterday, and her reaction --

MR. WHITE: I'm going to object for facts not in -- assumes facts not in evidence.

Actually, it's the other way around. She said

she had substantial discomfort at the end of her exam.

HEARING OFFICER GHUSIN: I agree.

Dr. Chambers, it's true, and I'm going to sustain that objection.

BY DR. CHAMBERS:

Q. Discomfort is not that same as pain, is it, Doctor?

A. No, sir.

Q. And --

THE WITNESS: Can I make a statement?

MR. WHITE: Wait for a question.

BY DR. CHAMBERS:

Q. Plastic surgeons, they have before and after photo galleries; correct?

A. Correct.

Q. Does that fall in disrepute of the medical profession?

A. We're talking about the -- there are different photographs. There's -- I want to be clear that the photographs that you took as a female genital -- I'm not going to say plastic surgeon -- it is acceptable to have before and after if you're in the plastic surgery field.

Q. But it's not acceptable if you're a cosmetic surgeon doing cosmetic surgery to alter someone's body?

A. It's not acceptable to alter the body?

Q. In other words, a plastic surgeon will do aesthetics on the breasts and the buttocks and the nose, they take before and after pictures?

A. Yes.

Q. What's the difference between that and a cosmetic gynecological surgeon taking before and after pictures of the patient's vulva that has been altered?

MR. WHITE: Objection. Asked and answered.

HEARING OFFICER GHUSIN: I --

DR. CHAMBERS: It hasn't been answered.

HEARING OFFICER GHUSIN: No. It hasn't. Overrulled. He was asking for clarification.

THE WITNESS: Well, I did say that you'd taken Dr. Alinsod's course and that I thought it acceptable for the photos that you took before and after. I believe I said that.

Q. Is it acceptable to take a photograph of the patient's vulva to teach her and to explain to her, using surgical markings, what needs to be done on her body?

A. I don't have problems with that. I had problems with how you --

Q. Okay. Okay. You answered. You have, as an OB-GYN, sized or measured patients; correct?

A. Are you talking about how tall they are?

Q. No.

A. What size their waist is?

Q. No.

A. Are you talking about the vagina?

Q. Correct, inside her pelvis. As an OB-GYN, have you sized patients?

A. Yes.

Q. In what capacity?

A. As an obstetrician.

Q. Okay. What did you size? Cervix?

A. You're sizing pelvic inlet, the pelvic outlet. As a gynecologist, you're doing a POP-Q test. So, you're sizing AA, which is from the introitus to the hymen; AB, which is from the hymen to the anterior cervix; C is the total length of the anterior cervix.

You're sizing the genital hiatus, you're sizing the perineal body, you're sizing the posterior of the vagina, taking the total vagina length, and then you're also assessing the prolapse of the anterior wall, the cystocele, you're sizing the prolapse of the rectocele.

You may put your finger in her rectum and evaluate her that way also.

Q. Okay. You did testify that my examination of Patient A was appropriate. Did I hear that correctly?

A. I thought you did a thorough history and physical, and I thought your pelvic exam was certainly

appropriate.

Q. Patient A had inconsistent memory.

MR. WHITE: Objection. Testifying.

HEARING OFFICER GHUSIN: Dr. Chambers, he made an objection. Did you hear his objection?

DR. CHAMBERS: I did. I'm going to rephrase.

HEARING OFFICER GHUSIN: Okay.

BY DR. CHAMBERS:

Q. You maintain that fisting constitutes sexual misconduct; correct?

A. No. I didn't say that.

Q. Would you consider it as sexual misconduct?

A. If you fisted or if an individual fisted a patient, I would consider that sexual misconduct.

Q. Or attempted to; correct?

A. If that's -- are you suggesting that you attempted to?

Q. I am asking a question. If someone attempted to, that would be considered sexual misconduct?

A. If a professional OB-GYN attempted to fist somebody, I would consider that sexual misconduct, yes.

Q. Is there any proof in Patient A's record that I fisted her?

MR. WHITE: Objection. I -- in the records?

HEARING OFFICER GHUSIN: According to her

testimony --

DR. CHAMBERS: In her medical records. In my notes.

HEARING OFFICER GHUSIN: Let's clarify the source, because we have in the records, we have her testimony.

BY DR. CHAMBERS:

Q. So, if you refer to the testimony, it was inconsistent.

MR. WHITE: Objection. It's -- now you're testifying again. For the -- yeah.

HEARING OFFICER GHUSIN: Dr. Chambers, I'm going to sustain it because Dr. Rafael was not privy and present for her testimony.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

Q. If there was -- let me put it to you this way --

HEARING OFFICER GHUSIN: But based -- but, sir, you could base it on the records he reviewed.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

Q. Based medical records, my notes, the photographs, did you see any evidence of fisting?

A. Certainly, based on your records, no.

But she has made an allegation, and I'm not -- she's made an allegation that the term "fisting" was used. Within the records, there was no proof you fisted her.

Q. Okay. And I contend did not use that word.

MR. WHITE: Objection.

HEARING OFFICER GHUSIN: Sustained.

BY DR. CHAMBERS:

Q. Are you familiar with the Q-Tip testing for pelvic pain on the external genitalia?

A. Sure. Q-Tip test. Yes.

Q. My use of the Q-Tip, was that inappropriate?

A. No.

Q. Is it possible that a patient with chronic pelvic pain or dyspareunia, painful sex, when you do a biannual examination, it might feel as if something is larger than expected inside the vagina to that patient? In your experience.

A. What you're suggesting, I believe, is that the patient felt something and she couldn't identify exactly what it was. Could it have been your four fingers? Yes, it could have been.

Q. And you testified that using four fingers can be appropriate; is that correct?

A. Correct.

Q. Dr. Rafael, thank you so much for your

testimony.

A. Thank you, sir.

HEARING OFFICER GHUSIN: Mr. White?

MR. WHITE: Thank you.

REDIRECT EXAMINATION

BY MR. WHITE:

Q. You were asked a question about addressing sexual fantasies with a patient by Dr. Chambers?

A. Yes.

Q. Is that something you would discuss with a patient if they brought it up first?

A. Yes.

Q. Okay. I think you answered this already for him, but do you agree that ACOG, on page 160 -- Exhibit 11, page 160, do you agree a chaperon needed to be in the room?

A. Yes, I do.

Q. You were asked some questions about whether having a chaperon and if this ACOG opinion is a suggestion or a mandate --

A. I don't think ACOG makes mandates.

Q. Right. Do they?

A. No.

Q. And -- but why is it a good idea to have a chaperone in the room?

A. It's a good idea for both the patient and the physician.

For the patient, I think it's reassuring that she's going through a safe exam. Certain things may be said, and that's why I think it's important for her to be -- or him, but it's generally her -- to be within a length where she can hear and see everything that's going on.

It's important for the physician because that chaperon protects the physician.

Q. How do they protect the physician?

A. Well, for example, if there was alleged sexual assault, and Dr. Chambers or any physician's chaperone is in the room, she can then testify and say, no, this did not happen.

Q. He asked you about an emergency, sometimes -- it talks about it in this ACOG thing. In an emergency, you might not have a chaperone?

A. True.

Q. Something needs to be done with that patient right away, chaperone's not available; correct?

A. Okay.

Q. Okay. Would you document that?

A. Yes.

Q. Now, do you see -- let's go to Exhibit 3.

A. (Witness complied).

Q. You've had sometime to review these records today?

A. I've seen these records.

Q. Can you point out anywhere in there when it mentioned there was a chaperone in the room or there wasn't because there was an emergency?

A. No, I do not see any documentation of a chaperon nor do I see an emergency.

Q. And he asked you a question, kind of stated that there in variations of a normal-looking vulva?

A. I think Dr. Chambers -- well, that is true, but I think the question was regarding labia minora. I could be wrong about that, but, yeah.

Q. So, there's a range of normal?

A. Absolutely.

Q. Does everyone require cosmetic surgery?

A. No. A lot of it depends on what the patient wants.

Q. What the patient wants?

A. Yes.

Q. You've seen all these records for Patient A and Patient B and Patient C, did Dr. Chambers do surgery on any of these patients?

A. No, sir.

Q. What was your primary concern regarding that

pictures taken with Patient A's cell phone?

A. Well, my primary concern is, in my opinion, it's putting the patient at risk. Also, it's seems to fly in the face of what HIPAA says, one shouldn't.

So, I think there's potential for abuse and putting a patient at significant risk. Should that picture get online, it could be spread all over the place, and I don't think that's in the best interest of the patient.

Q. Would it be -- in other words, would you agree that it would be disrespectful to patient privacy?

A. It could be.

Q. Do you remember when you reviewed the allegations regarding Patient A -- to try and clear some confusion, do you remember that Dr. Chambers -- the allegation was that Dr. Chambers said, "What I did during that exam was called fisting." Do you understand that?

A. That appears to be what I do recall.

Q. And that's what you based your review of this case on, as far as parts of Patient A's review?

A. Well, in and of itself, that's lewd language.

MR. WHITE: I have nothing further.

HEARING OFFICER GHUSIN: Any follow-up, Dr. Chambers?

DR. CHAMBERS: I do.

RECROSS-EXAMINATION

BY DR. CHAMBERS:

Q. Dr. Rafael, do you know what is the definition of fisting?

A. Fisting a sexual definition. It comes out of the LGBTQ1A literature and culture. There are two types of fisting. One is called "the duckbill," with the hands together; the other is a situation where the entire fist is placed within the vagina up to -- in order words, the whole first is in the vagina.

As you noted in your response to allegation, one of the things that is very difficult is when you have to remove the placenta, and it's a difficult thing to have to do.

But usually, I believe, fisting has to do with a sexual act.

Q. Okay. Would a lot of lubrication be necessary if fist someone?

A. Would it be necessary the fist someone?

Q. No. Would you need a lot of lubrication to fist someone?

A. I would think so. I would think you would need a lot of lubrication, yes.

Q. A standard packet of lubrication that we use during an exam, is that enough?

A. No.

Q. Enough lubrication to fist someone?

A. No, I don't think so. It's possible, I assume, I think you would be using more lubrication.

Q. Thank you very much.

A. Thank you, sir.

MR. WHITE: One more question.

FURTHER REDIRECT EXAMINATION

BY MR. WHITE:

Q. Based on that last question, you understand that Dr. Chambers is not accused of fisting Patient A; he's accused of saying that what I just did is called fisting. Do you understand the nuance?

A. I understand the nuance.

Q. Okay. Thank you.

HEARING OFFICER GHUSIN: Anything else, Dr. Chambers?

DR. CHAMBERS: Yes. Please.

FURTHER RECROSS-EXAMINATION

BY DR. CHAMBERS:

Q. Dr. Rafael, does it make sense to you, given the definition that you just gave about fisting, the amount of lubrication that you mentioned is necessary, that the same OB-GYN would say to a patient, I just attempted to fist you? Does that sound sane to you?

A. That is speculation. I would say, sir, do I think it's likely that you fisted her? No, I don't think it's likely you fisted her.

Q. Does it sound like that I attempted to fist her?

A. Does it sound like you --

MR. WHITE: Objection. It's -- calls for speculation, and it's asked and answered.

BY DR. CHAMBERS:

Q. Does it sound like a doctor who knows how much lubrication is necessary to perform that act would say to a patient, I tried to fist you?

A. Perhaps that's not what --

MR. WHITE: Objection to the word "sound" and objection to the form of the question.

HEARING OFFICER GHUSIN: Okay. Now we're getting into speculation, and I am going sustain that.

Let's try to wrap it up and see if we can get to your point, Dr. Chambers, so we can get through this.

BY DR. CHAMBERS:

Q. In other words, Dr. Rafael, does it make sense that I would say that?

MR. WHITE: Object to the form.

HEARING OFFICER GHUSIN: Sustained.

It's speculation, Dr. Chambers.

BY DR. CHAMBERS:

Q. Given your definition of fisting and what is required, would a doctor with no ill intention say that?

MR. WHITE: Again, objection. Calls for speculation, and it's asked and answered.

He -- Dr. Rafael has already told him in his questioning that he does not think he fisted her.

HEARING OFFICER GHUSIN: Yeah. I'll sustain it.

I agree, Dr. Chambers.

THE WITNESS: I think I was clear, sir, I do not think it is likely --

MR. WHITE: You don't have to answer it.

BY DR. CHAMBERS:

Q. Do you believe I said to her that I fisted her or attempted to fist her?

A. Speculation. Asked and answered.

MR. WHITE: Objection. Speculation.

DR. CHAMBERS: Okay. I rest. Thank you, Dr. Rafael.

HEARING OFFICER GHUSIN: Okay. Anything else, Mr. White?

MR. WHITE: No.

HEARING OFFICER GHUSIN: You're good. Okay.

I have a couple questions, and I'll try to make

it brief.

First, before getting into some of those questions, we were outside enjoying the weather for a moment, and you said you might have some questions about process, so we decided to wait until we came in here.

So, this would be the time and place if you have a question for us before I ask you a couple questions.

THE WITNESS: Well, we avoided talking about this case while we were outside. And I believe I can ask Mr. White that question.

HEARING OFFICER GHUSIN: Okay. Perfect.

MR. WHITE: I missed your question.

HEARING OFFICER GHUSIN: There wasn't a question. I wanted to see if -- he had indicated he had a question, and we avoided anything to do with this hearing outside so he could ask on the record back inside.

MR. WHITE: Okay.

THE WITNESS: We specifically avoided talking about anything that happened here.

EXAMINATION BY THE HEARING OFFICER

BY HEARING OFFICER GHUSIN:

Q. So, Dr. Rafael, I would like to boil this down because I will be going through these notes and the

transcript.

And I think Dr. Chambers did point out, and so did Mr. White that -- what I'd like to do is, what did you find was inappropriate and what did you find was okay?

You found that his exam notes were thorough and appropriate; that is correct?

A. His exam notes were appropriate.

Q. His exam notes?

A. Yes.

Q. That's what heard you say. Okay.

You also indicated that -- it was in reference to two to four fingers can be appropriate in certain exams?

A. Correct.

Q. Okay. There was a lot of discussion about definition and fisting. I think everyone's agreed that whether or not Dr. Chambers fisted Patient A is not an issue; correct?

A. Correct.

Q. It's Patient A's understanding that the curt is at issue?

A. It's my understanding that she heard Dr. Chambers use the term "fisting."

Q. Right. And that's a factual issue, I believe.

A. I think that's factual.

Q. Could there --

MR. WHITE: I --

THE WITNESS: That's her allegation.

HEARING OFFICER GHUSIN: Go ahead.

MR. WHITE: I was going to ask him one more question when you're done, if I could.

BY HEARING OFFICER GHUSIN:

Q. Could something else be mistaken for fisting?

A. Well, I do not believe -- and Dr. Chambers could be correct here, but I don't believe that he used a speculum during this exam.

Sometimes you will take a speculum, say -- break it down, so you're using the bottom and you push on the posterior of the vagina, and ask them cough to see the cystocele at large. You can reverse that speculum and pull up. So the speculum is an instrument.

But it's not clear to me whether Dr. Chambers used a speculum or not. And, perhaps, had he used the speculum, then, maybe, she would have thought that it was his fist.

Q. Listening to your testimony, it seemed to me your concerns were greatest about the taking of the photos.

A. No, ma'am. No. That's not my greatest concern.

Q. Okay. Let me just ask -- let me rephrase it then.

What I jotted down is the lack of trust that occurred because of that -- I don't want to put words into your mouth. So, what I did jot down was the taking of the photos, you were concerned about the security of the photos.

A. Correct.

Q. The encryption?

A. Correct.

Q. And also the trust between patient and physician? The integrity?

A. I'm concerned about integrity. I'm concerned about ethics. I'm concerned about code of conduct. I'm concerned about boundaries and unprofessional language, suggestive sexual language.

And there are number of things in the allegations of A, B, and C with various stories that step outside those boundaries, in my opinion, is inappropriate. Inappropriate not only to the patient that he's seeing, but also inappropriate to those people that he's talking about who were shown the video of -- or sharing stories about other patients.

Q. Okay. I'm looking at the complaint now, and based on that statement -- in the complaint, in the allegation under Count I, Nevada Revised Statute 630.301, sub 6, and I'm not going to read everything, I don't want prolong this it, but it provides that disruptive behavior

with patient that interferes with patient care or has any adverse affect on the quality of care rendered to a patient, and that that's regarding an issue of disciplinary actions.

Do you believe that based on your review of the record, there was disruptive behavior?

A. Yes, I do. And there were statements by the patients to that affect.

Q. Okay.

A. And if you want me to tell you those statements, I will.

Q. Okay.

A. Patient A really felt just disrespected. And it developed in her a situation where she actually, in her two pages after the original allegation, says that she was traumatized.

Now, in her police report, she said, "No, I wasn't sexual abused." And it was suggested she was traumatized.

In the second two pages, she is extremely upset, feels that she has been traumatized. And said, you know, I'd never go back to him, it was demeaning, and actually used some other words.

Q. That are in the record; right?

A. Right.

And the second, number B, she stated that

Dr. Chambers, in using -- after he had asked if she wanted to a thousand dollars for taking these things, he then says, "What I tell people for these photos, I suggest they fuck the camera." Which I consider lewd and obscene language, and he repeats same language with Patient C.

With B, he refers her to a sex store, and mentions that during one of her deliveries, she was all loosey-goosey, and she was offended by that. She lost confidence in Dr. Chambers, and alluded to the broken patient.

Q. I'm going to go ahead and -- because these are in the allegations, which Dr. Chambers refutes.

I would like to know -- okay. There was some discussion about -- in one page after the examination -- or there's a picture with four fingers?

A. Yes.

Q. And yet two fingers in Dr. Chambers's notes, and I believe both -- that Dr. Chambers pointed out and Ms. Mooneyhan, would you verify for me?

A. Sure.

Q. Because it didn't sound like you had an issue with that.

A. I did not have an issue.

Q. Okay.

A. And time is very important for a physician.

And, generally, I would say that we don't dictate if we have two fingers -- the picture of his examination is appropriate, and if you look at any atlas, whether it's plastic surgery or a GYN, you will see that in an evaluation of a pelvic prolapse, four fingers.

So I have no problems with that.

HEARING OFFICER GHUSIN: Okay. Because under Count III, correct me if I'm wrong, Mr. White, that is the issue.

MR. WHITE: It is.

HEARING OFFICER GHUSIN: Okay. So that it was an --

MR. WHITE: You're talking about failure to maintain proper medical records?

HEARING OFFICER GHUSIN: Right.

MR. WHITE: Yeah. I can ask him again.

HEARING OFFICER GHUSIN: Let me just see if I have anything else.

BY HEARING OFFICER GHUSIN:

Q. But, yes, I want to see -- is that the same, and you could clarify that too, Count IV, that's the basis for Count IV.

A. So, Exhibit 4, page 3.

Q. Right. Right. You're absolutely right. But I did note that you didn't have an issue with the

documentation of two fingers and the photo four fingers, and that's the basis for at least a couple of the counts here.

MR. WHITE: Okay. There's a nuance there. Can I ask a question of him?

HEARING OFFICER GHUSIN: Go ahead. Thank you.

FOLLOW-UP EXAMINATION

BY MR. WHITE:

Q. So, taking all this together, Patient A -- the treatment of Patient A, treatment of Patient B, the treatment of Patient C, taking that all together, and his record states two fingers, specifically, but there's a picture of using four, do you think it's likely that he could be hiding the fact he said -- well, hiding the allegation that he said two --

DR. CHAMBERS: Objection, Your Honor.

MR. WHITE: I'm not done yet.

BY MR. WHITE:

Q. That he said, "What I just did to you was fisting."

Could he have said that or not?

A. I'm a little bit confused.

HEARING OFFICER GHUSIN: Okay.

BY MR. WHITE:

Q. Based on these --

HEARING OFFICER GHUSIN: Sustained. Let's rephrase it. Help he out here with these counts because --

BY MR. WHITE:

Q. Based on his treatment of all three patients, including the lube comments to the patients, do you feel it's likely that he could have said to the Patient A, "What I just did to you is fisting"?

DR. CHAMBERS: Objection, Your Honor. Isn't that leading the witness?

HEARING OFFICER GHUSIN: I'm going to sustained it.

MR. WHITE: Okay.

BY MR. WHITE:

Q. Do you feel it's -- do you feel he said that?

DR. CHAMBERS: That's speculation.

HEARING OFFICER GHUSIN: It's the same.

THE WITNESS: It' speculation.

BY MR. WHITE:

Q. Do you believe Patient A when she made that allegation?

DR. CHAMBERS: Speculation again.

THE WITNESS: Let me think about that.

MR. WHITE: Is that sustained?

HEARING OFFICER GHUSIN: No. And my concern

here is I just wanted to boil it down so we could excuse Dr. Rafael as far these counts and what he believes.

I mean, what we've done is when Dr. Chambers was asking questions, and now we're doing it when you're asking questions, what he believes, let's not do that.

MR. WHITE: Okay.

BY MR. WHITE:

Q. Do you feel any comments that involve the word "fisting" to a patient --

DR. CHAMBERS: Objection. Do you believe, no, it's the same thing.

MR. WHITE: And you're --

HEARING OFFICER GHUSIN: Okay.

MR. WHITE: He's --

HEARING OFFICER GHUSIN: Dr. Chambers, wait.

Mr. White, say "in your opinion."

BY MR. WHITE:

Q. In your opinion, as someone who reviewed this case, a medical professional, do you feel like the use of the non-medical term "fisting" is appropriate with a patient?

A. I don't think the term "fisting" is appropriate.

Q. Okay thank you.

HEARING OFFICER GHUSIN: Okay.

BY MR. WHITE:

Q. Is it unacceptable?

A. I think if you asked a physician, would you describe any part of your exam as fisting, it would be unacceptable.

Q. Thank you.

Now, if you -- going back, if you inserted four fingers into a patient, but you specifically wrote two fingers, do you think anything -- why would that be done?

A. I just -- okay. So let's say in an average day, you do 30 patients. I just don't think that Dr. Chambers thought it was important because this is something he does every time where he's evaluating pelvic prolapse.

So, I think he just failed to mention that, you know?

HEARING OFFICER GHUSIN: Okay.

BY MR. WHITE:

Q. But if you're going to put it in your records, why wouldn't you be more accurate?

A. Well, again, I think time is important. You know, it's not unusual for me to think, well, this is something we do every day. But for a patient to say, you know, why didn't you document that or what is this? It's kind of like second nature, and I think that's is issue.

HEARING OFFICER GHUSIN: Okay.

BY MR. WHITE:

Q. Does it change your opinion, that that picture with the four fingers in it, was one of the pictures that was not used during this treatment?

A. No.

Q. Okay.

HEARING OFFICER GHUSIN: Okay.

DR. CHAMBERS: May I ask him a question?

HEARING OFFICER GHUSIN: Let me just finish, go around one more time, and I think we're done.

DR. CHAMBERS: Okay.

FURTHER EXAMINATION BY THE HEARING OFFICER

BY HEARING OFFICER GHUSIN:

Q. And I want to get to -- and I don't want to beat it to death and I don't want recreate the wheel, because I think lot of this has been asked and answered.

A. Yes.

Q. And I'm going to give you a little bit of latitude here. As we are, as I've mentioned, in an administrative hearing, and I think you have opinions to offer that maybe we can get to.

So, ultimately, just so understanding is clear -- and Mr. White has asked some clarifying questions, as I did, in response to mine, about the four fingers and the two, and

correct me if I'm wrong, you said, because you don't have a lot of time, it's busy, and basically you're saying that is not the big issue to you?

A. Correct.

Q. Okay. Tell me what are the big issues to you, one last time, and then I'll go one more round. I think we're done here.

A. Well, I have, essentially, three conclusions.

Q. Okay. Thank you.

A. My first conclusion is, in my professional opinion to a reasonable degree of medical certainty, that Dr. Chambers did not commit malpractice.

And I say that because there are four areas of malpractice. First being duty, the second, breach of duty, the third, injury, and the fourth --

Q. You said "did not"?

A. Did not.

Now, let me put a caveat in that. Because this is based on the records that I had reviewed. Patient A said that she was traumatized. Now, trauma-- and I know we're a couple of years since this happened, but post-traumatic stress disorder can occur one or two years later.

So, I'm not suggesting that she does this. I have -- but should she have a psychiatrist, a forensic psychiatrist, a sexual forensic psychiatrist say, yes,

indeed, you were traumatized, then there would be an injury, and then you would have to review that injury causation, etc cetera.

But in my opinion, from what I've reviewed, I do not think he committed malpractice.

MR. WHITE: Okay. I just want to clarify something. He's not charged with malpractice --

HEARING OFFICER GHUSIN: Right.

MR. WHITE: -- anywhere in here.

HEARING OFFICER GHUSIN: No.

MR. WHITE: Yeah. I just want to make sure --

THE WITNESS: 640.030, medical malpractice. It was a question I was asked when I was asked to review the -- as a peer review.

HEARING OFFICER GHUSIN: Okay.

THE WITNESS: That's why I mention it.

BY HEARING OFFICER GHUSIN:

Q. Okay. Your second opinion?

A. My second opinion has to do with sexual misconduct. He fulfilled -- his behavior fulfilled the definition of sexual misconduct and sexual inappropriateness. And I think we checked off each one of those, language, et cetera.

My third opinion is that Dr. Chambers did not commit sexual violence, and as you know, that is equal to

rape. I believe I'm correct.

Q. And that's not in the complaint either.

A. And sexual assault --

Q. Correct.

A. I do not believe Dr. --

MR. WHITE: Well, no. I mean, that would be --

HEARING OFFICER GHUSIN: Right.

MR. WHITE: -- in the complaint.

HEARING OFFICER GHUSIN: Right.

THE WITNESS: I do not believe Dr. Chambers sexually assaulted either Patient A, B, or C, but I do believe that there was sexual inappropriateness, sexual misconduct with Patient A, B, and C.

HEARING OFFICER GHUSIN: Okay. Follow-up?

MR. WHITE: I don't think I do.

HEARING OFFICER GHUSIN: Okay. Dr. Chambers?

MR. WHITE: I just want to make sure that we are clear that malpractice is not an issue.

HEARING OFFICER GHUSIN: Right.

MR. WHITE: And we're really just talking about the inappropriate comments and the inappropriate way of dealing with --

HEARING OFFICER GHUSIN: His second --

FOLLOW-UP EXAMINATION

BY MR. WHITE:

Q. Your second one, do you feel -- I think you may have just summed it up that you feel that there was sexual impropriety, based on the ACOG definition, with all three patients?

A. Yes, I do.

Q. Okay. Do you feel -- strike that.

In your opinion, do you -- would you have -- never mind. Strike that too.

Is -- you had stated earlier that Patient A was traumatized --

A. No.

Q. Felt?

A. I stated that Patient A felt that she was traumatized.

Q. Okay. In your opinion, then, and I think you might have stated this, it might have been asked and answered, but we're clarifying for the record, in your opinion, does the treatment of Patient A, B, and C by Dr. Chambers, does that bring the medical profession to disrepute?

A. Yes.

HEARING OFFICER GHUSIN: Okay.

BY MR. WHITE:

Q. Do you think he violated the trust of these patients?

A. Yes, I do. And I can make a statement on that.

Q. Is this -- would this be something you would consider disruptive behavior? And again, all three patients.

A. If disruptive behavior is interfering with the patient-physician relationship, yes.

Q. I can give you the definition, if that helps you?

A. Yes. Please.

Q. Okay.

"Disruptive behavior with patients that interferes with patient care or has an adverse impact on the quality rendered to a patient."

Is that --

A. I would say yes.

Q. For all three?

A. All three patients, yes.

Q. Count VI is continual failure to practice medicine properly.

The definition is this -- provides -- this is NRS 630.306 1(g), provides that:

"1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure: "(g) Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field."

Do you think that he failed to exercise his skill or diligence or use the methods ordinarily used by physicians in good standing?

And I want you to think about the comments and -- with regards to the comments he made and the pictures.

A. I'm having a little bit of difficulty with that question in a sense that when I think of skills, I think of operations, and there was no operation.

We talked about the art of medicine and patient treatment, so I think each of these patients did not feel that they were treated in a professional manner.

So, I think the answer would be yes.

Q. Okay.

MR. WHITE: Now that's all I have.

HEARING OFFICER GHUSIN: Thank you.

More questions, Dr. Chambers, and then

Mr. White gets the last bite of the apple.

THE REPORTER: I need to take a break.

HEARING OFFICER GHUSIN: Hold on. We're almost at a break.

DR. CHAMBERS: I just have one question, and I'm done.

HEARING OFFICER GHUSIN: Okay.

BY DR. CHAMBERS:

Q. Mr. White keeps referring back to my documentation of two fingers only. Would it surprise you to learn that the reason why I wrote two fingers is because two pictures were in front of me as I charted, and I saw the picture with two fingers?

A. I'm sorry. You're saying what you would --

Q. No. No. No. In other words, when I was charting, the only reason why two fingers ended up in my notes is because two photographs, one of which had my fingers examining the patient, was in front of me, I saw my two fingers, and I wrote two fingers.

A. No. I don't think that would surprise me.

Q. Thank you.

HEARING OFFICER GHUSIN: Mr. White?

BY MR. WHITE:

Q. Do you know who had possession of all 12 photographs after they were texted to Dr. Chambers?

A. I would -- I do not know, but I assume Dr. Chambers had the photos, and I would assume the patient had the photos.

Q. Okay. Thank you.

DR. CHAMBERS: I'm sorry. I didn't hear the question.

MR. WHITE: Do you want me to reask it?

HEARING OFFICER GHUSIN: It's up to you. He didn't hear it. He has a right to hear the question.

BY MR. WHITE:

Q. Do you know who had possession of all 12 photos of Patient A --

A. I --

Q. Hold on -- after she texted them from her phone to his?

A. No, I do not.

Q. You don't know who had possession of them? Did she text them to him?

A. My understanding was that she texted two pictures to him, but if you look at these photos, and there are, I believe, 12 photos here.

Q. Okay.

A. This is taken on an internal storage DCIN camera, Samsung, and my assumption is that the patient wouldn't have this camera.

Q. So, only two photos were texted; right?

A. That's what the record says.

Q. Okay. Who took them? Who took the photos?

A. Dr. Chambers.

Q. With whose phone?

A. With the Patient A's phone.

Q. Okay. Thank you.

DR. CHAMBERS: I'm confused, Your Honor.

HEARING OFFICER GHUSIN: Yes, Dr. Chambers?

DR. CHAMBERS: The question, as I understand it, is who has possession of the 12 pictures.

HEARING OFFICER GHUSIN: That was the question. Do you have any follow-up?

BY DR. CHAMBERS:

Q. Dr. Rafael, if she sent me two pictures, who would have the other -- who would have the twelve pictures if she sent me only two?

DR. CHAMBERS: Was that the question?

HEARING OFFICER GHUSIN: You what --

DR. CHAMBERS: Because I'm confused.

HEARING OFFICER GHUSIN: You know what, I'm -- Dr. Chambers, this is -- I -- I'm just going to cut this off now, and the question is, as far as relevancy, we've gotten into too many of the weeds right now, as far as the pictures.

I think we understand where pictures are, and Dr. Rafael has no idea. He can only guess, as we can, the most likely place for them.

So we're going to go ahead and take a break and set up; correct? Is that --

DR. CHAMBERS: How long is the break?

HEARING OFFICER GHUSIN: What -- is Dr. Goodman available? And I think everyone's tired.

I want to thank Dr. Rafael for your time and information.

THE WITNESS: Thank you.

HEARING OFFICER GHUSIN: So you tell me.

MS. FUENTES: If the next witness is Dr. Goodman, then, yes, we would need -- I would say 30 minutes --

HEARING OFFICER GHUSIN: Okay.

MS. FUENTES: -- to make sure we're --

HEARING OFFICER GHUSIN: 3:00? Is he available --

MS. FUENTES: -- setting everything up.

HEARING OFFICER GHUSIN: -- Dr. Chambers?

DR. CHAMBERS: Yes, he is.

HEARING OFFICER GHUSIN: Okay. So is 3:35 reasonable?

MS. FUENTES: I think so.

HEARING OFFICER GHUSIN: Okay. We'll be back here at 3:35, then.

(Recess 3:01 P.M. to 3:37 P.M.)

HEARING OFFICER GHUSIN: Good afternoon. Hope everyone is refreshed. That was a marathon session. Can you all hear me?

DR. CHAMBERS: Yes, we can.

MS. MOONEYHAN: Yes, we can. Can you hear us?

HEARING OFFICER GHUSIN: Yeah. Okay. I should have checked.

So we're all set up here. I want to thank the Board IT for making this happen for Dr. Chambers's expert.

It looks like what we will be doing is moving a laptop around and trying to get the best view possible. The sound will be fine. Is he in?

MS. FUENTES: He's in the waiting room.

HEARING OFFICER GHUSIN: Okay. Let's go ahead and bring him in.

Dr. Goodman, can you hear me?

DR. GOODMAN: Are you able to see me?

HEARING OFFICER GHUSIN: Hi. Is this Dr. Goodman? Can you hear me? All right.

DR. GOODMAN: I think we have it.

HEARING OFFICER GHUSIN: Can you hear and see

us, Dr. Goodman?

DR. GOODMAN: I can hear and see you.

HEARING OFFICER GHUSIN: Let me introduce myself. I'm Hearing Officer Nancy Ghusin. We are in Northern Nevada and Southern Nevada.

DR. GOODMAN: I am hearing you.

MS. MOONEYHAN: Ms. Ghusin?

HEARING OFFICER GHUSIN: Ms. Mooneyhan, I hear you. We're having some trouble. We're working on it up here.

(The oath was administered.)

THE WITNESS: I do.

HEARING OFFICER GHUSIN: Dr. Goodman, we're going to move the camera back around to Mr. Don White, who is counsel for the Board. Okay?

And how I'm going to start, Dr. Chambers will start by asking you questions and then Mr. White will follow up with some cross-examination, and we'll take turns.

And if there's ever a time no one can understand, let us know.

THE WITNESS: And that sounds fine. With your indulgence, I have a 60-second statement.

I just wanted to acknowledge the importance of the work that the Board in the State of Nevada does and

care taken in regards to the complaints in this action.

I thank the Board for their indulgence in allowing me to testify remotely, thus saving me considerable time, and Dr. Chambers additional expense. I realize that my remote testimony would take additional Board time and effort.

And I wish to acknowledge and commend the services of Dr. Rafael, who I am intimately aware is doing service above self, and I appreciate his duty and he's certainly not doing it for financial gain.

I have experience with the Medical Board of California as an evaluator.

I'm not here to venerate Dr. Chambers, that's your decision; I'm here only to educate and help the Board to make an informed decision.

HEARING OFFICER GHUSIN: Thank you.

Dr. Chambers?

DIRECT EXAMINATION

BY DR. CHAMBERS:

Q. Good afternoon, Dr. Goodman. Thank you for your time.

DR. CHAMBERS: I don't believe the Board has a copy of his curriculum vitae. Ms. Ghusin, may I present a copy?

HEARING OFFICER GHUSIN: Mr. White, do you have

the --

MR. WHITE: I have an objection. That, also, was something that needed to be disclosed on or before the date of the prehearing conference.

I thought that -- and I'll say this too: I thought that exhibit -- let's see. It's -- give me one second. I'm sorry. I have a list here.

THE WITNESS: If I may interject, my CV is extremely important in these matters. And I don't --

HEARING OFFICER GHUSIN: Just one moment, Dr. Goodman. Thank you.

THE WITNESS: -- feel it's proper for me to testify without the CV and without the Board understanding my position and my placement in the community.

HEARING OFFICER GHUSIN: Do you think it's in?

MR. WHITE: Exhibit R, which would be, I guess, 18, is listed as Dr. Goodman's curriculum vitae. That is that I've been going on.

HEARING OFFICER GHUSIN: It is. So he has not --

MR. WHITE: So I object to it being introduced now.

HEARING OFFICER GHUSIN: Well, wait, it's here, isn't it?

MR. WHITE: That's not --

DR. CHAMBERS: That's not it. That's a summary of -- that was downloaded from a website. I don't know where they got this from. But it's not --

THE WITNESS: I supplied my CV a good while ago. It's about a ten-page CV. I've written several books. I have many publications. I have approximately 70 patient presentations, and it's something that is important for the Board to understand before I give my testimony in this case.

HEARING OFFICER GHUSIN: Let me ask you, Mr. White, is there a prohibition if it's not by the prehearing conference, because I'm --

MR. WHITE: You have to show good cause of why it isn't in. And I don't see having been presented with that. And that would be your ruling.

HEARING OFFICER GHUSIN: I'm going to allow it. Under the circumstances with Dr. Chambers difficulties getting legal representation, I think it's a minor matter, and in order more to go forward, I'm going to go ahead and allow it.

MR. WHITE: Can I just make a little argument? If that's okay? Well, I mean, I just want to at least put on the record --

HEARING OFFICER GHUSIN: Okay.

MR. WHITE: -- our objection. Okay?

HEARING OFFICER GHUSIN: Uh-huh.

MR. WHITE: I understand you've already ruled, but pursuant NAC, Nevada Administrative Code --

HEARING OFFICER GHUSIN: And that was my question.

MR. WHITE: -- 465 -- 634.465, each party shall provide every other party a list -- this is subsection 2 -- okay. No. Actually subsection 1, at least 30 days before a hearing, but not earlier than 30 days after the date of service on the physician or physician assistant of a formal complaint that has been filed with the Board, unless a different time is agreed to by a presiding member of the Board or panel of members of the Board or the hearing officer, shall conduct a prehearing conference. All documents presented at that prehearing conference are not evidence, are not part of the record, and may not be filed with the Board.

Each party shall provide to other -- every other party a copy of the list of proposed witness -- we did get that -- and their qualifications and summary of the testimony of each proposed witness.

Witnesses whose names do not appear -- this is not really relevant. His name does appear. It's fine.

All evidence except rebuttal evidence -- which

this is not, that's my words -- not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown.

I have not heard that.

HEARING OFFICER GHUSIN: I'm going to find that there's --

THE WITNESS: Wouldn't --

HEARING OFFICER GHUSIN: No, no. No, no.

THE WITNESS: I think that --

HEARING OFFICER GHUSIN: Okay. Hold on.

THE WITNESS: I think --

HEARING OFFICER GHUSIN: I'm going to find that there's good cause in this case in extenuating circumstances in order for Dr. Chambers to be able to put on his case.

And that's what I asked: Is there a prohibition and is it mandatory.

But with good cause, because of his attorney withdrawing immediately before the prehearing conference --

MR. WHITE: Well, can I least make --

HEARING OFFICER GHUSIN: Of course.

MR. WHITE: -- this comment? There's a nuance here. Dr. Goodman can testify because he was listed as a witness on the prehearing conference --

HEARING OFFICER GHUSIN: Um-hum.

MR. WHITE: -- statement by Dr. Chambers. But his -- I'm still going to object to his CV coming in. Dr. Goodman's CV --

HEARING OFFICER GHUSIN: Okay.

MR. WHITE: -- coming in.

THE WITNESS: Excuse me.

MR. WHITE: The testimony's fine.

THE WITNESS: What is your name, counselor? I don't know you.

MR. WHITE: My name is Don white.

THE WITNESS: Don White. Mr. White, why are you so -- why do you so object to --

HEARING OFFICER GHUSIN: Okay.

MR. WHITE: I don't need to answer the questions here. I'm going to be asking them of you.

HEARING OFFICER GHUSIN: Okay, Dr. Goodman, I'm going to allow it in, and you said you need that to testify. We need to move along here.

MR. WHITE: I don't have a copy of it.

HEARING OFFICER GHUSIN: Yeah.

MR. WHITE: I don't have a copy of it.

HEARING OFFICER GHUSIN: Yep, that's true.

I'm sorry. What was that?

THE WITNESS: Mr. White, do you have copy of my

CV?

MR. WHITE: I do not. I haven't seen it, you said it's ten pages, I'm going need time to look at it too.

HEARING OFFICER GHUSIN: All right. That's fair.

THE WITNESS: Well, we can delay this, if you wish, at mutual convenience.

MR. WHITE: I think at this point --

THE WITNESS: I need to --

MR. WHITE: -- he needs to be -- his testimony --

THE WITNESS: Excuse me, sir, when I'm talking --

MR. WHITE: -- if you're going to let that in.

(Inaudible cross talk.)

THE REPORTER: Am I supposed to be reporting this?

MS. FUENTES: Ms. Ghusin, if you could just to remind everybody not to overlap, and it's --

THE WITNESS: -- you have presented an --

MS. FUENTES: -- really hard to hear the --

THE WITNESS: -- expert witness --

HEARING OFFICER GHUSIN: Okay. Dr. Goodman, the court reporter isn't able to take down anything if we

speak over each other. So we have to speak one at a time.

THE WITNESS: Fine. I have not been able to speak.

HEARING OFFICER GHUSIN: I mean, as far as -- you feel need your CV to come in in order to testify; is that correct?

THE WITNESS: That is correct. And the reason that is correct is you have heard from an expert who has absolutely no knowledge in the field --

HEARING OFFICER GHUSIN: Okay.

THE WITNESS: -- Dr. Chambers is engaged in.

I have a lot of knowledge and a lot of experience. So if this is to evaluated fairly, the Board needs to understand my experience.

HEARING OFFICER GHUSIN: Okay. Let's continue it.

MR. WHITE: Well, and here's the thing, we could --

HEARING OFFICER GHUSIN: If he's available.

MR. WHITE: -- start -- he can do, possibly, his -- but I can't even -- I don't even know when to -- and let me -- can I talk for a little bit? No one talk over me, please.

There may be things I would object to --

HEARING OFFICER GHUSIN: I understand.

MR. WHITE: -- possibly by looking at and having a review of ten pages of CV.

HEARING OFFICER GHUSIN: I understand, and you need to have that, but with due process considerations -- I understand there was a cut off time. I agree with you on that.

But in this case, I want to make sure that we adhere to every possible consideration to give Dr. Chambers due process, and it blew up in winter, as you know.

THE WITNESS: How can I help you?

HEARING OFFICER GHUSIN: Dr. Goodman, let us handle this. Okay? Thank you.

THE WITNESS: Okay. Good.

HEARING OFFICER GHUSIN: Do you want to -- I don't it think it's a huge deal, but I'd like to get it in so he feels comfortable testifying. If you want him to testify without it -- because we need to establish him as an expert, and Dr. Chambers isn't going to know how to do that.

MR. WHITE: No. And I -- and let me make this clear, I respect your decision. So it's coming in. I'm just saying that --

HEARING OFFICER GHUSIN: You need --

MR. WHITE: -- I don't know that I can effectively cross-examine him without having seen that. I thought I had the CV.

HEARING OFFICER GHUSIN: And that's fine. I thought you just said that he could go ahead and testify without it.

MR. WHITE: Oh, well, part of the problem is --

HEARING OFFICER GHUSIN: I'm going to leave it up to you.

MR. WHITE: Well, let me talk --

HEARING OFFICER GHUSIN: Okay. Yeah. I'm going to leave that --

MR. WHITE: -- with my cocounsel.

HEARING OFFICER GHUSIN: Right.

MR. WHITE: Part of the problem with that is without seeing a copy of it, I --

HEARING OFFICER GHUSIN: I understand.

MR. WHITE: -- may not have as effective --

HEARING OFFICER GHUSIN: I completely understand.

MR. WHITE: -- objections.

HEARING OFFICER GHUSIN: That's why I leave it up to you. I want you to have plenty of time also.

MR. WHITE: Brandee is asking if we can take a break?

HEARING OFFICER GHUSIN: Yeah. Sure.

Dr. Goodman, we're going to take a quick break to see if we can figure this out. Okay?

So we can hear your testimony, which we want to do.

THE WITNESS: Does the Board have a copy of the current CV, which is --

HEARING OFFICER GHUSIN: We're --

THE WITNESS: -- I believe --

HEARING OFFICER GHUSIN: We're --

THE WITNESS: -- let me just --

HEARING OFFICER GHUSIN: Dr. Goodman, we're going to take a quick break and see how to handle this since the Board did not have a copy of it. Okay?

THE WITNESS: How long a break?

HEARING OFFICER GHUSIN: Give us --

Is five minutes --

MR. WHITE: I'd say probably five, which will probably go ten.

HEARING OFFICER GHUSIN: Okay. We're going to take a five- to ten-minute break, whatever they need.

(Recess from 3:53 P.M. to 4:05 P.M.)

HEARING OFFICER GHUSIN: All right. Here we are again. Can everyone hear me?

THE WITNESS: We can.

DR. CHAMBERS: We can.

HEARING OFFICER GHUSIN: Okay. All right. This is the plan we think we have.

Dr. Goodman, that's quite a CV, and counsel for the Board would like to review it to be prepared to participate and ask you questions.

Dr. Chambers, what we are proposing is to continue this until June 1st, which is our Zoom hearing time for Patient C.

We also are hoping that we might have a better connection, the north and south, if we're all on Zoom, rather than closed-circuit and Zoom. This what the IT experts are telling me.

So, if everyone is in agreement, we will continue Dr. Goodman's testimony to June 1st.

This that -- are you available on June 1st Dr. Goodman?

And then, Dr. Chambers, you also?

THE WITNESS: And I thank you for that. I wasn't meaning to be combative, but I think it's really important to understand my education and what I bring to the table.

The answer is yes. I just checked my calendar and I am available on June 1st. It would be good to have an idea whether it's going to be in the morning or the

afternoon.

HEARING OFFICER GHUSIN: Okay. And we'll get there in just a moment.

Dr. Chambers, are you available? I know you will be because of Patient C's testimony; correct?

DR. CHAMBERS: Correct.

HEARING OFFICER GHUSIN: Okay.

Mr. White informs me he doesn't think Patient C is going to take that long. So what if we take the whole morning, starting at 9:00, and, of course, it's all approximate, Dr. Goodman, we could give you a window.

THE WITNESS: I notice that today.

HEARING OFFICER GHUSIN: Yeah. Split the -- take a break after Patient C, and would 9:30 possibly --

MR. WHITE: Oh, starting when?

HEARING OFFICER GHUSIN: Do you want to go in the afternoon. I'll have to rearrange something.

MR. WHITE: For whom?

HEARING OFFICER GHUSIN: Well, Patient C, 9 o'clock. And --

THE WITNESS: At this point, I'm available the full day, but I would like to have a window because of other things I'm doing here and -- it's hard for me to hold --

HEARING OFFICER GHUSIN: Of course.

THE WITNESS: -- day until that day.

HEARING OFFICER GHUSIN: Of course. Yes. For us all too. We're trying to nail that down too.

Dr. Chambers, are you good on June 1st all day?

DR. CHAMBERS: I have no choice, so yes.

HEARING OFFICER GHUSIN: Well, I'm going to ask counsel, then, would you prefer to try to fit Dr. Goodman in in the morning or would you like to do it in the afternoon, because I'll have to make some different arrangements.

MS. MOONEYHAN: Well, Ms. Ghusin, I would point out that in addition to Patient C, we also have identified Casey Carden as a witnesses. So, two witnesses.

HEARING OFFICER GHUSIN: Okay. So it would be the afternoon.

MS. MOONEYHAN: I would to defer to whatever you decide.

THE WITNESS: And I'm fine as well as far as the time, I just need to know it in advance.

HEARING OFFICER GHUSIN: Okay. I'm going to see if I can reschedule something and just clear the whole day.

Would you anticipate -- I'm asking, 1:30? How much time do you need for the two witnesses?

MR. WHITE: Who do you think, Ms. Mooneyhan?

MS. MOONEYHAN: I'm saying two hours to be safe.

MR. WHITE: For both?

MS. MOONEYHAN: Yes.

MR. WHITE: For both.

HEARING OFFICER GHUSIN: You're in California, Dr. Goodman?

THE WITNESS: Correct. Same time zone.

HEARING OFFICER GHUSIN: What if we did it later in the afternoon?

MR. WHITE: Okay.

HEARING OFFICER GHUSIN: Would three o'clock be acceptable?

THE WITNESS: I need the time. As long as I have an idea, I'll put on my calendar, and I'll put it aside.

Today, it was supposed to be 1:30, then maybe 10:20, then 2:30, then it didn't start until 3:00, so that did block off whole day, and I had an appointment I had to cancel.

So it would be nice to have an idea of the time.

HEARING OFFICER GHUSIN: Of course. We want to respect your time as well.

Dr. Chambers, do you anticipate about how long this might take?

DR. CHAMBERS: To examine Dr. Goodman?

HEARING OFFICER GHUSIN: Yes.

DR. CHAMBERS: I think it'll probably take two, three hours.

MR. WHITE: We better start earlier than 3, then.

HEARING OFFICER GHUSIN: Yeah. I'm going to see if I can clear my afternoon. I'll just say that.

So let's say -- I'll do what I can. Let's say 1:30.

MR. WHITE: Yeah.

THE WITNESS: I'll be available at and after 1:30.

HEARING OFFICER GHUSIN: Okay. I will confirm that, but we're all on the same page at 1:30.

MR. WHITE: You're going to confirm in an order?

THE WITNESS: Do you have my email address?

HEARING OFFICER GHUSIN: Dr. Goodman, I do not, no. I don't -- if you could send that to Dr. Chambers.

Do you have his email address, Dr. Chambers?

DR. CHAMBERS: I do. I'll forward it to you.

HEARING OFFICER GHUSIN: Can you share that

with me, Ms. Mooneyhan and Mr. White, please, and copy me.

DR. CHAMBERS: We'll do.

HEARING OFFICER GHUSIN: Okay. And we just do a formal (inaudible).

THE REPORTER: The formal what? I can't hear because of the plane flying over.

HEARING OFFICER GHUSIN: Scheduling order.

All right, Ms. Mooneyhan, I just have Dr. Chambers on screen here. I don't have you.

MS. MOONEYHAN: I think we're waiting to end the Zoom call.

HEARING OFFICER GHUSIN: Okay. Dr. Goodman, thank you. We're going to end the Zoom call now. We'll see you June 1st at 1:30.

THE WITNESS: Thank you.

HEARING OFFICER GHUSIN: Thank you very much. Nice to meet you.

THE WITNESS: Thanks for running a kindly meeting.

HEARING OFFICER GHUSIN: All right. We're back. As an aside, just because Dr. Goodman just said that, Dr. Rafael had pretty much said the same thing about everyone here. That everyone was so civil, and I just wanted to pass that on, Ms. Mooneyhan and

Dr. Chambers and Mr. White. Okay?

So, June 1st, I'll get a scheduling order out. Maybe I'll get before that, a confirming email, and then I'll get a scheduling order. So we're on at nine o'clock on June first at 1:30.

MS. MOONEYHAN: Your Honor, Dr. Chambers has other witnesses. I don't know if he intends to present them today.

DR. CHAMBERS: Yes.

HEARING OFFICER GHUSIN: Okay.

DR. CHAMBERS: I didn't hear you. Were you just adjourning?

HEARING OFFICER GHUSIN: I thought we were, actually. I thought that was it today, but we can go until 5:00.

MR. WHITE: Well, let me just say this, if that's the case, Dr. Chambers may want to testify too, or, you know, do his own --

HEARING OFFICER GHUSIN: Case.

MR. WHITE: -- sort of, narrative that he has the opportunity to do, and --

HEARING OFFICER GHUSIN: What about --

MR. WHITE: -- allow cross-examination. So, that's going to take sometime, and he has another witness. I think a patient or a former patient.

HEARING OFFICER GHUSIN: Here today?

MR. WHITE: Yeah. I think she's waiting in the wings.

HEARING OFFICER GHUSIN: Okay.

Dr. Chambers, we have 45 minutes, and we need to break up at that point. It's your call on how you want to use it.

DR. CHAMBERS: I will let her go first.

HEARING OFFICER GHUSIN: Okay. And with the understanding we may not be able to stop at an opportune moment of the testimony.

DR. CHAMBERS: That's fine.

HEARING OFFICER GHUSIN: Okay. All right. Thank you.

(The witness was seated.)

HEARING OFFICER GHUSIN: Good afternoon. Can you all hear me?

DR. CHAMBERS: Yes.

MS. MOONEYHAN: Yes.

HEARING OFFICER GHUSIN: I'll ask the witness to identify herself for the record, please.

THE WITNESS: Brittany Turner.

HEARING OFFICER GHUSIN: Will you spell your last name, please.

THE WITNESS: T-U-R (inaudible).

THE REPORTER: I can't hear her.

HEARING OFFICER GHUSIN: Ms. Mooneyhan, can you help guide her where to speak.

MS. MOONEYHAN: When you are answering the questions, if will look at that camera up there, that seems to provide better hearing for the court reporter, who is in Reno.

HEARING OFFICER GHUSIN: Okay. One more time with the name, if you would spell it, please?

THE WITNESS: T-U-R-N-E-R.

HEARING OFFICER GHUSIN: Okay. And Brittany?

THE WITNESS: Yes. B-R-I-T-T-A-N-Y.

HEARING OFFICER GHUSIN: Got it now. Thank you very much.

Good afternoon, I'm Hearing Officer Nancy Ghusin. Thank you for your patience and for being here this afternoon. We're going to get right with, and the first thing we're going to do is have you sworn.

And then, Dr. Chambers, go ahead.

(The oath was administered.)

THE WITNESS: Yes.

HEARING OFFICER GHUSIN: Okay. Dr. Chambers, all you.

DIRECT EXAMINATION

BY DR. CHAMBERS:

Q. Ms. Turner, I want to thank you for your time today. Ms. Turner, how do I know you?

A. I'm your patient.

Q. Okay. And what do you do for a living?

A. I am an adult film actress.

Q. And what is your stage name?

A. Mocha Minage (phonetic).

Q. Okay. In all the years I've known you, knowing that you're an adult entertainer, have I ever been inappropriate to you during your many office visits?

A. No.

MR. WHITE: Objection. Calls for speculation and her definition of inappropriate.

HEARING OFFICER GHUSIN: I'm going to allow it.

BY DR. CHAMBERS:

Q. In our interactions, have I used language that -- have I used non-medical terms to describe your anatomy?

A. No. You always use (inaudible).

Q. In the conversations that we have during your visit --

THE REPORTER: I'm sorry. Ms. Witness, could you repeat your last answer, please.

THE WITNESS: He uses proper medical terminology.

THE REPORTER: Thank you.

BY DR. CHAMBERS:

Q. Have you ever contacted me after filming a scene?

A. Have I ever contacted you?

Q. Yes. A movie scene.

A. If I had concerns?

Q. Correct.

A. Yes.

Q. And how did I deal with those issues?

A. If I felt something was alarming, you may ask me to come into the office so we can actually discuss my concerns I was having.

Q. Okay. And when you visited the office --

MR. WHITE: I'm going to object to -- well, I don't know what concerns we're talking about.

Can Dr. Chambers ask -- it's just the form of the question. It's vague.

HEARING OFFICER GHUSIN: Okay. Dr. Chambers, it's a fair request.

BY DR. CHAMBERS:

Q. In other words, knowing what you do for a living, have I ever used words to talk to you and to

evaluate you that wouldn't be proper to use in this setting in front of a child?

A. No.

Q. Are familiar with a sexual kink known as "fisting"?

A. Yes, I am.

Q. Okay. I've examined you; correct?

A. (Inaudible).

THE REPORTER: I didn't hear that answer.

MS. MOONEYHAN: Can you look at the camera there?

THE WITNESS: Yes.

THE REPORTER: Thank you.

BY DR. CHAMBERS:

Q. Have you ever fisted anyone?

A. Yes, I have.

Q. Have you ever been fisted?

A. No, I have not.

Q. And how much lubrication is necessary to fist someone?

MR. WHITE: Objection. Relevance.

HEARING OFFICER GHUSIN: Wait, Dr. Chambers.

MR. WHITE: Objection. Relevance. Is she a medical doctor?

DR. CHAMBERS: Well, she is an expert in this

field, and what I'm trying to show here is that, given her experience with my examinations in the office, with the amount of lubrication I use, it's not something that I would attempt to do nor say tried to do.

HEARING OFFICER GHUSIN: I'll allow it. It's been an issue. Let's get through it.

DR. CHAMBERS: Thank you.

BY DR. CHAMBERS:

Q. Given the amount of lubrication I use when I examine you, all these years, is that enough to fist someone?

A. No. No way.

Q. Why is it that you have never been a recipient of fisting?

A. I do not like the sensation of being really stretched out.

Q. Okay. Have you ever fisted anyone?

A. Yes, I have.

Q. Can you tell us how it's done. Actually, before you do that, when you fist someone, what is inside the patient's vagina or anus?

MR. WHITE: Objection. Relevance.

HEARING OFFICER GHUSIN: Dr. Chambers, I don't know if we need to go too far afield.

DR. CHAMBERS: What it is, I'm trying to define

fisting.

MR. WHITE: I would remind the Hearing Officer, he's not been accused of actually fisting.

HEARING OFFICER GHUSIN: Right. Dr. Chambers?

DR. CHAMBERS: Well, I'm trying to show that, while I haven't been accused, I have been accused of saying that I attempted to fist.

So I'm trying to be respectful and not say that it's ridiculous -- a ridiculous accusation. I'm trying to show that it makes no sense that I would say something like that, if I didn't attempt to do it or did it.

I don't know if that makes sense.

HEARING OFFICER GHUSIN: It does. Okay. I'll allow it.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

Q. So when you do fisting, what part of your body is inserted in the person?

A. All five of your digits, all the way up to your wrist. Your whole hand until your wrist, and if you partner's comfortable, you can go further, as far as they would allow you to.

Q. And how much lubrication is required?

A. Lots of lubrication. You even lube while you're doing it as well to make sure of its ease.

Q. Okay. With your hands, can you show me how you would do that maneuver?

A. Well, if I'm fisting a woman's vagina, you would start off with fingers, one at a time. (Indicating) one, two, then ease the third one in, and make sure the partner is comfortable, fourth, and then you put in your thumb, almost like a clasp, and then you slowly go in, and you ease it in until it gets to here. And if that's where they want it, it's all good.

Sometimes they want to actually ball into an actual fist, but that's a little extreme.

Q. And how long does that normally take?

A. Several minutes. It depends on the partner.

Q. If one were to try that maneuver without proper lubrication, what would be the end result?

A. It would be painful. It would be ripping, tearing, bleeding.

Q. Okay. Have you posed nude?

A. Yes.

Q. Are partners or husbands allowed on the set when you're posing nude?

A. No. They're never allowed on set.

Q. And why is that?

A. Sometimes the husbands, they may not -- they overstep boundaries, the model may not be comfortable

posing in certain things or doing certain things if her partner is at the job. So, it's usually a closed set.

Q. And how are you generally paid for these modeling gigs?

A. Depending on the company. The larger companies may have you on payroll. Smaller companies will either pay you in check or cash.

Q. Okay. Ms. Turner, thank you for your candor and your time. I'm most grateful.

HEARING OFFICER GHUSIN: Thank you, Dr. Chambers.

Mr. White?

MR. WHITE: Thank you.

CROSS-EXAMINATION

Q. Ms. Turner, you were not there for Patient A's visit, were you?

A. No.

Q. You weren't there for Patient B's visit?

A. No.

Q. And you weren't there for Patient C's visit?

A. No.

Q. And you don't consider yourself an expert in ethical behavior of an OB-GYNs, do you?

A. No.

Q. How long have you been a patient of

Dr. Chambers?

A. Since about 2016.

Q. So, you're here just say that you had a good experience with Dr. Chambers?

A. Yeah. Giving his expertise and knowledge on being an adult film actress and certain things that take place.

Q. Okay. Would it surprise you that a lot of people don't know what fisting is, would it?

A. No.

Q. Besides being a patient, do you have any other kind of relationship with Dr. Chambers?

A. No, I don't.

Q. Not intimate?

A. No, I do not.

Q. How about professional?

A. Besides being his patient, no I'm not.

Q. Any kind of fiduciary? Do you hold -- do you have a trust with him or anything like that?

A. Yes. As my physician, yes.

Q. Okay. Landlord/tenant?

A. No. He's just my physician.

Q. Okay. Has Dr. Chambers performed any surgeries on you?

A. Yes. He delivered my daughter back in 2017, if

that's considered surgery.

Q. Okay. But he's never done labiaplasty on you or anything like that?

A. No, he has not.

Q. Has Dr. Chambers taken pictures of you?

A. No, he has not.

Q. Dr. Chambers asked you a question about whether he uses non-medical terms when you're in his office as a patient.

What medical terms has he used?

A. The proper terms to describe body parts.

Q. Can you give us an example?

A. Vagina is one example.

Q. Okay.

A. We didn't really talk about any other parts besides that. He's my OB-GYN, so we don't really talk much besides the area that's of concern, which would be my vagina.

Q. Okay. Could you -- one more time because I didn't get it before, could you describe how far the hand has to be inserted --

A. Well, --

Q. -- to be fisting? I'm sorry. It was a terrible question.

How far does the hand have to be inserted to be

considered fisting?

A. It depends on your partner. Up to the wrist, I would say, would be starters for fisting.

Q. Okay. Thank you. That's all I have.

HEARING OFFICER GHUSIN: Dr. Chambers, any follow-up?

DR. CHAMBERS: None, Your Honor.

HEARING OFFICER GHUSIN: Okay.

Ms. Turner, again, thank you for your time and your patience. We appreciate it, and have a good rest of your afternoon.

So, it's not quite 4:35, Dr. Chambers, do you have any other witnesses there or just you?

DR. CHAMBERS: Just me.

HEARING OFFICER GHUSIN: Do you want to get started or do you want to --

DR. CHAMBERS: I think --

MR. WHITE: It's up to Dr. Chambers too. We can.

HEARING OFFICER GHUSIN: We could do it --

DR. CHAMBERS: I can keep going.

MR. WHITE: To until 5:00?

HEARING OFFICER GHUSIN: Okay. Well, we could go until 5:00, but we may -- it depends how far you get.

That may mean June 1st too; right?

MR. WHITE: Yes.

HEARING OFFICER GHUSIN: Okay. Let's go to a few minutes before 5:00, and then discuss how we're going to work that in. Okay?

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSIN: And I believe Ms. Mooneyhan would prefer you at the witness seat there; correct?

MS. MOONEYHAN: Correct.

HEARING OFFICER GHUSIN: Thank you. Do you have everything you need there?

DR. CHAMBERS: Yes, I do.

HEARING OFFICER GHUSIN: You remain under oath, Dr. Chambers.

DR. CHAMBERS: Okay.

DIRECT EXAMINATION

BY DR. CHAMBERS:

Words cannot describe the fear that I have about getting COVID-19. My perspective on getting a communicable disease whilst working as a physician changed after I had children.

MR. WHITE: Hold on. Objection. This sounds like a closing argument more than -- I would need him -- as best we can, I'm going to request, Ms. Ghusin, that he refer to evidence that he wants to present and refer to

the evidence in the binder, if that's possible.

I didn't mean interrupt him. I think --

HEARING OFFICER GHUSIN: No. I understand, and I kind of see where he's going with this too. Do you?

MR. WHITE: I do, except that if there -- that would have been something that he brought, like his policies for COVID-19 when that was a stronger concern.

HEARING OFFICER GHUSIN: I'm in a strange place here because I don't want to be an --

DR. CHAMBERS: I have that here.

HEARING OFFICER GHUSIN: -- but I don't want to guess.

So you have your policies -- is that it? -- now.

DR. CHAMBERS: I don't have the written policies, but I'm prepared to say what they were.

HEARING OFFICER GHUSIN: Okay.

He can testify -- correct? -- as far as his policies. It doesn't have to be documented. I mean, it's in -- yeah, it's -- I mean, we take testimony not just --

MR. WHITE: Yeah.

HEARING OFFICER GHUSIN: Go ahead, Dr. Chambers. Let me ask you a question, where are you going with your testimony about COVID-19?

DR. CHAMBERS: It was to explain why Casey was not in the room with me.

HEARING OFFICER GHUSIN: Okay. Thank you. Okay. Go ahead.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

In 2020, my son was a year and a half old, my daughter was three. I just need a minute.

HEARING OFFICER GHUSIN: Okay.

DR. CHAMBERS: I think I'll just skip over that part.

HEARING OFFICER GHUSIN: Okay.

BY DR. CHAMBERS:

I was traumatized in one six-hour period in the hospital, where the overhead page for code blue to different rooms in the ICU came about every 15 minutes.

My trauma was compounded by the fact that whilst walking to the doctor's lounge, I saw body after body being wheeled out of the hospital.

One labor nurse with whom I worked, got COVID-19 and took it home to her husband and he got infected and he died.

So I implemented certain office policies to help protect my patients, especially my pregnant patients as well as their -- my pregnant patients as their pregnancies made

them immunocompromised, my staff, and me.

Patients had to wait in their cars, and we called them when I was ready for them to be seen.

I initially only allowed one patient into the waiting room. I removed chairs from the waiting room to accommodate less people.

After the vaccine, I allowed up to four people. I allowed only my patient, my chaperone, and me in the patient care area. The doors to the patient care area have always been locked for security reasons. And I only allowed the patient and I alone in the exam room with my chaperone outside the room at the door.

In Patient A's case, my chaperone, Casey, was outside the room.

She will testify on June 1st, so she'll talk about this, Casey had gotten COVID at least once with her employment with me.

I rescheduled my patients and closed the office during her absence. It was difficult for me to find employees during this time because I could not compete with the $1,000 per week being paid to people for not working by the government.

I was not trying to do bad things to my patients; I was trying to stay alive. I relaxed the rules after we were vaccinated.

Yesterday my qualifications as a sexual health clinician were questioned, as I took four in-person teaching modules over a year.

The certification program was created by the American Academy of Antiaging Medicine. It was deemed sufficient by them to create this program and to award a certificate to those completing the course.

Yes, the field of antiaging medicine is not recognized by established medical organizations, such as the American Board of Medical Specialties and the American Medical Association.

However, it is recognized by the American Board of Antiaging slash Regenerative Medicine.

It is comprised of other like-minded physicians who have filled in the gap where traditional medical education has failed us, such in the education about female sexual health.

I assert that there is no other medical speciality more challenging than the OB-GYN residency training program.

Imagine completing an OB-GYN residency program, a specialty dealing with women's health, knowing nothing about sexual health. It was embarrassing to admit I virtually knew nothing on the topic, as do many of my OB-GYN colleagues.

Before then, the American Academy of Antiaging

Medicine filled that gap. Yes, I am not a trained plastic surgeon; I'm an expert in female pelvic anatomy and female pelvic surgery.

As such, I needed a brief course in plastic techniques and suture selection to enhance my skills and to qualify as a cosmetic GYN surgeon. I enrolled in such a course that was taught by Dr. Goodman, one of the pioneers in this field. I have practiced this subspeciality for almost a decade.

Like many other physicians of different specialities, such as dermatology, dentistry, and plastic surgery, I joined the National Society of Cosmetic Physicians to learn, educate, and advance the field of cosmetic GYN surgery.

From my curriculum vitae, you can see that I also served as chief resident from 2001 to 2001. I was inducted into the Alpha Omega Alpha Honor Medical Society, which is a society of the top ten percent of doctors, academically, in the United States.

I was awarded the best resident-student teaching award for three of four years I was in residency, and on the day of my graduation, I was awarded the Robert E L Nesbitt, M.D., outstanding resident in OB-GYN award.

At least ten times since my relocation to Las Vegas two decades ago, I've been voted top doctor by my

colleagues, and it was published in Vegas Inc. Health Care Quarterly. I've also received a plethora of patient choice awards.

In medical school, we're taught about the power of disparity of the patient-physician relationship. We're taught not to use medical jargon, as it may confuse them. We were taught to adopt to the patient's vernacular, when appropriate, to avoid any my understanding.

In sexual health medicine, patients don't want to see a stiff, conservative, judgmental physician. They do not want to see a physician who reminds them of their father or grandfather. They want to see a physician who makes them feel comfortable enough to share their problems and to get proper treatment. I provided that environment.

Medical school also teaches us to sit lower than the physician, so that she looks down at the physician during the encounter. So we sit on a stool whilst she sits on the examining table. This strategy is meant to empower patients.

Yesterday, Ms. Johnna LaRue of the Board, defined fisting based on what she saw in the photograph of my partially inserted four fingers in the vagina of Patient A. She said she believes that fisting is the insertion of these four fingers.

According to the Wikipedia, fisting, or brachial

vaginal or brachial proctic insertion, is a sexual activity that involves the slow insertion of a hand into a well-lubricated vagina or rectum.

I did not attempt to nor did I fist Patient A. Therefore, I did not say that I tried to.

I performed a standard rectal vaginal examination with one lubricated finger in her vagina, and another lubricated finger in her anus while assessing her for a rectocele, which is a herniation of bowel into the vagina.

A rectal vaginal exam is supposed to part of the annual GYN exam, but it has been largely abandoned during the routine annual exam. Today, I do it to evaluate patients with pelvic mass, patients with chronic pelvic pain, to asses the uterosacral ligaments, and patients with organ prolapse, such as a rectocele.

Yesterday, Patient A testified that I told her to hide photographs and to not show them to her husband.

Again, this was not about me nefarious; it was to protect her marriage. I have numerous examples of patient's marriages that went downhill sexually after their husbanded saw how wide their vaginas open for childbirth. These men do not understand how the vagina is a muscle, built to expand and return to its original state. It develops --

MS. FUENTES: We just lost the video

conference.

(Video conference was disconnected and reconnected.)

DR. CHAMBERS: Where did you lose me?

THE REPORTER: "Built to expand and return to" --

HEARING OFFICER GHUSIN: Right about "the vagina is a muscle," that's what I remember.

DR. CHAMBERS: Okay.

BY DR. CHAMBERS:

In performing vaginal restoration surgery, we focus on the posterior wall of the vagina using a modified form of a traditional posterior colporrhaphy, also known as a posterior repair, also known as a rectocele repair.

In traditional surgery, we reduce the bulk of the hernia to restore function. Aesthetics is not a concern.

In vaginal restoration surgery, we not only reduce the bulk, we also tighten the vaginal canal along it's entire length from the apex, or top, to the introitus opening.

So we constantly have to measure to make sure the patient's vagina can accommodate two fingers at all times during the procedure, because average width of man's penis is about two-fingers width or wide.

I had this discussion with Patient A, not to

insult her, but to give her the answers to the questions posed on Exhibit 3, pages 0023 and 0024. I was trying to make her understand why she felt the way she did, and to explain to her how surgery could solve her problem.

I had no intention of insulting her. I had no intention of causing her PTSD, and for that, I expressed my sincerest apologies.

It is for those reasons why I have never directly solicited patients for cosmetic GYN surgery. I allow them to privately read my marketing material in the privacy of the lavatory or when the exam room door is closed.

If they did not ask me about it, I do not mention it. If they ask if they need surgery and they do not, I say so. I reassure them that the labia minora, or inner vaginal lips, comes in different sizes and shapes and they are a variation of normal. I did not acquire this knowledge to hurt my patients; I did it to help them.

Thank you.

HEARING OFFICER GHUSIN: Is that your complete testimony?

DR. CHAMBERS: That's it. That's my testimony.

HEARING OFFICER GHUSIN: Mr. White, we have five, maybe ten minutes.

MR. WHITE: I don't know if I can get through him.

HEARING OFFICER GHUSIN: It's up to you. If you -- because we're all going to be together. I mean, Dr. Chambers clearly will be on the 1st.

MR. WHITE: It's going to take longer than 10 minutes. This might be a good time to break.

HEARING OFFICER GHUSIN: Makes sense to me.

MR. WHITE: What do you think, Brandee?

MS. MOONEYHAN: I agree. I believe the cross-examination will take significantly longer than ten minutes, and it may be a good idea to break now.

HEARING OFFICER GHUSIN: Okay. On June 1st, we have Dr. Goodman, we have Casey --

DR. CHAMBERS: Carden.

HEARING OFFICER GHUSIN: Okay. And that's the nine o'clock.

DR. CHAMBERS: And patient C.

HEARING OFFICER GHUSIN: So we have Patient C, and then we have cross-examination of Dr. Goodman.

How do you spell Casey's last name?

DR. CHAMBERS: C-A-S-E-Y C-A-R-D-E-N.

HEARING OFFICER GHUSIN: Carden, cross-exam. Okay. Thank you.

We will go ahead and break now. So, is Patient C scheduled for nine o'clock? That's a done deal?

MS. MOONEYHAN: No. Patient C -- for the

record, Patient C and Casey Carden are the IC's witness, and they are available all day on June 1st to provide testimony, whatever, during the proceeding.

HEARING OFFICER GHUSIN: Do you want to start by continuing with Dr. Chambers to finish that up and then go in fresh with the other witness? So, cross-exam of Dr. Chambers at nine o'clock.

MR. WHITE: Sounds fine.

MS. MOONEYHAN: Yes, I believe that would make the record clearer for anyone reviewing it.

MR. WHITE: I agree.

HEARING OFFICER GHUSIN: And we said Dr. Goodman at 1:30.

And so it's up to you, how you want to do the two witnesses in the morning. Okay? All right. Any other --

DR. CHAMBERS: I have a question. Will it be possible to question Dr. Goodman after me so that we're done, and your two patients -- your two witnesses can go after him, so my case is concluded?

HEARING OFFICER GHUSIN: Except we told him 1:30.

MR. WHITE: Wait. Your question was to question him after you?

DR. CHAMBERS: Yes. So that he can be done and

my case close and he has the rest of day to do what he needs to do.

MR. WHITE: Oh, so rescheduling him to the morning?

DR. CHAMBERS: After my testimony and questioning.

HEARING OFFICER GHUSIN: Have you, Ms. Mooneyhan, Patient C and Casey Carden, do they have times or are they just available all day?

MS. MOONEYHAN: They're available all day. They're available at the court's convenience.

HEARING OFFICER GHUSIN: Unless either of you have some objection to that, I see no reason not to do that.

MR. WHITE: Yeah.

MS. MOONEYHAN: I have no objection, it's just, maybe we can confirm because Dr. Goodman made a point that he wanted a specific time. So, if we can confirm all that first, that would be fine.

HEARING OFFICER GHUSIN: And, Dr. Chambers, I'm going to let you do that.

DR. CHAMBERS: I will do that.

HEARING OFFICER GHUSIN: I don't want to get in the middle of that.

DR. CHAMBERS: I will do that and get back to

you this afternoon.

HEARING OFFICER GHUSIN: Okay. So what you are requesting -- or what we would do is continue with your testimony at 9:00 A.M., and then go right into Dr. Goodman.

DR. CHAMBERS: Correct.

HEARING OFFICER GHUSIN: If you could set that up with him and then email all of us, that would be great.

DR. CHAMBERS: Okay. How much time do you think to question?

MR. WHITE: Probably an hour.

DR. CHAMBERS: Okay.

MR. WHITE: And then you might have some redirect of yourself to counter my questioning.

DR. CHAMBERS: So maybe 10:30?

MR. WHITE: Maybe 11:00 would be better.

DR. CHAMBERS: 11:00. Okay.

HEARING OFFICER GHUSIN: So 9:00 A.M., change to 11:00 possibly. And that would put your two other witnesses in the afternoon.

MR. WHITE: Afternoon.

HEARING OFFICER GHUSIN: Okay. All right. Ms. Mooneyhan, Dr. Chambers, Mr. White, everybody else up here, thank you, again. I know it's been a long day -- a

long couple of days. I thank you for your hospitality and help technically.

Anything else, Ms. Mooneyhan?

MS. MOONEYHAN: No. Thank you, Your Honor.

HEARING OFFICER GHUSIN: Okay.

(Proceedings ended at 4:55 P.M.)

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

I, BRANDI ANN VIANNEY SMITH, do hereby certify:

That I was present on May 3, 2023, at the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada, and took stenotype notes of the proceedings entitled herein, and thereafter transcribed the same into typewriting as herein appears.

That the foregoing transcript is a full, true, and correct transcription of my stenotype notes of said proceedings consisting of 213 pages.

DATED: At Reno, Nevada, this 15th day of May, 2023.

/s/ Brandi Ann Vianney Smith

_____
BRANDI ANN VIANNEY SMITH

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

In the Matter of Charges and Complaint Against: GEORGE PETER CHAMBERS, JR., M.D. Respondent.	Case No. 22-9436-1

TRANSCRIPT OF REMOTE HEARING PROCEEDINGS VIA ZOOM

Held at the Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, Nevada

Thursday, June 1, 2023

REPORTED BY:
NICOLE J. HANSEN
NV. CCR NO. 446
CAL. CSR 13909
RPR, CRR, RMR

JOB NO. 974169

APPEARANCES:

The Hearing Officer:

NANCY GHUSN, ESQ.

For the Investigative Committee of the Nevada State Medical Board of Examiners:

DONALD K. WHITE, ESQ.,
Senior Counsel
BRANDEE MOONEYHAN, ESQ.
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For the Respondent, George P. Chambers, Jr., M.D.:

IN PRO PER

I N D E X

RENO, NEVADA; THURSDAY, JUNE 1, 2023; 9:09 A.M.

-o0o-

ADMINISTRATIVE HEARING OFFICER GHUSN: All right. On the record then in the matter of George Chambers, M.D. Good morning. I'm Administrative Hearing Officer Nancy Moss Ghusn, and this is the time and place for the continued testimony in that hearing.

A couple of preliminary matters. We have people who are appearing, and we want to make sure we know who is who. So first, we have Ms. Hansen, who is the court reporter; correct?

THE COURT REPORTER: That is correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you. And we have Jennifer Norton. What I would like to say is if anyone here is going to be a witness or was a witness in the past, please identify yourselves at this time. I don't think we recognize anybody.

But do either -- Dr. Chambers, do you recognize anybody here?

DR. CHAMBERS: I do not.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Mr. White? Mr. White, Ms. Mooneyhan, do you recognize anyone here?

MR. WHITE: No, we do not.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. And we have an iPhone 166. All right. As long as we're not witnesses, it is a public hearing. I would request that you continue to remain on mute, and if you have a desire to identify yourselves, you could do so at this time. I'll wait a beat here.

If there's any media here, I will refresh everybody's memory that there is an order in effect that patients are not to be identified by name or likeness just in case anybody here is media. Thank you very much.

And a couple other matters. It looks like we have a good connection. Maybe the technology gods will smile upon us. I hope so. I've done innumerable Zoom hearings, and I would just like to say I thank you in advance for your courtesy.

We try not to speak over each other and have a clean record so we can understand each other. However, if there's ever a point that we cannot understand each other or if it gets glitchy, interrupt immediately so we don't plow on ahead and have to cover the same ground again. I will remind and I think in that case, Dr. Chambers, you're the only witness here that you remain under oath. Correct?

DR. CHAMBERS: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. I would also ask everyone to identify themselves for the record before we launch.

DR. CHAMBERS: I'm Dr. George P. Chambers, Junior.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you.

MR. WHITE: I'm Don White, Senior Deputy General Counsel for the Investigative Committee of the Nevada State Board of Medical Examiners.

ADMINISTRATIVE HEARING OFFICER GHUSN: Anyone else who is a participant in this hearing?

MS. MOONEYHAN: Yes, Your Honor. Brandee Mooneyhan, Deputy General Counsel.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you. And I assume -- and forgive me if I'm mispronouncing your name. Dimelanta is just here as an observer; is that correct? Is that Natalia Dimelanta?

DR. CHAMBERS: Yes. She's an observer.

ADMINISTRATIVE HEARING OFFICER GHUSN: You could go off video if you would, please.

And Jay Burbank, is that also the case?

MR. BURBANK: No. I'm with the Review

Journal.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Good morning, Mr. Burbank. Would you mind going off video? Good morning. Okay. That works better for me. All right. I'm just going to adjust my screen.

And so the rebuttal witness, Ms. Mooneyhan, is later on then? Because I have that we have Dr. Chambers now at 9:00 a.m. Dr. Goodwin is sort of on call around 11:00, is that correct, Dr. Chambers? Dr. Chambers, can you hear me?

DR. CHAMBERS: Yes. Yes, you're correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. When is Ms. Cardin coming on? In the afternoon, right?

MS. MOONEYHAN: Both Ms. Cardin and Patient C have been told that we tentatively scheduled them for 1:30 p.m., but they are available all day with some advance notice.

ADMINISTRATIVE HEARING OFFICER GHUSN: Sure. Okay. And your rebuttal witness, Mr. White and Mooneyhan, that's the afternoon also or just --

MR. WHITE: Yes.

MS. MOONEYHAN: Yes. At the close of testimony, I would call one more witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: All

right. Mr. White, we had finished up Dr. Chambers. You finished up with your direct testimony, is that correct, sir?

MR. WHITE: I have.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. And, Mr. White, you were ready to cross-examine Dr. Chambers. That's where we were; correct?

MR. WHITE: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: Any other preliminary matters or questions?

MR. WHITE: We do have one more preliminary matter. We just want to clear up what we kind of left it out there up in the air sort of that Patient B might be called back as a rebuttal witness, so we wanted to get clarifying on the ruling on that. And also, she may want to watch a little bit today.

MS. MOONEYHAN: She hoped to observe today, but Dr. Chambers had indicated he may call her for rebuttal, and we wanted to clarify before we went no, she couldn't.

ADMINISTRATIVE HEARING OFFICER GHUSN: I'm hearing a little -- some glitches too. I hope it's not a problem. Okay. So when do you plan on calling Patient B?

MR. WHITE: We don't.

MS. MOONEYHAN: We don't. But Dr. Chambers indicated he might, so we wanted to clarify that.

ADMINISTRATIVE HEARING OFFICER GHUSN: Oh, okay. Thank you. Hold on. There he is.

DR. CHAMBERS: Sorry about that.

ADMINISTRATIVE HEARING OFFICER GHUSN: No problem. I know we're in our home offices. And you may see -- go on and off mute if there's some sort of interference.

Dr. Chambers, do you intend or might you call Patient B for rebuttal?

DR. CHAMBERS: I might. I'm not sure yet.

ADMINISTRATIVE HEARING OFFICER GHUSN: All right. Well, there it is, Counsel.

MR. WHITE: Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: We have the rule of exclusion in effect. And, you know, it's up to Dr. Chambers if and when he wants to call her; correct?

MR. WHITE: Yes.

MS. MOONEYHAN: As long as he understands that rebuttal testimony is not a second chance at cross-examination, that it's truly rebuttal, yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Without the benefit of having that legal training, Dr. Chambers, thank you. And we aren't going to blow up a hearing again and go back. All right?

DR. CHAMBERS: Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: And you do understand that?

DR. CHAMBERS: I do understand that.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. We'll deal with it when we with get there. And I'm sure of course IC counsel will have the opportunity to object if it goes too broad. All right. Anything else?

MR. WHITE: I think that's it.

ADMINISTRATIVE HEARING OFFICER GHUSN: We're good? Okay.

Dr. Chamber, are you ready? Everyone has water and a good connection?

DR. CHAMBERS: I am.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you. Mr. White?

EXAMINATION

BY MR. WHITE:

Q Thank you. Good morning Dr. Chambers.

A Good morning, Mr. White.

Q You asked your patients to take pictures of their own genitalia?

A Excuse me?

Q You asked your patients to take pictures of their own genitalia.

A I do depending on if they're remote or not.

Q If they're remote?

A Correct. I have patients who fly in from overseas, and part of the understanding is they will have to remain in Las Vegas for some time after the procedure, and if they have to go back and they cannot come back, the only way to know if they're healing properly is for them to send me a photograph of the postop pictures. Correct.

Q Okay. But you also have, like with regards to Patient A in this matter, have them take pictures of their own genitalia right when they're in your room, in your exam room?

A I did not ask her to take pictures of her own genitalia, so that's no.

Q You told her to?

A I told her to have me use her phone to do that.

Q Okay. So you asked her for her phone?

A Correct.

Q And you did that with other patients too?

A If they are there for a consultation, yes.

Q You had mentioned before that you type your consultations, but you don't type something that's not a consultation. Do I have that correct?

A Yes.

Q This was typed for Patient A?

A Yes.

Q Because you knew that it was going to go to other providers; is that correct?

A Yes.

Q Okay. And you're aware that the other provider actually also said that there was nothing out of the norm in the pictures, right?

A Which other provider?

Q Was it Dr. Wasserman?

A Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: Let me jump in quickly just to ask Dr. Chambers. Do you have

exhibits in front of you?

DR. CHAMBERS: I do not, but I took some notes while I was there earlier. I have them somewhere else. Do you mind if I get them?

MR. WHITE: I think that would be a good idea.

ADMINISTRATIVE HEARING OFFICER GHUSN: Yeah. Do you need a few minutes, Dr. Chambers?

DR. CHAMBERS: Just a couple seconds.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Perfect.

THE WITNESS: I'm back.

Q (BY MR. WHITE:) Okay. So after they take a picture with their own phone or after you take a picture with their cell phone, you have them text those pictures to you?

A I have them text certain pictures to me.

Q Okay. And you had testified before that you don't know if -- Well, you don't know what their providers -- your patients have on their cell phones?

A Correct.

Q So you don't know if they're encrypted?

A Correct.

Q And you did not identify them in any way, the

pictures?

A There was nothing on the pictures that identified who they belonged to.

Q However, they can be traced back to the cell phone that took it?

A They can be traced back to the cell phone, but they could also have been downloaded photographs.

Q They could also be downloaded photographs from the Internet?

A They could be downloaded photographs from the Internet that were edited by the person's cell phone. Correct. But there's no way for a hacker or someone to say this belongs to this person.

Q Skipped a little bit. Those pictures are time stamped.

A Correct. But if they're edited and saved, they're also time stamped.

Q Well, a screen shot would be perhaps, but those pictures are time stamped, date stamped, and with the exact date of when at least in Patient A's -- concerning Patient A, the exact time she was at your office?

A Okay.

Q In fact, one of your patients texted their

pictures to the wrong person; correct?

A That was her allegation.

Q Didn't you tell Patient A that that had happened?

A I don't recall having that conversation with Patient A.

Q You must have thought more than once how bad it could be if those pictures ended up in the wrong hands.

A Of course.

Q Okay. Or even sent to a child's cell phone?

A Of course.

Q I want to get into a little bit about how you do not have spouses and boyfriends when you have them signed up for modeling pictures with you.

A Okay.

Q Explain that.

A As testified to on May 3rd, when you have a nude session, you don't want partners or spouses present because they create a disruption for the photographer. The models are not comfortable, they're not relaxed, and the person who is ordering the pictures cannot get the picture that one needs for the ad per se because they're disruptive. And so you still have to pay the model, you

have to pay the photographer, and you don't get what you want. So closed set.

Q Okay. Closed set, no boyfriends, no spouses, but these are done in your office?

A Correct.

Q And they are originally set up during what is purported to be a medical consultation?

A What do you mean, "set up"?

Q You solicit those models that are patients of yours, right?

A There's an ad. There was an ad in the lavatory, yes. So if they're in the office and they use a lavatory, they would see the ad. Correct.

Q So it's your testimony that you've never asked one of your patients to become a model?

A If they inquire, then I have the discussion.

Q So it's your testimony that the only patients that have become models for you've had that discussion with, they brought it up first?

A If they've seen the ad. Correct.

Q I'm sorry. I didn't hear you, Dr. Chambers. I think it skipped.

A Correct. Yes.

Q And you're aware that this is contrary to the

ethical rules provided by ACOG?

A What specific ethical rule?

Q Has anyone ever asked to have their family present at one of your sessions, whether you're photographing them or just seeing them for a consultation?

A Photographing, no. Consultation, yes.

Q Okay. And are their family members ever present?

A Family members -- between the periods of COVID, family members are not permitted in the office unless they were proven to be vaccinated or healthcare professionals who I know were vaccinated. Outside of that COVID window, family members have been, since I've been practicing up until this point, allowed in the office.

Q Okay. So is it your belief as a doctor that somebody who was vaccinated couldn't pass on COVID-19?

A You're asking me to testify about how I felt as a doctor during COVID. None of us knew what was going on with COVID. CDC didn't. Fauci didn't. I didn't. So we had to use their guidance, and hospitals are making up their own rules. I made up my own rules.

Q Fair enough. Regarding Patient A, you

understand Patient A did not accuse you of fisting her, right?

A I do.

Q Okay. If you've looked at the complaint again in this matter, what it talks about is that Patient A was severely uncomfortable because you said that you tried to do something called fisting to her. Do you understand that?

A I understand that.

Q But that you could only get your hand in a certain amount which was past the knuckles but before the wrist. So do you understand the difference about being accused of fisting and just making a patient severely uncomfortable?

A Yes, I do.

Q And you also understand that before that visit, she had never heard the term "fisting"?

A So she says.

Q I think there was some testimony, Dr. Chambers, that labioplasty could have alleviated Patient A's complaint of pain. Would you agree with that?

A Yes.

Q Okay. So she came in complaining of pain in

her perineum. Is that right?

A That might have been her chief complaint, but she had other concerns as well.

Q Correct. Right. She had -- we've talked about that. She had about two pages printed out of a list of her concerns, right?

A Correct.

Q And you don't do -- and you know -- correct me if I'm wrong -- you don't do like urodynamics, that kind of stuff, do you?

A She had -- no. No, I do not.

Q Okay. You've pretty much streamlined your practice to be cash-only plastic surgery, cosmetic surgery, all of the things we talked about earlier in this hearing, right?

A Not completely.

Q You still deliver babies?

A Yes. I still practice the full scope of OB-GYN with added sexual health medicine and cosmetic gynecologist surgery.

Q So you still have patients that come in for their yearly checkups?

A Yes.

Q One moment. So is it fair to say that if

labioplasty could have in your opinion alleviated her pain, her surgery could have been done by you and not referred to Dr. Wasserman?

A Yes. However, the etiology of pelvic pain is multifactorial. And specifically, the pain that would have been alleviated by doing the labioplasty was the fact that she complained about a pulling of her labia during sex, the fact that she had to spread her labia for entry of the penis.

MR. WHITE: He's frozen on the screen, but he's talking there.

ADMINISTRATIVE HEARING OFFICER GHUSN: I could see him.

THE WITNESS: Can you see me move?

MR. WHITE: Now I can see you move. Yes.

THE WITNESS: Okay. So the pain that would have been alleviated by the labioplasty would have been the discomfort with wearing certain underpants, the discomfort with wearing tight pants, the fact that she had to wear specific undergarments, and the pulling during sex. It wouldn't have alleviated her perineal pain which was caused by something else altogether.

Q (BY MR. WHITE:) Thank you for clarifying that. And you're correct. She did have some other

complaints about pain. Would you have done the perineal surgery or is that something you don't do anymore?

A I would have. While I'm not a urogynecologist like all OB-GYNs, we are trained to do those procedures. We just choose not to do them. The people who are called urogynecologists go on to three more years of fellowship. I think it's one to three more -- I can't remember -- of fellowship. But all of us know how to do those procedures. I choose not to do them. And when I do do them, I do them for cosmetic purposes.

Q Thank you. Dr. Chambers, I would like you to turn to one of your exhibits, and it's page 105 of your exhibit. It would be Exhibit 17.

A I don't have that. What is it?

Q Oh, sorry. Or Q. It's Exhibit Q. I'm sorry.

A I don't have it. What is it?

Q Oh, you don't have it? I thought you grabbed your --

A No, I didn't. I just made notes on things that I would use, but I --

Q You don't have the binder?

A I don't.

Q Okay. Well, it's -- I guess I'll have to be able to read it to you then. It's the ACOG Committee Opinion Number 795: Elective female genital cosmetic surgery, 2020.

A Okay.

Q All right? Is this one of your exhibits that you've had marked and submitted?

A I think I might have a copy. Excuse me. Ten more seconds.

Q You also have a thumb drive with all of the exhibits. Maybe that would help you. Maybe you can look at it on your computer, but go ahead. Go ahead. Take a minute.

ADMINISTRATIVE HEARING OFFICER GHUSN: It's also noted that it's in my exhibit binder. His Exhibit Q is number 17 if he has the same binder. His exhibit, it's tab number 17, but it's Exhibit Q.

MR. WHITE: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: If that's helpful.

MR. WHITE: Thank you, Ms. Ghusn.

ADMINISTRATIVE HEARING OFFICER GHUSN: I am here. I'm just shutting a window a little bit. Excuse me.

THE WITNESS: I don't have it, but I can pull it up on mine.

Q (BY MR. WHITE:) Okay. Take a moment.

A You said Committee Opinion Number 795?

Q Yes.

A Okay.

Q It appears to be Volume 135, number one, January 2020.

A Okay.

Q Do you have it?

A I have it pulled up on the ACOG site. Yes.

Q Oh, on the ACOG site?

A Yes.

Q Okay. Do you see where it says "abstract"?

A Yes.

Q Now do you see below where it says -- it starts with the sentence -- it's about a third of the way down. It says "Women"?

A "Women should be informed."

Q Yes.

A Yes.

Q Can you read that to us?

A "Women should be informed about the lack of high-quality data that support the effectiveness of

genital cosmetic surgery surgical procedures and counselled about their potential complications including pain, bleeding, infection, scarring, adhesion, altered sensation, dyspareunia, need for a reoperation."

Should I continue?

Q No, that's good. Thank you. I assume that you would be telling all of your patients about the risks and benefits or at least those risks that they talked about there?

A That is in the second visit when they come back to see me when we go over the three different consent forms that they have to sign. That is all delineated in there.

Q Okay. So the first visit, there might not be any verbal warning?

A No. The first visit is more for meet and greet. The second is to talk more in detail about the consents and to do a depression screen.

Q Okay. And do you charge them for that second visit?

A No.

Q You do not. They're charged for the first visit though, right?

A Correct. And that fee is taken out of the

surgical fee if they do the surgery with me.

Q We lost you again. Sorry.

A Can you hear me now? You're frozen.

ADMINISTRATIVE HEARING OFFICER GHUSN: Mr. White? Okay. We're going to hold on a second. I can see Dr. Chambers. I can hear him. So it is currently 9:42.

Ms. Hansen?

THE COURT REPORTER: I can hear you fine.

ADMINISTRATIVE HEARING OFFICER GHUSN: There we go, Mr. White. Okay. He's back.

Dr. Chambers, can you see him?

DR. CHAMBERS: Yes, I can.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Just as an aside, if things like that happen, I'm going to check with others in the room, with Ms. Hansen or Ms. Mooneyhan. And if we have an extended problem, I would probably take a quick break depending on the time. And also, we could communicate by email. Yes, I've done these before, okay? Just so we aren't sitting here staring at frozen images.

All right, Mr. White. Go ahead and continue. Thank you.

Q (BY MR. WHITE:) So I asked a question about

you had said that, Dr. Chambers, that the price of the first visit is taken out of the price of surgical, I think is what you said, and then that's when we had a problem.

A So the initial visit, they're charged. If they choose to have me do the cosmetic surgery, that initial fee is deducted from the surgical fee. If they choose not to do the surgery with me, they only pay that consultation fee.

Q Let me ask you this. I know you know a lot about what you're about to do. You went through a lot of schooling. You've been an OB-GYN for a long time. But let me ask you this. How would a patient know if they want to do this based on the first consultation if they want to go forward with the surgery when you haven't given them the possible risks of that surgery?

A Believe it or not, most patients who come in the door to seek consultation for any cosmetic gynecologic procedure already know whether or not they're going to do the procedure. The visit is merely to answer questions that they don't have the answers to. It's to --

Q Let me stop you. Like, for instance, the risks?

A That's all online. If they come in the door, they know just about as much as I do about the procedure with the exception of doing the procedure. So we talk about the benefits, the risks, as I did with patient. But I don't get into details about that until the second visit.

Q Okay. Now I'd also like to know if you tell them this. This is going back to page 105 of Exhibit Q. At the very bottom, the last paragraph starting with "Patients." Can you read that to us?

A Let's see here. The very last paragraph?

Q Yes.

A What does it start with?

Q Patients.

A We're still on the abstracts; correct?

Q Correct. Yes.

A "Patients should be made aware that surgery or procedures to alter sexual appearance or function excluding procedures performed for clinical indications such as clinically diagnosed female sexual dysfunction, pain with intercourse, interference, athletic activities, previous obstetric or straddle injury, reversing female genital cutting, vaginal prolapse, incontinence or genital a formation surgery are not medically indicated,

pose a substantial risk, and their safety and effectiveness have not been established."

Q So thank you. So as of 2020, at least, in January of 2020, according to ACOG, which we've already established is the pre-eminent authority on what you do as an OB-GYN, they recommend to all OB-GYNs that they warn their patients that really, there may not be any kind of medical effectiveness and certainly none that would outweigh the risks of cosmetic surgery; correct?

A Correct.

Q One moment. Okay, Dr. Chambers. There's been plenty of testimony regarding your certification. Let me get to those. You do not have the binder in front of you; is that correct?

A I do not.

Q Okay. But I think you remember what you've submitted, right?

A I do.

Q Okay. I'll remind you too, but if I'm correct, you submitted three different certifications; correct?

A You'd have to refresh my memory on the third one.

Q Okay. Well, number two is certificate of

completion: George P. Chambers, Jr. This was done November 22nd, 2013, and it --

A With Dr. Goodman. Yes.

Q Yes. And it is signed by Dr. Goodman, who is your expert who we will see today. And it was 16 hours in female genital plastic cosmetic surgery, Master's course. Is that correct?

A Correct.

MR. WHITE: Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: Dr. Chambers, do you have your exhibit binder within the reach? Can you get it?

THE WITNESS: I don't. I wasn't aware that I could take it with me.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. So she left it at the conference room. Okay. Just checking. As long as you're comfortable and you have access.

THE WITNESS: I can do it from memory.

MR. WHITE: We were just consulting, and Ms. Mooneyhan was reminding me that he also -- and I think I mentioned it before -- he was also given a thumb drive so he could have access to everything if he still has that thumb drive.

THE WITNESS: I do, but I don't want to -- I'm not very tech saavy, so I don't want to mess things up if that's okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: That's okay, but I want to make sure that you're comfortable --

THE WITNESS: I am.

ADMINISTRATIVE HEARING OFFICER GHUSN: -- recalling from memory.

THE WITNESS: I am.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Perfect. Thank you.

MR. WHITE: Thank you. And, Ms. Ghusn, I'll do my best to make it very clear what we're talking about.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you, Mr. White. I know no one is trying to pull fast ones. I just want to make sure Dr. Chambers is comfortable and doesn't need to, you know, have a moment to pull it up on his computer. Just let me know, Dr. Chambers.

THE WITNESS: I am. I am.

Q (BY MR. WHITE:) Okay. So we talked about Exhibit 2, which is your completion of the Master's course in November 2013.

A Correct.

Q Are you aware -- Okay. Thank you. Aware that that is not even -- that does not even qualify for CME's for this board?

A It was not meant to be a CME.

Q Okay. And then the next thing I think you completed or at least the next thing you submitted as Exhibit C is that you had completed sexual health and treatment?

A Correct.

Q This was through Dr. Jennifer Landa?

A The American Academy of Antiaging Medicine.

Q Yes. And that we have established -- I think you even mentioned it in your direct examination of yourself in your case-in-chief -- that that is not recognized by the American or any kind of board specialties of anything; correct?

A It is recognized by a board, yes. It is not by the American Board of Medical Specialty, but it's recognized by the Antiaging Board.

Q Okay. And then you went to Dr. -- it looks like you went back to Dr. --

A No, I did not. Those are -- I saw those when I was there in May. Those are just articles, I believe,

my former attorneys included.

Q Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: And can I get a description of what we're talking about? I know, Dr. Chambers, you know what he's talking about, but it --

Q (BY MR. WHITE:) Yeah, so -- and I actually just going back to C, that is also not you did not -- that did not qualify for CME's for this board. You understand that?

A I did not use it as my CME. It was not meant to be a CME program.

Q Exhibit D is another certification that you have from the National Society of Cosmetic Physicians?

A I was a member, not a certification.

Q Well, it says: This certifies that George P. Chambers, Junior, M.D. has participated in the educational activity titled: National Society of Cosmetic Physicians 7th Annual Congress on Aesthetic Vaginal Surgery October 20th through 21st, 2012. Do you remember that?

A I think that might have been a CME program.

Q Actually --

A Yeah, that's a CME program.

Q Yeah. That's where I'm going to. This one, you did get credits for this one?

A Correct.

Q So out of the three that you provided to us, you were provided credits for one; is that right?

A Correct. The other two were not meant for CME recognition. They were meant to expand my knowledge.

Q And according to what we have here, this the documents you provided, you've not taken any more CME's related to female genital cosmetic surgery since 2014?

A Correct.

Q And now it's 2023.

A Correct.

Q You mentioned in your direct examination of yourself that you joined the National Society of Cosmetic Physicians. Do you remember?

A Correct.

Q And you said to learn?

A Correct.

Q To educate?

A Correct.

Q And to advance the field of cosmetic OB-GYN surgery?

A Correct.

Q What do you think about this society?

A It's a society of doctors from different specialties: Dermatology, OB-GYN, plastics. There are some internists involved as well who we go there to learn about the different ways to do cosmetic procedures.

Now a lot of the doctors in this society, they go alone to learn Botox, fat transplant, liposuction and whatnot. I went specifically to learn things that were already within my scope of practice of gynecology. I don't use lip fillers. I don't use any of those things. All I do is the stuff that I already knew. I just needed to learn the proper closure techniques and the proper suture techniques. I didn't need to learn all of the other things that they were teaching.

Q And but you just went to one seminar of them back in 2012?

A Correct.

Q Okay. And does it concern you they don't even have a website?

A No.

Q Because when you Google them, it comes up as a LinkedIn page.

A No, that does not concern me. They are very reputable and well-esteemed physicians are a part of that

group.

Q Okay. Now you understand there's another -- there's other societies out there?

A Correct.

Q Okay. Like, for instance, there's one called the American Academy of Cosmetic Surgery?

A Correct.

Q And you've not joined that, right?

A No.

Q Okay. And why is that? Is it just much too time consuming?

A You know, if we run around joining every society, we would be spending $50,000 a year in society or membership fees. I chose to remain a member of ACOG because that is one organization that has protected us from government interference and from lawyers. I don't want to just join organizations just to put on my CV that I'm a member.

Q Okay. And also, I think you'd have to do a fellowship, correct, to get into the American Academy of Cosmetic Surgery?

A Correct. And I'm not a plastic surgeon nor do I pretend I am.

Q I want to skip over to chaperons a little

bit.

A Okay.

Q The subject of that. You didn't always have a chaperon present, did you?

A I've always used a chaperon. There's an -- I deviated during the onset of COVID, and when everybody got immunized via vaccine or natural immunity for the protection of people who are in my office including myself. And I still maintain I have a chaperon because my chaperon was outside the door not inside. The door was opened, and I was not alone in a locked room with a patient.

Q Are you referring to Patient A?

A Correct.

Q So your testimony is that your chaperon was present but outside the room?

A Correct.

Q But acting as a chaperon?

A Correct.

Q Listening, watching everything that you were doing?

A That's the idea. Yes.

Q I don't need to go over it and you don't have your binder in front of you, but I would assume that you

are familiar with the fact that ACOG recommends that you have a chaperon present for all breast, genital and rectal examinations?

A I am very much aware of that. I have the opinion in front of me. But I'm also aware of the testimony by Dr. Rafael in addition to this document.

Q And just to clarify for the record, that would be --

A Are you looking for the committee opinion?

Q I have it. It's Exhibit 11 of the Investigative Committee's exhibits, and it's page 156. And that's what talks about chaperones and the recommendation that they should be there?

A Correct.

Q Just some general questions now, Dr. Chambers. I'm almost done. You have no formal training in sexual health, do you?

A I did go to a course over a year's period where I did get training. Correct.

Q Did you give us -- Sorry.

A I did. You have that certificate.

Q Which one is it?

A It's the one from the American Academy of Antiaging Medicine.

Q Oh, okay. Four modules?

A Yes, correct, over a one-year period.

Q But they were at four different times a year, right? So we're really talking about 16 days?

A Correct.

Q But you wouldn't purport to have, for instance, training in the sociocultural factors or anything like that, would you?

A No, I would not. That's for a sexual health therapist, which I am not.

Q Okay. You don't purport to be a therapist, sexual health therapist?

A I do not.

Q Do you claim to be a sexual health expert?

A You're freezing. I claim to be a sexual what?

Q Sorry. You cut off again.

ADMINISTRATIVE HEARING OFFICER GHUSN: You froze, Mr. White. If you could ask the question again.

Q (BY MR. WHITE:) Oh. You don't purport to be a sexual health expert, do you?

A I do in the matters of which I was trained how to -- a clinical sexual health expert and how to treat hormonal diseases of female sexual health, surgical

treatment of sexual health problems, counseling of sexual health problems, and giving certain advice that's within the scope of my training. Anything above that gets referred out.

Q Okay. However, this is from roughly 20 hours give or take a couple of hours of CME's and --

A Correct.

Q -- things that did not qualify as CME's?

A Correct. You're attempting to denigrate the education that I have. And I have to respectfully disagree with you. It's also to help my patients.

Q And it's also from nine, ten, and 11 years ago.

A Nothing I do has changed. There have been very few changes in OB-GYN, cosmetic gynecologic surgery, except the equipment used and also in the sexual health medicine I practice.

Q When you were in medical school and doing your residency, you do the same training as Dr. Rafael as far as you know, right?

A Correct.

Q You were in an OB-GYN group until 2019; is that correct? According to your --

A Correct.

Q -- according to your CV?

A Correct.

Q And you left there?

A Wait. What do you mean? A group?

Q You were in a group, right? A group setting? You were one of other OB-GYNs there?

A Well, I've been a call group. But the last time I worked for a group outside of my practice was in 2000 -- was in 2009 when I resigned from that job to start my practice.

Q Okay. Yeah, they didn't mark the page. I apologize. But I think you had written down Women's Health Associates of Southern Nevada Laborists.

A So I was --

Q 2013 to 2018.

A I was an independent practitioner taking call for Wassen, and I functioned independently. I wasn't part of the group per se. I merely covered the hospital in shifts.

Q Okay. Is this what you're talking about when you say you were in a call group?

A Well, that's a laborist group with a bunch of independent doctors. It was formed by the independent community doctors who took turns covering the hospital's

ER and labor and delivery for unassigned patients, for private patients whose doctors weren't readily available for a 12-to-24-hour period. So we worked independently of each other because we came from different practices around the valley. I think you might be asking if I've ever worked in a group of doctors with multiple doctors in the office. Is that what you're asking?

Q Yes.

A So the last time I did that was with Centennial Hills OB-GYN in 2009 when I resigned to start my own practice and before that with Nevada Health Centers OB-GYN when I was a chief of OB and worked with several doctors in the practice.

Q Okay. So what made your decision to leave groups and leave call groups and go out on your own and do what you're doing now?

A Well, I went out on my own because I was getting taken advantage of. I am a workaholic. I was working too much, and I wasn't being compensated accordingly, so I decided to leave in terms of the call group.

Q Sorry, Dr. Chambers.

A So I left being an employed physician in large groups because I was not being compensated in a

manner that was commensurate with my contribution to the practice. I was being taken advantage of.

I also left my on-call group because I make it a point since residency to deliver virtually all of my patients. If I don't deliver them, it's because I'm in surgery or I'm out of the state or out of the country. And it was made -- it was my ex-wife who made me realize that I was increasing my liability, my exposure by delivering my call group partners' patients but not allowing them to deliver mine.

It was a quid pro quo situation where there was no money exchanged. We just delivered each other's patients for free, but they were never delivering any patients because I wouldn't allow them to, so I left the group. Does that make sense?

Q Yes. Thank you.

A Okay.

Q Now -- and I know I'm jumping around. These are all just general questions. Your patients trust you that you're going to give them the best care possible; correct?

A Correct.

Q And it's after they've given you some very intimate information about themselves?

A Well, it depends on why they are seeing me.

Q Okay. In terms of the Patient A, that was pretty intimate information that she gave you, right?

A Correct.

Q But you hardly addressed her pain. Would you agree?

A I most definitely did address her pain.

Q Definitely did not?

A I did address her pain. You know, I talked about Valium, non-surgical procedure, compounded Valium in the vagina, something learned from my sexual health training, something I've seen worked in real life, works for intractable pelvic pain, works for interstitial cystitis in the bladder which causes pain, can work for dyspareunia, penetration pain. I did suggest that.

I suggested labioplasty and I also suggested a posterior colporrhaphy, also known as a posterior repair or a cystocele repair, along with perineorrhaphy which is plastic repair of the perineum. So I did address it. If you read my assessment and plan, you would see it well-delineated there.

Q One moment.

ADMINISTRATIVE HEARING OFFICER GHUSN: Go ahead. Well, you do not have your records in front of

you, do you, Doctor?

THE WITNESS: I do.

Q (BY MR. WHITE:) Can you point out where it says -- talks about Valium like you just spoke about?

A Let's see.

Q Oh, I see. Actually, I do see it.

A The sentence that starts with "Gabapentin".

Q Yeah, I see it. Now these are the same records though that you specifically wrote down that you inserted two fingers, but there are pictures to prove that you inserted four fingers?

A Correct.

Q It doesn't show anywhere in the records here that you told her what you were going to be doing step-by-step?

A What do you mean, step-by-step?

Q Well, you heard from her that she was kind of -- not even kind of -- severely traumatized by this visit. And I know that you even in your own direct examination of yourself said that wasn't your intention and you offered your apologies. However, would it have helped if you would have step-by-step told her exactly what you're going to do slowly and have her understanding?

A Well, you know, in retrospect, I can see that Patient A and I were not on the same wavelength. She came in, and before you -- Don't take that wrong way. Listen to what I'm saying. She came in. She had what she said was her chief complaint: Perineal pain but handed me a document with other complaints which later on in testimony she admitted she wanted me to address.

I don't believe she was ready for the way in which I addressed her complaints because I was very methodical in what I said to her. I explained my physical findings. I told her I understand why she would be having the symptoms that she was having. And I then proceeded to explain what she needed done, so I thought she understood clearly what I was describing to her.

You know, it's not very often that a patient comes in with their thoughts written down like that. And she struck me as someone who was well educated. And I spoke in very simple terms not using any medical terminology to explain what was going to happen if she had stayed with me and what I propose. So I thought she understood. Everybody is frozen. I didn't hear you. You were frozen.

Q Yeah, I know. I didn't actually say anything. I couldn't hear the end of your answer.

A I merely said I thought she understood what I said to her because she was a fairly sophisticated woman, and I thought using the simple language I did that she would understand. You know, when you talk about sex or problems related to sex, people get uneasy. Most people are very uncomfortable. They're curious, but they're uncomfortable. And sometimes when they're uncomfortable, they stop hearing anything. So I was very clear with her. Everything I told her I documented in my books from my objective findings to my plan of care.

Q Yeah. I understand that people would be uneasy and they expect their doctor to put them at ease or at least give them the best diagnosis. Best isn't a good word. The most accurate diagnosis they can get from their doctor. That's why they go in there. But don't you think it would have been a little -- would have maybe put her more at ease if you would have said: Hey, I'm doing two fingers now and now I'm going to do four fingers? If it's uncomfortable, I'll stop. Say something. Why didn't you do that?

A You know, before I touch my patients, I was trained to walk my hand up their leg. In fact, I was the only male in my residency class. And my advisor so that I would understand what women were experiencing placed me

in the stirrups, asked me to get in the stirrups. And while she was talking to us, she touched my inner thigh and I jumped. And lesson she was trying to say is you don't just touch patients. So I don't do that.

I first touch their ankle and I say: Do you feel my hand? I touch their knee with the back of my hand. With my gloved hand, I say: Do you feel my hand? Yeah. I touch their mid thigh with my hand. I say: Do you feel my hand? They said yes. Before I touch their genitals.

And surprisingly, when the patient is in stirrups, if you touch her ankle and say: Do you feel my hand? She'll say no because she's anticipating you touching her genitals and you have to really tap her ankle for her to really feel what you're talking about. So I do explain what I'm doing. Before I insert the speculum, I say it. Before I insert my finger, I say it.

And if I -- well, as we do know now that I inserted four fingers, I would have told her that she's going to feel more pressure. You know, you don't want to explicitly say to a patient you'll feel three fingers, four fingers because that will freak people out and they'll tense up, which defeats the point of the exam. You don't use that word. You say: You'll feel pressure.

You'll feel more pressure. So you don't specifically get too bogged down into, you know, how many fingers you put in it. You just don't do that.

Q Okay. So but you -- Have you just stopped putting what you just told us in your records?

A What do you mean?

Q That you explain to them the physical examination as it's happening?

A No OB-GYN writes that down. We just do our work and write our findings down. Nobody writes that down. And I've reviewed enough charts, followed enough doctors to know that they don't write anything down. What you find is a checklist that they just check, check, check, check, check, and go on. Nobody says explains to the patient how the pelvic exam is going to be done.

You sit and you explain it to a woman coming for her first visit in details like when you get a teenager, you explain it. You give them a speculum to hold so they can feel it, get used to it so there are no surprises. But nobody sits at a table with a patient who is 36 years old who has had four children and specifically says: This is what I am going to do, what -- Nobody does that. That's unrealistic.

Q Okay. And you also didn't explain to her that ahead of time why you were going to use her phone for you to take pictures of?

A I did explain to her why I needed her phone. I said it was to make sure that we were on the same page so that we can look at the picture, look at your picture. I can draw surgical margins, I can teach and see what you're seeing. She complained of a bulging coming out her vagina. And I was able to show her that was her hymenal tag and educate her about that. So I did explain why I was going to use her phone and not my setup for taking pictures.

Q I want to jump to something that you said in your direct examination. You had mentioned alpha, omega, alpha?

A Correct.

Q You mentioned that only the top ten percent?

A Top ten to 20 percent.

Q Okay. Now it's 20? Okay.

A Ten to 20. I did say ten, but it's top 10 to 20.

Q Okay. And would it surprise you if you looked it up right now that it's 25 percent?

A It wouldn't surprise me. Times have changed.

Q So one in four doctors are admitted into that?

A In Nevada, they're not too many of us here.

Q Okay. You mentioned earlier in this testimony going back into May, you stated on your direct examination of yourself that Ms. Carter came down with COVID?

A Correct.

Q Did you provide her with time off?

A Yes, I did.

Q Did you provide her with a COVID test?

A Actually, I think during that time, the government was sending us the kits or she knew where to go and get the kits, so she would test herself.

Q And when did she come down with COVID?

A Gee. I can't remember. She had gotten it so many times during that period because of her daughter.

Q Oh, she got it more than once?

A Yes. Yes.

Q Just a few more questions, Dr. Chambers. Do you want to direct your attention to Patient B. So you asked her to pose for you and you would pay her a thousand dollars?

A The conversation started with her inquiring

about the ad she'd seen. And I said: If you'd like to pose, it would pay a thousand dollars.

Q The ad she'd seen in the bathroom?

A In the lavatory, correct.

Q Do you have a copy of what that looked like at all?

A I don't anymore. I just moved, so I don't have it anymore.

Q But it is your testimony that you had an ad on the back of the bathroom door? Is it -- I guess it would be as they walked out they would see that?

A Correct.

Q Sorry, everyone. We have a lawn mower next to our window right now for the moment.

ADMINISTRATIVE HEARING OFFICER GHUSN: Actually, it sounds great. I can't hear it.

Q (BY MR. WHITE:) Okay. Okay. Good. Now, Dr. Chambers, when you say that they inquire about posing nude for a thousand dollars, do you dismiss everybody else from the room?

A Not necessarily. I generally have students, so the students would stay behind.

Q So the students that are learning from you are watching you solicit models in your practice?

A Well, first of all, if it were illegal, I wouldn't be doing it. And if I thought it was illegal, I wouldn't be -- I wouldn't have posted the ad. And so if it's addressed by a patient and my students are present, I will answer them in the presence of the student. You're muted.

Q Yeah, now I'm unmuted, and I did not hear one bit of your answer, Dr. Chambers, regarding I said to you so you have students that are in the room when you are discussing paying a model a thousand dollars to model, but that person is also a patient.

A Correct. If I thought I was doing something illegal, I wouldn't have put the ad there. And if I felt it was illegal, I would not have addressed it in the presence of my students. It wouldn't have been addressed at all.

Q Okay. Just a sidebar here. We're getting an actual line attached to the laptop we're using so hopefully we won't have this problem anymore with freezing up.

Dr. Chambers, if you could, what did the advertisement say, if you can remember?

A Basically said I was looking for models for my cosmetic GYN surgery ad to be used to advertise in the

adult entertainment industry, and it would pay a thousand dollars. It was a very simple ad.

Q Do you remember writing a response to Ms. Johnna LaRue?

A I do.

Q With regards to Patient B?

A I do. I don't have it in front of me, but I can get it if you want.

Q If you'd like, I just have to -- yeah, go ahead and grab it really quick if you have it.

A Okay. I'm back.

Q Thank you. Do you have it?

A I do.

Q And I'm referring to, for the record, Exhibit 6 of the Nevada State Board of Medical Examiners, page 45 and 46. So, Dr. Chambers, you wrote?

ADMINISTRATIVE HEARING OFFICER GHUSN: So sorry, Mr. White. Which exhibit?

MR. WHITE: Oh, six.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you.

Q (BY MR. WHITE:) You're welcome. Dr. Chambers, you wrote in here, the end of the letter on page 46: "I was visibly livid as she was the one whose

curiosity led her to ask me about the notice on the door." So you let me get this straight.

A Where are you looking?

Q I'm sorry. Near the end of your letter on page 46.

A Yes. Now I found it.

Q Yeah. I think it starts out, to put it in context, she had sent you a text message. You said she excoriated you. She thought I was up to no good.

A Correct.

Q And her husband could not attend the shoot.

A Correct.

Q So let me get this straight. So you have an ad at your practice that might rouse some curiosity from your patients, and then you're mad because they're angry at you because their boyfriend can't be there and that you might be up to no good and you're visibly livid? Do you see how that sounds?

A Well, it's the way in which she addressed me in the text message. And I did explain to her why that's not allowed. And, you know, if she wasn't curious, we wouldn't have discussed it. And I explained my parameters. She didn't pose. It wasn't mandatory for her to pose. So the fact that she would get worked up

about it, yes, it made me livid.

Q Don't you think everybody almost would be curious if they saw that thing on the door whether they wanted to pose or not?

A Not all of my patients ask about it. Some saw it and didn't ask. In fact, many saw it and didn't ask.

MR. WHITE: One moment.

ADMINISTRATIVE HEARING OFFICER GHUSN: What I think we'll do as far as how this looks, we're into this about an hour and a half. And if everyone is good to continue, Mr. White, I can tell you're finished. I don't know where you are with things or if anyone needs a break, but after that, Dr. Chambers, you'll have an opportunity for redirect. If you want to address anything that Mr. White has questioned you about, I'll have an opportunity to ask questions, but I'll wait until the conclusion of everything.

Okay. Are we good to continue with Mr. White's questioning, Dr. Chambers?

THE WITNESS: Yes, I am.

ADMINISTRATIVE HEARING OFFICER GHUSN: And, Mr. White, you're good?

MR. WHITE: I'm good. How is the court

reporter?

THE COURT REPORTER: I'm fine. Thank you for asking.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you. So that will be a stopping point, Mr. White. Okay?

MR. WHITE: Yes. I don't have much more.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you very much. No rush. I just wanted to get that out there so we know what we're looking at after about an hour and a half.

And, Ms. Hansen, yeah, if you ever need a break, you're welcome to speak up again.

THE COURT REPORTER: Thank you.

Q (BY MR. WHITE:) Dr. Chambers?

A Yes.

Q Something changed. Sorry. I'm talking to myself. Something changed. I can't see. That's okay. I can see everybody up on the screen. I want to refer you to Exhibit 9 of the NSBME.

A And what is that?

Q And page 141. It is your response to Ms. Larue regarding Patient C.

A Okay. I have it.

Q So in this, you accused Ms. (Name) -- excuse

me. Can we strike that, please?

THE COURT REPORTER: Yes.

Q (BY MR. WHITE:) Strike that for the record, please. Patient C. Hold on a second. I apologize, Ms. Ghusn, for that.

ADMINISTRATIVE HEARING OFFICER GHUSN: It's fine. I'm making adjustments here, too.

Q (BY MR. WHITE:) Okay. Patient C, you accused her of being a liar. Do you see where it says that on the very first part of the second paragraph?

A Correct.

Q Anything you'd like to change about your answer to that now?

A I believe that was in reference to her getting results by me over the phone.

Q Yes.

A Why would I want to change that?

Q Why do you call her a liar?

A Because at some point in here, she said that -- Let's see. I think it was in reference -- I think it was in reference to number two of her allegations. No, it was number three. You called patient under the pretense of going over test results.

Q So let me get this straight then. You didn't

call Patient C under the pretense of going over test results?

A I did not call her.

Q You did not call her at all?

A No. I tried to leave some kind of written records, and I'll send a text message, your result is in, call me or the text message might say: Is it safe to send you this text message? But I did not call her.

Q So that's the reason for calling her a liar?

A Correct. And if you read the rest of the paragraph, it goes into that.

Q I did. Yeah. One moment. So, Dr. Chambers, is it your testimony that Patient C inquired about being paid a thousand dollars to pose nude?

A It is my testimony.

Q When? When did she inquire?

A The day we had the discussion.

Q What day?

A That would be the day of the appointment. That would have been --

Q Patient C comes in?

A That would have been September 24, 2019.

Q Patient C comes in with complaints, medical complaints that she thinks you might be able to help her

with. And somehow, the conversation leads to her posing nude?

A Most of my patients use the lavatory before an exam by me, and I am assuming she saw the ad in the lavatory. She was also having financial difficulty, and I assume that's why she inquired.

Q So you thought you could help her?

A Correct.

Q So then it's your testimony that Patient C went to the bathroom before you started physically examining her?

A It is my testimony that somehow she was in the bathroom. Most of my patients use the bathroom before being seen. I think it's customary in every gynecologist's office that a patient would use the bathroom before being examined.

Q And then when did it come up in the conversation as you've just testified to?

A It was at the end of the visit, I believe.

Q And let me -- yeah. Sorry. Let me finish. I think you know what I'm going to ask you, but when did it come up during the conversation or during her visit about posing nude?

A At the end of the visit.

Q And you know and understand that Patient C does not know your ex-wife?

A If you say so.

MR. WHITE: That's all I have.

ADMINISTRATIVE HEARING OFFICER GHUSN: All right.

MR. WHITE: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you, Mr. White. It's a quarter to 11:00. Let's talk about logistics here for a moment.

I know we're going to take a break, Dr. Chambers. Ideally, you would go directly after this cross-examination for your redirect. However, we have Dr. Goodman hanging out there, right, at 11:00 o'clock?

THE WITNESS: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: What is your preference? To get him while we can or to do your -- you have your opportunity to do redirect? Because it's possible you may not be able to testify again if we have --D o we have Casey Cardin at 1:30?

THE WITNESS: And then closing.

ADMINISTRATIVE HEARING OFFICER GHUSN: Patient C and Casey Cardin at 1:30. The rebuttal witness, Mr. White, is patient --

MR. WHITE: The other witness is Patient C. Oh, rebuttal. Sorry. I didn't hear what you said. It's Ms. Johnna LaRue.

ADMINISTRATIVE HEARING OFFICER GHUSN: I'm sorry?

MR. WHITE: Janna LaRue. She already testified, but she's our rebuttal witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay.

THE WITNESS: I just have one small thing to say.

ADMINISTRATIVE HEARING OFFICER GHUSN: Well, I want you to have the opportunity. And also, I may have some additional questions. You only have one small thing to say for your redirect.

THE WITNESS: Yes. It should take me no more than two minutes, if that.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay.

Ms. Hansen, are you good to continue on a few minutes before a break?

THE COURT REPORTER: I'm fine.

ADMINISTRATIVE HEARING OFFICER GHUSN: I know how this goes. And then I may have questions, and there are going to be follow-up questions, so okay.

Go ahead.

THE WITNESS: So both Ms. Mooneyhan and Mr. White have made much out of the fact that I did limited study to do the things I do. Let's address the cosmetic GYN surgery qualifications. I am an expert at pelvic and anatomy and pelvic surgery, being an OB-GYN. But more than that, I am a skilled expert in pelvic surgery.

And all I needed and all Dr. Goodman's course provide is for people like myself who are skilled and comfortable with their surgical technique to learn plastic techniques that are not taught in residency, OB-GYN residency programs. Virtually no plastic techniques are taught.

And so a course was meant to fine tune what I already knew to do and to use proper closing techniques, for example, for labioplasty so that there are no stippling of the edges and the proper sutures to use. Those are not taught to us. The sutures that we use in general OB-GYN might as well be ropes. They're just big sutures. And so he taught me the proper sutures.

As far as the sexual health training goes, this program was designed by the American Academy of Antiaging Medicine to teach doctors or mid-level providers a skill, one; to supplement their practice, and

two, to be able to help their patients. They designed the program. They felt it was adequate enough.

And given what I've gone through and what I've used it for, I felt that it's been adequate enough for me to incorporate with my GYN cosmetic surgery program. So it's somewhat offensive to say that a program formed by a well-respected medical organization that has thousands of doctors in it is not legitimate. And that's all I have to say.

ADMINISTRATIVE HEARING OFFICER GHUSN: Mr. White?

Q (BY MR. WHITE:) Just one question. Dr. Chambers, did you perform surgery, cosmetic surgery, on Patient A, B or C?

A I did not.

MR. WHITE: Thank you. That's all I have.

EXAMINATION

BY ADMINISTRATIVE HEARING OFFICER GHUSN:

Q A couple questions. One moment. Dr. Chambers, did you have anyone else on staff other than Casey Cardin?

A During COVID, no. My staff left because of the thousand dollars a week that was being given by the

government. I couldn't match that. So it was myself, Casey, and the nurse practitioner who was subleasing a space in my office. When Casey wasn't available, she chaperoned me.

Q That was my next question. So when Casey was ill, and you said multiple times during COVID; is that correct?

A Correct. If --

Q Go ahead.

A If the nurse practitioner was going to be in the office, I would keep the office open. If she was not, I would close the office and reschedule patients.

Q Thank you. Was that mostly early in the pandemic?

A It was -- I believe it was within the first -- yeah, yeah. It was within the first six months to a year of the pandemic. Yeah.

Q Was the situation the same for the nurse practitioner as far as standing in the doorway when she was present and not Ms. Cardin?

A Correct. She did mostly aesthetic works with her patients, so facials and whatnot. So sometimes, like when I had circumcisions of babies, she would come in and help me. In terms of like pap smears and whatnot, she

would stand at the door or sometimes would come in. She was a little bit more braver than I was with COVID. She took more risk than I did. I was strict about masks.

Q That was my next question. Thank you.

A Yeah.

Q So when Ms. Cardin or the nurse practitioner was standing in the doorway, there was no one else in the office?

A No. My office was designed so that the treatment area was completely shut off for security reasons from the lobby. You either had to be buzzed in or the door had to be opened for you to get back there.

And so one of the COVID policies I implemented was that there would be no more than one or two patients in the back office at that time, and if there were two patients, that door would be closed until we were done with the first patient. Then we'd deal with the second patient. But in general, we kept one patient in the back office, just me, the chaperon, and the patient with the exam door open.

Q That was not your practice pre-COVID?

A Before? No. Before I would have all of the exam rooms, six of them filled with patients. And I would go from room to room to room with my chaperon.

Q And the chaperon -- When did it change back that you allowed chaperons into the room and not the doorway?

A It was, I believe, once there was sufficient evidence from the CDC that people were getting immunized, when I was confident and comfortable that most of my patients were getting the vaccines. I knew the ones who weren't, and they were mostly the pregnant women.

And in the beginning, I didn't know what to tell them. They asked me what to do, and like most OB-GYN's, I didn't know what to tell them until the CDC said it was safe. Then I would tell them: Do it in the last trimester. Highly unlikely to hurt your baby then. And then as more data became available, first trimester. And it was once I was telling them to take the shot during the first trimester.

Q I don't want to get too far afield about the vaccination.

A Yeah, but I changed back to my original policy of letting people in the room.

Q Do you remember approximately when that was? We have 2022, '21, '22?

A I could not remember. I'm sorry.

Q How long did you -- If you don't remember

when, do you remember approximately how long did you have your chaperon standing in the doorway?

A I think it was until the second the person who came after Casey. Yeah, it was when she came that we started going back in the rooms.

Q And that was approximately when?

A You'd have to ask Casey when she stopped working there. I really cannot -- I don't have her employment dates.

Q That's fine. Thank you.

A Sorry.

Q And forgive me if I do jump around. The view from the open doorway --

A Yes.

Q -- can you describe it?

A I have a picture that I could hold up.

Q Were they able -- Was the chaperon able to see you?

A Yes.

Q And the patient?

A You could walk up to 15 feet away. The office was designed so that the -- and I was the one who designed the office. Myself and one of my students met with the architect.

All of the exam rooms are along the wall with the windows. And then on the wall without the window was the back desk, the medical assistant desk, if you will. And each room could be visualized from the desk. So the consultation room with Patient A occurred in room one which is a room where I did all of the cosmetic gynecology consultations. It had a poster of the different types of vaginas and why patients would choose to do surgery on each of the different types. It had a plastic replica of a vagina, and from that --

Q And I'm going to stop you. I wish we had more time --

A Yeah.

Q -- to discuss.

A From that room, yes. The room you can see the bed and you can hear what's going on --

Q Okay.

A -- at the desk. Yes.

Q Is there certain criteria or are there recommendations for chaperons where they're positioned?

A Well, as we learned during the last hearing, ACOG recommends that they're in the room, but it's a recommendation.

Q Is it just in the room in general or in a

certain position with respect to the patient?

A Well, it's in the room, but it's a good, good thing you asked that question. Most chaperons don't want to be at the business end of the table. They feel like they're spying on the patient. And they stand -- they tend to stand up ahead or next to the patient so they can hand them stuff. And I constantly have to tell them: Come down here. I motion with my finger, come down here because they try to not look at you or watch you. They try to look away. And I try to tell them no, you've got to pay attention.

In Casey's case, anything blood, she could not tolerate, so she tried to look away. So yes. They tried to stand where they feel less intrusive. I try to bring them where they can see everything.

Q I appreciate that, but my question was: Is there a recommendation --

A No --

Q -- where --

A -- none that I know of. They just need to be in the room.

Q Okay. And why would you encourage them to be at the business end as you say?

A Because I want them to see.

Q Okay.

A I want -- if there's any allegation, one of the things that they can say is if you poll all of the chaperons I've had since residency, the only difference that they'll say is that in residency, I used to wear a glove when I examined my patients' breasts. Afterwards, once I stopped doing it because it costs money. I have to pay for it now.

In residency, I used two gloves when I did a pelvic exam. And after residency, I use one glove because it costs money. That's the only difference. They will tell you, every single one of them, that my exam is pretty much the same.

Q Okay. When Ms. Cardin -- when you were distancing and so you shifted so your chaperon was in the doorway and not the room, was she masked?

A Yes. Casey was very -- She was a little bit more obsessive compulsive than myself about wearing a mask.

Q Were you masked?

A Always.

Q Did you require your patients to mask?

A I did. There was a sign on the door that required them to wear it. And if they refused, they were

not seen.

Q Did you take -- There was discussion about how some of these courses weren't certified for CME's.

A Yes.

Q Did you take other CME's?

A I did to satisfy not just the requirement of the medical board, but also for my curiosity. Just that these didn't offer CME's. And I knew I had enough, so it didn't matter to me whether or not they had it.

ADMINISTRATIVE HEARING OFFICER GHUSN: This is what I'm going to do is go ahead and let us take a break. It's possible if there's no objection, Mr. White, I may have other questions later on for Dr. Chambers. I don't anticipate them right now, but --

MR. WHITE: No objections.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. I believe that this is the time for a break, so we don't run too afoul of our schedule. And let's shoot for ten minutes because it's been a little while. And we'll all gather back here. Any questions?

THE WITNESS: None.

MR. WHITE: No. Thank you.

(Recess.)

ADMINISTRATIVE HEARING OFFICER GHUSN: It's

11:30. And, Dr. Chambers, have you been in touch with Dr. Goodman?

DR. CHAMBERS: Yes. I texted him, so he should be calling in.

ADMINISTRATIVE HEARING OFFICER GHUSN: I see him there. There he is. Okay.

Good morning, Dr. Goodman. Can you hear me? No? Okay.

THE WITNESS: Can you hear me?

ADMINISTRATIVE HEARING OFFICER GHUSN: Perfect. All right. Thank you. Good morning.

THE WITNESS: If you can hear me, can you put your thumbs up?

ADMINISTRATIVE HEARING OFFICER GHUSN: Yeah, I can hear you.

THE WITNESS: I can't hear you yet. I always have a problem with that. Let me get my sound settings. Okay. Are you able to hear me now?

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes. Can you hear me?

THE WITNESS: No, now I can't hear you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. A lot of the times -- Okay.

THE WITNESS: Oh, I can hear you now.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Good.

THE WITNESS: Can you hear me?

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes.

THE WITNESS: We can hear each other. Amazing.

ADMINISTRATIVE HEARING OFFICER GHUSN: A lot of times, it's the computer audio that you need to click on. It's not just --

THE WITNESS: I am always amazed when my electronics work. I'm of that generation that I just sort of, you know --

ADMINISTRATIVE HEARING OFFICER GHUSN: Well, knock on wood, we've had pretty good luck. I don't want to jinx it, however.

All right. Good morning again, Dr. Goodman. Thank you for being here. A couple preliminary matters. I don't recall whether you were sworn, so I'm going to have the court reporter swear your again.

THE REPORTER: Please raise your right hand to be sworn.

MICHAEL GOODMAN, M.D.,

having been first duly sworn, was

examined and testified as follows:

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you, Ms. Hansen.

Mr. White, any preliminary matters before Dr. Chambers questions Dr. Goodman?

MR. WHITE: I don't think we have any, no. Thanks.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Dr. Chambers, go ahead.

DIRECT EXAMINATION

BY DR. CHAMBERS:

Q Good afternoon, Dr. Goodman, or good morning.

A Good -- It's still morning here.

Q Thank you for taking the time to be with us today.

A And thank you all for allowing me to testify by Zoom.

Q Thank you. Dr. Goodman, where did you go to medical school?

A Wayne State University School of Medicine in

Detroit, Michigan.

Q And when did you graduate? What year?

A In 1968.

Q Where did you complete your residency training?

A I did a year of internship at Highland Alameda Hospital in Oakland, completed my residency training fourth year or all of the years at Stanford University and affiliated hospitals which were affiliated with Kaiser in Santa Clara, Santa Clara Valley Medical Center, and of course Stanford University.

Q And what year was that when you finished?

A I finished in 1972. I was chief resident in '72.

Q Are you still practicing, Dr. Goodman?

A I am, part-time.

Q Are you Board certified?

A I am and recertified.

Q And which boards are you certified by?

A American Board of Obstetrics and Gynecology: ACOG.

Q Are you a fellow of the American College of Obstetricians and Gynecologists?

A I am.

Q Do you have any other certifications or accreditations?

A I do. Let's see. I'm a North America Menopause Society certified menopause clinician in CMP, I'm a certified clinical bone densitometrist, although I have not kept up that credential. I'm an affiliate of the American Academy of Cosmetic Surgery, and I'm an elected fellow of the International Society for the Study of Women's Sexual Health.

Q Are you a published author?

A I am.

Q And were you published in peer-reviewed journals?

A All in peer review, all in first-line peer review except in very early on, I published about 15, 18 times. But about the last ten times are all in journals that have an impact factor around or over four.

Q Can you tell us a couple of those journals?

A Oh, my goodness. Early on -- and I'm referring to some notes here -- early on, Birth in the Family Journal, Mendocino Medicine, early on Fertility and Sterility, early on the Journal of Gynecologic Surgery. More recently, I've had several articles and also the Journal of Reproductive Medicine. I've had

several articles published in the Journal of Sexual Medicine. I'm published in what is called the Green Journal which is the official journal of ACOG which is obstetrics and gynecology.

I published in the Grey Journal, which is the American Journal of Obstetrics and Gynecology. I have about five publications in the Aesthetic Surgery Journal. I'm published in Plastic Surgery Clinics of North America, the Journal of the American Association of Gynecological Laparoscopists, and the Journal of Women's Health, and that's it.

Q That's pretty impressive. You've edited and authored --

MR. WHITE: Objection, vouching for the witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Sorry, Mr. White? What?

MR. WHITE: I said objection, he's vouching for the witness now.

THE WITNESS: I'm sorry. I didn't hear that, Mr. White.

ADMINISTRATIVE HEARING OFFICER GHUSN: What for the witness?

MR. WHITE: Vouching for the witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Vouching.

MR. WHITE: He said that's pretty impressive.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Sustained, Dr. Chambers. I know you're not an attorney, but try to avoid making those comments. You'll have an opportunity.

Q (BY DR. CHAMBERS:) Will do. You've edited and authored one of the primary textbooks used by cosmetic GYN surgeons; is that correct?

A That is correct. It's in its second printing about to go into a third printing.

Q Okay. Have you authored or contributed to any other textbooks?

A I have. I've contributed to the third edition of Nahai et al.'s the Art of Aesthetic Surgery, chapters 107 and 108 on revision labioplasty and complication avoidance. I've also written the introduction to Christine Hamori's Plastic Surgery Clinics of North America edition of 2022. The textbook that I authored is called Female Genital Plastic and Cosmetic Surgery. I am the editor and wrote probably about half of the chapters.

Q Dr. Goodman, are you a plastic surgeon?

A No, I'm not.

Q What is your trained specialty?

A Obstetrics and gynecology, special training in endoscopic surgery. And that's the end of my answer.

Q Okay. Have you done work for the California Medical Board?

A I have.

Q What have you done?

A I did both first and second-level review. I believe this was back in the '80s, '90s or for about ten years.

Q Okay. And between 1977 and 2022, you have been presented at almost 80 local and national medical conferences. Does that sound correct?

A Approximately, yeah. I'd have to check my CV, but that's pretty close.

Q You've taught and proctored many gynecologists in advanced operative laparoscopy. Is that correct?

A That is.

Q You've also been a peer reviewer for medical journals?

MR. WHITE: Objection, leading. He's done three of those in a row. Leading.

ADMINISTRATIVE HEARING OFFICER GHUSN: Sustained.

Q (BY DR. CHAMBERS:) All right. Between 2017 and 2019, did you receive any professional awards?

A Between 20 --

Q 2018 and 2022.

A And 2023. Actually, yes, I have received several.

Q And can you share some of those with us?

A Oh, goodness. In 2019, most of the awards were from the American Association -- excuse me. Were from the International Society of Cosmetogynecology. One of the awards was from the European Society for the Study of Gynecology.

I've received awards every year from 2017 to 2023, different best of categories. Best labioplasty and hood, best overall, best vaginoplasty and so forth. In 2019, I received the award for best teacher. That's not exactly what it was called. And in 2021 or 2022, I received the award for the best overall contributions to the specialty of cosmetic gynecology from the International Society of Cosmetogynecologists.

Q Is it fair to say that you're considered one of the pioneers in cosmetic GYN surgery?

A I am.

Q Dr. Goodman, what's the difference between a cosmetic gynecologist and a generalist OB-GYN surgeon?

A It's analogous in a way to the difference between a fetal-maternal medicine specialist and a generalist, between a urogynecologist and a generalist, between a hand surgeon and a general orthopedist and so forth. A cosmetic gynecologist is an individual, male or female, who has undergone training in OB-GYN and has taken additional training in a specific area, in this case, the field of what's called cosmetic gynecology.

Q Is it recognized by the American Medical Boards?

A No, it is not.

Q And why is that?

A It's not an efficient subspecialty. There are many boards that are recognized by the American Board Association, and that's not the name of it because -- I don't know the exact name of it -- that are official boards. There's many other boards that exist to regulate their individual subspecialties. This is one of them.

For example, there's plastic surgery boards, but there are no cosmetic surgery boards. And I think you can go on in many subspecialties like that. So it's

a self-policing activity. It's a training and self-policing activity. It is not an official board.

Q Did you train me in cosmetic GYN surgery, Dr. Goodman?

A It was my pleasure to do so. Yes.

Q Would you please describe the training that a gynecologic and plastic surgeon receives in your formal courses and what is covered and is it a reproducible protocol?

A Okay. My training -- I only train surgeons, so I'm not training someone who isn't already savvy in the type of surgery that I'm getting that I'm going into more detail. I train gynecologists, I train cosmetic surgeons, I train plastic surgeons, I train urogynecologists and urologists.

I don't train internists. I don't train family physicians. I don't train so-called or regenerative physicians, so I only train people who already know the field of surgery, already know how to use suture material.

And basically what I'm doing is taking up the knowledge that they already have and teaching them a little bit more about the aspect of cosmetic gynecology, about the sexual aspects, about the psychological

aspects, about the anxiety that's involved, about the type of people that they're dealing with, about how to interview people, about how to get into trouble and how to stay out of trouble and specific techniques.

Basically, I'm teaching the rules. I'm teaching how to stay out of trouble, how to do basic things, how to get started. I have a two and three-day training program, and that's sort of standard in the field. There's other people that have training programs also around the same length. It's very reproducible, and you can find the protocol on both of my websites.

The first day is talking a little bit about what we're going to be covering. It talks about the type of individuals we're dealing with, it talks about the sexual issue, it talks a lot about body -- this is an area of special interest of mine.

It has to do with body image and sexuality in women that are seeking and undergoing these procedures, so we talk a lot about body image. We talk about how to avoid operating on people you shouldn't be operating on. We talk about how to ferret out body dysmorphia. We talk about the fact that a woman who may have a body dissatisfaction, a man or woman may have a dissatisfaction with a part of their body they may wish

to change or reconstruct, but that's not necessarily a dysmorphia and how to distinguish between a dissatisfaction and a dysmorphia.

We talk a lot about sexual issues, sexual function issues, the fact that we are doing cosmetic and plastic-type surgery and that that should not necessarily be construed as something that's going to cure a sexual dysfunction. That's one portion.

We talk a lot about anatomy. We talk about blood supply, you know, different types of anatomy. We talk about specific procedures. We talk about the nerve supply. We talk about how not to get into trouble, how not to get into nerve plexuses, about how not to sever the dorsal nerve to the clitoris, which certainly has been done by entering gynecologists. We talk about the basic outline of different types of labioplasty procedure. We talk about pelvic anatomy. We talk about the different musculature. We talk about the levator plate, we talk about the bulbospongiosus, all of the different muscles that make up the pelvic floor.

We talk about the philosophy behind vaginal tightening, why women seek this. We talk about who is seeking this surgery. Is it the woman or her partner? We're operating on the woman -- we're not operating on

her partner -- and how to tell whether she's being forced or not.

Getting back to anatomy, we go over all of the anatomy, both of the vulva, which is outside of the hymenal ring, the labia, the clitoris, the clitoral hood are all part of the vulva. The vagina is internal. We talk about that anatomy. We talk about again specifically how to do the operations, how to stay out of trouble.

We talk a lot about anesthesia. I've performed quite a few labioplasties. I have not anesthetized a woman for labioplasty in almost 20 years. All done under local anesthesia. Typically, internal vaginal reconstructive procedures are done under general anesthetic. That's how most people do.

Until about ten years ago. A physician who is also very well known, one of the fathers of the specialty, a urogynecologist, started doing these other local anesthesia in the hospital and realized that they could be done under local and they were actually safer and better procedures.

I trained with Dr. Alan Saad regarding doing these procedures under local, and for the past almost ten years, I have not anesthetized a woman for a complete

vaginal reconstruction. It's obviously less expensive. It's less utilization of hospital facilities. It's safer. But also, it's a better operation because you're not worried about nerve damage because if you're someplace where you shouldn't be in putting your suture, your patient is going to tell you immediately.

So you can actually do a better surgery and get the patients tighter. And actually when my patients ask about anesthesia, I mention I'm going to be doing this under local, they're all happy because the thing that they're scared of the most a lot of times is being anesthetized. So we talk about proper administration of anesthesia.

Q Is that why we do the procedure in the office under local?

A Yes. Yes, because there more cost -- Well, in order of importance because they're safer and you can do a better procedure. They're also more cost effective.

Again, I have not anesthestized a woman other than local infiltration anesthesia in, I'd say, eight or nine years for a vaginal tightening operation, so-called vaginal reconstruction. I've not anesthetized general or regional anesthesia, a woman for labioplasty in probably about 20 years.

So first day is going through a lot of these things. Second day are videos. I have full-length surgical videos taken right over my shoulder with sound tracks that we stop at any time, and I have a video of a linear labioplasty, a video of a V-wedge type labioplasty, and a video of a combined vaginal reconstruction and wedge labioplasty. I also have a video of how to interview a patient.

We see those videos and we have a live tissue lab where we use tissue material, and my trainee or if it's an individual course or trainees if it's a group course, get to actually do these procedures and I help them with them.

I also, on the second day, we go over the uses and misuses of energy-based devices, laser and radiofrequency. We go over in detail platelet-rich plasma, we go over the administration of platelet-rich plasma to the Grafenberg's area which has been trademarked as the O-Shot. We talk about marketing, how people know that you exist. We talk about training your staff, and there's an optional third day we have material for training or trainees to view actually a real-time live case. And that's reproducible.

Q What is your understanding --

ADMINISTRATIVE HEARING OFFICER GHUSN: Dr. Chambers, I'm going to interrupt. Hold on one second. I see we may have someone or someone's new that have joined us, and I want to make sure since the rule of exclusion is in effect that we don't have any witnesses observing.

Mr. White, maybe you could help me with this to identify anybody. I don't recognize names.

MR. WHITE: I don't either. And then some of them are just -- I do see one that's just a number, and I'm not aware of any of these people if they're witnesses. Maybe perhaps, Your Honor, you can ask and make sure that they answer openly.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you. And I saw someone identified as Laura and two phone numbers. Last four: 1138 and 7898. I believe the others were with us before. Good morning to the three of you. Would you please identify yourselves and whether you're witnesses in this pending matter.

THE WITNESS: I am 1138, and I am not a witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Thank you very much, 1138.

THE WITNESS: You're welcome.

ADMINISTRATIVE HEARING OFFICER GHUSN: 7898.

THE WITNESS: How do I re-mute myself?

ADMINISTRATIVE HEARING OFFICER GHUSN: There should be an -- If you go to the bottom, there should be a little icon that you click on that says "mute". Thank you for asking.

THE WITNESS: I'm on the phone. I'm not on the actual --

ADMINISTRATIVE HEARING OFFICER GHUSN: Sorry. I'm not familiar enough with the phone to be able to coach you with it. If there is, I would appreciate that you figure it out or probably make sure it's quiet or there you go.

Okay. 7898? Hello? Phone number, last four 7898, are you there? Okay. You are Laura. I saw you join us.

LAURA: Hi. I'm Laura. I was on earlier.

7898: 7898.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Sorry. Is 7898 the same as 1138?

7898: No, I'm 7898. No, I'm a witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: You are a witness?

7898: Dr. Chambers? Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: You're

a witness. Okay.

7898: 7898. Correct. I was on earlier. However, I got disconnected, so I had to get back on again and log in.

ADMINISTRATIVE HEARING OFFICER GHUSN: And you are a witness in this matter?

7898: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: For Dr. Chambers?

7898: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: Dr. Chambers?

DR. CHAMBERS: She might be there to observe.

7898: I'm sorry. I guess I'm not a witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Then go ahead and mute. Thank you.

7898: Okay. Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: And an observer named Laura.

LAURA: Hi. I'm Laura. I'm not a witness. And I was on earlier. I might come and go throughout the day.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Thank you very much. I just saw you pop on. All right.

Thank you to the three of you for confirming that you are observers.

Everyone good with that?

MR. WHITE: Yes.

DR. CHAMBERS: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Thank you. Dr. Chambers, you may proceed.

Q (BY DR. CHAMBERS:) Dr. Goodman, what is your understanding of my medical practice?

A My understanding is that you are an obstetrician gynecologist practicing both obstetrics and gynecology and have taken additional training in sexual medicine and in cosmetic gynecology, specifically female genital cosmetic and reconstructive procedures, and that your practice is partly general GYN. I don't know, Dr. Chambers, whether you still do obstetrics.

Q I do.

A Good for you.

Q I do.

A I miss it a little bit except for the middle-of-the-night calls. And that a significant part of your practice -- I don't know what percentage -- is devoted to the field of sexual medicine and to cosmetic gynecology, and that you hold yourself out as having had

individual training in those two areas. Excuse me. Additional training.

Q Do you think the training I have with you was sufficient enough for me to do this kind of work, the cosmetic gynecology work?

A Yes. Yes. You, from my experience, you have good hands, you're intelligent, you understand the field, and I've trained you. And hopefully, you've learned and have progressed. I haven't seen your work.

Q Okay. How do we size or measure patients' vaginas in cosmetic gynecology?

A Let me give you an analogy to obstetrics. And I'm not sure if you've had any children, Ms. Ghusn, but women that are in labor are examined by their OB-GYN to see or by their midwife or by their obstetrical nurse to see how they're progressing.

And that exam takes place manually where their birth attendant puts her finger, usually two fingers, into the vagina and puts it up to the top of the vagina to measure the cervix. And what she will do is take and see if she can fit her finger or fingers inside. And sometimes, she can fit her fingers inside and actually separate them. And then she estimates: Okay. Here are my two fingers. I know that each finger is a

centimeter and a half, and it looks like I've got two -- I could put two more fingers in there, so I think she's about six centimeters. Frequently, six.

Healthcare practitioners, especially OB-GYN's, measure with their fingers. So if I'm measuring a woman's -- if I'm getting an idea of a woman's pelvic strength, if I'm getting an idea of the size of her pelvis and she's coming in saying that she's not feeling much in the way of friction, it's harder for her to orgasm, she's not able to achieve vaginally-activated orgasm and she would like to do something to improve friction and maybe her vaginal opening, the perineum, the perineal body is broken down secondary to childbirth, I want to get an idea of the muscular strength. I want to get an idea of the size. It's really for me to understand how large she is, what the muscular strength is, and what I'm able to do.

And obviously, I want to find out about her partner because I don't want to get the size so small if she has a robust-sized partner. So how I measure is with my fingers. Personally, I will use two or three fingers. Sometimes I'll separate them a little bit to get an idea of general size. I don't -- some people, you know, are very specific about two fingers, three fingers, four

fingers, six centimeters, seven centimeters.

I'm not one of those people. I just get an idea of size compared to and an idea of muscular strength. That's part of the reason to use your fingers to have your patient do what's called Kegel squeeze or squeeze the levator, the bulbospongiosus, the bulbocavernosus muscles to get an idea of where are they, have they separated, what can I do for this woman. Long answer to an easy question. We measure with our fingers.

Q So when you say we have the patient do Kegel exercises, is that being done with our fingers inside of the vagina?

A Yes.

Q And is that a standard thing that we do?

A Yes. Well, it depends on what you mean by "we".

Q OB-GYNs and cosmetic surgeons.

A The answer is yes.

Q Okay. In cosmetic GYN surgery, is the term "fisting" ever used to discuss measurements?

A The term fisting is used, but not used as it applies to measurement. One of the causes of -- relativity minor cause because to my knowledge not many individuals engage in the procedure of fisting, but one

of the causes of breakdown of perineal and vaginal muscle strength is the sexual activity that's called fisting. But as far as measuring, again, all I can speak for is myself. I'm not in other people's exam rooms, but no, I've never used the term fisting as it relates to measurements.

Q Would you expect one of your trainees to use that term?

A Oh, to use the term fisting, yes, because --

Q And in terms of measurements.

A I don't know, Dr. Chambers. I don't use it. I could see where a trainee might say or in describing measurements to describe that the size of the introitus would allow admission of a fist, I'm not dealing so much with a patient population that engages in fisting, so I'm not able to give you a real cogent answer on that question.

Q Gotcha. Why is preoperative and postoperative pictures necessary in cosmetic GYN surgery?

A Let me preface that by saying I will not operate on a woman who does not allow me to take photographs, and that's the case with most experienced cosmetic surgeons.

Preoperative photographs are very important.

They're important. Obviously, frequently, the patient would like to see what kind of progress she's made, but they're exquisitely important medical/legally to as part -- it's part of documentation. Photographs to a cosmetic and plastic physician are the same as office notes. They're part of the medical record. They're documenting what the patient is coming in for.

If you're doing a penile enlargement procedure, you want to document the size of this gentleman's penis before you do the surgery. If you're doing a labial reduction procedure -- so I got carried away on that, but I think I've answered your question. It's part of documentation. It's called photo documentation.

Q Is it appropriate for a cosmetic GYN surgeon to show these photographs of other patients as part of a gallery of his or her work during an initial consultation?

A With permission, yes. When I have personally -- and everyone has their own way of doing this. My patients sign a disclaimer that allows me to take photographs and allows me to use them as I may wish. Some patients -- not a very large number, but not a modest number, will say yes, you can take photographs,

but I don't wish you to share them. I don't wish you to share them online. I don't wish you to share them at a meeting. I don't wish you to share them with other patients. And I have a symbol that I use for those files. Did I answer the question?

Q Yes, you did. Yes, you did. Does the posting of marketing material in the office bring disrepute to the medical profession?

A Marketing material? I don't believe it does.

MR. WHITE: Objection. Objection, form of the question. What marketing material are we talking about?

DR. CHAMBERS: Dr. Goodman?

ADMINISTRATIVE HEARING OFFICER GHUSN: Go ahead. More specific question.

Q (BY DR. CHAMBERS:) Dr. Goodman, marketing materials advertising your surgical skills. What's your opinion on having them in the office?

ADMINISTRATIVE HEARING OFFICER GHUSN: Dr. Goodman?

THE WITNESS: I can't hear you.

ADMINISTRATIVE HEARING OFFICER GHUSN: You must be muted.

THE WITNESS: You can't hear me because I'm

trying to formulate my --

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. That's fine.

THE WITNESS: -- answer and I had a senior moment. I think it's very -- I think it's very fair and reputable that physicians have marketing materials in their office.

Certain specialties, there's a very long active specialty and a respected specialty of surgical specialty called plastic surgery. Plastic surgeons have marketed themselves for a long time. Other specialties have been less inclined to market, but that's increasing as medicine is changing. So there's nothing wrong with marketing.

I think it's not the style of some individuals. It is the style of other individuals. If you're a physician who is paid by a third-party and you're working in an HMO or you're working in a healthcare facility where you go in 9:00 to 5:00 and you see the patients that are assigned to you, there's no need for marketing unless that institution wishes to market for you. If you're in private practice and you're working for yourself, then you have competition, and marketing is one of the ways that you distinguish

yourself.

Q Okay. How is the marketing of a traditional OB-GYN practice?

MR. WHITE: Objection. The question is vague.

Q (BY DR. CHAMBERS:) Is there a difference between the marketing of a traditional OB-GYN practice versus that of a cosmetic GYN surgeon?

MR. WHITE: I'm going to object again, "traditional" being vague.

ADMINISTRATIVE HEARING OFFICER GHUSN: I think, Dr. Goodman, go ahead. Overruled. Do you understand the question?

THE WITNESS: Yeah. I do understand the question. Traditionally, obstetrician-gynecologists have not marketed themselves because they've been mostly paid by third-parties, and traditionally, OB-GYN's have held themselves above other surgeons who market themselves saying no, we don't market ourselves. It's, you know, it's cheap. We shouldn't do that. It's, you know, beneath us which is one of the reasons why the specialty have been taken over by big medicine and why so many individuals are leaving the specialty.

The practice of medicine has radically

changed. And this is one of the reasons why so many physicians are looking for other areas of medicine that they can take into their practice so that they're not really slaves of big business. And if you're in that situation, then you need to market.

People need, number one, people need to know that you're there. And number two, once they know that you're there, they need to speak with someone on the phone that can be kind to them that they don't have to wait 20 minutes on the phone tree that only has five seconds for them. That's part of marketing as well.

And then another part of marketing is when that person sees you, you need to take time with them and explain to them all, you know, marketing is at many different levels. It's not just putting a poster up and saying: Look how good I am. And so marketing is moving more into medicine than it used to be in the past.

Q Okay. Dr. Goodman, you're also trained in sexual health medicine?

A Yes.

Q Would you please briefly discuss the umbrella term "sexual medicine" and its place in gynecologic care for women, specifically with relations to the back-and-forth interaction between patient and provider.

A Well, it's wonderful that sexual medicine is creeping. And the word is creeping. It's very slow into the practice of gynecology and obstetrics. OB-GYNs are primary practitioners for women. And OB-GYN's are ill-trained and ill-equipped to talk about sex. There's such a stigma talking about sex. We all do it. We all enjoy it. We do it in our own ways. We can joke about different parts of our bodies, but there's a stigma about sex and sexual organs. And it's such an amazing part of human life. It just is not talked about.

The field of sexual medicine involves both men and women, and it's really the field of discussing, educating, acknowledging and helping individuals that you help care for in this important area of their life, and that's the field of sexual medicine and sexual medicine can be internal medicine. It can be in surgery. It certainly belongs in obstetrics and gynecology. It belongs in urology, urogynecology and many different areas. And slowly, slowly, slowly, it's getting there.

Unfortunately, residency training programs in OB-GYN do not spend a lot of time in sexual medicine. This is one of the reasons for the society that I'm a fellow of, the International Society for the Study of Women's Sexual Health. They are devoted to sexual

medicine, and they're a multi-specialty society. There's pelvic floor physical therapists, there's psychologists, there's psychiatrists, there's urogynecologists, there's OB-GYNs, there's sociologists and so forth all dedicated to this, I think we would all agree, important area.

Q Would you please speak to the doctor/patient relationship, the communication between the two, between the physician and the patient.

A Do you have six hours?

MR. WHITE: Objection, vague.

THE WITNESS: I was waiting for you, Mr. White, to make an objection. Can someone give me some guidance on that and I'll be happy to answer that?

Q (BY DR. CHAMBERS:) Certainly I can. Just be specific about the type of topics that would be discussed and how the questions being asked of the patient, how that would be compared to a generalist asking the same question.

MR. WHITE: I'm going to object again. Is this a question for Dr. Goodman specifically how he did his practice or -- I don't know how he can speak to -- calls for speculation as to how he can speak for every gynecologist in the country.

ADMINISTRATIVE HEARING OFFICER GHUSN: Of

course. And I'll sustain that, Dr. Chambers. You can ask the question how is it generally used and also in his particular practice.

Q (BY DR. CHAMBERS:) Yes. Dr. Goodman, how are these questions generally asked of patients who seek out sexual dysfunction treatment?

A Well, first, they're rarely asked. You know, physicians are under pressure to see many patients, bring in more income. So the last thing -- and again, keeping in mind that our specialty, obstetrics and gynecology, deals intimately, obviously, with women, but with sexual issues. You don't get pregnant -- at least it hasn't happened for a couple thousand years -- you don't get pregnant without having sex. So this is an area just innate to our specialty.

That said, with the time pressures and with the stigma about sex, a lot of times these questions aren't asked because the last thing a physician wants to do with ten minutes to see the patient is to say: How is your sexual relations? How is the relationship with your partner? Because she or he is opening a can of worms as she's asking this question with her hand on the door. So a lot of times it's not asked, and that's unfortunate.

But how it would be asked or should be asked

-- again, I know in my practice and I know in practice of other people I've spoken with, frequently we'll have a question on our intake questionnaire or our daily questionnaire if it's a return visit which has to do with is there anything involving your sexual life or experience involving your personal life or involving your relationship that you would like to talk about. Again, this is ideal medicine. And unfortunately, this is not practiced that much except by people who have trained in sexual medicine. God bless them all for getting into this, you know, this area.

And all you need to do is open the door because most of our patients are so ready to walk through that door, but the door usually is closed. So how you one would ask is having a question on the questionnaire, a non-leading question, but basically: Is there anything you'd like to discuss regarding your sexual life or, you know, some such question. And a non-leading question saying: Is everything okay sexually? Is there anything you'd like to ask me about?

Q Okay. Would you please explain what's the purpose of all of these cosmetic organizations and why they consist of physicians from different medical specialties including OB-GYN?

A Well, sexual medicine, again, is a multi-specialty area. It's not just OB-GYN's. It's all of the other M.D. and non-M.D. practitioners that I mentioned.

The importance of organizations, there's many different things for organizations. And I did make some notes on that which I may refer to. Actually, I don't need to refer to them. What are the importance of the organizations?

Well, there's obviously fellowship. There's obviously networking. I think that's a big part of it. But also, a huge part of it is standardization, is having -- since no one is really looking over the shoulder of many of these subspecialists, these organizations serve as a body, as quasi -- and the emphasis on "quasi" regulatory body and as an educational body.

I mean, I lecture frequently. I train frequently. But I've never been to a meeting that I haven't learned more than I've given. And that's what medicine is about. I'm sure that law is about as well. Things keep, you know, the bases are the same. Our bodies haven't changed, but many things do change. The importance of the organizations is to teach, to train, to reign in, you know, if you're doing a real cowboy doing

something off the wall and you present that, people are going to know it. And it all advances the specialty.

Q Okay. You've had a chance to look at Patient A's consultation note?

A I have.

Q Can you assess my consultation of Patient A?

A Well, Dr. Chambers, you shame me. I don't think I've ever written such a complete consultation note. And, you know, in the era of electronic medical records, which is just basically scribbling legibly on a chart, this is refreshing.

It's a complete listing of what your patients come in to see you for, what her mindset is, what she wishes to establish, your evaluation and your determination and what you've offered to her. You know, that's it in a nutshell. It's an excellent consultation. I hope you do that on all of your patients.

Q Thank you. Much has been made about --

A And I'm not just being a witness on your behalf. This is, you know, if anyone has read this, this is a really good consultation. Sorry.

Q Much has been made about the fact that I did not document the number of fingers I used to examine Patient A. Do you have any opinion on that?

A No. I mean, I've heard that. Not really. I go back to the analogy of doing an obstetrical exam. I mean, frequently, when a woman's in the latter part of labor, you can certainly put more than your two fingers in the vagina. And certainly after she's delivered, you can put your whole hand into the vagina.

So whether you're putting two fingers in and separating them and saying well, this is about four fingers' size or you're putting three fingers or you're putting four fingers, you're estimating size. My finger, I know, here the first notch is a centimeter and a half. I suspect other -- perhaps a woman's finger is more like a centimeter. Your fingers may be broader than mine, so it's not the approximate fingers. It's estimating the size from using the fingers.

And I can see where you do an exam and say oh, she's about four fingers, and you used four fingers and you describe it a little bit differently. I think that's a red herring, to be honest with you.

Q Okay. Are you familiar with the O-Shot?

A Very much so.

Q Tell us about a little bit about that.

A I'm a certified O-Shot instructor.

Q Can you tell us a little bit about it, its

uses and any available data on its effectiveness?

ADMINISTRATIVE HEARING OFFICER GHUSN: Sorry, Dr. Chambers. Will you first refresh what it stands for for me?

DR. CHAMBERS: The O-Shot.

THE WITNESS: O-Shot. I thought you said OSHA. That can't be right.

Q (BY DR. CHAMBERS:) Yeah. Go ahead, Dr. Goodman.

A The O-Shot is a trademarked term trademarked by Charles Runnels in Fairhope, Alabama. I've known Charles for years. I count him among my friends -- not just acquaintances but friends -- and we've talked about research projects and so forth.

Again, the O-Shot is trademarked. It's sort of like using the word "Kleenex" when you're talking about facial tissues. The O-Shot is a trademarked term when you're talking about the use of PRP or platelet-rich plasma injected into a specific area. Platelet-rich plasma -- and I don't want to give a whole treatise on platelet-rich plasma because that certainly would take hours.

Platelet-rich plasma has been used initially by orthopedic surgeons for many, many years. That's the

stuff that when they have a star running back who has torn his ACL and is out for the whole season, using platelet-rich plasma sometimes will facilitate healing because what platelet-rich plasma does is it has angiogenic properties, so it causes the growth of new blood vessels. And it has tissue-reproducing properties, so basically, it helps lay down new tissue and bring blood vessels into that tissue.

Platelet-rich plasma is produced from the individual, so it's not a foreign substance. It's produced by drawing blood and centrifuging out all of the cells except the platelets. And the platelets have this regenerative capacity. So the platelets are centrifuged and added to an aliquot of the serum so you have a basically concentrated platelets that are injected wherever.

Orthopedists will inject it into their difficult repairs to facilitate the recovery. Some specialists will inject it into scar tissue when they've done difficult dissections. Again, remember I said it has properties of facilitating tissue growth and what's called neo vasculogenesis. Neo means new, vasculo means blood vessels, genesis means genesis. So it has the properties of building tissue.

Okay. Material, I think we all know where the Grafenberg's area is, the so-called G-spot. That's a magical area in many ways. So there's many different nerves, nerve supply in this area. The G-spot is just inside the perhaps about two, three centimeters inside the upper vaginal wall is the area where the root of the clitoris -- where the clitoris basically roots, where the bulbs and where the pluri of the clitoris wrap around the urethra. It's erectile tissue, and it's quite sensitive and usually very pleasurable if manipulated correctly for the woman.

It has a dual nerve supply. It has a skeletal nerve supply through the pudendal nerve through the clitoral branch of the pudendal nerve, and it has an autonomic nerve supply through the hypogastric plexus. In other words, it's been proven, evidence based, that a woman that's had spinal cord transection below T3-4, she has no nerve supply to her clitoris can still have a vaginally-activated orgasm because of the nerves in that area. Okay.

There's also research that shows that the thicker this area is, the greater the stimulation and the greater the sexual response. Interesting. Published in the Journal of Sexual Medicine by Broissant and Pierre

Faldet in Paris has been reproduced. These are ultrasound studies that show -- that compare the thickness of the Grafenberg's area with sexual response.

Okay. So if material is put in that area, one would suspect -- and this has been proven and there is literature, and I've got the literature next to me. I'll quote some of the articles to you. It's not a richest literature in the world. It's not -- I'll talk to you why that isn't, but it's been shown that the thicker the Grafenberg's area is -- and again, platelet-rich plasma trademarked as an O-Shot, which is putting some PRP into both the clitoris and especially into the Grafenberg's area, thickens that area. So if something is inserted into the vagina and pushes against the anterior abdominal wall like a penis or a toy, the thicker that area is, the more pressure and the more sensitivity there is to the Grafenberg's area. That's the philosophy behind the O-Shot.

Q Is there any benefits to someone who has urinary incontinence?

A Yeah. Well, that was discovered serendipitously, actually, by Dr. Runnels that he had some patients that he was giving platelet-rich plasma to for sexual enhancement for increasing the odds of what's

called vaginally-activated orgasm that had mild-to-modest urinary incontinence and said, you know, Doc, since I got the O-Shots, I haven't been incontinent.

Okay. Think about the anatomy. You know, some things are discovered serendipitously. So many things in medicine are used for one thing, and it turns out they have benefits in other areas; so much in medicine.

So if you think: Okay. What is one of the reasons why women have what's called genuine stress or stress urinary incontinence? It's because they've lost support underneath the base of the bladder. So when there's an increase in intraabdominal pressure, they cough, they jump on the trampoline, they do exercises, they increase their intraabdominal pressure, there's loss of support and the bladder, what's called the bladder neck, which has an angle, that keeps them continent.

When they increase that pressure, it's almost like a funnel, and that bladder neck prolapses down a little bit and they leak a little urine and they go oh, my goodness. And when they do a Kegels exercise, it tightens the muscle and it helps.

Well, you're putting platelet-rich plasma into the Grafenberg's area, but some of it, if you think

of the anatomy, the base of the bladder is right next to there. So serendipitously, this has helped with urinary incontinence. It is not a urinary incontinence procedure.

In other words, if someone comes in and says: I've got incontinence, I'm not going to say let's do an O-Shot. But if someone comes in and is interested in seeing if they can enhance their sexual function and their odds of vaginally-activated orgasm and they happen to have some incontinence as well, then they're a great candidate. Although I'm not going to tell them: Hey, this is going to cure your incontinence, although frequently, it helps.

Q Got you.

A And they said there is -- most of the information is anecdotal. But, you know, research information starts as anecdotal information. There are several articles in the literature, not in what I would call really, really first-line journals that speak to the efficacy of the use of platelet-rich plasma for sexual reasons.

This is a real tough study to do because if you're going to do a study like this, you have to -- it has to be double or triple-blind. The patient can't know

what she's getting. The physician can't know. You have to compare dry needling with saline with platelet-rich plasma, and you have to have a large study group, and that's going to cost a lot of money, and who is going to pay for that?

It's not like some big drug company with some new drug, so it's tough research to do. It's research I've talked about with Dr. Runnels, and maybe one day we'll do it.

Q Thank you. Now, think back to when did you transition from being an OB-GYN to being a cosmetic GYN surgeon? Do you remember?

A Yeah, sort of. I stopped obstetrics in my full-time practice in 1988, but between 1988 and the early 2000s, I worked as an OB intensivist or a hospitalist. I delivered probably about another 3,000 babies during that time. But beginning in 1988, I became interested in operative endoscopy and was one of the pioneers in this country and taught that. And so my practice really turned from OB-GYN and infertility to a gynecology and operative endoscopy practice.

In 1997, a patient of mine who had had an obstetrical laceration where her labrum was transected and the edges was sort of floppy asked if I could fix

that. And this was right at -- nobody was doing that back then. And so I designed a procedure -- and her other labrum also was pretty robust. So I designed a procedure which has been called the V-wedge and fixed it and it worked. And she had a friend who had similar anatomy who came to me, and we did it and it worked again.

And around that time, Gary Alterdon of Beverly Hills came up with his first paper on wedges, and I began doing this a little bit just as part of the practice. And others began sort of doing this, and there was some fledgling organizations that David Matlock down in Los Angeles began doing this and training, Red Allenstad begin doing this in training. There was maybe a handful of us you could count on one hand that in the late '90s and early 2000s began doing this, and then I became more and more interested in this.

I became interested in it because I was good at it. It was really helping -- the satisfaction that a woman would experience after the surgery was impressive. And so the practice morphed, and I began doing and teaching in 2007. And really for the past, I'd say, 15 years almost, my practice has been entirely menopausal medicine, sexual medicine and genital plastics. And I

turned over the sexual medicine and menopausal medicine to my -- to a person that I trained as a fellow, and now all I do is genital plastics. So it's sort of morphed. I've done over 1,200 procedures altogether.

Q Okay. Think back to when you were just a traditionally-trained OB-GYN. Did you look at the genitals differently then versus the way you look at it now?

A Oh, goodness, yes. When I trained docs, we all get a little chuckle over this. You've never had a pelvic exam, and neither has Counsel White. I think that the hearing officer probably has.

But we've done -- Dr. Chambers and I -- we've done thousands of exams, and my trainees have done thousands of exams. And we hardly look at the vulva. Unless a woman is coming in and specifically talking about a vulvar issue, the vulva is sort of in passing. We'll open the introitus, put a speculum in, we'll take the Pap smear, do our manual and regular exam.

If she's talking about bleeding problems, we'll look for causes of the bleeding in the vagina. We'll look at the uterus. All always try to check the ovaries and so forth and so on. We barely look at the vulva. It's sort of in passing. But once you become a

cosmetic gynecologist, then you're paying a lot more attention to other areas. You're paying attention to the vulva because a lot of your clients that are coming in are talking about vulvar issues. You pay more attention to clitoral anatomy because sometimes they're talking about sexual issues. You pay attention, more attention to pelvic support.

Now, I may have a woman who comes in and she's coming in for her annual exam and she's got a very gaping -- a wide open introitus and very poor support. I'm not about to say to her: Hey, you've got to get yourself fixed. That's inappropriate. But as I become a cosmetic gynecologist, I may ask a question: Is everything okay down there? It's like opening the door sexually because women a lot of times are very shy about talking about this area that has so much stigma attached.

So being a cosmetic gynecologist and a sexual medicine practitioner does definitely change how you view the practice as opposed to a general OB-GYN. You're doing a lot more for your patients both sexually and in the area of pelvic support.

Q And can you explain why we do not accept health insurance payment for these procedures?

A Well, if you're honest and not all especially

general gynecologists who do this kind of surgery are not terribly honest, that insurance doesn't cover cosmetic procedures. I have mixed feelings about that. Financially, it's helpful for me, but it's not proper. And that's philosophically because there is a rich literature, a really rich literature in evidence-based literature in top-line journals that shows that a woman's comfort with her body, especially those parts of her body that has sexual connotations like breasts and bellies and butts and vaginas and vulvas, that a woman's confidence in that area directly affects her self-confidence and her sexual experiences. But this is all cosmetic. It's considered cosmetic.

Now I've never operated on a woman that doesn't have as part of her issue a functional issue like my lips get drawn in. They get pinched. When I'm exercising, there's this discomfort. There's usually that. But there's always an aesthetic issue as well. And insurance doesn't pay for cosmetic surgery. So that's why.

And of course obviously, we all work for a living. All of us are getting paid. And as a practitioner, whether you're practicing the law or whether you're practicing medicine, you need to get paid.

And you get paid better for cash procedures than you do from an insurance company, so it's a combination.

Q Given the reasons for me sitting here today with you giving expert witness on my behalf, is it fair that I'm being judged as an OB-GYN?

MR. WHITE: Objection, calls for a conclusory statement and speculation. Calls for a legal analysis.

DR. CHAMBERS: Dr. Goodman --

ADMINISTRATIVE HEARING OFFICER GHUSN: Hold on, Dr. Chambers. I'm going to sustain that, for the record.

And, Dr. Chambers, you can rephrase the question. I'd like to hear the answer.

Q (BY DR. CHAMBERS:) Dr. Goodman, should I be judged as an OB-GYN or as a cosmetic GYN surgeon given what you know about this case?

A Dr. Chambers, both. You are an OB-GYN. You deliver babies. You do gynecologic surgery. You should be judged as a general OB-GYN in those areas. But you've taken over training. It's like an orthopedic surgeon should be judged as an orthopod and a hand surgeon if she's taken additional training in hand surgery.

So you should be judged as an OB-GYN but also as one who has taken the time, energy, effort and

finances to get additional training in the areas of sexual medicine, which general OB-GYNs do not have, and cosmetic gynecology, which general OB-GYNs do not have.

God love general OB-GYNs. I love OB generals. We're all really -- I don't know. I don't know of any OB-GYN who is not trying to help his or her patients. But there's only so much training. And that's why there's -- that's why individual OB-GYN's that are doing GYN cancer operations get additional training.

I mean, they didn't have those subspecialty boards when I started out. I was a generalist, and I was doing big cancer operations because there wasn't anybody else to do them. If I got a patient with ovarian cancer now, no, I'd turn it over to a GYN onc. But you should be judged both as someone who is a cosmetic gynecologist and who is a sexual medicine practitioner. And a general OB-GYN, as intelligent and well-meaning and well-trained as that individual may be, is ill-suited to judge you in those areas in my opinion.

DR. CHAMBERS: Thank you very much, Dr. Goodman. Thank you for your time and for your expert testimony. I'm most grateful.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you, Dr. Chambers.

All right. Counsel, we're coming up on -- Well, we're over an hour again. Coming up on 12:30. And we have another witness at 1:30. Now last time we did this, we blew through lunch, and I don't think anyone was really happy with that.

Dr. Goodman, are you available later on today? Because we have some other witnesses, and of course Mr. White intends to cross-examine you, and I may have some questions as well. What does your day look like?

THE WITNESS: Actually, what I was going to do today in the afternoon that I had scheduled has been postponed to tomorrow. No, I have time this afternoon, Mr. White and Hearing Officer Ghusn.

ADMINISTRATIVE HEARING OFFICER GHUSN: All right.

Mr. White, do you think it's a good time to break then?

MR. WHITE: I agree. Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: And then come back? Okay. And let me look at my notes again.

THE WITNESS: Can we estimate a time though?

ADMINISTRATIVE HEARING OFFICER GHUSN: Yeah.

That's what I was going to try to do for you.

THE WITNESS: Or you can give me a rough estimate and then text me?

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. So we have --Mr. White, we have 1:30s, right, with Ms. Carden, Patient C. Did you give a rebuttal for Ms. LaRue a time or?

MR. WHITE: No, I don't think so. I don't want to speak for Brandee, but I don't think that she probably did because Ms. Larue is just -- she's here.

ADMINISTRATIVE HEARING OFFICER GHUSN: So that's not a problem?

MR. WHITE: Hold on a second though. But she does leave at 3:45, so we'd have to fit her in.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. So I'm looking at late afternoon.

What do you see, Mr. White?

MR. WHITE: Probably the same. Yeah.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. All right. So ballpark, Dr. Goodman --

MR. WHITE: 3:30, maybe.

ADMINISTRATIVE HEARING OFFICER GHUSN: That's conservative. It might even be later.

MR. WHITE: I was thinking 3:30.

ADMINISTRATIVE HEARING OFFICER GHUSN: I'm thinking 4:00 is probably realistic.

Does that give you a time frame, Dr. Goodman?

THE WITNESS: It does. I'd make myself available between 3:30 and 4:30 to start.

Mr. White, about how much time do you estimate, understanding that sometimes I get loquacious, although I'll try not to.

MR. WHITE: I don't see any more than an hour, maybe possibly less.

THE WITNESS: Cool.

ADMINISTRATIVE HEARING OFFICER GHUSN: And I may have, let's say, 15 minutes. Who knows. And Mr. White and Dr. Chambers also may follow up after some of my questions.

THE WITNESS: I'll be available as of 3:30, but if it's earlier, I've got my cell phone in my pocket, and I'm all done with my weed eating outside today so I can hear the phone ring.

ADMINISTRATIVE HEARING OFFICER GHUSN: Perfect. Okay. And so we'll logistically, Dr. Chambers can reach out to you. Is that how we'll work it?

THE WITNESS: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: Dr.

Chambers, you can text or call or something Dr. Goodman, and we'll take a break and give him a chance to log on with the sound, right?

DR. CHAMBERS: Will do.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Perfect. Thank you so much for your time, everybody. And is there anything else we need?

Ms. Hansen, are you good to go at 1:30?

THE COURT REPORTER: I'm good to go at 1:30.

ADMINISTRATIVE HEARING OFFICER GHUSN: See everybody then. Go stretch and eat and get some fresh air.

(Recess.)

ADMINISTRATIVE HEARING OFFICER GHUSN: Good afternoon again. I'm Hearing Officer Nancy Moss Ghusn, and this is the time and place for the continued hearing in the matter of Dr. George Chambers.

We have the parties that we need here. However, I am going to check because we have names out there, and for those of you who were with us in the morning, you know that I'm going to ask if anybody that I see is a witness coming up. And I will go through.

Ms. Norton, Jennifer Norton, is not a witness. I think you were here this morning.

MS. NORTON: Correct. I'm not a witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. And Burbank, I think we checked earlier, is not a witness. And Laura, I think she said, would be in and out. It is media?

MS. MOONEYHAN: Can we hold just a moment? We're having some technical difficulties here at the medical board.

ADMINISTRATIVE HEARING OFFICER GHUSN: Sure. Let me check with the people that are here first.

MS. MOONEYHAN: We can't see them.

ADMINISTRATIVE HEARING OFFICER GHUSN: I see the names, so at least we'll have that done. So and forgive me if I mispronounce names. Natalia Demilanta? Natalia Demilanta is not a witness; is that correct? We'll come back.

Jennifer Norton, I think, was here earlier and is not a witness; is that correct?

DR. CHAMBERS: Ms. Demilanta is not a witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Is that Dr. Chambers? Did you say that?

DR. CHAMBERS: Yes. Ms. Demilanta is not a

witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Do you recognize anybody else, Dr. Chambers?

DR. CHAMBERS: I don't. Just Ms. Carden.

ADMINISTRATIVE HEARING OFFICER GHUSN: We know Laura isn't. Lily Woods? Confirming. We would know if they were witnesses, right? Both sides are here?

MS. MOONEYHAN: I don't recognize any of these names.

ADMINISTRATIVE HEARING OFFICER GHUSN: They could be using someone else's computer though.

Lily Woods?

MS. WOODS: Hi. I'm not a witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Thank you very much.

Josephine.

JOSEPHINE: I am not a witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you very much. I think that's good because we had -- I think that's everyone.

Dr. Chambers, Ms. Mooneyhan, are you good with that?

MS. MOONEYHAN: Yes, I believe that's everyone that I could see. I think we need --

ADMINISTRATIVE HEARING OFFICER GHUSN: How much time? Do we need a five-minute break for your IT to tweak things?

MS. MOONEYHAN: Yes, please. Yes, please.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Five minutes. I'll be right back.

(Recess.)

ADMINISTRATIVE HEARING OFFICER GHUSN: Back on the record in the matter of George Chambers, M.D.

A couple of preliminary matters. We have checked to see if there were any other witnesses in the audience and confirmed there were not. Thank you all for remaining muted.

Any other preliminary matters, Ms. Mooneyhan?

MS. MOONEYHAN: None from me.

ADMINISTRATIVE HEARING OFFICER GHUSN:

Dr. Chambers.

DR. CHAMBERS: Not from me.

ADMINISTRATIVE HEARING OFFICER GHUSN: I'd like to have Ms. Carden sworn, please.

CASEY CARDEN,

having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. MOONEYHAN:

Q Ms. Carden, will you please state your full name and spell your first and last name for the record, please.

A Yes. Casey Carden: C-A-S-E-Y. C-A-R-D-E-N.

Q And do you know the respondent in this matter, Dr. George Chambers?

A Yes.

Q And how do you know Dr. Chambers?

A Dr. Chambers was my doctor, and then I worked for him as a receptionist.

Q Okay. How long approximately, if you know, were you a patient of Dr. Chambers?

A Probably like ten years, I would say. Yeah, no. Probably like eight to ten years.

Q Do you know approximately the years? Do you know when did you stop being a patient of Dr. Chambers?

A Last year.

Q You said you also worked for him as a

receptionist. Was that your title?

A Yes.

Q And how long do you think you worked for Dr. Chambers?

A I don't know it approximately, but it was under a year. Maybe like eight or nine months maybe.

Q Do you know when that eight or nine months were?

A I honestly don't. Was it like 2020 maybe? 2000 -- maybe beginning -- Honestly, sorry, like I really don't know.

Q Do you remember COVID restrictions being in place while you worked for him?

A Yeah, I remember wearing a mask and, you know, stuff like that.

Q Okay. Have you spoken to Dr. Chambers recently?

A Yes.

Q Approximately how recently?

A A couple weeks ago, I called him. I wanted to let him know that I would be testifying against him, and we had a brief conversation.

Q Would you say that you're still on friendly terms with Dr. Chambers?

A I wouldn't say like we're friends like we talk often or anything. I just, I mean, I, you know, I just wanted to like -- I didn't want him to be blind sided to see me testifying against him. I felt like I wanted to let him know that.

Q Okay.

A And previously, like he had said that his lawyer wanted to like, you know, she had questions for me and, you know, I just wanted to see if that was still same.

Q Okay. Why did you leave your employment at Dr. Chambers' practice?

A It was, I don't know, like sometimes like I didn't get paid like consistently. And I just felt like it was just time.

Q Okay. Did you ever act as a chaperon in Dr. Chambers' practice?

A Yes.

Q And how often would you say you acted as a chaperon?

A Not every day, but I'd say like it was like semi-consistent like I don't know. Not like terribly often, but not like, you know, only like once a month. I'd say it was irregular, but I don't know. Maybe like a

couple of times a month if there was like an underage patient or someone that he just wanted me to be in the room.

Q Okay. So you didn't act as a chaperon with every patient?

A No. I was like mainly doing reception stuff.

Q Were you Dr. Chambers' only employee while you were employed there?

A Like in the office and then he had someone doing insurance stuff out of the office, but I don't like I didn't ever like see her. I think she came in like one time and I met her, but yeah. And then there was another nurse that was in the office that she was like doing her own plastic surgery practice, but she wasn't like an employee of Dr. Chambers. She was there like towards the end of my employment.

Q Okay. How often -- what was your -- Did you work full-time? Part-time? What were your hours like?

A It wasn't 40 hours a week, but I think it was like -- it was more than part-time. Like maybe like 30 hours a week, I think it would usually work out to be. Sometimes it varied because, you know, he would leave early if he got called to the hospital or something like that, and then there would be no reason for me to be

there if there wasn't patients.

Q Okay. Sorry. I forgot to ask one question about acting as a chaperon. Did you have any training about acting as a chaperon?

A No.

Q Did you ever get COVID while you were working for Dr. Chambers?

A I've had COVID multiple times. I don't know if I got it while I was working for him. I'm trying to think. No, I think the first time I got it was after I was done working for him, I think, but I'm -- honestly, I don't think so.

Q Okay. Thank you. Do you remember Dr. Chambers, if he had a written COVID policy?

A Yeah. We had something in the lobby that said like, you know, you have to keep your mask on. Like something along those lines. I remember he was strict about patients wearing masks, but I don't -- I don't know.

Q The times you did act as a chaperon, where did you stand?

A Somewhere in the room. Sometimes like in the doorway or, you know, sometimes like behind him or off to the side.

Q When you chaperoned from the doorway, did you have a view of what was going on?

A Oh, yeah. I mean, like if I was in the doorway, like I would be like actually in the room.

Q Okay. So I just -- so you considered being in the doorway being in the room?

A Yeah. Like, I mean, like I would be on like on the inside of the doorway. Sorry if that's not -- yeah.

Q You're familiar with Patient A in this matter?

A Yes.

Q I know you have a binder of exhibits, so when we say Patient A, you know who we're referring to?

A Yes.

Q And do you remember her visit to Dr. Chambers' office?

A Yeah, I do.

Q Were you asked to chaperon her visit?

A No. I was doing charts while she was getting seen.

Q What does doing charts entail?

A I was just printing out name labels and putting them on paper charts at the back desk.

Q While you were doing that, could you see into the room?

A I don't -- I think the door was closed. I don't recall seeing into the room, but --

Q Could you hear what Dr. Chambers and Patient A were discussing?

A Not like what they were discussing, but Dr. Chambers has a pretty deep voice, so like it wouldn't be out of the ordinary for me to be able to kind of like not hear what they were talking about, but hear like laughter of, you know, kind of like muffled a little bit through the doorway. But no, I don't recall hearing anything like -- I don't know. Maybe I heard them talking, but I wouldn't have been able to like decipher what they were saying if I did hear it.

Q Would you say you had familiarity with Dr. Chambers' files in your position as a receptionist?

A Yeah. I mean, like I wouldn't -- like I wouldn't be reading people's files as I was putting their names on them, but like familiarity how?

Q Well, do you know what would have been included in them?

A I mean, I wouldn't have any reason to like open them and look like through them. Like if I was just

putting the names on them like that would be maybe like opening the first page, confirming that was the person, putting the name on the chart. Yeah.

Q Regarding Patient A's visit, did you speak to her before her examination?

A Yes. She and I had a pretty long conversation when she first arrived.

Q Okay. Was Dr. Chambers there during that conversation?

A I don't think so. I mean, he might have been behind me somewhere like in the back office, but no, I remember being like at the front desk and talking to her about her purse, talking about, you know, being moms and just generic conversation, but she was really friendly.

Q Did you speak to her after her encounter with Dr. Chambers?

A Yes. Yeah. I checked her out and then we discussed she was going to be doing -- Is it okay if I say this?

Q Well, sure. I mean, my next question was going to be what the contents of that conversation were.

A Okay. So she was going to be doing like a vaginal like reconstructing surgery, and she seemed really excited about it, you know. We talked about how

we don't do a lot for ourselves as moms and you kind of neglect yourself and, you know, she's excited about it saying she was finally going to do something for herself that she deserved and she hoped that I could do something for myself as a mom and just, you know, stuff like that.

Q Was Dr. Chambers there while you were having that conversation?

A I don't believe so.

Q Did you ever talk to Patient A? Did you follow up to schedule the surgery?

A I did. I tried to reach out to her, and I never got in touch with her after that. And I remember talking to Dr. Chambers about it and just being kind of like hey, like, you know, I didn't get in touch with Patient A. That's weird because she was so -- she was like overly excited about the surgery and she seemed really, you know, like she wanted to do it, so I was surprised that she didn't like schedule, you know, like immediately.

Like usually if someone is going to do that, when you call them, they're like: Hey, I want to schedule. Like let's do this now. And I never -- I didn't talk to her again after that. So I thought it was strange.

Q Okay. While you were a patient of Dr. Chambers, did you ever have cosmetic gynecological surgery?

A No.

Q Did Dr. Chambers ever offer you money to pose for photos?

A Yeah, once for like the AVN. I don't know or I don't know some adult porn convention that he would like sponsor or something. And he asked if I would be interested in posing for those pictures, and I said no.

Q Just a moment, please. While you acted as a receptionist, did Dr. Chambers ever show you photos of his patients' genitals?

A I did see a couple photos. One time a girl was there and I was like: Hey, like, you know, look at this. Like can you believe this? Like look at this work. And, you know, something like that. But I think like a couple times like I saw like pictures of like the vaginal reconstructive surgeries.

Q Did Dr. Chambers ever show you those photos or were those -- Sorry. Let me finish there. Did Dr. Chambers ever show you those photos?

A Yeah.

Q Do you know approximately how many times?

A I don't. I don't know. Not that many. I'm so sorry.

Hazel, you cannot be up here, Honey. You have to go downstairs. Go downstairs, okay? Be careful.

I'm so sorry.

Q No problem.

A I apologize.

Q Not at all. Do you recall the context in which you were shown those photos?

A Just the context would have been like, you know, showing the work that was done.

MS. MOONEYHAN: Thank you. I have no further questions at this time.

ADMINISTRATIVE HEARING OFFICER GHUSN:

Dr. Chambers?

CROSS-EXAMINATION

BY DR. CHAMBERS:

Q Hi, Casey. Good afternoon.

A Hi. Good afternoon.

Q Did you remain a receptionist the entire time you worked with me?

A Yeah.

Q Did you get promoted to the manager position?

A Well, yeah. I mean, I guess like you said, that I would be like office manager.

Q Do you have in front of you the book --

A I don't.

Q -- that shows the exhibits?

A I don't. I'm so sorry. I don't have the binder. I'm in Pennsylvania, and I was nervous about traveling with something like that, so I apologize. I don't have it. But I did look at it, so I should be able to answer most questions about it.

DR. CHAMBERS: Ms. Ghusn --

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes.

DR. CHAMBERS: -- there was an email that she sent me on May 18th, 2022. How can I get her to read that?

ADMINISTRATIVE HEARING OFFICER GHUSN: Do we have that as an exhibit, Ms. Mooneyhan?

DR. CHAMBERS: It is. It is on Exhibit 3, page NSBME 0028.

ADMINISTRATIVE HEARING OFFICER GHUSN: Is this one of your exhibits?

DR. CHAMBERS: It's one of the Board's exhibits.

ADMINISTRATIVE HEARING OFFICER GHUSN: Hold

on. We might be able to do this easily.

THE WITNESS: Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: It's already admitted. Okay.

THE WITNESS: Sorry. I should have brought the book.

ADMINISTRATIVE HEARING OFFICER GHUSN: It's okay. We're fine. It's Exhibit 3.

DR. CHAMBERS: Yes. Do you have the emails, Casey?

THE WITNESS: I do.

ADMINISTRATIVE HEARING OFFICER GHUSN: Just a moment, Dr. Chambers. Hold on. I'm sorry, Ms. Mooneyhan. What?

MS. MOONEYHAN: It's page 28.

DR. CHAMBERS: Oh, 28.

ADMINISTRATIVE HEARING OFFICER GHUSN: All right. Ms. Mooneyhan, would you have any objection to this being read by one of us if it's admitted into evidence?

MS. MOONEYHAN: I don't. My only precaution would be when Patient A's name is mentioned that we say "Patient A" instead of her actual name.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay.

Do you have a preference? Because this is unusual under the circumstances. Would you like me to read it, would you like Dr. Chambers to read it, or would you like us to take a break and email it to Ms. Carden?

DR. CHAMBERS: Would you please email it to her so she'll read it? Because I'd also like her to authenticate it.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. It's not admitted then.

MS. MOONEYHAN: It is admitted. It is admitted. He included it as part of Patient A's records, and it was admitted during our case-in-chief.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. That's what I was wondering.

MS. MOONEYHAN: And I can scan it and email it to Ms. Carden.

ADMINISTRATIVE HEARING OFFICER GHUSN: Ms. Carden, do you have access to email where you are?

THE WITNESS: Yeah. Yeah, if you guys send it to my email.

ADMINISTRATIVE HEARING OFFICER GHUSN: Can you log on?

THE WITNESS: Yeah.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay.

THE WITNESS: Can you tell me, is the email address Casey.Carden@yahoo.com? Is that the one?

MS. MOONEYHAN: Yes, it is.

THE WITNESS: Yeah, I'll be able to read that.

MS. MOONEYHAN: Okay. I'm going to need about five minutes.

ADMINISTRATIVE HEARING OFFICER GHUSN: Sounds good. And it is 2:03, so we'll see you in a few.

(Recess.)

THE WITNESS: I'm here. I read the email.

ADMINISTRATIVE HEARING OFFICER GHUSN: Sounds like it worked.

THE WITNESS: Yes, yeah. I just read it, and yeah, I recall.

ADMINISTRATIVE HEARING OFFICER GHUSN: Just a moment. Are we back on the record?

MS. MOONEYHAN: Before we do that, I just wanted to let you know there is one more person in the waiting room that Ms. Fuentes is going to admit. Her name is Claire Claudie, and I think she was here this morning, but I just want to let you know there's going to be one more person joining the group.

ADMINISTRATIVE HEARING OFFICER GHUSN: I'll

check. Thank you, Ms. Mooneyhan.

Dr. Chambers, you don't know this person?

MS. MOONEYHAN: You're on mute, Dr. Chambers.

DR. CHAMBERS: She's an observer.

ADMINISTRATIVE HEARING OFFICER GHUSN: Do you know her?

DR. CHAMBERS: Yes. She's one of my patients.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Not a witness then?

DR. CHAMBERS: No.

MS. CLAUDIE: Is that me, Claire?

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes.

MS. CLAUDIE: Sorry. I was having troubles logging in. I'm just an observer.

ADMINISTRATIVE HEARING OFFICER GHUSN: Just go ahead and mute. Thank you very much.

See anyone else, Ms. Mooneyhan?

MS. MOONEYHAN: No. The only other person in the waiting room is Patient C, and that's where she should stay for me.

ADMINISTRATIVE HEARING OFFICER GHUSN: So back on record. Go ahead.

Q (BY MR. CHAMBERS:) Casey, would you please

read aloud what you wrote to me, please, all of it?

A Yes.

Q Thank you.

A A little winded. Sorry. "To whom it may concern. The following is a statement I was asked to write by Dr. George Chambers regarding Patient A. When asked by Dr. Chambers if I recall the patient, I said that I had. He asked me to recount the interaction I had with her that day. Patient A was very pleasant when she came in for her appointment."

"After checking her in, we made small talk about her purse, little pleasantries. When she was called back to the room with Dr. Chambers, I was in the back desk area making labels for the charts that didn't have names on them. I didn't hear anything out of the ordinary. When Patient A exited the room, we talked while I checked her out. She was very excited at the prospect of having the reconstruction surgery, and we talked in depth about how we as mothers deny ourselves of the things that we need in order to take care of our children."

"She was ecstatic said she had taken care of her kids and it was her time to take care of herself. I told her she deserved the procedure and she told me I

hoped I could do something to take care of myself as well. Our interaction was very pleasant, and the conversation lasted longer than it does with most patients. Regards, Casey Carden."

Q When we finished the consultation -- Where did you have the conversation with Patient A?

A At the like the desk like not at the front desk, but the desk to the side where I would check out patients where we had our credit card machine and the computer to check patients out.

Q Where was I during that time?

A I mean, I think you were in the back area, but like you were always kind of underfoot, so like I don't -- I can't say for certain if you were like there or you weren't there. If you were there, I don't recall --

Q Okay.

A -- our conversation. Sorry. I honestly don't.

ADMINISTRATIVE HEARING OFFICER GHUSN: You don't have to speculate, Ms. Carden.

Q (BY DR. CHAMBERS:) No, that's okay. You said you could not recall having COVID while you were employed by me.

A Uh-huh. Yeah. I don't.

DR. CHAMBERS: Ms. Ghusn, is it okay if I read a text message from her with the date?

ADMINISTRATIVE HEARING OFFICER GHUSN: Ms. Mooneyhan?

MS. MOONEYHAN: Well, Your Honor --

DR. CHAMBERS: It goes to that COVID discussion.

MS. MOONEYHAN: I mean, it sort of depends on how she's going to frame it. She's already answered the question she doesn't recall.

DR. CHAMBERS: Well, I'm reading it to confirm that to refresh her memory.

ADMINISTRATIVE HEARING OFFICER GHUSN: Dates.

DR. CHAMBERS: Yes. Yes. There's also dates here. May I?

ADMINISTRATIVE HEARING OFFICER GHUSN: Ms. Mooneyhan? Just a moment.

MS. MOONEYHAN: Well, I think if he can ask it in a way if it refreshes Ms. Carden's recollection. Obviously, if she doesn't have the text, she can't say whether she received it or not or whether it stated that date or not. But if it refreshes her memory, then I think it may be appropriate.

Q (BY DR. CHAMBERS:) Ms. Carden, do you save your text messages with me?

A No. And I've had a new maybe one or two new phones since then, so --

Q Got you. Do you recall Hazel having tested positive for COVID while you were working for me?

A I don't recall, but again, she's also had COVID multiple times.

Q This one was dated December 13th, 2021.

A That would have been after her birthday party. I didn't realize I was working for you that late. That would fit in the timeline because the first time she got it was after her birthday party, which was November 25th. So that would --

Q Do you recall -- No, you don't recall.

Ms. Ghusn, may I read the text message?

ADMINISTRATIVE HEARING OFFICER GHUSN:

Ms. Mooneyhan?

MS. MOONEYHAN: Well, I have a question about its relevance. I believe he just said that it was dated December 13th, 2021, and Ms. Carden testified that she worked for him for about eight or nine months approximately 2020.

ADMINISTRATIVE HEARING OFFICER GHUSN: I will

tell you actually, Ms. Mooneyhan, excuse me. Some of my questions were going to be about trying to nail down these dates and these time frames if she could. So if this takes care of some of that, I'm going to have fewer questions later because it was kind of broad and vague and this may be helpful, so I find it relevant.

DR. CHAMBERS: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: That being said, that was your objection based on relevance?

MS. MOONEYHAN: Well, yes, because if I remember correctly from a few minutes ago, Ms. Carden testified that she worked for Dr. Chambers for eight to nine months, and some of that was in 2020. If she had COVID, if her daughter had COVID in 2020, December of 2021, I'm not sure if those times overlap, but if you want to explore that.

ADMINISTRATIVE HEARING OFFICER GHUSN: Yeah. I absolutely would like to get a better -- if possible, better handle on dates. And if this helps, yeah. Do you have any objection to Dr. Chambers reading it?

MS. MOONEYHAN: Well, we don't have a copy of the text, and it hasn't been produced, and Ms. Carden also doesn't have a copy. So, I mean, we're basically relying on Dr. Chambers to --

ADMINISTRATIVE HEARING OFFICER GHUSN: Unless we re-send everything again or forward it. I'm a little impatient about that because I think it could be helpful, but we allowed this previous document to be sent to her.

MS. MOONEYHAN: That was admitted, an admitted exhibit. This is a text message that he has never shared with anybody.

ADMINISTRATIVE HEARING OFFICER GHUSN: That's true.

DR. CHAMBERS: Well, it wasn't relevant before now.

MS. MOONEYHAN: I would argue it's not relevant now.

DR. CHAMBERS: Well, I think it is.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. The problem, Dr. Chambers, as much as I'd like to get a handle on the dates, if we're going to dance around this, is it wasn't produced and it's not admitted into evidence. There are relaxed rules of evidence in these administrative hearings.

DR. CHAMBERS: Well, this was sent from the same number that Casey called me from recently, so --

ADMINISTRATIVE HEARING OFFICER GHUSN: Do you know another way possibly -- Ms. Mooneyhan, would you

object if Dr. Chambers testifies some more, which we've reserved that possibility if he testified to it without reading it?

MS. MOONEYHAN: Well, does Ms. Carden recall sending a text about COVID in approximately 2021?

THE WITNESS: I don't, but to be very, very honest with you, I don't have a great memory, and like I am unsure about the dates that I worked for Dr. Chambers. That's the honest truth. So the fact that I don't recall, it doesn't mean it wasn't sent. I don't know. I'm not -- it -- I don't know.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. This is what we're going to do.

And, Dr. Chambers, I'm not tickled about this. I actually like to know and I'd like to have a better handle on the dates because I can see Ms. Carden is having some difficulty recalling dates and date ranges, but there are too many pitfalls in this one. There are too many layers, even with relaxed rules of evidence, for me to admit it over objection.

Q (BY DR. CHAMBERS:) Okay. All right. Was there ever a time that you had to call out because you or Hazel had COVID?

MS. MOONEYHAN: Objection, asked and

answered.

Q (BY DR. CHAMBERS:) Was there ever a time when we had to reschedule patients because of COVID?

A Because of Hazel's COVID or --

Q Because of COVID in general.

A Yeah, I remember some patients having COVID. Yeah, I remember.

Q Okay. How about me having to close the office because of COVID?

A I don't recall. Sorry.

Q Do you recall me ever having had COVID?

A I don't recall it.

Q Okay. All right. Well, without the ability to authenticate this text message, I have no further questions for Ms. -- Oh, one more question. Did I examine every patient who I saw in the office?

A You mean like --

Q Patients coming for a visit. Did all of them require examination?

A You mean like an examination where they would like dress down and then --

Q Correct. Correct.

A No. Sometimes like the patient would need something or --

Q Did all of them require an examination?

A No.

Q Okay. Do you recall when Patient A made her appointment to see me, do you recall what that appointment was for?

A I don't recall making the appointment with her, but I do recall her being there, and it was for the vaginal reconstructive surgery.

DR. CHAMBERS: Okay. Thank you very much, Ms. Carden.

THE WITNESS: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Ms. Mooneyhan.

MS. MOONEYHAN: I have no further questions.

EXAMINATION

BY ADMINISTRATIVE HEARING OFFICER GHUSN:

Q Okay. Ms. Carden, I just want to clarify a couple things to make sure I understood. So I jotted down that you believe you were Dr. Chambers' patient for approximately eight to ten years. Is that correct?

A Yeah. That's like a rough estimate because I'm thinking that my daughter is seven and a half. I stopped being his patient like last year, so it would be

like six and a half. And I think the first time I saw him was maybe like two years before she was born, so --

Q So approximately what year was that? And Hazel is your daughter? Let me clarify that too.

A Yeah, sorry. So she was born November 25th, 2015. And I think like the first time I saw Dr. Chambers was like around two years before that.

Q Okay. So I understand. Don't speculate, so approximately 2013, you said, so that would make sense if you saw him until approximately you said last year, so 2022?

A Yeah, I believe so. Yeah.

Q You don't remember more specifically when you quit going to him as a patient?

A I think it was more than a year ago but not more than -- I mean now that I know that I was working there in December of 2021 then, I mean, it probably would be like early 2022. But again, I am just speculating because I honestly don't know.

Q Okay. I also jotted down that you didn't -- that you stopped working for him because you weren't consistently getting paid; correct?

A Yeah.

Q You said? And it was time to move on. Is

that what you said?

A Yes.

Q I'm sorry. Nothing more specific than that?

A I mean, probably, you know, I was taking classes.

Q Don't speculate.

A Okay.

Q You don't have to speculate. No probably. Okay. But you continued being a patient after you discontinued working for him; is that correct?

Sorry. I couldn't hear you.

A Yes.

Q Yes? So you were comfortable being his patient?

A Yes.

Q Why did you stop being his patient?

A I don't -- I don't honestly recall. I remember that I had heard this one doctor was good, and I went to him. I guess that's probably the biggest reason why. I don't really recall. Sometimes with Dr. Chambers, you would wait to see him quite a while. You could be in the waiting room like two, three hours. Having a child is not super conducive to that.

Q Okay. So you also testified -- and I'm

trying to find it in my notes -- that you worked for him for under a year?

A Yeah.

Q Is that right? Maybe eight to nine months, I think you said?

A Pretty positive it was under a year.

Q And we don't remember what year?

A I'm really embarrassed about it, but honestly, I don't. I don't have a great memory.

Q Okay. Do you remember there being a receptionist there before you were a receptionist?

A Yeah. I remember the receptionist when I was a patient there. I remember them well. Do you want her name?

Q No, that's okay. When you were a patient all those years and you went in for your exams, did Dr. Chambers have a chaperon?

A Yeah.

Q Did she have someone in the -- Yes?

A Yes. Yeah. Her name was -- She was his medical assistant, I believe. Anelle. Sometimes Shasta would be in the room. She was the receptionist.

Q Do you ever remember a time when there wasn't a chaperon in the room when you were a patient?

A I don't recall.

Q Okay. Again, you don't have to speculate. You remember the people, it sounds like, pretty specifically?

A Yeah.

Q Okay. How about after the time that you were no longer working for Dr. Chambers but you were still a patient? Was there another receptionist after you moved on?

A There was another receptionist after a while. I know for a long time, he didn't have a receptionist and yeah, and then he had one.

Q Okay. And so when you went in after you were a receptionist and you were still a patient, do you recall there being a chaperon in the room? It's okay. Again, you don't have to speculate. You seem pretty certain about previously, but I don't want you to speculate.

A I wouldn't be -- I wouldn't want to speculate. I don't --

Q Thank you.

A -- know if she was or not.

Q Okay. Did you communicate with Dr. -- When you were a receptionist, did you communicate with

Dr. Chambers by text or email?

A Yeah, mostly not email because I wasn't great with email. Mostly text.

Q Mostly text. Okay. So that was a regular occurrence?

A Uh-huh. Yes.

Q Okay. And since we're trying to help me with dates, Hazel is your daughter; correct?

A Yeah.

Q Okay. And you said her birthday was the end of November?

A Yes.

Q Okay. But you don't recall the text message? Okay. Hold on. One thing. One moment. Do you recall, did you have COVID more than once?

A I had COVID more than once.

Q Do you know how many times?

A I think for certain, I tested positive three times.

Q Was it during the time you were working, do you recall, for Dr. Chambers?

A I don't recall.

Q Okay. And you said your daughter had COVID after her birthday?

A Yes.

Q I have 11-25, but I don't have a year. Do you recall that birthday party?

A No.

Q No. Okay. Did she have COVID more than once?

A She's had COVID more than once. Yeah.

Q And she's how old?

A She is seven and a half.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Any follow-up, Dr. Chambers or Ms. Mooneyhan, on my questions?

DR. CHAMBERS: None for me.

MS. MOONEYHAN: Yes, I do, Your Honor.

REDIRECT EXAMINATION

BY MS. MOONEYHAN:

Q Ms. Carden, you testified that when you were a patient, Dr. Chambers discussed with you posing for photos?

A Yes.

Q Do you recall if the chaperon was present during that conversation?

A No, it was -- no. It was over a text

message.

Q Have you ever texted, had text conversations with Dr. Chambers after you quit working for him?

A It wouldn't be weird if I did, so I'm pretty certain that I probably have, but I don't --

Q Okay. Thank you.

A -- if I would have a conversation after I had my daughter, like he would give out his number to patients to text about, you know, like medical issues or stuff like that if you wouldn't get in touch with him.

Q One more follow-up about asking you to pose for photos. Did Dr. Chambers initiate that or did you ask him about the possibility of posing for photos?

A No. He initiated it.

MS. MOONEYHAN: Thank you. I have no further questions.

ADMINISTRATIVE HEARING OFFICER GHUSN: Any follow-up, Dr. Chambers?

DR. CHAMBERS: None at all.

ADMINISTRATIVE HEARING OFFICER GHUSN:

Ms. Carden, thank you so much for your time. I know you're out of town, and I appreciate your patience with the time. And also, I guess your child was there a moment ago, so thank you for taking the time to talk to

us today.

THE WITNESS: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Will anyone recall her?

DR. CHAMBERS: No.

MS. MOONEYHAN: No.

ADMINISTRATIVE HEARING OFFICER GHUSN: Then you're excused.

THE WITNESS: Can I ask: Is this final then? Like will I be testifying any more or is that it?

ADMINISTRATIVE HEARING OFFICER GHUSN: No. You're good to go. Thank you again.

THE WITNESS: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: And have a good rest of your day.

THE WITNESS: Thank you. Bye-bye.

ADMINISTRATIVE HEARING OFFICER GHUSN: Hold on one second again, please. All right. So we are now looking at -- Did we lose you? Oh, there you are, Ms. Mooneyhan. Are we looking at Patient C now?

MS. MOONEYHAN: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. And is Ms. Fuentes there to let her in?

MS. MOONEYHAN: Yes. Are we ready to let her

in? And there's also another person. We'll let the other person in first so you can ask her, Your Honor.

ADMINISTRATIVE HEARING OFFICER GHUSN: Sure. Yes. Good afternoon. Ms. Sarpong, can you hear me?

MS. SARPONG: Yes, I can.

ADMINISTRATIVE HEARING OFFICER GHUSN: Are you a witness in this proceeding?

MS. SARPONG: I am not.

ADMINISTRATIVE HEARING OFFICER GHUSN: You're here as an observer?

MS. SARPONG: I am.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Thank you. And I'd just ask you to remain muted.

MS. SARPONG: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you. I see your earbuds going in.

All right. Patient C, you are muted.

MS. MOONEYHAN: Your Honor, before we swear in Patient C, can I request that you remind all present of your order?

ADMINISTRATIVE HEARING OFFICER GHUSN: So reminded. Anybody and everybody who is observing this, there is an order in effect that all patients, including Patient C, who is here with us now, shall not have their

name or likeness revealed. And I'd ask everyone for their understanding, but I trust that you all understand. Thank you.

And, Patient C, good afternoon.

THE WITNESS: Good afternoon.

ADMINISTRATIVE HEARING OFFICER GHUSN: Can you hear me?

THE WITNESS: Yes. Can you hear me as well?

ADMINISTRATIVE HEARING OFFICER GHUSN: Yeah, no, it's great. We've had really good luck. I'm really happy with this. I'm probably going to jinx it now, knocking on wood, but I'm going to ask the court reporter to swear in Patient C, please.

Patient C,

having been first duly sworn, was examined and testified as follows:

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you.

Ms. Mooneyhan?

DIRECT EXAMINATION

BY MS. MOONEYHAN:

Q Patient C, we're going to be referring to you by that name instead of your actual name, but last week, I sent you a packet of documents including a patient designation that was filed on September 21st, 2022. Do you have that there?

A I believe so. Yes.

Q And I just want to confirm the other patients' names and birth dates have been redacted, but is the name and birth date set forth there for Patient C, is that your name and birth date?

A Yes, ma'am.

Q Thank you. Patient C, do you know the respondent, Dr. George Chambers?

A Yes.

Q And how did you become acquainted with Dr. Chambers?

A He was my OB-GYN.

Q For approximately how long was he your OB-GYN?

A I'm not sure exact dates. I believe I saw him -- I'm not sure how many visits. Maybe four to five times. That's a guesstimate. I'm not sure.

Q Okay. Do you have the binder of exhibits that we sent you?

A I do.

Q If you could please turn to Exhibit 10 starting at page NSBME 0145.

A Thank you for your patience. Yes.

Q Okay. So on page NSBME 0146, it shows a date of September -- in the upper right corner, it says a date of September 24th, 2019?

A Yes.

Q And then, for example, if you turn over to page NSBME 0148, in the upper right-hand corner, it shows a date of November 11th, 2019?

A Yes.

Q And there are some pages in between. Does that sort of approximate -- Does that correspond with what your memory is of when you might have been his patient?

A Yeah.

Q Have you had a chance to look at this Exhibit 10?

A Briefly. I reviewed it last night.

Q Okay.

A Sorry.

Q Does that look to accurately represent the number of times approximately that you saw Dr. Chambers?

A Yes. There wasn't anything that seemed out of order.

Q Okay. Do you remember what motivated your first visit to Dr. Chambers?

A Yes. I was experiencing extremely painful periods.

Q And how did you decide to see Dr. Chambers?

A I originally had looked online at reviews and thought that his reviews were excellent and so chose him based upon that and what my insurance would cover.

Q And during your visits with Dr. Chambers, did he have a chaperone present on each visit?

A He did. Yeah.

Q Was the chaperone present for the entire length of the visit, the encounter?

A Yes, I believe so.

Q Are you aware that Dr. Chambers does cosmetic gynecological surgery?

A Yes.

Q Did you ever inquire about such surgery?

A No. Never.

Q How did you become aware that he offered it?

A There was an ad in the bathroom one time when I used the restroom.

Q Can you describe the ad, what it was for, what it was?

A I'm not sure. There was some pictures in the bathroom, and it showed that some kind of surgery could be done, but no, I think -- yeah, I don't remember anything too specific. It was a long time ago.

Q Did you ever see an ad offering patients the opportunity to model for ads?

A No, never.

Q Did you ever have any other kind of surgery done by Dr. Chambers?

A No.

Q Did Dr. Chambers ever call you outside, you know, at home?

A Like did he ever call me at home?

Q Yes.

A Yes, he did.

Q How many times did he do that?

A Once.

Q And what was the subject of that phone call?

A He had offered me money, a thousand dollars, to take photos. I thought -- I don't know how much I

should elaborate.

Q What kind of photos? Did he say what kind of photos?

A He did not. That was something that I inquired about, and if I remember correctly, what he just said that I was going to be a model. And then when I had asked him why because I didn't understand, he just had assured me the price of the amount that I was going to be paid for it and said that like it will be okay essentially.

Q Did you believe that these photos were meant to be nude photos?

A I was concerned about that, yes, because I -- yes.

Q Did he mention that?

A I don't know what exactly was said, but I know that I was uncomfortable with it being somewhat implied that it would be nude because I was worried about distribution of like how could I protect myself in an environment or if, you know, these kind of photos were being shared, I wanted to make sure that I was protected essentially. So I do remember something being said that it was going to be exposure of some kind.

ADMINISTRATIVE HEARING OFFICER GHUSN: May I

clarify? Is this still part of the same phone call?

THE WITNESS: Yes. Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you.

Q (BY MS. MOONEYHAN:) How long do you think this phone call took?

A Maybe ten to 15 minutes.

Q Do you remember what time of day it was?

A Late afternoon.

Q Did you tell anybody about the phone call?

A Yes. I told my partner at the time and I also told a friend of mine who I had originally recommended to see Dr. Chambers who was also a patient of his. I was pretty upset, having recommended him to her and then experiencing something like that with him. I wanted her to be aware of his character as well.

Q Did you ever receive any other phone calls from his practice like from somebody else at his work at the practice besides Dr. Chambers?

A Yes, I did.

Q Do you know -- Can you explain that phone call or phone calls?

A Yes. I received a phone call from his office shortly before he called explaining my results or just

that my results had come in, and so when he originally called me, I thought it was to discuss those things in further detail. Yeah. So I did receive a phone call shortly before that from his office.

Q When you say shortly before, was it the same day?

A Yes.

Q How did this request -- How did this affect you?

A I think it still affects me. I think it's interesting having -- I'll talk about how it affected me in the moment and maybe how it's progressed over time. I think in the moment, it was a really hard. It was a really hard thing because I was really -- I considered it. It was hard because I was struggling for money at the time. And to have something like that presented to me and then to turn it down was hard. I think so in the moment, I felt that way.

And it then affected my relationship with my friend, who I cared about and who had a more intimate procedure with him. That was hard because I felt like I had really done my research and felt confident in choosing Dr. Chambers as a physician.

Through time, it's affected me more to

understand, I think, human behavior and humans in general and how lines can be so easily misconstrued. And I think it was really like even choosing my physician now, my lack of trust in physicians has just really changed since then.

Q Thank you. You mentioned that you were struggling financially. Did you ever mention that to Dr. Chambers?

A Yes, I did. It was something I was very concerned about. There were more tests that had to be ran, and I was always concerned whether it was going to be covered by my insurance. In one of our visits, he had even given me like coupons to help an offer to say like hey, you might be able to use these if they don't. No, it was definitely something he knew I was struggling with. I think even in the phone call, he had presented it that way as an opportunity to help.

Q Are you acquainted at all with Dr. Chambers' ex-wife?

A No.

MS. MOONEYHAN: I have no more questions at this time. Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you, Ms. Mooneyhan.

Dr. Chambers?

CROSS-EXAMINATION

BY DR. CHAMBERS:

Q Good afternoon, Patient C. Can you hear me?

A Yes, I can.

Q Have you had any contact with Patients A or B?

A No, none.

Q No contact whatsoever?

A No.

DR. CHAMBERS: Okay. I have no further questions, Ms. Ghusn.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you.

Any follow-up, Ms. Mooneyhan?

MS. MOONEYHAN: No, Your Honor.

ADMINISTRATIVE HEARING OFFICER GHUSN: One moment. Patient C, thank you very much for your time.

THE WITNESS: Likewise. I am very grateful for people taking it seriously. I appreciate your time and your energy.

ADMINISTRATIVE HEARING OFFICER GHUSN: All right. Last chance anybody? Dr. Chambers or

Ms. Mooneyhan or possible recall?

DR. CHAMBERS: Not from me.

MS. MOONEYHAN: Not from me, Your Honor.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Good luck, Patient C. Have a good rest of your day.

THE WITNESS: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. All right. I hate to say it but again, jinx it, but we're rolling along here. So I think we are at -- What time is it? It's ten to 3:00. We have rebuttal witness. Right, Ms. Mooneyhan? We have cross-examination, Dr. Chambers, and we have Dr. Goodman. So but he's expecting at 3:30 to 4:30, so we'll put that off.

DR. CHAMBERS: I can text him if you want him sooner.

ADMINISTRATIVE HEARING OFFICER GHUSN: No. I think we're probably going at a good order here. So would it be Ms. LaRue would probably be the best thing to do next. And I assume Mr. White is going to come back in for cross-examination?

MS. MOONEYHAN: Yes. I'll be examining Ms. LaRue, and then Mr. White will be cross-examining.

ADMINISTRATIVE HEARING OFFICER GHUSN: Why

don't we do it in that order. What do you think, Ms. Mooneyhan? LaRue, Chambers, Goodman?

MS. MOONEYHAN: Yes, that sounds good to me if you give me a moment to get Ms. LaRue.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. How are we doing, Ms. Hansen? Is this a good time for a break?

THE COURT REPORTER: Yeah, a real short break.

(Brief recess.)

MS. MOONEYHAN: I'm recalling Janna LaRue.

ADMINISTRATIVE HEARING OFFICER GHUSN: There you are.

THE WITNESS: Hi.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Hello. So we just have your first name. But, Ms. LaRue, you were sworn; correct?

THE WITNESS: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: And you remain under oath; correct?

THE WITNESS: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: So go ahead, Ms. Mooneyhan.

DIRECT EXAMINATION

BY MS. MOONEYHAN:

Q Thank you, Your Honor. Ms. LaRue, just to remind everyone, can you please tell us your title at the State Medical Board.

A Deputy Chief of Investigations and Compliance Officer.

Q And you've investigated the matter that we are discussing today regarding Dr. Chambers; is that correct?

A Yes.

MS. MOONEYHAN: Okay, Your Honor. I do have an exhibit that I would like this witness to look at. I have emailed a copy to you and Dr. Chambers, if you would like a moment to --

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes. Thank you.

MS. MOONEYHAN: It would be pre-marked as Exhibit -- IC Exhibit 17, and we have attached Bates stamp numbers, and I'll give you a moment to look at it.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you.

DR. CHAMBERS: Miss Ghusn, I have a question.

ADMINISTRATIVE HEARING OFFICER GHUSN: Just

one moment. Forgive me. Hold on. I need to -- the video pops off when I'm looking at emails, so there you are. Yes, Dr. Chambers.

DR. CHAMBERS: So I'm looking at this new entry that they're trying to make. I object to it for the same reason why they objected to me introducing a picture of my office and exam room for the same reason they object to me providing you a copy of how you evaluate someone for pelvic pain for the same reason they objected to me not entering Casey's text message. If I was not allowed to introduce evidence, how can they?

ADMINISTRATIVE HEARING OFFICER GHUSN:

Ms. Mooneyhan?

MS. MOONEYHAN: Thank you, Your Honor. Of course this is rebuttal evidence. This was not meant to be a part of our case-in-chief. It's offered in rebuttal to testimony that Dr. Chambers made regarding this placement of advertisements in the Adult Video Network.

We did ask him about that on direct examination, and if his testimony was consistent with what we had found out, there would have been no need for rebuttal evidence, but rebuttal evidence, of course, is introduced to rebut evidence that comes up during the testimony, and we weren't planning on introducing this

during our case-in-chief except when it contradicted what he said.

DR. CHAMBERS: My evidence was also rebuttal, and I just read that, and I have two things. In fact, you have two things that contra -- that's opposite to what's stated here. So my evidence was rebuttal evidence. That was not admitted.

Why is it okay that you introduce yours? That is my question. If it was not introduced initially, according to the law that was read by Mr. White, when I tried to introduce evidence, I object to it being presented here as well. I cannot be allowed to introduce evidence that support your case but not allow me to do the same for mine.

ADMINISTRATIVE HEARING OFFICER GHUSN: Right. Is that your response: It's rebuttal evidence and what he offered was not rebuttal evidence?

MS. MOONEYHAN: Right. And he was trying to offer this in his case-in-chief, and it wasn't as -- This is to rebut evidence that came about during direct examination.

DR. CHAMBERS: And mine was to rebut your evidence to show the proximity of Ms. Carden to my exam room.

MS. MOONEYHAN: Your Honor, may I ask that Dr. Chambers be directed to allow you to make your ruling before he argues back? I've tried to be careful in that regard, and I believe Mr. White has too. I would like to hear your ruling before Dr. Chambers repeats his arguments.

ADMINISTRATIVE HEARING OFFICER GHUSN: And I appreciate the actual back-and-forth because he has a point. And I understand and I've tried to adhere at least loosely to the rules of evidence. And as far as and I'm not going to go revisit each piece of evidence. But, for example, the last one, the text message, how does that compare to this? I mean, and I don't want to be a lawyer is the problem, Dr. Chambers, so --

DR. CHAMBERS: It was.

ADMINISTRATIVE HEARING OFFICER GHUSN: I have -- Hold on. So I have questions. And, you know, it's a fine line, Ms. Mooneyhan, with him not being represented as well.

MS. MOONEYHAN: Yes, I understand Dr. Chambers is not represented, but all of the evidence that's going to be presented in a case-in-chief or that you believe he may rely on in cross-examination needs to be produced when we do the prehearing. My understanding

-- I did research --

ADMINISTRATIVE HEARING OFFICER GHUSN: I'm sure you did.

MS. MOONEYHAN: -- Nevada cases. Rebuttal evidence is evidence that -- Rebuttal is different than, for example, information that you may use on cross-examination. Rebuttal evidence is evidence that comes -- that basically contradicts information that came about during the testimony.

This information -- we had this information, but we weren't planning on relying on it at all because we believed that the testimony would be consistent with what this information showed, but it was not. So I would like to offer it now because it bears on Dr. Chambers' credibility.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Give me a moment here.

DR. CHAMBERS: May I say something?

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes.

DR. CHAMBERS: I have two pieces of documents that contra -- that counters what I just read and my evidence regarding the text rebuttal to Casey's memory or lack thereof. Again, my fully drafted --

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay.

So you're saying you have pieces of evidence --

DR. CHAMBERS: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN:

-- that relate to what you just read?

DR. CHAMBERS: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. The other -- as I'm thinking this through, is you're not done with your testimony. We're not done with Dr. Chambers. And, you know, even though he's representing himself, he would be able to introduce evidence as rebuttal as well and then rule on it at the time. Different circumstances than when he introduced it before.

My approach in these hearings is less isn't better. And unless it's completely prejudicial, it's not probative, it's not relative or it's immaterial, it comes in. And if there's a hard-and-fast rule of evidence that I must adhere to in order to streamline it, then I will adhere to it. So there may be -- and I understand that this is unbalanced as Dr. Chambers isn't represented.

Again, I have to be careful not to be a lawyer here and to be a hearing officer, but I need what will be helpful to me, and so Dr. Chambers can re-introduce some of this as he completes his testimony

with the same circumstances, and we could revisit it then, some of these other pieces of evidence. And we could look at it a piece at a time to see if it checks the boxes because technically, legally speaking, Ms. Mooneyhan is correct. And as such, that evidence would come in.

And I know you're at a disadvantage, Dr. Chambers. But again, you're not complete -- your testimony isn't complete. And I want anything that may help me reach conclusions to make my recommendations. So at this point, I'm not going to argue it. Dr. Chambers, okay. She's right as a matter of law, and it will come in and you'll have an opportunity to reintroduce your pieces of evidence and to contradict this, okay? Do you understand?

DR. CHAMBERS: And how do I get my evidence -- Well, you do have both of them actually.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. So that may simplify things. I don't want to get ahead of ourselves. You're coming back on as a witness, and we could deal with it there, but okay. But if it's there, let me know that it's there so I don't have to deal with it later on. We're good with time, and I don't want to blow that because I know we have a couple of hours left,

okay? So it's coming in and --

MS. MOONEYHAN: Okay. Thank you, Your Honor. I will have this --

ADMINISTRATIVE HEARING OFFICER GHUSN: And I'd like to thank you both because it's a civil discussion, and I want you to understand where I stand on this as far as evidence coming in. So thank you both for that discussion.

Ms. Mooneyhan, go ahead.

Q (BY MS. MOONEYHAN:) Thank you. Ms. LaRue, as part of your investigations in this matter, you're aware that Dr. Chambers indicated that in part, he was seeking photographs for advertisements in the AVN program; is that correct?

A Yes.

Q And did you seek to confirm that information?

A Yes.

Q And how did you do that?

A I went to the AVN Network portal and sent a request for public information or information about their publications, and I received an email back from the vice-president of the AVN Media Network stating that she would require me to provide her with the licensee's name, so I did. I sent an email providing Dr. Chambers' name,

and she responded back to me that he had inquired once in 2016 about an expo with AVN but never submitted any artwork.

Q Okay. So did that square with the information you had been given up to that point in time?

A No, it was contradictory to the responses that Dr. Chambers put in his responses to the board in regards to the patients and the allegations that I made with Patient B and Patient C.

Q Did you ask AVN -- Did you follow up with them to confirm that that was -- that the information they had provided was correct?

A Yes. I followed up again -- the first email that I sent was in June of 2022. I followed up again in April of 2023, asking the vice-president again via email the same question if she could verify the information. I was a little bit more specific about what publications that I was looking for, and her response was the same, that previously she had told me that he'd inquired in 2016 and never submitted any artwork.

Q Do you have in front of you what we've marked as exhibit for identification as Exhibit 17? It has page numbers NSBME 0236 through NSBME 0241.

A Yes.

Q And can you describe that document?

A 0236 is the last inquiry that I made in April. 0240 -- 0240 and 0241 are the initial copies of what you submit when you go onto AVN's website, they have a box that you can submit for information to answer those questions, and then it starts Ms. Newman vice-president of the AVN Media Network. Her response to me was they asking me to give her the provider's information, so I did. I provided her with Dr. Chambers' name and she responded back. Those are pages 239 and 238, and then the email chain goes all the way through to the first at page 236 and 237.

Q So does this document represent a true-and-correct copy of the email conversation you had back and forth with Ms. Noonan?

A Yes.

MS. MOONEYHAN: Move to admit, Your Honor.

ADMINISTRATIVE HEARING OFFICER GHUSN:

Dr. Chambers, you've stated your objections already. Do you have any other objection?

DR. CHAMBERS: I object, but I want to know when will I be able to cross-examination Ms. --

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes.

DR. CHAMBERS: -- LaRue?

ADMINISTRATIVE HEARING OFFICER GHUSN: Of course. Yes.

DR. CHAMBERS: Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: Of course. So Exhibit -- IC's Exhibit 17 will be admitted into evidence.

Q (BY MS. MOONEYHAN:) Thank you. Ms. LaRue, have you had any further communications with Ms. Noonan?

A No.

MS. MOONEYHAN: I have no further questions. Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you, Dr. Chambers.

DR. CHAMBERS: First of all, Ms. Ghusn, Ms. Noonan was not my contact at AVN. It was a Ms. Sarah Harder.

ADMINISTRATIVE HEARING OFFICER GHUSN: What I'm going to ask you to do -- and again, we're loosely with the rules of evidence, but at this point, I'm going to ask you to try to adhere to asking questions.

DR. CHAMBERS: Will do.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. And then you'll have an opportunity again to jot it down to --

DR. CHAMBERS: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: -- to testify on your own and make argument.

DR. CHAMBERS: Will do.

ADMINISTRATIVE HEARING OFFICER GHUSN: Right now, she's here for you to cross-examine.

CROSS-EXAMINATION

BY DR. CHAMBERS:

Q Ms. LaRue, can you go to Section 9, Exhibit H: Chambers 026?

A I don't have that binder in front of me. I only have Exhibit 17.

Brandee, do you want me to come into the room?

DR. CHAMBERS: I submitted two advertisements that were produced by AVN.

THE WITNESS: I'm sorry. I wasn't given a copy of those two exhibits, so if you don't mind, I'm right around the corner from where Brandee is.

ADMINISTRATIVE HEARING OFFICER GHUSN: That's what we're to going to do, Dr. Chambers, so she can take a look at what you're talking about.

THE WITNESS: I don't have in front of me

what you're stating, so --

ADMINISTRATIVE HEARING OFFICER GHUSN: Ms. Mooneyhan, let's not speak over everybody. Everyone stop. Ms. Mooneyhan?

MS. MOONEYHAN: We can take a one-minute break.

ADMINISTRATIVE HEARING OFFICER GHUSN: Yeah. Just going to be a second. She's going to go down the hall so she can see what you're talking about, Dr. Chambers. Okay?

DR. CHAMBERS: Ms. Ghusn, can I email you guys two things since I have one page to one of them but I don't know the page number to the next one?

ADMINISTRATIVE HEARING OFFICER GHUSN: I don't know if that's necessary. Are these exhibits that are already in the binders?

DR. CHAMBERS: Correct. But I want to make sure we're looking at the same things. And also, I would like to introduce a copy of the awards ceremony brochure with my ad in it that was produced by Avian.

ADMINISTRATIVE HEARING OFFICER GHUSN: Ms. Mooneyhan?

DR. CHAMBERS: That I did not previously -- I gave it to my former attorney, but they did not submit

it.

MS. MOONEYHAN: Yeah, Your Honor, as we discussed previously, I think that's probably more appropriate for Dr. Chambers, any information he wants to offer during his testimony.

ADMINISTRATIVE HEARING OFFICER GHUSN: If he wants to question Ms. LaRue about it while she's here.

MS. MOONEYHAN: He can ask her about the things that are already part of the binder, and he can -- I mean, he can ask her about the information he has as well, but I just submit that she's given you all of the --

ADMINISTRATIVE HEARING OFFICER GHUSN: He can call her as a rebuttal witness too, right? Okay. Let's stop. Ms. Mooneyhan, he could call her as a rebuttal witness and introduce it then; correct?

MS. MOONEYHAN: Well, he could try. I'm not sure Ms. LaRue can verify information from the Adult Video Network. She can say it appears to be. She doesn't work for the Adult Video Network. She's testified as to the information she received directly from the Adult Video Network.

ADMINISTRATIVE HEARING OFFICER GHUSN: So the best way to do this, Dr. Chambers, is if she has no

knowledge of this, you can testify to it. And if you need to recall her as a rebuttal witness, she's in the building.

DR. CHAMBERS: But she's talking to a woman at AVN I never communicated with. I don't know who this woman is. And she's introducing evidence from Ms. Noonan, and my contact is Sarah Harder. I have a printed brochure.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Stop. Stop. You can testify about that --

DR. CHAMBERS: Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: -- okay? And you can ask her questions about that. And it sounds like that you have evidence to introduce.

DR. CHAMBERS: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: So right now, I would just like you to ask questions about her testimony and --

THE WITNESS: I'm going to head into the boardroom where Brandee is so I can look at what he's talking about, and then she can ask me questions from there so I can see what's she's talking about. Okay?

ADMINISTRATIVE HEARING OFFICER GHUSN: I'm going to allow her to walk down to the conference room,

Dr. Chambers, so we'll take a brief recess.

DR. CHAMBERS: No problem.

THE WITNESS: Okay. There we go. Okay. I'm ready. So if you could refer back to the pages you were asking about, I'd be happy to find them in the binder.

DR. CHAMBERS: Okay. So one of them is Chambers 025.

ADMINISTRATIVE HEARING OFFICER GHUSN: Which exhibit is that?

DR. CHAMBERS: Exhibit G025.

THE WITNESS: Okay.

DR. CHAMBERS: That's one of them.

ADMINISTRATIVE HEARING OFFICER GHUSN: Hold on. Okay. Thank you. Okay.

Q (BY DR. CHAMBERS:) That's an ad you're looking at; correct?

A Yeah, it looks like an advertisement. I've seen it before.

Q Okay. And there's another one. I don't remember where it was, but Mr. White had mistakenly thought it was the patient in question, Patient B or C. There are two ads that I submitted into evidence: One with the patient laying down, with the model laying down on her tummy, and the other with her standing up with her

hand over her head or behind her head.

A Okay.

Q Do you have those two? I have the one.

A I have the one you just mentioned. Hold on. I don't see the second one. I only see 025, but I think it's --

Q I think it's mixed up in one of the patient's --

A Yeah. Yeah.

Q Do you have it?

A Yes, I have it.

Q Okay. That was produced. Those two pictures were produced by AVN. Ms. Noonan had mentioned those two pictures, those two ads?

A Well, there's no -- there's nothing on these two advertisements that state that AVN is involved in any way at all, so I --

DR. CHAMBERS: Okay. Ms. Ghusn, when can I show the awards brochure for AVN?

ADMINISTRATIVE HEARING OFFICER GHUSN: So the issue here, if you're to do it, is you didn't introduce it in your case-in-chief. If we're going to get technical about it, perhaps we'll discuss this without --

DR. CHAMBERS: Well --

ADMINISTRATIVE HEARING OFFICER GHUSN: No interruptions. As far as checking the boxes, Ms. Mooneyhan, is because he has cross-examination coming up, and then he could do redirect, so you'll have an opportunity then.

MS. MOONEYHAN: I would submit that's the appropriate time to be explored. Ms. LaRue has testified she can't tell if they came from AVN or not, so he can address that during his testimony and cross-examination.

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes. I'm thinking out loud as you can hear and hoping to not drag this out as well, getting bogged down, but that would be the correct way to do it, Dr. Chambers.

DR. CHAMBERS: Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: You're not done yet. You're going to have cross-examination.

DR. CHAMBERS: I do have questions.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. So you want -- and I didn't get that second one. I got Exhibit G jotted down, but I was going to ask about the next one.

DR. CHAMBERS: It's mixed in with one of the other patients.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay.

MS. MOONEYHAN: Your Honor, it's in IC Exhibit 10, page NSBME 0144.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you. And has that been admitted?

MS. MOONEYHAN: It has.

ADMINISTRATIVE HEARING OFFICER GHUSN: So he can ask questions about that.

THE WITNESS: Should we clarify that this was submitted as part of Patient C's medical records?

MS. MOONEYHAN: Well, yes. That was -- Ms. LaRue was just pointing out this was submitted as part of patient, you know --

DR. CHAMBERS: I think it got mixed up with it, but it was an example of my ad ran in AVN. So I don't know why --

ADMINISTRATIVE HEARING OFFICER GHUSN: I'm going to allow it. And, Dr. Chambers, I'm going to caution you not to speak over people. Wait until we're done, okay?

DR. CHAMBERS: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Ms. Mooneyhan, you had said -- or Ms. LaRue, I couldn't hear -- that it was Exhibit 10. It was mixed in and it got mixed up. So it's in.

MS. MOONEYHAN: Yes. It's been admitted. I don't believe it was mixed up. I believe and we can ask Ms. LaRue if she received the records. I believe Dr. Chambers included it in his response to the request for records for Patient C, but --

ADMINISTRATIVE HEARING OFFICER GHUSN: If I allow him to ask questions about this, we're going to be doing this all afternoon.

MS. MOONEYHAN: Of course. I just want to clarify that it wasn't mixed up, that that is what he provided, and he can ask Ms. LaRue questions about it to the extent that she knows about it.

ADMINISTRATIVE HEARING OFFICER GHUSN: Dr. Chambers, you can ask questions about IC Exhibit 10.

Q (BY DR. CHAMBERS:) And, Ms. LaRue, was that exhibit submitted as a part of Ms. -- of Patient B or C's record or an example of the advertisement?

A This came as part of the records. When you sent your response and the medical records for Patient C, this was along with it. It came right in with the original. This is presented exactly how it was received by you from me when you sent it to me.

Q I believe it was sent in to address the AVN ad as part of Patient C's stuff. Anyway, I'll save

everything else for when I'm able to introduce the evidence.

ADMINISTRATIVE HEARING OFFICER GHUSN: All right. Well, this is your opportunity to ask her questions about this one. This is in.

DR. CHAMBERS: Well, I don't know who Ms. Noonan is. She's not the one I dealt with from 2013 until 2019.

ADMINISTRATIVE HEARING OFFICER GHUSN: Well, okay then. You can -- okay then. No more questions about Exhibit 10, page 0144; correct?

DR. CHAMBERS: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. That one is in. We can check that off if you don't have any more questions for Ms. LaRue about that exhibit.

DR. CHAMBERS: I have no questions for her.

ADMINISTRATIVE HEARING OFFICER GHUSN: Any more questions or about that exhibit?

DR. CHAMBERS: About that exhibit.

ADMINISTRATIVE HEARING OFFICER GHUSN: Do you have any other questions for her?

DR. CHAMBERS: Nothing at all.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. And you understand you can testify as to your -- directly

about who you had contact with or whatever, right?

DR. CHAMBERS: I do.

ADMINISTRATIVE HEARING OFFICER GHUSN:

Ms. Mooneyhan, anything?

MS. MOONEYHAN: I have no further questions.

ADMINISTRATIVE HEARING OFFICER GHUSN: Any possible recall? I know she's going to be there, so --

MS. MOONEYHAN: No. I believe Ms. LaRue can be excused.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Dr. Chambers, at this point --

DR. CHAMBERS: No, I will not be calling her.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Thank you, Ms. LaRue, for your time.

THE WITNESS: Thank you. I appreciate it.

ADMINISTRATIVE HEARING OFFICER GHUSN: And for your long journey down the hall.

THE WITNESS: No problem. Thank you very much.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you for being available. Okay.

All right, folks. So we have the rest of Dr. Chambers and we have Dr. Goodman. I believe jumping on to the rest of Dr. Goodman's testimony would be the

most expedient thing to do. We're right on the dot. It's 3:30. Unless anyone has any better ideas, and then we'll leave the rest of Dr. Chambers for the last bit of testimony.

Ms. Mooneyhan and, Mr. White, hello again.

MR. WHITE: Hi.

ADMINISTRATIVE HEARING OFFICER GHUSN: Are we good with that?

MS. MOONEYHAN: Just to clarify, we're doing Dr. Goodman now?

ADMINISTRATIVE HEARING OFFICER GHUSN: That's what I'm asking. Does that make sense to you?

MS. MOONEYHAN: Yes.

MR. WHITE: Yeah, that will work. And I think we're on cross-examination of that, right?

ADMINISTRATIVE HEARING OFFICER GHUSN: We are.

So, Dr. Chambers, are you reaching out to him now?

DR. CHAMBERS: I am.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: We're taking lots of little breaks. Is everyone okay right

now?

MS. MOONEYHAN: Can we take a three-minute break until 3:30?

ADMINISTRATIVE HEARING OFFICER GHUSN: Sure.

(Recess.)

ADMINISTRATIVE HEARING OFFICER GHUSN: Dr. Goodman came back, and I will remind you you remain under oath; correct?

THE WITNESS: I understand that.

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes. Thank you. And Mr. White is back.

MR. WHITE: Yes. Are we all ready to go?

ADMINISTRATIVE HEARING OFFICER GHUSN: We are.

RECROSS EXAMINATION

BY MR. WHITE:

Q Good afternoon, Dr. Goodman. You specialize in labioplasty; correct?

A I specialize in -- correct. One of the procedures I do is labioplasty. I specialize in gynecologic surgery and female genital cosmetic and reconstructive surgery, so you're close.

Q And the O-Shot?

A I perform the O-Shot.

Q And you've developed some courses; is that correct?

A That is.

Q And you are, I would assume, proud of those courses and certifications that you have developed and teach?

A Yes, that is correctly stated. I am.

Q And you, I think, in what was designated as your CV before but no longer is your CV, which is Exhibit R?

A My CV is updated over time.

Q Right. Right. And if you recall, back on the second day of hearings back in May, we didn't have your CV. No one had it, and that's why you're here today because we had to continue your matter until you had a chance to look at your CV?

A And thank you for that.

Q No, no problem. And so what was originally designated as your CV, which is Exhibit R, I believe, I think it's Exhibit R. Hold on. Sorry. I want to get this right. Yes. Exhibit R. If you'd turn to page 113, Chambers 113. Do you have your binder?

A I have no binder.

Q You do not have a binder?

A No, I have no binder and I can't access my old CVs because I basically add to them, update them. I can --

Q Let me just read to you what it says. I believe it comes from your website.

A My website has been recently updated because I've changed office locations, and I am no longer with an associate that I was with. So my website has been very recently updated.

Q Okay. Well, at the time of this matter and what was sent to the IC as one of the exhibits the IC --

A What is that abbreviation?

Q Sorry. Investigative Committee.

A Okay. Thank you.

Q That's who Ms. Mooneyhan and I represent. So as a part of the exhibits that were sent by Dr. Chambers' former counsel, I would represent to you that it says here -- and this might jog your memory -- it says: Since 2010, he has trained surgeons in techniques via both format -- excuse me -- formal in-office, mini fellowship training programs and through his training entity: The Labioplasty and Vaginoplasty Training Institute of America, Incorporated. Do you remember that?

A And that continues.

Q Yeah. Oh, yeah. I'm just reading one small part.

A Yeah.

Q You or whoever wrote this -- and you approved it. You called this a mini fellowship. Is that correct?

A I wouldn't represent it as such. It depends on your definition of "fellowship". Some other trainees call their programs -- their two or three-day programs mini fellowships, and we sort of used to call them that. And I don't like that designation anymore because it really represents it as more than it is.

Q Yeah, because, I mean, you doctors work very hard to achieve a fellowship, an actual fellowship. That's a lot of work; correct?

A And I have trained a fellow formally in an 18-month program. The programs that I train in, I train in many different, you know, modalities. Sometimes I'll do very short half-day courses, I'll do one-day courses, and I'm very clear that these short courses do not prepare someone for operating in this field.

I feel and others feel: Dr. Matlock, Dr. Alanstod, several others feel that in two to three days, if you take someone that already is savvy in the

field, they can begin doing work in the field so long as they're not getting in over and above their head at the beginning. So the term "mini fellowship" is a very squiggly term that's used differently by different people. It depends on your interpretation of the word "mini", but I think it would be misrepresenting it to call it a fellowship, the two and three-day courses. Does that answer your question?

Q You've already answered my next question which is I was going to say this master's course is two days; correct?

A Two to three days. It's accredited. It's AMA category one accredited, so these aren't -- these courses are accredited for 14.5 hours. They're altogether about 18 hours, but some of the times we're eating meals, we're informally talking. It's accredited for 14.5 hours.

Q Correct. And you did you weren't a part of it, but I did go through that with Dr. Chambers, and out of the three CME's or -- excuse me -- slash certificates that he sent us, yours was the only one actually that is ABA accredited for CME's, for CME hours just so you understand.

A We worked hard on that. It's difficult to be

accredited. You can't have any commercial content. When I was accredited, a representative of the accrediting organization sat in on the whole course, so it's a lot of hoops to jump through.

Q Fair. Sure. Absolutely. So I think you'll agree with me and I think you said it was squiggly. Your wording was squiggly. You referred that if you had the opportunity to change this because it is misleading, you would call it a mini fellowship, would you say?

A I don't believe that my CV presently calls it that.

Q No, no. I'm referring to what was sent originally as your CV mistakenly. I know you don't know that, but it's really, I think, just a printout if your website.

A Yeah. And I haven't seen it, Counsel, and so can't comment on it.

Q Yeah. And I unfortunately, you don't have a binder in front of you, so you don't have anything to go on, but I can assure you and represent that everybody else is looking at the same thing, and it's something that comes from you and is definitely you in the picture, and it is Dr. Michael Goodman.com. So okay. I'm going to move on from there.

O-Shot and these procedures -- I think it was talked about before -- they're not covered by insurance?

ADMINISTRATIVE HEARING OFFICER GHUSN: Sorry, Mr. White. I was trying to ask a question and --

MR. WHITE: Sorry.

ADMINISTRATIVE HEARING OFFICER GHUSN: -- it was muted. Can you tell me where you're looking at in these materials?

MR. WHITE: Which part?

ADMINISTRATIVE HEARING OFFICER GHUSN: I'm here with the printout.

MR. WHITE: Okay. So if you look -- Sorry. Yeah. At the very top of page 113.

ADMINISTRATIVE HEARING OFFICER GHUSN: 113. Okay.

MR. WHITE: It says, "Since 20."

ADMINISTRATIVE HEARING OFFICER GHUSN: Got it. I see it. I got it.

MR. WHITE: Okay. And I was just questioning him about the --

THE WITNESS: And this might be something that really does not represent what I represent myself as. So if I could see that, that would be -- I can answer your question a little bit better.

Q (BY MR. WHITE:) Yeah. I understand, Dr. Goodman. Just understand too that this is what we received which was purported to be your CV, so that's where these questions are coming from.

A Yeah. Well, I can't say anything more because I haven't -- I don't -- I haven't seen what you're seeing.

Q We are literally not on the same page right now, I don't think.

DR. CHAMBERS: Ms. Ghusn, may I say something?

ADMINISTRATIVE HEARING OFFICER GHUSN: I'm going to allow Mr. White -- I don't want to draw this out, Dr. Chambers.

DR. CHAMBERS: It's to help Dr. Goodman.

ADMINISTRATIVE HEARING OFFICER GHUSN: No. No. I think if we're in the middle of cross-examination, I will say just for later purposes, Dr. Goodman, it's stated you have 1822, but you can clear that up later on on your own time.

Okay. Mr. White?

Q (BY MR. WHITE:) Okay. And so and I think you said you had mixed feelings that all of these procedures are not covered by insurance. You had mixed

feelings.

A I do. I would like to see some of them covered by insurance. I think they're necessary procedures, but they're cosmetic and they're not covered by insurance, period.

Q Do you feel that something that's not covered by insurance, if you know, do you profit more that way or less if you have cash-only business?

A On a cash-only, obviously more if I have a cash-only business. And I don't accept insurance. Then I don't profit at all if I don't accept the insurance. If I don't buy the car, I can't drive it.

Q True. Dr. Chambers completed your Master's course, as he talked about with you in his direct examination of you, right?

A Correct.

Q And that was completed in November of 2013?

A I don't have the dates. If that's what it is represented, then that sounds about right.

Q Okay.

A I know it was a while ago. That sounds about right.

Q You want the practitioners who attend your course to be properly trained, right?

A I do my best.

Q And you want them to be successful?

A Yes.

Q I would also imagine that you'd want them to be safe.

A Definitely.

Q And I would imagine also that you would want them to -- anybody who attends your course, you would want them to be a good representative of people who attend your course?

A I would hope so.

Q You would probably want your practitioners, the practitioners who attend your class, to represent the very best of the practitioners who are practicing labioplasty and other plastic surgeries of the vaginal region. Would you agree with that?

A I wish them to be competent, so I'm agreeing a little bit lateral to what you said.

Q Fair enough. You realize -- and I think we talked about it before a little bit -- you realize Dr. Chambers used words like with patients that are involved in this matter, he used words like fisting and fuck the camera?

A Fisting is a word. In sexual medicine, if

you use straight medical words like cunnilingus, they don't know what we're talking about. We say when your partner goes down on you, they know what we're talking about. So it's a thin line using words that a patient can relate to and not be up on a, you know, high stool and using ivory tower words. So if we're talking about a sexual activity that involves putting large objects in the vagina, this seems words that our patients use.

Q How about what's wrong with the option of saying: I tried to put my whole hand inside of you?

A Nothing wrong. We are talking about semantics here, Counsel.

Q I would say that fisting almost qualifies something like cunnilingus. People don't know what that means. There's a lot of people that don't understand that as a sexual term or anything. Wouldn't you agree?

A You might not, but many people do. We all come from our own place of understanding. I haven't used that term very much because it just hasn't come up in my practice very much.

But if I had to talk about fisting, I feel -- and I don't have patients in front of me right now -- if I'm using the word "fisting," I'm not quite sure that my patient would know what I'm talking about. If I use the

term putting your whole hand in the vagina, they might not. If I use the term "cunnilingus," they might not. If I use the term "go down on," they will. So I'm not sure what you're getting at. I'll do my best to answer your question, but I'm not sure your path here, Counselor.

Q That's okay. You understand then the allegations are that Dr. Chambers referred to what he had tried to do is fisting. The patient didn't bring it up. That patient didn't know what fisting was. Do you understand that?

A I understand that that's the allegation, Counselor.

Q So would it change your opinion if the patient doesn't bring it up, would you use a word like that if the patient hadn't brought it up?

A Please give me a context. It's out of context. I can't help you there.

Q Well, I mean, what if the patient said: I was really uncomfortable. I suffered a lot of discomfort with that last part of the treatment you just did, Doc. What were you doing? Would it be better to say: I tried to insert four fingers?

DR. CHAMBERS: Objection, Your Honor,

speculation.

MR. WHITE: Well, he asked me to speculate.

ADMINISTRATIVE HEARING OFFICER GHUSN: Yeah. Yeah. I'm going to sustain it. We're getting into like multiple layers of hypothetical and speculation here.

MR. WHITE: Are you going to sustain the objection?

ADMINISTRATIVE HEARING OFFICER GHUSN: Uh-huh. You can ask it in a different way.

Q (BY MR. WHITE:) Okay. If the patient said: What were you putting up there? If they asked you what were you putting up there because it was really uncomfortable, would you say my fist? I fisted you?

A I'd probably say my hand, but someone else might say their fist. If I'm doing this, this is a hand. If I'm doing this, this is a fist. And diameter might be similar. I would probably use the word "hand," but that doesn't mean that another word can't be used.

Q Doctor, when was it ever appropriate because you had talked about before -- Let me kind of preface this question. You had talked about before how your fingers are, I think, a centimeter and a half in diameter above the knuckle?

A Correct. Approximately, yes.

Q So how would you ever measure somebody you definitely said you wouldn't fist somebody for measurement purposes or even refer to it for measurement purposes, right?

A I am not an expert in fisting.

Q No, I'm not asking you to be.

A And I'm not the person to answer these questions. I'm not sure why you're asking them.

Q Because they were brought up in your direct examination, so I'm going to explore that.

A And how --

Q Let me ask this. Let me ask this, Doctor. Did plaintiffs or did defense counsel, which is in pro se, bring up the term fisting? In other words, I'm asking the hearing officer whether that was brought up and whether this line of questioning is appropriate. I believe you can only follow that line of questioning if it was brought up.

ADMINISTRATIVE HEARING OFFICER GHUSN: And I will have to -- I'm looking back at my notes which of course aren't complete like the court reporter's.

DR. CHAMBERS: May I answer that?

MR. WHITE: No, no, no. Hold on.

THE WITNESS: Did Dr. Chambers ask me about

fisting?

ADMINISTRATIVE HEARING OFFICER GHUSN: Mr. White, are you representing that's -- I'm looking. I'm looking here.

MR. WHITE: I didn't write down time, but in my notes, it talks about fisting as far as not being a form of measurement or he would --

THE WITNESS: Which was brought up.

ADMINISTRATIVE HEARING OFFICER GHUSN: That's what I'm -- yeah. I have and of course this is not exact language. Fisting is not used for measurement. Fisting is used as a term for measurement, and then I have an incomplete sentence. It breaks down the perineal, and I couldn't get the rest of the sentence. So it was brought up on direct.

Q (BY MR. WHITE:) Okay. Yeah. I have also that it could break down muscles. I just kind of took down a quick note.

Doctor, my question is: You had just shown your hand like this with the four fingers. This would be a fist, and we could all agree what a fist is. When would it ever be appropriate, if at all, to do this to somebody in a gynecologic practice with one of your patients, a fist?

A Personally, I wouldn't do that, I don't believe.

Q Okay. Dr. Goodman, you're aware that Dr. Chambers did not do any surgeries for these three patients; correct?

A I hadn't been informed one way or the other, so now I'm so informed.

Q And you can say -- this is yes or no. You've never checked to see if Dr. Chambers knows how to do labioplasty at his practice, have you?

A I have not.

Q And you've never checked any of his charts at his practice, have you?

A Only the chart records from Patient A.

Q Oh, correct. Yeah. But not since he's gone to your class as a master course, right?

A No, I haven't.

Q Or any of his records, right?

A No, I haven't. The same way a residency director hasn't checked the records of their residents when they're in practice. Pretty much the same as someone who trains, who educates doesn't necessarily follow the person to their practice and look at their records and look over their shoulders. And that's

unfortunate that we're not able to do that, but such is the situation with every residency and pretty much every training program. We do our best to train, and then we let people go and hope they'll do their best.

Q Fair enough. But if we're going to compare residency to your two-to-three-day course, you have a lot more exposure to your residents than you have with these doctors that show up for your short course?

A Yes and no. I'm on the staff of training programs and sometimes we have very little exposure, especially if we're in clinical faculty. But certainly as a residency director, you have far more training, far more observation.

Q Now, I was going to just by habit say I need you to turn to a certain page, but --

A I don't know.

Q -- I'm going to have to try to represent what's in --

A May I speak for a minute?

ADMINISTRATIVE HEARING OFFICER GHUSN: Mr. White, what were you looking for?

Wait, Dr. Goodman. Let's try to clear this up.

What are you doing, Mr. White? Are you

looking for a --

MR. WHITE: I found it, but he doesn't have the binder, so I'm going to have to read it to him, I suppose.

THE WITNESS: Or you can go up on the screen. I'm not sure if you have that capability.

MR. WHITE: We don't have an Elmo in here or anything, I don't think, so no.

ADMINISTRATIVE HEARING OFFICER GHUSN: No. Screen share on Zoom is what he's referring to.

MR. WHITE: We're doing this on a laptop. I don't think we have that ability, no. I'm getting a head shake no.

ADMINISTRATIVE HEARING OFFICER GHUSN: Is this an admitted exhibit?

MR. WHITE: No. It's actually one of Dr. Chambers' exhibits of the ACOG Committee Opinion that he read before, and it was just two short paragraphs that he read before: Chambers 105. And it's --

ADMINISTRATIVE HEARING OFFICER GHUSN: We'll get there.

MR. WHITE: Yeah. I will tell you it's Q, Exhibit Q.

ADMINISTRATIVE HEARING OFFICER GHUSN: So I

have to translate because the tabs are numbered, but his exhibits are lettered, so hold on.

MR. WHITE: Sorry. The number is 17 because we have numbers. Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: Well, I did that myself, so hold on. Thank you. All right. I'm there.

Q (BY MR. WHITE:) So, Dr. Goodman, you had said before that you are a member of ACOG; correct?

A I have been a member of ACOG. I resigned from ACOG approximately two years ago or I became -- didn't resign. I became inactive. I stopped paying dues two years ago.

Q Okay. Would you agree that during that -- or maybe you still agree. Would you agree that that is pre-eminent guidelines for gynecologists and OB-GYN's?

A For general OB-GYN. For cosmetic gynecology, not at all.

Q Well, so I'm looking at what's called ACOG Committee Opinion. Committee on Gynecologic Practice. It was number 795, and it was written or at least submitted and published in January 2020. So and I will read you what it says. I want to know if you agree or not because this is ACOG, their committee opinion. This

is in the abstract.

It says: Women should be informed about the lack of high-quality data that support the effectiveness of genital cosmetic surgical procedures and counselled about their potential complications including pain, bleeding, infection, scarring, adhesions, altered sensation, dyspareunia and need for reoperation. That is just a snippet of that, but do you agree with that?

A I agree with it. And the patients I operate on are so informed. And the reason that I got into doing research and publishing in this area has to do with ACOG and the fact that ACOG has their head in the sand, the fact that ACOG feels that gynecologists that are at home in this area shouldn't be doing plastic work, and we've had a big argument.

I've offered to train for ACOG. I've offered to lecture for them. There's no love lost between myself and ACOG. ACOG, I happen to be plaintiff's expert for a number of medical/legal actions, and every single female genital mutilation that I have seen has been done by genital OB-GYNs that are Board certified by ACOG and have not been trained as Dr. Chambers has, ACOG does a disservice to women by burying their head in the sand.

I am very aware of the document that you are

quoting from. I'd have to go to another screen. I've got it on my publications. I've got it on my computer. Yes, this data exists, but it exists in journals. The ACOG chooses not to look at. It exists in plastic surgery journals that have impact factors as great as ACOG's journals. It exists in the Journal of Reconstructive -- of Plastic and Reconstructive Surgery. It exists in the Journal of Sexual Medicine. It exists in the Aesthetic Surgery Journal, but ACOG has chosen not to even look there. So that's my comment.

Q Okay.

A And that's why I stopped paying dues.

Q I was going to ask you that. Okay. So and if you go down to the very end of the abstract, I'm just telling you I know you don't have it in front of you, but the end of the abstract says:

"Patients should be made aware that surgery or procedures to alter sexual appearance or function, and then in paren (excluding procedures performed for clinical indications such as clinically-diagnosed female sexual dysfunction, pain with intercourse, interference in athletic activities, previous obstetric or straddle injury, reversing female genital cutting, vaginal prolapse, incontinence or gender affirmation, surgery)

are not medically indicated pose substantial risk, and their safety and effectiveness have not been established?"

Is it your same answer as before that you do not agree with ACOG on that?

A I totally do not agree. There is a rich data about the safety, a rich data in many journals that ACOG has just chosen to ignore. ACOG will say that breast augmentations are fine. Is there a medical reason for breast augmentations? Of course there is. ACOG has their head buried -- I'd say it kindly -- in the sand. I would say it a different way if we were having a drink together.

ACOG chooses not to look at this literature. It is there. And if counsel wishes, if the hearing officer wishes, I can send you that very rich literature in -- we're not talking about open-access journals. We're not talking about journals that have an impact factor of one or two. We're talking about very respected journals, but they happen to be journals of sexual medicine, they happen to be journals of plastic and cosmetic surgery. And ACOG has decided they don't want to look at those journals. Certain people in ACOG have decided that. And this opinion is not just my opinion.

It's shared by many OB-GYN's, and it's shared by virtually every cosmetic gynecologist.

And thank goodness there are individuals such as Dr. Chambers who have chosen to get trained instead of just saying well, this is my area, the vulva, I know how to do this. You just sort of put a clamp on it and cut it.

I'm the guy that sees these poor women that have poor self-esteem or have functional issues with the labia getting trapped with intercourse or experiencing chaffing, and then they go to see their general OB-GYN who has not been trained in this and goes ahead and maims them. And these poor women then, after finally deciding to do something about it, are so far worse off, it's devastating. And ACOG is responsible. ACOG is responsible for that.

And individuals such as Dr. Chambers and many others who have decided to go ahead get the training, do their due diligence are not acknowledged by ACOG. And I hope that you and the hearing officer would understand that.

Q I'm going to ask you if you wrote that. And this is, by the way, from the same number 795 ACOG Committee Opinion. Did you --

ADMINISTRATIVE HEARING OFFICER GHUSN: One at a time, please, Dr. Goodman. One at a time so I can hear both of you so the court reporter can get it down. Thank you.

Q (BY MR. WHITE:) Did you have a part in writing -- It refers to you on page 110 of Dr. Chambers' documents. Do you refer to yourself as MP or Goodman MP?

A Yes.

Q Okay. So do you -- and if this happens to be on page or clarification for everybody else that has a binder, we're looking at page 108 and 110.

A Are we talking about a reference, Counselor?

Q Yes.

A Okay. Yeah. In reference to this, the names that are listed, last name and then first two initials. So you would be White, D, for example.

Q Okay. So did you write this? Is that what they're referring to you? And it says here at the top left of page 108: "Although this study."

ADMINISTRATIVE HEARING OFFICER GHUSN: Sorry, Mr. White. You're giving me pages. Are we still looking at Exhibit G, Q and 17?

MR. WHITE: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank

you.

MR. WHITE: Absolutely. May I go ahead and read this really quick --

ADMINISTRATIVE HEARING OFFICER GHUSN: Yes.

MR. WHITE: -- to see if it refreshes Dr. Goodman's memory? Okay.

THE WITNESS: Are you reading from the ACOG bullet or are you reading a reference?

Q (BY MR. WHITE:) I'm reading from the ACOG. And there's a footnote, and it has your name attached to the footnote.

A I remember that reference. I was quoted, but I was improperly quoted, and I spoke with ACOG about that. But go ahead.

ADMINISTRATIVE HEARING OFFICER GHUSN: Where is it? Sorry. I see page 108 and page 110. I don't see specifically. Oh, here. I see it. Okay. I got it.

THE WITNESS: I believe it might be the Aesthetic Surgery Journal. Go ahead and tell me the reference.

Q (BY MR. WHITE:) Okay. Let me just read it, and maybe we can move on from there.

A Before -- I'm going to interrupt for a moment so I can understand what you're going to read. Are you

reading -- if you could read me the name of the reference, it will say Goodman MP -- there might be others and the name of the article -- then I'll know what you're talking about.

Q Oh, certainly. Yes. It says Goodman MP, plastic OJ --

A Right,

Q -- comma, Matlock, DL?

A Got it.

Q Comma, Somopolis --

A Somopolis, yeah.

Q Dalton, TA.

A I believe this is the first article we wrote on genital plastic and cosmetic surgery and body image. I believe it's a body image article. I think it was in the American Journal of Cosmetic Surgery. It will say near the end what the name of the journal is. It will be abbreviated.

Q It says: Evaluation of Body Image and Sexual Satisfaction in Women Undergoing Female Genital Plastic/ Cosmetic Surgery; Aesthetic Surgery Journal 2016. And it --

A Okay. That's the big article. Yes. That's the 120-page article. There was a shorter article first

that didn't really -- wasn't powered high enough, and so then we did a research for about three years and gathered a lot more data. And I am familiar with the article.

Q So did you write this? I'm going to start now. "Although this study reported high patient satisfaction and enhancement in sexual function, these results should be interpreted with extreme caution given the lack of a comparison group and use of poorly-constructed questionnaires none of which were validated."

A Okay. That's why I took issue with that. That editorializes because number one, we had a comparison group. It had a control group, number one. Number two: All of the testing instruments that were used were validated. So that was straight editorializing by an individual who never read the article.

So I a hundred percent disagree with that because it did have a control group, number one. I'm happy to send you the article. I'm happy to send the hearing officer the article. I can fire that off to you while we're talking that it had a control group.

It was 120 individuals in the study group. They were followed for two years. There were 50 individuals in the control group. All of the instruments

-- questionnaires are called testing instruments medically. All of the testing instruments were validated. So that was straight editorializing, and that's why I stopped paying dues with ACOG. Understand a little bit what ACOG is about.

Q Okay. Thank you, Dr. Goodman. I'm getting down to it. I just have a few more questions, I think.

A Would you like me to send a copy of that article? I can get that to you.

Q No. We're okay, I think. I think you've got your point across.

A Okay.

Q Dr. Goodman, you would agree that doctors need to continue training in this field of cosmetic gynecological surgery?

A I think any physician continuing medical education is wonderful, whether it's reading the journals, whether it's going to Congresses, whether it's taking post-grad courses, whether you're an endoscopic surgeon, whether you're a hand surgeon, whether you're a brain surgeon, whether you're a cosmetic surgeon. It's not mandatory. And to be honest, most physicians don't. But I think that's exemplary, and I encourage it.

Q Do you offer brush-up courses, for lack of a

better term?

A Yes, I just did one a couple of weeks ago. If any of my previous trainees would like to come and go over some specific things, yes. We arrange that individually. And that's only happened twice. Only three of the trainees have come back for additional training.

Q Only three?

A Only three.

Q Okay. So and those other ones, you would -- We have evidence that Dr. Chambers has never come back for any brush-up courses with you?

A He has not.

Q In fact, wouldn't you be surprised to know that he has not brushed up on any of the other courses including antiaging or anything since 2014?

A Statistics that I'm aware of show that over 99 percent of physicians of specialty trained physicians don't go back for additional training which is unfortunate. I'm not talking about as far as going to meetings, but as far as going back to additional training.

Usually once someone is trained, they hit the ground ruining, they're in their practice and they don't

go back. That said, I encourage additional training. I encourage my trainees to go to meetings and so forth. I encourage my patients to do pelvic floor physical therapy. Doesn't mean they're going to do it.

Q Did you do a lot of extra training after you had learned this procedure or these procedures?

A Yes.

Q Do you have any concern that -- Well, let me back up a second. During direct examination, Dr. Chambers asked you a question regarding body image and dysmorphia.

A Body image and what? I'm sorry.

Q Dysmorphia.

A Yes. Body dysmorphia. Okay.

Q And do you have any concerns that there could be doctors out there that sort of create and encourage even more or propagate body dysmorphia by telling a patient, you know, things don't look right down here. Rather than asking them the question like you say, you had said before on direct examination, I would just ask them: Is everything okay down there?

But if somebody tells you: Hey, you've got some problems down there, but, Doctor, you're sitting in a doctor's office and they say I see some problems down

there, you've got a gaping vagina or something like that, do you think that that propagates -- are you concerned that that might propagate the problem?

DR. CHAMBERS: Objection, Ms. Ghusn. What's the point of this question?

ADMINISTRATIVE HEARING OFFICER GHUSN:

Mr. White?

MR. WHITE: What? Is that an objection?

ADMINISTRATIVE HEARING OFFICER GHUSN:

Please, Dr. Goodman. I understand. But, Mr. White?

MR. WHITE: I don't understand the objection.

DR. CHAMBERS: Well, has it been alleged that I did something of the sort? You're asking him a question as if I have done something of such.

ADMINISTRATIVE HEARING OFFICER GHUSN:

Mr. White?

MR. WHITE: Well, there's a question about the timing of when you saw or -- excuse me. I'll address the hearing officer.

Ms. Ghusn, there's a question about the timing of when Dr. Chambers saw the two-page list from Patient A. It has not been -- It is still up in the air really and inconclusive as to when he saw that, and so there could have been -- Let me finish please,

Dr. Chambers. So it's inconclusive as to whether he saw that at the end of her physical exam or somewhere during it or in the beginning. And so the question would be: Are doctors like Dr. Chambers propagating body dysmorphia by telling patients they have a problem down there rather than ask the question: How is everything down there?

ADMINISTRATIVE HEARING OFFICER GHUSN: I'm going to just jump in, Dr. Chambers, because this was covered. I remember it specifically. And I can't say I remember which patient specifically.

DR. CHAMBERS: Patient A.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay -- thank you -- testifying, and you may disagree or have different testimony, but I remember her testifying about the allegations or comments you made, so it's fair ground. I don't think it's a huge issue. I wouldn't spend a lot of time on it, but I do remember it, and so it's fair. It's a fair question.

MR. WHITE: Okay. So I think just to clarify the record, I believe that Dr. Goodman did say yes, it concerns him.

THE WITNESS: I am going to ask you to ask the question again in a way so as not to lead the witness.

ADMINISTRATIVE HEARING OFFICER GHUSN: I don't think he fully answered the question.

MR. WHITE: Well, I'm going to address Ms. Ghusn. I think, Ms. Ghusn, as a fellow member of the Bar, I am allowed to ask leading questions. In fact, I am encouraged to ask leading questions on cross-examination.

ADMINISTRATIVE HEARING OFFICER GHUSN: That is the case, Dr. Goodman.

THE WITNESS: Okay. And I'm allowed to demur. Ask your question.

ADMINISTRATIVE HEARING OFFICER GHUSN: Well, Dr. Goodman, you are under oath to answer if you know the answer.

THE WITNESS: I understand.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay.

Q (BY MR. WHITE:) Does it concern you that doctors out there and perhaps Dr. Chambers, the way he runs his practice, could propagate body dysmorphia by telling vulnerable patients that are there for medical advice and possibly surgery that they have a problem?

A I see no evidence that Dr. Chambers has acted in such a way. It would concern me whether that person was a plastic surgeon, whether that person was an

orthopedic surgeon would ask a question in a leading way. So the answer to your question is it would concern me, but I see no evidence that this was done.

Q Dr. Chambers had asked you a question: What is your understanding of my medical practice? Do you recall him asking you that?

A I do.

Q My question is: How do you know what is your -- How do you get your understanding of his medical practice when you've never been to his medical practice?

A I believe or I did my best to make that clear at the outset of the question which is I've never been to his medical practice. So it's just my understanding if he practices obstetrics, if he practices gynecology, I know what that field encompasses.

I know he's been trained in sexual medicine and I understand a little bit about sexual medicine. And I know he's been trained in cosmetic gynecology, which I know a little bit about. Exactly what he does in his practice, in his office, I know nothing about other than what I've seen on one medical record on one patient, and it was a decent workup.

Q Did you speak with Dr. Chambers to prepare for your testimony today?

A Yes, but we didn't talk about his practice at all. That was not one of the things. He gave me a list of the questions he was going to ask, and that was it really.

Q He gave you a list of his questions?

A I have a list. I had a list. I had a list of his questions. Every one of them were asked. I think he went by that list, but there was no end. We discussed no answers. We discussed nothing about what I was going to say and so forth.

He did prepare me for the questions that he would be asking me, and I looked them over and most of them I could answer. There was a couple I got some evidence from the literature about O-Shots in case I was asked about that. I made a list of the journals that I published in so I wouldn't stumble when I was asked about that. That's about all.

Q You had talked about preoperative photos, that they are so important that you won't even operate on a patient unless you're permitted to take those; correct?

A Correct. There's a reason for that.

Q Could you give it to us very briefly?

A If a patient sends no photos for me, that's a red flag.

Q Okay. But you get consent before you take any photos; correct?

A Yes. It's part of the consent that we get. There's a large informed consent document, and that is on the document.

Q And it is written consent, right?

A Correct. And again, I can send you a copy of that if counsel wishes.

Q No, I, you know, you're under oath, and I believe you. I believe what you're saying here. You would also probably have to agree that you only take the amount of photos necessary for medical purposes?

A I agree with that. There are others who take an amazing amount of photos. There is someone who is also one of the fathers of cosmetic gynecology, and his name is Red Alanstodd who takes maybe 20 photos with black velvet for offset to see them better.

I take a minimum amount of photos. I usually take a straight-on photo. I'll take a photo from the angle that the patient is looking at from above. I take a minimum amount of photographs unless with the patient's consent, I'm using her case as a teaching opportunity. Then I may take more photographs or if I'm publishing an article.

Q And, Dr. Goodman, are you familiar with deidentification of these photos?

A I'm sorry. The: T-H-E or D as in David?

Q D-E like deidentification like --

A No, I'm not.

Q Okay. Do you take any precautions as to not giving away the identity of the patient that takes the photos?

A I do. I code them. The photos live on my computer, and they're coded.

Q Who takes those photos?

A I do most of the time. Sometimes my medical assistant does.

Q What kind of camera or cell phone or what do you use to take those pictures?

A I used to use a Minolta camera. I now use my cell phone. I take them off the cell phone, put them on my computer.

Q Your cell phone?

A My own cell phone. I think what Dr. Chambers does is probably more secure. I like that idea. I'm always a little nervous of my cell phone. I take them on my cell phone. I put them on the computer. I've never had an issue with that, but I agree there's some space

there that things could fall through.

Q You'd have to agree though. You said secured just now. You'd have to agree that you're in control of encrypting your cell phone.

A Yes.

Q Whereas if you use a patient's cell phone, you don't know what kind of encryption if any they have or what provider they're using and where they may end up?

A Different ways of looking at it. One way of looking at it it is the patient's cell phone. It's her personal cell phone. It's in a way more secure because it's taken with her phone.

Another way of looking at it is exactly what you said: That there may not be encryption technology. And I'm not an expert in this area. I can say what I do. Others do it in different ways. I really don't know what Dr. Jones does and Dr. Smith does and so forth.

I know what Dr. Chambers does because we're involved in this action. I know what I do, but that's as far as it goes. And I don't know what's right and proper or if there's been any legal determination. Certainly plastic surgeons take photographs all over the place, and I'm not sure if there's something in the literature or any decisions have been made as far as protecting those

photographs, so I'm ignorant in that area.

Q I want to jump over for a minute, redirect you to there was some questions regarding marketing.

A Yes.

Q And you had said marketing your surgical skills in your office is appropriate.

A Yes.

Q I'll come right out and ask you this. What about soliciting patients to pose nude and then speaking with them during treatment when they're gowned and exposed? You do you feel that that's appropriate marketing?

A I wouldn't do it, but I'm not the one to -- I'm not -- I can give you my opinion which is I wouldn't do that. I wouldn't feel comfortable with that. But that doesn't necessarily mean it's inappropriate. And I don't know if I'm the person to make that determination which is the best and honest answer that I can give.

And also, I wasn't there at the time, so I don't know how it's presented. You know, it can be presented in one way. It can be presented in another way. Sometimes we'll present things to patients in a certain way, and the patients will hear it differently. It's very interesting.

There are a lot of studies that show what doctors say it's recorded and what patients heard. And the reality is, patients hear -- patients understanding what the doctor said is less than 50 percent. You ask a patient have you had your -- Did the doctor remove your ovaries with a hysterectomy? They would be right 50 percent of the time. So we just politely go on and say things. And what the patients hear is sometimes very different.

Q How about --

A Long answer, but I'm trying to give the flavor of -- I'm trying to give an honest answer to you.

Q Yeah. And I appreciate that. Thank you. What about a poster soliciting -- What about a poster in a bathroom soliciting nude photos from your patients for an adult video magazine? Would you do that?

A I wouldn't do that because that's not my patient population. If my patient population involved that industry, then that might be a way to, you know, to market it. It's not my style. Would I do it? No. That doesn't mean it's improper. What I do doesn't mean it's all totally proper. What I don't do doesn't mean it's improper.

Q Just a few more questions. You had talked

about there are many organizations regarding sexual health.

A There are many organizations --

Q On direct exam. Sorry.

A Go ahead. The answer is yes, there are.

Q And you had said something about standardization, right?

A You'll have to refresh my memory as far as what I said about standardization.

Q That's the only word I wrote, so are you -- Do you think that better standardization or I suppose less society's in charge of sexual health, in sexual gynecological health would be perhaps better if streamlined?

A Can you say that in a different way? I don't --

Q Yeah. Would it be --

A I don't understand the question.

Q Would it be better if there were less organizations regarding, I guess, gynecological plastic surgery cosmetic surgery and not more?

A Not necessarily. That's like saying should there be five political parties, you know, the libertarians, the liberals, the ultraconservatives,

Republicans, conservative Republicans. Human nature is such that it's rare for three people to agree on anything. And certainly physicians, who are all prima donnas so, you know, it would be nice to have more standardization, but that's not going to occur. Everybody goes on their own path.

Q You would agree that as far as having a vast knowledge, a vast working knowledge of women's issues and even men's for that matter, in sexual terms, that most doctors out there don't have the same kind of knowledge as, say, a sexual therapist?

A Definitely. Those doctors that haven't, you know, been additionally trained, either trained in one of SSTAR's courses or one of ISSWSH's courses or in the course that Dr. Chambers took. I'm not as familiar with that particular course as I am with some of the others, but there are courses and training.

I took a couple of courses of training, and most doctors have not. They certainly don't get a lot of time in sexual medicine in their medical school training or in their residency. They'll get a thimble full, but that's about all. So I wish more doctors would be trained and feel comfortable in talking about that area, but --

Q And you had mentioned -- Sorry.

A Only a handful have been trained.

Q And you mentioned it was really important, you know, sex and you had said something like everybody does it, everybody has fun in their own way. Right?

A Sex is the most fun you could have without laughing. Woody Allen said that.

Q So why wouldn't a -- and I just want to get your opinion as the expert here that he is called to support his side of this case. Why wouldn't a doctor like you or Dr. Chambers either employ or refer someone -- and maybe you do refer someone that has real deep-seeded sexual issues, why wouldn't you refer them to a sexual therapist or have you?

A Oh, I definitely do. I definitely do. I mean, I have knowledge in sexual medicine, but nowhere near as much as some of, you know, my colleagues. So of course if, you know, if this is a sexual issue that you see, especially if you're an OB-GYN, you're a primary care provider for women. Women come in for their annual exams. They come in if they're pregnant. They may come in with vaginitis and different things, and it's an opportunity to open the door.

Sometimes just opening the door and getting

people talking, that's all that's needed with your knowledge. But certainly, if there is a dysfunction and there's a psychosexual dysfunction, then of course you'd want to refer that out.

Q Thank you for your honest answer. I don't mean to pick on you, but here I'm going to have to pick on you a little bit. So you had said before OB-GYN and then having some sexual sex health knowledge is the same as an orthopedic surgeon and having the knowledge to work on hands. But surely, you're not comparing a two-to-three-day class to learn sexual health and some CME's to, I think it's required that -- at least from what I've been able to look at -- it's required if you're going to become a hand surgeon, you have to have a fellowship in like upper extremity not just --

A Oh, certainly. Of course not. Of course not. Well, first, you know, in my particular courses, I talk about sexual health, but I am not giving the sexual health courses. I'm just letting my trainees know that that's an area that they should be cognizant of. And I'll let them know the questions to ask, and I'll let them know some questionnaires that they can use. And I'll let them know if it looks like that there may be a sexual dysfunction that that's a patient that they should

refer.

So of course even if you're talking about the rudimentary aspects of performing a labioplasty or a vaginal reconstruction, I'm teaching surgeons, number one, how to stay out of trouble; number two, the basic rules and sort of how to do things. But no, this is nowhere like a hand fellowship at all. It's the best we can do in the circumstances. It's better than nothing.

Q Thank you. Now, I just have a couple more. That's it. Dr. Goodman, you do not practice medicine in Nevada?

A No, I don't.

Q And you never have; correct?

A Correct.

Q So is it fair to say you're not familiar with the standards for which the Investigative Committee has alleged against Dr. Chambers with respect to the Nevada statutes and regulations?

A No, I have not.

MR. WHITE: Okay. That's all I have. Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: All right. So we're a little after 4:30, Dr. Chambers. Are you going to have redirect for Dr. Goodman?

DR. CHAMBERS: I just have a couple of questions for Dr. Goodman.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Hold on one second. And I have a couple of questions as well before we cut him loose.

Go ahead, Dr. Chambers.

REDIRECT EXAMINATION

BY DR. CHAMBERS:

Q Dr. Goodman, other than for you and me, how many other OB-GYNs do you know who went specifically to be trained for sexual health medicine and cosmetic GYN surgery?

A How many that have been dual trained? Understanding that these are not, you know, year and a half or two-year training fellowships, not a lot. And again, this is my impression. I have no statistics on this, Dr. Chambers, but I know that the men and women that I've trained, very few of them have had additional sexual medicine training.

Q Okay. And you operate on --

A And an addendum there which is why I bring it up. And I encourage my trainees to join an organization like I encourage them to go to their post-grad courses

and so forth. How many do, I don't know.

Q Okay. When you operate on patients who travel to the States from overseas, how do you assess their postoperative course if they're not local?

A About 75 percent of my patients come from out of the area. They drive either over three hours or fly in, both from the United States and offshore. I make sure if someone is flying from a distance from New York City or Miami or from London or something like that that they, number one, stay a requisite amount of time. It's not like: Okay. We're done. Goodbye. They stay for several days. I encourage them for staying close to a week, number one. I always evaluate them before they hit the road.

Number two: I make sure that I know of a practitioner in their area. I know someone in Germany. I know someone in Poland, and I know people in New York, etcetera. So I make sure that I know someone that's sort of in their area in case they get into trouble that they can go to.

We then have a virtual visit somewhere seven to ten days after their surgery in which the patient sends me photographs and we talk on the phone either by the FaceTime or one of the other platforms or just on the

phone. My patients have my cell phone number. They're welcome to call me at any time if there's a question. They can send me photographs if they're concerned about something. I also like to see them somewhere around a month or six weeks afterward for a final visit and any time they wish. And that's how I manage.

DR. CHAMBERS: Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Any other questions, Dr. Chambers?

DR. CHAMBERS: No, Ms. Ghusn.

ADMINISTRATIVE HEARING OFFICER GHUSN: Follow up, Mr. White?

MR. WHITE: No, Ms. Ghusn. Thank you.

EXAMINATION

BY ADMINISTRATIVE HEARING OFFICER GHUSN:

Q I have a couple of questions, Dr. Goodman. First, did you have an opportunity to review the complaint filed by the IC?

A Yes, I did, but it was a good while ago. I haven't re-reviewed it for this portion of my testimony. So my --

Q What did you review?

A What did I review? I reviewed the complaint.

I believe it was the complaint. I don't think I have it in my records. I probably have it on a different screen. I'd have to go and get to it in my documents. I believe I have it in my documents, and I believe that --

Q That's okay. We may get there. Thank you. And actually, there it is. Because there were quite a few allegations, and I was wondering your thoughts on then but I'll move on to another question regarding the IC's expert, Dr. Rick Rafael.

And I think you know there was pretty good discussion that went on for a while that he concluded and he was allowed to share his conclusions without interruption and he reached three conclusions. And I want to extend that same opportunity to you. Are you okay?

A Yeah. I'm getting over bronchitis.

Q Okay. Let me see if I have any other more specific questions first. I know we've been pretty thorough. So did I understand you that you've just reviewed Patient A's files and none of the others?

A I reviewed the complaint, and I do remember reviewing a little bit about Patient B and C, but I'd have to go back to the records to refresh my memory.

Q Okay. Well, you were very clear earlier that

you were impressed with Dr. Chambers' -- his note keeping. I'm not sure what to call it properly. The records he -- His notes from the exam of Patient A?

A Call it history and physical.

Q Okay.

A Or an H&P. Yes, I reviewed that, and I did see the allegations. And as I mentioned, things change a lot in the patients' minds after they leave the office after they speak with someone, after they quote or misquote and they hear from different people. There's a lot of different reasons that patients get confused.

Q Okay. Again, I would like to give you the opportunity. It would be helpful to me if there aren't any objections. I see Mr. White looking at his watch.

A Does he get overtime?

ADMINISTRATIVE HEARING OFFICER GHUSN: I realize the time. Yes.

MR. WHITE: No, it wasn't for the time, but that's okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: Stats. No stats today, Mr. White.

MR. WHITE: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: So I have written down Dr. Rafael 's three conclusions. But

I'd like to hear if you would like to share any. And I don't know if Dr. Chambers or Mr. White would have any objection to my reading my notes of his three conclusions.

Mr. White?

MR. WHITE: Yeah, we do object, Your Honor.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay.

MR. WHITE: The IC objects to Dr. Goodman's conclusions in that he -- first of all, he wasn't asked that on direct. He doesn't have the requisite expertise in Nevada law which is what I just brought up at the very end of his cross-examination.

Q (BY ADMINISTRATIVE HEARING OFFICER GHUSN:) I still am going to and I can give that weight -- allow him extend the same opportunity we extended to Dr. Rafael with the understanding that he's not a licensed Nevada physician.

So, Dr. Goodman, would you like to share any conclusions after your review of the records about the allegations?

A Well, as I understand, there are three. There's allegations from three different individuals. There's an allegation from a woman that from all I can see in the records, and there's no reason for me to not

believe the records which were dictated or which were dictated at the time or shortly after the meeting that patient came in for issues that included sexual issues and included the fact that she was unhappy with appearance and function of her genitalia in a sexual way. And this must have been very -- and this must have been very hard for her to do. And there must have been a lot of emotion involved.

I've been practicing for 50 years. I've done a lot of different things in medicine. I've worked with a lot of patients, and I think I have a decent handle as a lot of seasoned attorneys do as well who work with people that sometimes there's confusion afterward and sometimes there's embarrassment afterward. And sometimes a person will discuss aspects of the visit with others.

And then when they admit something to their trusted provider, something that's very personal, especially something that's sexually personal and then they go to explain it, it gets very confused and they get very defensive that oh, my goodness. I'm saying that I was not happy in my sexual relationship. I'm saying I'm not happy with this or that. And it's very hard for them with all of the stigma that are applied to this to then admit yeah, I went in because I'm having some orgasm

issues, and I feel loose and so forth. It's very hard to say that.

And so then they get sideways and then the person he spoke with said: He did what? He said what? And he gets very confused. And what ends up is something that I feel that you're seeing here. I am not seeing that anything dastardly was done in the case of Patient A from all that I can see including seeing what her complaint was. I really don't feel that there was.

As far as the advertising for photographs -- and I don't know Patient B and I don't know Patient C and their individual situations. Was it appropriate to advertise and talk about taking nude photographs in the way that Dr. Chambers did? I wouldn't do it that way. No, that's not my style. But that doesn't mean it brings dishonor to the profession. That doesn't mean it's entirely inappropriate.

I think Dr. Chambers may have learned from this. His practice is a little different than mine. So assuming that I don't feel there's anything terribly nefarious that went on with Patient A, I think he did his best to understand what her complaints were and to give her options.

The language that he used, I don't know. I

wasn't there. We say something and the patient hears something very different. There's country songs, rock songs have been written about that. He said/she heard. I forgot the name of who wrote that song. He said/she heard. We have that all the time. I'm sure attorneys know about that. And I think that's a he said/she heard kind of situation.

As far as the other two, it's not inappropriate to market. This is a way of saying okay. I will reimburse you for photographs that I can use appropriately in my practice. Was it a good way of doing it? That's open to debate. But I don't think it's anything that would say this brings dishonor on the profession and his license should be taken away or anything like that. I don't think it reaches that level at all.

I believe that's about all I have to say. I know Dr. Chambers minimally. I trained him. He seemed like an honorable individual. We've spoken in the course of this. He's very emotional about it because he's passionate about his specialty. He feels he's been done wrong, and he's very passionate about it.

He's acting in pro se, which is not what I would recommend, so it puts him in a difficult position

being both his attorney and being the defendant, especially in an action where you're considered guilty until proven innocent. This is one of the few areas, unfortunately, that people are considered guilty until proven innocent and that's --

ADMINISTRATIVE HEARING OFFICER GHUSN: And I'm going to stop you here, Dr. Goodman.

MR. WHITE: I would actually like to comment on that. He's been given -- All due process has been given, afforded. He's been afforded all of the due process rights he has and then some possibly.

THE WITNESS: I know I get into trouble with that, but --

ADMINISTRATIVE HEARING OFFICER GHUSN: And okay. Yes, Dr. Goodman. I don't want to get too far afield here.

THE WITNESS: Okay.

Q (BY ADMINISTRATIVE HEARING OFFICER GHUSN:) That's not for our discussion today. Let me ask you another question --

A Sure.

Q -- if I may. Maybe to wrap this up because it did come up. Do standards of care and practice, do they differ greatly between jurisdictions?

A In relating to cosmetic gynecology, it used to. It no longer does because patients right and left cross jurisdictions. So standards of care in cosmetic gynecology should not be different in Las Vegas or Henderson or San Francisco or Peoria, Illinois. If they have the same complaints, there should be similar standards of care, and I so testified in court to that.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you, Dr. Goodman.

Any follow-up?

DR. CHAMBERS: None, Ms. Ghusn.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you, Dr. Chambers.

Mr. White?

FURTHER CROSS-EXAMINATION

BY MR. WHITE:

Q Yes. Dr. Goodman, are you familiar or did you hear testimony from Patient A?

A No, I did not. I've heard no testimony from any of the people involved in this other than and -- I haven't heard Dr. Chambers' testimony.

Q Did Dr. Chambers make you aware of what the testimony was from Patient A?

A No, I don't believe -- Dr. Chambers, did you? I don't remember that.

DR. CHAMBERS: I did not.

Q (BY MR. WHITE:) Same question for Patients B and C.

A Not at all. I don't know what they said.

Q And then you had kind of mentioned I thought I heard that you said that you saw Patient A's complaint. Are you referring to the complaint, the formal complaint in this matter or did you see Patient A's written complaint?

A Oh, no, no, no. I saw there was a complaint in front of the Board, a multi-page complaint. And I was provided a copy of that which I believe I have in my documents that I have that I spoke to her earlier. But no, this was written up by the Board, I think by the IC, or it was in legalese.

ADMINISTRATIVE HEARING OFFICER GHUSN: Sounds like the formal complaint.

THE WITNESS: Yes, I believe that's it. Yes. This.

Q (BY MR. WHITE:) And again, just to reiterate, you do not know the standards of Nevada law that have been applied in this matter?

A Correct.

MR. WHITE: Okay. Nothing further. Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you.

Anything else?

DR. CHAMBERS: Thank you, Dr. Goodman.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you so much for your time, Dr. Goodman. Nice to meet you, and thank you so much for making yourself available today. I'm glad it all worked out.

THE WITNESS: Likewise. Thank you for both of your courtesies in this matter.

MR. WHITE: Certainly. Thank you, Dr. Goodman.

THE WITNESS: My place is only to educate. You guys make the decision.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you again. Have a good evening. All right, folks. I actually thought we might get through today. We were making really good progress. There's just a lot to talk about. I understand that.

We have -- Mr. White, you have your cross-examination of Dr. Chambers remaining and also

possibly Dr. Chambers redirect which would be your testimony in response to the cross-examination and closing arguments. Is that correct?

DR. CHAMBERS: I thought I was cross-examined this morning by Mr. White.

MR. WHITE: Yeah. I think we might be on redirect. I'm not sure.

ADMINISTRATIVE HEARING OFFICER GHUSN: You're correct. Sorry. You're right. Right. So we have Dr. Chambers -- thank you. You have your redirect, and then we have closing arguments. Yes.

MS. MOONEYHAN: And, Your Honor, if I may. Our IT staff and Ms. Fuentes, who has been assisting us in running the meeting, they --

ADMINISTRATIVE HEARING OFFICER GHUSN: 5:00 o'clock. I understand.

MS. MOONEYHAN: -- they have to leave by 5:00 o'clock.

ADMINISTRATIVE HEARING OFFICER GHUSN: That's why I'm bringing this up while we have time is there's not a lot left but, Dr. Chambers, I assume you want to have your redirect after --

DR. CHAMBERS: Yes.

ADMINISTRATIVE HEARING OFFICER GHUSN: -- and

both want to have your closing arguments, correct, Mr. White?

MR. WHITE: Correct.

MS. MOONEYHAN: Can I ask if we're going to set a date for --

ADMINISTRATIVE HEARING OFFICER GHUSN: That's what I'm doing. That's what I want to do before 5:00 o'clock.

MS. MOONEYHAN: Sorry. I thought Dr. Chambers was going to give his redirect at this point.

ADMINISTRATIVE HEARING OFFICER GHUSN: No, no. I just want to get it in so we can cut IT and Ms. Fuentes loose by 5:00 clock. There's no way we're going to do that today.

MS. MOONEYHAN: Yeah. Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Yeah. Not at all. So, everyone, if you want to try to set it another time or because we're going to be rushing into looking at our calendars right now with an audience.

MS. MOONEYHAN: Can we have a moment to consult our calendar here?

ADMINISTRATIVE HEARING OFFICER GHUSN: And I figure it looks like I don't even think it would take

half a day, but let's plan a couple -- a morning or an afternoon just to have it, okay?

MS. MOONEYHAN: I think we're available as soon as tomorrow, but we'll look at some dates where we have a half day available and we'll get back to you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay.

Dr. Chambers, can you look at your calendar?

DR. CHAMBERS: I'm available as soon as tomorrow. I really would like this thing over with.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Let me look at mine as well. I am game to do that.

MS. MOONEYHAN: Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: Ready when you are. If you can hear me.

MS. MOONEYHAN: We have checked our calendars. We're just waiting to hear about the Board's calendar. We heard that the room is clear. Okay. So we're all available tomorrow.

ADMINISTRATIVE HEARING OFFICER GHUSN: I can do it. I'll do it.

MS. MOONEYHAN: Okay. The room is available and we're all available. And yes, and --

MS. MOONEYHAN: IT just stated they sent the Zoom link for tomorrow this evening.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Can we do 9:30 tomorrow morning?

MS. MOONEYHAN: Yes. Certainly.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Great. We should be done tomorrow morning.

DR. CHAMBERS: Now I have a question, Ms. Ghusn. How do I introduce the new evidence that shows my relationship with AVN dating back a decade?

ADMINISTRATIVE HEARING OFFICER GHUSN: And I am in a tough position, Dr. Chambers.

DR. CHAMBERS: Because it was brought up.

ADMINISTRATIVE HEARING OFFICER GHUSN: You can introduce it and I will rule on it. I can't tell you how to do it. Maybe you can talk to someone, but certainly you are free to introduce whatever evidence you'd like.

THE WITNESS: In other words, do I email it to you, to all of you before the meeting or do I do it during the hearing?

ADMINISTRATIVE HEARING OFFICER GHUSN: Oh, it's something that's not in the --

THE WITNESS: Correct.

ADMINISTRATIVE HEARING OFFICER GHUSN: -- packet already? Please email it --

DR. CHAMBERS: Okay.

ADMINISTRATIVE HEARING OFFICER GHUSN: -- to Mr. White. That would be appropriate just so we're ready to go tomorrow and we don't have to take a break for that. And what else would I like to say?

Doctor, Mr. White, there's going to be a point when we wrap this up, and I am going to want to know what exhibits are admitted that I can consider because it's a pretty full binder, and I'm not sure everything is admitted, so I want to recap it.

MR. WHITE: I believe we've admitted everything of our -- all of our exhibits are admitted.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Because I want to run down and then also with Dr. Chambers, if you could help me out with that so I'm not considering things that haven't been admitted.

MR. WHITE: I certainly can't do that. I'd have a conflict of interest if I advocate and help him out. I wouldn't be able to do that.

ADMINISTRATIVE HEARING OFFICER GHUSN: Well, no. Of course.

MR. WHITE: I don't understand your question.

ADMINISTRATIVE HEARING OFFICER GHUSN: I need to know what's admitted, and I have some marked without

wading through it.

MR. WHITE: I'm getting it from my assistant, Ms. Fuentes, who are keeping track of it. All of our exhibits are admitted. None of Dr. Chambers's are.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Thank you.

MR. WHITE: Sorry. I misunderstood you before.

ADMINISTRATIVE HEARING OFFICER GHUSN: Yeah. No. I was surprised at that. So, Dr. Chambers, there you have it.

DR. CHAMBERS: Are they saying what is in the binder currently is not admitted?

ADMINISTRATIVE HEARING OFFICER GHUSN: That's what they're saying.

DR. CHAMBERS: How can it be in the binder and not be admitted?

ADMINISTRATIVE HEARING OFFICER GHUSN: So this is what I'd like to do. I'd like to have this discussion first thing tomorrow morning because we're at 5:00 o'clock.

And, Dr. Chambers, it is a disadvantage not to be represented as far as these matters. I have reiterated over and over again that I am willing to take

evidence, and I am not going to strictly apply the rules of evidence. I've made that clear to both sides. That's the best I can do.

So we're good at 9:30. Dr. Chambers, it's your redirect and closing arguments. Anything else, Counsel?

MR. WHITE: And any recross.

ADMINISTRATIVE HEARING OFFICER GHUSN: Of course. And any questions I have, too. We'll finish up with Dr. Chambers. That's all we have left.

MR. WHITE: Correct. Thank you.

ADMINISTRATIVE HEARING OFFICER GHUSN: Thank you. Dr. Chambers, yes?

DR. CHAMBERS: Yes. I'm okay with that.

ADMINISTRATIVE HEARING OFFICER GHUSN: Okay. Thank you very much. And, Ms. Mooneyhan. See you tomorrow morning.

(The proceedings concluded at 5:01 p.m.)

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STATE OF NEVADA)
)
WASHOE COUNTY)

I, NICOLE J. HANSEN, Official Court Reporter for the State of Nevada, Nevada State Board of Medical Examiners, do hereby certify:

That on the 1st day of June, 2023, I was present at said meeting for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 261, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 8th day of June, 2023.

Nicole J. Hansen

NICOLE J. HANSEN, NV CCR #446
CAL. CSR 13,909 RPR, CRR, RMR

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

In the Matter of Charges and Complaint Against: Case No. 22-27891-1

GEORGE PETER CHAMBERS, M.D.,

Respondent.
_____/

TRANSCRIPT OF HEARING PROCEEDINGS

VOLUME IV

Held Via Zoom

Friday, June 2, 2023

Reported by: Brandi Ann Vianney Smith

Job No. 993112

A P P E A R A N C E S:

THE HEARING OFFICER:	NANCY GHUSN, ESQ. nmg416@gmail.com
FOR THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS:	BRANDEE MOONEYHAN, ESQ. DONALD K. WHITE, ESQ. Deputies General Counsel Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 mooneyhandb@medboard.nv.gov dwhite@medboard.nv.gov
FOR THE RESPONDENT:	GEORGE PETER CHAMBERS, M.D., In Pro Se
ALSO PRESENT:	MERCEDES FUENTES Legal Assistant Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 fuentesm@medboard.nv.gov

I N D E X

E X H I B I T S

RENO, NEVADA -- JUNE 2, 2023 -- 9:30 A.M.

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HEARING OFFICER GHUSN: We are on the record in the continued hearing of Dr. George Chambers. This is a continued hearing, and we anticipate that we'll wrap up. Nothing's for sure. We may need cross-examination of Dr. Chambers and his -- I expect, redirect after that, and closing arguments.

I will remind any observers to remain muted, please. And I don't think we have any other witnesses except for Dr. Chambers, who I will remind, you remain under oath; correct?

DR. CHAMBERS: Correct.

HEARING OFFICER GHUSN: Okay. And it looks like -- now, Ms. Smith, you're welcome to stay on camera or off camera. It's up to you. Completely your call.

Any preliminary matters, counsel?

MR. WHITE: I think we have to, possibly, deal with what we were all sent in an email early this morning, about three o'clock in the morning, I guess, or almost four o'clock in the morning, from Dr. Chambers.

Do you want to address that Ms. Ghusn, or do you want to address it as it comes up?

HEARING OFFICER GHUSN: Yeah. I figured we would address it when it was his turn, after your cross. I could take it now, if you'd like, or why don't we just go ahead and do the cross.

DR. CHAMBERS: I thought I was already crossed.

HEARING OFFICER GHUSN: I'm sorry. I keep saying that. I apologize for that.

Yes. Yes, you were. So, it is your turn for the redirect, and we will take it. Go ahead, Mr. White and Dr. Chambers.

DR. CHAMBERS: Would you mind dealing with the email?

HEARING OFFICER GHUSN: That's what we're talking about.

All right. And Mr. White, you're correct.

MR. WHITE: What's that?

HEARING OFFICER GHUSN: Let's take it now.

MR. WHITE: Oh, take it now. Okay. Well, you want to have him go first and --

HEARING OFFICER GHUSN: Yes, I did.

MR. WHITE: You've seen the email. Okay. I'm sorry. You hadn't seen it before that?

HEARING OFFICER GHUSN: No. I saw it this morning.

MR. WHITE: Okay. Yeah, I just thought is he going to try and -- I mean, obviously he's going to try to get those things in. We're obviously going to object.

We can talk about that now or we can wait until he does his redirect and tries to lay foundation for these things.

HEARING OFFICER GHUSN: Just take it. Deal with it now.

DR. CHAMBERS: Okay. Well, an email was introduced yesterday.

HEARING OFFICER GHUSN: I'm sorry. Hold on, Dr. Chambers.

Mr. White, were you finished?

MR. WHITE: Yes.

HEARING OFFICER GHUSN: Okay.

MR. WHITE: I'll wait to hear what he has to say.

HEARING OFFICER GHUSN: Okay. Go ahead, Dr. Chambers.

DR. CHAMBERS: An email was introduced yesterday during testimony by a rebuttal witness, Ms. Johnna LaRue that questions my credibility as to

whether or not I lied about my dealings with the Adult Video Network Media and the purposes for the photographs that were taken.

And it is my contention that I should be able to rebut that evidence with my evidence showing a ten-year relationship with the AVN, that I have included ad in various publications in their company, that I have never communicated with Ms. Noonan, the author of that email to Ms. LaRue, and go from there.

I do not believe justice or the truth will be learned if that is evidence kept out.

HEARING OFFICER GHUSN: Thank you.

Mr. White?

MR. WHITE: Our objection would be based on lack of foundation. We don't know where these came from. Obviously -- and I'm just looking at them this morning for the first time.

HEARING OFFICER GHUSN: And I have not, just so you know.

MR. WHITE: Okay. And some of these actually -- I don't know if they could be -- they're ads, it like looks like there's a picture of a string of emails, like screen shots of emails that are all advertisements. The last email is from AVN,

so I'm not sure what that would prove anyway.

But I just wanted to say that it's not exactly true how he just couched that. How Dr. Chambers just couched what happened.

So, he had answered, if everybody will recall, back on May 2nd -- one of the reasons that we introduce rebuttal evidence is because he had said that he had done these ads, and then when he was asked about on direct exanimation, when we called him as a witness and Ms. Mooneyhan was questioning him, if you go back to the transcript, which we all have available to us now, on page 88, starts out with:

"QUESTION: Who was your contact in the Adult Video Network for placing these ads?

"ANSWER: I can't remember her name."

And I'm going to skip around a little bit, but just kind of to give it context.

Then over to page 90, talking about the photographer:

"QUESTION: And you don't remember her name?

"ANSWER: I don't. Not off the

top of my head."
And then we skip to page 93:
"QUESTION: In terms of compiling the ads, though, do you do that yourself?
"ANSWER: No. I used -- professionally done. It was professionally done by a young woman who helped design my website. The company that I've used to design any website before.
"QUESTION: What's the name of that company?
"ANSWER: I'd have to look it up and tell you.
"QUESTION: Do you remember the woman's name?
"ANSWER: No.
"QUESTION: And just to clarify, that woman put together the ad for the AVN program?
"ANSWER: That was done through AVN. They directed me to the company that designed the ads

for their pages because they had to meet certain specifications."

So, he says that we're attacking his credibility all the time, but it's not exactly the way it is. We're also just trying to get to the bottom of it.

All this stuff that he sends at four o'clock in the morning, or almost four o'clock in the morning, could have been sent prior to hearing time in May. He had plenty of time. He had -- he blames his attorneys all the time for not sending things in, but that was back in November.

And then between November and January when his attorneys were off the case, he could have realized that some of these things were not sent in.

And then his hearing was continued from February to May. And then there was another month's span in between May and now, where we could have presented those things, knowing it was very important, and he springs them on us -- on everyone, actually, this morning.

I think they lack foundation. Like I said, I see pictures of screen shots of advertisements that came to his email.

I see some -- maybe some preliminary

talks, looks like another email back on October 30th, 2013. I don't know what particular order these are in. And then October 31st, 2013, talking about possibly doing an ad. And then I see from AVN Adult Entertainment Expo, it looks like --

HEARING OFFICER GHUSN: Again, Mr. White, I haven't seen these, and you're telling me what they are.

MR. WHITE: Oh. I'm sorry. Are you going to look at them?

HEARING OFFICER GHUSN: I'm going to rule on them, and then we're going to move on.

MR. WHITE: Do you want to go page by page?

HEARING OFFICER GHUSN: I can take a look at them. I don't want to beat this to death or prolong this.

Is there anything else?

DR. CHAMBERS: Yes. He said I sprung it on them. I didn't think these things were relevant, and the last time I tried to introduce evidence during the hearing, I was told I was not allowed to.

Therefore, between May and now, I didn't feel I had the right to introduce this.

But it was sprung on me yesterday. I have

no way of verifying the email gotten by Ms. LaRue.

The emails that I submitted, many of them with full text, have the contact information of the people who sent them. Very easily verified.

There is a contact information for Ms. Sara Harter. There's information for the woman who designed the page, Ms. Jess Dena. Everything is there.

If you want the full truth to be known, these things need to be introduced. And if you'll note, the contact information for all these people are included in what I sent you.

HEARING OFFICER GHUSN: Thank you.

Mr. White, anything else?

MR. WHITE: Well, I still think they lack foundation. They're ads. They shouldn't be given much weight, if they are to be introduced or admitted, because they really are just ads. You can tell from reading them that they're just -- some of these are blast emails that went out to probably a number -- numerous, numerous people that may have looked into or inquired about advertising. That's what I see here.

I see not complete invoices, not even signed by somebody purported to work for the AVN.

It's all signed by Dr. Chambers and filled out, but there's nothing that says that it was ever done.

Then, as far as -- I know you haven't looked at them yet, I'm just trying to -- it's kind of hard to do it out of context and argue these.

HEARING OFFICER GHUSN: I understand that. I thought it would be better if I didn't look at them first and that we had this discussion.

MR. WHITE: Okay.

HEARING OFFICER GHUSN: I appreciate --

DR. CHAMBERS: Um --

HEARING OFFICER GHUSN: Dr. Chambers?

DR. CHAMBERS: Take the two email -- the two pictures away that showed the multiple listing of emails, you do have a full conversation between Ms. Harter and myself in the email dated January 29, 2016. You have the conversation between me and Ms. Dena, on January 4, 2016. You have the conversation again with me in 2014.

You have a picture of the front cover, the table of content, and the page of my ad picture in one of the AVN awards program.

So I don't understand when you say it lacks foundation and it cannot be verified. You

have the document right there.

So if the suggestion is that I fabricated this, it's very easy to check. And I stand here right now and say if you call any of those numbers and it suggests that I fabricated those data, I will personally give up my medical license to practice in the State of Nevada this very minute. That's how I feel about those things it sent you.

HEARING OFFICER GHUSN: Thank you, Dr. Chambers.

Anything else, Mr. White?

MR. WHITE: Just one moment, Your Honor.

(Off-the-record discussion.)

Okay. We're back. Thank you for that.

Your Honor, it's -- that's -- it usually comes down to when you're trying to introduce something that, whether in rebuttal or in your case in chief, you always have to establish foundation -- a foundational basis for its admission. That would be our argument, that it lacks foundation.

Also, should you -- like I stated before, I just want to remind you, should it be -- I also want to state that he knew these ads were important to get in. It had been talked about before, and how many years he had inquired, possibly, 2013, 2014,

2016, possibly 2020, it was made an important thing back in -- and the reason for us having to bring in Ms. LaRue as a rebuttal witness and her continued trying to request contact with AVN is because he was very unclear, as I just read in the transcript, from back in May. He didn't remember anybody.

He knew it was important from the beginning because the reason he took the pictures of his patients, and one of the things that we have charged him with as the Board, is that that was just unprofessional and not a way to treat your patients when they're at your office for a visit for medical help.

And then he has been talking about how, no, I did that. Those pictures, they're separate. I have a separate advertisement on the window. They are on the window, in the bathroom --

HEARING OFFICER GHUSN: And Mr. White, we're getting into your closing argument a little bit too, I think.

MR. WHITE: A little bit, but I think it has to do with just the fact that -- the reason. I just wanted to give the reason we had to call a rebuttal witness.

And also I just -- like I said, I do think

these lack foundation; however, if you're inclined to admit them, I would certainly just give them the weight they deserve, which some of these don't deserve much.

HEARING OFFICER GHUSN: Okay. I appreciate that. And I appreciate, again, the discussion and the argument.

As I said, I thought it was prudent not to open them and take a look, but to be prepared, as throughout this hearing, I think you've heard me say along the same lines the approach in administrative hearings with respect to evidence that comes in is no secret.

And I will admit them, and I heed Mr. White's recommendation as to the weight given to them.

I don't want to prolong it. As far as I understand the situation, I lived it also with you as far as the months that have passed and what has happened in the interim, whether it had to do with Dr. Chambers' counsel or he had opportunities or whatever.

I will also mention for the record, NRS 622A.370 2 where it states, and I will paraphrase:

"The hearing officer is not

bound by the strict rules of procedure or rules of evidence when conducting the hearing, except that evidence must be taken and considered in the hearing pursuant to NRS 233B.123."

And I'm not going to dig in deep into the rules of evidence, but a couple of notes.

So, 322B.123 states in relevant part: "Irrelevant, immaterial, or unduly repetitious evidence must be excluded. It may be admitted, except when precluded by statute if it is of a type commonly relied upon by a reasonable and prudent person" --

Which also has definitions, and, again, I'm not going to follow that whole line.

-- "in the conduct of their affairs."

Blah, blah, blah.

"Subject to the requirements of this subsection when a hearing

will be expedited and the interest of the parties will not be prejudiced substantially, any part of the evidence may be received in written form."

Again, I believe that, especially in the light of the rebuttal evidence introduced yesterday and under the relaxed rules of evidence in an administrative hearing, it's proper for these to come in and for the parties to argue as to the weight and credibility given.

So that's what we're going to do, and we're going to move on from there. Any comments or questions before we do that?

MR. WHITE: No, Your Honor.

DR. CHAMBERS: No, Your Honor.

HEARING OFFICER GHUSN: Okay. Thank you, Mr. White and Dr. Chambers, for the fruitful discussion.

THE REPORTER: I'm sorry to interrupt, Ms. Ghusn. Do you have an exhibit number, please?

HEARING OFFICER GHUSN: I haven't been doing Dr. Chambers' job for him as far as keeping track. That's how come -- and Mr. White made a comment along the same lines yesterday.

But here we are wanting to keep the record straight, if we could pull it together between us. So we are --

MR. WHITE: Your Honor, just to clarify, we are just talking about the emails -- the email we received last night with the attachments? And for clarification for the record, are we going to admit this as one exhibit?

HEARING OFFICER GHUSN: My recommendation would be anything that's weighted to be admitted as one exhibit, and not unrelated exhibits.

MR. WHITE: Okay.

DR. CHAMBERS: I'm assuming the reason for his is question because the email also included photographs of my office that you had questioned me about yesterday and --

HEARING OFFICER GHUSN: Again -- and that's why I said I would not include them as a group if they're unrelated.

MR. WHITE: They are unrelated. Well, there are emails -- there are pictures of his office, which are, you know, a different argument as far as rebuttal to AVN -- purported AVN contacts and advertisements.

The last -- it looks like the last, let's

see here, three pages, at least the way I have them printed out in front of me, are of his office, a couple of different views of his office, it looks like from his desk.

HEARING OFFICER GHUSN: And I will interrupt. Again, I believe anything related to AVN can be admitted as a group in one exhibit. Let's not mix them up with the other exhibits.

DR. CHAMBERS: No, that was not related to AVN. I included those as a way of answering the questions you asked me yesterday.

HEARING OFFICER GHUSN: Right. And my discussion, and I assume Mr. White's too, this was related to AVN, and we haven't discussed as far as text message or map of your office.

MR. WHITE: Yeah. Sorry about that. I didn't quite get done.

And there's also a text in there from Casey that's not related to AVN also.

HEARING OFFICER GHUSN: Let's finish what we're doing here, Mr. White, as far as what exhibit, the one that was just admitted.

MR. WHITE: That's what I am trying to figure out. Sorry. Yeah, I'm trying to figure that out, and we're going to have to list it as, I guess,

Exhibit U, the stuff regarding AVN.

HEARING OFFICER GHUSN: And I will print it out later. I don't want to do that on everyone's time now. I will take a look later.

That would be U.

(Dr. Chambers' Exhibit U was admitted.)

HEARING OFFICER GHUSN: And I appreciate the assistance from counsel and Ms. Fuentes, any assistance you can give me.

MR. WHITE: You can't see her, but she's following my lead, and she's writing stuff down.

HEARING OFFICER GHUSN: I know. I know what's going on in there, and I understand it. And, again, I do appreciate the assistance in keeping track of the exhibits. Dr. Chambers should appreciate it as well.

DR. CHAMBERS: Yes, I do. Thank you.

MR. WHITE: No problem.

HEARING OFFICER GHUSN: I don't want to get this in a week or two and think, oh, crud. If we had just been careful about keeping track of this.

MR. WHITE: Right.

HEARING OFFICER GHUSN: Whenever your

ready, Mr. White.

MR. WHITE: I think -- I thought he was on his redirect.

HEARING OFFICER GHUSN: He is. I just don't want to --

MR. WHITE: He's on his redirect.

HEARING OFFICER GHUSN: Okay. So we're good as far as Exhibit U? We're not waiting for that are anymore?

DR. CHAMBERS: I'm good.

MR. WHITE: Oh, I'm sorry. We're going to put in anything like the emails that have to do with -- anything that has to do with AVN, we'll put in as Exhibit U.

I think Ms. Fuentes has marked down -- they're just marked at this point, not admitted, the text from Casey Carden, and then the three pictures of his office are marked but not admitted as separate exhibits.

Is that correct?

MS. FUENTES: Yes.

MR. WHITE: Yes. That's where we are right now.

DR. CHAMBERS: And how do we go about getting them admitted?

HEARING OFFICER GHUSN: Okay. Hold on. So I've got U, and I have in my exhibit binder, exhibits from Dr. Chambers, A through T, and now I have U.

We may have to do some housekeeping at the end, so when we walk away from this, I know what we have here. All right.

So, the question about the maps and the texts, Mr. White, do you have argument? About the -- do you want to -- it's up to you.

MR. WHITE: I think that would probably be -- just -- this is just a suggestion, Ms. Ghusn, I think that would probably something he may try and get in on redirect, and we can attack those issues as they come up or deal with those issues as they come up.

HEARING OFFICER GHUSN: Okay. I'm fine with that either way.

MR. WHITE: Okay.

HEARING OFFICER GHUSN: Since we took these first, I didn't know if you would prefer to take everything at once.

Let's just jump in with the testimony. I agree. And I would just like to say let's keep our eye on the ball here of what we're doing and what's

important and what are the important issues, and not get bogged down in the weeds over -- and skirmishes over smaller matters that may not be as important.

And there may be other ways -- and I am directing this more to you, Dr. Chambers, since you're representing yourself, things that you can testify to, if you have personal knowledge to. Okay?

DR. CHAMBERS: Yes.

HEARING OFFICER GHUSN: There are ways to do things, and we don't have to fight about everything.

But if you have personal knowledge and you're testifying, you're good, mostly. Okay?

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSN: Subject to any objections, which Mr. White will offer up. Okay?

DR. CHAMBERS: Okay.

HEARING OFFICER GHUSN: Okay.

DR. CHAMBERS: Now, as I can't question myself, I prepared a statement. Is that okay with you, Ms. Ghusn?

HEARING OFFICER GHUSN: That is fine.

REDIRECT EXAMINATION

BY DR. CHAMBERS:

Yesterday we saw numerous attempts to discredit me personally, academically, and professionally.

But I would first like to address the gotcha moment from rebuttal witness, Ms. Johnna LaRue.

Ms. LaRue was called as a rebuttal witness by Ms. Mooneyhan to present evidence from Ms. Beth Noonan, vice president of Adult Video Network Media to say that I requested an ad for 2016 AVN expo, but didn't submit artwork. While I've never dealt with Ms. Noonan, there was also no know mention of my other dealings with AVN.

Thank you, Ms. Ghusn, for allowing me to submit my evidence showing the evidence from yesterday was wrong.

The evidence I submitted shows, one, a plethora of communication between me and the AVN network dating back to 2013.

One is an email dated January 29, 2016, between Ms. Sara Harter, AVN Media director of sales and me, in which I requested my copy of the AVN 2016 show guide featuring my ad, because I had not received a copy.

Ms. Harter's response dated January 29, 2016, was, "We're just waiting on our shipment to get back from the show, and I'll get it sent out ASAP."

An email dated January 4, 2016, from Ms. Jessie Dena, graphic designer for the AVN, in which she sent me a low resolution copy of my ad to proof. You have a copy of said ad in the folder already. I responded the same date by writing, "I love it. Cheers."

Ms. Dena responded on January 5, 2016, by writing, "Thanks, Doc. Hope to see you at the show."

I also submitted a copy of the contract I signed for the AVN adult entertainment expo dated December 30, 2015. I submitted a photo of the cover, table of content listing my ad on page 31, as well as photo of my ad on page 31 of the 2014 AVN awards show program.

There's an email dated October 30, 2013, between Ms. Terry Hernandez and me -- she's from AVN -- in which I attach my ad for an invoice of the November issue of AVN magazine.

I responded on October 31, 2013, telling her that there was an error in the billing.

I sent another email dated November 4, 2013, requesting the correct invoice so that I could make my quarterly payment.

I submitted a copy of one of the invoices from my ad in the AVN magazine.

I also submitted an email dated January 19, 2019, from me to Ms. Harter, requesting information about ad space in the 2020 AVN awards show program.

Yesterday, Mr. White wanted to know if I saw anything wrong with the fact that the National Society of Cosmetic Physicians does not have a website, just a link. While I've not been a member since 2015, and I have not kept up with their affairs, so I did not understand the point of the question.

What I do know is that I met Dr. Red Alinsod, Dr. Michael Goodman, and Dr. Otto Plasic, who Mr. White discussed with Dr. Goodman yesterday, at the 7th Annual Congress on Aesthetic Vaginal Surgery in 2012, sponsored by the National Society of Cosmetic Physicians.

These three prominent physicians are amongst the founders of cosmetic GYN surgery, and who are highly published in their subspeciality.

So if the organization no longer has a website, it is of no importance to me.

In terms of my skills as a cosmetic GYN surgeon, I do have a gallery of my work, which I show to potential patients during their initial consultations.

Yes, my staff has seen my gallery because they're my staff, and they helped put the gallery together. There are before and after photographs of my work. They compare to the works of my contemporaries. The photos in the gallery have been de-identified.

I have not gone back for a repeat course in cosmetic GYN surgery for the same reason I have not gone back for a review course in how to perform a hysterectomy, a Caesarian section, or advanced operative laparoscopic surgeries, and that is because I'm competent in those areas.

I'm not trying to invent or design a surgical technique as Dr. Goodman was doing when he was doing multiple tries and experimentation to present the world with what we now have.

Mr. White asked Dr. Goodman, and I'm paraphrasing because I cannot recall the exact quote, he asked Dr. Goodman if he had a problem with

doctors like me who promote body dysmorphia --

MR. WHITE: I'm going to object. Hold on one second. I'm going to object to the form of this statement, this part at least.

This is not a redirect of himself. This is now a redirect of Dr. Goodman. He had that opportunity. That time has passed. The arguing over how Dr. Goodman was -- whether he was convincing and credible and --

DR. CHAMBERS: That's not what I was doing.

MR. WHITE: -- all the other things we talked about in the law.

Let me finish please.

All the other things we talked about in the law about witnesses, that time has passed.

He's now vouching for the credibility of Dr. Goodman. He had the opportunity to rehabilitate his witness yesterday, and that time is gone. And I cannot recross Dr. Goodman right now.

DR. CHAMBERS: May I answer, Ms. Ghusn?

HEARING OFFICER GHUSN: Yes, you may. And I'd like to know, actually, the content of the comment, because I'm not sure if it has to do with rehabilitation of an expert or remarking on --

DR. CHAMBERS: I --

HEARING OFFICER GHUSN: Yeah, I don't think we got there yet.

DR. CHAMBERS: I am not trying to rehabilitate Dr. Goodman, because he was an excellent witness.

There was a question about --

MR. WHITE: Objection. Vouching for the witness.

HEARING OFFICER GHUSN: Okay. Sustained.

DR. CHAMBERS: There was a question regarding the timing of which Patient A gave me the document that she did. He could not remember when the document was given to me.

It was in the transcript, and so the assumption was made that it was given to me after, and I was promoting cosmetic surgery and thus promoting dysmorphia, and I wanted to address that.

HEARING OFFICER GHUSN: I don't believe it has to do with commenting on the expert witness, but remarking on his own procedures.

Let's see where it goes. I'm going to overrule it.

MR. WHITE: Okay. Let me -- may I just make one more comment?

HEARING OFFICER GHUSN: Go ahead, Mr. White. Yeah, make a record.

MR. WHITE: To put into context, I did ask Dr. Goodman regarding whether certain doctors out there, including, maybe, doctors like Dr. Chambers, were propagating body dysmorphia by advertising, and maybe, sort of, encouraging -- let's just put it in context, women, since we're talking about three women patients -- women to get, possibly, surgeries done that maybe were unnecessary.

That's what I did ask, so it did have to do with Dr. Goodman -- my cross of Dr. Goodman. So now he's attempting to rehabilitate Dr. Goodman's answer.

HEARING OFFICER GHUSN: Okay. Except I'm not sure he is, Mr. White. I just don't think we're there yet. I thought he was trying to comment on his approach and his reasons for doing it.

I actually am not sure at this point if that's what's going on.

MR. WHITE: Okay.

HEARING OFFICER GHUSN: Do you understand what I'm saying? I think it's premature.

MR. WHITE: I respect your ruling.

HEARING OFFICER GHUSN: You may understand

that is what he's saying. I don't, as far as rehabilitating Dr. Goodman. That isn't -- I didn't get that from where he was going, but I could be wrong.

I just feel like we're not there yet.

DR. CHAMBERS: You're correct, Ms. Ghusn.

HEARING OFFICER GHUSN: Dr. Chambers, we may interrupt again.

DR. CHAMBERS: That's fine.

HEARING OFFICER GHUSN: I'm going to allow you to continue with that understanding.

DR. CHAMBERS: Thank you.

BY DR. CHAMBERS:

The timing of the presentation of the list given to me by Patient A on May 2nd, 2023, was transcribed in Volume I of the transcripts, page 149, line 3. I asked:

"QUESTION: At what point during the encounter did you give me this form?

"ANSWER: At the very beginning."

Mr. White, I do not promote body dysmorphia. That may be your perception, but it is wrong.

Patient A had a 12-year problem with the fact that she was poorly repaired after having an

extensive obstetrical laceration that extended down her perineum to her rectum. This was mentioned on the very first line of the form she gave to me.

This had caused her significant psychological trama, along with urinary and fecal disfunction, orgasmic sexual disfunction, and dyspareunia.

I speculated that it was the reason why Drs. Parker, Wilson, and Lewis recommended perineorrhaphy or perineoplasty, same thing, but did not perform the surgery given all the sexual issues involved, so Dr. Lewis referred her to me.

I turn away more patients than I operate on because they do not need surgery or they're depressed or they're, in fact, having body dysphoria, given the numerous cosmetic surgeries, they have yet still dissatisfied with their body image.

I stay clear of those people because they will become a nightmare for the surgeon who operates on them. This is the reason for my multiple office visits before the actual surgery that we talked about yesterday.

I'm proud of the fact that I was elected to the Alpha Omega Alpha Honor Medical Society in

2000. Amongst doctors of my generation, there are not too many of us working in Nevada.

I was wrong when I said in May that only ten percent of doctors are chosen, but it is also not 25 percent or one in four doctors, as stated yesterday. We're not that common.

Each school may elect up to 20 percent of the graduating class of students, of the 25 residents or fellows, of the ten faculty, and three to five alumni, who, based on merit, demonstrate the characteristics of being excellent physicians.

During the 2020 to 2021 COVID years, the impact on business owners was devastating, as everyone knows. I did not take any of the money from the government, personally nor professionally, to support my business. I suffered through it like everyone else, and I survived. I came out on the other end, surviving.

Making payroll was sometimes difficult, but I did make payroll. And because of the difficulties, I felt it trickled down to Casey, and that's why Casey left my employment.

Thank you.

HEARING OFFICER GHUSN: Is that your completed statement, Dr. Chambers?

DR. CHAMBERS: Yes, it is, Ms. Ghusn.

HEARING OFFICER GHUSN: Mr. White, any recross?

MR. WHITE: One moment please.

HEARING OFFICER GHUSN: Sure.

THE REPORTER: Ms. Ghusn, once again, I apologize for the interruption. I just wanted to get clarification in my mind what Dr. Chambers just did, and now Mr. White is recrossing, what was Dr. Chambers -- what did he present?

HEARING OFFICER GHUSN: It's confusing because we've jumped around and out of order. This would have been his redirect, if he were to have counsel. Instead he is offering it in the form of a statement.

Now, Mr. White can recross at this point. But we jumped around to accommodate witness schedules.

Thank you for asking, Ms. Smith.

THE REPORTER: Of course.

HEARING OFFICER GHUSN: Mr. White, we could take a break if you'd like. I feel like you didn't expect this to happen so quickly.

MR. WHITE: Yes. It's not that it was so quickly, it's the form of how we're doing this. I

do need a few minutes, because the form of him just making a five-minute statement is a little different than having a lawyer question him, and then --

HEARING OFFICER GHUSN: Absolutely it is. Yes.

MR. WHITE: So it does throw you off a little bit, when you've done this a few times. So, yeah, I would like a few minutes. Maybe if we could take five, ten minutes?

HEARING OFFICER GHUSN: Do you want to do 10:30, and make it even?

MR. WHITE: Let's go 10:30, make it even.

HEARING OFFICER GHUSN: Okay.

Dr. Chambers, you're good?

DR. CHAMBERS: Yes, I'm fine with it.

HEARING OFFICER GHUSN: Thank you.

(Recess from 10:18 to 10:30 P.M.)

HEARING OFFICER GHUSN: Back on the record. Ready to go.

MR. WHITE: Are we ready?

HEARING OFFICER GHUSN: Yes, sir.

RECROSS-EXAMINATION

BY MR. WHITE:

Q. Dr. Chambers, Patients B and C where not there for cosmetic procedures. You'd have to agree

with that; correct?

A. I agree.

Q. And you'd also agree, by the timeline, that the emails and communications with AVN that you just talked about, and I believe were admitted now, these were four, five, and six years before you had any encounters with Patients A, B, and C, mainly B and C?

A. You will also see in the timeline communication dating 2019, 2017, and 2018, so it was during the timeline I saw the patients.

Q. I see 2016, and all I see is a low res copy. And then in 2014, was the purported ad itself. I see 2016, communication.

I'm really talking about the ad itself, and where do you see --

A. Well, those are old ads. There's communication with me and Sara Harter.

If you look at the reel that you discounted earlier -- and the reason I did it like that was to show the many times I communicated with her.

And if you look next to her name, you'll see the amount of times, six times, four times, six times, eight times, dating, if you look at bottom,

July 12, 2017, all the way up to January 29, 2016, in that one reel. November 2, 2018. June 14, 2019.

When you're trying to inquire about the upcoming year's advertisement, you have to start inquiring early before the spots are filled up.

Q. Let me point out something you had just mentioned. June 14, 2019, you see it says "advertisement" next to that?

A. Correct.

Q. Are you claiming that you had contact with Sara Harter when she just sent you a blast email on advertising in AVN? Is that your testimony?

A. Hold on.

HEARING OFFICER GHUSN: Counsel, are you referring to an email or an ad, 6/14/19?

MR. WHITE: I'm actually referring to the first page, that I have printed out, of the ads -- not ads. Excuse me. It looks like a screen shot of emails of just a string of emails, but they say "advertisement."

THE WITNESS: It is. It is.

Here's a better one, June 14, 2019:

"Hello, Ms. Harter.

"I'm interested in placing an ad in one of the 2020 AVN award

program. Would you please send me information regarding my options.

"Thank you."

BY MR. WHITE:

Q. Which page is that? Since we don't have them numbered yet.

A. That would have been the one that starts off at the top with "Sara," and it listed her salutation, her contact information, and then about two-thirds of way down, it says, "June 14, 2019."

Q. Okay. So you responded to an advertisement?

A. Correct.

Q. Did you have any further discussion with her, and do you have proof of that? I don't see it anywhere.

A. For 2020, no. By the time --

Q. Yeah, for 2020.

A. By the time I was able to gather money and things to put the ad in, it was too late for the 2020 program.

Q. Okay. Okay. Now, do you recall how many patients you may have made these $1,000 offers to, like you did with B and C?

A. It was on the door, so everyone had seen it who went into the lavatory.

Q. The question is: How many did you make the offer to? How many either --

A. How many did I talk to?

Q. -- (inaudible) or you made the offer?

HEARING OFFICER GHUSN: I'm going to caution both you, please, one at a time for our court reporter. Okay?

Dr. Chambers, let him ask the question.

THE WITNESS: Okay.

So, I can't remember how many people talked to me about it.

BY MR. WHITE:

Q. Now, at some point you had to realize, and you would have to agree, that you knew that the pictures you took would not qualify; right?

A. What do you mean?

Q. You were taking pictures of the models. You took pictures of models; right?

A. Correct.

Q. Of people that you say were models that were your patients?

A. Correct. And their pictures were on the door.

Q. You knew that they wouldn't qualify, though, for AVN magazine; right?

A. Some of those were not in AVN; however, those pictures were on the back of the door, highlighting different labias, and why patients would want those procedures done.

That was the primary purpose of those shots.

Q. And the reason I say that is because you even said in your testimony that the boudoir photographer that you said you hired for Patients B and C, that wouldn't qualify either for AVN magazine, would it?

A. Of course it would. Of course it would.

Q. You said AVN had a specific criteria that you had to adhere to?

A. Well, they had specific criteria for the dimensions of the ad, and -- they had specific criteria for the dimensions of the ad, and that's where Ms. Jessie came in.

So we gave her -- I gave her all the stuff we needed. I gave her the data, I gave her my photographs, the special one of me in the ad, I gave her that, I gave her some of the pictures I'd taken, and we decide which ones to include.

Q. Who did AVN ask you to use to take the photographs?

A. AVN did not ask me to use anyone to take the photographs.

Q. Okay. Who did they ask you to use to design the ads?

A. The ad was -- so they got all the pieces, and Ms. Dena, the graphic designer, put those together to meet the criteria for the ad.

Q. So this -- so what we have here that you sent us is, potentially, the -- that you put one ad in in 2014?

A. Actually, they had -- there are different publications I had the ad in. One was a program, the awards program, one was a show guide, and one was the AVN magazine, over the years.

But they're different publications that I used or included for my ad.

Q. But we don't have proof of that; right?

A. You have it right in front of you.

Q. Which one is it?

A. I gave it to you in those emails that we included. And if Ms. LaRue would take up the task, all she has to do is call the numbers on those emails.

Q. So, what other magazine are you talking about? I see the AVN awards show 2014 official program. I see APAC, Adult Performer Advocacy Committee, but there's no proof that that's an ad in there, and --

A. There's the --

Q. -- then so -- so, the picture you have that we've seen many times of the person laying down in your ad --

A. Correct.

Q. -- which does that belong to?

A. That was featured in the 2014 AVN awards show program, and that I sent you overnight.

Q. Right.

A. Page 31.

Q. Yep. I see that. Also see APAC. What does that have to do with anything as far as this APAC?

A. What do you mean APAC?

Q. You sent it. Adult Performer Advocacy Committee. It's open to a page, table of contents.

A. Oh, that's in the -- that's in the award show program. That's a table of content.

Q. Okay.

A. So that people attending the program would

know the categories of nominations and where to find who was involved in those -- who were included in those categories.

So that's a table of content from the program, and at the very bottom, it shows, on page 31, in the ad section, Chambers & Associates.

Q. Okay. So, this is from the one magazine. You said you --

A. That is the AVN.

Q. -- (inaudible) magazine.

A. That is the AVN awards show program, the program itself, the awards program.

Q. Okay.

A. There's also a monthly -- there was also a monthly subscription to AVN magazine, and there was also my submission, in 2016, to the AVN show guide.

Q. But you don't have your monthly subscription ad here to the industry magazine, do you?

A. It's the industry magazine.

Q. Yeah. That's what I said.

A. You have the picture. You have the photographs. And I believe you have the invoice, one of the invoices.

Q. Dr. Chambers, I just have the one photo.

That's it. I don't have a photo of another ad in another industry magazine.

A. You have --

Q. I don't know if you did --

A. Hold on. You have the email, at the top it says, "Jess Dena, January 4, 2016."

Q. Give me a moment.

A. You'll see the photograph of my second --

Q. You gotta give me a moment to get there.

A. Okay.

Q. Okay.

A. It's the page where half the woman printed in the email.

Q. Okay. Yeah, I see that it's an email that they sent you a low res proof.

A. Correct.

Q. Low res copy for you to proof it?

A. Correct.

Q. Okay. And that's where it ended?

A. And at the bottom, it says, "Thanks, Doc. Hope to see you at the show."

If you look at the very bottom of that picture I sent, the attachment, another email from Jessie Dena.

Q. Okay.

A. They don't put your ad together before you pay them. So, you have to pay them, they put everything together, and then they send to you the proof.

Q. Okay. And where's proof of your payment?

A. I don't have it there, but I am sure they can give you --

Q. No. It's okay. Thanks.

MR. WHITE: I have no further questions.

HEARING OFFICER GHUSN: Okay, Mr. White, that's it for your recross?

MR. WHITE: Yes.

HEARING OFFICER GHUSN: Okay. I think we're tricking down here.

Dr. Chambers, you have to keep it very narrow at this point, and then we're going to head to closing arguments.

DR. CHAMBERS: I have no questions, Your Honor.

MR. WHITE: You know what? One moment.

(Off-the-record discussion.)

We're back.

HEARING OFFICER GHUSN: Still no more questions, counsel?

MR. WHITE: No more questions.

HEARING OFFICER GHUSN: Okay. Just so it doesn't come back to bite us, the other documents that were hanging out there, let's address rather than ignore.

One was the text from Casey Carden, and I guess -- I don't know what else is there as far as a map of the office.

Frankly, Dr. Chambers, I'm going to let Mr. White address those individually, and you can respond.

All I need is information and facts, and I know that the description of the office was given.

Mr. White, I know you would like to object to the admission of those two documents.

MR. WHITE: Yeah. I think, probably, the easiest way to say it is there was zero foundation laid for these -- for the texts from Casey Carden and the pictures of his office.

He had that opportunity just now, and it was never done.

HEARING OFFICER GHUSN: Well, I'm asking --

MR. WHITE: There's no foundation. We don't know -- we have no idea that this purports -- how would I know -- and I would think Your Honor

too, how do you know this is a picture of his office? We don't even know anything about this.

I'm looking at a picture of a countertop, it looks like a granite countertop, and then a carpet and a door.

There's zero foundation laid. You can't even see that it says anything as far as there's no one in the picture. There is nothing that says it's Dr. Chambers's office anywhere.

So those three pictures should not come in. There's no foundation, no authentication.

DR. CHAMBERS: May I speak, Ms. Ghusn?

HEARING OFFICER GHUSN: Go ahead.

DR. CHAMBERS: You know, it's amazing how much proof is needed. It's very simple to prove those pictures.

MR. WHITE: Objection.

DR. CHAMBERS: It's very --

HEARING OFFICER GHUSN: Okay. Wait. Wait.

Mr. White, I mean, this could be a simple matter. And as I said, the purpose here is for me to have an understanding, and I feel like I do have an understanding from your testimony, from the testimony of Ms. Carden of how things were laid out.

So, let's not get bogged down in the weeds here.

MR. WHITE: Okay.

HEARING OFFICER GHUSN: You know, whether or not it's -- they need to be authenticated or the foundation, I assume Dr. Chambers could do that. We don't want to go back and open things up. I figure they would be there to help me see what I'm envisioning, which is the purpose of this hearing.

But it is true, Dr. Chambers, I will allow you to speak to that now, just so we understand what we're doing here.

DR. CHAMBERS: Thank you.

So, the simplest way to prove or authenticate those pictures is to send them to your four witnesses. They've been in my office, they know what it looks like.

HEARING OFFICER GHUSN: Dr. Chambers, I'm just not going to waste anyone's time. We're not doing that. We're not calling people. We're not brining people back.

DR. CHAMBERS: Okay. Ms. Ghusn, you said that my description of the layout of the office in Casey's yesterday was fine, so I'm fine with that.

The reason I sent the picture of the text was because you had wanted a timeline yesterday, and

Casey could not remember when she was there versus when COVID affected the practice. And that was the only reason why I sent the text message.

If it's not significant, we don't have to introduce it. Nor do we have to introduce the pictures, because it was not meant to complicate things; it was just mean to simplify them.

It's not going to make or break me.

HEARING OFFICER GHUSN: Exactly.

And I did ask about that, Mr. White, that is something I'd like to --

MR. WHITE: I'd like to comment --

HEARING OFFICER GHUSN: I can't --

MR. WHITE: Go ahead. Sorry to interrupt you.

HEARING OFFICER GHUSN: On the text, that is something as far as Ms. Carden's recollection, if there's something that will help.

Go ahead, Mr. White.

MR. WHITE: I don't know if it would. I haven't commented on the text yet, but I can't tell whether Ms. Carden, at this point when she sent this text on December 2021, is a patient or employee.

It looks to me like she was a patient, because he does -- he did testify that he gives out

his cell phone number to all his patients so they can reach him.

HEARING OFFICER GHUSN: That's a good point. Yeah.

MR. WHITE: So, it's kind of irrelevant, I guess. It's just a date and a text from Casey Carden, but we have no idea what it has to do with.

HEARING OFFICER GHUSN: Dr. Chambers?

DR. CHAMBERS: It has to do with the fact that she worked with me, her daughter had COVID, she said she didn't -- she wasn't positive, and she wanted to know about rescheduling.

And I told her to reschedule patients in an abbreviated way for the next day at a certain time.

And, basically, I only wanted to see the patients who did not require an examination, so I didn't have to come into close proximity to Casey.

HEARING OFFICER GHUSN: I'm letting it in.

And, Mr. White, I would like you to comment as far as what you were just saying in argument, whether it's unclear what it's for.

I think it could be helpful, but I want you make to argument. Okay?

MR. WHITE: Okay.

HEARING OFFICER GHUSN: If it's uncertain what its purpose was and whether she was a patient or employee or whatever, you can make those arguments.

But I think it will be probative and helpful to me, so it's coming in.

(Dr. Chambers' Exhibit V was admitted.)

MR. WHITE: Okay.

HEARING OFFICER GHUSN: All right. I think we worked through everything. Correct? We're done with that. Yes? I just wanted to address it before we launched into closing arguments.

MR. WHITE: Yeah. I'm looking at it.

HEARING OFFICER GHUSN: Okay. Thank you both.

DR. CHAMBERS: I have a question.

HEARING OFFICER GHUSN: Hold on. Let me give him a moment.

MR. WHITE: Let me ask you, Ms. Ghusn, did you have -- did you rule on whether the pictures of office are coming in?

HEARING OFFICER GHUSN: Pictures are not; text is.

MR. WHITE: Thank you.

DR. CHAMBERS: I have a question, Ms. Ghusn.

HEARING OFFICER GHUSN: Yes, Dr. Chambers?

DR. CHAMBERS: Yesterday it was noted that the information, the exhibits in the folder that I had while I was at the hearing room in May, that they were in the book, but they weren't admitted.

I'm afraid I don't understand that, and how do we go about getting those documents admitted? Since they were submitted and included in that book.

HEARING OFFICER GHUSN: And that's what I've been asking also, is what is admitted and what isn't. The answer came back: None of them were admitted.

And my guess is, Mr. White, that you weren't inclined to revisit this.

MR. WHITE: No. It's your call, Your Honor, if we have to revisit this and talk about what was admitted. I just want to make sure the record's clear.

Obviously, it's your call whether things are admitted or not, and that's what you've just been doing for the last ten minutes too.

We just keep track. And that's -- when we said yesterday -- I don't want it to sound like -- I

wanted to make sure, we were just keeping track. That's all we were doing.

And we did not have any of his exhibits admitted at that point you asked.

HEARING OFFICER GHUSN: And, of course, there is a balance issue as far as the rules of evidence and offering up exhibits and having them admitted.

I guess, then, my question is: Do you have any objection to the admission of any or all of these exhibits? Are we going to be doing this?

He's asking for them to be admitted, and how can he get them admitted.

MR. WHITE: We will -- counsel and I have talked about it. Lead counsel and I have talked about it, and we will stipulate to the admission of his documents, of his disclosures.

HEARING OFFICER GHUSN: Thank you very much for the simplification of that.

(Dr. Chambers' Exhibits A through T were admitted.)

DR. CHAMBERS: Thank you.

HEARING OFFICER GHUSN: So, we have Chambers Exhibits A through -- well, U is already admitted, so A through U, which I've got number 1

through 21, -- is that right? -- those are the tabs, just for ease of access. Is that correct? Everyone's on the literal and figurative same page?

Ms. Fuentes, A through U, 1 through 21?

MR. WHITE: Correct.

HEARING OFFICER GHUSN: Yeah.

Dr. Chambers, you don't have it in front of you, but I do. I just want to make sure we're all talking about the same thing.

So I've got my binder in front of me, my exhibit binder.

MR. WHITE: The way Ms. Fuentes wrote it down is U has to do with AVN communications and ads.

HEARING OFFICER GHUSN: And his emails.

MR. WHITE: V is Casey's text.

HEARING OFFICER GHUSN: Oh, wait. Wait. Wait. Did you just say "U"? You said "U"; right?

MR. WHITE: U is AVN communications and ads.

HEARING OFFICER GHUSN: That was emailed. Okay.

MR. WHITE: Yes, from the email this morning.

HEARING OFFICER GHUSN: Right.

MR. WHITE: V is Casey's text.

HEARING OFFICER GHUSN: Oh, thank you.

MR. WHITE: Yes. No problem. That you've just admitted.

HEARING OFFICER GHUSN: Thank you. Yeah.

MR. WHITE: Then we had marked W, office pictures, but those are not admitted, to make the record very clear.

HEARING OFFICER GHUSN: Okay. Perfect. Okay. We're good. Okay.

Dr. Chambers?

DR. CHAMBERS: I'm okay with that. Thank you.

HEARING OFFICER GHUSN: Okay. All right. Any other housekeeping matters? I'll start with you, Mr. White.

MR. WHITE: No, I don't believe so.

HEARING OFFICER GHUSN: Is Ms. Mooneyhan there?

MR. WHITE: We rest, by the way too. Yeah.

HEARING OFFICER GHUSN: Okay. All right. Any other housekeeping matters --

MS. MOONEYHAN: (Inaudible).

HEARING OFFICER GHUSN: I'm sorry?

MR. WHITE: Oh, I guess there is one. I'm

going to be doing the closing for Ms. Mooneyhan. She can barely speak.

HEARING OFFICER GHUSN: Oh, no. I'm sorry.

MR. WHITE: So, she has prepared a closing argument that I will be doing for her.

HEARING OFFICER GHUSN: Since you have a voice. Okay. I'm sorry to hear that.

Dr. Chambers, any housekeeping matters before we launch into closing?

DR. CHAMBERS: Yes. If I'm not mistaken --

HEARING OFFICER GHUSN: Let me explain to you how it works first.

DR. CHAMBERS: Yeah.

HEARING OFFICER GHUSN: So, IC has the burden of proof -- okay? -- by a preponderance of the evidence.

And so Mr. White, with Ms. Mooneyhan in the background there, they get the first and last bite of apple since they have the burden of proof.

So, they go first, then you go, then they go again. It's like an inverse funnel. All right?

DR. CHAMBERS: All right.

HEARING OFFICER GHUSN: He won't be

opening it up again, he will just be, perhaps, commenting on your closing, and then that's it. Okay? Do you have questions about that?

DR. CHAMBERS: No, I don't.

But I've read in one of your orders or motions -- orders, that you wanted the closing arguments in writing; is that correct?

HEARING OFFICER GHUSN: I don't recall that. Did I do that, Mr. White?

MR. WHITE: No, I don't recall that.

DR. CHAMBERS: Okay. Okay. Thank you.

HEARING OFFICER GHUSN: Did you do that?

DR. CHAMBERS: I must have misread the document, so thanks for the clarification.

HEARING OFFICER GHUSN: Ms. Mooneyhan, can you -- do you recall anything like that? I don't.

MS. MOONEYHAN: I don't recall that.

HEARING OFFICER GHUSN: She doesn't either?

MS. MOONEYHAN: I don't recall that.

MR. WHITE: No. You can barely hear her. She does not recall that.

HEARING OFFICER GHUSN: Okay. She doesn't have to speak, she can talk through you. Okay. I don't either.

And, Dr. Chambers, it's all going to be transcribed.

DR. CHAMBERS: Oh, okay.

HEARING OFFICER GHUSN: So there you go. It's going to be in writing anyway; right?

DR. CHAMBERS: Yeah.

HEARING OFFICER GHUSN: Okay. All right. Let me just -- does anyone need a moment or are you good?

MR. WHITE: I'm good. Is the court reporter okay?

HEARING OFFICER GHUSN: She's saying yes. Off you go, Mr. White.

MR. WHITE: Okay. Thank you, Ms. Ghusn.

HEARING OFFICER GHUSN: Thank you.

CLOSING ARGUMENTS

BY MR. WHITE:

Thank you to everyone who participated as witnesses.

Thank you, Dr. Chambers, for being here in your defense.

And thank you, Ms. Ghusn, as the hearing officer in this matter.

And thank you, Ms. Court Reporter.

In our opening statement, we stated that

the evidence in this hearing would show that the respondent, Dr. George Chambers, fundamentally disregarded the required boundaries between a physician and a patient, and the evidence presented in this matter has shown just that.

Throughout these proceedings, beginning with his response to the investigator's inquires, and continuing to through today, Dr. Chambers has dodged, deflected, and deceived regarding the allegations in this case.

However, notably absent has been any evidence to support these attempts to divert your attention, any substantial evidence.

Examining the evidence that was presented in this proceeding in the context of the complaint demonstrates that each allegation has been proven by a preponderance of the evidence.

Before I go through the evidence with to each count, I point out that NAC 630.470, subsection 8, subsection b, tasks you, Your Honor, with making a recommendation to the Board on the veracity of witnesses if there is conflicting evidence where the credibility of witnesses is a determining factor.

Of course, some of the evidence in this matter is not conflicting. For example,

Dr. Chambers has never denied that he offered Patients B and C $1,000 each to pose nude for photos, or at least to pose for modeling photos for a magazine -- or for his advertising. With respect to testimony, this is conflicting.

I point out that there are several instances in this matter that sincerely undermine Dr. Chambers' credibility, and I will discuss those instances as we explore the counts in this matter.

The first four counts of the compliant arise from Dr. Chambers' encounter with Patient A during their only meeting in November of 2020.

Patient A testified how she went to Dr. Chambers in hopes of addressing long-term pain, and walked out traumatized, physically and mentally, by what occurred.

In trying to refute the allegations about what happened during Patient A's visit, Dr. Chambers relied in part on the presence of a chaperone, Casey Carden.

For example, in exhibit 2, on page NSBME 6, approximately six lines down, he wrote: Her visit was chaperoned by my office manager, Casey.

Also in exhibit 2, on page NSBME 8, two lines down, we wrote: I left the door open with

Casey standing outside the door with full view of me and Patient A whilst labeling charts.

Later in that letter on NSBME 12, Dr. Chambers wrote, towards the bottom of the page under the bold statement numbered 4: Patient A seems to have forgotten that there was a chaperone present. To reiterate, her visit was chaperoned by Casey.

During his narrative testimony during his case in chief, Dr. Chambers testified that Casey was present during Patient A's visit outside the room at the door.

But you heard Ms. Carden testify yesterday, she did not act as a chaperone with Patient A's exam, and she could not see or hear what was happening during the exam.

On cross-examination, Dr. Chambers asked Ms. Carden no questions in this regard.

He stated repeatedly that Casey was tasked with chaperoning Patient A's visit and was observing from the doorway and could refute some of Patient A's assertions, but Ms. Carden told you that this was not true.

And Ms. Carden's testimony corresponds with Patient A's testimony with respect to their

being no third-party witness of Dr. Chambers' actions and comments during that encounter.

Counts I and II of the complaint charged Dr. Chambers with violating NRS 630.301, subsection 6. That statute prohibits a physician from engaging in disruptive behavior with a patient that interferes with a patient's care or has an adverse impact on the quality of care rendered to the patient.

Count I is based on Dr. Chambers' behavior in taking ten photographs of Patient A's vaginal area that were not for the purposes of medical examination or treatment, which humiliated and sexually demeaned her, and thus adversely affected the quality of care rendered to her.

Exhibit 4 contains the 12 photos that Dr. Chambers took of Patient A's body during her encounter with him.

Dr. Chambers admitted that he only used two of the photos, which were of Patient A's vulva, in his discussion with her, and included these photos in the record of his visit.

This was also confirmed by Ms. LaRue's testimony, Patient A's testimony, and the records themselves, which are in Exhibit 3 at pages NSBME 20

and 21.

The other ten photos were not for purposes of examination or treatment.

Dr. Chambers' explanation for the ten photos that he never used was that all 12 photos were taken in a burst. He testified that he pressed the shutter release button in rapid succession, and only kept the best photos.

In asking you to believe such an explanation, Dr. Chambers is asking you to ignore the evidence and ignore common sense.

If you look at Exhibit 4, they are the photos Dr. Chambers took with Patient A's cell phone. The photos are date and time stamped.

And Ms. Mooneyhan wanted to apologize that they are not in order, they're kind of in reverse order of time, but that is something that can be dealt with, that they are in reverse order of time, if you notice that.

But if you start with the last page in the exhibit, page NSBME 40, you will see that that photo was stamped at 11:17 A.M. on November 17th, 2020. That's also true of the photos on pages NSBME 39, 38, 37, and 36.

The photo on NSBME page 35 is time stamped

a minute later at 11:18 A.M. on that date.

Those photos are all very similar photos of Patient A's vulva. If the pictures stopped here, Dr. Chambers' explanation might make sense.

However, the photo on NSBME page 34 was taken two minutes later at 11:20 A.M., and shows two gloved fingers spreading the labia.

The photo on NSBME page 33 is stamped a minute after that at 11:21 A.M., and similarly shows two gloved fingers spreading the labia.

The photos on NSBME pages 32 and 31 are stamped a minute later still at 11:22 A.M., and show two gloved fingers inserted in the vagina.

The photo on NSBME page 30 is stamped a minute later after that at 11:23 A.M., and shows four gloved fingers inserted into the vagina.

The photo on NSBME page 29 is stamped another minute after that at 11:24 A.M., and shows a rectocele via a finger inserted in the rectum and pushing on the vaginal wall.

So Dr. Chambers is asking you to believe that the explanation for his -- for the dozen photos, of which he only used two, was that they were taken in a burst.

But to believe that, you would have to

believe that that burst of 12 photos took seven minutes and included several different configurations, including the insertion of different numbers of fingers into the patient's vagina and rectum.

Again, Dr. Chambers' own testimony undermines his credibility in this matter.

Photos of a patient's vaginal area should only be taken for clinical purposes comes from ACOG, Opinion Number 796, in Exhibit 11 on page NSBME 160, under heading "photography and video recordings," states that:

"Photographs of unclothed or internal anatomy must be de-identified, to the extent possible, and used only for clinical documentation or academic purposes."

While Dr. Chambers did offer an outlandish explanation for how he took 12 photos when he only needed two, he did not offer a clinical or academic reason for why he needed to take them.

During the IC's case in chief, he was asked why he took 12 photos during the patient's encounter with him. He did not offer a clinical or

academic reason. He simply reverted to his explanation of taking several in a burst and selecting the best.

The ten unused were not for clinical documentation or academic purposes. Dr. Chambers did not use them in his explanations to Patient A, and he never looked at them again.

The two photos he asked her to text him were of her vulva. There was no explanation why he needed to take a photo with fingers inserted in her vagina, or a photo with four fingers inserted in her vagina.

However, after the encounter, those photos remained on Patient A's phone, ready to remind her of the way she has been humiliated and demeaned in her encounter with Dr. Chambers.

She testified that she was embarrassed and humiliated about what happened during that encounter.

Taking the ten photos with Patient A's cell phone that he did not use for a clinical reason, and which humiliated and demeaned Patient A, was disruptive to Patient A, and had an adverse impact on the quality of care rendered to her.

This behavior violated NRS 630.301,

subsection 6, and Count I has been proven.

As noted earlier, Count II also charges Dr. Chambers with violating NRS 630.301, subsection 6; however, Count II is based on Dr. Chambers' behavior in telling Patient A that he attempted to fist her during his examination of her.

It is this allegation that has been the subject of much of Dr. Chambers' presentation. He has gone to great lengths to assure you that he didn't not fist Patient A.

He has reiterated that fisting is painful, that he would need significant amounts of lubrication to do so, and even had a person experienced in performing the act of fisting describe it.

But by pretending that he has been accused of fisting Patient A, Dr. Chambers is attempting to deflect attention from what he is actually accused of, the evidence that supports the accusation, and how it violated the Medical Practice Act.

This has been his tactic from the very beginning of these proceedings.

In Exhibit 1, Ms. LaRue's letter to Dr. Chambers, page NSBME 2, in the allegation number 13, Ms. LaRue alleged that after returning to the

exam room, Dr. Chambers told the patient that during the exam, you had done something called "fisting," where you tried to insert your entire fist in the patient's vagina.

The next allegation, number 14, states:

"You showed the patient how much of your fist you got inside, then compared the size of your fist to the size of a man's penis."

His response to that letter is Dr. Chambers' first attempt at deflection. Page NSBME 10, the paragraph that he has numbered 13 to correspond to Ms. LaRue's allegation letter.

Rather that respond to the allegation that he told the patient he had done something called "fisting," he states he never fisted any patient's vagina.

In the next paragraph numbered 14, Dr. Chambers completely dodges the portion of the allegation about showing the patient how much of his fist he was able to get inside of her vagina, and instead addresses only the portion of the allegation about whether Patient A's vagina is too big for a man's penis.

Paragraph 16 of the compliant filed on September 21, 2022, in this matter states:

"After his physical examination of Patient A, respondent informed Patient A that during the examination he had attempted to fist her, that is, insert his entire hand into her vagina, but he had been unable to insert his entire hand, and showed her how much of his hand he had been able to insert."

Count II also specifies that the behavior supporting that charge was Dr. Chambers telling Patient A that he had attempted to fist her.

Dr. Chambers continued this strategy during this hearing, continuing to attempt to deflect and dodge the question of what he told Patient A, and instead focused on vehemently denying that he fisted her.

You heard Patient A testify that during her examination, she felt a lot of stretching, as though she was being stretched as far as she could be stretched and beyond, and it was very uncomfortable.

Patient A further testified that after he returned to the room after her exam, Dr. Chambers told her during the exam he tried to do something called "fisting," but had been unable to insert his entire hand.

She testified that he showed her how far he was able to get his hand, and how he compared that to what he characterized as the size of the average penis.

Patient A testified she was not familiar with the term, and later asked her regular gynecologist, Dr. Lewis, about whether that was something gynecologists did or said.

Notably, Dr. Chambers' witness, Brittany Turner, testified about having performed fisting. She testified that to begin fisting, she begins by slowing inserting four fingers and thumb bunched together. This is consistent with Patient A's testimony that Dr. Chambers told her he had only been able to get his hand this far, and he showed her a bit past the knuckles.

Dr. Rafael explained that the use of the term "fisting" is inappropriate for a gynecologist. Dr. Goodman said he would not use this term in this context.

Patient A testified she was humiliated and demeaned by this discussion. Telling Patient A that he had tried to fist her and showing her how far he was able to get his hand was disruptive to Patient A and had an adverse impact on the quality of care rendered to her.

This behavior violated NRS 630.301, subsection 6, and Count II has also been proven.

Count III accuses Dr. Chambers of engaging in conduct intended to deceive, thereby violating NRS 630.306, subsection 1, subsection b, subsection 1.

This count is based on Dr. Chambers going out of his way in both the record of his encounter with Patient A and in response to the Board's inquiry in the matter to point out that he never inserted more than two fingers in Patient A's vagina during the encounter.

We know from the photos he took with Patient A's phone, in Exhibit 4, that he inserted four fingers into her vagina, and we know that Patient A's testimony that he told that during another part of the exam, he inserted at least four fingers and part of his hand into her vagina.

In his records of the encounter, at

Exhibit 3 at page NSBME 0018, Dr. Chambers stated that he sized Patient A's introital opening "with my two examining fingers."

When Ms. LaRue inquired about his encounter with Patient A, in response, Dr. Chambers repeatedly noted the number of fingers he inserted in Patient A's body.

If you turn to Exhibit 2, page NSBME 9, he stated that during his exam of Patient A, he inserted one finger into her vagina while palpating parts of her anatomy and asking whether she felt pain or pressure, then inserted a second finger to check her muscle tone.

Later on in that same page, he also states that prior his examination, he used "a single packet of lubricating jelly to lubricate his two fingers."

Dr. Chambers stated repeatedly that he inserted one or two fingers into Patient A's vagina during the encounter. He never mentioned that he inserted four fingers, which we know he did because he took a photo of it, and that photo is in Exhibit 4 at NSBME page 30.

Additionally, Patient A testified that had Dr. Chambers told her that during a separate part of the exam he had inserted more than two fingers in

her vagina; specifically, that he had been able to insert a bit past his knuckles into her vagina.

As noted by Dr. Rafael, there is generally no reason for a gynecologist to hide the insertion of four fingers if such insertion is part of a normal pelvic examination.

However, in this case, doing so coincided with Dr. Chambers' extremely inappropriate comment to Patient A that he had tried to fist her, but was able to only get a portion of his hand inside of her.

In his questioning of Dr. Rafael, Dr. Chambers seemed to imply that he wrote in his records "two fingers" because the pictures he printed out and included in the record showed two fingers.

However, reviewing the photos in his records in Exhibit 3, pages NSBME 20 and 21, shows that those photos did not show the insertion of any fingers; one shows two fingers spreading the labia and one simply shows the labia.

Dr. Chambers made up this excuse on the fly, but it doesn't match the evidence.

Dr. Chambers' records of the encounter and his explanation of it to Ms. LaRue were inaccurate

and deceptive because they were made to conceal the highly unprofessional parts of the encounter where he took photos of Patient A's vaginal area for no clinical reason and when he told her he had attempted to fist her.

Count III has also been proven.

Count IV accuses Dr. Chambers of failing to maintain accurate medical records, a violation of NRS 630.3062, subsection 1, subsection a. Specifically, NRS 630.3062 1 (a) provides that a licensed physician may be disciplined for failure to maintain timely, legible, accurate, and complete medical records related to the diagnosis, treatment, and care of a patient.

Count IV alleges that Dr. Chambers violated the statute by failing to maintain accurate and complete medical records for Patient A when he failed to document that during his encounter with her, he inserted four fingers into her vagina.

Of course, there is photographic evidence that he inserted four fingers into her vagina, because he documented this action with Patient A's phone. Again, I point your attention to Exhibit 4, page NSBME 30.

Dr. Rafael testified that inserting four

fingers was not automatically problematic, and he did not think that failing to record such insertion was necessarily problematic.

Dr. Goodman thinks the records show a good encounter; however, Dr. Goodman only reviewed the record created by Dr. Chambers and was not familiar with Patient A's testimony about what occurred during the exam.

We submit that the records of the encounter with Patient A were inaccurate and incomplete because they calculated to obscure the improprieties that occurred during the encounter with Patient A.

Dr. Chambers didn't forget to mention how many fingers he'd used in examining Patient A. He made a point of explaining, repeatedly, how he'd used one finger during some parts of the examination and two fingers during a different part of the examination.

Dr. Chambers was precise when it suited him, and then less precise when that suited him.

When the medical records are contrived to make it appear that a different examination occurred than the one that actually did occur, the record is inaccurate and incomplete, and the records violate

the requirements of NRS 630.3062 1 (a), and that count is proven.

Counts V and VI deal with Dr. Chambers offering money to Patient B and Patient C to take nude photos of them.

Both counts accuse Dr. Chambers of engaging in conduct that violates the trust of a patient, and exploits the relationship with the patient for financial or other personal gain, a violation of NRS 630.301, subsection 7.

Count V is based on an offer made to Patient B.

Patient B explained that after her October 2018 exam with Dr. Chambers, he asked other staff present to leave the room, leaving just Patient B and Dr. Chambers in the room.

Once he had her alone, he asked her if she would model nude for photos to be taken by him, and that he would pay her $1,000 if she did so.

Dr. Chambers quibbled about how this offer came to Patient B's attention, but he has never disputed that he offered $1,000 to her to model for an ad he allegedly hoped to create.

Count VI is based on a similar offer made to Patient C.

Yesterday you heard Patient C testify that Dr. Chambers also offered her $1,000 to pose for photos, and she was concerned about them being disseminated. She was upset about the highly inappropriate nature of the offer. She made it clear that Dr. Chambers initiated the conversation, contrary to his testimony.

Again, Dr. Chambers did not dispute that he made this offer to Patient C; indeed he testified that he has made similar offers to numerous patients. In fact, you heard that he even made such an offer to Casey Carden when she was a patient.

With respect both Patient B and Patient C, making such an offer in the middle of the medical encounter or by phone violated his physician-patient relationship with these patients, and violated their trust in him, and it was for the purpose of him realizing a personal gain for himself.

Dr. Rafael testified that such conduct was unprofessional, unethical, against the Code of Conduct, and against society's rules and would violate a patient's trust.

Counts V and VI have been proven.

In the context of the offers of money for photos, once again, I point to evidence that

undermined Dr. Chambers' credibility.

Dr. Chambers maintained throughout this matter that he wanted such photos to be advertised in the award ceremony program in the Adult Video Network, and we still don't have all the -- we do have some proof that you have admitted, Ms. Ghusn, that he did do an ad that looks like -- and you're going to give it the weight it deserves, but he has offered some evidence of -- again, that you have admitted -- his one attempt or at least one successful ad, in 2014, in the AVN program.

So, this does not excuse the behavior of asking patients, while they're disrobed and have a paper gown on and they're exposed, to talk to them -- excuse people out of the room and talk to them about taking pictures like this.

It's just yet another instance showing that Dr. Chambers lacks credibility.

Count VII. To this point, we have discussed how Dr. Chambers' conduct with respect to each patient violated various provisions of the Medical Practice Act.

Count VII charges Dr. Chambers with violating NRS 630.3061 (g), continual failure to practice medical properly.

ACOG Opinion Number 796, in Exhibit 11, explains that sexual improprieties, such as behavior, gestures, or expressions that are sexually suggestive, disrespectful of patient privacy or sexually demeaning are a form of sexual misconduct.

Dr. Chambers' behavior with Patient A, Patient B, and Patient C was sexually suggestive, disrespectful of patient privacy, and sexually demeaning, and therefore were sexual improprieties, constituting sexual misconduct.

As a physician, as a licensee of the Board, Dr. Chambers has been placed in a position of trust, and in particular, Patient A, Patient B, and Patient C trusted Dr. Chambers with their health.

They were dependent upon on him to use his education and position to help him -- help them maintain or improve their health.

They trusted him with their most intimate issues and questions, and Dr. Chambers violated that trust egregiously and repeatedly.

The fact that he engaged in such conduct with more than one patient demonstrated a pattern of failing to use the care, skill, and knowledge used by OB-GYNs in good standing.

Count VII has been proven.

Count VIII. Finally, Count VIII asserts a violation of NRS 630.301, subsection 9, engaging in conduct that brings the medical profession into disrepute.

As shown in these proceedings, Dr. Chambers acted in a sexually inappropriate manner while examining three patients:

Engaging in sexual misconduct in a repeated fashion undermines the public trust and respect for the medical profession.

Taking photos of a patient's vaginal area, including some with various configurations of his fingers, for no reason related to medical treatment or diagnosis.

Telling a patient that he attempted to fist her but could only fit part of his hand into her vagina, and comparing it with the average size of a penis to imply that her vagina was too large.

Going out of his way in his record of the encounter and the response to the Board's inquiry about the encounter to repeatedly state that he'd never inserted more than two fingers into Patient A's vagina, when a photo shows he inserted four, and Patient A's testimony is that he told her he was able to insert a significant portion of his hand

into her vagina.

Offering patients money to allow him to take nude photos of them, ostensibly for advertisements that appear, at least most, never to have been placed, and doing all of this in the context of providing gynecological care, a context of extreme vulnerability and sensitivity.

As ACOG points out in its Opinion in Exhibit 11, the relationship between OB-GYNs and their patients requires a high level of trust and responsibility because the practice of gynecology includes interactions in times of intense emotion and vulnerability for patients and involves sensitive physical examination and medically necessary disclosure of private information about symptoms and experiences.

Abusing his position of trust causes the public to lose trust in the profession. Acting in such a highly unprofessional manner damages the esteem in which the public generally holds doctors.

A doctor who humiliates and demeans patients and shows a total disregard for their privacy causes dishonor to the profession and damages the profession's reputation and causes the public to hold it in a lower regard than it did

before.

You heard Dr. Rafael, who practiced gynecology in Nevada for over 30 years, testify that the treatment received by Patient A, Patient B, and Patient C brought the medical profession into disrepute.

Count VIII has been proven.

Dr. Chambers attempts to differentiate himself from other gynecologists by focusing on the limited additional training he had in cosmetic gynecology and sexual assault health medicine, but there is no focus or speciality that makes it okay to violate the trust placed in an OB-GYN.

One moment, please.

He brought in Dr. Goodman as his expert, and it was just another attempt at deflection. None of these patients had cosmetic surgery, none of them had an O-Shot. He went on for numerous moments, minutes talking about the O-Shot and all those things in cosmetic surgery, and it didn't even pertain to these patients because none of them had that.

His marketing, he was asked to comment on marketing, about before and after pics, and asking them to pose nude, but it really had to do with the

clinical part of taking a before and after pic and using them in clinical situations, not for advertising purposes in a magazine like that.

And then you also heard that Dr. Goodman always gets written consent before taking photos. And you heard Dr. Chambers, on direction examination back in May, talk about how he would get just verbal consent from patients before taking photos of them, specifically, Patient A, and his own expert wouldn't do that.

In his opening statement, Dr. Chambers stated that this was all a misunderstanding. However, there's been no evidence of any misunderstanding, other than Dr. Chambers' apparent misunderstanding of what is acceptable behavior for a gynecologist licensed in the State of Nevada.

This case is not about cosmetic gynecological surgery. None of these patients had such surgery.

The case is not about fisting or whether Dr. Chambers was successful in attempting to fist Patient A.

It's not about Patient B trusting him enough to share a fantasy with him three years before he offered her money to pose nude for him.

It is not about a conspiracy against him, Dr. Chambers.

It is about three patients who entrusted a gynecologist with their care, who went to him hoping to get help with their health, to help with long-term perineal pain, to get help with nipple discharge, to get help with painful periods.

Instead, these patients received something they didn't bargain for, as they sat in paper gowns and discussed intimate concerns with a person in a position of power, who they trusted to exercise that power for their benefit. They were treated with a lack of respect and professionalism.

Dr. Chambers engaged in such conduct repeatedly, then tried to deceive others, including this body about that conduct, and brought disrepute to the medical profession in the process.

Quite simply, the credible evidence presented in this matter supports each allegation made in the complaint, and we ask that your recommendation reflect that.

Thank you for your attention during these proceedings.

HEARING OFFICER GHUSN: Thank you, Mr. White and Ms. Mooneyhan.

I think we're going to take a brief break, as it's 11:30.

Dr. Chambers, that will give you a moment, which I think would be a prudent thing.

And let's say five minutes. We'll shoot for five minutes. Okay?

DR. CHAMBERS: Okay.

MR. WHITE: Thank you.

HEARING OFFICER GHUSN: Okay. Thank you.

(Recess from 11:32 A.M. to 11:40 A.M.)

HEARING OFFICER GHUSN: Back on the record in the matter of Dr. George Chambers.

Dr. Chambers, are you prepared to go forward with your cross?

DR. CHAMBERS: I am prepared.

HEARING OFFICER GHUSN: Okay. Everyone can hear? Are we good?

MR. WHITE: To clarify for the record, Ms. Ghusn, you just said "cross." I think it's the Doctor's closing.

HEARING OFFICER GHUSN: Closing.

DR. CHAMBERS: Yes, I am.

HEARING OFFICER GHUSN: Okay. I have cross stuck in my head. Okay. Thank you.

Go ahead, Dr. Chambers.

BY DR. CHAMBERS:

First and foremost, all praise and thanks to God.

Ms. Ghusn, thank you for your time and attention as well as your patience, guidance, and the latitude you've given me during this hearing.

I thank Dr. Richard Rafael for his expert testimony. I'm grateful to him for his honesty and decency.

I thank Ms. Turner for her eloquent testimony regarding a very taboo topic.

My eternal gratitude and thanks to my mentor and teacher, Dr. Michael Goodman, for his knowledge, wisdom, expertise, and testimony. Whether or not Dr. Goodman practices in Nevada, he's world-renown as one of the founders of cosmetic GYN surgery, and he provides expert testimony on behalf of plaintiffs in medical malpractice lawsuits nationwide.

He did not represent me as legal counsel, meaning to know Nevada laws, he provided expert testimony on my behalf as a cosmetic GYN surgeon.

I also thank the Board's attorneys for their time.

Being a physician is who I am. It's not a

job, it was a calling that I was blessed to have recognized at a very young age. Being a physician is my identity.

I've used my diagnostic skills and my talent as a surgeon to do good and to serve the women of our community and beyond.

I have had at least 150,000 patient contacts and have delivered over 12,500 babies in my career.

I'm sitting here for questionable allegations from three patients. I have had an exemplary record that refutes any allegation of sexual misconduct or sexual impropriety.

I've had an award-winning career, which includes being voted top doctor by my physician peers 11 times out of the two decades that I've served the Las Vegas Valley.

I was a National Health Service scholar from 2005 to 2007, for my work with the undeserved women in North Las Vegas.

I was awarded the Robert E L Nesbitt, M.D., outstanding resident in obstetrics and gynecology award in 2002.

I listed my academic and non-academic accolades during this hearing not because I want to

brag, not because I'm smarter than anyone else, but because I've have to work ten times as harder and be ten times more cautious than my counterparts.

This is another reason why I sought out additional training in my post-residency years.

Although I was not charged with sexual misconduct in the complaint, it incriminated me and painted a lurid picture of me as a sex fiend of some sort, praying on patients for some twisted purposes of my own.

In the eyes of Investigative Committee, my role as a cosmetic GYN surgeon was seen as a depraved means to allegedly sexually victimize women.

This was a common theme against me by the opposing counsels throughout this case as they tried to present me as a charlatan. Sexual deviance has a historical pattern. They're not formed overnight.

To reiterate, the Investigative Committee ordered me to see a psychiatrist. The psychiatrist, who was chosen by the Board, said:

"It is my professional opinion, to a reasonable degree of psychiatric probability, that Dr. Chambers does not suffer

from a psychiatric condition which impairs his ability to reasonably and safely practice medicine within his scope or specialty of choice."

The complaint filed against me on September 21, 2022, contained allegations. It read as facts, and still, after two-and-a-half days of testimonies, when these allegations are examined objectively, with understanding in the context of cosmetic gynecological surgery and its relationship to sexual medicine, facts have not been proven.

Let us look at the charges against me and what was proven during this case.

Firstly, I would like to highlight the fact that Dr. Rafael, the Board's expert witness, went out of his way to say, "I do not think he committed malpractice. Dr. Chambers did not commit sexual violence."

Count I, NRS 630.301, subsection 6, disruptive behavior.

The complaint alleged that my taking ten photographs of Patient A's vagina and rectal area, allegedly not for purposes of medical examination or treatment, constituted disruptive behavior.

NRS 630.30, subsection 6, provides that disciplinary action may be initiated for disruptive behavior "if behavior interferes with patient care or has adverse impact on the quality of care rendered to a patient."

The complaint alleged that Patient A was evaluated by me for an initial consultation only. The complaint does not allege that Patient A received any treatment from me.

The complaint alleged that I took 12 photographs with Patient A's mobile telephone and then directed her to text two of those photographs to me, and they were included in her record. The remaining ten photographs were left in Patient A's exclusive possession and control.

The photographs were taken after obtaining her verbal consent.

I did not use my designated camera to take the photographs, because it is reserved for patients who will be having cosmetic GYN surgery done by me, and after perusing three consent forms: a preoperative consent, female genital plastic surgery consent, which includes a photography consent, as well as the aftercare consent.

I gave Patient A very clear instructions

regarding the disposition of the 12 photographs. I told her that if she chose to keep them, she should store them in a hidden folder or delete them. Had she deleted them, they would have stayed in her deleted folder for 30 days and disappeared.

I did not forward the two photographs to anyone. In fact, after Patient A texted them to me on November 17, 2020, there were immediately printed, then deleted from my mobile telephone, along with her mobile telephone number, before she left my office. They were filed in her chart.

These photographs did not contain any name, tattoos, or anything that identified them as her pictures. Even if her mobile phone had been hacked, which is not easy to do, no one would have known they were hers. There was nothing to indicate that those photographs were of her vulva. They could have been photographs of another woman. They could have also been easily downloaded from the internet and added to her photo gallery.

I did not distribute the two photographs; she was the one to distributed them. She sent them to the Board where they were duplicated.

They fail to establish that Patient A's consultation was incomplete, inadequate, or

adversely impacted by the photographs that I took.

As for the 12 photographs, they were taken the way I take regular photographs with the intent to keep the good ones and discard the bad ones.

The photographs showing my finger in Patient A's rectum was to demonstrate to her the rectocele.

The photos involving the plain pictures of her vulva was not just to demonstrate the vaginal gape, but also to demonstrate the protruding tissue that she complained about, which turned out to be her hymenal tags.

As Dr. Goodman testified yesterday, some surgeons take many photographs. He takes just what he needs. I took many, and took from them what I needed.

What was Dr. Rafael's opinion? Whilst he disagreed on whether or not the photographs were safe on Patient A's mobile telephone, he did say:

"I wish to be fair.

Dr. Chambers has taken a course from Dr. Red Alisod. He's held in esteem within the cosmetic community, and in that course, Dr. Alisod has papers and

recommendations to take photos."

Count II, NRS 630.301, subsection 6, disruptive behavior.

The complaint alleged that had I told Patient A that I attempted to fist her, allegedly constituting disruptive behavior. Ms. Turner, the adult entertainer, testified because of her expertise in fisting.

The purpose of her testimony was not to add sensationalism to this case; it was to educate all of us regarding what it takes to fist someone. She discussed the amount of lubrication and time needed to complete the act.

To refresh everyone's memory, according to Wikipedia, fisting, or brachial vaginal or brachial proctic insertion, is a sexual activity that involves the slow insertion of a hand into a well-lubricated vagina or rectum.

Knowing all of this information, it defies logic that I would tell Patient A that I attempted to fist her when my fingers were minimally lubricated, with one packet of gel, with the remainder of my size 8, gloved hand dry. I did not make this statement, nor did I do the act.

As Casey Carden, my former office manager

and chaperone during Patient A's consultation, recounted in her email message to me, "I didn't hear anything out of ordinary."

Had I attempted to fist Patient A with a mostly dry glove, a normal reaction would be to scream. I asked Patient A during cross-examination if she had screamed during the examination, and she said, "No."

Patient A was questioned by Ms. Mooneyhan:

"QUESTION: I'm sorry, Patient A, but for clarification, when Dr. Chambers said that he was only able to get his hand this far, you touched your hand at -- approximately where on his hand was he pointing to? Did it include four fingers?

"ANSWER: Above his knuckles and below his wrist.

"QUESTION: Between his knuckles and wrist?

"ANSWER: Yes."

This is contrary to what she had previously stated. On one hand, she said she didn't know what she felt, and on the other hand, she's now

offering testimony that she felt my knuckles and I had inserted my hand past my knuckles.

A review of that photograph with my two fingers and the one with the four fingers will show that there was no lubrication above my fingertip, which were in her introitus. The entire glove beyond that was dry. There was to indication of moisture from vaginal discharge nor artificial lubrication.

She falsely testified that I attempted to fist her with a dry glove. It never happened.

I performed a standard rectal examination with one lubricated finger in her vagina and another lubricated finger in her anus, while assessing her for rectocele, which I demonstrated to her.

Rectocele is a herniation of the bowel into the vagina. A rectovaginal exam is supposed to be a part of an annual GYN exam, but it has largely been abandoned. It is used to diagnose certain pelvic floor conditions now.

NRS 630.301, subsection 6, provides that disciplinary action may be initiated for disruptive behavior "if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient."

What we have here is hearsay. It does not make any sense that I would say that.

In her testimony, Patient A stated during a visit with her regular OB-GYN, Dr. Michelle Lewis, six days later, she discussed that I had mentioned fisting during her consultation.

Patient A testified that she tried to verify if fisting is a medical term with Dr. Lewis. Patient A stated: "She said, 'No, I've never heard that term before.'"

Yes, there's no corroborating testimony nor affidavit from Dr. Lewis. Patient A also reportedly discussed the matter with her therapist, yet again no proof.

What we do have is a consultation from Dr. Richard Wasserman, who's a male urogynecologist to whom I'd referred Patient A, who concurred with my findings of pelvic organ prolapse.

Patient A told the police, when asked during the testimony, that I assaulted her. Yet she still trusted me and my recommendation to go see Dr. Richard Wasserman.

Therefore, it's my conclusion that the fact alleged in Count II has not been proven.

Count III, NRS 630.306, subsection 1 (b)

1, engaging in conduct intended to deceive.

The complaint alleged that I knowingly made statements to the Board designed to conceal that I had inserted four fingers into Patient A's vagina during my examination.

When I appeared before the Investigative Committee well over a year after the consultation, I was asked if I had inserted four fingers into Patient A's vagina.

I responded by saying, "No," not because I was willingly misleading the IC, but because I genuinely could not recall doing so.

Also, when I made the entry into Patient A's medical record, I was looking at the two photographs, one which showed two fingers separating Patient A's vaginal introitus or opening, and the other did not.

It was not until the discovery phase of this case that I saw and authenticated the photograph showing my four fingers in Patient A's vaginal introitus that I recall doing so.

The complaint alleged that I did not document in the medical record, nor inform the IC during its investigation, and failed to otherwise document that I had inserted four fingers in Patient

A's vagina.

The complaint does not allege that the insertion of four fingers constitutes fisting or attempted fisting or that using four fingers to measure the vaginal introitus would be inappropriate or clinically significant for documentation purposes.

What did the Board's expert witness think? Dr. Rafael said:

"So, this exam, in my opinion, is a perfectly normal exam. You put four fingers into the posterior floor and push down because he's trying to evaluate the size of the introitus. And a lot of her complaints are in this area."

So I don't see anything abnormal with this exam, thus the complaint and the testimonies fail to show that I intended to deceive the Board or that I was up to something nefarious by describing using two instead of two to four fingers during my assessment.

Count IV, NRS 630.3062, subsection 1 (a), failure to maintain accurate medical records.

Both Dr. Goodman and Dr. Rafael complimented me on the thoroughness of my consultation note on Patient A.

Dr. Rafael testified that he saw nothing wrong with me documenting that I sized or measured Patient A's vaginal opening with two fingers, but did not document four fingers.

Dr. Rafael went on to say that he believes that I simply forgot to chart it. In fact, the following dialogue took place between Dr. Rafael and Mr. White:

"QUESTION: How many fingers is he using there?

"ANSWER: There are four fingers in the vagina.

"QUESTION: Would you have documented that you used four fingers?

"ANSWER: No, I would not have.

"QUESTION: You would not have?

"ANSWER: I would not have.

"QUESTION: You would have documented you only used two fingers?

"ANSWER: I wouldn't document

how many fingers."

An attempt was made during redirect questioning of Patient B by Ms. Mooneyhan, who once again questioned my medical record documentation.

On cross-examination by me, Patient B acknowledged a statement that she had privately read. She was asked by Ms. Mooneyhan if she had seen the note on the date of the visit, April 27, 2015, she said, "No."

The assertion here was that I falsified the note. My note was accurate.

It is not customary practice for physicians to share written notes on the same date of a visit with patients.

Now, if they ask to see their note, there's a simple process to achieve said goal. As part of the 21st Century Cures Act, effective April 5, 2021, it was nationally mandated that patients be granted access to all information in their records if requested.

The law did not exist in 2015, but most importantly, Patient B did not request to see said note.

In short, I tried to be thorough, made an error, and it landed me a charge.

However, the allegations in Count IV have not been proven; therefore, they do not form sufficient basis for discipline.

Count V and VI, NRS 630.301, subsection 7, engaging in conduct that violates the trust of a patient and exploits the relationship with the patient or financial or other personal gain.

The complaint alleging that I expressed to Patients B and C, in the midst of a medical encounter, that I would paid her or them and other patients $1,000 to pose for nude photographs to use in my marketing materials.

The complaint and testimonies failed to assert how my expressing a general offer for a compensated modeling job violated the trust of Patient B and/or C, or exploited our doctor-patient relationships.

There were no representations made that the photographs would be for the purposes of medical examination or treatment, or that Patient B's or C's treatment will be contingent upon their acceptance of the offer.

The complaint alleged that had I informed them at the outset that the photography would be nude, thereby avoiding any misunderstanding or

misrepresentation as to the nature of the modeling offer.

The complaint alleged that I offered financial compensation in exchange for modeling. This contraindicates the exploitation charge.

The photographs were to be used in marketing materials, highlighting my cosmetic GYN surgical services, which would necessarily generate additional costs for me without any guarantee of return on my investment, thus negating any financial or other gain. More than that, neither Patient B nor Patient C posed for any photographs.

The facts alleged by the complaint do not support the charges that I violated the patient's trust or exploited the therapeutic relationship, let alone both, as required under the statute.

Mr. White stated yesterday that my actions violated the Code of Medical Ethics. I have the AMA, American Medical Association, Code of Medical Ethics book, and I cannot find anywhere in that book where my actions were unethical.

Count VII, NRS 630.306, subsection 1 (g), continual failure to practice medicine properly.

The count alleged that by engaging in sexual misconduct with Patient A, B, and C, I have

continually failed to exercise the skill and diligence and a use a method ordinarily exercised under the same circumstances by physicians in good standing practicing in the field of obstetrics and gynecology.

NRS 630.306, subsection 1 (g), provides that continual failure to exercise a skill or diligence of the use or use the methods ordinarily excised under the same circumstances by physicians in good standing practicing in the same speciality or field.

The statute calls for a comparison with the skill, diligence, and methods under the same circumstances by physicians practicing in the same speciality or field.

However, the complaint charges or charged me in comparison with the field of obstetrics and gynecology. As each of the charges in the complaint related to my practice as a cosmetic GYN surgeon, the comparison with general obstetrics and gynecology standards is inconsistent with the statute.

Only by comparison with the skill, diligence, and methods of other cosmetic GYN surgeons under the same circumstances could my

practice be judged. General obstetrics and gynecologist standards do not address, for example, utilization of photography for patient education, before and after documentation, and advertisement for cosmetic GYN procedures.

The complaint's support for this charge that I allegedly repeatedly engaged in sexual misconduct is wholly unjustified.

Although neither NRS nor NAC chapter 630 define sexual misconduct, an article published in the Board's newsletter in December 2016, characterize physician sexual misconduct as malpractice and/or criminal conduct.

At no point does the complaint accuse me of engaging in sexual misconduct with any of the patients.

Count VIII, NRS 630.301, subsection 9, disreputable conduct.

This count provides that engaging in the conduct that brings the medical profession into disrepute is grounds for initiating disciplinary action.

While sexual misconduct was not in the compliant, sexual impropriety became the theme for this case.

Firstly, as stated by Dr. Rafael during his testimony, we're taught during medical school to use lay words, layman's terms, and language to help the patient to understand us without any ambiguity.

I use plan language when I speak with my patients. At the bedside, I do not use vulgarities.

Much has been said about what I have allegedly said, but I did not use the words attributed to me. They were fabricated hearsay.

Dr. Rafael mentioned that I told Patient B that her vagina was loosey-goosey. There's no labor nurse, including the ones who cannot stand my guts, who do not like me, would testify under oath that I would ever say that to a patient.

During Patient B's obstetrical laceration repair, there was a labor nurse and a surgical scrub tech present. They would have heard me.

Patient B's testimony was unreliable because she came in with an agenda, would not answer my questions, to be hostile, to insult, and finally on the way out of the hearing room, she flipped me the middle finger in front of every person present in the Vegas hearing room, including the media.

I understand that people in general get uncomfortable when there's a sexual discussion.

They're curious, but uncomfortable, nonetheless.

I had a discussion with Patient A, not to insult her, but to give her answers to the questions that she posed on Exhibit 3, pages NSBME 0023 and 0024.

I was trying to help her understand why she felt the way she did. I now realize that whilst Patient A opened the door to feel out issues regarding her sexual health and pelvic floor dysfunction, she was not ready for the conversation. For that, I apologize, and I do empathize with her embarrassment.

As far as there not being a chaperone in the exam room, it is my continued assertion that I did have a chaperone, because Casey was outside an opened door.

Patient B and C, as well as Ms. Casey Carden testified that had they had chaperones during their pelvic examinations.

And, yes, Ms. Ghusn, you had a question of Ms. Carden yesterday that she could not answer. During her last appointment with me in 2022, she did have a chaperone present.

I did what I thought was the right thing to do during on the onset of COVID and the immunity

by vaccination on natural infection. The Centers for Disease Control was changing its recommendation on a daily basis, and I had to decide what was the best COVID policy to implement in my office, as there were no real solid guidance.

Dr. Rafael testified that my chaperone should have been six feet away. But six feet away puts my chaperone outside the exam room door. The door was opened to the exam room. I know, like everyone, that it was not the most ideal, but it was what I thought was the best and safest thing to do at the time to protect everyone from COVID.

I'm familiar with the ACOG recommendation for chaperones because it is my custom to have one present as confirmed by three of your witnesses. But I made the necessary adjustments during COVID.

Dr. Rafael even admitted that there have been extenuating circumstances during which he has examined patients alone. I have someone outside an open door; he examines them in a room with a closed door, alone.

It doesn't matter if one documents a patient declined a chaperone or that the chaperone is outside the door, if a patient intends to complaint about a doctor, she's going to do it.

Not having a chaperone inside the room makes Dr. Rafael and I vulnerable to the accusations as I have been accused.

Dr. Rafael testified in that my marketing material bring disrepute onto the medical community.

My marketing material found in the patient's lavatory, in the consultation room, as well as in the adult entertainment industry publications were truthful and not deceptive or misleading.

It did not violate NRS 629.076, which delineates the standards for physician advertisement.

My marketing material was decent, they were artful, and consistent with those of my plastic surgery colleagues.

I've hired many of my patients to work for me over the years. Therefore, I did not see anything wrong with hiring them to model for my marketing material.

I will admit my naivete in this matter. Dr. Goodman testified whilst it is not his style, personally, to pay patients to model for his marketing material, it is his opinion that it is not outside the standard of practice to do so.

I chose to do a subtle recruitment so I could include my ad in a magazine targeting women who have been largely forgotten or avoided because of the nature of their work.

It probably was not my wisest decision, and I would reassess going forward whether or not I would do it again.

Finally, I would be failing in my own defense if I did not mention that it is strange that Patient B and C, not knowing each other, filed their complaints in February, 2022, when they were seen and evaluated years apart.

But Patient C has denied any contact amongst the three patients, and I do not believe that to be the case.

The most astounding thing to have witnessed during this case was a significant degree of selective amnesia in women in their 30s, as it relates to the passage of time, yet the same courtesy was not afforded to me, not remembering, without being shown the photograph that I had examined Patient A with four fingers.

They all could recall with great details what I had allegedly said to them, but anything that favored my cause was forgotten.

At least Ms. Carden recalled that the reason for Patient A's visit was for a vaginal rejuvenation consultation, despite the repeated claim that it was for perineal pain.

For two decades I have dotted all my Is, and crossed all Ts. I've been very careful because I'm a male OB-GYN. More than that, I'm a black, male OB-GYN. I recognized early in my career that we do not get to make mistakes the same as our counterparts, so I have been very careful.

My work has been sexualized and sullied, but not by me.

It takes courage to add sexual health medicine that one's medical practice. Courage because everyone fears ending up in a situation like this. Courage because people are afraid to have the discussion, yet they want the knowledge. Courage because one can be dubbed a pervert for taking on this cause.

I am one of those brave physicians who sought out post-residency training in sexual health medicine. I did it to help my patients.

But my name has been besmirched. My professional reputation has been stained. My life was turned upside down.

I'm reminded of a quote by the comedian Dave Chappelle: "Nothing feels better to a coward than to watch a brave guy fall."

With that said, I've been tried and convicted in the local media, because anything sexual sells, by one reporter in particular who has recklessly and irresponsibly gone out of her way to try and cancel me, but thank God the police and the district attorney did their due diligence.

I ask you, Ms. Ghusn, to please look carefully at the evidence presented during this hearing as you deliberate. You will see that my work and my behavior are being judged as a traditional OB-GYN and not as a cosmetic GYN surgeon as well as a sexual health clinician, due to the lack of understanding of these two specialties.

Yesterday Dr. Goodman eloquently explained the differences between traditional OB-GYN and cosmetic GYN surgery. He talked about the challenges between the two specialties. One is established, and the other evolving and trying to gain acceptance by the other. He talked about his course and whether or not I'm qualified to do this work.

After you have gathered all the

information, you'll see, as I've stated in the beginning of this case, that I'm innocent of these charges.

I thank you for your time.

HEARING OFFICER GHUSN: Thank you, Dr. Chambers.

We are at 12:20. Mr. White, are you good to go or would you like five minutes?

MR. WHITE: I'm good to go. Everybody else okay?

HEARING OFFICER GHUSN: Ms. Court Reporter. Are you good to go?

THE REPORTER: I am. Thank you.

HEARING OFFICER GHUSN: Okay. Thanks.

MR. WHITE: Thank you.

BY MR. WHITE:

More dodging, more deflecting, and more deceiving is what we just heard.

You heard him talk about his own expert, Dr. Goodman, and how important it was, and he even ended off with that. He talked about how Dr. Goodman, his opinion of Dr. Chambers was that he was well educated because he attended his, Dr. Goodman's, two- to three-day course on sexual health.

However, he also testified yesterday, and Dr. Chambers just failed to mention this, that it is also very important and he wishes -- Dr. Goodman said he wishes a lot of his attendees would continue education.

And Dr. Chambers has not been to a continued education on sexual health or anything outside of that, his normal role as an OB-GYN, since 2014.

And you did hear Dr. Goodman say, yes, he -- about three of his former attendees have done it, and it's important to do. He's done it. He's been to lots of classes, continues his education, continues trying to better his skill. And Dr. Chambers has not done that.

You also heard that Dr. Goodman takes pictures, but only the necessary ones -- and I think Dr. Chambers did mention this -- but only the necessary ones, and he does not just get verbal consent, he gets written consent, formal written consent.

I'd like Hearing Officer Ghusn to please take into account that Dr. Chambers referred numerous times, but just for a couple of examples, to things that are not in evidence.

For example, a Wikipedia fisting definition, which we don't have. And also whether the glove was dry or not, that wasn't really talked about too much in the -- or at all, really, in the photo of the four fingers in Patient A's vaginal area.

Dr. Chambers also, during his closing, tries to make a little, hey, that Patient A acted differently at her visit, as opposed to her testimony at this hearing.

But she also made a point -- and she addressed this in her testimony, she also made a point to address this traumatic experience with her therapist, and she didn't do that until after the visit with Dr. Chambers when she realized that Dr. Chambers traumatize her throughout that visit.

He also continues his dodging, deflection, deceiving by really just blaming patients, former patients of lying. That's what he does, and that's what he did during his closing arguments, blame Patient A for having different testimony than what the visit appeared to be, and then he blames Patient C and Casey Carden of just all of a sudden fabricating hearsay, I think is what he said, which that's a legal definition that doesn't belong in a

closing argument anyway.

And so that continues with him. That's what he's done since the outset of this case, and it makes sense that he would change -- or not keep accurate records, like he did with writing down that he only inserted two fingers when he actually inserted four. There's a picture of it.

He also said that there was selective amnesia when he talked about some of his former patients what were witnesses for the Board, for the IC, and I don't think there's any proof that Dr. Chambers is educated in diagnosing amnesia.

Again, it's just more -- like we stating from the beginning in our opening and in the closing argument, he just deceives and dodges the truth, and does it on the fly, and I would like you to take that into account.

And especially take into account, Ms. Ghusn, when you're writing your recommendations that he did refer to -- again, I'll repeat that he did refer to many things that are not in evidence.

Thank you.

HEARING OFFICER GHUSN: And thank you all. Here we are. Finally. It's been quite a road, north and south.

A couple of statements in general:

I would like to thank those observing and the media for treating this matter with respect and dignity because I know on Zoom like this that it's at your discretion whether you mute or unmute, and everybody was great. And I'm happy that those of you who are observing, whether private individuals or the media, had the opportunity to do so. I think it's not only required, but I think it's important.

I have 60 days in which to render my recommendations. I believe from today's date, not from the date of receiving a transcript; correct, Mr. White?

MR. WHITE: Yes, that's correct.

HEARING OFFICER GHUSN: Okay. Sixty days is August 1st.

I have a couple of matters I need to write, decisions and recommendations, that are in line before this one. I hope to complete this -- this before August 1st, but I know that will be the date to look for.

I also want commend counsel, witnesses, and Dr. Chambers for comporting yourselves in a manner worthy of a hearing, and especially this hearing.

I am impressed with everybody. You were all helpful, because the task is before me, and I thank you for your indulgence when I asked for some information or questions because I know I can't go back.

Dr. Chambers, thank you.

Mr. White Ms. Mooneyhan, thank you. I know there was some travel involved as well.

Which I'll also comment, technology, I think we were lucky. I think it worked great, and I just wanted to bring that to everyone's attention that it worked wonderfully, even without being north and south.

So to the IT folks there at the Board offices, thank you.

And to administrative assistants, thank you. I know we'll be in touch.

Court reporters, thank you for staying on top of it if we start talking over each other or getting muddled or we should get a break. And cookies, of course. Thank you.

With that, thank you for the privilege.

Dr. Chambers and Mr. White, do you have anything before we sign off here?

DR. CHAMBERS: I have nothing. Thank you

very much for the guidance you gave me.

HEARING OFFICER GHUSN: And I wish you the best.

DR. CHAMBERS: Thank you very much.

HEARING OFFICER GHUSN: And I know I'm in touch other matters with the Board, but, again, thank you, counsel for the IC.

Mr. White, anything?

MR. WHITE: No. Thank you, Ms. Ghusn.

HEARING OFFICER GHUSN: Okay. All right. Well, everyone have a good rest of your day and weekend.

And you will hear from me, hopefully, well before August 1st, but by August 1st for sure.

Thank you again, and good luck.

(Hearing ended at 12:29 P.M.)

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

I, BRANDI ANN VIANNEY SMITH, do hereby certify:

That I was present on June 2, 2023, at the Nevada State Board of Medical Examiners, via Zoom, Reno, Nevada, and took stenotype notes of the proceedings entitled herein, and thereafter transcribed the same into typewriting as herein appears.

That the foregoing transcript is a full, true, and correct transcription of my stenotype notes of said proceedings consisting of 121 pages.

DATED: At Reno, Nevada, this 12th day of June, 2023.

BRANDI ANN VIANNEY SMITH

HEALTH INFORMATION PRIVACY & SECURITY: CAUTIONARY NOTICE

Litigation Services is committed to compliance with applicable federal and state laws and regulations (“Privacy Laws”) governing the protection andsecurity of patient health information.Notice is herebygiven to all parties that transcripts of depositions and legal proceedings, and transcript exhibits, may contain patient health information that is protected from unauthorized access, use and disclosure by Privacy Laws. Litigation Services requires that access, maintenance, use, and disclosure (including but not limited to electronic database maintenance and access, storage, distribution/ dissemination and communication) of transcripts/exhibits containing patient information be performed in compliance with Privacy Laws. No transcript or exhibit containing protected patient health information may be further disclosed except as permitted by Privacy Laws. Litigation Services expects that all parties, parties’ attorneys, and their HIPAA Business Associates and Subcontractors will make every reasonable effort to protect and secure patient health information, and to comply with applicable Privacy Law mandates, including but not limited to restrictions on access, storage, use, and disclosure (sharing) of transcripts and transcript exhibits, and applying “minimum necessary” standards where appropriate. It is recommended that your office review its policies regarding sharing of transcripts and exhibits - including access, storage, use, and disclosure - for compliance with Privacy Laws.

4

IC'S EXHIBITS ADMITTED INTO EVIDENCE

EXHIBIT 1

EXHIBIT 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive
Reno, NV 89521

Victor M. Muro, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

September 2, 2021

George Chambers, M.D.
[redacted]

RE: BME CASE #: [redacted]
PATIENT: [redacted]

Dear Dr. Chambers:

We have received information and a complaint regarding your disruptive behavior towards the above named patient. The complaint alleges your unprofessional demeanor and treatment and care of the patient may have fallen below the standard of care which may have had an adverse impact on the quality of care rendered to the above named patient.

It is alleged:

1. The patient presented to you on November 17, 2020, for a consult on perineal repair. The patient was also interested in learning about vaginoplasty and labiaplasty.

2. Before you left the room to allow the patient to prepare for an exam, you advised the patient to keep her cell phone, as you would use it to take pictures.

3. After coming back into the exam room, you left the door open.

4. The patient expressed her discomfort at having the door left open during the exam and was assured by you no one was in the office and all the doors were locked so no one could enter.

5. As you proceeded with the exam, you instructed the patient to put her feet together and open her legs a far as possible, instead of putting her legs in the traditional stirrups during a vaginal exam.

6. During the exam, you began pressing on different areas of the patients vagina and asked if she was feeling any discomfort. You took several pictures and continued to ask if the patient was feeling any pain or discomfort.

7. You began a very uncomfortable exam and the patient felt as if you were stretching her to see how far her vagina would stretch.

8. During this stretching, you stated to the patient you were surprised she was not hurt.

9. After the exam, you pulled out what should have been your fingers, but was much too painful and large to have only been your fingers.

10. After the exam, you took more pictures and then proceeded with a rectal exam.

11. You inserted one finger into the patient's rectum at the same time asked the patient to remove the soiled glove from your other hand so you could take more pictures.

12. You took a total of 12 pictures. After the exam, you asked the patient to text you 2 of the 12 pictures so you could print them out and review with the patient.

13. You printed the pictures, returned to the exam room, and told the patient that during the exam you had done something called "fisting" where you tried to insert your entire fist into the patient's vagina.

14. You showed the patient how much of your fist you got inside, then compared the size of your fist to the size of a man's penis and told the patient her vagina was too big for a man's penis.

It is further alleged;

1. You showed the patient videos of previous patients and their experiences.

2. You then showed the patient pictures of the previous patient's before and after pictures of her vulva.

3. You explained to the patient that you do the surgeries in your office under a local anesthetic instead of at a surgery center or hospital with staff and general anesthesia.

4. You also told the patient during the surgery you would stimulate her clitoris multiple times and it was okay for the patient to come if she needed.

5. You then asked the patient specifically about her sex life with her husband.

6. After leaving your office, the patient experienced pain in her vulva and vagina. She had a pelvic exam done and it was determined the Bartholin gland had been swollen due to a trauma to her vagina and vulva.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above.** Please include any further information you

believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 30 calendar days.**

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the NPMA until a thorough investigation is completed.

As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.301(5)(6)(7)(9).

Respectfully,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

In the Matter of the Investigation of:)
)
) Case No. [redacted]
George Chambers, M.D.)
)
License No. **10476**)
_____)

ORDER TO PRODUCE HEALTH CARE RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

George Chambers, M.D.
[redacted]

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records of **Patient:** [redacted] **from January 1, 2020 through the present date**.
2. The name and contact information for any entity, facility, or person that you believe may possess the health care records of **Patient:** [redacted] **from January 1, 2020 through the present date**.
3. If health care records are provided electronically, they must be in a **searchable** format.

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 21 days of service** of this Order (Investigation Division, Attn. Johnna LaRue, CMBI, Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521). Failure to comply and produce said records in the aforesaid manner may subject you to potential

disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(1)(d); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this 2nd day of September 2021.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

Bret Frey, M.D., Chairman
Victor M. Muro, M.D., Chairman
Nevada State Board of Medical Examiners
Investigative Committee

EXHIBIT 2

EXHIBIT 2

Chambers & Associates

OBGYN and Gynecological Surgery, PLLC

Competent, Compassionate & Reliable Care for Women™

George P. Chambers Jr., M.D., FACOG
Medical Director

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

January 20, 2022

Re: BME CASE #: [redacted]
PATIENT: [redacted]

Dear Ms. LaRue:

This is my response to the allegations that my "unprofessional demeanor and treatment and care of the patient may have fallen below the standard of care which may have had an adverse impact on the quality of care …" After perusing the two-page document entitled "Vaginal Repair Consultation" given to me by [redacted] at her consultation on 11/20/2020, I used the document as a guide and answered all the questions that she had written. I also wondered why she had consulted so many experienced and skilled OB/GYNs regarding this matter. Her visit was chaperoned by my office manager (Casey). After the examination, she stood at the counter in the patient care area with Casey and me. We all talked for about 15 to 20 minutes about how excited she was to finally do this surgery. Imagine my surprise when I received a letter dated 04/19/2021 from Det. C. Vensand [redacted] stating that "a report has been filed with the Las Vegas Metropolitan Police Department listing you as a suspect to an alleged crime." I called Det. Vensand and asked what was my alleged crime? He said that "[redacted] reported that you 'fisted' her during the exam for your sexual pleasure." I then chose to be interviewed without an attorney, because I had nothing to hide, by Det. Vensand and two other detectives for 2.5 hours on 05/03/2021 in my office. Before leaving my office, all three detectives (two men and one woman) informed me that no charges would be filed, but they were obligated to investigate the complaint. Casey was also interviewed separately by them. I asked Casey to write a summary of her memory of our encounter with [redacted] I included said summary with the copy of [redacted] medical record.

In terms of the allegations:

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1. **The patient presented to you on November 17, 2020, for a consult on perineal repair. The patient was also interested in learning about vaginoplasty and labiaplasty.**

[redacted] presented to me with a reported referral from Dr. Michelle Lewis because I have post-residency training in GYN cosmetic surgery and I am certified in sexual health medicine. [redacted] stated that "the doctor (who delivered her children) did a poor job repairing the tear leaving me open and in pain and discomfort." In addition, she also stated that she has rare fecal incontinence, has occasional stress urinary incontinence, has discomfort wearing tight clothes, has to constantly shift in her seat to avoid tugging or pinching of her labia minora, has perineal pain, *et cetera*.

2. **Before you left the room to allow the patient to prepare for an exam, you advised the patient to keep her cell phone, as you would use it to take pictures.**

Yes, I did make this request. Since medical school I have used illustrations to explain my clinical findings and planned surgical approach. Patients generally appreciate my drawings, but a photograph of the patient's own body is generally more educational for them. During the initial consultation for GYN cosmetic surgery, I always ask potential patients' permission to use their mobile phones to take pictures of their genitalia. It also serves to create realistic expectations of possible outcomes. The patients maintain control of their pictures if they choose another surgeon for their surgery. If they select me to do the surgery, a formal consent is signed and I take official before and after photographs.

3. **After coming back to into the exam room, you left the door open.**

After I had taken a thorough history and was about to leave the exam room, I took the time to explain to [redacted] the measures that I had implemented to protect my patients, staff and me from covid-19. I told her that I do not allow more than three patients in my office lobby at a time and no more than one patient in the patient care area at a time. I told her that spouses or partners are not allowed in the office and that they are welcomed to attend the appointment via FaceTime. I told her that I no longer close the exam room door during examinations because I do not want my patient, the chaperone and I to be trapped in a small exam room given the risk of getting covid-19. Remember, no vaccination was available in November 2020. I asked her as I did with every patient at that time if that was ok with her and she looked at the door between the office lobby and the patient care area. So, I further explained that the two doors between the office lobby and patient care area are security doors and cannot be opened without a key from the

lobby. Therefore, her privacy would be guaranteed. I asked again if leaving the door open would be ok with her and she said yes. So, I left the door open with Casey standing outside the door with full view of me and [redacted] whilst labelling charts.

4. **The patient expressed her discomfort at having the door left open during the exam and was assured by you that no one was in the office and all the doors were locked so no one could enter.**

See #3 above. And yes, the only people in the patient care area of the office during her visit were her, Casey and me.

5. **As you proceeded with the exam, you instructed the patient to put her feet together and open her legs as far as possible, instead of putting her legs in the traditional stirrups during a vaginal exam.**

There is no requirement for an OB/GYN to use the stirrups during a pelvic examination. In fact, I have yet to meet a patient who finds the stirrups comfortable. I only use the stirrups if I am going to be inserting a speculum into the patient's vagina. If I am only doing a manual pelvic examination, I instruct my patient on how to place her legs in a frog-legged position. It is preferred by most patients because unlike when the stirrup is used, they have more control of their legs in frog-legged position. It is how we examine patients in labour in the United States of America. This position was not new to [redacted] because she has had four vaginal deliveries.

6. **During the exam, you began pressing on different areas of the patient's vagina and asked if she was feeling any discomfort. You took several pictures and continued to ask if the patient was feeling any pain or discomfort.**
7. **You began a very uncomfortable exam and the patient felt as if you were stretching her to see how far her vagina would stretch.**
8. **During this stretching, you stated to the patient you were surprised she was not hurt.**

Ms. Ross sought evaluation for treatment of her dyspareunia and pelvic/perineal pain. In OB/GYN we tend to lump the assessment of genital pain under one heading, pelvic pain. However, in sexual health medicine, determining the location of the pain is essential for proper diagnosis and treatment. I needed to know if her pain was insertional (as this accounts for 80% of all dyspareunia), vaginal, or deep in the pelvis.

In evaluating Ms. Ross' pain, I was very methodical in order to find any trigger points of pain. Externally, I used a cotton Q-tip to touch lateral then medial to Hart's line. I touched the vestibule at 1 o'clock and 11 o'clock adjacent to the urethral opening and Skene's glands. I also touched the vestibule at 4 o'clock and 8 o'clock at the Bartholin's glands. I also touched the vestibule at the 6 o'clock position. As I palpated the aforementioned areas, I asked Ms. Ross if she felt pain or pressure. She responded by saying, "pressure," except at the 6 o'clock position where she said, "pain."

In order to evaluate her pelvic floor muscles, I inserted one finger into her vagina. I then palpated her pubococcygeus, transverse perinei and obturator internus muscles. As I palpated each muscle, I asked her if she felt pain or pressure. I then inserted my two examining fingers to check the tonicity of her pubococcygeus muscles by asking her to squeeze her vagina. Her muscles were extremely weak. I palpated her urinary bladder transvaginally to evaluate for pain. I palpated the pudendal nerves bilaterally at the ischial spines to see if there was pain. At no time did she say she was in pain. She said that she had some discomfort. So, knowing that a regular patient would report discomfort when her ischial spines are palpated, I told Ms. Ross that I was surprised that I could not trigger the pain that she had reported.

9. **After the exam, you pulled out what should have been your fingers, but was much too painful and large to have only been your fingers.**

Given her sensitive vagina, she may have had the perception that my fist was in her vagina. I wear size 8 gloves; nonetheless, my bimanual examinations have always been reported as being gentle. Prior to my internal examination of [redacted] I used a single Cardinal Health™ Lubricating Jelly (0.11 oz.) packet to lubricate my two fingers. I did not fist [redacted]. Had I done so, she would have screamed and it would have been witnessed by Casey (who is also my patient). "Fisting" is a sexual activity that I will never understand because I believe it is abusive and can result in damage, including laceration, to a woman's pelvis. Furthermore, on Labour and Delivery I hate it when I must do a manual extraction of a retained placenta. In this maneuver, I use betadine to rinse my gloved right hand. I then lubricate my entire right hand with copious amounts of lubrication to reach all the way up to the uterine fundus to separate placenta intact from the uterine wall. It is best done if the patient has an epidural; if not, I generally have the nurses use IV narcotics or ask the anaesthesiologist to do IV sedation. So, the fact that [redacted] would accuse me of "fisting" her is complete lunacy.

10. After the exam, you took more pictures and then proceeded with a rectal exam.

Yes, I did do this.

11. You inserted one finger into the patient's rectum at the same time asked the patient to remove the soiled glove from your other hand so you could take more pictures.

I use my right hand in all examinations. My left hand is generally used to separate the patient's labia. I did not ask [redacted] to remove any gloves. My left glove was essentially clean. My soiled glove was still in her rectum when I took the photograph.

[redacted] reported rare fecal incontinence. She also wrote that she has "extra skin around anus and possible rectal prolapse? My rectum can protrude when having a bowel movement. A few times I've had some bowel leakage. Often have an urge to poo but cannot go." Prior to performing the rectovaginal examination, I had her bear down and there was no rectal prolapse. I did find a rectocele and I used my left hand to take a photograph of it so I could explain what it was and how it could be repaired.

12. You took a total of 12 pictures. After the exam, you asked the patient to text you 2 of the 12 pictures so you could print them out and review with the patient.

I took many photographs; how many, I do not know. I did ask her to send me only two of them that would allow me to properly do pre-surgical markings so she could see what would be done. Those photographs are included with her medical records that I am providing to you.

13. You printed the pictures, returned to the exam room, and told the patient that during the exam you had something called "fisting" where you tried to insert your entire fist into the patient's vagina.

To reiterate, this is pure fiction and lunacy! I have never "fisted" any patient's vagina.

14. You showed the patient how much of your fist you got inside, then compared the size of your fist to the size of a man's penis and told the patient her vagina was too big for a man's penis.

[redacted] read what she had written to me. "I feel like my vagina is just too open and not supported. I do Kegels on my own or tightening during sex and I feel the tightening in the upper part of my vagina but closer to the opening I feel like I just can't get it tight. It feels unsupported. It feels like everything is just open and coming out. When I am uncomfortable sitting down I try tightening that area but can't tighten it enough to feel comfortable." She also stated that tampons sometimes fall out of her vagina.

I have never been comfortable telling any patient that her vagina is loose because I am aware of the negative psychological impact of such a statement. Therefore, I would never compare the size of my fist with a penis and tell any patient that "her vagina was too big for a man's penis." During my bimanual exam and sizing of her introitus, I determined that her introitus was 7cm wide. So after the examination, I opened my two fingers to 7cm and told her that your vaginal opening is this wide. I said that "I understand why you cannot feel your husband's penis." I explained that the posterior colporrhaphy or vaginoplasty would correct the vaginal canal to its proper anatomical shape and create a sensation of a tighter feel.

It is further alleged:

1. **You showed the patient videos of previous patients and their experiences.**

I do not videotape my patients. So, this is a blatant lie.

2. **You then showed the patient pictures of the previous patient's before and after pictures of her vulva.**

Every patient who seeks GYN cosmetic surgery wants to know my credentials in performing these procedures and wants to see samples of my work. [redacted] was no different, she read from her list of questions. She asked "how often do you do this surgery?" "How satisfied are your patients?" … "Do you have training in cosmetic surgery?"

I answered all her questions. I also showed her before-and-after photos on a "B/A" App that slides the photos back and forth. I also showed her a Power Point presentation of before-and-after photos. This is no different that a plastic surgeon who shows before-and-after photos of augmented breasts or buttocks. These pictures are taken for medicolegal, advertisement, educational and teaching purposes. Interestingly, she also asked about Dr. Red Alinsod who

taught me about the importance of medical photography in GYN cosmetic surgery. She wrote that "I saw some terms on a urogynecologist's website, Dr. Red Alinsod." Therefore, she knew that before-and-after photographs are a standard necessity.

3. **You explained to the patient that you do the surgeries in your office under local anesthetic instead of at a surgery center or hospital with staff and general anesthesia.**

I was trained to perform these procedures using sterile technique in the office by Dr. Michael Goodman who has authored one of the only textbook in GYN cosmetic surgery and who is regarded as one of the "founding fathers" of this new and upcoming subspeciality of OB/GYN. By performing these procedures in the office, the cost is significantly lower than if they were done in the hospital. It offers a more discrete and comfortable environment as well as decreased the risk from general anaesthesia. In terms of pain control, after her vulva has been prepped using betadine or hexadine, a topical local anaesthetic is applied to her vulva. Thereafter, local anaesthesia using bupivacaine 0.5% with epinephrine buffered with 0.25 mL of bicarbonate is injected. She is also given an oral anxiolytic with an oral narcotic. The patient's vitals are monitored and recorded. The procedure room is equipped with an AED. Intravenous fluid hydration is available if necessary. I am assisted by a registered nurse and we both wear sterile gowns and gloves. The patient is draped in surgical drapes as is done in the hospital.

4. **You also told the patient during the surgery you would stimulate her clitoris multiple times and it was okay for the patient to come if she needed.**

I never said this. [redacted] seems to have forgotten that there was a chaperone present. To reiterate, her visit was chaperoned by Casey (who is now studying nursing and knows the difference between ethical and unethical behaviour). Not only would this behaviour have been unethical on my part, it would have made no sense as a topical anesthetic agent is applied to the entire vulva at the start of the surgery to prevent her from feeling any sensation.

5. **You then asked the patient specifically about her sex life with her husband.**

[redacted] is being disingenuous. She sought a consultation with me because I sub-specialise in sexual health medicine. In fact, to my knowledge, I am the only board certified OB/GYN in the state of Nevada who is also certified in sexual health medicine. She brought up her sex life. She

read the following statements and asked the following questions from the document that she gave me:

"Sex can be painful if not very well lubricated. My husband has learned some areas not to touch, Lubricant used to be an occasional thing that we didn't use very often, now it is necessary in abundance for any touching or penetration."

"The inner labia seem to be tugged a lot when I'm sitting or during sex and it's uncomfortable. Often I have to manually open the labia for sex. And they get tugged during sex which is uncomfortable."

"It takes more clitoral stimulation to orgasm now and orgasms are less intense."

"How will this change feeling/sex? How likely is the surgery to decrease sexual pleasure?"

Was I not supposed to address her concerns or answer her questions?

6. **After leaving your office, the patient experienced pain in her vulva and vagina. She had a pelvic exam done and it was determined the Bartholin's gland had been swollen due to a trauma to her vagina and vulva.**

I can assure the investigative committee of the NSBME that I performed the standard Q-tip touch test and bimanual examination for the evaluation of pelvic pain on [redacted] Nothing I did would have caused edema of the Bartholin's gland. An edematous Bartholin's gland is a result of a clogged gland that results in a cyst and when infected an abscess. There is nothing that an OB/GYN does in the office or surgery that would result in a problem with the Bartholin's gland. This is just totally absurd.

I did not violate the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA). If I had done what [redacted] accused me of doing, I would have been arrested, dragged disgracefully in front of the media and ruined. Rather, I suspect that [redacted] was an agent for my ex-wife. My ex-wife was referred to her divorce attorney by her dentist. They are friends. [redacted] husband is a dentist. Is this a coincidence? I do not know, but it is highly suspicious. I once told my ex-wife that the fastest way to end an OB/GYN is to accuse him of a sexual misconduct. Both her and her divorce attorneys were obsessed with two things during the divorce, my money and how

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many NSBME complaints had been filed against me in the previous 10 years. Both of their first and second sets of interrogatories were sent and answered before these three complaints were filed against me. A third was sent after they insured that I had been notified by the NSBME. The plan was to use the NSBME to discredit me in hopes that the family court judge would grant her full custody of our children.

Being granted primary legal and physical custody would have ensured that she would not need to work for the next 16 years as she would survive on my child support payments. Despite joint legal and physical custody being granted, my ex-wife continues to scheme to this day. In a text conversation on June 7, 2021, I asked her why she would try to destroy me by collaborating with two of my patients; one of whom tried to extort me. Her response was that "you filed a restraining order against me. I was pissed!" I had filed a restraining order on her after she was arrested for domestic violence against me in November 2020.

This concludes my response. Thank you for your patience with me in getting this document back to you. I can be reached at (702) 901-1249.

Respectfully,

George P. Chambers, Jr., MD, FACOG
Board Certified, Obstetrician and Gynecologist
Certified, Sexual Health Medicine

EXHIBIT 3

EXHIBIT 3

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 4

EXHIBIT 4

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 5

EXHIBIT 5

NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive
Reno, NV 89521

Victor M. Muro, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

February 3, 2022

George Chambers, M.D.
[redacted]

RE: BME CASE #: [redacted]
PATIENT: [redacted]

Dear Dr. Chambers:

We have received information and a complaint regarding your disruptive behavior towards the above-named patient. The complaint alleges your unprofessional demeanor and treatment, and care of the patient may have fallen below the standard of care which may have had an adverse impact on the quality of care rendered to the above named patient.

It is alleged:

1. The patient presented to you on October 29, 2018, for an exam.
2. You asked your staff to leave the exam room so you could speak with the patient privately.
3. You then asked if the patient would model nude for you. You said you would pay the patient $1000 for the gig telling the patient you are the photographer.
4. You described what you tell your other patients that model for you, such as "fuck the camera" and other things of that nature.
5. You told the patient after the photo shoot you would offer to give a copy of the photos to the patient but that she cannot tell her husband you were the photographer.
6. You also asked the patient to stand up, while she was naked on the exam chair, so you could see what she looked like naked from that angle.
7. You gave the patient your approval and reminded the patient not to tell her husband.
8. You told the patient to think about it and to text you with her decision but to not use any details in the text.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above, including, as well as complete health care records for the aforesaid patient[s]. Include copies of any imaging, x-ray or other films that were produced during treatment of this patient.** Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 30 calendar days.**

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the NPMA until a thorough investigation is completed.

As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.301(5)(6)(7)(9).

Respectfully,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

In the Matter of the Investigation of:)
)
) Case No. [redacted]
George Chambers, M.D.)
)
License No. **10476**)
_____)

ORDER TO PRODUCE HEALTH CARE RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

George Chambers, M.D.
[redacted]

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records of **Patient:** [redacted]**; from January 1, 2018 through the present date**.
2. The name and contact information for any entity, facility, or person that you believe may possess the health care records of **Patient:** [redacted] **from January 1, 2018 through the present date**
3. If health care records are provided electronically, they must be in a **searchable** format.

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 21 days of service** of this Order (Investigation Division, Attn. Johnna LaRue, CMBI, Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521). Failure to comply and produce said records in the aforesaid manner may subject you to potential

disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(1)(d); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this 3rd day of February 2022.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

Bret W. Frey, M.D., Chairman
Victor M. Muro, M.D., Chairman
Nevada State Board of Medical Examiners
Investigative Committee

EXHIBIT 6

EXHIBIT 6

Chambers & Associates

OBGYN and Gynecological Surgery, PLLC

Competent, Compassionate & Reliable Care for Women™

George P. Chambers Jr., M.D., FACOG
Medical Director

March 17, 2022

Ms. Johnna LaRue
NSBME
9600 Gateway Drive
Reno, NV 89521

Re: BME Case # [redacted]
Patient: [redacted]

Dear Ms. LaRue:

First, let me convey that I have not violated the Nevada Medical Practice Act, Nevada Revised Statues, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA). During my hearing last month, it was suggested that my chaperones are employed by me so their testimonies will not be objective. The American College of Obstetricians and Gynecologists recommends chaperones so that there is a third party present. I have given you a list of staff, former medical students, a nurse practitioner and a registered nurse who will provide testimony as to my behaviour in the office with my patients. I maintain that this is part of a conspiracy between my now ex-wife and disgruntled former patients whom she tracked down after reading their negative online reviews of me. [redacted] is no exception.

In 2012 I decided to pursue doing business with women who work in the adult entertainment industry. I started to advertise my GYN cosmetic surgery and sexual health medicine services in the awards ceremony program for the Adult Video Network (AVN). In the Fall of 2018, as we began getting ready for my ad for the 2019 AVN award ceremony, I placed an 8.5" x 11" recruitment notice behind the door of the patient lavatory in my office. This way, they would see it as they unlock the door after using the bathroom. I offered $1000 to anyone who was willing to model for the ad.

[redacted] saw the notice during her last visit to my office and asked what it was about. I explained to her that Obamacare had scared the crap out of me because I thought we were going to a form of socialise medicine in America so I went and got trained in GYN cosmetic surgery and sexual health medicine so I could set up a cash-pay medical practice. I thought the adult industry would be the perfect source of income for my services. I also explained that I also donate to a group called the Cupcake Girls that offer spa-like treatment for the actresses during the award ceremony. It was one way to rescue young women in the adult entertainment industry who were being trafficked.

I told her that I hired a professional boudoir photographer to take the photographs for my ad. I informed her that if she were interested that there was one rule. That is, she was not allowed to bring her husband on the day of the shoot. I jokingly said, don't even tell him about the shoot. I explained that the husbands and boyfriends

Chambers & Associates

OBGYN and Gynecological Surgery, PLLC

Competent, Compassionate & Reliable Care for Women™

are disruptive for the photographer because they want to control the poses used and sometimes the model cannot relax because they are present. Thus, the photographer did not want them at the shoot. I added that I have to pay the photographer for her time whether or not we get a photograph that is usable. Furthermore, I also offer the model, in addition to the $1000, a USB copy of the boudoir shots so she may present them to her partner. I did not ask her to stand up naked so I could look at her.

The vast majority of my patients are given my mobile phone number so they may have direct access to me. It is something that I have done since I was a resident physician to ensure that I knew when my pregnant patients were in labour so that I would deliver their babies. [redacted] later sent me a text message which I have since deleted as I have since changed mobile phones. In the text message she excoriated me because she thought I was up to no good when I told her that her husband could not attend the shoot. I was visibly livid as she was the one whose curiosity lead her to ask me about the notice on the door. I was at home when I read the text message and I shared it with my now ex-wife. I responded to the message attempting to clarify what I had told her. That was the last time that I communicated with her.

Thank you for your time. I can be reached at (702) 901-1249.

Sincerely,

George P. Chambers, Jr., MD, FACOG
Board Certified, Obstetrics and Gynecology
Certified, Sexual Health Medicine

7220 S. Cimarron Road • Suite 200 • Las Vegas, NV 89113 • ph 702-463-0800 • fax 702-463-0801

EXHIBIT 7

EXHIBIT 7

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 8

EXHIBIT 8

NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive
Reno, NV 89521

Victor M. Muro, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

February 17, 2022

George Chambers, M.D.
7220 S. Cimarron Road, Suite 200
Las Vegas, NV 89113

RE: BME CASE # [redacted]
PATIENT: [redacted]

Dear Dr. Chambers:

We have received information and a complaint regarding your disruptive behavior towards the above-named patient. The complaint alleges your unprofessional demeanor and treatment, and care of the patient may have fallen below the standard of care which may have had an adverse impact on the quality of care rendered to the above-named patient.

It is alleged:

1. The patient presented to you on October 15, 2019, for an exam.
2. During the patient's appointments, you regularly made comments about porn stars and his personal experiences of sexual intercourse.
3. You called the patient under the pretense of going over test results and offered the patient $1000 to do a photoshoot of her vagina for his portfolio.
4. You advised the patient boyfriend or husband was not allowed to come with her.
5. You told the patient, "I do this all the time. Boyfriends and husbands get very jealous and cannot come."
6. You were very aware the patient was struggling financially based on her insurance and had previously given her healthcare saving coupons.
7. The patient felt you used your position of power to take advantage of the patient and her situation.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above, including, as well as complete health care records for the aforesaid patient[s]. Include copies of any imaging, x-ray or other films that were produced during treatment of this patient.** Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 30 calendar days.**

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the NPMA until a thorough investigation is completed.

As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.301(5)(6)(7)(9).

Respectfully,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

In the Matter of the Investigation of:)
)
) Case No. [redacted]
George Chambers, M.D.)
)
License No. **10476**)
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ORDER TO PRODUCE HEALTH CARE RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

George Chambers, M.D.
[redacted]

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records of **Patient:** [redacted]**; from January 1, 2018 through the present date**.
2. The name and contact information for any entity, facility, or person that you believe may possess the health care records of **Patient:** [redacted] **from January 1, 2018 through the present date**.
3. If health care records are provided electronically, they must be in a **searchable** format.

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 21 days of service** of this Order (Investigation Division, Attn. Johnna LaRue, CMBI, Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521). Failure to comply and produce said records in the aforesaid manner may subject you to potential

disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(1)(d); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this 17th day of February 2022.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

Bret W. Frey, M.D., Chairman
Victor M. Muro, M.D., Chairman
Nevada State Board of Medical Examiners
Investigative Committee

EXHIBIT 9

EXHIBIT 9

Chambers & Associates

OBGYN and Gynecological Surgery, PLLC

Competent, Compassionate & Reliable Care for Women™

George P. Chambers Jr., M.D., FACOG
Medical Director

March 17, 2022

Ms. Johnna LaRue
NSBME
9600 Gateway Drive
Reno, NV 89521

Re: BME Case #: [redacted]
Patient: [redacted]

Dear Ms. LaRue:

First, let me convey that I have not violated the Nevada Medical Practice Act, Nevada Revised Statues, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA). During my hearing last month, it was suggested that my chaperones are employed by me so their testimonies will not be objective. The American College of Obstetricians and Gynecologists recommends chaperones so that there is a third party present. I have given you a list of staff, former medical students, a nurse practitioner and a registered nurse who will provide testimony as to my behaviour in the office with my patients, including during [redacted] visits. I maintain that this is part of a conspiracy between my now ex-wife and disgruntled former patients whom she tracked down after reading their negative online reviews of me. [redacted] is no exception.

[redacted] is a liar. I personally do not give results to patients over the telephone. I have always felt that giving results over the telephone was another way of taking advantage of physicians. Patients want to talk for 30 minutes, avoid waiting in the office and the physician is not compensated. Besides, I didn't have time in my daily schedule for phone calls. Furthermore, when it came to diseases, such as gonorrhea, chlamydia, trichomonas, mycoplasma or *Ureaplama*, in which I treated the sexual partner, a visit to my office was necessary. As you will note from my notes, [redacted] had many medical issues. My medical assistant, however, was permitted to notify my patients of benign vaginitis diagnoses, such as candidiasis and bacterial vaginosis. She would call for their pharmacy number and I called in the prescriptions.

In 2012 I decided to pursue doing business with women who work in the adult entertainment industry. I started to advertise my GYN cosmetic surgery and sexual health medicine services in the awards ceremony program for the Adult Video Network (AVN). In the Fall of 2019, as we began getting ready for my ad for the 2020 AVN award ceremony, I offered $1000 to anyone who was willing to model for the ad. Furthermore, I also offer the model, in addition to the $1000, a USB copy of the boudoir shots so she may present them to her partner.

I recalled that [redacted] had mentioned to me during her initial visit that she was having financial hardship. I thought I was helping her when I told her that I was seeking models for my advertisement. I told

Chambers & Associates

OBGYN and Gynecological Surgery, PLLC

Competent, Compassionate & Reliable Care for Women™

her that the ad would be printed in the award ceremony program for the Adult Video Network. I did not discuss the porn stars nor did I share information regarding my private sex life with her. The only time sex was discussed was when I talked to her about how she might have gotten the mycoplasma/*Ureaplasma*.

I told her that I hired a professional boudoir photographer to take the photographs for my ad. I informed her that if she were interested that there was one rule. That is, she was not allowed to bring her husband on the day of the shoot. I jokingly said, don't even tell him about the shoot. I explained that the husbands and boyfriends are disruptive for the photographer because they want to control the poses used and sometimes the model cannot relax because they are present. Thus, the photographer did not want them at the shoot. I added that I have to pay the photographer for her time whether or not we get a photograph that is usable.

Thank you for your time. I can be reached at (702) 901-1249.

Sincerely,

George P. Chambers, Jr., MD, FACOG
Board Certified, Obstetrics and Gynecology
Certified, Sexual Health Medicine

7220 S. Cimarron Road • Suite 200 • Las Vegas, NV 89113 • ph 702-463-0800 • fax 702-463-0801

EXHIBIT 10

EXHIBIT 10

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 11

EXHIBIT 11

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 796 *(Replaces Committee Opinion No. 373, August 2007)*

Committee on Ethics

This Committee Opinion was developed by the American College of Obstetrician and Gynecologists' Committee on Ethics in collaboration with committee member David I. Shalowitz, MD, MSHP.

Sexual Misconduct

ABSTRACT: The practice of obstetrics and gynecology includes interaction in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences. The patient–physician relationship is damaged when there is either confusion regarding professional roles and behavior or clear lack of integrity that allows sexual exploitation and harm. Sexual misconduct by physicians is an abuse of professional power and a violation of patient trust. Although sexual misconduct is uncommon in clinical care, even one episode is unacceptable. Routine use of chaperones, in addition to the other best practices outlined in this Committee Opinion, will help assure patients and the public that obstetrician–gynecologists are maximizing efforts to create a safe environment for all patients.

Recommendations and Conclusions

On the basis of the principles outlined in this Committee Opinion, the American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Sexual misconduct by an obstetrician–gynecologist is an abuse of power and a violation of patients' trust. Sexual or romantic interaction between an obstetrician–gynecologist and a current patient is always unethical, is grounds for investigation and sanction, and in some cases should be considered for criminal prosecution.
- It is unethical for obstetrician–gynecologists to misuse the trust, knowledge, or influence from a professional relationship in pursuing a sexual or romantic relationship with a former patient.
- Physical examinations should be explained appropriately, undertaken only with the patient's consent, and performed with the minimum amount of physical contact required to obtain data for diagnosis and treatment. Draping should be used to minimize patients' exposure during examinations. Patients should be offered the opportunity to ask questions or raise concerns about any element of the examination.
- It is recommended that a chaperone be present for all breast, genital, and rectal examinations. The need for a chaperone is irrespective of the sex or gender of the person performing the examination and applies to examinations performed in the outpatient and inpatient settings, including labor and delivery, as well as during diagnostic studies such as transvaginal ultrasonography and urodynamic testing.
- Obstetrician–gynecologists are obligated ethically and professionally to report sexual misconduct or suspected sexual misconduct by any health care professional to appropriate authorities, such as supervisors, department chairs or other institutional officials, peer review organizations, and professional licensing boards. Law enforcement should be involved in cases of sexual or physical assault.
- Institutions should have clear guidelines that allow clinical staff to report sexual misconduct or suspected sexual misconduct without concern for retaliation. Patients, family members, and loved ones should have the opportunity to express concerns about interactions with clinical staff without fear of adversely affecting clinical care.
- Medical students and trainees in obstetrics and gynecology should be educated about the inherent power imbalance in the patient–physician relationship, avoidance of sexually offensive or denigrating language, risk factors for sexual misconduct, and procedures for reporting suspected misconduct.

Introduction

The practice of obstetrics and gynecology includes interaction in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences. The relationship between obstetrician–gynecologists and their patients therefore requires a high level of trust and professional responsibility. The patient–physician relationship is damaged when there is either confusion regarding professional roles and behavior or clear lack of integrity that allows sexual exploitation and harm. Sexual misconduct by an obstetrician–gynecologist is an abuse of power and a violation of patients' trust (1).

Although sexual misconduct is uncommon in clinical care, even one episode is unacceptable. The ethical prohibition of sexual misconduct is forceful, and its application in medical practice is essential (2). This Committee Opinion has been revised to incorporate current data on the prevalence of physician sexual misconduct, to delineate ACOG's expectations for obstetrician–gynecologists' interactions with their patients to ensure that all patients are cared for safely and professionally (2), and to provide clinical best practice recommendations to support obstetrician–gynecologists' mission to provide the highest quality health care to their patients.

Background

Definition

The Federation of State Medical Boards categorizes the range of behaviors that constitute sexual misconduct into "sexual impropriety" (behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient) and "sexual violation" (physical sexual contact between a physician and patient, whether or not initiated or consented to by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual) (Box 1) (3). Examination of the breast or genitals without appropriate consent from a patient or surrogate decision maker qualifies as sexual misconduct under both of these categories. Sexual misconduct may be grounds for disciplinary action, and sexual misconduct that falls under the category of sexual violation also may meet the criteria for criminal prosecution (eg, sexual assault). The U.S. Department of Justice defines s*exual assault* as "any nonconsensual sexual act proscribed by Federal, tribal, or State law, including when the victim lacks capacity to consent" (4). Sexual assault encompasses a continuum of sexual activity that ranges from sexual coercion to contact abuse (unwanted kissing, touching, or fondling) to rape (5, 6).

Scope of the Problem

It is difficult to estimate accurately the incidence of sexual misconduct. Available data rely heavily on patient reporting, and it is estimated that less than 10% of patients subjected to sexual misconduct report their experience (7). One prominent report by *The Atlanta Journal-Constitution* identified 3,100 individual physicians named in sexual misconduct reports brought to state medical boards between 1999 and 2016. *The Atlanta Journal-Constitution* identified an additional 450 physicians from allegations during 2016 and 2017 (8). Additionally, between 2003 and 2013, 1,039 physicians had at least one sexual misconduct-related report filed with the National Practitioner Data Bank by hospitals, state medical boards, or other eligible entities (9). A review of cases brought to the American Medical Association (AMA) Council on Ethical and Judicial Affairs between 2004 and 2008 found that 32 of 298 cases were related to possible sexual misconduct (10). However, this number may be an underestimate because sanctions related to sexual misconduct may not be identified as such (11).

Limited data suggest that the greatest number of reported allegations of sexual misconduct involves physicians who practice family medicine, psychiatry, internal medicine, and obstetrics and gynecology (12, 13). An analysis of 101 cases of sexual abuse of patients by physicians revealed a strong, consistent association with male physician gender (100% of cases), age more than 39 years (92%), lack of board certification (72% of cases involving "nonconsensual sex"), consistent examination of patients without a chaperone (85%), and practice in nonacademic medical settings (94%) (14).

Sexual misconduct by clinicians during labor and delivery may be more prevalent than previously thought. A large survey of U.S. and Canadian obstetric support personnel raised concern that clinicians may at times use sexually degrading language with laboring women or perform genital examinations or procedures without appropriate consent or despite the patient's refusal (15). Again, although sexual misconduct during obstetric care likely is uncommon, the experience of sexual violation during childbirth may be associated with long-lasting consequences for patients' mental health. Intimate examinations and procedures performed without consent or under circumstances perceived by the patient to be coercive are associated with psychological trauma during childbirth (16, 17). Likewise, patients may find being physically exposed to more personnel than necessary for their clinical care during childbirth to be a dehumanizing and traumatic experience (16). Patients who experience childbirth as a traumatic event are at high risk of developing depression and posttraumatic stress disorder in the postpartum period (18). Although the interpretation and generalizability of these data are limited by the studies' methods, patients' vulnerability to perceived sexual violation during childbirth deserves special consideration, especially given the sometimes intensive and acute nature of intrapartum care.

Box 1. Examples of Physician Sexual Misconduct From the Federation of State Medical Boards

Sexual Impropriety

Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient that may include, but are not limited to, the following:

- Neglecting to employ disrobing or draping practices respecting the patient's privacy, or deliberately watching a patient dress or undress
- Performing an intimate examination or consultation without clinical justification or appropriate consent
- Subjecting a patient to an intimate examination in the presence of medical students or other parties without the patient's informed consent or in the event such informed consent has been withdrawn
- Examination or touching of genital mucosal areas without the use of gloves
- Inappropriate comments about or to the patient, including but not limited to, making sexual comments about a patient's body or underclothing, making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation, making nonclinically relevant comments about potential sexual performance during an examination
- Using the patient–physician relationship to solicit a date or romantic relationship
- Initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician
- Requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of examination or consultation

Sexual Violation

Sexual violation may include physical sexual contact between a physician and patient, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual, including but not limited to the following:

- Sexual intercourse, genital-to-genital contact
- Oral-to-genital contact
- Oral-to-anal contact, genital-to-anal contact
- Kissing in a romantic or sexual manner
- Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or when the patient has refused or has withdrawn consent
- Encouraging the patient to masturbate in the presence of the physician*
- Masturbation by the physician while the patient is present
- Offering to provide practice-related services, such as drugs, in exchange for sexual favors

*ACOG recognizes the value of physician-guided sexual health counseling in the proper clinical context by an appropriately trained provider.

Modified from Federation of State Medical Boards. Federation of State Medical Boards. Addressing sexual boundaries: guidelines for state medical boards. Adopted as policy by the House of Delegates of the Federation of State Medical Boards. May 2006. Euless (TX): FSMB; 2006. Available at: https://www.fsmb.org/siteassets/advocacy/policies/grpol_sexual-boundaries.pdf.

Ethical and Professional Guidelines

Romantic or Sexual Relationships With Current Patients

Sexual or romantic interaction between an obstetrician–gynecologist and a current patient is always unethical, is grounds for investigation and sanction, and in some cases should be considered for criminal prosecution. Such interactions may exploit patients' vulnerability, compromise physicians' ability to make objective judgments about patients' health care, and ultimately be detrimental to patients' long-term health (19, 20). Furthermore, an uncomfortable or traumatic experience in a physician's office may become a major barrier to seeking needed health care in the future.

Sexual or romantic behavior by a physician toward a current patient constitutes misconduct regardless of whether a patient appears to initiate or consent to such behavior. Physicians' professional codes of ethics have historically precluded the initiation of romantic or sexual contact with a patient because such a relationship is likely to compromise the physician's objectivity regarding treatment decision making and may exploit a power differential for personal gain (1, 21). The inherent imbalance of power in the patient–physician relationship makes coercion or its appearance more likely; for example, there may be an explicit or implicit suggestion that continued care is contingent on the patient's willingness to accept sexual contact. Additionally, obstetrician–gynecologists should be aware of the possibility that a patient's apparent desire for a romantic or sexual relationship with a treating

physician may be a manifestation of a transference reaction related to gratitude for clinical care (22, 23). For these reasons, a patient's apparent consent to enter into a romantic or sexual relationship with a treating physician does not make the relationship permissible.

Romantic or Sexual Relationships With Former Patients

Consensual romantic or sexual relationships between physicians and former patients are ethically challenging because of the potential for these relationships to be unduly influenced by the power dynamic accompanying the former patient–physician relationship. The Committee on Ethics agrees with the AMA that it is unethical for obstetrician–gynecologists to misuse the trust, knowledge, or influence from a professional relationship in pursuing a sexual or romantic relationship with a former patient (21). For example, it would be unethical for an obstetrician–gynecologist to coerce a former patient into a romantic or sexual relationship under the threat of disclosing private information obtained during treatment. Treating a person who is not a current patient, but with whom the obstetrician–gynecologist has a current romantic or sexual relationship, may not be sexual misconduct but instead may violate ethical proscriptions against treating family members (24).

Obligation to Report Misconduct

In addition to involving harm to the victim, an episode of sexual misconduct may not be isolated and could indicate a history of misconduct toward other patients or a risk of future misconduct. Furthermore, physician misconduct damages public trust in medical professionals. The ACOG Code of Professional Ethics states that "obstetrician–gynecologists should strive to address through the appropriate procedures the status of those physicians who demonstrate questionable competence, impairment, or unethical or illegal behavior. In addition, the obstetrician–gynecologist should cooperate with appropriate authorities to prevent the continuation of such behavior" (1). Therefore, to protect patients and colleagues, obstetrician–gynecologists are obligated ethically and professionally to report sexual misconduct or suspected sexual misconduct by any health care professional to appropriate authorities, such as supervisors, department chairs or other institutional officials, peer review organizations, and professional licensing boards. Law enforcement should be involved in cases of sexual or physical assault (see the "Definition" section earlier in this document). Additional guidance on reporting unethical behavior by colleagues is available from the AMA and the Federation of State Medical Boards (25–27).

Best Practices for Clinical Care

The American College of Obstetricians and Gynecologists is invested in ensuring that the standards for an obstetrician–gynecologist's behavior in a clinical encounter are transparent. In some situations, patients may have experienced sexual misconduct as part of an obstetric or gynecologic encounter but not recognized or reported it as such. Conversely, patients may perceive an interaction as sexual or romantic when in fact there was no such intent on the part of the obstetrician–gynecologist. The following clinical best practices are recommended to decrease the risk of misunderstandings related to the provision of appropriate clinical care and to increase patients' ability to recognize and report inappropriate interactions in the clinical setting.

Maintaining Appropriate Boundaries

Regardless of intent, any clinical or nonclinical contact with a patient that may be perceived as a romantic or sexual overture should be avoided. For example, clinical evaluation of a patient outside of a usual clinical setting may blur the boundaries between professional and nonprofessional interactions and, therefore, is discouraged; however, exceptions may include emergency care or a medically indicated home visit. Likewise, obstetrician–gynecologists should strictly avoid sexual innuendo, sexually suggestive humor, and sexually provocative remarks in professional settings. Nonclinical communication with current patients, including interactions by telephone, e-mail, text-messaging, or social media, should be approached with caution, and professional boundaries should be maintained at all times (28).

Under some circumstances, limited physical contact between physician and patient (eg, hugging or holding a patient's hand) may be a valuable, therapeutic expression of support. However, obstetrician–gynecologists should be careful to ensure that patients are open to such contact and that its duration is appropriately limited. If inappropriate contact is initiated by a patient, obstetrician–gynecologists should feel empowered to separate themselves from the patient, reinforce professional boundaries, and request assistance if needed.

Physical Examinations

Physical examinations should be explained appropriately, undertaken only with the patient's consent, and performed with the minimum amount of physical contact required to obtain data for diagnosis and treatment. Draping should be used to minimize patients' exposure during examinations. Patients should be offered the opportunity to ask questions or raise concerns about any element of the examination. The Committee on Ethics re-emphasizes that patients capable of decision making must provide consent for all procedures, and that patients have the right to refuse any and all examinations and procedures (29). Best practices for physical examination also apply to diagnostic tests involving instrumentation of the genital, urinary, or lower gastrointestinal tracts, such as transvaginal ultrasonography or urodynamics.

Photography and Video Recordings

Patients must consent to any photograph or video taken of them, and consent should be documented in the medical record. Photographs of pathology and unclothed or internal anatomy must be de-identified to the extent possible and used only for clinical documentation or academic purposes, including education of colleagues and trainees and publication in peer-reviewed medical literature. Identifiable images should be stored and sent (if necessary) in a secure manner, and images no longer being used for the above purposes should be destroyed securely.

Trauma-Informed Care

For some patients with a history of sexual trauma, even commonly used gestures and language may trigger memories of past physical or sexual abuse and may cause discomfort or fear during a clinical encounter. Because trauma often involves an experience of powerlessness, it is important to refrain from behaviors that a patient may perceive as overpowering or threatening (30–33). Common triggers include leaning over a patient during a discussion or pelvic examination, using commands such as "try to relax" before an internal examination, and exposing or touching parts of a patient's body during a physical examination without adequate warning (32, 33). All obstetrician–gynecologists should become familiar with the principles of trauma-informed care and seek to integrate them into general practice (34). Issues related to the care of survivors of sexual abuse, intimate partner violence, and reproductive and sexual coercion are detailed in other ACOG documents (35–37).

Chaperones

The presence of a third party, or "chaperone," in the examination room can provide reassurance to the patient about the professional context and content of the examination and the intent of the obstetrician–gynecologist. The chaperone also serves as a witness to the events taking place should there be any misunderstanding or concern for misconduct. In the obstetric setting, chaperones may decrease the risk of patient-perceived trauma during childbirth by advocating for patients and serving as a deterrent to potentially inappropriate behavior. The American College of Obstetricians and Gynecologists previously recommended an "opt-in" approach regarding the presence of chaperones, in which a chaperone was required if mandated by a clinical practice's policy or if requested by the patient or obstetrician–gynecologist. Given the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone, ACOG now believes that the routine use of chaperones is needed for the protection of patients and obstetrician–gynecologists. Therefore, it is recommended that a chaperone be present for all breast, genital, and rectal examinations. The need for a chaperone is irrespective of the sex or gender of the person performing the examination and applies to examinations performed in the outpatient and inpatient settings, including labor and delivery, as well as during diagnostic studies such as transvaginal ultrasonography and urodynamic testing. Chaperones currently are required by the U.S. Veterans Health Administration health care system, and routine use of chaperones is considered essential by the Royal College of Obstetricians and Gynaecologists (38, 39).

Exceptions should be made in circumstances in which it is likely that failure to examine the patient would result in significant and imminent harm to the patient, such as during a medical emergency. If a patient declines a chaperone, it should be explained that the chaperone is an integral part of the clinical team whose role includes assisting with the examination and protecting the patient and the physician. Any concerns the patient has regarding the presence of a chaperone should be elicited and addressed if feasible. If, after counseling, the patient refuses the chaperone, this decision should be respected and documented in the medical record. Under such circumstances, obstetrician–gynecologists may defer breast, genital, or rectal examinations for the protection of the patient and the physician. If an unchaperoned examination is performed, the rationale for proceeding should be documented. This approach allows patients to opt out of a chaperoned examination if they feel strongly but does not compel physicians to examine the patient without the protection of a chaperone, except in the case of a medical emergency, as discussed previously.

Chaperones should clearly understand their responsibilities to protect patients' privacy and the confidentiality of health information. Obstetrician–gynecologists also should ensure that an opportunity exists for private conversation with patients so that the presence of a chaperone does not inhibit the communication of information important to the clinical encounter. Although chaperones may deter or discourage sexual misconduct by physicians (14), sexual misconduct still can occur in their presence. Chaperones should, therefore, be trained in the requirements of best clinical practices as stated previously and empowered to report concerning behavior through a process independent of the health care provider being chaperoned. Family members should not be used as chaperones and should be present for physical examination only if requested by the patient (40). Use of trainees (eg, medical students or residents) as chaperones generally is discouraged unless they are trained in appropriate clinical practices and empowered to report concerns about the health care provider's behavior during an examination.

Implementation of Routine Chaperoning

The Committee on Ethics recognizes that recommending the routine use of chaperones for obstetric, gynecologic, and diagnostic examinations may require some practices

to adjust staffing procedures. There also may be concern about the time and resources needed to implement changes and their potential effect on patient care. Although these concerns merit study, there is robust evidence of the detrimental effects of sexual misconduct on patients' well-being, the patient–physician relationship, and public perception of the medical profession. Therefore, there is a need for obstetrician–gynecologists and clinical practices to institute routine chaperoning as an ethical best practice measure to reduce the risk of sexual misconduct (41). Steps taken to prioritize patients' safety and comfort likely will improve public trust in obstetric and gynecologic care and may thereby improve patients' willingness to seek care when indicated.

Institutional Responsibilities

Examination areas should protect patients' privacy, and staffing should be adequate to permit routine use of chaperones for physical examination and procedures. Institutions and clinical practices also should consider providing patients with a "what to expect" guide before obstetric or gynecologic appointments so that patients are prepared for their clinical encounters and better able to recognize deviations from proper medical practice. For example, see ACOG's related patient education resource, *Your First Gynecologic Visit* (42).

Institutions should have clear guidelines that allow clinical staff to report sexual misconduct or suspected sexual misconduct without concern for retaliation. Patients, family members, and loved ones should have the opportunity to express concerns about interactions with clinical staff without fear of adversely affecting clinical care. All such reports should be promptly and thoroughly investigated, and appropriate disciplinary or remedial action, or both, should be taken.

Medical Education

Teaching physicians are expected to be exemplars of appropriate behavior for trainees; likewise, residents and fellows-in-training should model best practices for medical students and other trainees. Relevant elements of the clinical examination should be highlighted specifically when appropriate (eg, draping methods, explanation of examination to patient, use of trauma-sensitive language, appropriate use of chaperones, and solicitation of questions and permission to proceed with an examination). Trainees taking part in patient care should be introduced, and the patient should be given the opportunity to agree to their participation. Breast, genital, and rectal examinations (including examinations under anesthesia) that are for educational purposes only may not be performed without patients' specific informed consent (43).

Medical students and trainees in obstetrics and gynecology should be educated about the inherent power imbalance in the patient–physician relationship, avoidance of sexually offensive or denigrating language, risk factors for sexual misconduct, and procedures for reporting suspected misconduct (44–47). Although education may not eliminate the possibility of misconduct, formalized clinical and didactic training will help to make best clinical practices routine and may assist obstetrician–gynecologists in managing the boundaries between clinical care and inappropriate behavior and in identifying and reporting when these boundaries have been crossed by others.

Conclusion

Sexual misconduct by physicians is an abuse of professional power and a violation of patient trust. Such behavior jeopardizes the well-being of patients and carries immense potential for harm. Obstetrician–gynecologists should implement best clinical practices to ensure that patients are afforded a safe environment for their health care. Routine use of chaperones, in addition to the other best practices outlined in this Committee Opinion, will help assure patients and the public that obstetrician–gynecologists are maximizing efforts to create a safe environment for all patients. Obstetrician–gynecologists are ethically obligated to model responsible clinical practices and to report sexual misconduct or suspected sexual misconduct. Health care institutions, likewise, should provide resources to support best clinical practices and to ensure that patients are protected to the greatest extent possible.

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EXHIBIT 12

EXHIBIT 12

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

AUGS
Advancing Female Pelvic Medicine and Reconstructive Surgery

INTERIM UPDATE

ACOG PRACTICE BULLETIN

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 214

(Replaces Practice Bulletin Number 185, November 2017)

Committee on Practice Bulletins—Gynecology and American Urogynecologic Society. This Practice Bulletin was developed by the Committee on Practice Bulletins—Gynecology and the American Urogynecologic Society in collaboration with Paul Tulikangas, MD.

INTERIM UPDATE: This Practice Bulletin is updated as highlighted to reflect the U.S. Food and Drug Administration (FDA) order to stop the sale of transvaginal synthetic mesh products for the repair of pelvic organ prolapse.

Pelvic Organ Prolapse

Pelvic organ prolapse (POP) is a common, benign condition in women. For many women it can cause vaginal bulge and pressure, voiding dysfunction, defecatory dysfunction, and sexual dysfunction, which may adversely affect quality of life. Women in the United States have a 13% lifetime risk of undergoing surgery for POP (1). Although POP can occur in younger women, the peak incidence of POP symptoms is in women aged 70–79 years (2). Given the aging population in the United States, it is anticipated that by 2050 the number of women experiencing POP will increase by approximately 50% (3). The purpose of this joint document of the American College of Obstetricians and Gynecologists and the American Urogynecologic Society is to review information on the current understanding of POP in women and to outline guidelines for diagnosis and management that are consistent with the best available scientific evidence.

Background

Definition

Pelvic organ prolapse is the descent of one or more aspects of the vagina and uterus: the anterior vaginal wall, posterior vaginal wall, the uterus (cervix), or the apex of the vagina (vaginal vault or cuff scar after hysterectomy) (4). This allows nearby organs to herniate into the vaginal space, which is commonly referred to as cystocele, rectocele, or enterocele. Mild descent of the pelvic organs is common and should not be considered pathologic. Pelvic organ prolapse only should be considered a problem if it is causing prolapse symptoms (ie, pressure with or without a bulge) or sexual dysfunction or if it is disrupting normal lower urinary tract or bowel function. Pelvic organ prolapse can be defined using patient-reported symptoms or physical examination findings (ie, vaginal bulge protruding to or beyond the hymen). Most women feel symptoms of POP when the leading edge reaches 0.5 cm distal to the hymenal ring (5).

Epidemiology

According to the National Health and Nutrition Examination Survey, approximately 3% of women in the United States report symptoms of vaginal bulging (3). In one review, the prevalence of POP based on reported symptoms was much lower (3–6%) than the prevalence identified by examination (41–50%) (6). This discrepancy likely occurs because many women with POP are asymptomatic. Pelvic organ prolapse usually is due to global pelvic floor dysfunction, so most women will present with POP in multiple compartments (anterior, apical, and posterior vaginal wall) (7).

There are few studies of the natural history of POP. In one study that monitored women with symptomatic, untreated POP for an average of 16 months, 78% of the women had no change in the leading edge of the prolapse (8). Most of the women had stage II–IV pelvic organ prolapse (Box 1). In women who do not want treatment for their POP, most will have no change or only a small increase in the size of the POP over the next year (9).

Box 1. Stages of Pelvic Organ Prolapse

Stages are based on the maximal extent of prolapse relative to the hymen, in one or more compartments.

Stage 0: No prolapse; anterior and posterior points are all −3 cm, and C or D is between −TVL and − (TVL − 2) cm.

Stage I: The criteria for stage 0 are not met, and the most distal prolapse is more than 1 cm above the level of the hymen (less than −1 cm).

Stage II: The most distal prolapse is between 1 cm above and 1 cm below the hymen (at least one point is −1, 0, or +1).

Stage III: The most distal prolapse is more than 1 cm below the hymen but no further than 2 cm less than TVL.

Stage IV: Represents complete procidentia or vault eversion; the most distal prolapse protrudes to at least (TVL − 2) cm.

Abbreviations: C, cervix; D, posterior fornix; TVL, total vaginal length.
Data from Bump RC, Mattiasson A, Bo K, Brubaker LP, DeLancey JO, Klarskov P, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 1996;175:10–7.

The incidence of POP surgery is 1.5–1.8 surgeries per 1,000 women years (10, 11). There are approximately 300,000 POP surgeries each year in the United States (12).

Risk Factors

Risk factors for developing symptomatic POP include parity, vaginal delivery, age, obesity, connective tissue disorders, menopausal status, and chronic constipation (13–17). Modifiable risk factors (obesity and constipation) should be addressed in patients at wellness visits because improvement in these factors may reduce the risk of developing POP.

It is not clear if hysterectomy for non-POP conditions is a risk factor for developing POP. In a subanalysis of a cohort study from the United Kingdom, patients who underwent a hysterectomy had a 5% cumulative risk of undergoing prolapse surgery within the next 15 years (13). A more recent study found no increased risk of POP in women who underwent prior hysterectomy for non-POP indications (18).

Older studies reported that women who underwent primary POP surgery had an approximate 30–50% chance of needing a second prolapse surgery (19). More recent studies show a lower reoperation rate of approximately 6–30%, with most estimates consistent with the lower end of this range (19–22). This lower reoperation rate may reflect improvement in surgical technique as well as stratification of urinary incontinence as a separate risk in the outcomes data (19). Pelvic organ prolapse surgery that includes suspension of the vaginal apex is associated with a decreased reoperation rate (23). Risk factors for recurrent prolapse include age younger than 60 years for patients who underwent vaginal surgery for POP, obesity, and preoperative stage III or stage IV prolapse (24–26).

Clinical Considerations and Recommendations

▶ ***What is the recommended initial evaluation for a woman with suspected pelvic organ prolapse?***

The recommended initial evaluation for a woman with suspected POP includes a thorough history, assessment of symptom severity, physical examination, and goals for treatment. Symptom assessment is the most important part of the evaluation of a woman with POP.

History

In addition to a complete medical, surgical, obstetric, and gynecologic history, the nature of vaginal bulge symptoms and the degree of bother associated with the bulge should be recorded. Key information to elicit from the patient includes whether the protrusion is limiting physical activities or sexual function or becoming progressively worse or bothersome. Many women with POP on physical examination do not report symptoms of POP. Treatment is indicated only if prolapse is causing bothersome bulge and pressure symptoms, sexual dysfunction, lower urinary tract dysfunction, or defecatory dysfunction (27).

Lower urinary tract function should be assessed. This includes an evaluation for urine loss and type (stress or urgency urinary incontinence) and adequacy of bladder emptying. The relationship between urinary symptoms and prolapse can be inferred if voiding becomes more difficult when the effects of gravity are more pronounced, such as after long periods of standing (4). In addition, splinting (ie, the need to push on or support the bulging tissue) may be required to initiate or complete voiding.

Assessment of bowel function should be undertaken to determine if there is a history of straining with bowel movements, laxative use, fecal incontinence, and incomplete rectal emptying. The symptom of splinting often is correlated with the presence of a posterior compartment defect (eg, rectocele). Each patient should be assessed for symptoms of dyspareunia, coital incontinence (of urine or stool), and sexual dysfunction that is related to the prolapse.

Physical Examination

Physical examination should include an abdominal and pelvic examination to rule out pelvic masses. The external genitalia and vaginal epithelium should be evaluated for vaginal atrophy, skin irritation, or ulceration (27). Simply spreading the labia while examining the patient in a supine position can be helpful to assess the maximum descent of the prolapse. A detailed examination of the POP should be performed with a split speculum (ie, separate a bivalve speculum and use only the posterior blade to examine the apex and anterior vaginal wall, then turn the blade over and use it to hold the anterior wall while examining the postvaginal wall and perineal body as the patient performs the Valsalva maneuver, repetitive coughing, or both). Performance of a pelvic organ prolapse quantification (POP-Q) examination is recommended before treatment for the objective evaluation and documentation of the extent of prolapse (see *Is the pelvic organ prolapse quantification examination necessary before treatment for pelvic organ prolapse*?) If a patient's prolapse symptoms are not confirmed by the extent of prolapse observed during supine pelvic examination, repeating the pelvic examination in the standing position may reveal the greatest descent of POP.

Pelvic floor muscle tone should be assessed (27). It should be noted if the pelvic floor muscles can contract and relax volitionally. The strength of the contraction should be described as "absent," "weak," "normal," or "strong" (4).

▶ *Is additional testing beyond history and physical examination needed to evaluate women with pelvic organ prolapse?*

In general, no additional testing beyond a complete gynecologic, urologic, and defecatory history and physical examination is needed before treatment. However, if the prolapse is beyond the hymen or the patient has voiding symptoms, a postvoid residual urine volume should be recorded either with a catheter or ultrasonography (27). If there is urinary urgency or other lower urinary tract symptoms, minimum assessment involves a urinalysis, with culture and microscopy performed if indicated. Urodynamic testing may help inform patient counseling and may be considered if there is bothersome incontinence with stage II or greater prolapse or voiding dysfunction. If findings on initial assessment do not concur with symptoms, more specific imaging or referral to a specialist in urogynecologic care may be needed.

▶ *Is the pelvic organ prolapse quantification examination necessary before treatment of pelvic organ prolapse?*

A POP-Q examination is recommended before treatment of POP to objectively evaluate and document the extent of prolapse. Evaluation and documentation of the extent of the prolapse is important before treatment so that the surgeon has a preoperative comparator by which to measure postoperative anatomic success. The POP-Q system is the only validated method for objective measurement of prolapse in the three pelvic compartments: 1) anterior, 2) apical, and 3) posterior (Fig. 1) (28–30). The POP-Q system is recommended by the major national and international urogynecologic health organizations, including the American Urogynecologic Society, the Society of Gynecologic Surgeons, and the International Continence Society (31). In addition, POP-Q is used in most scientific publications on POP (32). Although the Baden–Walker system clinically describes prolapse findings, the POP-Q system is more precise and has been shown to be reproducible.

The POP-Q system does not use the terms "cystocele" and "rectocele" but instead uses terms for each prolapsed segment because the exact organ that lies behind the prolapsed vaginal epithelium may not be clear from the clinical examination. It incorporates measurements of the vaginal length, genital hiatus, and perineal body. The POP-Q measurements can be converted to stages based on the most severely prolapsed vaginal segment (Box 1) (28).

A validated examination allows for consistency in reporting and facilitates communication between gynecologic care providers. It is particularly important if a patient has a recurrent prolapse because it will allow a new gynecologic care provider to understand the patient's POP history. Outcomes can be evaluated only if pretreatment POP measurements are recorded accurately.

For patients desiring expectant management, documentation of the prolapse with the POP-Q allows an objective, validated, baseline measurement that can be referred to if symptoms change over time. Although recording a POP-Q examination is not necessary for these patients, it may be helpful to determine if there is an anatomic change over time.

▶ *Are effective nonsurgical treatments available for women with pelvic organ prolapse?*

For women with asymptomatic prolapse, education and reassurance are appropriate. Women may not realize that symptoms of voiding or defecatory dysfunction are related to prolapse, so education about how prolapse symptoms manifest can be helpful.

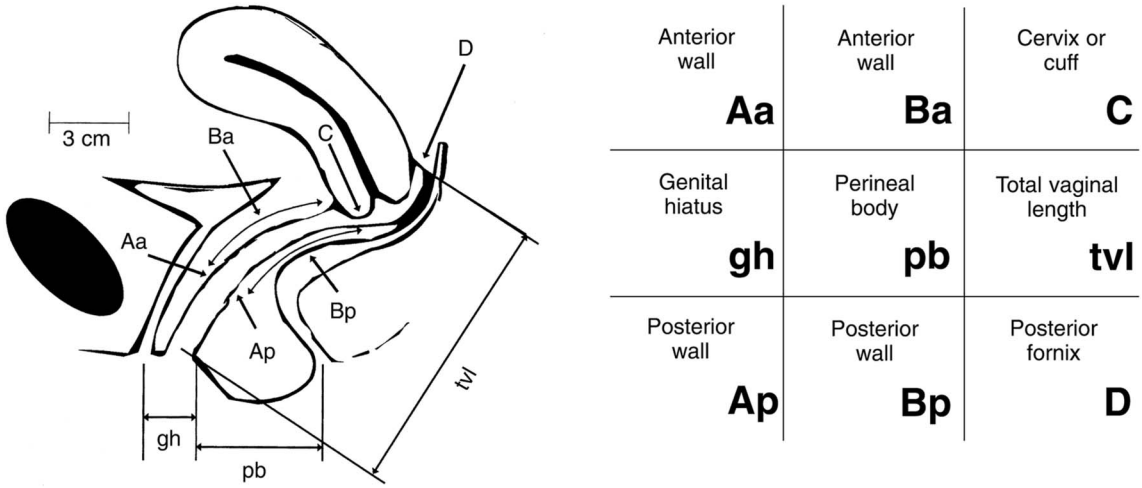

Figure 1. Pelvic Organ Prolapse Quantification System. Nine defined points measured in the midline and relative to the hymen assessed during maximal Valsalva except for TVL: Aa, 3 cm proximal to the external urethral meatus; Ba, most prolapsed portion of the anterior vaginal wall; C, leading edge of the cervix or vaginal cuff; gh, middle of the urethral meatus to the midline of the posterior hymen; pb, middle of the posterior hymen to the middle of the anal opening; tvl, maximum depth of the vagina with prolapse reduced; Ap, 3 cm proximal to the posterior hymen; Bp, most prolapsed portion of the posterior vaginal wall; D, posterior fornix in a woman who has a cervix. (Reprinted with permission from Bump RC, Mattiasson A, Bo K, Brubaker L, DeLancey J, Klarskov P, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol. 1996;175:10–17.)

Some symptoms related to pelvic organ prolapse may be managed with lifestyle modifications. For example, defecatory dysfunction may improve with fiber supplementation and use of an osmotic laxative (33). Sitting with feet elevated may decrease bulge symptoms. Pelvic muscle exercises, performed either independently or under professional supervision, may improve symptoms or slow the progression of POP (34, 35).

There is limited evidence for the treatment or prevention of POP with local or systemic estrogen (36). However, some clinicians believe that local estrogen may help with the vaginal irritation associated with POP.

Women considering treatment of POP should be offered a vaginal pessary as an alternative to surgery. A pessary should be considered for a woman with symptomatic POP who wishes to become pregnant in the future. A vaginal pessary is an effective nonsurgical treatment for women with POP, and up to 92% of women can be fitted successfully with a pessary (37). In one study protocol, a ring pessary was inserted first, followed by a Gellhorn pessary if the ring did not stay in place. Ring pessaries were used more successfully with stage II (100%) and stage III (71%) prolapse, and stage IV prolapse more frequently required Gellhorn pessaries (64%) (38). If possible, women should be taught to change their pessaries independently. If a woman is unable to remove and replace her pessary, regular follow-up (such as every 3–4 months) is necessary. Annual follow-up is recommended for patients who are able to maintain pessary hygiene on their own.

Pressure on the vaginal wall from the pessary may result in local devascularization or erosion in 2–9% of patients (39). Therapy should consist of removing the pessary for 2–4 weeks and local estrogen therapy. Resolution may occur without local estrogen therapy. If the problems persist, more frequent pessary changes or a different pessary may be required (39). Caregivers to patients with dementia should be made aware of the regular pessary changes needed to avoid complications. Although rare complications such as fistula can occur, pessary use is a low-risk intervention that can be offered to all women who are considering treatment of POP (40).

▶ *When is surgery indicated for the management of pelvic organ prolapse, and what are the primary approaches?*

Surgery is indicated for the treatment of POP in women who are bothered by their POP and have failed or declined nonsurgical treatments. There are various vaginal and abdominal surgical approaches for the treatment of POP (Table 1). Important considerations for deciding the type and route of surgery include the location and severity of prolapse, the nature of the symptoms (eg, presence of urinary, bowel, or sexual dysfunction), the patient's general health, patient preference, and the surgeon's expertise (41).

Table 1. Types of Pelvic Organ Prolapse Surgery

Surgical Technique	Aim	Indication
Abdominal sacral colpopexy	To correct upper vaginal prolapse	Most commonly used in women with recurrent cystocele, vault, or enterocele
Uterosacral ligament suspension	To correct upper vaginal prolapse	Performed at the time of hysterectomy or in patients with posthysterectomy vaginal vault prolapse
Sacrospinous fixation	To correct upper vaginal prolapse	Performed at the time of hysterectomy or in patients with posthysterectomy vaginal vault prolapse
Anterior vaginal repair (anterior colporrhaphy)	To correct anterior wall prolapse	May be used for the treatment of prolapse of the bladder or urethra (bladder, urethra, or both, herniates downward into the vagina)
Posterior vaginal repair (posterior colporrhaphy) and perineorrhaphy	To correct posterior wall prolapse	May be used for the treatment of rectocele (rectum bulges or herniates forward into the vagina), defects of the perineum, or both
Vaginal repair with synthetic mesh or biologic graft augmentation	To correct anterior wall prolapse, apical vaginal prolapse, or both	Depending on the specific defect, the mesh augmentation can either be anterior, apical, or both. This repair is not routinely recommended.

Adapted from Maher C, Feiner B, Baessler K, Christmann-Schmid C, Haya N, Marjoribanks J. Transvaginal mesh or grafts compared with native tissue repair for vaginal prolapse. Cochrane Database Syst Rev. 2016 Feb 9;2:CD012079.

▶ *Are vaginal surgical approaches effective for the management of pelvic organ prolapse?*

Vaginal hysterectomy and vaginal apex suspension with vaginal repair of anterior and posterior vaginal wall prolapse as needed are effective treatments for most women with uterovaginal and anterior and posterior vaginal wall prolapse (21, 22, 42, 43). Vaginal native tissue repairs are performed without the use of synthetic mesh or graft materials. These are relatively low-risk surgeries that may be considered as surgical options for most women with primary POP.

If a patient has uterine prolapse, vaginal hysterectomy alone is not adequate treatment. Vaginal apex suspension should be performed at the time of hysterectomy for uterine prolapse to reduce the risk of recurrent POP (23, 44). Vaginal apex suspension involves attachment of the vaginal apex to the uterosacral ligaments or sacrospinous ligaments. Uterosacral and sacrospinous ligament suspension for apical POP with native tissue are equally effective surgical treatments of POP, with comparable anatomic, functional, and adverse outcomes (21). In the Operations and Pelvic Muscle Training in the Management of Apical Support Loss trial, the 2-year follow-up surgical success rate was 64.5% for uterosacral ligament suspension compared with 63.1% for sacrospinous ligament fixation (adjusted odds ratio [OR], 1.1; 95% confidence interval [CI], 0.7–1.7) (21). The serious adverse event rate at 2-year follow-up was 16.5% for uterosacral ligament suspension compared with 16.7% for sacrospinous ligament fixation (adjusted OR, 0.9; 95% CI, 0.5–1.6) (21). Uterosacral ligament suspension can be performed by attaching the vaginal apex bilaterally to the ipsilateral uterosacral ligament or by attaching the vaginal apex to uterosacral ligament complex that is plicated in the midline (42, 43, 45). It is important that an adequate segment of uterosacral ligament is secured to the vagina. This often requires attachment to the midportion of the uterosacral ligament close to the ischial spine. Alternatively, the sacrospinous ligament can be used to support the vaginal apex. A unilateral right sacrospinous ligament fixation usually is used for the attachment point to avoid dissection around the colon (46).

Anterior colporrhaphy is an effective treatment for most anterior vaginal wall prolapse (47). Many women with anterior vaginal wall prolapse also have an apical prolapse (48). In these women, surgery should correct the apical prolapse and the anterior vaginal wall prolapse. Resupport of the vaginal apex concurrently with repair of the anterior vaginal wall defect reduces the risk of recurrent POP surgery (23). Paravaginal defects are lateral detachments of the vaginal wall from the fascial condensations over the levator ani muscles (49, 50). Diagnosis of paravaginal defects by physical examination is unreliable (51, 52). Moreover, if a paravaginal defect is suspected, there usually is apical loss of support (50). Apical support procedures may address most anterior vaginal wall defects, including paravaginal defects (53).

Posterior vaginal wall repair traditionally has been performed through a midline plication of the posterior vaginal wall fibromuscular connective tissue (54). The repair should be performed without placing tension on the levator ani muscles because this may lead to dyspareunia (55). Perineorrhaphy that results in reattachment of the perineal muscles to the rectovaginal septum can be performed as needed if a perineal defect is present. An alternative technique for performing posterior vaginal wall repair is site-specific repair, which involves dissection of the vaginal epithelium off the underlying fibromuscular connective tissue and repair of localized tissue defects with sutures. A finger often is placed in the rectum and directed anteriorly to identify various tissue defects of the posterior vaginal wall (56). Although a retrospective comparison of site-specific repair and midline colporrhaphy found that site-specific repair was associated with a higher rate of recurrence of a symptomatic bulge (11% versus 4%, $P=.02$) (57), a prospective study showed comparable outcomes for the two techniques (58).

▶ *When is abdominal sacrocolpopexy indicated for the management of pelvic organ prolapse?*

Abdominal sacrocolpopexy is a proven and effective surgery for the treatment of POP (20, 59). This procedure involves placement of a synthetic mesh or biologic graft from the apex of the vagina to the anterior longitudinal ligament of the sacrum. Women who may be candidates for abdominal sacrocolpopexy include those who have a shortened vaginal length, intra-abdominal pathology, or risk factors for recurrent POP (eg, age younger than 60 years, stage 3 or 4 prolapse, and body mass index greater than 26) (24–26). In women who are at increased risk of synthetic mesh-related complications (eg, chronic steroid use, current smoker), sacrocolpopexy with a biologic graft or alternatives to a sacrocolpopexy could be considered.

Studies evaluating abdominal sacrocolpopexy with biologic grafts show conflicting results. Abdominal sacrocolpopexy with porcine dermis xenograft had efficacy similar to that of abdominal sacrocolpopexy with synthetic polypropylene mesh. However, the porcine dermal xenograft used in this study is no longer available (60). In a study that evaluated the 5-year surgical outcomes of abdominal sacrocolpopexy among patients randomized to receive polypropylene mesh or cadaveric fascia lata, use of synthetic mesh resulted in better anatomic cure than use of cadaveric fascia lata grafts (93% [27 out of 29] versus 62% [18 out of 29], $P=.02$) (61).

Abdominal sacrocolpopexy with synthetic mesh has a lower risk of recurrent POP but is associated with more complications than vaginal apex repair with native tissue. Data from randomized controlled trials also show a significantly greater likelihood of anatomic success with mesh abdominal sacrocolpopexy compared with vaginal apex repair with native tissue (pooled OR, 2.04; 95% CI, 1.12–3.72) (62). Surgical complications that are more common after abdominal sacrocolpopexy with mesh include ileus or small-bowel obstruction (2.7% versus 0.2%, $P<.01$), thromboembolic phenomena (0.6% versus 0.1%, $P=.03$), and mesh or suture complications (4.2% versus 0.04%, $P<.01$) (62). In addition, sacrocolpopexy with mesh is associated with a significant reoperation rate due to mesh-related complications. Long-term (ie, 7-year) follow-up of participants of the Colpopexy and Urinary Reduction Efforts (CARE) trial found that the estimated rate of mesh complications (erosion into the vagina, visceral erosions, and sacral osteitis) was 10.5% (95% CI, 6.8–16.1), with a significant number of reoperations (20). Many of the CARE trial sacrocolpopexies, however, were performed with non-type 1 mesh, which may have increased the mesh complication rate. Because of complications attributed to multifilament and small-pore-size synthetic mesh, type 1 synthetic meshes (monofilament with large pore size) currently are used in the United States.

▶ *Do patients benefit from a minimally invasive approach to pelvic organ prolapse surgery?*

Sacrocolpopexy with or without supracervical hysterectomy or total hysterectomy can be performed laparoscopically with or without robotic assistance (63). Although open abdominal sacrocolpopexy is associated with shorter operative times (222 minutes versus 296 minutes; $P<.02$), minimally invasive sacrocolpopexy is associated with less blood loss (122 $\pm$ 146 mL versus 187 $\pm$ 142 mL; $P<.01$) and shorter hospitalization (1.3 $\pm$ 1 days versus 2.9 $\pm$ 1.6 days; $P<.01$) (64). Similar results were seen in a randomized controlled trial that compared open abdominal sacrocolpopexy with laparoscopic sacrocolpopexy, in which mean blood loss was significantly greater in the open arm (mean difference [MD] 184 mL; 95% CI, 96–272), and there were fewer inpatient days in the laparoscopic group (MD, 0.9 days; 95% CI, 0.1–1.7) (65).

Although robotic assistance shortens the learning curve for performing laparoscopic sacrocolpopexy and improves surgeon ergonomics (66–68), it has not been shown to improve short-term outcomes for patients (69–72). In two randomized controlled trials that compared robot-assisted sacrocolpopexy with laparoscopic sacrocolpopexy, operating time, postoperative pain, and cost were found to be significantly greater in the robot-assisted group (69, 72). The groups had similar anatomic and functional outcomes 6 months to 1 year after surgery, although the robotic experience of the surgeons was low at the start of the study, which may have affected the results (73). Overall, the current literature is too scant to adequately indicate

which minimally invasive approach should be recommended. Further comparative studies that assess long-term anatomic and functional outcomes and patient safety and that identify subgroups of patients who would benefit from a robotic approach are warranted (74).

▶ *Is posterior vaginal wall prolapse repair more effective with a transanal or transvaginal incision?*

Posterior vaginal wall prolapse repair is more effective when performed through a transvaginal incision than a transanal incision. Systematic review findings show that, compared with transanal incision, posterior vaginal repair results in fewer recurrent prolapse symptoms (relative risk [RR], 0.4; 95% CI, 0.2–1.0), lower recurrence on clinical examination (RR, 0.2; 95% CI, 0.1–0.6), and a smaller mean depth of rectocele on postoperative defecography (MD, –1.2 cm; 95% CI, –2.0 to –0.3) (75).

▶ *Are surgical approaches available to treat pelvic organ prolapse in women with medical comorbidities?*

Obliterative procedures—which narrow, shorten, or completely close the vagina—are effective for the treatment of POP and should be considered a first-line surgical treatment for women with significant medical comorbidities who do not desire future vaginal intercourse or vaginal preservation (76–79). Obliterative procedures have high reported rates of objective and subjective improvement of POP (98% and 90%, respectively) (80) and are associated with a low risk of recurrent POP (76, 80, 81). Because obliterative surgical procedures can be performed under local or regional anesthesia, these procedures may be especially beneficial for the treatment of POP in women with significant medical comorbidities that preclude general anesthesia or prolonged surgery, such as cardiac disease, chronic obstructive pulmonary disease, or thromboembolic disease. In addition, obliterative procedures for the treatment of POP are associated with low rates of complications, intensive care unit admissions, and mortality (6.8%, 2.8%, and 0.15%, respectively) (82). Patients undergoing obliterative procedures must be committed to no longer having vaginal sexual intercourse. In a multisite prospective study of older women (mean age 79 years) who underwent obliterative repair of POP, 95% of patients (125 out of 132) reported being satisfied or very satisfied with the results of the procedure 1 year after surgery (79). Patient regret also has been reported to be low. Among women interviewed more than 1 year after obliterative prolapse repair, only 9% (3 out of 32) reported they regretted having the procedure (81).

Common types of obliterative surgical repair of POP include a Le Fort-style partial colpocleisis and total colpectomy. Le Fort partial colpocleisis is performed when the uterus is preserved at the time of prolapse repair. This procedure involves denuding a strip of epithelium from the anterior and posterior vaginal walls and then suturing them together (83). This leaves lateral canals to drain the secretions from the cervix. Because the uterus is difficult to access postoperatively, normal results from cervical cytology and human papillomavirus testing and an endometrial evaluation usually are documented before surgery. For posthysterectomy vaginal prolapse, a colpectomy or tight anterior and posterior colporrhaphy creating a constricted vagina is a surgical option if a patient is amenable to an obliterative procedure. In total colpectomy procedures, the entire vaginal epithelium is denuded and sutures are used to invert the vagina (83). With any obliterative procedure, a suburethral plication or midurethral sling and a perineorrhaphy often are recommended to decrease the risk of postoperative stress urinary incontinence and recurrent posterior vaginal wall prolapse (80).

▶ *What can be recommended regarding currently available synthetic mesh and biologic graft materials for use in vaginal pelvic organ prolapse surgery?*

Availability of Transvaginal Synthetic Mesh

There are currently no available U.S. Food and Drug Administration (FDA)-approved transvaginal mesh products for the treatment of POP. Many transvaginal mesh products were removed from the market after the 2011 FDA announcement that identified serious safety and effectiveness concerns about the use of transvaginal mesh to treat POP (84). In April 2019, the FDA ordered the manufacturers of all remaining surgical mesh products indicated for the transvaginal repair of POP to stop selling and distributing their products in the United States (85). The FDA determined that the manufacturers' premarket approval applications—a requirement since the device's 2016 re-classification as "high risk" (86)—had failed to demonstrate an acceptable long-term benefit–risk profile for surgery with these devices compared with transvaginal native tissue prolapse repair. It is important to note that the FDA announcement applies only to mesh placed transvaginally to treat POP. The FDA order does NOT apply to transvaginal mesh for stress urinary incontinence or transabdominal mesh for POP repair.

The FDA advises that no intervention is needed for patients who received transvaginal mesh for the surgical repair of POP and are not experiencing any symptoms or complications (85). These patients should be counseled to continue with routine care and report any complications or

symptoms, including persistent vaginal bleeding or discharge, pelvic pain, or dyspareunia, to their gynecologic care provider. For more information, see Committee Opinion No. 694, *Management of Mesh and Graft Complications in Gynecologic Surgery* (87).

Although the 2019 FDA announcement stopped the sale of available transvaginal mesh POP repair products, some surgeons might still offer transvaginal mesh-augmented surgery for select patients with anterior and apical POP. Pelvic organ prolapse vaginal mesh repair should be limited to high-risk individuals in whom the benefit of mesh placement may justify the risk, such as individuals with recurrent prolapse (particularly of the anterior or apical compartments) or with medical comorbidities that preclude more invasive and lengthier open and endoscopic procedures. Before placement of synthetic mesh grafts in the anterior vaginal wall, patients should provide their informed consent after reviewing the benefits and risks of the procedure and discussing alternative repairs.

Vaginal Prolapse Repair With Transvaginal Mesh or Biologic Grafts

The use of synthetic mesh or biologic grafts in POP surgery is associated with unique complications not seen in POP repair with native tissue. A systematic review of seven randomized controlled trials that compared native tissue repair with synthetic mesh vaginal prolapse repair found that more women in the mesh group required repeat surgery for the combined outcome of prolapse, stress incontinence, or mesh exposure (RR, 2.40; 95% CI, 1.51–3.81) (41). The rate of mesh exposure was 12%, and 8% of women required repeat surgery for mesh exposure up to 3 years after the initial surgery (41). Systematic review findings show that vaginal repair of prolapse with biologic grafts (tissue from human cadaver or other species) results in similar rates of "awareness of prolapse" and reoperation for prolapse compared with repairs using native tissue (41). However, it is difficult to make an overall recommendation about the use of biologic grafts for vaginal prolapse repair because the available evidence is of low quality, and most of the biologic grafts that were used in studies to date are no longer available.

Posterior Vaginal Repair

The use of synthetic mesh or biologic grafts in transvaginal repair of posterior vaginal wall prolapse does not improve outcomes (41). In addition, there are increased complications (eg, mesh exposure) associated with placement of mesh through a posterior vaginal wall incision (54). In two randomized trials that compared native tissue with biologic graft material for the repair of posterior prolapse, the objective failure rate was significantly lower at the 1-year follow-up in the native tissue group (10% [10 out of 98]) as compared with the biologic graft group (21% [20 out of 93]) (RR, 0.47; 95% CI, 0.24–0.94), and the subjective failure rate was similar between the groups (RR, 1.09; 95% CI, 0.45–2.62) (58, 75, 88). There was no difference in the rate of postoperative dyspareunia between the groups (RR, 1.26; 95% CI, 0.59–2.68). Another trial that compared posterior biologic graft repair with traditional repair noted worse anatomic outcomes with posterior biologic graft repair than with traditional repair (46% versus 14%; $P=.02$) (19, 58). Thus, synthetic mesh or biologic grafts should not be placed routinely through posterior vaginal wall incisions to correct POP for primary repair of posterior vaginal wall prolapse.

Anterior Vaginal Repair

The use of biologic grafts in transvaginal repair of anterior vaginal wall prolapse provides minimal benefit compared with native tissue repair (89). Systematic review results indicate that native tissue and biologic graft-augmented anterior repair result in similar rates of prolapse awareness (RR, 0.98; 95% CI, 0.52–1.82) and risk of repeat surgery (RR, 1.02; 95% CI, 0.53–1.97) (89). Native tissue anterior repair appears to have an increased risk of anterior prolapse recurrence when compared with repair using any type of biologic graft (RR, 1.32; 95% CI, 1.06–1.65). However, subanalysis by biologic graft type showed no significant difference in recurrence risk between native tissue and porcine dermis graft (RR, 1.29; 95% CI, 0.98–1.70), which was the most commonly used graft among the included studies (89).

Compared with native tissue anterior repair, polypropylene mesh augmentation of anterior vaginal wall prolapse repair improves anatomic and some subjective outcomes but is associated with increased morbidity (89). Vaginally placed polypropylene mesh is associated with longer operating times and greater blood loss compared with native tissue anterior repair (89, 90). In addition, the use of vaginally placed polypropylene mesh is associated with an increased risk of repeat surgery for prolapse, stress urinary incontinence, and mesh exposure (composite outcome) (89).

▶ *Is special training required to perform pelvic organ prolapse procedures that use mesh or biologic grafts?*

Surgeons who perform POP surgery with biologic grafts or synthetic mesh grafts should have training specifically for these procedures and should be able to counsel patients regarding the risk–benefit ratio for the use of mesh compared with native tissue repair. There are unique risks and complications associated with the use of mesh in surgeries to treat POP. Special training regarding patient selection, anatomy, surgical technique, postoperative care, and management of complications is necessary for physicians

who perform POP surgery using mesh or biologic grafts (84, 90, 91). The American Urogynecologic Society has published guidelines for training and privileging for the performance of abdominal sacrocolpopexy and vaginal mesh prolapse surgery (92, 93).

▶ *Is it necessary to perform intraoperative cystoscopy during pelvic organ prolapse surgery?*

Routine intraoperative cystoscopy during POP surgery is recommended when the surgical procedure performed is associated with a significant risk of injury to the bladder or ureter. These procedures include suspension of the vaginal apex to the uterosacral ligaments, sacrocolpopexy, and anterior colporrhaphy and the placement of mesh in the anterior and apical compartments (94, 95).

Intraoperative cystoscopy is performed after completion of POP repair while the patient is still under anesthesia and should include a complete survey of the bladder and assessment of efflux of urine from the ureteral orifices. Identified issues such as no flow or reduced flow from the ureter or an injury to the bladder should be addressed intraoperatively. Delay in recognition of a urinary tract injury may lead to increased morbidity (96).

▶ *Are there effective pelvic organ prolapse surgical treatment methods available for women who prefer to avoid hysterectomy?*

Women who desire surgical treatment of POP may choose to avoid hysterectomy for a variety of reasons, including preservation of fertility, maintenance of body image, and beliefs about adverse effects on sexual function (97–99). Alternatives to hysterectomy for the surgical treatment of POP include hysteropexy (ie, uterine suspension) and Le Fort colpocleisis.

Hysteropexy

Hysteropexy is a viable alternative to hysterectomy in women with uterine prolapse, although there is less available evidence on safety and efficacy compared with hysterectomy (99). Hysteropexy may be performed through a vaginal incision by attaching the cervix to the sacrospinous ligament with sutures (100) or mesh (101). Hysteropexy also may be performed abdominally or laparoscopically by placing a mesh or biologic graft from the cervix to the anterior longitudinal ligament (99). Shortening the uterosacral ligaments laparoscopically with or without robotic assistance or by an abdominal incision also can be performed. A 2016 cohort study that compared laparoscopic sacral hysteropexy with vaginal mesh hysteropexy found that, at 1-year follow-up, the two procedures had similar efficacy and no significant differences in the rate of complications, blood loss, or length of hospitalization (101).

Benefits of hysteropexy compared with total hysterectomy include shorter operative time and a lower incidence of mesh erosion if mesh augmentation is used. In comparison, women with uterine prolapse who choose hysterectomy will have a lower risk of uterine and cervical cancer or any procedures that involve abnormalities of the cervix or uterus (eg, endometrial biopsy). They will not become pregnant and will not have uterine bleeding or pain.

Outcome data comparing hysterectomy with hysteropexy are not clear. In one study, vaginal hysterectomy for the treatment of stage II or greater POP was associated with a lower risk of recurrent prolapse than hysteropexy (100). However, in a randomized trial that compared sacrospinous hysteropexy with vaginal hysterectomy and uterosacral ligament vaginal vault suspension for stage 2 or greater POP, sacrospinous hysteropexy was found to be noninferior to vaginal hysterectomy (for anatomic recurrence of the apical compartment with bothersome bulge symptoms or repeat surgery for recurrent apical prolapse): sacrospinous hysteropexy 0% (n=0) versus vaginal hysterectomy 4.0% (n=4), a difference of −3.9% (95% CI, −8.6% to 0.79%) over 12 months (102). Longer-term follow-up on this cohort of women is needed. Another study that compared postoperative sexual function in women who underwent hysteropexy with women who underwent hysterectomy found no significant difference between the two groups (98). There is little information regarding pregnancy after uterine suspension (103).

Le Fort Colpocleisis

In women with POP who want to avoid hysterectomy or who have significant comorbidities and no longer desire vaginal coital function, a Le Fort colpocleisis is a therapeutic option. This is an effective treatment for POP with a high success rate and high patient satisfaction. However, patients should be counseled that this surgery is irreversible (77). For more information, see *Are surgical approaches available to treat pelvic organ prolapse in women with medical comorbidities*?)

▶ *Can the occurrence of stress urinary incontinence after surgery for pelvic organ prolapse be anticipated and avoided?*

All women with significant apical prolapse, anterior prolapse, or both should have a preoperative evaluation for occult stress urinary incontinence, with cough stress testing or urodynamic testing with the prolapse reduced (104). Some women will have a positive cough stress test result only when their POP is in the reduced position. Prolapse may obstruct the urethra or the urethra might kink from an anterior vaginal wall prolapse. This could mask stress urinary incontinence, which then may present after surgery. In

women with bothersome POP and current stress urinary incontinence symptoms, it is prudent to correct both disorders to reduce persistent or worsening stress incontinence after surgery. Because there is no single procedure that adequately treats POP and urinary incontinence, two procedures are done concomitantly. Thus, women with bothersome stress urinary incontinence who are undergoing POP surgery should consider having concomitant treatment for both disorders. The type of continence procedure often is selected based on the route of access for the prolapse repair (104).

Patients with POP but without stress urinary incontinence who are undergoing either abdominal or vaginal prolapse repair should be counseled that postoperative stress urinary incontinence is more likely without a concomitant continence procedure but that the risk of adverse effects is increased with an additional procedure (104). Burch colposuspension at the time of abdominal sacrocolpopexy and retropubic midurethral sling at the time of vaginal surgery for POP repair decrease the risk of postoperative stress urinary incontinence in women without preoperative stress urinary incontinence (104–106). In the CARE trial, women with no reported preoperative stress urinary incontinence who were undergoing open abdominal sacrocolpopexy for prolapse repair were randomized to receive concomitant Burch colposuspension or no continence procedure (105). Fewer women who underwent concomitant Burch colposuspension had postoperative stress incontinence compared with those who underwent sacrocolpopexy alone (34% versus 57%, $P<.001$). Similar results were found in the outcomes after the Vaginal Prolapse Repair and Midurethral Sling trial, which evaluated placement of a prophylactic midurethral sling at the time of vaginal prolapse surgery (106). Among the women who underwent prophylactic midurethral sling placement at the time of vaginal surgery, 24% developed stress urinary incontinence after surgery, compared with 49% in those who underwent only POP surgery.

In women undergoing vaginal POP surgery, the risks of complications from the stress urinary incontinence surgery should be weighed against the risk of postoperative stress urinary incontinence. Some practitioners favor a staged approach in which women undergo stress urinary incontinence surgery after POP surgery only if they develop stress urinary incontinence. For more information, see Practice Bulletin No. 155, *Urinary Incontinence in Women* (104).

▶ *What are the complications of pelvic organ prolapse surgery, and how are they managed?*

Complications after native tissue POP surgery include bleeding, infection (typically urinary tract) and voiding dysfunction (which usually is transient). Less common complications include rectovaginal or vesicovaginal fistula, ureteral injury, foreshortened vagina, or a restriction of the vaginal caliber (21, 75). In the Operations and Pelvic Muscle Training in the Management of Apical Support Loss trial, dyspareunia was noted in 16% of women 24 months after native tissue POP surgery (107). Changes in vaginal anatomy may lead to pelvic pain and pain with intercourse. Fistula and ureteral injury require prompt referral to specialists with expertise in managing these conditions. A short vagina or vaginal constriction after POP surgery often can be managed with vaginal estrogen and progressive dilators (108). If these management methods are not successful, referral to a specialist who is experienced with surgical correction of postoperative POP complications is recommended.

There are unique complications associated with synthetic mesh when they are used in POP surgery. These include mesh contracture and erosion into the vagina, urethra, bladder, and rectum. The rate of mesh erosion is approximately 12% after vaginal mesh prolapse surgery (41). When mesh is used for anterior vaginal wall prolapse repair, there is an 11% risk of mesh erosion, with 7% of these cases requiring surgical correction (89). The rate of dyspareunia is approximately 9% after vaginal mesh prolapse surgery (109). Multiple procedures often are required to manage mesh-related complications (110). Referral to an obstetrician–gynecologist with appropriate training and experience, such as a female pelvic medicine and reconstructive surgery specialist, is recommended for surgical treatment of prolapse mesh complications. For more information, see Committee Opinion No. 694, *Management of Mesh and Graft Complications in Gynecologic Surgery* (87).

▶ *How should recurrent pelvic organ prolapse be managed?*

Recurrence of POP is possible after any POP surgery. Recurrence rates between 6% and 30% have been reported (19). Women should be counseled about the risk of recurrence before undergoing POP surgery.

Women who present with recurrent POP should undergo counseling similar to that for women who present with primary POP. It is helpful to review the preoperative examination results and prior surgical reports. Many patients may choose not to undergo a repeat surgery. They may choose instead to monitor the prolapse or to use a pessary.

If a patient chooses to undergo surgery for recurrent vaginal apex prolapse, abdominal sacrocolpopexy, vaginal colpopexy with possible mesh or graft augmentation, or colpocleisis may be considered if the patient has failed a vaginal native tissue apical suspension. If the surgeon is not comfortable performing these procedures, referral of the patient to a surgeon who sub-specializes in pelvic reconstructive surgery and can offer these procedures is recommended.

Summary of Recommendations and Conclusions

The following recommendations and conclusions are based on good and consistent scientific evidence (Level A):

- Uterosacral and sacrospinous ligament suspension for apical POP with native tissue are equally effective surgical treatments of POP, with comparable anatomic, functional, and adverse outcomes.
- The use of synthetic mesh or biologic grafts in transvaginal repair of posterior vaginal wall prolapse does not improve outcomes.
- Compared with native tissue anterior repair, polypropylene mesh augmentation of anterior vaginal wall prolapse repair improves anatomic and some subjective outcomes but is associated with increased morbidity.

The following recommendations and conclusions are based on limited or inconsistent scientific evidence (Level B):

- Many women with POP on physical examination do not report symptoms of POP. Treatment is indicated only if prolapse is causing bothersome bulge and pressure symptoms, sexual dysfunction, lower urinary tract dysfunction, or defecatory dysfunction.
- Women considering treatment of POP should be offered a vaginal pessary as an alternative to surgery.
- Vaginal apex suspension should be performed at the time of hysterectomy for uterine prolapse to reduce the risk of recurrent POP.
- Abdominal sacrocolpopexy with synthetic mesh has a lower risk of recurrent POP but is associated with more complications than vaginal apex repair with native tissue.
- Obliterative procedures—which narrow, shorten, or completely close the vagina—are effective for the treatment of POP and should be considered a first-line surgical treatment for women with significant medical comorbidities who do not desire future vaginal intercourse or vaginal preservation.
- The use of synthetic mesh or biologic grafts in POP surgery is associated with unique complications not seen in POP repair with native tissue.
- Hysteropexy is a viable alternative to hysterectomy in women with uterine prolapse, although there is less available evidence on safety and efficacy compared with hysterectomy.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- A POP-Q examination is recommended before treatment for the objective evaluation and documentation of the extent of prolapse.
- A pessary should be considered for a woman with symptomatic POP who wishes to become pregnant in the future.
- Pelvic organ prolapse vaginal mesh repair should be limited to high-risk individuals in whom the benefit of mesh placement may justify the risk, such as individuals with recurrent prolapse (particularly of the anterior or apical compartments) or with medical comorbidities that preclude more invasive and lengthier open and endoscopic procedures. Before placement of synthetic mesh grafts in the anterior vaginal wall, patients should provide their informed consent after reviewing the benefits and risks of the procedure and discussing alternative repairs.
- Surgeons who perform POP surgery with biologic grafts or synthetic mesh grafts should have training specifically for these procedures and should be able to counsel patients regarding the risk–benefit ratio for the use of mesh compared with native tissue repair.
- Routine intraoperative cystoscopy during POP surgery is recommended when the surgical procedure performed is associated with a significant risk of injury to the bladder or ureter. These procedures include suspension of the vaginal apex to the uterosacral ligaments, sacrocolpopexy, and anterior colporrhaphy and the placement of mesh in the anterior and apical compartments.
- All women with significant apical prolapse, anterior prolapse, or both should have a preoperative evaluation for occult stress urinary incontinence, with cough stress testing or urodynamic testing with the prolapse reduced.
- Patients with POP but without stress urinary incontinence who are undergoing either abdominal or vaginal prolapse repair should be counseled that postoperative stress urinary incontinence is more likely without a concomitant continence procedure but that the risk of adverse effects is increased with an additional procedure.

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The MEDLINE database, the Cochrane Library, and the American College of Obstetricians and Gynecologists' own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 2000 and October 2016. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles. When reliable research was not available, expert opinions from obstetrician–gynecologists were used.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

- I Evidence obtained from at least one properly designed randomized controlled trial.
- II-1 Evidence obtained from well-designed controlled trials without randomization.
- II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.
- II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
- III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

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EXHIBIT 13

EXHIBIT 13

Physician Sexual Misconduct

Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct

Adopted as policy by the Federation of State Medical Boards
May 2020

Section 1: Introduction and Workgroup Charge

The relationship between a physician and patient is inherently imbalanced. The knowledge, skills and training statutorily required of all physicians puts them in a position of power in relation to the patient. The patient, in turn, often enters the therapeutic relationship from a position of vulnerability due to illness, suffering, and a need to divulge deeply personal information and subject themselves to intimate physical examination. This vulnerability is further heightened in light of the patient's trust in their physician, who has been granted the power to deliver care, prescribe needed treatment and refer for appropriate specialty consultation.

It is critical that physicians act in a manner that promotes mutual trust with patients to enable the delivery of quality health care. When there is a violation of that relationship through sexual misconduct, such behavior and actions can have a profound, enduring and traumatic impact on the individual being exploited, their family, the public at large, and the medical profession as a whole. Properly and effectively addressing sexual misconduct by physicians through sensible standards and expectations of professionalism, including preventive education, as well as through meaningful disciplinary action and law enforcement when required, is therefore a paradigmatic expression of self-regulation and its more modern iteration, shared regulation.

In May of 2017, Patricia King, M.D., PhD., Chair at the time of the Federation of State Medical Boards (FSMB), created and led a Workgroup on Physician Sexual Misconduct (hereafter referred to as "the Workgroup"), and charged its members with 1) collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct; 2) identifying and evaluating barriers to reporting sexual misconduct to state medical boards, including, but not limited to, the impact of state confidentiality laws, state administrative codes and procedures, investigative procedures, and cooperation with law enforcement on the reporting and prosecution/adjudication of sexual misconduct; 3) evaluating the impact of state medical board public outreach on reporting; 4) reviewing the FSMB's 2006 policy statement, *Addressing Sexual Boundaries: Guidelines for State Medical Boards,* and revising, amending or replacing it, as appropriate; and 5) assessing the prevalence of sexual boundary/harassment training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps.

In carrying out its charge, the Workgroup adopted a broad lens with which to scrutinize not only the current practices of state medical boards and other professional regulatory authorities in the United States and abroad, but also elements of professional culture within American medicine, including notions of professionalism, expectations related to reporting instances of misconduct or

impropriety, evolving public expectations of the medical profession, and the impact of trauma on survivors of sexual misconduct. In analyzing these issues, the Workgroup benefited tremendously from discussions with several of the FSMB's partner organizations and stakeholders that also have a role in addressing the issue of physician sexual misconduct. The Workgroup extends its thanks, in particular, to the American Association of Colleges of Osteopathic Medicine (AACOM), Association of American Medical Colleges (AAMC), Student Osteopathic Medical Association (SOMA), Australian Health Practitioner Regulation Agency (AHPRA), American Medical Association (AMA), American Medical Women's Association (AMWA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), Federation of Medical Regulatory Authorities of Canada (FMRAC), Federation of State Physician Health Programs (FSPHP), several provincial medical regulatory colleges from Canada, subject matter experts from Justice3D, PBI Education, and additional physician experts, and especially the victim and survivor advocates who bravely shared their experiences with Workgroup members. This report has been enriched by these partners' valuable contributions.

A call for cultural change

The Workgroup acknowledged the importance of the environment and culture, from medical school to practice, for the development of and commitment to positive professional values and behaviors in medicine. In this regard, the Workgroup also acknowledged the existence of several highly problematic aspects of sexual misconduct in medical education and practice, many of which permeate the prevailing culture of medicine and self-regulation. The National Academies of Sciences report that organizational culture plays a primary role in enabling harassment and that sexually harassing behaviors are not typically isolated incidents.[1] Medical students and trainees who are subjected to environments in which harassment is accepted suffer not only as victims, but may also be undermined in their educational and professional attainment, resulting in loss of talent for the profession. To the extent that a culture that is permissive of sexual harassment results in perceived license to engage in such conduct oneself, patients are ultimately put at risk of dire consequences. Permissive environments could also reduce the likelihood that bystanders will feel responsibility to report misconduct.

Beyond the many instances, both reported and unreported, of sexual assault and boundary violations, concerns about sexual misconduct in medicine include various aspects of the investigative and adjudicatory processes designed to address them; the professional responsibility of health care practitioners to report suspected instances of sexual misconduct and patient harm; variation in state medical board policies and processes, as well as in state laws; transparency of state medical board processes and actions; a widespread need for education and training among medical regulators, board investigators, attorneys, and law enforcement personnel about trauma and how it might impact complainant accounts and the investigative process; and challenges posed for decisions about re-entry to practice and remediation.

This report summarizes these problematic elements so that they may be more widely appreciated, while offering potential solutions and strategies for state medical boards to consider for their

[1] National Academies of Sciences, Engineering, and Medicine. 2018. *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/24994.

jurisdictions. It aspires to provide best practice recommendations and highlight existing strategies and available tools to allow boards, including board members, executive directors, staff, and attorneys, to best protect the public while working within their established frameworks and resources. The report also advocates for an educational focus to change and improve culture, awareness, and behaviors across the continuum of medical education and practice, so as to improve care for and protection of patients.

Section 2: Principles

The analysis in this report is informed by the following principles:

- **Trust**: The physician-patient relationship is built upon trust, understood as a confident belief on the part of the patient in the moral character and competence of their physician.[2] In order to safeguard this trust, the physician must act and make treatment decisions that are in the best interests of the patient at all times.
- **Professionalism**: The avoidance of sexual relationships with patients has been a principle of professionalism since at least the time of Hippocrates. Professional expectations still dictate today that sexual contact or harassment of any sort between a physician and patient is unacceptable.
- **Fairness**: The principle of fairness applies to victims (also sometimes described as survivors) of sexual misconduct, who must be granted fair treatment throughout the regulatory process and be afforded opportunities to seek justice for wrongful conduct committed against them. Fairness also applies to physicians who are subjects of complaints in that they must be granted due process in investigative and adjudicatory processes; proportionality should be considered in disciplinary actions.
- **Transparency**: The actions and processes of state medical boards are designed in the public interest to regulate the medical profession and protect patients from harm. As such, the public has a right to information about these processes and the bases of regulatory decisions.

Section 3: Terminology:

Sexual Misconduct:

For the purposes of this report, physician sexual misconduct is understood as behavior that exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, can occur in person or virtually,[3] and may include expressions of thoughts and feelings or gestures that are of a sexual nature or that a patient or surrogate[4] may reasonably construe as sexual. Hereinafter, the term "patient" includes the patient and/or patient surrogate.

[2] Beauchamp T and Childress J., (2001) *Principles of Biomedical Ethics*, 5th ed., 34.
[3] Federation of State Medical Boards, *Social Media and Electronic Communication*, 2019.
[4] Surrogates are those individuals closely involved in patients' medical decision-making and care and include spouses or partners, parents, guardians, and/or other individuals involved in the care of and/or decision-making for the patient.

Physician sexual misconduct often takes place along a continuum of escalating severity. This continuum comprises a variety of behaviors, sometimes beginning with "grooming" behaviors which may not necessarily constitute misconduct on their own, but are precursors to other, more severe violations. Grooming behaviors may include gift-giving, special treatment, sharing of personal information or other acts or expressions that are meant to gain a patient's trust and acquiescence to subsequent abuse.[5] When the patient is a child, adolescent or teenager, the patient's parents may also be groomed to gauge whether an opportunity for sexual abuse exists.

More severe forms of misconduct include sexually inappropriate or improper gestures or language that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient. These may not necessarily involve physical contact, but can have the effect of embarrassing, shaming, humiliating or demeaning the patient. Instances of such sexual impropriety can take place in person, online, by mail, by phone, and through texting.

Additional examples of sexual misconduct involve physical contact, such as performing an intimate examination on a patient with or without gloves and without clinical justification or explanation of its necessity, and without obtaining informed consent.

The severity of sexual misconduct increases when physical contact takes place between a physician and patient and is explicitly sexual or may be reasonably interpreted as sexual, even if initiated by the patient. So-called "romantic" behavior between a physician and a patient is never appropriate, regardless of the appearance of consent on the part of the patient. Such behavior would at least constitute grooming, depending on the nature of the behavior, if not actual sexual misconduct, and should be labeled as such.

The term "sexual assault" refers to any type of sexual activity or contact without consent (such as through physical force, threats of force, coercion, manipulation, imposition of power, etc., or circumstances where a person lacks the capacity to provide consent due to age or other circumstances) and may be used in investigations where there is a need to emphasize the severity of the misconduct and related trauma. Sexual assault is a criminal or civil violation and should typically be handled in concert with law enforcement. Sexual assault should be reported to law enforcement immediately, except in cases where reporting would contravene the wishes of an adult complainant and non-reporting in such an instance is permitted by applicable state law.

While the legal term "sexual boundary violation" is a way of denoting the breach of an imaginary line that exists between the doctor and patient or surrogate, and is commonly used in medical regulatory discussions, the members of the Workgroup felt that it was an overly broad term that may encompass everything from isolated instances of inappropriate communication to sexual misconduct and outright sexual assault. Thus, this report avoids the term in favor of more specific terms.

[5] American Academy of Pediatrics "Protecting Children from Sexual Abuse by Health Care Providers," Committee on Child Abuse and Neglect, 2010-2011, Published in *Pediatrics*, August 2011, Vol. 128, Issue 2.

Trauma:

For the purposes of this report, the definition of trauma provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) is used:

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[6]

According to SAMHSA, "a program, organization, or system that is *trauma-informed* realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[7]

Patient:

A patient is understood as an individual with whom a physician is involved in a care and treatment capacity within a legally defined and professional physician-patient relationship.

Physician:

While this report primarily addresses physician licensees, the content and recommendations should be viewed as applying to all health professionals licensed by member boards of the FSMB, as well as other members of the health care team, including medical students.

Section 4: Patient Rights and Expectations for Professional Conduct in the Physician-Patient Encounter

Communication and Patient Education

Communication between a physician and patient should occur throughout any examination or procedure (provided the patient is not under general anesthetic during the procedure), including conveying the medical necessity, what the examination or procedure will involve, any discomfort the patient might experience, the benefits and risks, and any findings. This is especially important during the performance of an intimate examination. This not only lays out the parameters of the interaction for both parties; it may also help minimize the possibility that the patient will misinterpret the physician's actions.

[6] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[7] *Id*. Emphasis added.

The use of educational resources to educate patients about what is normal and expected during medical examinations and procedures is encouraged and should be provided by both physicians and state medical boards.

Informed Consent and Shared Decision-Making

The informed consent process can be a useful way of helping a patient understand the intimate nature of a proposed examination, as well as its medical necessity. The informed consent process should include, at a minimum, an explanation, discussion, and comparison of treatment options with the patient, including a discussion of any risks involved with proposed procedures; an assessment of the patient's values and preferences; arrival at a decision in partnership with the patient; and an evaluation of the patient's decision in partnership with the patient. This process must be documented in the patient's medical record.

Where possible, the consent process should take place well in advance of any procedure so that the patient has an opportunity to consider the proposed procedure in the absence of competing considerations about cancellation or rescheduling. Requiring decisions at the point of care puts patients at a disadvantage because they may not have time to consider what is being proposed and what it means for themselves and their values. However, it is recognized that obtaining consent well in advance is not always possible for urgent, emergency, or same-day procedures. The consent process should also include information about the effects of anaesthesia, including the possibility of amnesia, because these can be particularly problematic with respect to sexual misconduct. Use of understandable (lay, or common) language during the consent process is essential.

In instances where a patient is unable to provide consent to a pelvic or otherwise intimate examination due to the presence of anesthesia or for any other reason, an intimate examination should only be performed when it is medically necessary. Intimate examinations must never be performed for purely educational purposes when consent cannot be obtained.

Section 5: Complaints and the Duty to Report

In order for state medical boards to effectively address instances of sexual misconduct, they must have access to relevant information about licensees that have harmed or pose a significant risk of harming patients. The complaints process and physicians' professional duty to report instances of sexual misconduct are therefore central to a regulatory board's ability to protect patients.[8]

Complaints and Barriers to Complaints

It is essential for patients or their surrogates to be able to file complaints about their physicians to state medical boards in order that licensees who pose a threat to patients may be investigated and appropriate action taken. However, studies have estimated that sexual misconduct by physicians

[8] Additional reporting to entities other than state medical boards may also be warranted for purposes of patient protection, including law enforcement, hospital or medical staff administration, and medical school or residency program directors and supervisors.

is significantly under reported, and several challenges which may dissuade patients from filing complaints must be overcome.[9] These include distrust in the ability or willingness of institutions such as state medical boards, hospitals and other health care organizations to take action in instances of sexual misconduct; fear of abandonment or retaliation by the physician; societal or personal factors related to stigma, shame, embarrassment and not wanting to relive a traumatic event; a lack of awareness about the role of state medical boards and how to file complaints; or uncertainty that what has transpired is, indeed, unprofessional and unethical.

State medical boards can play an important role in providing clarity about the complaints process by providing information to the public about the process itself and how, why, and when to file a complaint. Recommended methods for optimizing the complaints process include:

- Providing the option to file complaints via multiple channels, including in writing, by telephone, email, or through online forms
- Making the process accessible to patients with information about filing complaints that is clearly posted on state medical board websites
- Ensuring that information about the complaints process is made available via translation for complainants who do not speak English

State medical boards, the FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures may also wish to provide education for patients on topics such as:

- The types of behavior that should be expected of physicians
- Types of behavior that might warrant a complaint
- What to do in the event that a physician's actions make a patient uncomfortable
- Circumstances that would warrant a report directly to law enforcement

State medical boards can also restore public trust and confidence in the complaints process by demonstrating swift and appropriate action on verified complaints.

The ability to file a complaint anonymously may be especially important in instances of sexual misconduct. The trauma and fear associated with sexual misconduct can pose barriers to legitimate complaints, especially when anonymity is not granted. While the ability of complainants to remain anonymous to the general public is recommended, complainant anonymity to the state medical board may not be possible.

State medical boards should address complaints related to sexual misconduct as quickly as possible for the benefit and protection of the complainant and other patients. Initial stages of investigations should be expedited to determine whether there is a high likelihood of imminent risk to the public, meriting steps to modify or cease practice while the investigation is completed.

[9] Dubois J, et al. Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases. *Sexual Abuse* 2019, Vol. 31(5) 503–523

State medical board staff and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative processes and to ask complainants about their preferred mode and frequency of communication, as well as their expectations from the process. Where possible, boards should consider having a patient liaison or navigator on staff who would be specially trained to provide one-on-one support to complainants and their families.

Duty to Report

In a complaint-based medical regulatory system, it is imperative that state medical boards have access to the information they require to effectively protect patients.[10] In addition to a robust complaints process, it is therefore essential that patients, physicians and everyone involved in healthcare speak up whenever something unusual, unsafe or inappropriate occurs. All members of the healthcare team, as well as institutions, including state medical boards, hospitals and private medical clinics also have a legal as well as an ethical duty to report instances of sexual misconduct and other serious patient safety issues and events. This duty extends beyond physician-patient encounters to reporting inappropriate behavior in interactions with other members of the healthcare team, and in the learning environment.

Early reporting of sexual misconduct is critical. This includes reporting of those forms of misconduct at the less egregious end of the spectrum that fall under potential grooming behaviors. Evidence indicates that less egregious violations that go unreported frequently lead to more egregious ones. Less egregious acts and grooming behaviors are almost always committed in private or after hours where they cannot be witnessed by parties external to the physician-patient encounter and therefore go unreported. Early reporting is therefore one of the only ways in which sexual misconduct with patients can be prevented from impacting more patients.

The ethical duty to report has proven insufficient in recent years, however, to provide the information state medical boards must have to stop or prevent licensees from engaging in sexual misconduct. There are likely several factors that inhibit reporting, including the corporatization of medical practice, which has led many institutions to deal with instances of misconduct internally. While corporatization increases accountability for many physicians and internal processes may be effective in addressing some types of sexual misconduct, it can also cause some institutions to neglect required reporting and the need for transparency. Physicians may also avoid reporting because of the moral distress and discomfort some physicians feel when asked to report their colleagues, and the impracticality of reporting where power dynamics exist and where stakes are high for reporters.

Thus, rather than relying on professional or ethical duties alone, alternative strategies and approaches should be considered. State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct. While many boards already have statutory ability to do so, they are reluctant to engage in legal proceedings with hospitals or other institutions with far greater resources at their disposal. An ability to publicize reasons for levying fines may also be helpful as the reputational risk to an institution could provide added incentives to report.

[10] Federation of State Medical Boards, *Position Statement on Duty to Report*, 2016.

Results of hospital and health system peer review processes should also be shared with state medical boards when sexual misconduct is involved. This type of conduct is fundamentally different from other types of peer review data related to performance and aimed at quality improvement and, while still relevant to medical practice, should be subject to different rules regarding reporting. Hospitals should also be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

Boards should have the authority to impose disciplinary action on licensees for failure to report. Where such authority does not currently exist, legislative change may be sought.[11] Language used in state laws describing when reporting is mandatory varies and can include "actual knowledge" of an event, "reasonable cause" to believe that an event occurred, "reasonable belief," "first-hand knowledge," and "reasonable probability" (as distinguished from "mere probability").[12] Despite the variance in language, the theme of reasonability runs throughout. If it is reasonable to believe that misconduct occurred, this should be reported to the state medical board and, in most instances, to law enforcement.

Reporting to Law Enforcement

There is variability in state laws that address when state medical boards are required to report instances of sexual misconduct to law enforcement. Despite this variability, best practices dictate that boards have a duty to report to law enforcement anytime they become aware of sexual misconduct or instances of criminal behavior. When reporting requirements are unclear, consultation with a board attorney is recommended, but boards are encouraged to err on the side of reporting. Protocols and consensus can also be established in collaboration with law enforcement to help clarify reporting requirements. This can also help to clarify circumstances where law enforcement should report instances of physician sexual misconduct to state medical boards.

In limited circumstances, boards may choose not to report to law enforcement. These may involve less egregious forms of sexual misconduct such as inappropriate speech or include circumstances where a complainant requests that law enforcement not be notified, as long as there is no law establishing a mandatory reporting requirement. Wishes of complainants should be respected in such circumstances, as victims may be at different stages of coming to terms with the trauma they've experienced. However, reporting to law enforcement must occur for any instance of child abuse, abuse of a minor, and abuse of a dependent adult, regardless of whether the complainant wants reporting to occur. In any instance where reporting sexual misconduct to law enforcement is considered, especially in instances where a decision is made *not* to report, a clear rationale for the board's decision should be documented. Boards can also facilitate the reporting process for patients by offering assistance or educational resources about the reporting process and relevant contact information.

[11] See, e.g., N.C. Gen. Stat. § 90-5.4
[12] Starr, Kristopher T Reporting a Physician Colleague for Unsafe Practice: What's the Law? *Nursing2019*: February 2016 - Volume 46 - Issue 2 - p 14

Cultivating Professionalism

Empowering physicians and physicians in training to report violations of professional standards is essential given the barriers posed by the hierarchical structure of most health care institutions.[13] Those in a position to observe and report sexual misconduct should be protected from retaliation and adverse consequences for medical school matriculation, training positions, careers or promotions. Cultivating positive behavior through role modelling and establishing clear guidance based on the values of the profession is the responsibility of multiple parties, not the state medical board alone. A broader notion of professionalism should be adopted that goes beyond expectations for acceptable conduct to include a duty to identify instances of risk or harm to patients, thereby making non-reporting professionally unacceptable. Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.

Unscrupulous, frivolous or vexatious reporting motivated by competition or personal animus is counterproductive to fulfilling this notion of professionalism and protecting the public, so should be met with disciplinary action. Processes for reporting and complaints should be normalized by making them a core component of medical professionalism, rather than a burdensome responsibility that befalls particular unfortunate individuals. This may help physicians feel less like investigators and more like responsible stewards of professional values. Those physicians and other individuals who do report in good faith should be protected from retaliation through whistleblower legislation and given the option to remain anonymous.

Section 6: Investigations

State Medical Board Authority

It is imperative that state medical boards have sufficient statutory authority to investigate complaints and any reported allegations of sexual misconduct. State medical boards should place a high priority on the investigation of complaints of sexual misconduct due to patient vulnerability unique to such cases. The purpose of the investigation is to determine whether the report can be substantiated in order to collect sufficient facts and information for the board to make an informed decision as to how to proceed. If the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.

Each complaint should be investigated and judged on its own merits. Where permitted by state law, the investigation should include a review of previous complaints to identify any such patterns of behavior, including malpractice claims and settlements. In the event that such patterns are identified early in the investigation, or the physician has been the subject of sufficient previous complaints to suggest a high likelihood that the physician presents a risk to future

[13] Dubois J. et al. Preventing Egregious Ethical Violations in Medical Practice, Evidence-Informed Recommendations from a Multidisciplinary Working Group. *Journal of Medical Regulation* 2018, Vol.104(4), 23-31.

patients, or in the event of evidence supporting a single egregious misconduct event, the state medical board should have the authority to impose terms or limitations, including suspension, on the physician's license prior to the completion of the investigation.

The investigation of all complaints involving sexual misconduct should include interviews with the physician, complainant(s) and/or patient and/or patient surrogate. The investigation may include an interview with a current or subsequent treating practitioner of the patient and/or patient surrogate; colleagues, staff and other persons at the physician's office or worksite; and persons that the patient may have told of the misconduct. Physical evidence and police reports can also be valuable in providing a more complete understanding of events.

In many states, a complaint may not be filed against a physician for an activity that occurred beyond a certain time threshold in the past. There is a growing trend among state legislatures in recent years to extend or remove the statute of limitations in cases of rape, sexual assault and other forms of sexual misconduct. Given the impact that trauma can have on a victim of sexual misconduct, the length of time that it may take to understand that a violation has occurred, to come to terms with it, or be willing to relive the circumstances as part of the complaints process, the members of the Workgroup feel that no limit should be placed on the amount of time that can elapse between when an act of misconduct occurred and when a complaint can be filed.

Trauma-Informed Investigations

Because of the delicate nature of complaints of sexual misconduct and the potential trauma associated with it, state medical boards should have special procedures in place for interviewing and interacting with such complainants and adjudicating their cases. In cases involving trauma, emotions may not appear to match the circumstances of the complaint, seemingly salient details may be unreported or unknown to the complainant, and the description of events may not be recounted in linear fashion. Symptoms of trauma may therefore be falsely interpreted as signs of deception by board investigators or those adjudicating cases.

Professionals who are appropriately trained and certified in the area of sexual misconduct and victim trauma should conduct the state medical board's investigation and subsequent intervention whenever possible. Best practices in this area suggest that board members and staff should undergo specialized training in victim trauma. It is further recommended that all board staff who work with complainants in cases involving sexual misconduct undergo this training to develop an understanding of how complainants' accounts in cases involving trauma can differ from other types of cases. This can inform reasonable expectations on behalf of those investigating and adjudicating these cases and help eliminate biases. The FSMB and state medical boards should work to identify and ensure the availability of high-quality training in trauma and a trauma-informed approach to investigations. While a greater understanding of victim trauma is a priority, additional training in implicit bias related to gender, gender identity, race, and ethnicity would also help ensure fair and comfortable processes for victims.

Where state medical boards have access to investigators of different genders, boards should seek the complainant's preference regarding the gender of investigators and assign them accordingly. State medical boards should also allow inclusion of patient advocates in the interview process

and treat potential victims (survivors) with empathy, humanity, and in a manner that encourages healing. Questioning of both complainants and physicians should take the form of an information-gathering activity, not an aggressive cross-examination.

Section 7: Comprehensive Evaluation

State medical boards regularly use diagnostic evaluations for health professionals who may have a physical or mental impairment. Similarly, the use of diagnostic evaluations when handling a complaint regarding sexual misconduct provides significant information that may not otherwise be revealed during the initial phase of the investigation. A comprehensive evaluation may be valuable to the board's ability to assess future risk to patient safety.

A comprehensive evaluation is not meant to determine findings of fact. Rather, its purpose is to:

- assess and define the nature and scope of the physician's behavior,
- identify any contributing illness, impairment, or underlying conditions that may have predisposed the physician to engage in sexual misconduct or that might put future patients at risk,
- assist in determining whether a longstanding maladaptive pattern of inappropriate behavior exists, and
- make treatment recommendations if rehabilitative potential is established.

If its investigation reveals a high probability that sexual misconduct has occurred, the state medical board should have the authority to order an evaluation of the physician and the physician must be required to consent to the release to the board all information gathered as a result of the evaluation. The evaluation of the physician follows the investigation/intervention process but precedes a formal hearing.

The evaluation of a physician for sexual misconduct is complex and may require a multidisciplinary approach. Where appropriate, it should also include conclusions about fitness to practice.

Section 8: Hearings

Following investigation and evaluation (if appropriate), the state medical board should determine whether sufficient evidence exists to proceed with formal charges against the physician. In most jurisdictions, initiation of formal charges is public and will result in an administrative hearing unless the matter is settled.

Initiation of Charges

In assessing whether sufficient evidence exists to support a finding that sexual misconduct has occurred, corroboration of a patient's testimony should not be required. Although establishing a pattern of sexual misconduct may be significant, a single case is sufficient to proceed with a

formal hearing. State medical boards should have the authority to amend formal charges to include additional complainants identified prior to the conclusion of the hearing process.

Open vs Closed Hearings

If state medical boards are required, by statute, to conduct all hearings in public, including cases of sexual misconduct, many patients may be hesitant to come forward in a public forum and relate the factual details of what occurred. State medical boards should have the statutory authority to close the hearing during testimony which may reveal the identity of the patient. Where closing a hearing is not possible, great care should be taken to deidentify any personally identifying or sensitive information in transcripts and medical records. The decision to close the hearing, in part or in full, should be at the discretion of the board. Neither the physician nor the witness should control this decision. Boards should allow the patient the option of having support persons available during both open and closed hearings.

Patient Confidentiality

Complaints regarding sexual misconduct are highly sensitive. Therefore, enhanced attention must be given to protecting a patient's identity, including during board discussion, so that patients are not discouraged from coming forward with legitimate complaints against physicians. State medical boards should have statutory authority to ensure nondisclosure of the patient's identity to the public. This authority should include the ability to delete from final public orders any patient identifiable information.

Testimony

Sexual misconduct cases involve complex issues; therefore, state medical boards may consider the use of one or more expert witnesses to fully develop the issues in question and to define professional standards of care for the record. Additionally, the evaluating/treating physician or mental health care practitioners providing assessment and/or treatment to the respondent physician may be called as witnesses. The evaluating clinician may provide details of treatment, diagnosis and prognosis, especially the level of insight and change by the practitioner. Also, a current or subsequent treating practitioner of the patient, especially a mental health provider, may be called as a witness. All these witnesses may provide insight into factors that led to the alleged sexual misconduct, an opinion regarding the level of harm incurred by the patient, and describe the physician's rehabilitative potential and risk for recidivism.

Implicit Bias

In any case that comes before a state medical board, it is important for those responsible for adjudicating the case to be mindful of any personal bias that may impact their review and adjudication. Bias can be particularly strong where board members themselves have been victims of sexual assault or have been subject to previous accusations regarding sexual misconduct. Bias may even influence the decisions of state medical board members by virtue of their being

physicians themselves. Training about implicit bias is recommended for board members and staff in order to help identify implicit bias and mitigate the impact it may have on their work.[14]

Diverse representation on state medical boards in terms of gender, age, and ethnicity is important for ensuring balanced discussion and decisions. The inclusion of public members on state medical boards can also contribute to the reduction of bias in adjudication, while also amplifying the patient perspective through commitment to the priorities and interests of the public.[15] In order to ensure effective and meaningful participation from public members, appropriate orientation and education about their role should occur.

Section 9: Discipline

State medical boards have a broad range of disciplinary responses available to them that are designed to protect the public. Upon a finding of sexual misconduct, the board should take appropriate action and impose one or more sanctions reflecting the severity of the conduct and potential risk to patients. Essential elements of any board action include a list of mitigating and aggravating factors, an explanation of the violation in plain language, clear and understandable terms of the sanction, and an explanation of the consequences associated with non-compliance.

Findings of even a single case of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician's medical license. Certain serious forms of unprofessional conduct should presumptively provide the basis for revocation of a license in order to protect the public. Misconduct in this class would include sexual assault, conduct amounting to crimes related to sex, regardless of whether charged or convicted, or egregious acts of a sexual nature. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

In a limited set of instances, state medical boards may find that mitigating circumstances do exist and, therefore, stay the revocation and institute terms and conditions of probation or other practice limitations. If a physician is permitted to remain in practice and gender- or age-based restrictions are used by state medical boards, consideration may also be given to coupling these restrictions with additional regulatory interventions such as education, monitoring or other forms of probation.

In determining an appropriate disciplinary response, the board should consider the factors listed in **Table 1**.

[14] Project Implicit, accessed November 13, 2019 at https://implicit harvard edu/implicit/
[15] Johnson DA, Arnhart KL, Chaudhry HJ, Johnson DH, McMahon GT, The Role and Value of Public Members in Health Care Regulatory Governance *Acad Med*, Vol. 94, No. 2 / February 2019

Table 1: Considerations in determining appropriate disciplinary response	
• Patient Harm[16] • Severity of impropriety or inappropriate behavior • Context within which impropriety occurred • Culpability of licensee • Psychotherapeutic relationship • Existence of a physician-patient relationship • Scope and depth of the physician-patient relationship • Inappropriate termination of physician-patient relationship	• Age and competence of patient • Vulnerability of patient • Number of times behavior occurred • Number of patients involved • Period of time relationship existed • Evaluation/assessment results • Prior professional misconduct/disciplinary history/malpractice • Recommendations of assessing/treating professional(s) and/or state physician health program • Risk of reoffending

Boards should not routinely consider romantic involvement, patient initiation or patient consent to be a legal defense. Sexual misconduct may still occur following the termination of a physician-patient relationship, especially in long-standing relationships or ones that involve a high degree of emotional dependence. Time elapsed between termination of the relationship is insufficient in many contexts to determine that sexual contact is permissible. Other factors that should be considered in assessing the permissibility of consensual sexual contact between consenting adults following the termination of a physician-patient relationship can include documentation of formal termination; transfer of the patient's care to another health care provider; the length of time of the professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's health problem; and the degree of emotional dependence and vulnerability.[17] Termination of a physician-patient relationship for the purposes of allowing sexual contact to occur is unacceptable and would still constitute sexual misconduct because of the trust, inherent power imbalance between a physician and patient, and patient vulnerability that exist leading up to, during and following the decision to terminate the relationship. Any consent to sexual or

[16] Broadly understood as inclusive of physical and emotional harm, resulting distrust in the medical system and avoidance of future medical treatment, and other related effects of trauma.
[17] Washington Medical Commission, *Guideline on Sexual Misconduct and Abuse*, 2017.

romantic activity provided by a patient within the context of a physician-patient relationship or immediately after its termination should be considered invalid.

Society's values and beliefs evolve, and some individuals may be slower to abandon long-held beliefs, even where these may be sexist or prejudiced in other ways. However, adherence to an outdated set of generational values that has since been found to be unacceptable is not a reason to overlook or excuse sexual misconduct.

The potential existence of a physician workforce shortage or maldistribution, or arguments related to particular restrictions being tantamount to taking a physician "out of work" should also not be used as reasons for leniency or for allowing patients to remain in harm's way. In cases involving sexual misconduct, it is simply not true that unsafe or high-risk care is better than no care at all. A single instance, let alone many instances, can cause an extremely high degree of damage to individuals and the communities in which they reside. However, staying true to the principle of proportionality also means considering the fact that some forms of discipline, including public notifications, generate significant shame upon the disciplined physician. This can compound the degree of severity of a disciplinary action and may be taken into consideration by state medical boards where less egregious forms of sexual impropriety are involved.

Temporary or Interim Measures:

In the event that a state medical board decides to remove a licensee from practice or limit the practice of a licensee as a temporary measure in order to reduce the risk of patient harm while an investigation takes place, there are several different interim measures that can be used. Common measures include an interim or summary suspension/cessation of practice, restrictions from seeing patients of a certain age or gender, restrictions from seeing patients altogether, or the mandatory use of a practice monitor (to be understood as distinct from a chaperone, as explained below) for all patient encounters.

The appropriateness of age and gender-based interim restrictions should be considered carefully before being imposed by state medical boards. Sexual misconduct often occurs for reasons related to power, rather than because of a sexual attraction to a particular gender or age group, thereby making these restrictions ineffective to protect patients in many cases.

Remediation

As discussed above, many forms of sexual misconduct and harmful actions that run against the core values of medicine should appropriately result in revocation of licensure. However, there may be some less egregious forms of sexual impropriety with mitigating circumstances for which a physician may be provided the option of participating in a program of remediation to be able to re-enter practice or have license limitations lifted following a review and elapse of an appropriate period of time.

The decision to allow a physician who has committed an act of sexual misconduct the opportunity to undergo a program of remediation with an end goal of potential license reinstatement is difficult for boards to make. Boards are therefore encouraged to draw from the

professional resources that already exist in making determinations about remediation potential and license reinstatement.

State medical boards should be mindful that not all physicians who have committed sexual misconduct are capable of remediation. Reinstatement and monitoring in such a context would therefore be inappropriate. For those who are considered for remediation, if at any point it becomes clear that the physician presents a risk of reoffending or otherwise harming patients, the remediation process should be abandoned, and reinstatement should not occur.

In determining whether remediation is feasible for a particular physician, state medical boards may wish to make use of a risk stratification methodology that considers the severity of actions committed, the mitigating and aggravating factors listed in section 9 above (Discipline), the character of the physician, including insight and remorse demonstrated, as well as an understanding of how their actions violated standards of professional ethics and state medical practice acts, and the perceived likelihood that they may reoffend. The consequences to patients and the general public of allowing a physician to engage in remediation and re-enter practice after a finding of sexual misconduct should be considered, including any erosion of the public trust in the medical profession and the role of state medical boards.

The goals of the remediation process should be clearly outlined, including expectations for acceptable performance on the part of the physician. The process of remediation should take place in-person (online or other forms of distance learning would not be sufficient), require full disclosure of and relate to the physician's offense(s) and be targeted to identified gaps in understanding of their particular vulnerabilities and other risks for committing sexual misconduct. As a condition of successful completion of a program of remediation, participants should be required to articulate not only *why* their actions were wrong, but also *how* they arrived at the point at which they were willing to commit them, and *how* they will guard against arriving at such a point again. For this to occur, assessment and remediation partners must be provided access to investigative information in order to properly tailor remedial education to the particular context in which the misconduct occurred. Finally, state medical boards should be mindful that remediation cannot typically be said to have "occurred" following successful completion of an educational course. Rather, a longitudinal mechanism must be established for maintaining the physician's engagement in a process of coming to terms with their misconduct and avoiding the circumstances that led to it. The longitudinal mechanism both demonstrates the physician's commitment to accountability and the effectiveness of a board's monitoring reach.

The members of the Workgroup acknowledge that shortcomings exist in the current evidence base regarding the effectiveness of remediation in instances of sexual misconduct. As noted elsewhere in this report, recidivism is exceedingly difficult to study well. Recommendations about the use of consistent terminology and improving the tracking of disciplined physicians will contribute to understanding what kinds of remedial interventions are most appropriate and effective in the context of sexual misconduct. Moreover, the Workgroup feels that further research is needed in several other areas, such as group learning experiences, instruction in victim empathy, remedial instruction with or without additional interventions, and identification of subgroups of offenders who may be at higher risk of reoffending.

License Reinstatement/Removal of License Restriction(s)

In the event of license revocation, suspension, or license restriction, any petition for reinstatement or removal of restriction should include the stipulation that a current assessment, and if recommended, successful completion of treatment, be required prior to the medical board's consideration to assure the physician is competent to practice safely. Such assessment may be obtained from the physician's treating professionals, state physician health program (PHP),[18] or from an approved evaluation team as necessary to provide the board with adequate information upon which to make a sound decision.

Transparency of board actions:

As state medical boards regulate the profession in the interest of the public, it is essential that evolving public values and needs are factored into decisions about what information is made publicly available. It has been made clear in academic publications and popular media, as well as through the #MeToo and TimesUp movements that the public increasingly values transparency regarding disciplinary actions imposed on physicians. It is likely that any action short of a complete revocation of licensure will draw scrutiny from the public and popular media. Such scrutiny can also be expected regarding decisions to reinstate a license or remove restrictions. The public availability of sufficient facts to justify a regulatory decision and link it to a licensee's behavior and the context in which it occurred can help state medical boards to explain and justify their decision.

The ability to disclose particular details of investigative findings and disciplinary actions is limited by state statute in many jurisdictions. State medical boards are encouraged to convey this fact to the public in order to protect the trust that patients have in boards, but also make efforts to achieve legislative change, allowing them to publicize information that is in the public interest. Where disclosure is possible, boards should select means for conveying information that will optimally reach patients. This should include making information available on state medical board websites and reporting to the FSMB Physician Data Center, thereby allowing for disciplinary alerts to be sent to other jurisdictions in which the physician holds a license and making information about disciplinary actions publicly available through FSMB's docinfo.org website, and the National Practitioner Data Bank. The use of private agreements or letters of warning in cases involving sexual misconduct is inappropriate because of the importance of disclosure for public protection and data sharing with other state medical boards or medical regulatory authorities from other jurisdictions.

Boards should also consider additional means of communicating, such as through mobile phone applications,[19] notices in newspapers and other publications. California[20] and Washington[21] both

[18] "A Physician Health Program (PHP) is a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions." Source: Federation of State Physician Health Programs.
[19] The Medical Board of California has launched a new mobile application allowing patients to receive updates about their physician, including licensure status and practice location.
[20] CA Bus and Prof Code §1007 (2018)
[21] RCW 18.130.063

require that patients be notified of sexual misconduct license stipulations/restrictions at the time of making an appointment and that the patient verify this notification. Other boards have required licensees to obtain signatures from all patients in their care acknowledging their awareness of an adjudication for professional sexual misconduct. Boards may wish to consider whether these could be viable options in their states.

State medical boards are also encouraged to implement clear coding processes for board actions that provide accurate descriptions of cases, and clearly link licensee behaviors to disciplinary actions. Where sexual misconduct has occurred, the case should be labeled as such. A label of "disruptive physician behavior" or even "boundary violation" is less helpful than the more specific label of "sexual misconduct." State medical boards and the FSMB should work together to develop consistent terminology that allows a violation and the underlying causes of discipline to be stated explicitly, thereby promoting greater understanding for the public and the state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures.

Where particular actions on the part of the physician may not meet a threshold for disciplinary action, but might nonetheless constitute grooming or other concerning behaviors, state medical boards should consider ways in which to allow previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of education or concern which remain on a licensee's record. The ability to revisit previous cases involving seemingly minor events can help identify patterns of behavior in a licensee and provide additional insight into whether a licensee poses a risk to future patients.

Section 10: Monitoring

Following a finding of sexual misconduct, if a license is not revoked or suspended, it is essential that a state medical board establish appropriate monitoring of the physician and their continued practice. Monitoring in the context of sexual misconduct occurs differently from monitoring substance use disorders and the resources available to boards differ from state to state. Many PHPs do not offer monitoring services for physicians who have faced disciplinary action because of sexual misconduct and even where such monitoring by a PHP is possible, it is typically only part of a way forward, rather than a solution on its own.[22]

For the purposes of this report, the members of the Workgroup understand the use of a *chaperone* as an informal arrangement of impartial observation, typically initiated by physicians themselves. A chaperone in this context is meant to protect the doctor in the event of a complaint, although their presence may also offer comfort to the patient.[23] The patient may request that the chaperone not be present for any portion of the clinical encounter. The American College of Obstetricians and Gynecologists (ACOG) has recently recommended that a chaperone be present for all breast, genital, and rectal examinations because of the profoundly negative

[22] Federation of State Physician Health Program Statement on Sexual Misconduct in the Medical Profession, May 2019.

[23] Paterson, R. Independent review of the use of chaperones to protect patients in Australia, Commissioned by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, February 2017.

effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone.[24]

The Workgroup supports ACOG's recommendation because of the potential added layer of protection that an impartial third party brings, while acknowledging that the use of board-mandated chaperones has been discontinued in some international jurisdictions and by particular state medical boards, because of a belief that they merely provide the illusion of safety and may therefore allow harmful behaviors to go unnoticed. There is risk of this occurring in instances where a chaperone is untrained or uninformed about their role, is an employee or colleague of the physician being monitored or does not adequately attend to their responsibilities. In order to distinguish a chaperone in a less formal arrangement with a physician from one mandated by a state medical board with established reporting requirements and formal training, the Workgroup recommends referring to the latter individual as a "practice monitor."

A *practice monitor* differs from a chaperone. We define a practice monitor as part of a formal monitoring arrangement mandated by a state medical board, required at all patient encounters, or all encounters with patients of a particular gender or age. The practice monitor's primary responsibility is to the state medical board and their presence in the clinical encounter is meant to provide protection to the patient through observation and reporting. Costs associated with employing a practice monitor are typically borne by the monitored physician, but practices may vary across states. The patient must be informed that the practice monitor's presence is required as part of a practice restriction. As the practice monitor is mandated for all clinical encounters, the patient may not request that the practice monitor not be present for any portion of the encounter. If a patient is uncomfortable with the presence of a practice monitor, they will need to seek care from a different physician. Patient supports (parents, family members, friends) may be present during examinations but do not replace, nor can they be used in lieu of a board mandated practice monitor.

While even this formal arrangement with a clearly defined role, training and direct reporting may have limitations, the practice monitor may be a useful option for boards in certain specific circumstances. In particular, in instances where there is insufficient evidence to remove a physician from practice altogether, but significant risk is believed to be present, the opportunity to mandate practice monitoring provides boards with an additional option, short of allowing a potentially risky physician to return to independent practice. As such, when practice monitors are implemented judiciously, the Workgroup believes that their use can enhance patient safety and should therefore be considered by state medical boards.

Practice monitors should only be used if the following conditions have been met:

- The practice monitor has undergone formal training about their role, including their primary responsibility and direct reporting relationship to the state medical board (as opposed to the physician being monitored).

[24] Sexual misconduct. ACOG Committee Opinion No. 796. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;135:e43–50.

- It is highly recommended that all practice monitors have clinical backgrounds. If they do not, their training must include sufficient content about clinical encounters so they can be knowledgeable about what is and is not appropriate as part of the monitored physician's clinical encounters with patients.
- The practice monitor should be approved by the state medical board and cannot be an employee or colleague of the monitored physician that may introduce bias or otherwise influence their abilities to serve as a practice monitor and report to the board or intervene when necessary. Pre-existing contacts of any sort are discouraged, but where a previously unknown contact is not available, the existing relationship should be disclosed. In some states, practice monitors are required to be active licensees of another health profession as it is felt that this reinforces their professional duty to report. When health professionals serve as practice monitors, they should not have any past disciplinary history.
- The practice monitor has been trained in safe and appropriate ways of intervening during a clinical encounter at any point where there is confidence of inappropriate behavior on the part of the physician, the terms of the monitoring agreement are not being followed, or a patient has been put at risk of harm.
- The practice monitor submits regular reports to the state medical board regarding the monitored physician's compliance with monitoring requirements and any additional stipulations made in a board order.
- Where possible, state medical boards should consider establishing a panel of different practice monitors that will rotate periodically among monitored physicians to ensure monitor availability and that a collegial relationship does not develop between a practice monitor and a monitored physician, unduly influencing the nature of the monitoring relationship.

Monitoring should be individualized and based on the findings of the multidisciplinary evaluation, and, as appropriate, subsequent treatment recommendations. If a diagnosis of contributory mental/emotional illness, addiction, or sexual disorder has been established, the monitoring of that physician should be the same as for any other mental impairment and state medical boards are encouraged to work closely with their state physician health program as a resource and support in monitoring. Conditions, which may also be used for other violations of the medical practice act, may be imposed upon the physician. Examples are listed in **Table 2**.

Table 2: Possible Conditions of Practice Following a Finding of Sexual Misconduct
• Supervision of the physician in the workplace by a supervisory physician • Requirement that practice monitors are always in attendance and sign the medical record attesting to their attendance during examination or other patient interactions as appropriate.[25] • Periodic on-site review by board investigator or physician health program staff if indicated. • Practice limitations as may be recommended by evaluator(s) and/or the state physicians health program. • Regular interviews with the board and/or state physician health program as required to assess status of probation. • Regular reports from a qualified and approved licensed practitioner, approved in advance by the board, conducting any recommended counseling or treatment. • Completion of a program in maintaining appropriate professional boundaries, which shall be approved in advance of registration by the board.

Section 11: Education

Education and training about professional boundaries in general and physician sexual misconduct in particular should be provided during medical school and residency, as well as throughout practice as part of a physician's efforts to remain current in their knowledge of professional expectations.

State Medical Board Members and Staff

State medical boards and the FSMB should take a proactive stance to educate physicians, board members and board staff about sexual misconduct and the effects of trauma. Members of state medical boards and those responsible for adjudicating cases involving sexual misconduct can also experience trauma. Education for dealing appropriately with traumatic elements of cases and finding appropriate help and resources would also be valuable for board members.

[25] Where a practice monitor does not have authority to make entries in a medical record, alternatives such as handwriting and scanning the attestation should be considered.

Medical Education and Training

Education and training should include information about professionalism and the core values of medicine; the nature of the physician-patient relationship, including the inherent power imbalance and the foundational role of trust; acceptable behavior in clinical encounters; and methods of reporting instances of sexual misconduct. For both medical schools and residency programs, this education and training should also include tracking assessment across the curriculum, identification of deficiencies in groups and individuals, remediation, and reassessment for correction, appropriate self-care, and the potential for developing psychiatric illness or addictive behaviors. Early identification of risk for sexual misconduct and unprofessionalism is central to public protection and maintaining public trust.

Physicians

For practicing physicians, because of lack of education or awareness, physicians may encounter situations in which they have unknowingly violated the medical practice act through boundary transgressions and violations. A reduction in the frequency of physician sexual misconduct may be achieved through education of physicians and the health care team. Engagement in accredited continuing medical education that addresses professionalism, appropriate and acceptable behavior, and methods for reporting sexual misconduct should be encouraged among physician licensees and other members of the healthcare team.

Resources should also be made available to physicians to help them develop better insight into their own behavior and its impact on others. These could include multi-source feedback and 360-degree assessments, and self-inventories with follow-up education based on the results. As with apology legislation, the use of these resources and the results from self-assessment or other forms of assistance should not be used against physicians. Such resources would likely be used more broadly if they came from specialty and professional societies, rather than from state medical boards alone.

Cooperation and Collaboration

State medical boards should develop cooperative relationships with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs to provide physicians and medical students with educational information that promotes awareness of physician sexual misconduct. This information should include a definition of physician sexual misconduct, what constitutes appropriate physician-patient boundaries, how to identify and avoid common “grooming” behaviors such as adjusting appointment timing to facilitate time alone with a particular patient, contacting patients outside of clinical hours, or divulging personal information to a patient, and the potential consequences to both the patient and the physician when professional boundaries are not maintained. Physicians should be educated regarding the degree of harm patients experience as a result of sexual misconduct.

Patients

Education for patients is also essential so that they may be better informed about what to expect during a clinical encounter, what would constitute inappropriate behavior, and how to file a complaint with their state medical board. Information about boundary issues, including physician sexual misconduct, should be published in medical board newsletters and pamphlets. Media contacts should be developed to provide information to the public. Efforts should also be made by state medical boards and the FSMB to better educate the public about the existence and role of state medical boards.

Section 12: Summary of Recommendations

The goal of this report is to provide state medical boards with best practice recommendations for effectively addressing and preventing sexual misconduct with patients, surrogates and others by physicians, while highlighting key issues and existing approaches.

The recommendations in this section include specific requests of individual entities, as well as general ones that apply to multiple parties, including state medical boards, the FSMB and other relevant stakeholders. The Workgroup felt strongly that effectively addressing physician sexual misconduct requires widespread cultural and systemic changes that can only be accomplished through shared efforts across the medical education and practice continuum.

Culture:

1. Across the continuum from medical education to practice, continue to eliminate harassment and build culture that is supportive of professional behavior and does not tolerate harassment of any type.

Transparency:

2. State medical boards should ensure that sufficient information is publicly available (without breaching the privacy of complaints) to justify regulatory decisions and provide sufficient rationale to support them.

3. State medical boards should implement clear coding processes for board actions that provide accurate descriptions of behaviors underlying board disciplinary actions and clearly link licensee behaviors to disciplinary actions.

4. State medical boards and the FSMB should work together to develop consistent terminology for use in board actions that allows greater understanding for the public and the state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures. These should support research and the early identification of risk to patients.

5. The means of conveying information to the public about medical regulatory processes, including professional expectations, reporting and complaints processes, and available resources should be carefully examined to ensure maximal reach and impact. Multiple communication modalities should be considered.

Complaints:

6. State medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

7. State medical boards and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative process, according to the preferred mode and frequency of communication of the complainant.

8. Complaints related to sexual misconduct should be addressed as quickly as possible given their traumatic nature and to protect potential future victims.

9. State medical boards should have a specially trained patient liaison or navigator on staff who is capable of providing one-on-one support to complainants and their families.

Reporting:

10. Institutions should be required by statute to report instances of egregious conduct to state medical boards and be subject to fines levied by the state medical board, another appropriate regulatory agency or the state attorney general for failing to report.

11. Results of hospital and health system peer review processes should be shared with state medical boards when sexual misconduct is involved.

12. Hospitals should be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

13. Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.

14. Unscrupulous, frivolous or vexatious reporting motivated by competition should be met with disciplinary action.

15. Physicians and other individuals who report in good faith should be protected from retaliation and given the option to remain anonymous.

Investigations:

16. If the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.

17. Where permitted by state law, investigations should include a review of previous complaints to identify any patterns of behavior, including malpractice claims and settlements.

18. State medical boards should have the authority to impose interim terms or limitations, including suspension, on a physician's license prior to the completion of an investigation.

19. Limits should not be placed on the length of time that can elapse between when an act of alleged physician sexual misconduct occurred and when a complaint can be filed.

20. Investigators should use trauma-informed procedures when interviewing and interacting with complainants alleging instances of sexual misconduct and adjudicating these cases.

21. State medical board members involved in sexual misconduct cases (either in investigation or adjudication) and all board staff who work with complainants in cases involving sexual misconduct should undergo training in the area of sexual misconduct, victim trauma, and implicit bias.

22. Where possible, boards should seek the complainant's preference regarding the gender of investigators and assign them accordingly.

23. State medical boards should also allow inclusion of patient advocates in the interview process.

24. The FSMB and state medical boards should work to identify and ensure the availability of high-quality training in sexual trauma and a trauma-informed approach to investigations.

Comprehensive Evaluation:

25. State medical boards should have the authority to order a comprehensive evaluation of physicians where investigation reveals a high probability that sexual misconduct has occurred.

Hearings:

26. State medical boards should have statutory authority to ensure nondisclosure of the patient's identity to the public, including by closing hearings in part or in full, and deleting any identifiable patient information from final public orders. Patient identity must also be protected during board discussion.

Discipline:

27. Certain serious forms of unprofessional conduct should presumptively provide the basis for revocation of a license in order to protect the public. Misconduct in this class would include sexual assault, conduct amounting to crimes related to sex, regardless of whether charged or convicted, or egregious acts of a sexual nature. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

28. Gender and age-based restrictions should only be used by boards where there is a high degree of confidence that the physician is not at risk of reoffending.

29. Practice monitors should only be used as a means of protecting patients if the conditions outlined in this report have been met, including appropriate training, reporting relationship to the state medical board and lack of pre-existing relationship with the monitored physician.

30. When considering remedial action after sexual misconduct, state medical boards should employ a risk stratification model that also factors in risk of erosion of public trust in the medical profession and medical regulation.

31. As part of remedial efforts, any partners in the assessment and remediation of physicians should be provided access to investigative information in order to properly tailor remedial education to the context in which the sexual misconduct occurred.

32. Following remedial activities, state medical boards should monitor physicians to ensure that they avoid being in circumstances similar to those in which they engaged in sexual misconduct.

33. State medical boards should consider ways in which to allow pertinent information from previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of concern or education which remain on a licensee's record.

Education:

34. Education and training about professional boundaries and physician sexual misconduct should be provided during medical school and residency, as well as throughout practice as part of a physician's efforts to remain current in their knowledge of professional expectations. This should include education about how to proceed with basic as well as sensitive/intimate exams and the communication with the patients that is required as a component of these exams. This education should be informed by members of the public, as best possible.

35. State medical boards and the FSMB should provide education to physicians, board members and board staff about sexual misconduct and the effects of trauma. This should include resources to help physicians develop better insight into their own behavior and its impacts on others. Resources and materials should be developed in collaboration with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs.

36. As stated in Recommendation #6 regarding complaints, state medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

37. The FSMB, state medical boards, medical schools, residency programs, and medical specialty and professional societies should provide renewed education on professionalism and the promotion of professional culture. A coordinated approach facilitated by ongoing communication is recommended to ensure consistency of educational messaging and content.

38. The FSMB should facilitate the adoption and operationalization of the recommendations in this report by providing state medical boards with an abridged version of the report which highlights key points and associates them with resources, model legislation, and educational offerings.

Appendix A: Sample Resources

The following is a sample list of resources available to support greater understanding of sexual misconduct, sexual boundaries, the impacts of trauma, and implicit bias. The FSMB has not conducted an in-depth evaluation of individual resources, and inclusion herein does not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality. Further, while some resources listed below are available free of charge, others are only accessible through purchase.

1. Sexual misconduct, sexual/personal/professional boundaries:
    - AMA: Code of Medical Ethics: Sexual Boundaries
        - Romantic or Sexual Relationships with Patients
        - Romantic or Sexual Relationships with Key Third Parties
        - Sexual Harassment in the Practice of Medicine
    - AMA: CME course: Boundaries for physicians
    - AAOS: Sexual Misconduct in the Physician-Patient Relationship
    - FSMB Directory of Physician Assessment and Remedial Education Programs
    - North Carolina Medical Board: Guidelines for Avoiding Misunderstandings During Patient Encounters and Physical Examinations
    - University of Vermont: Mandatory Reporters and CSAs (Sample Reporting Guidelines)
    - Vanderbilt University Medical Center: Online CME Course: Hazardous Affairs – Maintaining Professional Boundaries
    - Vanderbilt University Medical Center: Boundary Violations Index

2. Trauma-related resources:
    - SAMHSA: Concept of Trauma and Guidance for a Trauma-Informed Approach
    - National Institute for the Clinical Application of Behavioral Medicine: How Trauma Impacts Four Different Types of Memory
    - Frontiers in Psychiatry: Memory distortion for traumatic events: the role of mental imagery
    - Government of Canada, Department of Justice: The Impact of Trauma on Adult Sexual Assault Victims
    - National Institutes of Health: Trauma-Informed Medical Care: A CME Communication Training for Primary Care Providers
    - Western Massachusetts Training Consortium: Trauma Survivors in Medical and Dental Settings
    - American Academy of Pediatrics: Adverse Childhood Experiences and the Lifelong Consequences of Trauma
    - American Academy of Pediatrics: Protecting Physician Wellness: Working With Children Affected by Traumatic Events
    - Public Health Agency of Canada: Handbook on Sensitive Practice for Health Care Practitioners
    - Psychiatric Times: CME: Treating Complex Trauma Survivors
    - NHS Lanarkshire (Scotland): Trauma and the Brain (Video)
    - London Trauma Specialists: Brain Model of PTSD - Psychoeducation Video

3. Implicit bias:
    - AAMC: Online Seminar: The Science of Unconscious Bias and What To Do About it in the Search and Recruitment Process
    - AAMC: Proceedings of the Diversity and Inclusion Innovation Forum: Unconscious Bias in Academic Medicine
    - AAMC: Exploring Unconscious Bias in Academic Medicine (Video)
    - ASME Medical Education: Non-conscious bias in medical decision making: what can be done to reduce it?
    - APHA: Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits
    - Institute for Healthcare Improvement: Achieving Health Equity: A Guide for Health Care Organizations
    - BMC Medical Education: Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review
    - American Psychological Association: CE - How does implicit bias by physicians affect patients' health care?
    - Joint Commission: Implicit bias in health care
    - Oregon Medical Board: Cultural Competency – A Practical Guide for Medical Professionals
    - StratisHealth: Implicit Bias in Health Care (Quiz)

WORKGROUP ON PHYSICIAN SEXUAL MISCONDUCT

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EXHIBIT 14

EXHIBIT 14

Part I - Special from Missouri Physicians Health Program

Sexual Misconduct by Professionals: A New Paradigm of Understanding

by Gregory E. Skipper, MD & Stephen Schenthal, MD

Illustrations

The following are but a few fictional examples drawn from compilations of real cases:

An overworked married pediatrician was attracted to a single mom in his practice. They became friendly and one day he offered to help if she ever needed anything fixed around the house. Eventually she called and asked him to come over to fix a leaky faucet. This started an affair that lasted several months. When his wife discovered the affair, he broke it off. The mother became angry, felt exploited, and retained an attorney.

Comment

It's important to realize that the family of patients can be considered patients too, especially in pediatrics, where the parents are considered patients along with their children.

A general surgeon kissed an employee, who was also his patient, when she came to him crying about a problem she was having. Word got out in the office and a formal complaint was made to the medical board.

Comment

Treating an employee, neighbor, or anyone else, means that the person then becomes a patient.

A family practitioner finally gave in to a seductive patient who brazenly seduced him.

Comment

Claiming that an affair was the patient's fault doesn't work. It's the doctor's sole responsibility to set limits and act professionally. If you are uncomfortable with a seductive patient, refer them.

Professional Sexual Misconduct

Betrayal and exploitation are among the most egregious of human offenses, and when they involve a health professional preying on a vulnerable patient, the most basic of ethical principles are violated. When the patient-physician relationship is exploited and Professional Sexual Misconduct (PSM) occurs, it is particularly problematic because it strikes at the core spirit of the profession. The breech of trust associated with PSM is damaging to the patient, the health professional and to the medical profession at large. It's damaging to the patient, who is exploited and may never trust a health professional again. It's damaging to health professionals, who often lose their reputations, find their finances plundered, licenses revoked, and in more than two dozen states, find themselves subject to criminal charges and imprisonment. Finally, it's damaging to the medical profession at large because of degradation in the perceived legitimacy of the profession each time this happens.

Unfortunately, claims of PSM are not rare. A confidential survey[1] found that 8% of physicians admitted committing some degree of PSM with one or more patients, and most physicians acknowledge they've been tempted. Despite this, there is a generalized denial in the health professions regarding the risks and/or existence of PSM and a taboo regarding discussing it. Even with the "sexual" nature of the offense, it turns out that health professionals who've committed PSM rarely have any type of sexual disorder. Very few are true sociopaths. Most of the time, in fact, these physicians simply lose good judgment and believe they've "fallen in love" with the patient. Most physicians who commit PSM do so in times of personal trauma or professional crisis, when judgment is diminished. Unresolved vulnerabilities may arise associated with overwork or professionally dissatisfaction. The turbulent times of midlife often trigger PSM. To flee the pain of parental death, a failing marriage or empty nest issues with the departure of children to college are times when physicians may "act out" inappropriately.

All this becomes more relevant by the fact that PSM is preventable. Educating physicians about good boundaries and helping them become more aware of their

vulnerabilities and risks and ways of setting up their practice to protect patients and themselves is critical. Not only is PSM preventable but doctors who commit PSM are usually treatable, and relapses are rare when good treatment and education occurs and precautions are taken.

Considering the very damaging real life consequences of PSM it is surprising how casually PSM is depicted on TV and in movies. The discordance between how professional boards and criminal agencies view PSM versus its media portrayal is troubling, and may contribute to the risk of PSM because it creates a false sense of acceptability for inappropriate relationships with patients. Additionally, there are many stories about relationships between doctors and their patients leading to successful marriage, without any apparent harm. These, however, are the exceptions. More typically, the patient eventually becomes aware of a sense of exploitation and becomes very angry. Not uncommon are cases in which a physician-patient marriage ends in divorce at which time the ex-spouse files a complaint and law suit... and wins. It's tragic that as terrible and devastating as PSM is, it is essentially a taboo subject; little or nothing is taught regarding PSM in medical schools, and it's rarely a subject for postgraduate training.

Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way, whether verbal or physical, or expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual.

To help prevent PSM it's important to have a basic understanding of boundary theory and the dynamics that underlie boundary violations, to develop vigilance for early warning signs of potential boundary problems with patients, and to gain insight into professional and personal vulnerabilities and risk factors. Excellent CME-based courses are available for further in-depth training.

PSM (synonymous with "sexual boundary violation") can be defined as any action of a sexual nature that oversteps or disregards ethical or legal limits of professional behavior. For our purposes, sexual refers to any erotic physical contact, and may also include sexual behavior involving language or gesture. Even the use of sexual humor or informal speech can be deemed misconduct. The somewhat vague concept of "boundary" is made more explicit by reference to professional ethical and legal norms.

Ethical prohibition against sexual relations with patients dates back at least as far as the Hippocratic Oath of ancient Greece. An abbreviated version of the passage states: "[I] will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of free men or slaves." Most professional societies have a code of ethics which contains clear statements regarding what constitutes appropriate sexual boundaries. The major area in which these codes differ is regarding how long, if ever, it is necessary following termination of the patient-physician relationship before a relationship can be pursued. On the subject of where the lines are drawn inside the professional relationship, they are essentially identical.

The Federation of State Medical Boards, in a policy statement in 2007, clearly defines what it considers sexual boundaries, and states that disciplinary action should be taken against any physician who violates them. Here are some salient excerpts from that document:

"Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way. This behavior ... may be verbal or physical, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual. ...There are primarily two levels of sexual misconduct: sexual violation and sexual impropriety. Behavior listed in both levels may be the basis for disciplinary action by a state medical board ....Sexual violation may include physician-patient sex, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual. Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient."

The documents goes on to state, "Findings of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician's medical license, although a lesser action may be considered for cases of sexual impropriety."

It is important to know that most acts of PSM occur following progressive problems with boundaries that precede the PSM. Often these steps are referred to as "boundary crossings," which may be initiated with the best of intentions, but progressively tumble down a "slippery slope" of professional destruction. While these precedent behaviors are not necessarily unethical in and of themselves, they are major warning signs. In order to prevent sexual boundary violations it is important to understand this progression and the precedent boundary disturbances. Sometimes these boundary disturbances are limited to one patient or one particular type of patient, and in

other cases they may characterize the clinician's general practice style. In the context of rehabilitation from sexual boundary violation(s), it is incumbent on the professional to address all of these boundary issues.

Precedent boundary problems can include time issues, such as extending the time of office visits (often by scheduling at the end of the day), conducting the visit during non-business hours or by extending the visit from the last appointment of the day into non-business hours (after the staff leave the office). Another category of precedent behaviors includes "concepts of place and space." For example, making home visits (except when clearly part of regular practice), meeting a patient at a social occasion or agreeing to share a meal with a patient at a restaurant. Another area, giving or receiving gifts, can be a problem if it tends to "deprofessionalize" the relationship, encourage romanticizing of the relationship or interferes with therapeutic aims. In general, it is a good idea to have an office policy that gifts from patients are not accepted (except to the office as a whole).

Physical contact is another area of concern. There are times in the course of clinical practice where touching the patient outside of a physical examination is accepted, such as a handshake at the beginning or end of an appointment, or the placing of a hand on the shoulder as a comforting gesture. Some practitioners also feel it is permissible to hug patients at times, though, depending on the characteristics of the patient, this can be very dangerous. Context is clearly important in determining to what extent a hug may be thought of in this way. Hugging can cause serious confusion in the professional relationship, be interpreted or experienced in a romantic way by the patient, and can lead to greater intimacy. An important adage to remember is that when it comes to boundaries, "perception is everything." The misinterpretation of a therapeutic hug as romantic may be impossible to defend.

Boundary issues involving money can precede PSM. Examples include lending or borrowing of money from patients, business activities with patients or even bartering in place of the standard fee. It's also important to be careful with language with patients. Using the title of doctor, for example, helps establish the professional relationship. The use of too familiar a tone of voice, the use of inappropriate colloquial language or the use of first names can be risky, especially in some settings. Wearing a white coat reenforces the professional image. Informal dress may convey the opposite. Finally, the issue of self-disclosure should be mentioned. While it is not uncommon for clinicians to occasionally share a story with a patient or to reveal selective aspects of their personal experience, the injudicious sharing of private information is clearly a boundary crossing, and interferes with the aim of the professional relationship. The disclosure of personal problems is virtually always inappropriate. Sharing by the doctor with the patient that he has an unethical attraction to them is highly inappropriate. This type of boundary crossing commonly precedes PSM.

Preexisting vulnerabilities afflicting the physician, such as psychiatric illness, alcohol and/or substance abuse disorder, paraphilias, personality disorder, mood disorder, sexual compulsivity or addiction and/or insufficient support, supervision, oversight or accountability make PSM more likely to occur. Other factors that can predispose the physician to PSM include marital/family problems, midlife or late midlife stage-of-life crisis and burnout. Similar preexisting vulnerabilities affecting a patient can also increase risk. Patients with histories of sexual abuse appear to be particularly vulnerable. It's important for every physician to know that PSM is unethical and can carry harsh consequences. Physicians should recognize inappropriate behaviors and not act inappropriately due to their emotional attractions to patients. Ultimately, it's best to refer the patient causing concerns to another physician. Before pursuing a relationship with a patient, contact your specialty society and/or the Missouri Board of Healing Arts for more guidelines to be sure it is ethical and safe. Consulting a good therapist prior to taking any action is also a good idea. We physicians are also ethically responsible to protect our colleagues. If we see red flags of an evolving boundary problem in another physician, we must consider an intervention. Stepping in can save a professional and protect a patient. Failing to follow these recommendations is very likely to be costly to everyone involved.

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Acknowledgment

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EXHIBIT 15

EXHIBIT 15

Code *of* Professional Ethics

of the American College of Obstetricians and Gynecologists

Obstetrician–gynecologists, as members of the medical profession, have ethical responsibilities not only to patients, but also to society, to other health professionals and to themselves. The following ethical foundations for professional activities in the field of obstetrics and gynecology are the supporting structures for the Code of Conduct. The Code implements many of these foundations in the form of rules of ethical conduct. Certain documents of the American College of Obstetricians and Gynecologists also provide additional ethical rules, including documents addressing the following issues: seeking and giving consultation, informed consent, sexual misconduct, patient testing, relationships with industry, commercial enterprises in medical practice, and expert testimony. Noncompliance with the Code, including the above-referenced documents, may affect an individual's initial or continuing Fellowship in the American College of Obstetricians and Gynecologists. These documents may be revised or replaced periodically, and Fellows should be knowledgeable about current information.

Ethical Foundations

I. The patient–physician relationship: The welfare of the patient (beneficence) is central to all considerations in the patient–physician relationship. Included in this relationship is the obligation of physicians to respect the rights of patients, colleagues, and other health professionals. The respect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental. The principle of justice requires strict avoidance of discrimination on the basis of race, color, religion, national origin, sexual orientation, perceived gender, and any basis that would constitute illegal discrimination (justice).

II. Physician conduct and practice: The obstetrician–gynecologist must deal honestly with patients and colleagues (*veracity*). This includes not misrepresenting himself or herself through any form of communication in an untruthful, misleading, or deceptive manner. Furthermore, maintenance of medical competence through study, application, and enhancement of medical knowledge and skills is an obligation of practicing physicians. Any behavior that diminishes a physician's capability to practice, such as substance abuse, must be immediately addressed and rehabilitative services instituted. The physician should modify his or her practice until the diminished capacity has been restored to an acceptable standard to avoid harm to patients (*nonmaleficence*). All physicians are obligated to respond to evidence of questionable conduct or unethical behavior by other physicians through appropriate procedures established by the relevant organization.

III. Avoiding conflicts of interest: Potential conflicts of interest are inherent in the practice of medicine. Physicians are expected to recognize such situations and deal with them through public disclosure. Conflicts of interest should be resolved in accordance with the best interest of the patient, respecting a woman's autonomy to make health care decisions. The physician should be an advocate for the patient through public disclosure of conflicts of interest raised by health payer policies or hospital policies.

IV. Professional relations: The obstetrician–gynecologist should respect and cooperate with other physicians, nurses, and health care professionals.

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PO Box 96920
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V. Societal responsibilities: The obstetrician–gynecologist has a continuing responsibility to society as a whole and should support and participate in activities that enhance the community. As a member of society, the obstetrician–gynecologist should respect the laws of that society. As professionals and members of medical societies, physicians are required to uphold the dignity and honor of the profession.

Code of Conduct

I. Patient–Physician Relationship

1. The patient–physician relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments.
2. The obstetrician–gynecologist should serve as the patient's advocate and exercise all reasonable means to ensure that the most appropriate care is provided to the patient.
3. The patient–physician relationship has an ethical basis and is built on confidentiality, trust, and honesty. If no patient–physician relationship exists, a physician may refuse to provide care, except in emergencies. Once the patient–physician relationship exists, the obstetrician–gynecologist must adhere to all applicable legal or contractual constraints in dissolving the patient–physician relationship.
4. Sexual misconduct on the part of the obstetrician–gynecologist is an abuse of professional power and a violation of patient trust. Sexual contact or a romantic relationship between a physician and a current patient is always unethical.
5. The obstetrician–gynecologist has an obligation to obtain the informed consent of each patient. In obtaining informed consent for any course of medical or surgical treatment, the obstetrician–gynecologist must present to the patient, or to the person legally responsible for the patient, pertinent medical facts and recommendations consistent with good medical practice. Such information should be presented in reasonably understandable terms and include alternative modes of treatment and the objectives, risks, benefits, possible complications, and anticipated results of such treatment.
6. It is unethical to prescribe, provide, or seek compensation for therapies that are of no benefit to the patient.
7. The obstetrician–gynecologist must respect the rights and privacy of patients, colleagues, and others and safeguard patient information and confidences within the limits of the law. If during the process of providing information for consent it is known that results of a particular test or other information must be given to governmental authorities or other third parties, that must be explained to the patient.
8. The obstetrician–gynecologist must not discriminate against patients on the basis of race, color, religion, national origin, sexual orientation, perceived gender, and any basis that would constitute illegal discrimination.

II. Physician Conduct and Practice

1. The obstetrician–gynecologist should recognize the boundaries of his or her particular competencies and expertise and must provide only those services and use only those techniques for which he or she is qualified by education, training, and experience.
2. The obstetrician–gynecologist should participate in continuing medical education activities to maintain current scientific and professional knowledge relevant to the medical services he or she renders. The obstetrician–gynecologist should provide medical care involving new therapies or techniques only after undertaking appropriate training and study.

3. In emerging areas of medical treatment where recognized medical guidelines do not exist, the obstetrician–gynecologist should exercise careful judgment and take appropriate precautions to protect patient welfare.

4. The obstetrician–gynecologist must not publicize or represent himself or herself in any untruthful, misleading, or deceptive manner to patients, colleagues, other health care professionals, or the public.

5. The obstetrician–gynecologist who has reason to believe that he or she is infected with a bloodborne pathogen or other serious infectious agent that might be communicated to patients should voluntarily be tested for the protection of his or her patients. In making decisions about patient-care activities, a physician infected with such an agent should adhere to the fundamental professional obligation to avoid harm to patients.

6. The obstetrician–gynecologist should not practice medicine while impaired by alcohol, drugs, or physical or mental disability. The obstetrician–gynecologist who experiences substance abuse problems or who is physically or emotionally impaired should seek appropriate assistance to address these problems and must limit his or her practice until the impairment no longer affects the quality of patient care.

III. Conflicts of Interest

1. Potential conflicts of interest are inherent in the practice of medicine. Conflicts of interest should be resolved in accordance with the best interest of the patient, respecting a woman's autonomy to make health care decisions. If there is an actual or potential conflict of interest that could be reasonably construed to affect significantly the patient's care, the physician must disclose the conflict to the patient. The physician should seek consultation with colleagues or an institutional ethics committee to determine whether there is an actual or potential conflict of interest and how to address it.

2. Commercial promotions of medical products and services may generate bias unrelated to product merit, creating or appearing to create inappropriate undue influence. The obstetrician–gynecologist should be aware of this potential conflict of interest and offer medical advice that is as accurate, balanced, complete, and devoid of bias as possible.

3. The obstetrician–gynecologist should prescribe drugs, devices, and other treatments solely on the basis of medical considerations and patient needs, regardless of any direct or indirect interests in or benefit from a pharmaceutical firm or other supplier.

4. When the obstetrician–gynecologist receives anything of substantial value, including royalties, from companies in the health care industry, such as a manufacturer of pharmaceuticals and medical devices, this fact should be disclosed to patients and colleagues when material.

5. Financial and administrative constraints may create disincentives to treatment otherwise recommended by the obstetrician–gynecologist. Any pertinent constraints should be disclosed to the patient.

IV. Professional Relations

1. The obstetrician–gynecologist's relationships with other physicians, nurses, and health care professionals should reflect fairness, honesty, and integrity, sharing a mutual respect and concern for the patient.

2. The obstetrician–gynecologist should consult, refer, or cooperate with other physicians, health care professionals, and institutions to the extent necessary to serve the best interests of their patients.

V. Societal Responsibilities

1. The obstetrician–gynecologist should support and participate in those health care programs, practices, and activities that contribute positively, in a meaningful and cost-effective way, to the welfare of individual patients, the health care system, or the public good.

2. The obstetrician–gynecologist should respect all laws, uphold the dignity and honor of the profession, and accept the profession's self-imposed discipline. The professional competence and conduct of obstetrician–gynecologists are best examined by professional associations, hospital peer-review committees, and state medical and licensing boards. These groups deserve the full participation and cooperation of the obstetrician–gynecologist.

3. The obstetrician–gynecologist should strive to address through the appropriate procedures the status of those physicians who demonstrate questionable competence, impairment, or unethical or illegal behavior. In addition, the obstetrician–gynecologist should cooperate with appropriate authorities to prevent the continuation of such behavior.

4. The obstetrician–gynecologist must not knowingly offer testimony that is false. The obstetrician–gynecologist must testify only on matters about which he or she has knowledge and experience. The obstetrician–gynecologist must not knowingly misrepresent his or her credentials.

5. The obstetrician–gynecologist testifying as an expert witness must have knowledge and experience about the range of the standard of care and the available scientific evidence for the condition in question during the relevant time and must respond accurately to questions about the range of the standard of care and the available scientific evidence.

6. Before offering testimony, the obstetrician–gynecologist must thoroughly review the medical facts of the case and all available relevant information.

7. The obstetrician–gynecologist serving as an expert witness must accept neither disproportionate compensation nor compensation that is contingent upon the outcome of the litigation.

EXHIBIT 16

EXHIBIT 16

Richard W. Rafael, M.D.

[redacted]

[redacted]

[redacted]

[redacted]

Nevada Medical License #5289 August 10,1985-June 30, 2023

Nevada State Board of Pharmacy License expires 10-3-2024

SUMMARY OF EXPERIENCE

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7/1/1986 - 12/31/2018

Residency in Obstetrics and Gynecology, Mount Sinai Hospital, Hartford, CT 7/1/1982 - 6/30/1986

Chief Resident — Department of Obstetrics and Gynecology, Mount Sinai Hospital Hartford, CT
1/30/1986 - 6/30/1986

Associated Clinical Professor, University of Nevada, School of Medicine, Reno, NV 1986-1991

Clinical Assistant Professor of Obstetrics, University of Nevada, Reno School of Medicine April 2019 – 2022

Diplomate of the American Board of Obstetrics and Gynecology
November 10,2000 through December 31, 2022

Fellow American College of Obstetrics and Gynecology Nevada Medical License #5289, Issued 8/10/1985 - current

Member ProAssurance Indemnity Claims Underwriting Committee, Quarterly Claims Review Proceedings Sept 19, 2013 – June 2020

Peer Review: Nevada State Board of Medical Examiners
3/12/20 – present and active

EDUCATION

1892 — 1986 Residency in Obstetrics and Gynecology, Mount Sinai Hospital, Hartford, Ct.

1978— 1982 St. George's University School of Medicine, Grenada, WI

1975 -1977 University of Nevada, Reno NV, B.S., Medical Sciences

1968-1972 University of California Santa Barbara, Goleta, CA, B.A., Political Sciences

1970— 1971 Institute of European Studies, Vienna, Austria, Comparative Government

CONTINUING MEDICAL EDUCATION

1. Boston University School of Medicine: Review and Update Course In Obstetrics and Gynecology, Cambridge, MA, 3/14/1984
2. Harvard Medical School: Reproductive Endocrinology, Advances in Gynecology, Cambridge, MA, 10/15/1984
3. Lasers in Obstetrics and Gynecology: S.U.N.Y., Upstate Virginia Beach, 08/1984
4. University of Connecticut and Yale University: Ella Grasso Memorial Lecture Series, Hartford, CT, 1984
5. Advanced-Colposcopy: American Society for Colposcopy and Cervical Pathology, 01/14/84
6. Johns Hopkins University, Emil Novak Memorial Course Baltimore, MD, 10/85
7. The American Fertility Society, Clinical Reproductive Endocrinology, Reno, NV 1987
8. Loss Prevention and Risk Management for Health Care Professionals, Nevada State Medical Association, Reno, NV 11/14/87
9. Osler Obstetrics and Gynecology Review Course, Osler Institute, San Francisco, CA 1987
10. The California Medical Association annual Session and Western Scientific Assembly, Reno, NV 03/9/88
11. Perinatology and Neonatology, University of California Irvine, 06/16/88
12. Clinical Workshop in Hysteroscopy Northern California Obstetrical and Gynecological Society, Sacramento, CA, 09/10/88
13. Clinical Obstetrics and Gynecology, review course, 1989
14. Changing Times in Obstetrics and Gynecology 1989
15. Osler Review Course Obstetrics, Gynecology, Pathology, Infertility, 1989
16. Loss Prevention for Physicians and Staff— 5 part series, Nevada Medical Liability, Reno, NV 1/20/89

17. Infertility Management in an Office Practice — Ultrasound Workshop, 9/29/89

18. Real time Ultrasound in Clinical Obstetrics 05/10 — 05/12/90

19. Comprehensive Review Course, University of California School of Medicine, 11/5 - 11/9/90

20. Clinical Care of Patients with Reproductive Failure, American Fertility Society, 06/10/91

21. Gynecological Update Applications of New Surgical Techniques and Medical Management, 10/1 — 10/3/92

22. 11th Annual Perinatal Medicine & Nursing Conference, Barbados, 10/30 — 11-6/93

23. Seventh Annual Techniques in Gynecologic Sur e , 11/10 — 11/12/94

24. American College of Obstetricians and Gynecologists, self-assessment program, PROLOG, 09/9/94

25. University of Chicago, Obstetrics and Gynecology Review Course, 09/9/95

26. American College of Obstetricians and Gynecologists, Reproductive Endocrinology and Infertility, 04/17/96

27. University California Davis Medical Center and School of Medicine, 8th Annual Ultrasound Update, 09/28 — 09/29/96

28. Washoe Medical Center, Hormone replacement therapy: Minimizing the Risks, 09/96

29. St. Paul Medical Services Risk Management in Ambulatory Care Seminar, 10/96

30. Washoe Medical Center How to Educate and Negotiate Managed Care Contracts, 12/96

31. Washoe Medical Center Medical Specialist and Managed Care, 12/96

32. Saint Mary's Regional Medical Center, OB/GYN M/M Conference, case presentation, 01/97

33. University of Colorado School of Medicine, Comprehensive Management of HIV Disease, 02/19/97

34. American College of Obstetricians and Gynecologists, PROLOG Gynecologic Oncology and Surgery, Third edition 02/26/97

35. Saint Mary's Regional Medical Center, OB/GYN Conference, Antibiotic Therapy in PPROM & M.S.A.F., The ABC's of STD's, 03/97

36. Saint Mary's Regional Medical Center, Quality Outcomes Management, 05/97

37. Practice Management Institute, Can Your Office Withstand an Audit, 06/17/97

38. University of California San Francisco, Essentials in Primary Care, 08/17 _08/22/97

39. University of California, San Francisco, OB-GYN, Histopathology Clinic, 10/13/97

40. Mayo School of Continuing Medical Education, Techniques in Advanced Laparoscopic and Gynecologic Surgery, 11/6 — 11/8-97

41. Washoe Medical Center Tumor Board, case presentation, 02/18/98

42. American College of Obstetricians and Gynecologists, Patient Management in the Office, 04/98

43. University of Chicago, Obstetrics and gynecology Review Course, 06/1 — 06/6/98

44. American Society for Clinical Laboratory Science, Give Your Clinic a Checkup,
05/14/99

45. St. Paul Medical Services Risk Management Seminar: Fraud and Abuse in
Medicare Billing, 05/99

46. Washoe Medical Center Women & Depression, 08/3/99

47. Washoe Medical Center, Bioethics: Death, Dignity, Caring, 09/21/99

48. Washoe Medical Center Type 2 Diabetes, 11/2/99

49. Washoe Medical Center, Non-Cardiac Chest Pain, 11/30/99

50. P.A.C.E., Negotiating Managed Care, 04/4/00

51. University of Wisconsin-Madison Medical School, Understanding Bladder Symptoms, 05/11/00

52. University of Chicago, Videotape, Obstetrics & Gynecology Review, 06/5 _06/10/00

53. American College of Obstetricians and Gynecologists, PROLOG, 07/27/00

54. Washoe County Medical Society, Managed Care Contracts — How to Negotiate and Maximize Reimbursement, 11/15/00

55. Health Science Center Clinical Issues in Women's Health for 21st Century, 10/13/01

56. Gynecare Thermachoice Il, Uterine Balloon Therapy System, Reno, NV 11/29/01

57. American College of Obstetricians and Gynecologists, PROLOG Obstetrics 4th Edition, 12/28/01

58. University California Davis Medical Center, Gynecare TVT Tension-Free Support for Incontinence, 02/13/02

59. University of Nevada School of Medicine, Clinical, Ethical, and Psychological Aspects of Non-Essential Medical Treatments, San Diego, CA, 05/3/02

60. Johns Hopkins University School of Medicine, Current Perspectives on HRT and Breast Health, 06/1/02

61. American College of Obstetricians and Gynecologists, PROLOG: Reproductive Endocrinology and Infertility, 4th edition, 08/21/02

62. Nevada Academy of Family Physicians, Washoe Medical Society, HIPAA Regulation Compliance, 09/12/02

63. University of Wisconsin, Patient Management Issues in Menopause, 11/20/02

64. American College of Obstetricians and Gynecologists, Patient Management in the office, 4th edition, 02/03/03

65. Domestic Violence, Ethics, Washoe Medical Center, 01/03

66. Washoe Health Systems, HIPAA-Bioethics, 02/24/03

67. American College of Obstetricians and Gynecologists, Coding Workshop, Module
1, 11, 07/25/03

68. University of Nevada School of Medicine, New Developments in the Diagnosis and Management of Heart Disease, 10/22/03

69. American College of Obstetricians and Gynecologists, Advances in Urogynecology, 11/03

70. American Association of Gynecologic Laparoscopists, Laparoscopy Workshop,

02/04

71. University of Nevada School of Medicine: Washoe Medical Center, Weapons of Mass Destruction (Medical ethics) 04/04

72. American Society for Reproductive Medicine, Advanced Gynecologic Surgery,
09/04

73. Nevada Academy of Family Physicians, Targeting Cholesterol in Heart Disease,
10/04

74. Bard PACE Preceptor Program, Preceptorship training in Acellular Collagen Matrix and Acellular Collagen Bio Mesh, 11/04

75. Global Congress of Gynecologic Endoscopy, AAGL appraisal of Surgical techniques for Pelvic Prolapse, 11/04

76. USS Women's Healthcare a division of Tyco Healthcare Group LP, Incontinence and Vaginal Prolapse Sling Surgery, 07/05

77. American College of Obstetricians and Gynecologists, PROLOG Gynecology and Surgery, 5th edition, 07/05

78. American College of Obstetricians and Gynecologists. PROLOG Gynecology Oncology and Critical Care, 01/06

79. American college of Obstetricians and Gynecologist. PROLOG Gynecologic Oncology and Critical Care, 04/06

80. Avaulta Biosynthetic and Ureters Trans obturator Urethral Support System, 05/16/06

81. University of Nevada School of Medicine, Current Issues of Medical Liability Risk Management, 10/06

82. Gynecare TVT Secure System Professional Education Program, 04/27/07

83. American College of Obstetricians and Gynecologists, PROLOG, Patient Management in the Office, 07/07

84. University of Nevada School of Medicine. Risk Management for Nevada Physicians, 11/07

85. Mayo Clinic World Robotics, Symposium in Gynecology, 02/08

86. University of Nevada School of Medicine, Risk Management for Nevada Physician – Improving Patient Care: Ethics, Communication and Litigation, 10/08

87. Boston Scientific — University of Nevada School of Medicine, Advances in Pelvic Floor Technology, 09/08

88. Saint Mary's Regional Medical Center, Cyber knife Stereotactic Radiosurgery, 01/09

89. Saint Mary's Regional Medical Center, Bio-Identical Hormone Replacement Therapy, 07/09

90. University of Nevada School of Medicine, Ethical Treatment of Patients: The Many Forms of Good Communication, 10/09

91. IND Insurance Exchange, Ethic, EMR's, and Elixirs 10/09

92. American College of Physicians Executives, 2009 PIM-Finance Express, 09/09

93. American College of Physicians Executives, 2009 PIM-Communication Express,
09/09

94. American College of Physicians Executives, 2009 PIM-Influence Express, 09/09

95. American College of Physicians Executives, 2009 PIM-Management Skills Express, 09/09

96. American College of Physicians Executives, 2009 PIM Marketing Express, 09/09

97. American College of Physicians Executives, 2009 PIM Negotiation Express, 09/09

98. American College of Physician Executives, IT change Management, 03/10

99. American College of Physicians Executives. Successful IT Change Mgmt., 04/10 100. Conceptus Inc., Physician Training for Essure, 08/10

101. American Board of Obstetrics and Gynecology, MOC Part Il-ABC exam, 10/10

102. The Christ Hospital, Pelvic Anatomy and Gynecologic Surgery Symposium, 12/10

103. Lifelong Health, Achieving Optimum Well-Being at Any Age, 04/11

104. American College of Physician Executives, Techniques of Financial Decision Making, 05/11

105. ACPE, Financial Decision Making , 06/11

106. ACOG, Antibiotics in Minor Gynecologic Procedures, 07/11 107.

ACOG, Informed consent, 07/11

108. ACOG, Gynecologic Oncology and Critical Care, 10/11

109. University of Nevada School of Medicine, Documents, Depositions, and Difficult Patients, 10/11

110. ACOG, 2012 Maintenance of Certification Part 11, 08/12

111. University of Nevada School of Medicine, Physician Risk Management Essentials
2012, Resources, Remedies, and Relationships, 10/12

112. ACOG, Prolog, Patient Management in the Office, 10/12

113. ACOG, Gynecologic Pelvic Ultrasound, 11/12 114. ACPE, Interact-

Health Law Express, 01/13

115. ACPE, Interact- Liabilities in HER Express, 01/13

116. American College of Physician Executives, Essentials of Health Law, 03/13

117. American College of Physician Executives, Liabilities in Electronic Health Record, 05/13

118. Renown Regional Medical Center, Osteoporosis Management of Fragility Fractures, 06/13

119. ACOG Prolog, Obstetrics 7th Edition, 07/13

120. ProAssurance Indemnity, Claims Review Proceeding —CUC, 09/13

121. Washoe County Medical Society and Nevada Academy of Family Physicians, What Physicians Need to Know About the ACA, 09/13

122. Advanced Practice Strategies, Inc., Informed Consent: A Medical Legal Case study, 09/13

123. ACOG, Maintenance of Certification 2013, 11/13 124. ProAssurance Indemnity, Claims Review Proceedings —CUC, 12/13, 2 AMAPRA CME Credits

125. ABOG, Maintenance of Certification 2014, 02/14

126. ACOG, Gynecology and Surgery 7th edition, 04/14

127. University of Chicago, 23rd Annual Advances in Urogynecology and Reconstructive Pelvic Surgery,16 AMA credits June 6-7, 2014

128. ProAssurance Indemnity, Claims review proceedings — CUC, 2.0 AMA PRA Category 1 credits 06/2014

129. American College of Physician Executives, Three Faces of Quality, 08/2014

130. Applied Medical, GelP01NT GYN Single Site/Reduced Workshop, 09/2014

131. ABOG,(MOC)Maintenance of Certification 2014, 25 AMA PRA credits 09/28/2014

132. Pelvic Anatomy and Gynecologic Surgery, 28 AMA CME December 4-6, 2014

133. Advances in Urogynecology and Reconstructive Pelvic Surgery, University of Chicago Pritzker School of Medicine, Northshore University Health Systems, June 4-6, 2015, 16 AMA CME

134. ABOG MOC Part II Article Review 25 AMA PRA Category Credits 12/31/2015

135. University of California Irvine School of Medicine Ethics for Professional, Honoring Choices 2 AMA PRA category 1 credits-Ethics 4/25/16

136. Marijuana Summit- What Healthcare Professionals, Law Enforcement Officers, Employers and Members of the Court Need to Know, May 11, 2016

137. MOC Part IV – Non surgical Therapies for Stress Urinary Incontinence 3 AMA PRA category 1 credits 8/25/16

138. ProAssurance Indemnity Claims Review Proceedings- CUC 2,o CME Credits Nov. 3, 2016

139. ProAssurance: The Anatomy of a Claim 2.0 AMA PRA Category 1 credits, Reno, NV. Nov 10, 2016

140. Diabetes Day for Primary Care Clinicians: Advances in Diabetes Care Feb 6, 2016, 4.50 AMA PRA Category 1 CME

141. ABOG MOC II MOC Requirements Article Review 25 AMA Category 1 AMA PRA credits 8/25/16

142. PROLOG, Female Pelvic Surgery and Reconstructive Surgery 14 AMA PRA Category 1 Credits 1/15/17

143. Annual Spring Conference on Women's Health 18 AMA PRA CME Credits, March 8-11, 2017

144. ProAssurance Indemnity 2.0 AMA PRA Category 1 credits June 29,2017, CUC meeting Las Vegas

145. American Association of Physician Leadership, Managing Physician Performance 24 AMA PRA Credits Category 1 credits, 8/6/17

146. ABOG Maintenance of Certification 2017, 28 AMA Category 1 CME Sept.15, 2017

147. The Risk of Poor Communication 1.75 AMA PRA Category 1 credits Relias Learning, ProAssurance1/10/18

148. Disclosure and Apology Module 1,2,3,4,5,6,7- 3.5 AMA PRA credits 1/13/18

149. Risk Management Basics: Protections and Pitfalls 2.00 AMA PRA CME 1/24/18

150. Disclosure of Unanticipated Outcomes 2 AMA PRA CME 0n 1/16/18

151. ProAssurance Indemnity, Claims review proceedings, February 15, 2018, 2 AMA PRA Category 1 CME credits

152. ABOG Maintenance of Certification 2018 (MOC) 28 AMA PRA CME Credits, Feb. 6, 2018

153. ACOG, Women's Healthcare 35 AMA PRA credits March 15, 2018

154. ProAssurance Indemnity, Claims Review Proceedings -2 AMA PRA credits June 21, 2018

155. ProAssurance Indemnity, Claims Review Proceedings - 2 credits September 13, 2018

156. Responsible and Effective Opioid Prescribing NetCE 3 AMA PRA Category 1 credits December 8, 2018

157. Suicide Prevention 2018, Kaiser Permanente, 6 AMA PRA Category 1 credits

158. American Red Cross-Adult First Aid/CPR/AED 2/16/18 date completed and valid for 2 years

138. Prolog, Gynecology and Surgery 8th edition, ACOG self-study, 25 credits May 31, 2019

139. Cleveland Clinic: Clinical Decisions: Management of Resistant Hypertension, AMA Category 1, 4/22/19 credit date 10/28/19

140. Cleveland Clinic: Clinical Decisions: Diabetes AMA Category 1 Credit date 10/28/19

141. Cleveland Clinic: Clinical Decisions: Urinary Incontinence in Women AMA Category 1 10/28/19

142. Cleveland Clinic: Clinical Decisions: Asthma, 10/29/19

143. ProAssurance Indemnity: Claims Review Proceedings-CUC, 2.0 AMMA PRA Category 1 credits, June 20, 2019

144. Medscape: Prediabetes Awareness in the Primary Care Setting, October 20,2019 0.25 AMA PRA Category 1 Credits

145. Cleveland Clinic: Clinical Decisions: Immunization in Immunocompromized Patients, AMA PRA Category 1, 10/31/19 Certificate 5048589

146. Cleveland Clinic: Clinical Decisions: Psoriasis, AMA PRA Category 1, 10/31/19 Certification number 5048565

147. Cleveland Clinic: Clinical Decisions: The Diagnosis and Evaluation of Hematuria in Adults, AMA PRA Category 1, 10/29/19 Certification 5046131

148. Cleveland Clinic: Clinical Decisions: Dermatology in Primary Care, AMA PRA Category 110/31/19 Certificate 5048264

149. Certificate of Completion: Intersections: Preventing Harassment and Sexual Violence, 7/16/19, University of Nevada Reno-UNR-NSHE, Ethics

150. Medscape: Pain Management and Opioids: Balancing Risks and Benefits, 3.5 AMA PRA category 1 credits, Jan 31, 2020

151. American Board Obstetrics and Gynecology Maintenance of Certification, 25 AMA PRA Category 1 Credits, American Board Certification Obstetrics and Gynecology valid through 12/31/21,

152. LDL-C, Cardiovascular risk, and Nonstatin Therapy: Identifying Patients and Improving Outcomes. Jan. 24, 2020.75 Category 1 AMA PRA

153. Certificate for Continuing Medical Education Credits 20 CME hours awarded, BME Case 18-18173, June 30, 2020.

154. Medscape: Omega-3s vs Pure EPA in Clinical Practice: What do CV Outcome Trials Tell Us? Jan 23,2020, 0.5 AMA PRA Category 1 Credits.

155. Medscape: Ring the Bell: Improving T2D Management With CVD, Jan. 21, 2020, 0.5 AMA PRA Category 1 Credits.

156. Basic Life Support Provider Jan.03,2020, BLS Provider, Recommended renewal Date Jan. 03, 2020, ACLS Medical Training completion.

157. Touro University of Nevada: Suicide: Identifying and Supporting People at Risk, 2 AMA PRA Category 1 credits June 4, 2020 – Jan 03, 2022

158. Nevada State Board of Medical Examiners BME Case # 17-17534 period. Peer review. 13 hours awarded July 1, 2019-June 30,2021 biennial period.

159. ProAssurance Indemnity: Claims Review Proceedings, Claims Underwriting Committee, Jan. 16, 2020, 2 AMA PRA Category 1 credits

160. Touro University Nevada: Opioid Law Prescribing Mandates, Opioid Use Disorder and Treatment, 2 AMA PRA Category Credits May 21, 2020.

161. University of Nevada, Reno School of Medicine Simulation Class: Safety in Maternity Care, Assisted vaginal Delivery, Vacuum Extraction, Postpartum Hemorrhage, Group Testing. Shared teaching of this class with Dr. McCarthy et al., June 19, 2020

162. University of Nevada, Reno School of Medicine Physical Examination MS 2 Students, "Evaluation of Overall Quality and thoroughness of building a History: HPI, PMH, Fam history, Social History, ROS, Meds., Allergies and thoroughness of Physical Exam. Communications skills.

163. Understanding Fetal Heart Rate Tracings, University of Nevada Ren, School of Medicine, Lecture for MS 3 students July 16, 2020.

164. Disease Management Clinical Decisions: Clinical Overview: Polycystic Ovarian Syndrome, AMA PRA 08/13/20, Cert. 5308016 0.75

165. Preventing Harassment and Discrimination, University of Nevada Reno, 9/29/20

166. Nevada State Board of Medical Examiners. BME Case # 18-18173,3/12/20, 20 CME credits

167. Nevada State Board of Medical Examiners, BME Case#18-18151, 16 CME Credits awarded 12/29/2020

168. Nevada State Board of Medical Examiners, BMW case #18-18159, 1/8/21, 17 CME credits awarded 1/8/2021

169. Nevada State Board of Medical Examiners 6/16/2021, BME case #20-19342, CME hours awarded: 20

170. Nevada Board of State Medical Examiners, BME Case #20-19593 CME hours awarded: 20 CME credits awarded.

171. Nevada Board of State Medical Examiners. BME Case #20-19417, CME 20 hours awarded 7/2/21

171. Medscape: Achieving Lipid Goals: Expert Cardiologist Perspectives on Strategies Beyond Statin Therapy, JANUARY 3, 2022. 0.5 ama PRA Category 1 Credits

172. Medscape: Novel Approaches to Postsurgical Analgesia: Getting a Head Start of Post-Op Pain, Jan. 3, 2022, 0.75 AMA PRA Category 1 Credits.

173. NetCE: Opioid Use Disorder, Course 96963, Opioid Use Disorder, 10 CME credits, Jan. 2022, recognized by Nevada State Board Medical Examiners

174. NetCE: Pneumonia, Course #94673, 10 CME Credits, recognized by BSBME, performed Jan 2022

175. NetCE Pancreatic Cancer, Course 90240, 10 CME awarded, recognized by Nevada State Board of Medical Examiners, performed Jan. 2022

176. Basic Life Support Certificate of Completion January 29, 2022, HCP-CPR (Adult/Child/Infant/Choking), Automated External Defibrillation/First Aid demonstrating proficiency in the subject by passing the examination in accordance with the Terms and Conditions of the National CPR Foundation. Valid for 2 years, course administered in accordance with the 2020 ECC/ILCOR and AHA guidelines. ID #4A2384

177. Nevada State Board of Medical Examiners BME Case Number 20-19786, CME hours awarded 20 (Twenty hours)date: 2/10/22

178. Nevada State Board of Medical Examiners BME Case #21-20708, 3/8/22

CME hours awarded 20.

179. American Board of Obstetrics and Gynecology 2022 Maintenance of Certification. 28 AMA PRA Category 1 Credits for completing 2022 MOC requirements.

180. Addressing the Diabetes and Obesity Pandemic, April 2, 2022, 6.50 HRS, Title NV CEA, University of Nevada Reno School of Medicine Certification. AMA PRA Category 1 Credits

181. Nevada State Board of Medical Examiners Peer Review BME Case Number 21-20043, 16.5 Category 1 CME hours.

182. Nevada State Board of Medical Examiners Peer Review 7/25/2022, BME Case # 21-20483, 17 credit hours Category 1 CME

183. Nevada State Board of Medical Examiners Peer Review 9/16,/2022,BME Case # 21-20464 20 CME Hours awarded Category 1

184. Nevada State Board of Medical Examiners Peer Review,9/28/22 BME Case Number 22-21253 during the July,2021-June 30,2023. CME hours awarded 20 hours Category 1 CME

185. Preventing Harassment and Discrimination for Higher Education: Module 1.Building Positive Workplace, Module 2. Developing Awareness and Recognizing Discrimination, Module 3.Cultivating Attitudes and Identifying Harassment, Module 4. Taking Action against Retaliation, Module 5.Building Supportive Communities, 6. Maintaining Positive Workplaces.

185. Nevada State Board of Medical Examiners BME Case#:21-20791, CME awarded 20 hours, Biennial period July 1, 2021-2023,

AWARDS

The Robert Hingson Humanitarian Award, St. George's University School of Medicine

Best Doctors Award — Gynecology, Top Doctors Chosen by Their Peers, Cleveland Monthly, March 2007

Best in Community Service, Renown Medical Center 2007

St. Mary’s Regional Medical Center Recognizes the Devotion You Provided for 35 years – Emeritus Staff Status

University of Nevada Reno School of Medicine, Office of Community Faculty "Thank you for sharing your knowledge and serving as a role model to support medical education" UNR Med Students

LITERARY ACCOMPLISHMENTS

The Influence of Weight in the Induction of Ovulation with Menotropins (HMG) and Human Chorionic Gonadotropin (HGG), Augusto Chong, M.D., Richard W. Rafael, M.D., Carol Forte, N.P.

PROFESSIONAL AFFILIATIONS: Past and Present

Diplomate of the American Board of Obstetrics and Gynecology
Dipolmate — December 2010

Fellow American College of Obstetrics and Gynecology

The American College of Obstetrics and Gynecology and Cervical Pathology

The Gynecological Laser Society

The Nevada State Medical Society
Task Force for Medical Liability Insurance, 1996-1997

Nevada State Medical Association Delegate 1997-1998, 2001, 2002

The Washoe County Medical Society
Board of Directors, January 1997 — December 1999, 2002
Vice President, January 2000 — December 2001
President, January 2001 — December 2001

Health Access Washoe County (H.A.W.C.), Board Member 2006, Board Member 2011 Financial Committee Member 2011, Search Committee Member 2012, Chairman of First Annual Fundraiser — HAWC Community Health Alliance 2012, Currently Community Health Alliance

IND — Insurance Co., Board Member 2007 to 2012, Subscribers Advisory Committee

ProAssurance 2013- 2019 Nevada Claims and Underwriting Committee- malpractice case review. Total 12 years in Peer Review Experience.

Clinical Assistant Professor of Obstetrics and Gynecology -

University of Nevada, Reno School of Medicine March 2019- present

Nevada State Board of Medical Examiners Peer Review – review malpractice cases

CLINICAL LECTURES

1. Hypertension in Pregnancy, 9/86, Medical Residents, Reno, NV
2. Diabetes in Pregnancy, 11/86, Medical Residents, Reno, NV
3. Evaluation and Management of I.U.G.R., 2/87, Reno, NV
4. Antenatal Fetal Monitoring, Churchill County Medical Society
5. Premature Onset of Labor, Nursing Staff, Washoe Medical Center, Reno, NV
6. Pelvic Inflammatory Disease, 3/88, Family Practice Residents, Reno, NV
7. Ectopic Pregnancy, 11/88, Family Practice Residents, Reno, NV
8. Gestational Diabetes, 12/99, Family Practice Residents, Reno, NV
9. Pelvic Organ Prolapse, 12/99, Family Practice Residents, Reno, NV
10. Ectopic Pregnancy 9/11/19 Morbidity and Mortality, UNR Family Practice Residents
11. Physical Diagnosis Female History and Physical 8/31/19 Student Outreach Clinic, UNR Medical Students
12. Vaginitis – 6/22/19 Student Outreach Clinic
13. Neuroanatomy – 6/10/19 review of Neuroanatomy Questions
14. Abnormal Uterine Bleeding – 5/18/19 SOC Clinic
15. Prevention and Screening for Cervical Cancer – 4/10/19 SOC Clinic
16. Safety in Obstetrics and Gynecology, Vacuum Extraction, Forceps Delivery, Postpartum Hemorrhage, Assisted Vaginal Delivery Workshop 6/19/2020, University of Nevada, Reno School of Medicine
17. Understanding Fetal Heart Rate Tracings, University of Nevada, Reno School of Medicine, July 16, 2020
18. Physical Diagnosis: History and Physical Examination, Medical Students, University of Nevada School of Medicine, July 17 and July 7/18/2020

Dr. Richard Rafael is a board certified Obstetrician and Gynecologist who has completed 32 years of private practice as a solo 0b/Gyn. He retired from private practice 12/31/18.

Dr. Rafael was President of the Washoe County Medical Society and served on the Board of Community Health Alliance, promoting access to care for the underserved. Dr. Rafael helped develop the major fund raising event for the Community Health Center. He was voted "Best Doctor" by his colleagues in 2007 and he was recognized by Renown Regional Medical Center as "Best in Community Service" for his work with Health Alliance.

Dr. Rafael was asked to join the IND Malpractice Insurance Board when Nevada was facing a crisis due to non-competition in malpractice insurance. IND grew and was acquired by ProAssurance, a global malpractice insurance company. He continues to contribute to the committee reviewing malpractice cases for the Western United States.

Dr. Rafael is currently working with the Student Outreach Clinic at University of Nevada, Reno School of Medicine and is a Clinical Assistant Professor of Obstetrics and Gynecology through the Department of Obstetrics and Gynecology.

Dr. Rafael is working with the Nevada State Board of Medical Examiners Peer Review and is responsible for reviewing records associated with Peer review of Obstetrical and Gynecology cases.

Dr. Rafael believes the needs of the patient comes first, and he seeks to treat all patients, students and professional staff with dignity and respect.

EXHIBIT 17

EXHIBIT 17

From: Johnna S. LaRue [redacted]
Sent: Monday, April 10, 2023 1:18 PM
To: Brandee Mooneyhan [redacted]
Subject: FW: [Marketing] Copies of Event Ads from Previous Years

Confirmed that Dr. Chambers only ever inquired in 2016 but never submitted any art or photos.

Thank you,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 324-9377 Phone
(775) 688-2553 Fax
jlarue@medboard.nv.gov
www.medboard.nv.gov

From: Beth Noonan [redacted]
Sent: Monday, April 10, 2023 1:16 PM
To: Johnna S. LaRue [redacted]
Subject: Re: [Marketing] Copies of Event Ads from Previous Years

Hi Johnna,

As previously stated he requested an ad for the 2016 AVN Expo but did not submit artwork for the advertisement.

Thanks,
Beth

Beth Noonan
Vice President
AVN Media Network
9400 Penfield Ave
Chatsworth, CA 91311

Phone: 818-671-3907
Mobile: 661-312-9533

Skype: avnbeth

On Mon, Apr 10, 2023 at 10:13 AM Johnna S. LaRue <jlarue@medboard.nv.gov> wrote:
Good Morning Ms. Noonan,

I am following up on the inquiry I made last year in regards to a physician and advertising with you company.

Can you please verify that George Chambers, MD or Chambers and Associates did not have any advertisements in any brochure or program of an award ceremony that your company is associated with?

Thank you,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 324-9377 Phone
(775) 688-2553 Fax
jlarue@medboard.nv.gov
www.medboard.nv.gov

From: Beth Noonan [redacted]
Sent: Friday, June 03, 2022 2:16 PM
To: Johnna S. LaRue [redacted]
Subject: Re: [Marketing] Copies of Event Ads from Previous Years

Yeah, that is what my records show.

Beth Noonan

Vice President
AVN Media Network
9400 Penfield Ave
Chatsworth, CA 91311
Phone: 818-671-3907
Mobile: 661-312-9533

Skype: avnbeth

On Fri, Jun 3, 2022 at 2:05 PM Johnna S. LaRue [redacted] wrote:
Is that the only time he has submitted for an ad?

Thank you,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 324-9377 Phone
(775) 688-2553 Fax
jlarue@medboard.nv.gov
www.medboard.nv.gov

From: Beth Noonan [redacted]
Sent: Friday, June 03, 2022 12:52 PM
To: Johnna S. LaRue [redacted]
Subject: Re: [Marketing] Copies of Event Ads from Previous Years

Hi Johnna,

It looks like he requested an ad for the 2016 AVN Expo but did not submit artwork for the advertisement.

Thanks,

Beth

Beth Noonan
Vice President
AVN Media Network
9400 Penfield Ave
Chatsworth, CA 91311
Phone: 818-671-3907
Mobile: 661-312-9533

Skype: avnbeth

On Fri, Jun 3, 2022 at 12:40 PM Johnna S. LaRue [redacted] > wrote:
Hi Beth,

Thank you for responding so quickly.

George Chambers, MD is the provider I am inquiring about.

Thank you,

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 324-9377 Phone
(775) 688-2553 Fax
jlarue@medboard.nv.gov
www.medboard.nv.gov

From: Beth Noonan [redacted]>
Sent: Friday, June 03, 2022 12:39 PM
To: Johnna S. LaRue [redacted]>
Subject: Re: [Marketing] Copies of Event Ads from Previous Years

Hi Johnna,

To further assist you, please provide the name of the medical provider in question.

Thanks,

Beth

Beth Noonan
Vice President
AVN Media Network
9400 Penfield Ave
Chatsworth, CA 91311
Phone: 818-671-3907
Mobile: 661-312-9533

Skype: avnbeth

On Fri, Jun 3, 2022 at 12:20 PM AVN Media Network Inc. <support@avn.com> wrote:

Copies of Event Ads from Previous Years.

Name: Johnna LaRue
Email: jlarue@medboard.nv.gov
Company: Nevada State Board of Medical Examiners
Phone: 775-324-9377
Subject: Copies of Event Ads from Previous Years
Department: Marketing

Message:
I am looking for ads placed during events or in the magazine for a specific medical provider. Please contact me at the email or phone number above for more information as pertaining to my request.

Submitted on: 2022-06-03 19:20:06
IP Address: 167.154.72.236
User Agent: Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/102.0.5005.63 Safari/537.36

Block email | Block domain | Block ip

RESPONDENT'S EXHIBITS ADMITTED INTO EVIDENCE

EXHIBIT A

EXHIBIT A

GEORGE P. CHAMBERS, JR., M.D., F.A.C.O.G.

7220 SOUTH CIMARRON ROAD, SUITE 200
LAS VEGAS, NEVADA 89113
WEB: www.chambersobgynlv.com
PH: (702) 463-0800

EDUCATION

- 1998 to 2002 — **SUNY UPSTATE MEDICAL UNIVERSITY**
  Syracuse, New York 13210
  Obstetrics and Gynecology Residency Program
  • **Chief Resident, July 2001 to June 2002**
  • ***Alpha Omega Alpha* Honor Medical Society, Inducted 2000**

- 1994 to 1998 — **MEDICAL COLLEGE OF PENNSYLVANIA**
  Philadelphia, Pennsylvania 19129
  • **Doctor of Medicine, May 1998**

- 1992 to 1994 — **HAHNEMANN UNIVERSITY**
  Philadelphia, Pennsylvania 19102
  • **Graduate Studies in Biomedical Sciences**

- 1988 to 1992 — **AMERICAN UNIVERSITY**
  Washington, D.C. 20016
  • **Bachelor of Science in Chemistry, May 1992**

- 1987 to 1988 — **GEORGETOWN UNIVERSITY**
  Washington, D.C. 20057
  • **High School College Internship Program**

POST-RESIDENCY TRAINING

- 12/2013 — Certified, Sexual Health and Treament,
  The American Academy of Anti-Aging Medicine

- 11/2013 — Certificate of Completion,
  Female Genital Plastic/Cosmetic Surgery Masters Course,
  Preceptor: Michael P. Goodman, M.D., FACOG
  Davis, California 95616

BOARD CERTIFICATION

- 07/2008 — Fellow, American College of Obstetricians and Gynecologists

- 11/2007 — Diplomate, American Board of Obstetrics and Gynecology,
  Effective November 8, 2007 through December 31, 2021

EXPERIENCE

- 11/2009 to Present — Chambers & Associates OBGYN and Gynecological Surgery, PLLC, **Medical Director and Owner**, 7220 S. Cimarron Road, Suite 200, Las Vegas, Nevada 89113
- 04/2013 to 11/2018 — Women's Health Associates of Southern Nevada, **Laborist**, 9525 Hillwood Drive, Suite 130, Las Vegas, Nevada 89134
- 04/2011 to 03/2014
- 06/2007 to 07/2009
- 09/2003 to 06/2006

  Nevada Health Centers, Incorporated (Main Office)
  3325 Research Way, Carson City, Nevada 89706
  - **Hospitalist Ob/Gyn**, April 2011 to March 2014
  - **Hospitalist Ob/Gyn**, June 2007 to July 2009
  - **Attending Ob/Gyn**, September 2005 to June 2006
  - **Service Clinical Director**, September 2003 to August 2005
- 07/2006 to 10/2009 — Centennial Hills Ob/Gyn Associates, **Attending Ob/Gyn**, 1815 East Lake Mead Boulevard, Suite 314, North Las Vegas, Nevada 89030
- 05/2003 to 09/2003 — Women's Wellness OB/GYN, **Attending Ob/Gyn**, 10170 S. Eastern Avenue, Suite 160, Henderson, Nevada 89052

ACADEMIC APPOINTMENTS

- 2007 to 2020 — **Adjunct Assistant Professor** of Obstetrics and Gynecology, TOURO University Nevada College of Osteopathic Medicine, Henderson, Nevada 89014
- 2013 to 2015
  2005 to 2008

  Clinical Assistant Professor of Obstetrics and Gynecology
  University of Nevada School of Medicine
  Las Vegas, Nevada 89102
- 2006 to 2007 — **Adjunct Assistant Professor** of Obstetrics and Gynecology, TOURO University College of Osteopathic Medicine, Mare Island, Vallejo, California 94592

ACADEMIC HONORS AND AWARDS

- 2002 — Robert E.L. Nesbitt, M.D. Outstanding Resident in Ob/Gyn Award
- 2001 — Best Presentation by a Senior Resident Award
- 2000 to Present — *Alpha Omega Alpha* Honor Medical Society
- 1999 to 2001 — Best Ob/Gyn Resident-Student Teacher Award
- 1992 — National Organization of Black Chemists and Chemical Engineers Undergraduate Research Award
- 1992 — Distinguished Frederick Douglass Scholar Award
- 1988 to 1992 — Frederick Douglass Scholar (American University)

NON-ACADEMIC HONORS AND AWARDS

- 2020 — Recognized as one of Las Vegas "Top Doctors" in *Vegas Inc Healthcare Quarterly* magazine, vol. 29, 2020
- 2019 — Recognized as one of Las Vegas "Top Doctors" in *Vegas Inc Healthcare Quarterly* magazine, vol. 24, 2019
- 2019 — Recognized as one of Las Vegas "Top 100 Doctors & Dentists" in the Spring 2019 issue of *MYVEGAS* magazine
- 2018 — Recognized as one of Las Vegas "Top 100 Doctors & Dentists" in the Summer 2018 issue of *MYVEGAS* magazine
- 2018 — Recognized as one of Las Vegas "Top Doctors" in *Vegas Inc Healthcare Quarterly* magazine, vol. 20, 2018
- 2018 — Patient Choice Award, on vitals.com
- 2015 — Recognized as one of Las Vegas "Top Doctors" in *Vegas Inc Healthcare Quarterly* magazine, vol. 8, 2015
- 2014 — Recognized as a "Top 10 Doctor in City, Metro Area and State," on vitals.com
- 2011 — Recognized as one of Las Vegas "Top Doctors" in the Spring 2011 issue of *Las Vegas Life* magazine
- 2010 — Cited in the second edition of Who's Who In Black Las Vegas®
- 2009 to 2015 — Listed in *Guide to America's Top Obstetricians and Gynecologists*
- 2008 to 2015 — Patient Choice Award, on vital.com
- 2008 & 2010 — The Las Vegas Chamber of Commerce Customer Service Excellence Award
- 2007 — Recognized as one of Las Vegas "Top Doctors," in the June 2007 issue of *Las Vegas Life* magazine
- 2006 — Recognized as one of Las Vegas "210 Top Doctors," in the June 2006 issue of *Las Vegas Life* magazine
- 2005 to 2007 — National Health Service Corp Scholar

LICENSURE

- # 41471 — Colorado — (Inactivated by Dr. Chambers on 04/30/2017)
- # 10476 — Nevada — (Active & Unrestricted)
- # 228191 — New York — (Inactivated by Dr. Chambers on 08/11/2010)

PROFESSIONAL AFFILIATION

- 2009 to Present — American Congress of Obstetricians and Gynecologists
- 1998 to Present — American College of Obstetricians and Gynecologists
- 2012 to 2015 — National Society of Cosmetic Physicians
- 2012 to 2013 — The American Academy of Anti-Aging Medicine

PRESENTATIONS

- "Very-Low birth Weight Babies in Syracuse, New York," **9th Annual Chief and Senior OB/GYN Residents' Scientific Forum**," SUNY Upstate Medical University. Syracuse, New York; June 2002.

PRESENTATIONS (CONTINUED)

- "Uterine Atony at Caesarean Section," **Grand Rounds**, SUNY Upstate Medical University. Syracuse, New York; May 2002.

- "Abdominal Wall Defects: The Patient with the Massive Panniculus," **8th Annual Chief and Senior OB/GYN Residents' Scientific Forum**," SUNY Upstate Medical University. Syracuse, New York; June 2001.

- "Increasing Human Sexuality Awareness Through Youth Education," Generalist Physicians in Training 4th Annual Poster Session, **46th Annual Convention of the American Medical Student Association**, Arlington, Virginia; March 1996.

- "Synthesis and Characterization of 2,5-Dibutyl-1-oxa-cyclopentan-2-ol," Division of Industrial and Engineering Chemistry: Undergraduate Research in Washington, D.C. Area Universities, **204th American Chemical Society National Meeting**, Washington, D.C.; August 1992.

- "Synthesis and Characterization of 2,5-Dibutyl-1-oxa-cyclopentan-2-ol," Technical Sessions, **19th Annual National Conference of the National Organization of Black Chemists and Chemical Engineers**, New Orleans, Louisiana; April 1992.

PUBLICATION

- Chambers GP, Roscher NM, Yang L. "Synthesis and Characterization of 2,5-Dibutyl-1-oxa-cyclopentan-2-ol." In *Proceedings of the National Conference of the National Organization of Black Chemists and Chemical Engineers*. Held in New Orleans, Louisiana, April 20-24, 1992, vol 19. Washington, D.C.: NOBCChE, 1992.

EXHIBIT B

EXHIBIT B

CERTIFICATE OF COMPLETION

This certificate is awarded to

George P. Chambers, Jr., M.D., FACOG

For Successfully Completing the
Female Genital Plastic/Cosmetic Surgery Masters Course: 16 hours

Awarded By Dr. Michael P. Goodman

22 November 2013
Date

EXHIBIT C

EXHIBIT C

The American Academy of Anti-Aging Medicine

Upon the recommendation of the Executive Board, and after
successfully completing all of the certificate requirements
The Board has conferred upon

George Chambers, MD

a certificate in

Sexual Health and Treatment

and is entitled to all the rights and honors thereto appertaining, given at the Offices
of the American Academy of Anti-Aging Medicine, Chicago, Illinois
This fourteenth day of December, two thousand and fourteen

Robert M. Goldman, MD, Ph.D, DO, FAASP
The Chairman of The American Academy of Anti-Aging Medicine

Jennifer Landa, MD
Director, Anti-Aging and Regenerative Medicine Fellowship

Ronald M. Klatz, MD, DO
The President of The American Academy of Anti-Aging Medicine

Sexual Health and Treatment

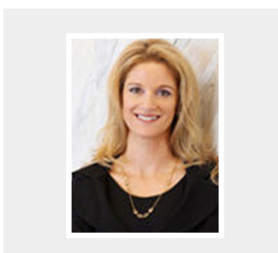
Certification Description:

The Sexual Health Certification provides comprehensive education to practitioners in the diagnosis, evaluation and treatment of sexual health disorders in men and women.

There is a dual emphasis on learning evidence based scientific literature in the area of sexual health, and learning clinical practice protocols, and practices to allow participants to treat patients with the most up to date and comprehensive treatment tools. The teachings combine didactic learning as well as participatory and lab learning within four online modules.

After completion of the 4 modules, the participant will be considered a Certified Sexual Health Clinician. The modules are lively, engaging and informative providing the participant with the essential knowledge and skills needed to be able to comprehensively care for patients who have sexual health challenges.

Director Of The Sexual Health Certification:



Jennifer Landa, MD, Ob/Gyn specializes in helping women and men balance their hormones, restore their energy, and replenish their sex lives. At the heart of her practice is the belief that maintaining one's health is hard work and she encourages her patients to make lifestyle changes that will result in increased health.

Dr. Landa's focused, energetic, and straightforward style comes across well when she speaks in front of groups and on camera. She lectures nationally on preventive medicine and has appeared on national and local television. Dr. Landa just completed her first book with co-author Virginia Hopkins. Their book, The Sex Drive Solution for Women, is a no-nonsense approach to many of the sex drive issues that Dr. Landa addresses with her patients every day.

Module A: Female Sexual Health

Online Certification - Sexual Health **Only: $1,800** ADD TO CART (/cart;cart,add_to_cart,sh_online_module_1,1.html)

Sexual Health and Treatment - Module A

Course Description:

Chambers 007

The first of the four module series will introduce and cover many essential issues in female sexual health. Treatment protocols that are both evidence based and clinically relevant will be given throughout the lectures. The vulvar anatomy and disorders of the vulva will be covered thoroughly including the evaluation and treatment of such disorders by an expert in the field of vulvovaginal disorders and treatments for vaginal dryness from a Harvard gynecologist that includes everything from the conventional to the Ayurvedic.

Selected Topics:

- Overview of female sexual dysfunction
- Women's sexual health–anatomical concerns
- Causes and treatment of dyspareunia
- Treatment of vulvar/vaginal atrophy
- Perform diagnostic evaluations on patients with FSD
- Be familiar with surgical treatment of sexual dysfunction
- Understand adrenal function as it affects sex drive and how to address in patients
- Be familiar with newer modalities including orgasmic meditation and certain tantric principles and techniques
- Prescribe novel tools, methods, and various sexual aids for patients to boost sex drive

Module B: Male Sexual Health, Gay and Transgender Therapy

Online Certification - Sexual Health
Sexual Health and Treatment - Module B

Only: $1,800

ADD TO CART (/cart;cart,add_to_cart,sh_online_module_2,1.html)

Course Description:

Sexual Health Module B will cover all aspects of male sexual health, encompassing evaluation and treatment of male sexual dysfunction, including a comprehensive look at male hormone therapy, through discussion of testosterone therapy, treatment of premature ejaculation, and sexuality treatment for the LGBT population.

Selected Topics:

- Evaluation and Hormonal Treatment of Male Sexual Dysfunction
- Erectile Dysfunction - Advanced Therapeutics
- Transgender Hormone Therapy Protocol
- Oxytocin Use in Male Sexual Function
- Comprehensive Look at Male Hormone Therapy
- Discussion of Testosterone Pellet Therapy, Oxytocin and Treatment of Premature Ejaculation Therapies for Erectile Dysfunction
- Treatment of Sexual Dysfunction after Prostate Cancer
- Sexuality in the Lesbian, Gay and Transgender communities will be discussed extensively including sexual function, dysfunction and special considerations in treating these populations

Module C: Impact of Medical and Psychological Conditions on Sexuality

MedEd Library (https://tarsus.geniussis.com/Registration.aspx) CONTACT US (/contact-us.html) CART (/cart.html) MY ACCOUNT (/my-account.html)

MENU

Online Certification - Sexual Health
Sexual Health and Treatment - Module C

(/) **Only: $1,800**

ADD TO CART (/cart;cart,add_to_cart,sh_online_module_3,1.html)

Chambers 008

Course Description:

This module will focus on various physical and emotional issues which result in sexual dysfunction. Treatment modalities will be discussed with focus on breast cancer patients and uro-gynecologic issues. Examples and discussion will be reviewed to gain an understanding on identifying and/or properly referring patients with psychologic aspect of sexual dysfunction.

Selected Topics:

- Discuss sexual problems and issues that may result as a consequence of various medical conditions and their management
- Understand and treat sexual problems of patients with breast cancer
- Identify and possibly treat or make proper referral for uro-gynecologic issues leading to sexual dysfunction
- Understand various paraphilia and unusual sexual practices and evaluation and treatment of patients with concerns in these areas
- Identify and treat and/or proper referral of patient with psychologic aspects of sexual dysfunction

Module D: Hormones and sexual dysfunction plus sex and pregnancy (prenatal, pregnant and post-partum)

Online Certification - Sexual Health
Sexual Health and Treatment - Module D

Only: $1,800

ADD TO CART (/cart;cart,add_to_cart,sh_online_module_4,1.html)

Course Description:

This module with focus on advanced endocrinology in the male patient. Male sexuality, late-life hypogonadism, benign prostatic hyperplasia, lower urinary tract symptoms, prostate cancer and the use of hormonal therapies, nutrition and the aging male, osteoporosis in men and sarcopenia will all be subjects of discussion in this module. The male athlete will also be a focus of this very interesting course.

Selected Topics:

- Understand treatment of sexual dysfunction with oxytocin
- Be able to identify and treat adrenal dysfunction leading to sexual dysfunction
- Learn about pellet therapy, indications, dosing and benefits
- Know how hormones besides estrogen and progesterone play a role in sexual dysfunction and how to address these issues
- Understand improvement of prenatal status, fertility, postpartum sexuality and contraception

Chambers 009

Learn More

Learn More

A4M Membership

(/a4m-membership.html)

Learn More

(/)

The **American Academy of Anti-Aging Medicine** (A4M) is dedicated to the advancement of healthcare technologies and transformations that can combat chronic diseases associated with aging. A4M offers continuing medical education, activities, and training through its advanced education entity **Metabolic Medical Institute** (MMI).

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(https://www.tarsusmedicalgroup.com/)

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EXHIBIT D

EXHIBIT D

IMNE | Institute for Medical and Nursing Education

Certifies that

George P. Chambers Jr, MD

has participated in the educational activity titled

National Society of Cosmetic Physicians
7th Annual Congress on Aesthetic Vaginal Surgery
October 20-21, 2012

at The Cosmopolitan of Las Vegas in Las Vegas, NV

and is awarded 16 AMA PRA Category 1 Credits ™

Steve Weinman, RN
Executive Director

11/01/12

150 West End Avenue | Somerville, NJ 08876 | USA | +1 609 936 7015 (Phone) | +1 609 207 7032 (Fax)| www.IMNE.com

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UROGYNECOLOGY
THE ALINSOD INSTITUTE FOR
AESTHETIC VAGINAL SURGERY

AND

NATIONAL SOCIETY
OF
COSMETIC PHYSICIANS

7th Annual Congress On Aesthetic Vaginal Surgery

CAVS 2012

OCTOBER 20-21, 2012
The Cosmopolitan
Las Vegas, Nevada

RED M ALINSOD, M.D., FACOG, FACS, ACGE
Program Director and Chairman
www.urogyn.org

AL SOCIETY
OF
PHYSICIANS

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WELCOME LETTER FROM THE CHAIRMAN

Dear Friends and Colleagues, Welcome to CAVS 2012!

Once more I am thrilled to bring to you this year's 7th Annual Congress on Aesthetic Vaginal Surgery, CAVS 2012. We continue to grow as a supportive and professional association of surgeons whose goals are totally committed to our patient's safety and well-being. Thank you for joining us again this year as we learn from experts from around the United States and the world. It is wonderful to be back in Las Vegas to enjoy the thrills of the vibrant city and to rekindle friendships. CAVS is the first and longest running CME conference in the world on Aesthetic Vaginal Surgery and continues to be the "Grand Daddy" of them all. Thank you for your loyalty and desire for learning. Our goal is to live up and surpass your expectations. It has been an amazing seven years of growth as we see societies focusing on Aesthetic Vaginal Surgery arising from countries all over the globe from numerous European countries, Brazil, Korea, China, and others. We welcome our sister societies with open arms. We support organizations that educate and promote safety in the care of women. This year, we intend to raise this support and awareness to a higher level with opportunities offered to our attendees to give of their talents and time in the compassionate service for genitally harmed women.

As in past meetings, our focus is pinpoint sharp on labial and vaginal surgery and what it takes to perform these safely, beautifully, and with care. I would like to thank our renowned experts, across the nation and abroad, who have graciously accepted to share their knowledge with us. The preliminary agenda attached gives an outline of topics to be discussed and presented. CAVS 2012 will be the place to hear and learn of new ideas and new techniques in Aesthetic Vaginal Surgery and to expand on those already established. We will keep you on the cutting edge.

I would love to meet each and every one of you and start a long friendship. Please feel free to contact me for further information and details.

Warmest regards,

Red Alinsod, MD, FACOG, FACS, ACGE
Program Director and Chairman, CAVS 2012
red@urogyn.org
www.urogyn.org
www.pelvicsurgeon.com
949-499-5311 Office
949-499-5312 Fax

Day 1, Saturday, October 20, 2012
Symposium on Aesthetic Labial Surgeries
Program Chairman: Red Alinsod, MD

07:00 – 08:00 Breakfast, On-Site Registration

08:00 – 08:10 L0: Welcome
NSOCP and CAVS: From Evolution to Revolution
Red Alinsod, MD

08:10 – 08:45 Keynote Address
L1: New and Evolving Treatments for
Female Sexual Dysfunction
Jennifer Berman, MD (35 min)

Medical management and treatment of female sexual function complaints is becoming more mainstream and gradually evolving as more clinical and basic science studies are dedicated to solving this problem. Aside from hormone replacement therapy, medical management of female sexual function complaints still remains in the experimental phases and requires "off label" use. The goal of this talk is to educate health care professionals that not all female sexual complaints are psychological/emotionally based and that there are possible medical treatment options available. Attendees should gain a general understanding of female sexual function complaints, the etiologies that are medically based, as well as a comfort level with the treatment options available. Studies are currently in progress assessing the effects of vasoactive substances, adrenal and gonadal hormones and pituitary activating hormones, as well as other neuromodulators on the female sexual response. Aside from hormone replacement therapy, all medications discussed in this talk, other than over the counter products, are not FDA approved for use in women, are still in phases of clinical trials, however, some can be prescribed off label.

Literature about vag. aesthetics
- grace@cosmeticphysicians.org
- Michaelgordon2350@gmail.com
- [illegible]

08:45 – 09:05 L2: The Ev
Michael G
This presentation will revie
date in the following areas
1) Reasons women give f
(AVS).
2) Psychological, sexual,
requesting AVS.
3) Outcome studies of AV

The goal of this lecture is t
reviewed medical literatur
Excluded are all "opinion p
theoretical editorializing.

Suggestions will be made f
answers to audience queri
protocol and coordination

"...Only the facts, Mam..!"

09:05 – 09:25 L3: Body I
Otto Placil
Issues of abnormal body ir
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09:25 – 09:45 L4: The G-
Gul Zikria,
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concept that has intrigued
sexologists and therapists
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09:45 – 10:05 L5: Labia M
Bernard S
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Methods: Sculpted linear
wedge, and Z-plasty techn
Results: "Satisfied" cosme
Conclusions: The aesthetic
evolving and continuously
results are based on indivi
the technique itself!

- about vag. aesthetics
cosmeticphysicians.org
...250@gynmd.com

08:45 – 09:05 L2: The Evolution of AVS: A Literature Review
Michael Goodman, MD (20 min)
This presentation will review the peer-reviewed medical literature to date in the following areas:

1) Reasons women give for requesting aesthetic vulvovaginal surgery (AVS).
2) Psychological, sexual, and body image makeup of women requesting AVS.
3) Outcome studies of AVS.

The goal of this lecture is to familiarize attendees with the sum of peer-reviewed medical literature involving the areas outlined above. Excluded are all "opinion pieces," anecdotal information, and theoretical editorializing.

Suggestions will be made for areas of useful potential study with answers to audience queries regarding the mechanics of writing a study protocol and coordination a publishable study.

"...Only the facts, Mam..!"

09:05 – 09:25 L3: Body Image and AVS
Otto Placik, MD (20 min)
Issues of abnormal body image, real and imagined, are discussed to help the surgeon analyze patient reasons for requesting surgery and to help set achievable end points and expectations

09:25 – 09:45 L4: The G-Spot: Science and Fiction
Gul Zikria, MD (20 min)
Since the term was coined in the early 1980s. The G Spot has been a concept that has intrigued the lay public. It has also been a boon for sexologists and therapists publications and practices. In the 1990s it reemerged as a marketing term as G Spot Amplification by Dr. David Matlock. Whereby the area called the G Spot was bulked up with collagen. Despite the lack of scientific evidence, the public influenced by lay press and marketing gimmicks, is demanding this procedure as a panacea for their sexual enhancement. In this lecture I will be discussing the Myth and science of the G Spot.

09:45 – 10:05 L5: Labia Minora Plasty Techniques: A Review
Bernard Stern, MD (20 min)
Background: Once uncommon and rarely asked for surgery, now enormous demand by women from all walks of life.
Methods: Sculpted linear resection, deepitheliazation, Modified V-wedge, and Z-plasty techniques.
Results: "Satisfied" cosmetic result initially 91.6%
Conclusions: The aesthetic and functional results achieved by these evolving and continuously refined techniques, are remarkable. The results are based on individual surgeons skills at "his" technique, not the technique itself!

"Colpoperineoplasty"

- Use 4-0, 5-0, 6-0 sutures

13:55 – 14:10 L15: Surgical Management of the Camel Toe
Red Alinsod, MD (15 Min)
A modification of a standard Vulvectomy, Labia Majora Plasty, is presented for the purpose of reducing the discomfort, sagging and looseness of the Labia Majora in an aesthetically pleasing and elegant manner. The first long term results of this technique is presented performed over seven years.

14:10 – 14:45 **Panel Q&A, Break & Exhibits**

14:45 – 14:55 L16: The Unified Approach to Labiaplasty: Minora/Majora/Hood Combined Surgery
Red Alinsod, MD (10 Min)
An advanced technique is presented that combines labiaplasty of the minora, majora, and clitoral hood as a unified whole. This radical labiaplasty technique allows for one single layered closure per side. This technique is used in a select subset of patients who request maximum comfort and elimination of the labia minora. (video presentation)

14:55 - 15:10 L17: Herpes Outbreaks Complicating Aesthetic Vaginal Procedures
Bernard Stern, MD (15 Min)
Although herpetic outbreaks have been well documented in Cosmetic Surgery literature (almost exclusively though in relation to cosmetic facial procedures mostly laser and/or TCA peals), there is nothing in Aesthetic Vaginal Surgery literature addressing this problem. Preventive pre/intra/and post operative treatment with Acyclovir or Valtrex has become commonplace for these procedures. Having had 3 outbreaks in the previous year's cosmetic vaginal procedures, no patient of which admitted to previous exposure to the virus, one with a significant sequellae, preventive prophylactic treatment is now being suggested.

15:10 – 15:25 L18: Medical Photography and Videography for Idiots
Red Alinsod, MD (15 Min)
A medical practice is often judged by the quality of its photographs. It is imperative in a cosmetic practice to know how to take advantage of today's technologies in photography. Medical photography can be low cost and simple when basic tenets are followed. Medical photography can be used for medical documentation, medico-legal protection, marketing, advertising, staff training, and patient education. This presentation focuses on the typical types of photography done for an aesthetic vaginal surgery practice.

If ZP patient doesn't allow pre-op photo, politely ask her to see another surgeon.

If for short zoom, need these lens:
- 24-70 mm or longer
- Macro [100 mm F2.8 for close ups] lens

III Positions for pre-op + post-op photos.
- Sides (45°, 90°, 180°)
- Front lying in stirrups
- Patient view from above looking downward
- Front view standing.
- Rear view standing
- Rear view on hands & knees
- Rear view lying on abdomen
- Make sure patients understands these poses

Alinsod's course cost?
VS
Goodman's course cost?

15:25 – 15:50 L19: Relations
Subtlety (25 M
Monique Ram
It's not about the tools it's abo
will cover the elements of a
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Google+, Pinterest, Twitter,
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15:50 – 16:05 L20: Searc
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18:30 – 22:00 **Welco**
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FACULTY LISTING

RED M. ALINSOD, MD, FACOG, ACGE LAGUNA BEACH, CA
South Coast Urogynecology and The Laguna Laser Center
31852 Coast Hwy, Suite 203, Laguna Beach, California 92651
Phone: (949) 499-5311 Fax: (949) 499-5312
Email: red@urogyn.org
Website: www.urogyn.org, www.pelvicsurgeon.com

Dr. Alinsod graduated from Loma Linda University School of Medicine in 1986 and completed his OB/GYN residence from Loma Linda University Medical Center in 1990. His focus is in pelvic and vaginal surgery. He was the first Rutledge Fellow at MD Anderson Cancer and Tumor Institute and was also accepted to Yale's Gynecologic Oncology fellowship. While heading the Gynecological Services at George Air Force Base, California, and Nellis Air Force Base, Nevada. Dr. Alinsod concentrated on benign gynecology, urogynecology and pelvic surgery. During his 12-year military career, he trained extensively in vaginal surgery, hysteroscopic, and advanced laparoscopic surgery. He became a fellow of The Accreditation Council of Gynecologic Endoscopy in 1995, Certificate #20, the first surgeon to achieve this distinction in Nevada. He is one of the first surgeons in the United States to perform and teach the "trans-obturator tape" incontinence sling, Anterior IVS sling, and Posterior IVS vaginal suspension. He has taught pelvic reconstructive surgery for various companies (AMS, BARD, Boston Scientific, Tyco, Caldera Medical, Coloplast/Mpathy Medical) over the past 15 years and knows of the products and technologies that relate to incontinence and pelvic reconstructive surgery, specifically mesh augmented repairs. Dr. Alinsod was the first surgeon to attach biologic and polypropylene mesh to the Posterior IVS device and use it for posterior compartment repair along with apical vault suspension now copied by many companies. He invented a vaginal approach to uterine suspension using standard sling material and mesh suspension kits in 1997. He owns several patents including the one for the Lone Star APS Retractor System and the "Sling with Bladder Support" from which came systems such as Perigee, Avaulta A, Prolift A, and Ascend A. Most recently, he was awarded the patent for a surgical stand and stray for pelvic/vaginal/colorectal/urologic surgery. Dr. Alinsod is the primary designer and inventor of Caldera Medical's Ascend Pelvic Floor Mesh device and also the designer of Coloplast/Mpathy Medical's shaped Restorelle Mesh. He is the inventor of the LoneStar APS Vaginal Retractor System, APS Draping System, Alinsod UroGyn Scissors/Pickups/Table, APS Balloon Catheter Pain Pump System, and Alinsod Labiaplasty Pain Catheters. Dr. Alinsod continues to be active in surgical teaching and product design and development as it relates to vaginal and pelvic surgery.

After a ten-year career in Los Angeles working for a very busy medium sized multi-specialty group, Dr. Alinsod decided to try a solo urogynecologic practice. In 2004, he was recruited by South Coast Medical Center in Laguna Beach, California, to develop the Women's Center and head up the Urogynecology services. Today, he is the director and owner of South Coast Urogynecology and the Alinsod Institute for Aesthetic Vaginal Surgery. He developed the first CME approved course in AVS and founded CAVS 7 years ago to educate surgeons on AVS, provide a medium for the exchange of ideas, and to protect the health of patients.

He is very active in presenting talks locally and nationally and in teaching physicians the art and science of incontinence/pelvic reconstructive surgery and aesthetic gynecology. He has presented talks in AVS for The American Academy of Cosmetic Surgeons, International Society of Cosmetogynecologists, National Society of Cosmetic Physicians, American Association of Gynecologic Laparoscopists, and he was the first Honorary Chairman of Brazil's aesthetic Gynecology Symposium, 2009. Recently, Red has presented his vaginal mesh clinical study at the IUGA meeting in Brisbane, WS-AUA in Hawaii and AUGS in Chicago. Before the year ends he will be presenting at AAGL in Las Vegas, in Warsaw, Poland and in China. He continues his world class teaching program in both pelvic reconstructive surgery and aesthetic vaginal surgery in Laguna Beach.

FACULTY LISTING

JUAN CARLOS DIAZCADENA, MD — PHOENIX, AZ

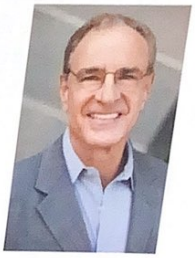
6036 N 19TH Ave, Ste 301, Phoenix, Arizona 85015
Phone: (602) 710-2040
Email: cdiazcadena@cox.net
Website:

Dr. Diazcadena graduated from Universidad Nueva Granada Military School of Medicine and Health sciences, Bogota Colombia in 1986. He completed his Family Practice residency at the University of Minnesota in 1995 and completed his OB/GYN residency at Good Samaritan Regional Medical Center in Phoenix, Arizona in 1998.

Dr. Diazcadena is a sole practitioner in Phoenix, AZ. He is currently the Department chair of OB/GYN for Phoenix Baptist Hospital and Director/President of Clinica Central, a non-profit organization directed to proving healthcare for uninsured women and women in need.

His caring and focus is on the individual's overall health and well-being. The goal of his practice is to provide the best and most current medical management on urogynecology with minimally invasive surgery including robotic surgery, pelvic reconstruction and cosmetic gynecology.

MICHAEL GOODMAN, MD, CMP, CCD — DAVIS, CA



"Caring For Women Wellness Center"
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Email: info@drmichaelgoodman.com
Website: www.drmichaelgoodman.com

Stanford University trained in obstetrics and gynecology, Dr. Michael Goodman began his practice in rural Mendocino County, California in 1972, where he was one of the early pioneers of Family-Centered Maternity Care. In the early 1980s his interest turned to the new area of advanced operative laparoscopy. He became one of the first credentialed Advanced Operative Laparoscopists, and taught, wrote, and lectured on the subject, as well as functioning as a peer reviewer for the Journal of the American Association of Gynecologic Laparoscopists (now called the Journal of Minimally Invasive Surgery.)

Beginning in the mid- '90s, Dr. Goodman developed an interest in integrative, menopausal and sexual medicine, as well as female genital plastic and cosmetic surgery. After moving to Davis, CA in 2000 he became certified as a Clinical Bone Densiometrist and Certified Menopause Practitioner. After additional training, he incorporated a long- time interest in Sexual Medicine into his practice. His present practice in Davis, California specializes in difficult gynecologic issues, peri-menopausal medicine, health and vitality enhancement, male and female sexuality issues, bone densiometry, pelvic ultrasound and vulvovaginal aesthetic surgery. He has been an invited guest at numerous seminars on these subjects, and has appeared as an invited guest many times on area network TV and talk radio. His six citations in peer-reviewed scientific literature on the subject of female genital plastic/cosmetic surgery are by far the most internationally of any researcher.

Dr. Goodman is the proud father of four children, ages 13 to 39, and enjoys exercising, tennis, gardening, music and writing. He is the author of two popular books on menopause, and many peer-reviewed articles on female genital plastic surgery, genital aesthetics and sexuality/body image, hormone therapy, advanced operative laparoscopy, and family-centered maternity care.

EXHIBIT E

EXHIBIT E

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT F

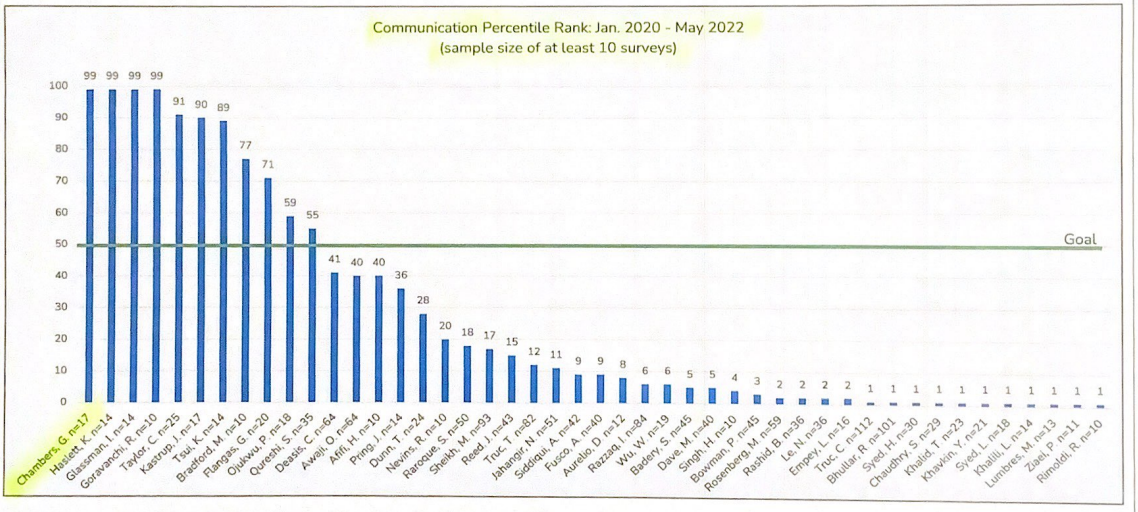
EXHIBIT F

Physician Communication

Patients are asked three questions about their physicians' communication on the HCAHPS survey

1. How often did doctors **explain** things in a way you could **understand**?
2. " " " " **listen carefully** to you?
3. " " " " treat you with **courtesy and respect?**

Press Ganey compares raw scores to generate a national percentile ranking, seen below



Behaviors that improve communication with patients

- Use layman's terms
- Use the whiteboard
- Sit while speaking with patients
- Round with the nurse
- Eliminate medical jargon
- Ask patient to teach-back instructions
- Reflective listening
- Use simple explanations
- Demonstrate empathy
- Give patients your business card
- Explain information multiple times

SPRING VALLEY HOSPITAL MEDICAL CENTER

Chambers 024

EXHIBIT G

EXHIBIT G

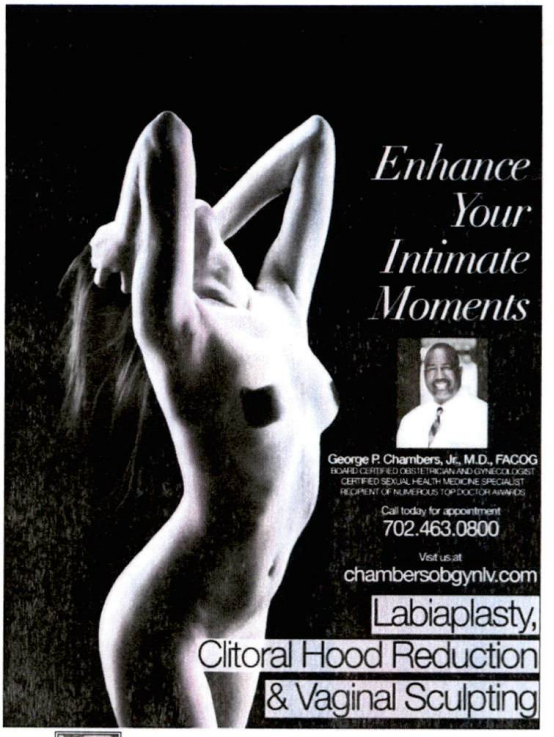

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EXHIBIT I

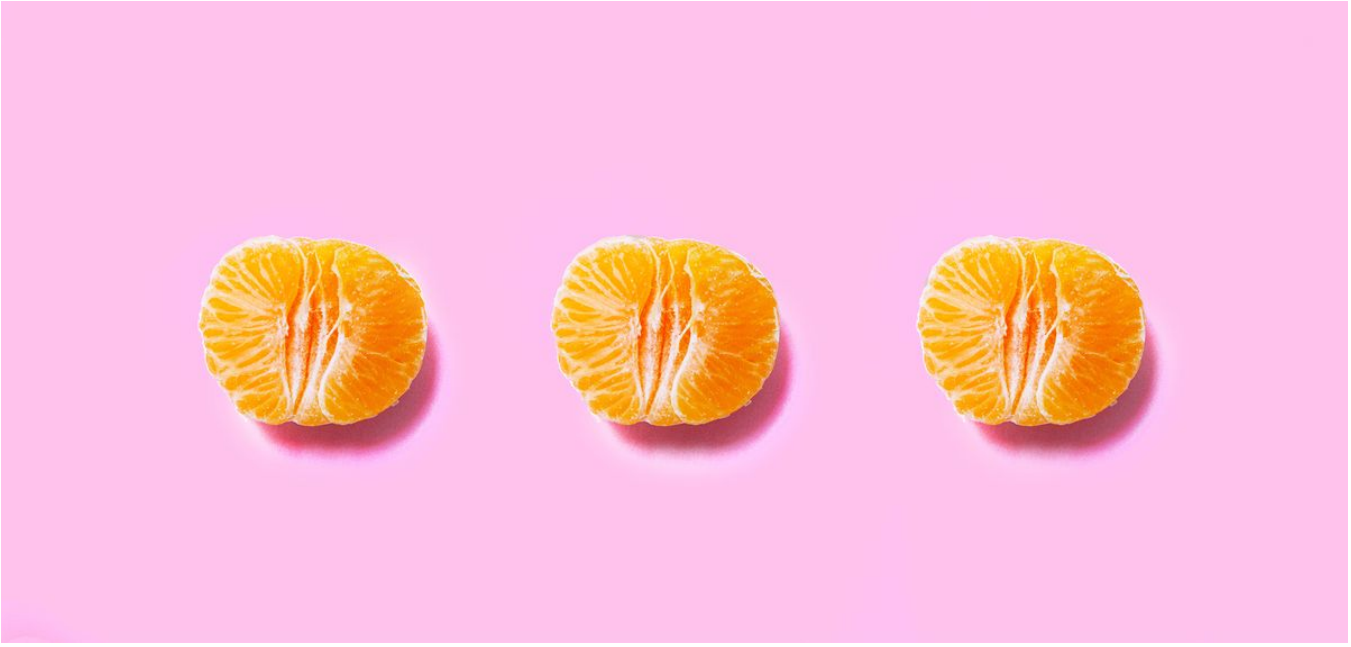
EXHIBIT I

Health

What Exactly Is A Designer Vagina? What To Know About Labiaplasty

Basically, it's a surgical vulva makeover.

BY **MARA SANTILLI** PUBLISHED: FEB 15, 2020



GETTY IMAGES

If celebs have taught us anything in recent years, it's that the vulva and vagina aren't off-limits when it comes to cosmetic treatments. From the Kardashian sisters' openness about getting laser vaginal rejuvenation to Sharon Osborne talking about her vaginal tightening procedure, it's clear that beautification treatments below the belt are becoming commonplace. And the trend is growing among non-celebrities too. In fact, when it comes to labiaplasty (aka "designer vagina" surgery, which involves altering the labia), there was a 53 percent increase in procedures from 2013 to 2018 in the U.S., according to the American Society for Aesthetic Plastic Surgery.

This growing trend might be due to an increase in awareness and conversation about vaginal health, suggests Juliana Hansen, MD, professor of surgery and division chief of plastic and reconstructive surgery at Oregon Health and Science University School of Medicine. “For many generations, vaginal health has been considered taboo, and procedures and options for care for female genitalia weren’t available,” Dr. Hansen says.

The number of labiaplasty procedures increased 53 percent in the U.S. between 2013 and 2018.

Regardless of the the exact reason behind the trend, vaginal health, and plastic surgery in and around the vaginal area, are getting more attention than ever before. Here, everything you need to know about labiaplasty and other common vaginal cosmetic procedures.

MORE FROM WOMEN'S HEALTH
Everything to Know About Your Menstrual Cycle

What is labiaplasty?

WATCH: Everything to Know About Your Menstrual Cycle

Labiaplasty is mostly an aesthetic procedure, but it could also be functional (more on the reasons women have it done below). In most cases, the surgery alters the labia minora, or the inner lips of the vagina, Dr. Hansen explains, but it could be tailored to alter the labia majora, or outer lips, as well. Basically, the plastic surgeon shortens the labia to remove excess tissue, which might be bothering the patient for aesthetic or functional reasons, e.g., it gets in the way during sex or exercise.

Labiaplasty is different from a vaginoplasty, which is a surgical procedure for vaginal tightening, Dr. Hansen explains. Certain patients may have this done because of pelvic-floor issues, such as incontinence, after multiple childbirths, she says. But, it's also often done to help increase vaginal tightness for sexual pleasure purposes. However, "there is not a ton of evidence that [vaginoplasty] procedures work well," Dr. Hansen says, "and there may be potential for causing chronic pain and harm."

Labiaplasty involves shortening the labia to remove excess tissue, which might be bothering someone due to aesthetic or functional reasons.

There are also non-surgical vaginal rejuvenation treatments, which fall into the "designer vagina" trend but are totally different than labiaplasty. “These include lasers to stimulate the mucosa, or inner lining, of the vagina, and LED light treatments that supposedly stimulate the vagina to produce more tissue,” Dr. Hansen says. However, she warns that most of these treatments are not FDA-approved or scientifically proven to increase vaginal tightness or reduce dryness.

Surgeries for transgender women are generally completely separate from labiaplasty procedures and vaginal rejuvenation procedures as well. Gender confirmation surgeries often involve creating a vulva for a male-to-female transgender patient, but typically the new vulva then needs to be dilated and stretched to function properly, Dr. Hansen says—which is

labiaplasty procedures.

Why would someone get a labiaplasty?

There are a few reasons for undergoing a labiaplasty procedure, but most of them involve aesthetics as opposed to medical necessity:

- **Dissatisfaction with the labia’s appearance**: This is the number-one reason women tend to have labiaplasty done. They might experience embarrassment or lack of confidence in how their labia look, especially during sex. In many women, the labia minora hang lower—which is completely normal!—but doesn't match the very narrow beauty standards women see in media, Dr. Hansen says.
- **Discomfort with long labia:** Having larger or longer labia could actually cause functional problems for some patients. This could include discomfort riding a bike or wearing underwear or a thong, or excess moisture coming from the vagina.
- **Pain during sex:** Dissatisfaction with the appearance of the labia may affect a patient’s confidence in the bedroom—but having enlarged or longer labia could also get in the way during sex, potentially causing a painful, or at the very least, uncomfortable experience. “Just by reducing the size of the labia, sexual function might be improved, if anything, because you’re not as worried about the tissue getting pulled or stretched during intercourse,” Dr. Hansen says.
- **Cancers or pre-cancerous conditions:** One medical reason for a labia reconstruction might involve having to remove part of the labia that contains cancer cells in the vaginal area. “Cancers or pre-cancerous conditions that can grow there might require excisions,” Dr. Hansen says.

What are the risks of labiaplasty?

Like any medical procedure, labiaplasty doesn't come 100 percent risk-free. Possible complications include wound separation and scarring. Some researchers have also raised concerns about possible loss of sexual

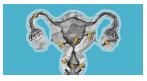
sensation as a result of labiaplasty, as well as an increased risk of trauma to the perineal area during vaginal delivery, though all of these risks need to be researched further.

What are the steps of a labiaplasty procedure?

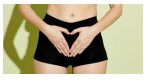
Getting labiaplasty starts with a consultation with a plastic surgeon. This is a discussion of what the problem with the vulva is, pre-operation. The doctor has to see the same issue that the patient sees with their labia, says Dr. Hansen. If there isn't a good surgical solution, which would involve shortening or reconstructing the labia, then the surgeon won't recommend surgery to the patient, Dr. Hansen notes.

The procedure itself is always surgical, but it can be done in-office, under local anesthesia in a clinic, or can be done under general anesthesia in a hospital, Dr. Hansen says. During the operation, the surgeon will reduce the size and length of the labia minora, and make a stitch line. It takes some time to heal, so she recommends two to three weeks of resting and icing the area, and keeping it clean.

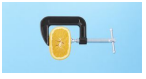
RELATED STORIES



'I Had Vaginal Reconstruction Surgery'



12 Reasons Your Vagina Hurts So Damn Much



Can Your Vagina Be Too Tight For Sex?

"We also recommend that patients avoid activities that will traumatize or stretch out the stitch line for about six weeks to three months," Dr. Hansen says (so it might involve getting creative with your typical sexual activity).

Patients tend to agree that the surgery goes quickly (it typically only takes about an hour), but the healing process is long. "Post operation was

extremely painful, as I expected. I took a lot of pain medicine and avoiding being on my feet at all costs for at least a week. It hurt badly when I walked for about seven days, and I felt a burning pain which was worse during urination," wrote one patient in a review of her experience with the procedure at Labiaplasty Boston in Boston, Massachusetts. "You should make sure you have at least a week off if you plan on getting this done. However, this procedure was well worth the pain."

(You can check out real before-and-after images from the Labiaplasty Center of NYC here—but, warning, they are *NSFW.*)

How much does labiaplasty cost?

These are typically considered elective cosmetic surgeries, Dr. Hansen says, so it would be difficult to get it covered by any insurance company, even if you could argue that the procedure might be medically beneficial (such as in the case of pain during sex or reconstruction after the removal of cancerous cells).

Are labiaplasty procedures off-limits for anyone?

Generally speaking, if the surgeon doesn't see a valid reason for performing labiaplasty on a patient, they won't. Other than that, patients who have other medical conditions, especially those that might affect healing, would not be good candidates, Dr. Hansen says. If you have other medical conditions, it's best to consult your primary care physician first before seeing a plastic surgeon.

Also, the procedure is a no-go for pregnant women, because giving birth would affect healing. "A natural childbirth would impact that area, and women might tear their stitch line or need an episiotomy after birth," Dr. Hansen says, so most surgeons would never recommend that.

The bottom line: Labiaplasty may help if you feel that your labia are interfere with your ability to function sexually or cause pain or discomfort. But keep in mind that it's normal for vulvas and vaginas to come in all shapes and sizes—so only take the medical risk if *you* want to.

MARA SANTILLI

Mara is a freelance writer and editor specializing in culture, politics, wellness, and the intersection between them, whose print and digital work has appeared in Marie Claire, Women's Health, Cosmopolitan, Airbnb Mag, Prevention, and more. She's a Fordham

University graduate who also has a degree in Italian Studies, so naturally she's always daydreaming about focaccia.

EXHIBIT J

EXHIBIT J

Guidelines for the Standardization of Genital Photography

Natalie R Joumblat, BS, Jimmy Chim, MD, Priscila Gisselle Aguirre Sanchez, MD, Edgar Bedolla, MD, Christopher J Salgado, MD

Special Topic

Guidelines for the Standardization of Genital Photography

Aesthetic Surgery Journal
2018, Vol 38(10) 1124–1130

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Natalie R. Joumblat, BS; Jimmy Chim, MD; Priscila Gisselle Aguirre Sanchez, MD; Edgar Bedolla, MD; and Christopher J. Salgado, MD

Abstract

Plastic surgery relies on photography for both clinical practice and research. The Photographic Standards in Plastic Surgery laid the foundation for standardized photography in plastic surgery. Despite these advancements, the current literature lacks guidelines for genital photography, thus resulting in a discordance of documentation. The authors propose photographic standards for the male and female genitalia to establish homogeneity in which information can be accurately exchanged. All medical photographs include a sky-blue background, proper lighting, removal of distractors, consistent camera framing, and standard camera angles. We propose the following guidelines to standardize genital photography. In the anterior upright position, feet are shoulder-width apart, and arms are placed posteriorly. The frame is bounded superiorly by the xiphoid-umbilicus midpoint and inferiorly by the patella. For circumferential documentation, frontal 180 degree capture via 45 degree intervals is often sufficient. Images in standard lithotomy position should be captured at both parallel and 45 degrees above the horizontal. Images of the phallus should include both the flaccid and erect states. Despite the increasing incidence of genital procedures, there lacks a standardized methodology in which to document the genitalia, resulting in a substantial heterogeneity in the current literature. Our standardized techniques for genital photography set forth to establish a uniform language that promotes more effective communication with both the patient as well as with colleagues. The proposed photography guidelines provide optimal visualization and standard documentation of the genitalia, allowing for accurate education, meaningful collaborations, and advancement in genital surgery.

Editorial Decision date: January 15, 2018; online publish-ahead-of-print February 6, 2018.

In medicine, photography enables objective analysis of results by using validated scoring methods based on visual assessments. Especially in plastic surgery, a visually oriented specialty, photography plays an extremely important role in both clinical practice and research.[1] Clinically, photographs are used for preoperative planning, intraoperative visual referencing, postoperative documenting, and assessing surgical outcome.[1-3] In addition, photographs can be utilized in patient education to clearly communicate the surgical plan as well as provide pre- and postoperative comparisons.[2] In research, photography is used in presentations and publications to demonstrate an objective analysis of applied techniques and outcomes.[1,2] From a legal standpoint, photography should be an integral part of the patient's record as it could support the defense of the surgeon in the event of litigation.[2]

From the Division of Plastic, Reconstructive, Aesthetic and Transgender Surgery, University of Miami Hospital, University of Miami Miller School of Medicine, Miami, FL

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Consistency is crucial in medical photography. Standardized photography reduces variables that can produce false postoperative comparisons as well as provides reliable reproducibility for valid photographic results in academic research.[1] Studies show that minor deviations from accepted standards decreases the clinical value of the photography, thus reducing its validity in medicolegal litigation, surgical planning, and communication amongst surgeons.[2,4-6]

In order to ensure accurate comparisons amongst colleagues, the American Society of Plastic Surgeons and the Plastic Surgery Educational Foundation issued Photographic Standards in Plastic Surgery[7] in 1991. This publication standardized photography of the face, ears, mouth, breasts, abdomen, hips/thighs, calves/feet, forearm, hands, and fingers.[6,7] Despite the increasing incidence of genital procedures, there is a paucity of literature that establishes photographic standards for the genitalia. We utilize our experience in genital surgery and photography to propose standard techniques that best capture the genital anatomy in a uniform manner.

GENERAL TECHNIQUES FOR PHOTOGRAPHIC STANDARDIZATION

The following generic guidelines, applicable to all medical photography, are based on review of the medical literature in addition to our own personal experience. The proposed criteria include uniform background, lighting, camera positioning, patient preparation and positioning, and photo editing.[1,3,8]

Photography Background

The standard background color in medical photography is sky blue, converted to 18% gray Kodak standard in grayscale, because it is a medium tone that contrasts with most skin colors.[9] Most camera meters are calibrated to make everything medium toned, thus having a medium toned background to lock in an exposure reading that produces color tones closest to reality. By the same token, if the camera is metered to a background lighter than sky blue, the photo will be darker, and the converse holds true as well.[9] In the clinic, this can be achieved through a handheld drape, a window shade, a roll of seamless backdrop paper, or a painted wall.[10] In the operating room, sterile blue towels may be used.[9]

Photographic Lighting

In a studio setting, optimal illumination may be achieved by placing two lights anterior, one light posterior, and one light superior of the patient being photographed.[8,11] The two anterior lights are best placed 90° apart so that each lamp is 45° with respect to the patient, one on the left side, and the other on the right.[8,11] The posterior light is best placed 30 to 60 cm from the background to minimize shadows being cast onto the background.[8,11] Strub et al described a similar symmetric multilight source positioning, but found it inferior to asymmetric lighting when photographing the nose.[12] Asymmetric lighting increases contrast and shadowing, thus enhancing 3-dimensionality and detail rendition, both important in surgical planning of rhinoplasties.[12] In genital photography, symmetric lighting is preferred, as it minimizes the shadows casted on the patient and thus reduces its distorting effect on the patient's form.[11] When selecting the light source's bulb, color temperature must be considered. "Cold" light (≥6000 K) is preferred to "warm" light (≤3500 K), as it does not produce a soft yellow glow that "warm" light does, but rather a blueish-white quality, equivalent to the high noon sun, that produces the best representation of true color.[11,13] In the clinic and in the operating room, frontal lamps in optimal positioning can be impractical. When relying on a camera's flash for lighting, special attention should be paid to positioning the camera parallel to the area of interest in order to minimize shadows.[6,11] In the operating room (OR), we turn away the adjustable lights for two reasons. First, OR lights can vary in color temperature, distance, and angle, which can alter the color, magnification, and shadowing of the subject Second, modern sensors are unable to detect the difference in intensity between the OR and ambient lighting. The camera's automatic settings have shown to produce the truest color in the setting of mixed lighting.[1]

Camera Positioning

To standardize magnification, the lens should be kept at a constant level and distance from the patient. When positioning the camera, anatomic landmarks and a tripod may assist with consistent distances and angles.[8,10,11] The camera should be placed at the height of the desired anatomic region and placed at a distance where the appropriate bounds and magnification are achieved, thus avoiding the need for zoom.[11] When possible, zoom should be avoided as it may distort the patient to look wider and adds another variable to the operator, making consistency more difficult to achieve. In cases where desired magnification cannot be accomplished mechanically, zoom may be utilized, but when doing so, the subject at hand must remain in the frame's center in order to preserve the photograph's focal point.[11] When photographing an area 8 cm or less, place a ruler in at least one of the photographs to provide a frame of reference for true size.[11]

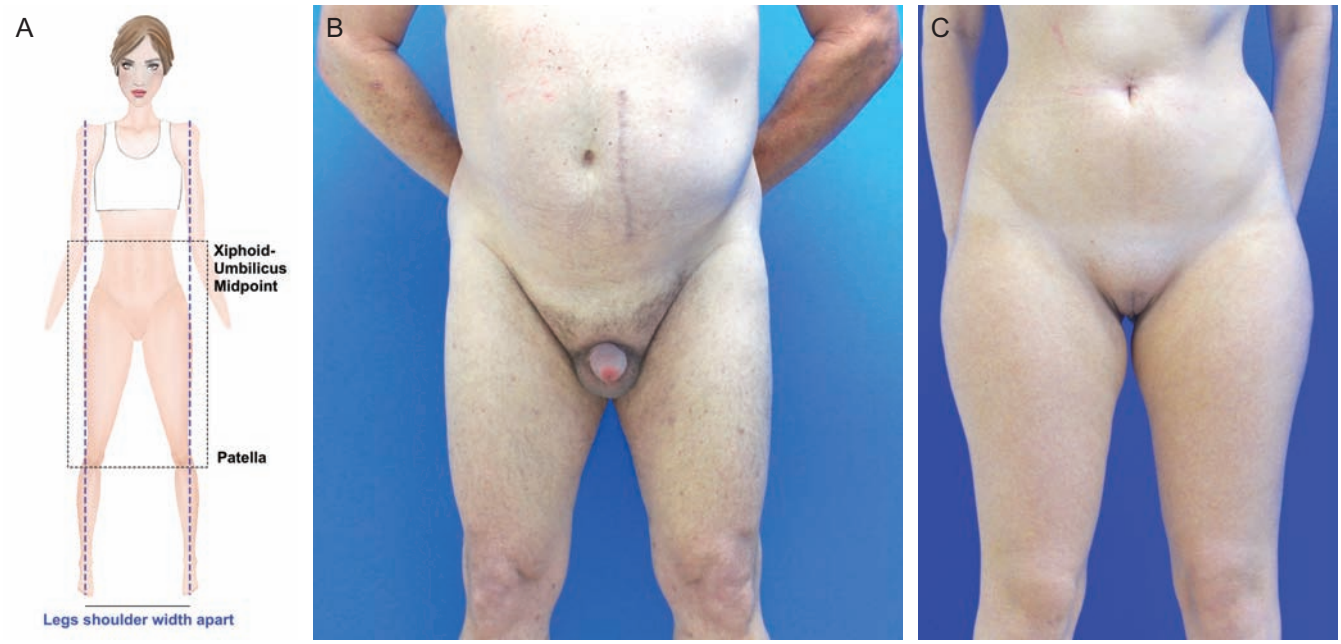

Figure 1. (A) Schematic illustration of a patient standing with legs shoulder width apart and the bounds for framing when taking a photograph of a patient's genitalia in the antero-posterior (AP) view (courtesy of Priscila Sanchez, MD). (B) AP standardized view of a 53-year-old man's external genitalia with a diagnosis of a hidden penis. (C) AP standardized view of a 26-year-old woman's external genitalia who presents with lichen sclerosis (not visible in this view).

Patient Preparation and Positioning

In medical photography, unobscured visualization of the area of interest is achieved through eliminating distractors, including the patient's clothing, gown, undergarments, jewelry, glasses, piercings, and makeup.[3,7,8,10,11] Position the patient approximately 3 feet in front of the background to minimalize distracting shadows.[14] At this position, the patient will angle themselves to assume the 5 standard views: one AP (0°), two oblique (±45°), and two lateral (±90°).

Photo Editing

If photographs are not standardized at the time of capture, editing software may be utilized to zoom and crop in order to uniformize magnification, allowing for more accurate side-by-side comparisons.[9,11] While photo editing is a useful tool, anytime an image is digitally manipulated, the authenticity is compromised. Thus, the photographic techniques describe should not be replaced by postproduction editing, and the attention to detail should be placed at the time of capture.[11]

SPECIFIC TECHNIQUES FOR PHOTOGRAPHIC STANDARDIZATION OF THE GENITALIA

With the senior author's extensive experience in performing and documenting varied genital procedures, we propose the following guidelines to standardize genital photography (C.J.S.). For the anterior-posterior image, we found that an upright standing position with the feet at shoulder-width apart is a readily acquired position for most patients in the clinical setting (Figure 1). This allows not only expeditious acquisition of the standard position, but also adequate and natural spacing between the lower extremities, thus permitting evaluation of the genital appearance in situ. Framing of the patient is somewhat arbitrary, and the authors found that the image should at least capture the xiphoid-umbilicus midpoint superiorly and the entire patella inferiorly. For the remarkably endowed male genitalia, adjustments in the framing may be made at the clinician's discretion. The lens should be positioned in level with the mons to allow for direct focus of the genital region in relation to the abdomen and lower extremities.

Arm positioning has little effect on the positioning of the genitalia, but the upper extremities can impede visualization, especially in the lateral views. The authors recommend that the patient's arms and hands hang slightly posteriorly at the sides to allow for complete capture of protuberant or retracted genitalia (Figure 2). In the female patient, lateral and oblique views do not typically reveal useful information and the anterior upright and lithotomy views suffice in most instances. A unilateral upper extremity should be utilized for retraction to capture ventral views of the penis and visualization of the scrotum.

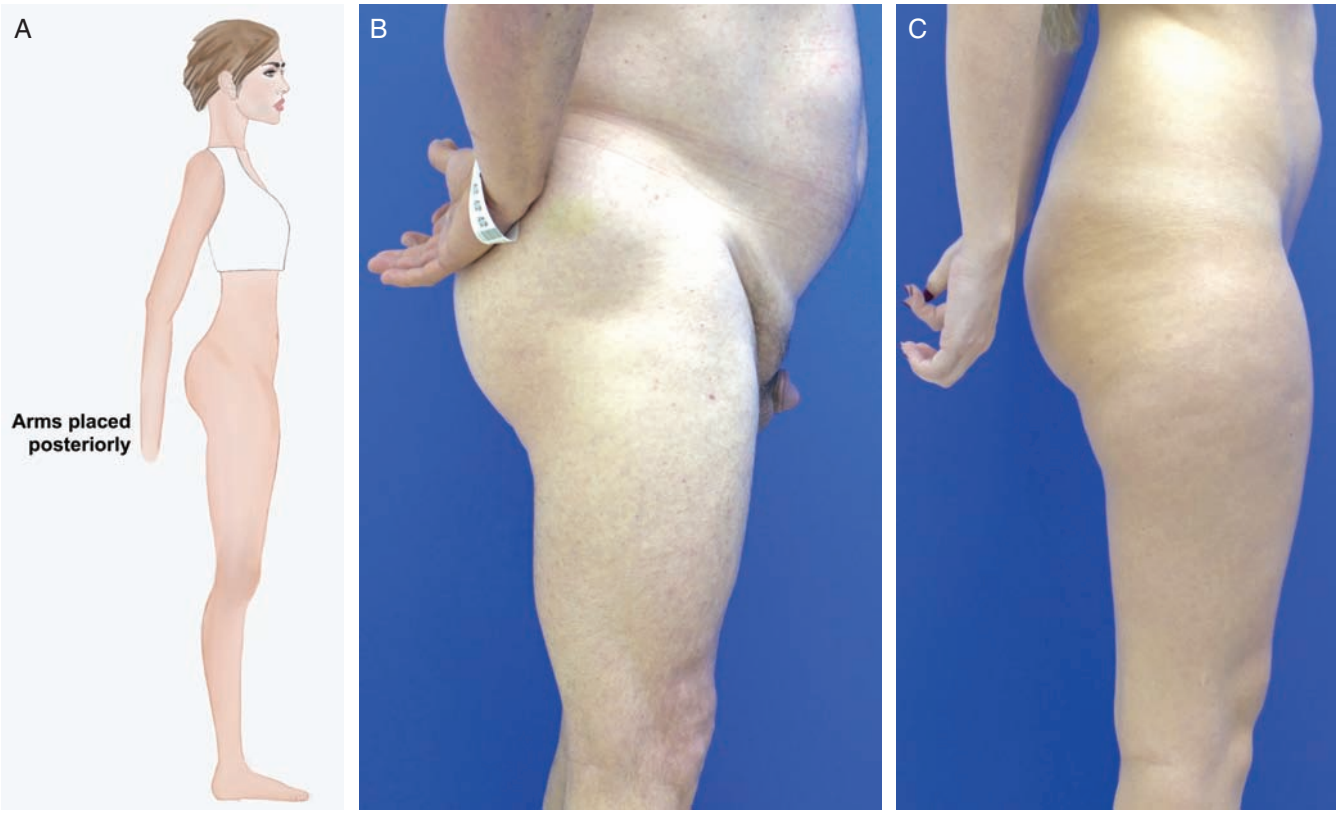

Figure 2. (A) Schematic illustration of a patient standing with arms placed posteriorly in the lateral view (courtesy of Priscila Sanchez, MD). (B) Lateral view of a 53-year-old man's external genitalia with arms placed posteriorly. (C) Lateral view of a 26-year-old woman's external genitalia with arms placed posteriorly.

In regards to differing angles of imaging, we found that frontal 180 degree capture via 45 degree intervals is often sufficient (Figure 3). Circumferential documentation can be utilized as well if further body contouring procedures are being considered. Thus 5 images should be documented for the frontal 180 degree photographs and 8 images would result from a full 360-degree circumferential series.

Lithotomy views were also found to be critical in the documentation of genital photography. These views assist in examination, objective diagnosis, and operative planning. To achieve standard lithotomy position in the clinic and in the operating room, the hips should be flexed 80 to 100° from the torso with the thighs abducted approximately 30 to 40° from the midline (Figure 4). Stirrups should support the legs at a position roughly parallel to the trunk.[15] OR lighting, as previously mentioned, is limited. Turning off the adjustable overhead lights and positioning the camera parallel to the genital's plane is simplest technique for easily reproducible, least distorted photographs in the setting of minimal equipment. For framing, the horizontal axis should include midthigh, and the vertical axis should include the entire genitalia and inferior border of the buttocks.

We found that that the genital images should be captured on a level parallel and in line with trunk as well as 45 degrees above the horizontal axis. These 2 views allow for evaluation of the mons, clitoris, clitoral hood, and labial tissues in females, and the ventral penis and scrotum in males. Retraction of specific anatomic regions of the genitalia or the surrounding skin is often necessary by the patient or the clinician to expose key aspects of the exam. In the female patient, retraction of the clitoral hood and labial tissues exposes key aspects including the introital characteristics, labial length, interstices, and genital wounds/scars. In cases of labia minora hypertrophy, it is important to document the length of the labia minora from base to distal edge, to facilitate acquisition of insurance coverage for the operation. In the male patient, retraction of the foreskin and elevation of the scrotal skin exposes the glans penis and perineal region, respectively. Photography of the male phallus should be done in both the flaccid and erect state. In the office, the erect length can be approximated by applying outward traction to the penis and measuring from the phallus base to the most distal tip of the glans.[16] Otherwise, we accept the patient providing photographic documentation of their truly erect penis obtained in the privacy of their own home. The latter

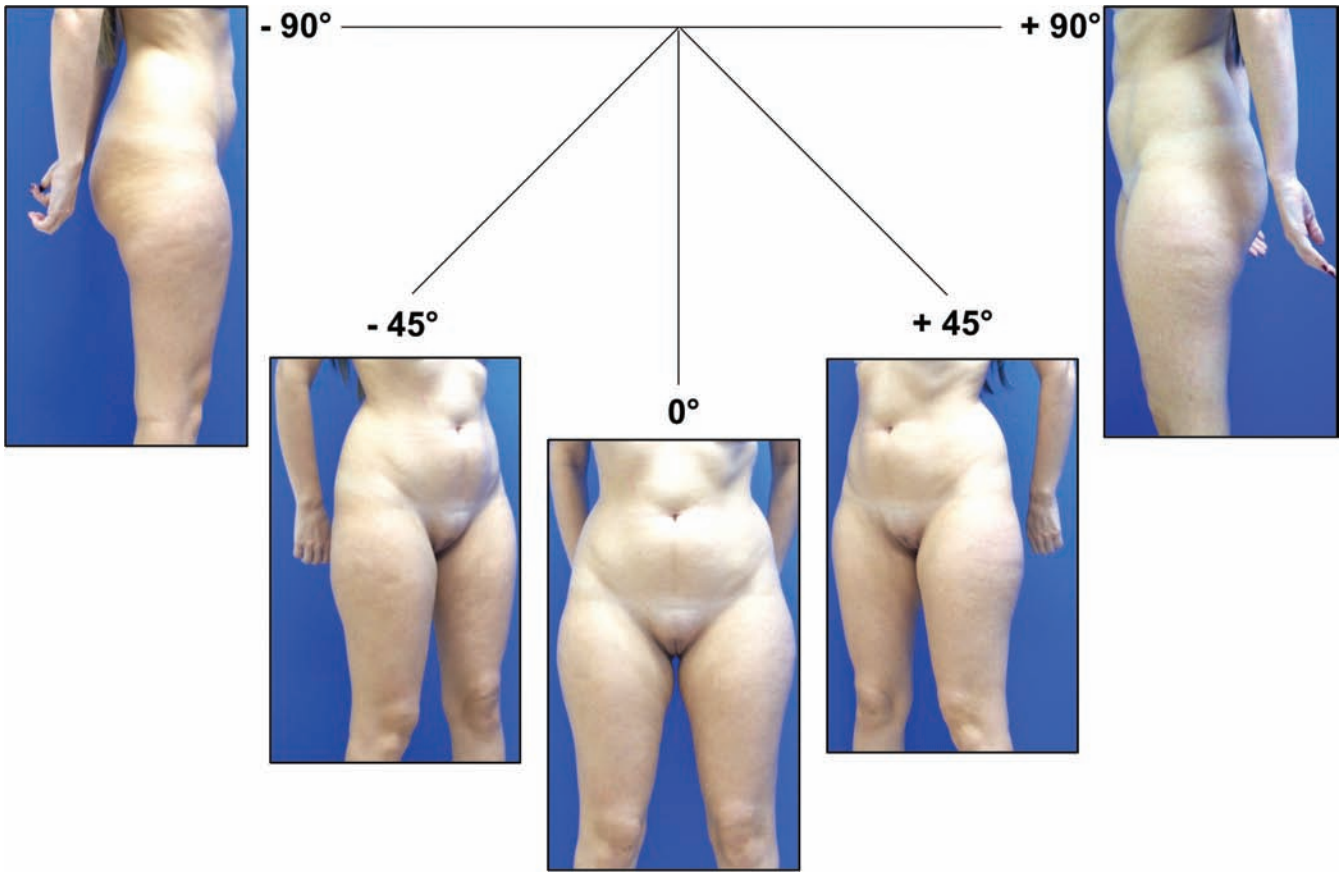

Figure 3. A 26-year-old woman positioned at −90°, −45°, 0°, +45°, and +90° (courtesy of Natalie Joumblat).

may prove more useful in circumstances where the phallus appears as a micropenis in the flaccid state, and only in the truly erect state does it become of normal length (5.5 to 6 inches), in addition to Peyronie's disease evaluation.

In cases of excessive body and genital hair we ask our patients to depilate these areas. Often, abundant hair not only conceals potential pathology, but obscures a clear view of the genital anatomy, thus compromising the operative plan.

DISCUSSION

Surgery of the genitalia, especially aesthetic procedures, has grown exponentially since the early 2000s, with some of the most popular procedures including the labiaplasty, vaginal rejuvenation, labia majora resection, mons lift, clitoral hood reduction, and volume augmentation of the mons pubis and labia majora.[17] According to the American Society for Aesthetic Plastic Surgery's Cosmetic Surgery National Data Bank Statistics, vaginal rejuvenation procedures increased by 12.5% between 2007[18] and 2013,[19] and labiaplasty procedures increased by 43% between 2014[20] and 2016.[21] Despite the increasing incidence of genital procedures, the current literature does not include any clear guidelines for photography of the male and female genitalia.[7,15] As a consequence, genital photography is substantially varying, as evidenced in peer-reviewed literature as well as national and international meetings.

With a busy practice caring for patients with aesthetic and functional problems of the genitalia, the authors believe that genital photographic standards are vital in communication with both the patient as well as with colleagues. Uniformity in pre- and postoperative photography minimizes distractors and allows surgeons to more effectively educate the patient on their surgical outcomes.[22] Reproducible guidelines enable surgeons to standardize genital photography, thus generating a homogenous language in which meaningful comparisons can be made, multicenter studies performed, and further advancement in genital surgery achieved.

CONCLUSION

The proposed photography guidelines provide optimal visualization and standard documentation of the genitalia, allowing for accurate education, meaningful collaborations, and advancement in genital surgery.

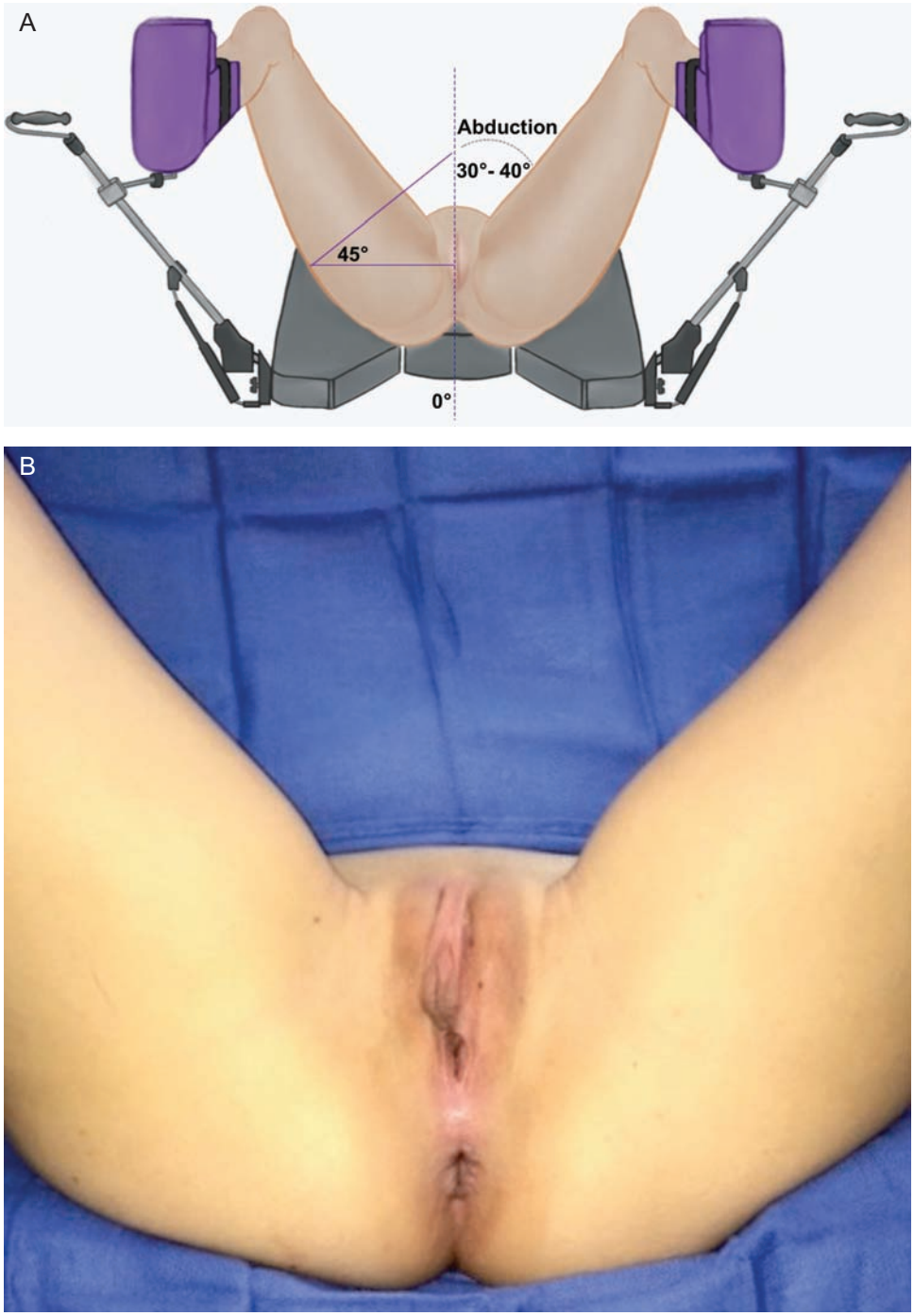

Figure 4. (A) Schematic illustration of a patient in standard lithotomy position (courtesy of Priscila Sanchez, MD). Hips are flexed 80 to 100°. Thighs are abducted 30 to 40° from midline. Capture images at 0° and 45° above the horizontal axis. (B) A 32-year-old woman in standard lithotomy position captured in the operating room with surgical blue towels as the background. Hips are flexed at 90° and legs are abducted 40° from the midline. Image is captured at 0° from the horizontal axis, an additional image should be captured at 45° above the horizontal (not shown).

Disclosures

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Female Genital Plastic and Cosmetic Surgery Goodman

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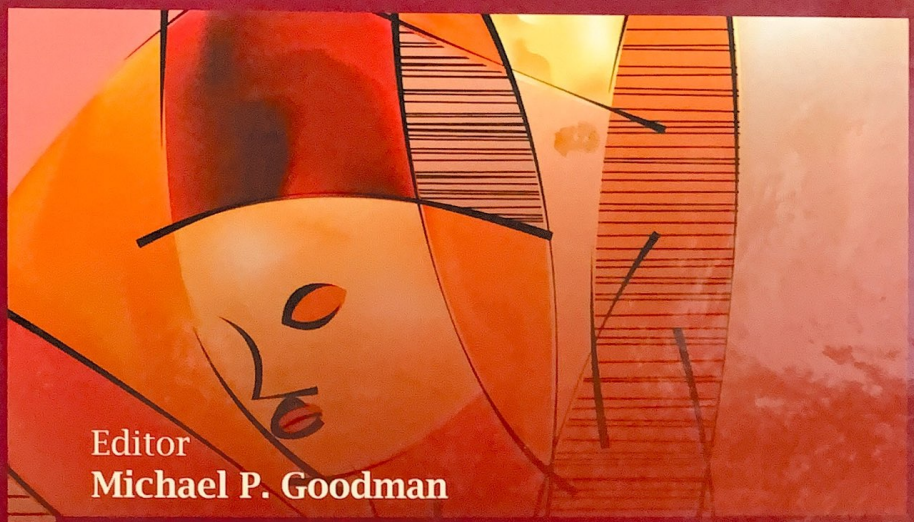

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- outcome statistics
- sexual issues
- patient selection
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Michael P Goodman, MD, FACOG, Medical Director, Caring For Women Wellness Center, Davis, CA, USA.

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Female Genital Plastic and Cosmetic

Female Genital Plastic and Cosmetic Surgery

EDITED BY

Michael P. Goodman MD, FACOG, AAACS, IF, NCMP, CCD
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Contents

CHAPTER 1
Introduction

Michael P. Goodman
Caring for Women Wellness Center, Davis, CA, USA

The time is the time. After the time is sometimes the time. Before the time is never the time.
Francois Sagan

Female genital plastic/cosmetic surgery (FGPS), aka female cosmetic genital surgery (FCGS), vulvovaginal aesthetic surgery (VVAS), aesthetic (vulvo)vaginal surgery (AVS), or cosmeto-plastic gynecology (CPG), has mounted the stage of twentieth-century cosmesis. Adding in the promise of improvement in sexual function makes for an intriguing debut.

As this elective plastic/cosmetic surgical discipline, like many novel surgical and medical disciplines, traces its genesis to a community rather than academic setting, the succession of different but related names have mirrored the semantic directions of individuals and subspecialty organizations. Although any of the terms noted above will do, for the purposes of this textbook the quite descriptive term FGPS will be utilized.

As women become more comfortable with the idea of elective procedures on their faces, breasts, skin, and so forth designed to enhance their appearance and self-confidence, it is not surprising that they may wish to alter, change, "rejuvenate," or reconstruct even more intimate areas of their bodies [1].

Although surgeons for years have unofficially performed surgical procedures resulting in alterations in genital size, appearance, and function (labial size alteration, perineorrhaphy, anterior/posterior colporrhaphy, intersex and transsexual surgical procedures, and alterations on children and adolescents for benign enlargements of the labia minora), Honore and O'Hara in 1978 [2], Hodgekinson and Hait in 1984 [3], and Chavis, LaFeria, and Niccolini in 1989 [4] were the first to discuss genital surgical alterations performed on adults for purely aesthetic reasons. While there are at present no accurate and ongoing published statistics from either the American Society of Plastic Surgeons, American Academy of Cosmetic Surgeons, or American College of Obstetricians and Gynecologists, it has become apparent in the lay press that aesthetic surgery of the vulva and vagina is gaining significantly in popularity. As far back as 2004, Dr. V. Leroy Young, chair of the emerging trends task force of the Arlington Heights, Illinois, American Society of Plastic Surgeons, commented in a personal communication that he felt that "labiaplasty and vaginal cosmetic surgery are the fastest growing emerging growth trend in cosmetic plastic surgery."

Aesthetic surgery of the vulva and vagina has heretofore not been officially described as such, nor "sanctioned" by specialty organizations, as they are community rather than university or academically driven. The operations themselves, however, are really not new; the only new thing is the concept that women may individually wish to alter their external genitalia for appearance or functional reasons, or tighten the vaginal barrel to enhance their sexual pleasure. However, since any surgery has potential for causing morbidity including pain and distress (both physical and psychological) if not performed properly, and especially since FGPS involves concepts and procedures that are not yet fully researched

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nor understood, guidelines for training, surgical technique, and patient selection should be discussed.

This textbook will give an overview of the most commonly performed procedures: labiaplasty of the minora and majora (LP-m; LP-M), size reduction of redundant clitoral hood epithelium (RCH), clitoral hood exposure for symptomatic phimosis (RCH-p), perineoplasty (PP), vaginoplasty (VP), colpoperineoplasty (CP; a combination of VP and PP), and hymenoplasty (HP), and will discuss rationale for surgery, ethical issues, patient expectations, patient selection and patient protection, complications, training issues, psychosexual issues, the procedures themselves, and all presently available outcome data. "Vaginal rejuvenation" (VRJ), a slippery and colloquial—although frequently used—term used to mean elective VP, PP, and/or CP (and for some, even LP) will be discussed.

First performed by community gynecologists or plastic surgeons in response to occasional patient requests in the mid-/late 1990s and early 2000s, by the mid-2000s the alternative of surgical alteration or reconstruction for "enlarged" labia/clitoral hood, and vaginal operations geared primarily to a goal of tightening for reasons of enhancement of sexual satisfaction, became more widely available and a subject of comment, blog, search, and consultation.

Although certainly the vulva and vagina are areas under the purview of gynecology and gynecologic training, *virtually no training* is offered in OB/GYN residencies in plastic technique, cosmetic labiaplasty, or pelvic floor surgery designed specifically for enhancement of female sexual pleasure (see Chapter 21). With the subject adequately addressed by only a portion of plastic surgery residencies (and in these, usually LP/RCH only), an individual patient finds herself on her own when endeavoring to navigate a path to successful reconstruction. With little guidance from specialty or regulatory agencies, "caveat emptor" became the rule, and un- or undertrained surgeons began performing these plastic procedures, frequently with less-than-optimal, and occasionally disastrous, results.

A textbook cannot substitute for a teaching program, observation of proper technique, and actual performance of procedures with expert proctoring. However, this text will point the way and provide guidance toward those ends. It is designed to be a complete teaching guide to be used concomitantly with a hands-on teaching program, designed to develop competency leading to proficiency for female patients putting their trust in the hands of their gynecologic, plastic, or cosmetic surgeon. It is intended to educate the uninitiated and point the way toward the goal of comfort working with—psychologically, sexually, physiologically, and surgically—women who desire a guide to help them achieve their cosmetic, functional, sexual, and psychological goals.

After an introduction to the relatively brief "history" of the surgical specialty and discussion of pertinent anatomy, and after a thorough discussion of patient rationale for surgery, elements of patient protection, and the relevant ethical issues involved, the specifics of the most commonly utilized surgical techniques for both vulvar and vaginal procedures will be dissected and discussed in detail. Following this, patient selection technique and the biomechanics and physiology of tightening operations as they relate to the female orgasmic cascade will be discussed in depth. After a review of surgical risks, individual chapters will be devoted to important topics such as choice of anesthesia, surgical venue, complication avoidance, transgender surgery, and the important topic of revisions and re-operations. The book continues with in-depth discussions of psychosexual issues, up-to-date outcome data, and a chapter devoted entirely to brief "pearls" involving physician and patient protection. The editor's suggestions for implementing training programs and minimal "standards of care" will conclude the book.

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CHAPTER 2

Genital plasti

Michael P. Goodman
Caring for Women Wellness Center, Davis,

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Female Genital Plastic and Cosmetic Surgery

CHAPTER 2

Genital plastics: the history of development

Michael P. Goodman
Caring for Women Wellness Center, Davis, CA, USA

With a contribution from David Matlock

> The only reason some people get lost in thought is because it's unfamiliar territory.
>
> *Paul Fix*

Documented since the time of the pharaohs in ancient Egypt, women throughout history have modified their genitalia via adornments, devices, colorations, bleaches, and reductive and expansive techniques.

Although gynecologic surgeons have for years performed surgical procedures resulting in alterations in genital size, appearance, and function (repairs after obstetrical delivery, perineorrhaphy, anterior/posterior colporrhaphy, intersex and transsexual surgical procedures), in addition to reductions for pediatric labial hypertrophy, Honore and O'Hara in 1978, Hodgekinson and Hait in 1984, and Chavis, LaFeria, and Niccolini in 1989 were the first to discuss genital surgical alterations performed for aesthetic and/or sexual reasons (see references 2–4 in Chapter 1).

Traditionally taught in OB/GYN residencies as surgical procedures designed for symptomatic pelvic floor herniations of bladder, urethra, rectum, or peritoneal cavity, but never proposed as a sexual-enhancing surgical procedure, traditional anterior and posterior "repairs" (colporrhaphies) are being adapted to improve sexual function by strengthening the pelvic floor and tightening the vaginal barrel to produce greater friction and vaginal wall pressure. This "shifting" of indications and modification of traditional gynecologic surgery primarily for reasons of enhancement of sexual function has not been without controversy, as gynecologic academic organizations such as the American Congress of Obstetricians and Gynecologists (ACOG) have officially decried this representation [1].

In step with ACOG, the Society of Obstetricians and Gynaecologists of Canada (SOGC) published its Policy Statement No. 300, December 2013 [2], in which they opine that the literature "does not support non-medically indicated female cosmetic surgery procedures considering the available evidence of efficacy and safety." This document appears to be a modification of the ACOG Opinion No. 378, September 2007, referenced above and, as was the ACOG opinion, was written by non-community academics, few if any of whom have any experience in the field of genital plastics or the benefit of consultation with or study of women seeking genital cosmetic care.

The same SOGC document advises practitioners in Canada that "Physicians who choose to undertake cosmetic procedures to the vagina and vulva should be appropriately trained in the gynaecologic and/or plastic surgery aspects of cosmetic surgery of the lower genital tract."

Although multiple articles describing vulvar labiaplasty technique, along with small retrospective case series, are available in the literature from the late 1980s onward (3–15), it was not until the early twenty-first century that procedures designed specifically for reduction of labial and clitoral hood size, narrowing of the hymenal aperture, and increasing vaginal wall pressure by surgical narrowing of the vagina were widely publicized in the lay press and online. As an extension of "women's liberation" and the owning of her own sexuality, and with the advent of social sharing

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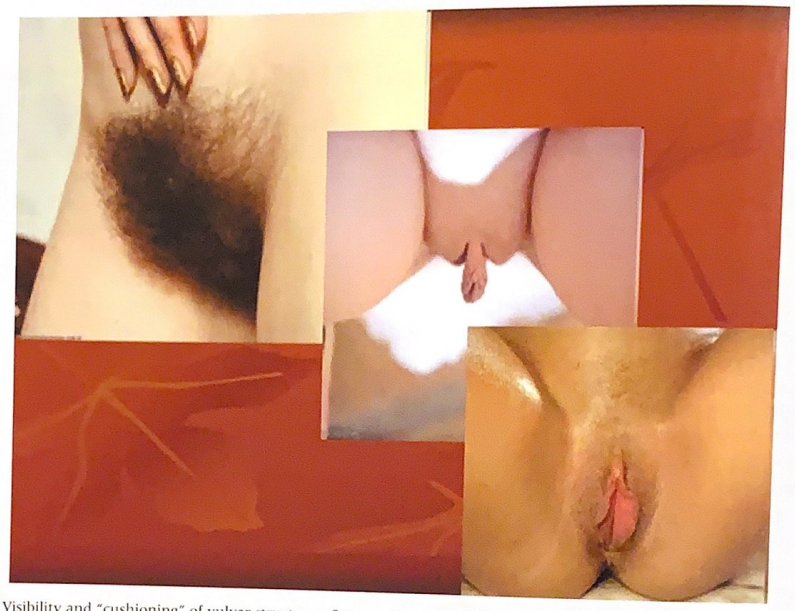

Figure 2.1 Visibility and "cushioning" of vulvar structures. Source: Michael P. Goodman. Reproduced with permission.

sites, more vulvar visibility secondary to various depilation techniques (Figure 2.1), and wishing to improve one's self-image to "feel more comfortable in her own skin," women in increasing numbers are seeking vulvar and vaginal aesthetic and plastic modifications.

While no "official" statistics on the varied FGPS procedures are kept by either the American Academy of Cosmetic Surgeons, the British Association of Aesthetic Plastic Surgeons, or the American Society of Plastic Surgeons (ASPS), the ASPS did note a 30% increase in "VRJ" procedures between 2005 and 2006 (793 to 1,030) but did not keep statistics beyond 2006 (16). The American Society for Aesthetic Plastic Surgery (ASAPS) kept demographic data for "VRJ" procedures in 2007 and found that of 4,505 procedures noted, 38.1% were in the 19–34 age group, 54.4% age 35–50, 2.4% 18 and under, and 5.1% 51 and older (17). According to the ASAPS 2012 statistics presented at their 2013 annual meeting, over 3,500 vaginal rejuvenation (CP, VRJ, PP) procedures were performed, representing a 64% increase from 2011. Informal polls of high-volume genital plastic/cosmetic surgeons by the editors of the journal of the ASAPS, along with the increase in volume of liability actions referable to genital cosmetic surgery, suggest a continued rise in the public's interest in these procedures. Although, in this author's estimation, obstetrician-gynecologists perform a volume equal to that of plastic surgeons, gynecology specialty organizations have taken no interest in promoting these procedures in any way, including keeping statistics involving numbers performed annually by their members. I suspect both plastic surgery and OB/GYN societies would be surprised at the actual volume.

Mirzabeigi *et al.* in 2009 surveyed members of the ASPS via electronic mail (18); 750 surgeons responded (a 19.7% response rate.) Although selection bias very likely increased the rate, 51% of the sample currently offered labiaplasty, and responding members performed a total of 2,255 procedures in the previous 2 years (2007, 2008).

A major milestone in the development of surgical technique was reported in the 1998 article by Gary Alter, MD (8), describing the "modified V-wedge" procedure for reducing labial volume. Developed in response to the often poor cosmetic appearance and edge sensitivity noted by many patients receiving a linear resection-based labiaplasty performed with large-caliber suture and

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often a continuous running suture technique, Alter's procedure, although requiring a longer learning curve and representing an increased risk of wound disruption, offered the promise of better cosmetic appearance and little risk of neurological alteration, a potential benefit not proven by prospective research.

Instruction in plastic tissue handling and suturing technique and the specific procedures of cosmetic labiaplasty and aesthetic hood reduction, as well as sexual pleasure-enhancing perineoplasty, is absent from virtually all OB/GYN residency programs. Cosmetic labiaplasty technique is taught in only a percentage of plastic surgery residencies (and pelvic floor surgery rarely taught). Due to the lack of training in academic centers, it was inevitable that community surgeons would respond to the emerging and burgeoning demand for cosmetic female genital procedures. Unfortunately, many gynecologists, by virtue of being vaginal surgeons and having observed or performed a limited number of extirpative labial techniques (for in situ or invasive malignancies) in residency, feel that they are equipped to perform both labial reductive and vaginal floor-tightening procedures for reasons of enhancing sexual pleasure. Although gynecologists are trained in pelvic floor restoration, they are undereducated in the use of these surgical techniques specifically for sexual indications. The reality is that, in the absence of any meaningful instruction in careful plastic technique, or instruction in aesthetic labiaplasty or sexuality-oriented vaginoplasty/perineoplasty, general gynecologists, as well as a large percentage of plastic surgeons, are ill equipped to perform these procedures. Academic physicians, most recently Cheryl Iglesia, MD [19], who write editorials, "regulations," and "practice advisories," are also not specifically trained and/or experienced in these procedures and appear to shun what they do not understand.

In his own words, Dr. David Matlock, one of FGPS's early pioneers, describes his seminal experience.

> The history of the development of female genital plastic and cosmetic surgery
>
> *David Matlock*
>
> My path in FGPS started in 1996. In general, my interest in cosmetic surgery started in 1987 with the implementation of liposuction into my gynecology practice. The tumescent liposuction technique revolutionized liposuction and eventually was employed in other procedures including breast reductions performed via tumescent liposuction. During this time, I was also interested in the emerging trend of laser technologies for surgery. I took as many hands-on laser courses as available and read the latest textbooks. It wasn't long before I had a desire to apply this cosmetic and laser knowledge to vaginal surgery. My goal at the time was to restore form, function, and appearance.
>
> To formulate my knowledge base and surgical technique I reviewed research papers and pertinent chapters of *Gray's Anatomy*, *Te Linde's Operative Gynecology*, and *Grabb and Smith's Plastic Surgery*. The objective was to extrapolate from scientific knowledge and formulate a procedure consistent with the goals of enhancing form, function, and aesthetic appearance. The vulvovaginal structures of young nulliparous patients in my practice served as a model to emulate in surgery. A big part of cosmetic surgery is restoring youth or creating a more youthful appearance. I took a common gynecologic procedure, anterior, posterior colporrhaphy and perineorrhaphy, with well-documented outcomes, efficacy, risk, and complications and modified it to accomplish cosmetic and sexual objectives. The modifications included a tumescent solution infiltration of the vaginal mucosa, a 980 nm diode laser to perform all the cutting and dissecting, plastic surgery suturing techniques, attention to detail and alignment of structures (hymenal ring, ends of the labia minora and outer border of the labia majora). The patients were also given a pudendal block with 0.5% Marcaine with epinephrine, which provided prolonged post-op pain-control anesthesia. I felt the purpose of the procedure would be better served if I thought more like a plastic surgeon than a gynecologist.
>
> My first case was a 42-year-old G4 P4 with mild stress urinary incontinence and a POP 2 cystourethrocele and rectocele. She was consented for an anterior, posterior colporrhaphy and perineorrhaphy. Her surgery and post-operative course were uneventful. Shortly after resuming normal sexual activity the patient and her husband called me and she said, "Sex is great now." The patient's husband went on to say, "It is like having the same wife, but a new woman." I didn't make much of it at the time. Instead, I kind of filed it away in the back of my mind.
>
> Shortly after this, the patient's friend came in requesting the same procedure because her friend had reported improved sex. This patient was 38 years old with three children. She noted that her sexual gratification had diminished with the birth of each subsequent child. She stated that she didn't have a functional problem such as stress urinary incontinence, rather wanted the procedure to enhance sexual gratification. After careful thought and consideration, I ultimately performed the procedure and achieved similar results as with the first patient. This second patient reported enhancement of sexual gratification for her and her partner. Shortly thereafter, I coined the term Laser Vaginal Rejuvenation (LVR).
>
> Over time, more and more patients came in requesting LVR for enhancement of sexual gratification. It eventually became clear to me that a true need existed for this type of procedure. Prior to launching a program, I wanted to

establish parameters to avoid going against the grain of the "medical establishment." These were as follows:

- The procedures were viewed as strictly cosmetic, fee for service, not covered by insurance.
- As with any cosmetic surgery (breast augmentation, breast reduction, liposuction, rhinoplasty, blepharoplasty, etc.), LVR is more about lifestyle, personal preference, and choice.
- Patients had to request the surgery under their own volition. If they were coerced, influenced, or forced, the surgery would be denied.
- If patients had body dysmorphia syndrome, psychological disorders, sexual dysfunction, pelvic pain, unrealistic expectations, and so forth, the procedure would be denied.
- If the patient wanted the procedure to produce vaginal orgasms due to the fact that she only experienced clitoral orgasms, the procedure would be denied. It would also be explained to the patient that perhaps this was normal for her. I wanted to convey that the procedure was for the enhancement of sexual gratification, which among other things is directly related to the amount of frictional forces generated. This was a clinical observation.
- The environment had to be one where patients felt comfortable in opening up to discuss their medical, physical, sexual, and social self.
- Patients' participation in their healthcare and surgical design was strongly encouraged. In the final portion of the consultation, patients were given a mirror and were shown what the procedure entailed.
- The husband/partner was encouraged to be present during the consultation, if the woman so desired.
- A mission statement was developed: Our mission is to empower women with knowledge, choice and alternatives.
- Medical legal concerns: I collaborated with a healthcare attorney to devise a comprehensive informed consent document.

My launch strategy initially involved marketing and media, feeling additionally that research on a new procedure/technique/concept, and so forth is to be done as soon as feasible. Like most new procedures (e.g., laparoscopic hysterectomy) time is required to build caseloads and surgical experience before embarking on research. I felt that it was more prudent to help create awareness among physicians and patients and in so doing caseloads could be developed and ultimately research would be done. I also felt that I was on solid ground since LVR was based upon a standard existing surgical procedure.

I went on and placed an ad in a weekly newspaper. Over time, the practice was inundated with calls, consultations, and surgeries. I had to pull the ad because I couldn't keep up with the demand.

Local, national, and international media began requesting interviews on the subject matter. Additionally, patients started requesting reduction of their labia minora and the excess prepuce. I approached each request with literature searches, extensive review of the anatomy, and lab work on animal models (pig ears). I continued until I successfully developed a laser reduction labioplasty with the reduction of the excess prepuce and named this technique Designer Laser Vaginoplasty (DLV). Each of the procedures was developed based upon the request of women. All of the procedures were developed with systems and methods in mind, so that they could easily be reproduced and taught to other surgeons. The procedures are as follows:

- [laser reduction] labioplasty of the labia minora;
- reduction of the excess prepuce;
- [laser reduction] labioplasty of the labia majora via a vertical elliptical incision;
- [laser] perineoplasty as a modification of posterior colporrhaphy;
- liposuction of the fatty mons pubis and superior aspect of the labia majora;
- augmentation of the labia majora via autologous fat transfer;
- supra-pubic lift of the vulvar structures;
- [laser] hymenoplasty.

Around 1998, I started getting calls from gynecologists from around the country inquiring about a training program. This was something I had not thought about. While pursuing a healthcare executive MBA program at the University of California at Irvine, I developed a training program with the assistance of my professors and fellow graduate students. By the time I matriculated in 2000, I had a comprehensive business plan to launch a training program called the Laser Vaginal Rejuvenation Institute of America. The course would be three days in length and include eight hours of didactics, a full day of intraoperative observation of the procedures, and a day in the inanimate lab. The lab was where the surgeons would perform all of the procedures on animal models. As of 2013, 411 surgeons including gynecologists, plastic surgeons, and urologists from over 46 countries have been trained.

I have had the privilege of treating patients from all 50 states and over 65 countries. As predicted, FGPS has been brought into the mainstream. Surgeons are performing the procedures throughout the world and the research is flowing!

Politically, the waters remain muddy. Although a robust literature regarding the rationale, safety, and effectiveness of genital plastic/cosmetic procedures exists, and is quoted extensively throughout this text, this literature apparently "disappears" for the authors of "official positions" for the hierarchy of some specialty organizations. ACOG, the organization purporting to represent OB/GYNs, made clear their opinion, discussed above, in 2007. Their position was further discussed in 2012 as a "College Statement of Policy" ("The Role of the Obstetrician-Gynecologist in Cosmetic Procedures") [20], where they opined that "Obstetrician-gynecologists who offer procedure typically provided by other specialists should possess

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an equivalent level of competence," and that "the obstetrician-gynecologist must be knowledgeable of the ethics of patient counselling and informed consent." This opinion finds no argument from your editor. However, they also advise that "Special care must be taken when patients are considering procedures in a effort to enhance sexual appearance and function, as female sexual response has been shown to be an intricate process determined predominantly by brain function and psychosocial factors, not by genital appearance." As discussed and referenced especially in Chapter 17 in this text, the authors of this statement have not been diligent in their research, as there is a robust literature (21–26) showing exactly the opposite: that female sexual response, while admittedly complex, *is* certainly influenced by genital appearance.

Further "guidance" has been forthcoming from ACOG, following up on their 2007 statement of "caution." In regards to vaginal tightening procedures [1], a new Committee Opinion, replacing a 2008 statement on non-traditional surgical procedures, was issued in October of 2013 [27]. The statement was written by the ACOG's Committee on Ethics and published in the November 2013 issue of *Obstetrics and Gynecology* [27], ACOG's official publication. In it, ACOG acknowledges that "the importance of patient autonomy and increased access to information, especially information on the Internet, has prompted more requests for surgical interventions not traditionally recommended." In drafting the statement, the committee aimed "to provide an ethical framework to guide physicians' responses to patient requests for surgical treatment that is not traditionally recommended." While written more for the eventualities of elective Cesarean section before onset of labor, and prophylactic removal of ovaries in a woman at very significant risk for breast or ovarian cancer, the committee notes that, "depending on the context, acceding to a request for a surgical option that is not traditionally recommended can be ethical," and that "decisions about acceding to patient requests for surgical interventions…should be based on strong support for patients' informed preferences and values."

While the politics remain interesting, the handwriting is on the wall: patient autonomy (see Chapter 6) is paramount, and physicians can and will perform these procedures, provided that the patient is well informed, not pressured, and the physician adequately trained for the specific procedure he or she plans to perform.

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CHAPTER 4
Definitions

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To steal ideas from one person is plagiarism; to steal from many is research.

Steven Wright

A need exists to develop a reasonable nomenclature to replace proprietary terms such as "vaginal rejuvenation" (VRJ), "Designer Laser Vaginoplasty," "revirgination," and so forth, as delightful as they may be, before they become entrenched in the rubric of medical and lay terminology. No one specific term is accepted to describe these procedures, although labiaplasty (LP), labial reduction, vaginoplasty (VP), clitoral unhooding, "intimate operations," and, more encompassing, female genital plastic/cosmetic or plastic/aesthetic surgery (FGPS), female cosmetic genital surgery (FCGS), vulvovaginal aesthetic surgery (VVAS), aesthetic vulvovaginal surgery (AVS), and cosmeto-plastic gynecology (CPG) are among the many utilized. Although all terms are acceptable and descriptive, I have chosen FGPS, and shall use this term throughout the textbook.

FGPS is surgery on the female external genitalia and vagina designed to subjectively improve appearance, diminish discomfort, and/or potentially provide psychological and functional improvement in sexual stimulation and satisfaction.

Labiaplasty involves surgical alteration, usually via reduction, of the size of the labia. Although this usually involves reduction of the labia minora (LP-m) or, less frequently, labia majora (LP-M), occasionally LP involves reconstruction after obstetrical injury or, more rarely, enlargement via injection of bulking agents or autologous fat transfer. The procedure may be performed utilizing sharp dissection with instrumentation including scalpel, stem iris or plastictype fine Metzenbaum scissors, electrosurgical or radiofrequency needle electrode, or laser (usually via a "touch" fiber). Surgical techniques include V-wedge resection and its modifications, (curvi) linear reduction/resection/excision of the leading edge, excision of the inferior-most portion of the labum, with rotation of the superior flap, Z-plasty, de-epithelization, and other less-utilized techniques (Figures 4.1 and 4.2).

Clitoral hood reduction (RCH or CHR) (aka "clitoriplasty," "clitoral unhooding") involves size reduction of redundant and/or "wrinkly" central hood or redundant lateral prepucial folds for cosmetic reasons or, less commonly, midline surgical separation of the female prepuce designed to produce more "exposure" of the clitoral glans in cases of phimosis, theoretically providing improved sexual stimulation. "Unhooding" for exposure of a clitoral glans entirely "trapped" by a phimotic clitoral hood and a reduction procedure designed to reduce aesthetically displeasing redundant folds of the clitoral prepuce are entirely separate procedures, performed for different indications. However, patients report "more feeling" and appear to be quite satisfied after removal of clitoral hood redundancy (author's experience, and personal communication from Drs. Robert Moore and John Miklos; not confirmed by peer-reviewed research). Whether this is secondary to more friction transmitted to the clitoral glans and body or to psychosexual reasons secondary to what this woman considers to be a more pleasing countenance is unknown.

Figures 4.1 and 4.2 are anatomic drawings. Figures 4.3 through 4.5 display anatomy with redundant clitoral

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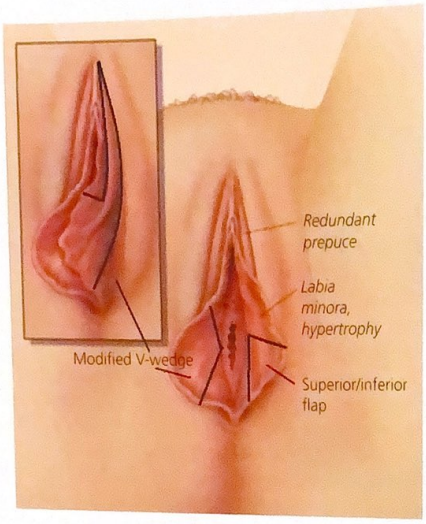

Figure 4.1 V-wedge with reduction clitoral hood; superior-inferior flap procedures. © R. Moore and J. Miklos, modified by M. Goodman. Used with permission.

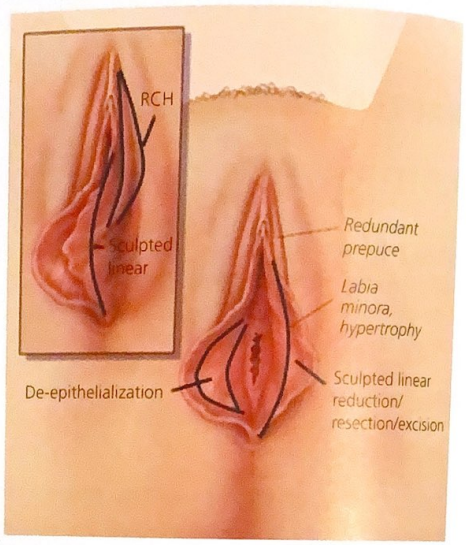

Figure 4.2 Sculpted curvilinear resection with RCH and de-epithelialization. © R. Moore and J. Miklos, modified by M. Goodman. Used with permission.

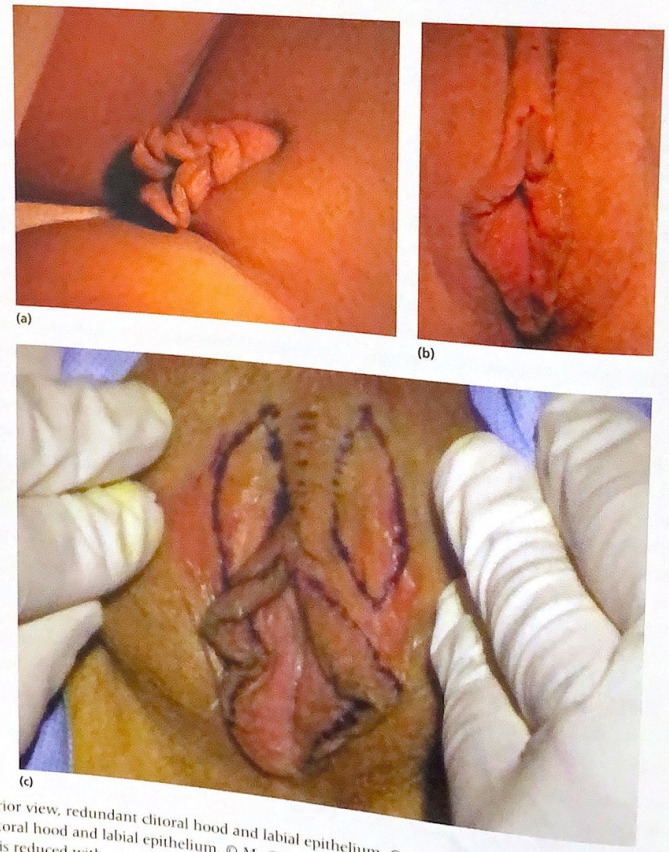

Figure 4.3 (a) Superior view, redundant clitoral hood and labial epithelium. © M. Goodman. Used with permission. (b) Anterior view, redundant clitoral hood and labial epithelium. © M. Goodman. Used with permission. (c) Linear resection and RCH markings. (Hood redundancy is reduced with retraction, which "stretches" the redundancy.) © M. Goodman. Used with

Figure 4.4 (a) Anterior vie
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Figure 4.5 (a) Superior view, red
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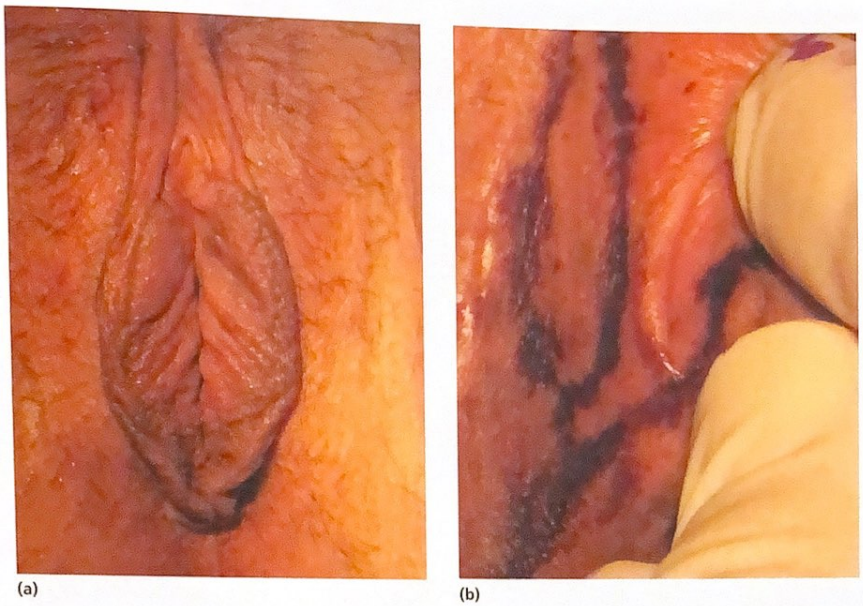
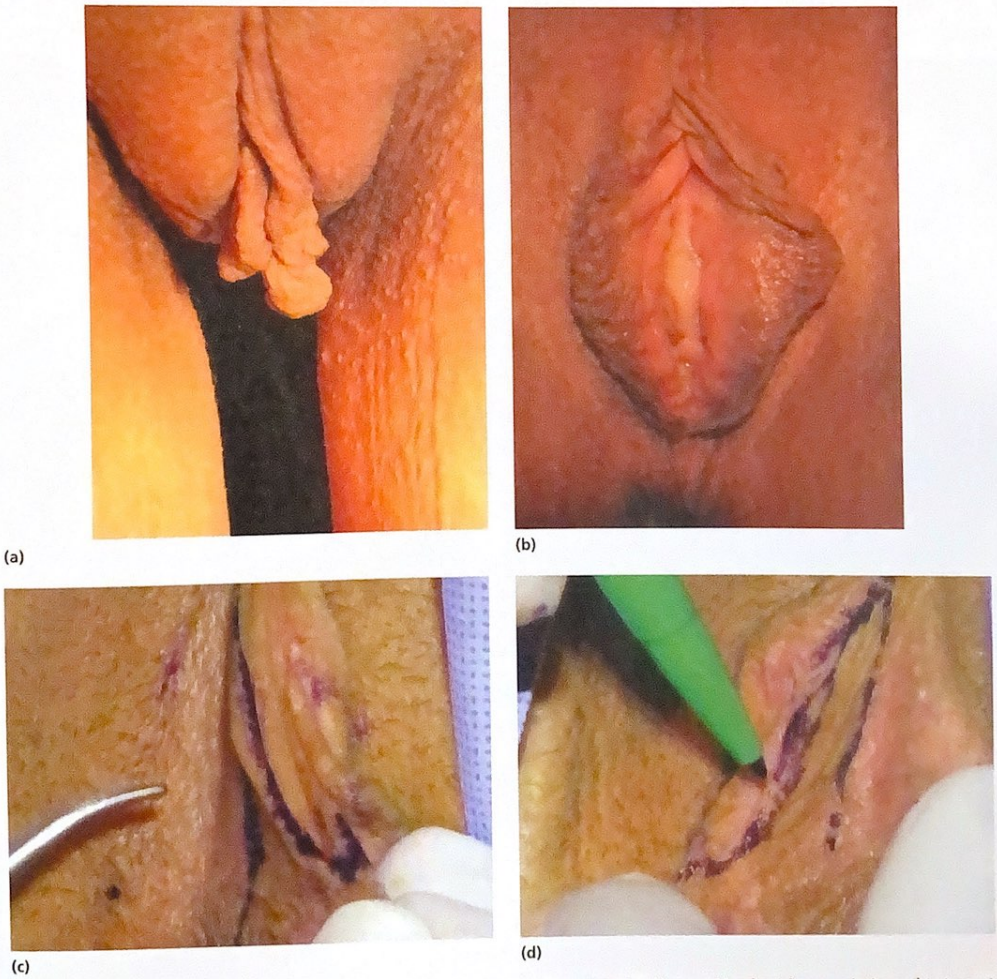


(a) (b)

Figure 4.4 (a) Anterior view, redundant clitoral hood and labial epithelium. © M. Goodman. Used with permission. (b) Markings for linear resection plus separate hood redundancy excisional lines. © M. Goodman. Used with permission.



(a) (b)

(c) (d)

Figure 4.5 (a) Superior view, redundant clitoral hood and labial epithelium. © M. Goodman. Used with permission. (b) Anterior view, redundant clitoral hood and labial epithelium. © M. Goodman. Used with permission. (c) "Y" modification of V-wedge resection to incorporate clitoral hood redundancy, #1. © M. Goodman. Used with permission. (d) "Y" modification of V-wedge resection to incorporate clitoral hood redundancy. Redundancy noted in Figure 4.5(a) reduced by lateral retraction. © M. Goodman. Used with permission.

and labial epithelium, along with placement of incisional lines for LP and RCH. Only superficial epithelium is resected along these lines. The mechanics and performance of labiaplasty and clitoral hood resections will be well reviewed in Chapter 8.

Vaginal rejuvenation originated as a proprietary term first defined and marketed as "Laser Vaginal Rejuvenation" by David Matlock, MD, MBA, and commonly referred to simply as "vaginal rejuvenation." VRJ is a colloquial term that, unfortunately, can mean different (surgical and non-surgical) things to different people. This may prove especially confusing with new non-surgical laser and radiofrequency vaginal tightening techniques presently being tested and brought to market. However, the term is widely utilized in the literature [1,2] and is here to stay. When referring to FGPS, it should be considered an "umbrella term" encompassing an array of elective vaginal tightening procedures designed to tighten the vaginal barrel, provide additional pelvic floor support, and increase friction to the vaginal walls and cervix for reasons of improving sexual pleasure and, potentially, orgasmic function. As such, VRJ is utilized by many surgeons to describe any surgical procedure utilized on either the distal, or both proximal and distal vagina, to produce increased functional tone in order to improve sexual pleasure and facilitate orgasmic function. The physiology and biomechanics of these procedures and their effects on orgasmic function will be discussed in Chapter 10. As utilized herein, VRJ may include colpoperineoplasty, perineoplasty, and/or vaginoplasty. The procedures themselves will be discussed and dissected in Chapter 9.

Perineoplasty (PP) involves surgical reconstruction of the vulvar vestibule, vaginal introitus, perineum, and perineal body whereby scarred and redundant tissue is excised, any distal posterior compartment defect is repaired, and the superficial transverse perineal musculature is re-approximated in layers in the midline, thus elevating and bulking the perineal body, introitus, and vulvar vestibule. The perineum is re-approximated in an attenuated and carefully anatomic manner (Figures 4.6–4.8).

The term *vaginoplasty*, like "vaginal rejuvenation," is a descriptive but unofficial term, not found in medical nomenclature but present, like VRJ, in patient and marketing vernacular. As defined by genital plastic/cosmetic surgeons, it refers to a general tightening procedure involving the vaginal barrel, from the distal vagina, always up to or proximal to the mid-vagina, and always involving both removal of scarified submucosal tissue and re-approximation of the levator ani musculature. It may or may not involve the proximal vagina, either via a high posterior colporrhaphy, anterior

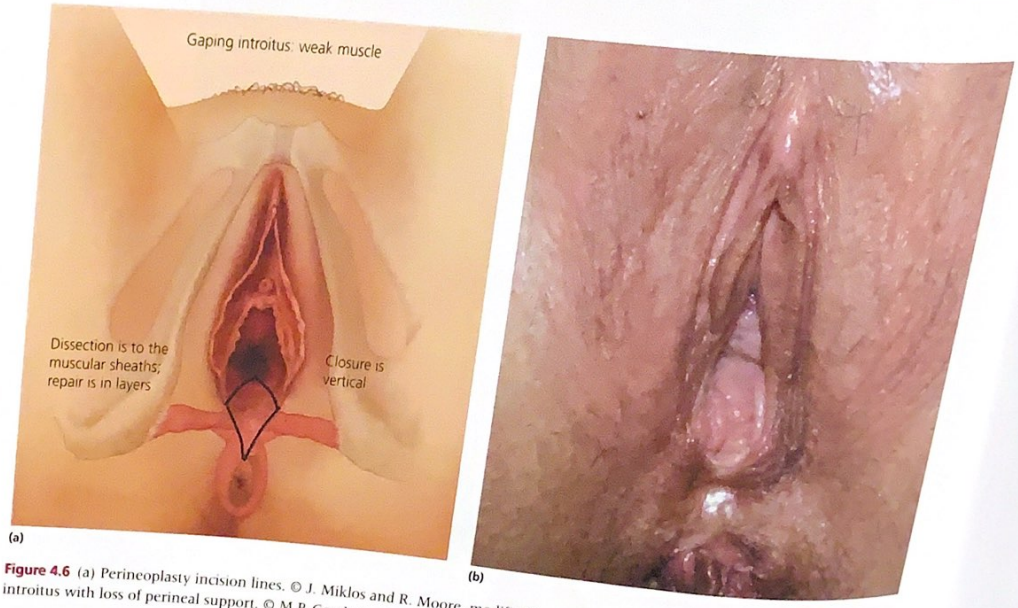


Figure 4.6 (a) Perineoplasty incision lines. © J. Miklos and R. Moore, modified by M. Goodman. Used with permission. (b) Gaping introitus with loss of perineal support. © M.P. Goodman. Used with permission.

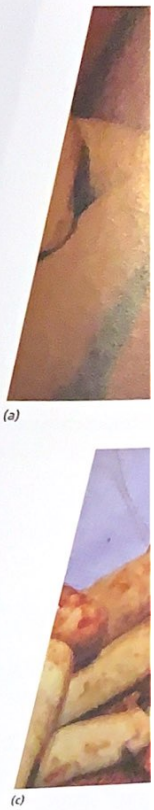


Figure 4.8 (a) Pre-op PP. © M. Goodm
(c) Reconstructing introitus. © M. Go
Used with permission.

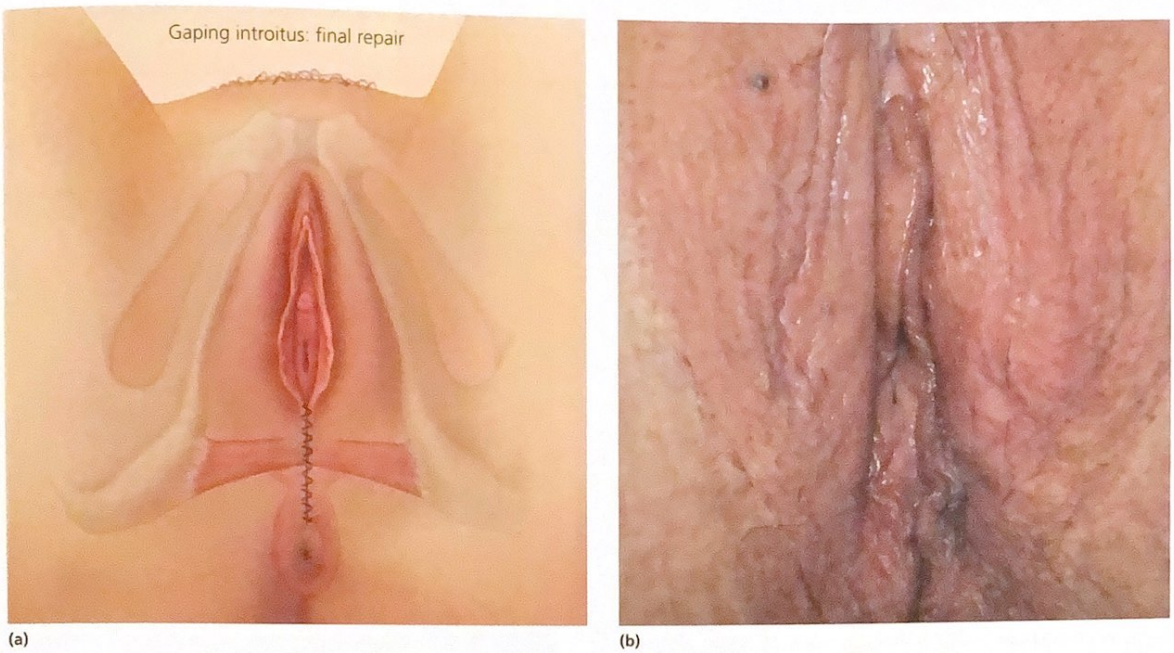


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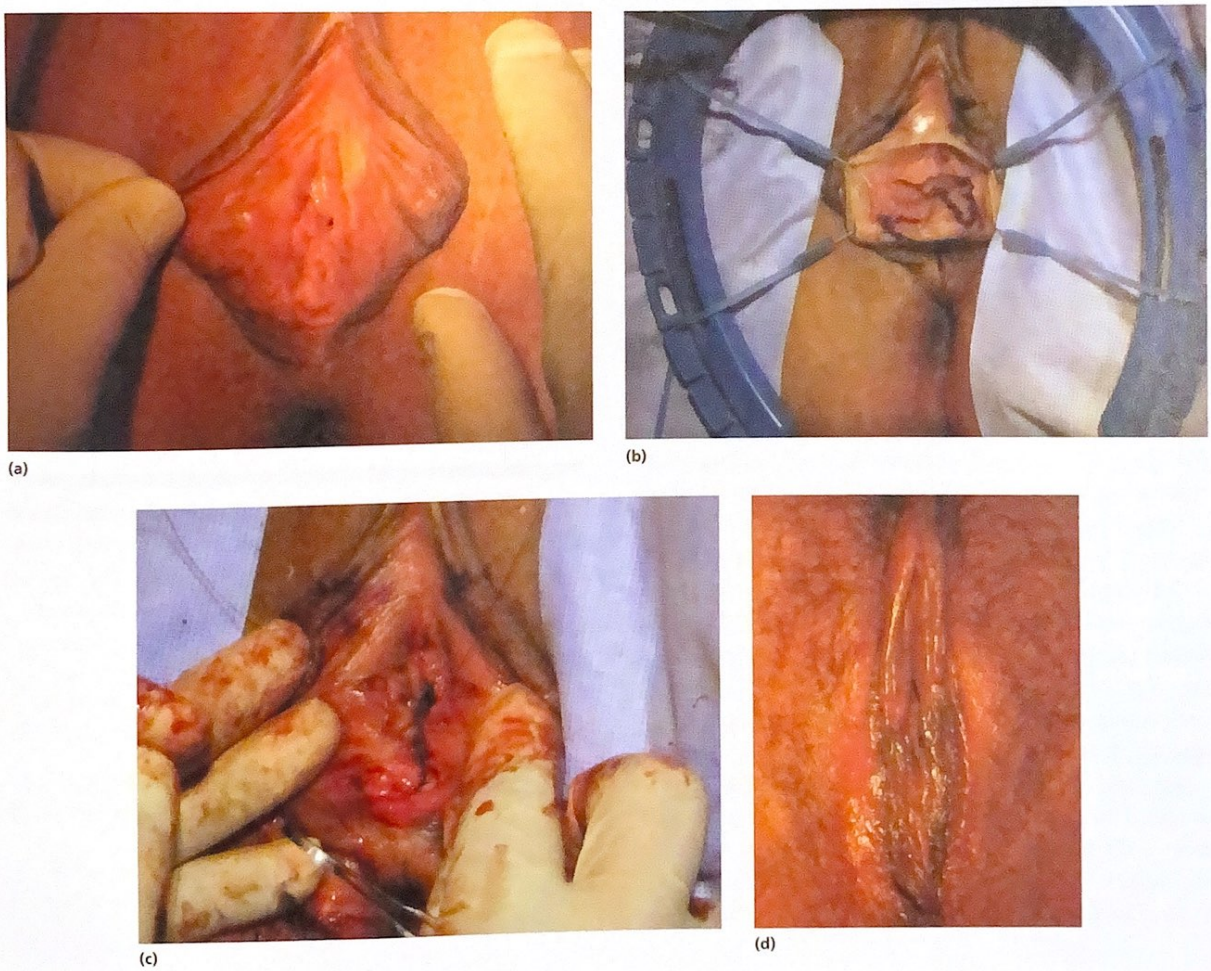
Figure 4.7 (a) Completed perineoplasty repair. © J. Miklos and R. Moore. Used with permission. (b) Post-op perineoplasty. © M.P. Goodman. Used with permission.



(a) (b) (c) (d)

Figure 4.8 (a) Pre-op PP. © M. Goodman. Used with permission. (b) Incision lines for PP. © M. Goodman. Used with permission. (c) Reconstructing introitus. © M. Goodman. Used with permission. (d) Completed LP and PP, 6 weeks post-op. © M. Goodman. Used with permission.

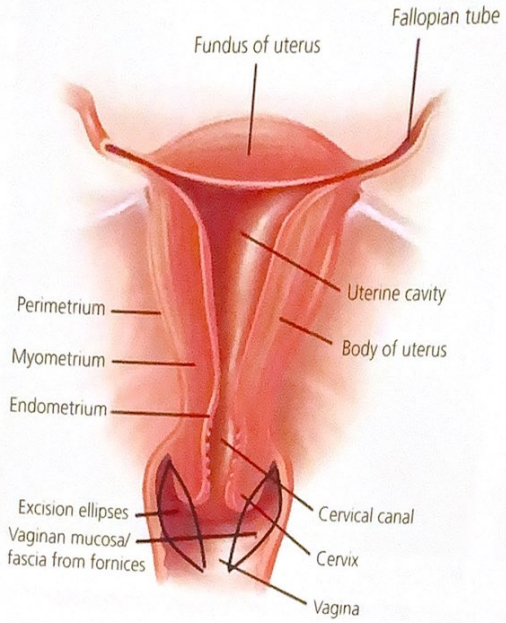


Figure 4.9 Excising elliptical strips of vaginal mucosa from proximal vaginal fornices, occasionally added to vaginoplasty procedures in patients with excessively widened proximal vaginal fornices. From collection of AUA Foundation. Public domain. Modification © M. Goodman. Used with permission.

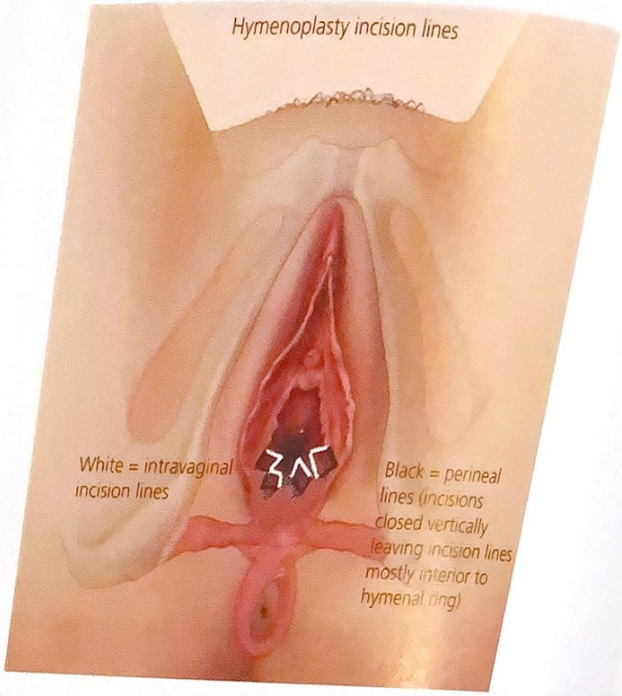


Figure 4.10 Hymenoplasty repair of rents in hymenal ring. White lines are intra-vaginal; black extend slightly into vulvar vestibule. Incisions closed vertically to approximate hymenal aperture. © J. Miklos and R. Moore, modified by M. Goodman. Used with permission.

colporrhaphy, and/or removal of elliptical strips of lateral forniceal mucosa to provide superficial mucosal and fascial approximation (Figure 4.9). A vaginoplasty usually involves a posterior colporrhaphy modified to more tightly re-approximate vaginal walls and strengthen and bulk the posterior vaginal wall utilizing a three- to four-layer closure technique. Tools utilized include scalpel, needle electrode, scissors, laser, or radiofrequency electrode. Site-specific defects are repaired, and fascial defects are re-approximated either horizontally or vertically. The term may be confusing, as it applies to tightening of the vaginal barrel, and can include mid-distal vaginal repair of the pelvic floor, but may incorporate proximal vaginal work as well. In the author's opinion, and in the aesthetic vulvovaginal surgical community, most vaginal tightening procedures take place in the distal half of the vagina. Size-limiting alterations of the proximal vagina may be considered only for those women who have a symptomatic cystourethrocoele and/or significant symptomatic widening of the vaginal fornices.

Colpoperineoplasty (CP) is a rather recent addition to the nomenclature on the subject, first suggested by Jack Pardo S from Chile [3]. It is a valid and descriptive term meant to encompass both VP and PP and will be utilized hereafter to describe the combination of VP and PP procedures.

Hymenoplasty (HP) is a surgical procedure whereby the hymenal ring is surgically altered, frequently via small tightening revisions or denuding/approximation sutures, to produce size minimization of the vaginal aperture, designed to produce temporary introital tightening and facilitate bleeding with subsequent coitus (Figure 4.10). HP is most usually requested as a pre-marital cultural imperative in a previously sexually active Muslim woman facing an arranged marriage at the consummation of which she is expected (mandated!) to exhibit difficulty with initial penetration and lose a modest quantity of blood upon penetration.

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CHAPTER 14

Anesthetic choices and office-based surgery

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I've had so much plastic surgery, when I die they will donate my body to Tupperware.

Joan Rivers

Choices are available for you and your patients in both anesthetic method and surgical venue.

Anesthesia

Although novice surgeons may do well to begin their genital plastic work in a hospital or surgical center operating room under general or conduction anesthesia, certainly vulvar procedures, and in experienced hands even intra-vaginal procedures, lend themselves to an outpatient venue and local and local tumescent anesthesia.

Of course both general and sub-arachnoid block will supply adequate anesthesia for vulvar and vaginal genital plastic procedures. However, for a well-prepared patient and physician, local infiltrative anesthesia or a regional block works well, with or without pre-operative sedation.

If the procedure is to be performed in a surgical center or hospital environment, choices of anesthesia are legion and include general endo-tracheal, sub-arachnoid block, regional block, or local tumescent with or without conscious sedation. Certainly local with conscious sedation or spinal anesthesia are safe and elegant anesthetics and usually have the additional benefit of expedited recovery.

Sedation

Sedation may be helpful for alleviating anxiety especially at the outset of a procedure where the patient is awake. An anxiolytic and/or a narcotic analgesic may be suitable. Personally, in his "awake" cases in an office setting, the author uses 1 mg lorazepam p.o. 30–45 minutes prior to surgery. Another 1 mg lorazepam may be given sub-lingually, as decided by the patient and her office circulating RN, several minutes prior to prep. Both other benzodiazepines and types and doses of analgesics may be substituted, and the route may be either oral or parenteral.

For office procedures, patients are instructed to prehydrate and eat a light meal prior to coming to the office, but in any case all patients are given a fiber/protein bar and a large (22 oz.) bottle of Gatorade (tm) or equivalent upon arrival to the office, in an effort to further hydrate and prevent post-procedure hypotension.

Regional block

A pudendal block is an elegant anesthetic for work on the vulva and distal vagina and may be an anesthetic of choice in an outpatient setting for those women amenable to this choice and physicians facile in utilizing this modality. The author prefers a total of ~5–10 ml 0.25–0. % bupivacaine with epinephrine per side for

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long-lasting (3–5 hour) anesthesia. However, technical difficulties with administration and risk of vascular injection, nerve or vascular injury, and failure of achieving anesthesia of ~10–20% are risks of regional pudendal nerve block.

Local infiltrative

The author prefers local incisional injection as his agent of choice for office-based vulvo-vaginal aesthetic surgery, as it is reproducible, extremely safe, and, depending upon the agent, confers relatively long-acting anesthesia.

Any local injectable anesthetic agent singly or in combination, with or without epinephrine, may be utilized. The author prefers 0.5% bupivacaine with epinephrine, if the patient has no known sensitivity to either agent. Care must be taken with any of the local anesthetics, both to avoid intravascular injection and to not exceed toxicity dosages. A conservative limit per patient for 0.5% bupivacaine is 30 ml; 60 ml for 0.25% bupivacaine. Local anesthetic agents are acidic, causing discomfort upon injection. This may be diminished by buffering the solution with ~0.15 ml sodium bicarbonate/10 ml anesthetic.

Local anesthetic volume makes a difference. The greater the volume, the greater the difficulty in precise control of bleeders. The greater the anesthetic volume and the greater the use of electrocautery, the greater the amount of tissue necrosis, and the greater the risk of excessive post-operative edema, discomfort, and distortion of epithelium, adversely affecting final results.

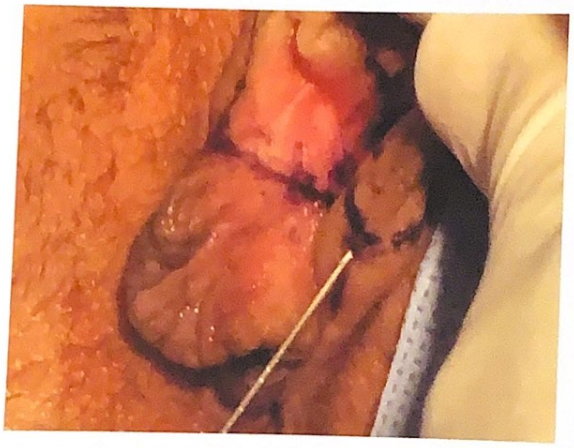
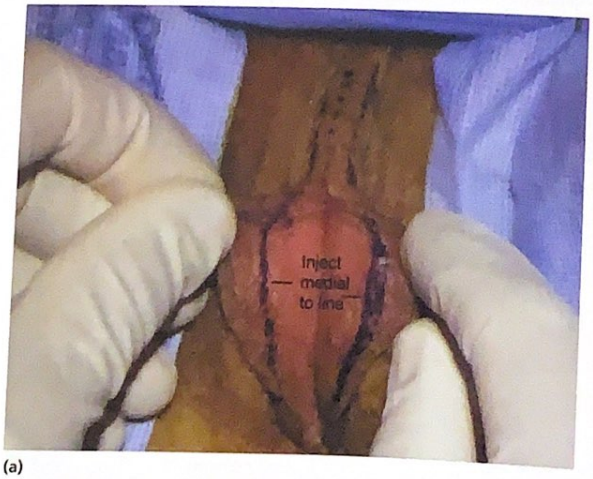


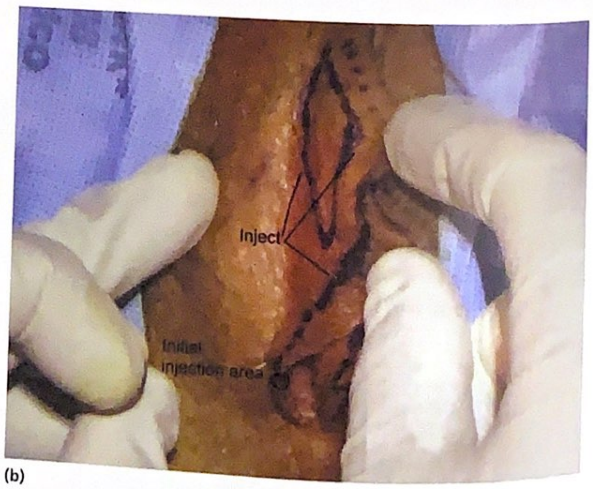
Figure 14.1 Initial injection of local at the base of the incision line. Source: M. Goodman. Reproduced with permission.

Technique for labia minora/clitoral hood local injection

The mixture of local anesthetic and sodium bicarbonate is drawn from a medicine cup into a 3–5 ml syringe. A 25 or 27 ga. 1.5-inch needle is utilized for injection. A small bleb of anesthetic is injected at the base of the labum or initiation of the surgical line (Figure 14.1). The needle is advanced superficially sub-cutaneously laterally to the drawn incision lines on the lateral labial surfaces, medially on the mucosal surfaces, and a thin ribbon of anesthesia is slowly laid down as the needle is withdrawn (Figure 14.2). As one advances along the incision line care is taken to utilize already injected areas as needle entry sites. If operating on a conscious patient, "verbal analgesia" via



(a)



(b)

Figure 14.2 (a) Injection diagram 1. (b) Injection diagram 2. Source: M. Goodman. Reproduced with permission.

communication with the patient by the surgeon, and "hand-holding" via the surgical suite nurse or surgical assistant is helpful. The patient should have been informed pre-operatively by her surgeon about the discomfort inherent in the injection, but that the time necessary is very short (usually well <30–60 seconds per side). The surgeon may limit individual injections to 20-second intervals, which may be counted out with the patient by the physician or nurse assistant. Incision lines are tested with a forceps prior to skin incision. At least 5 minutes should be allowed to elapse for the epinephrine to take effect and induce vasoconstriction.

Several different methods have been proposed to aid in skin analgesia prior to injection, including applying 4% Emla cream or 5% lidocaine gel to the area and occluding with plastic film an hour or so prior to procedure, or applying ethyl chloride spray or a local anesthetic spray just prior to local injection. This author has given fair trial to them all and has found all wanting. The time and effort do not appear to offer any advantage. By the time the patient is evaluated, readied, prepped, and lines drawn, the cream/gel analgesia wears off, ethyl chloride spray application is almost as uncomfortable as the needle stick, and, even if the momentary skin penetration pain is mitigated, the sub-cutaneous infiltration is still painful. The author has found that buffering the anesthetic with sodium bicarbonate as described appears to offer the best reduction of injection pain.

On average, no more than a total of 6–10 ml total is necessary for labiaplasty, depending on the complexity of the incision lines and whether hood reduction is part of the procedure.

Technique for labia majora local injection

Anesthetic preparation is similar as for labia minoraplasty, but injection with needles <25 gauge is difficult secondary to resistance of the labia majora epithelium. A total volume of ~8–10 ml usually suffices for both sides. Injection is made just outside of the incision lines (Figure 14.3).

Technique for PP and HP local injection (office cases, local tumescent anesthesia)

Anesthetic mixture is the same, but close attention must be paid to total volume utilized. In my hands, I rarely use more than 20–30 ml, averaging 15–25 ml for PP, and approximately one-quarter of that for hymenoplasty. When PP alone is performed, 0.5% bupivacaine solution may be used, but if combining procedures (e.g., LP+ PP),

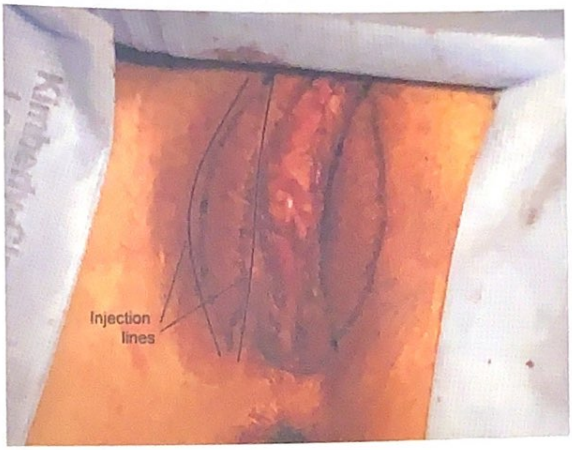


Figure 14.3 Injection lines for LP-M. Source: M. Goodman. Reproduced with permission.

I will estimate the size and complexity and will frequently either mix 0.5% with 0.25% bupivacaine 50/50, giving a 0.375% solution, with a maximal allowed volume of 45 ml, or utilize 0.25% bupivacaine. No side-by-side studies exist, but the amount of anesthesia produced with the more concentrated solution is impressive, with less volume necessary for anesthesia, resulting in better hemostasis.

Performing PP or HP under a local anesthetic with mild sedation is a technique reserved for only the occasional surgeon well experienced in both PP/VRJ type procedures, and in working on other vulvar aesthetic procedures in-office under local anesthetics.

Perineoplasty/vaginoplasty or hymenoplasty procedures, whether performed in a surgical center/hospital or office setting, are greatly facilitated by the usage of the Lone Star Retractor System (Cooper Surgical, Inc., 75 Corporate Dr., Turnbull, CT 06611), especially the self-affixing horseshoe-shaped model designed by Dr. Red Alinsod, of Laguna Beach, California. Dr. Alinsod is the pioneering surgeon who first began performing perineoplasty in an office-based,setting under local anesthesia. This retractor system is imperative for procedures performed in an office setting. Prior to placing the retractor system the vulvar vestibule and perineum are manually separated and a small mark made with a sterile marking pen at ~2:30, 4:00, 8:00, and 9:30 o'clock just inside or just outside of the hymenal ring as placement sites for a minimum of 4 rubber stays that provide retraction and visualization, as well as marks at the apex in the mid-pelvic floor, the nadir of the incision line above the anal verge,

and the lateral-most points of dissection at both the hymenal ring and vulvar vestibule, and an initial "dotted line" drawing is produced, linking these areas. (See also Chapter 9.) This drawing will be formalized after the retractor system is placed. Small blebs of anesthetic agent are injected sub-mucosally at the retractor hook sites, and the stays are attached to the previously placed retractor horseshoe.

After placement, the lines are formalized, and local anesthetic is injected sub-cutaneously and sub-mucosally along the lines and deeper into the levator, transversalis, and anal sphincter muscle sheaths and rectovaginal fascial sheath in several different locations (Figures 14.4 and 14.5).

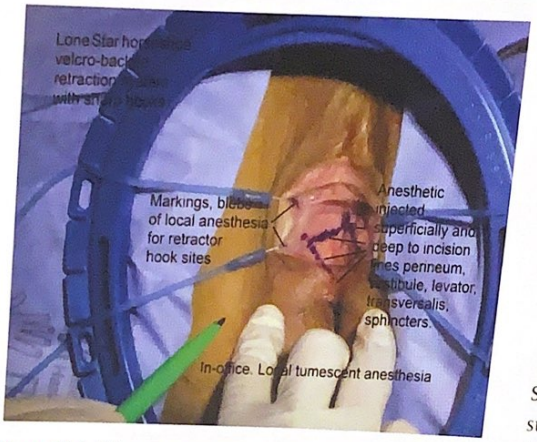


Figure 14.4 Office perineoplasty. Source: M. Goodman. Reproduced with permission.

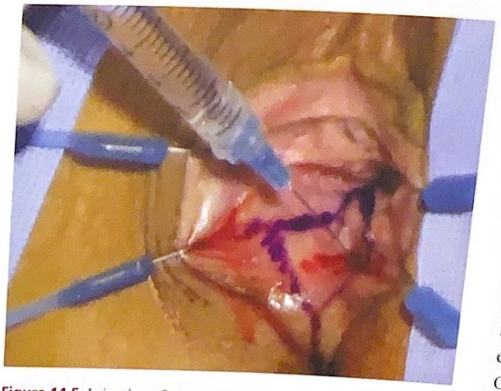


Figure 14.5 Injection. Source: M. Goodman. Reproduced with permission.

Candidates

Anesthetic choice depends on physician comfort with the procedure, patient choices, and finances, as both facility and anesthesia fees are significantly more costly in a surgical center/hospital environment. It is advisable for the surgeon to have a requisite number of cases under her or his belt under general or conduction anesthesia to feel confident and at ease prior to operating on an awake patient.

Novice genital plastic surgeons may attempt placing a pudendal block or local tumescent anesthesia in patients scheduled for general, converting to conscious sedation if the block is successful, while utilizing the block for initial post-operative analgesia. Additionally, novice surgeons may become facile with local tumescent anesthesia by injecting after induction of general anesthesia, additionally utilizing the local anesthetic for initial post-operative analgesia.

For a physician to utilize awake anesthesia, the patient must not be overly anxious, the physician must be trained in the technique, and the patient should have an attendant to comfort her during the injection.

Office-based surgery

Surgical venues may include hospital OR, a freestanding surgical center, or an office-based facility. If office-based, minimal medical, mechanical, and IV supplies sufficient for resuscitation must be available. That said, what—besides expertise, a comfortable patient, and a savvy surgeon—is requisite for successful office-based surgery?

Room setup

A space of adequate size is needed to hold an exam/operative table, back table, generator and cautery unit (Figure 14.6), supply cabinets, space to move around, and space at the head of the table for a friend or partner if the patient so desires. There must be space at the foot of the table for either a slide-out table-mount unit or Mayo stand of sufficient size to both hold instruments and for the surgeon to lean his or her elbows to both steady hands and minimize fatigue. One or two spotlights either ceiling mounted overhead or wall or stand mounted behind the surgeon is recommended.

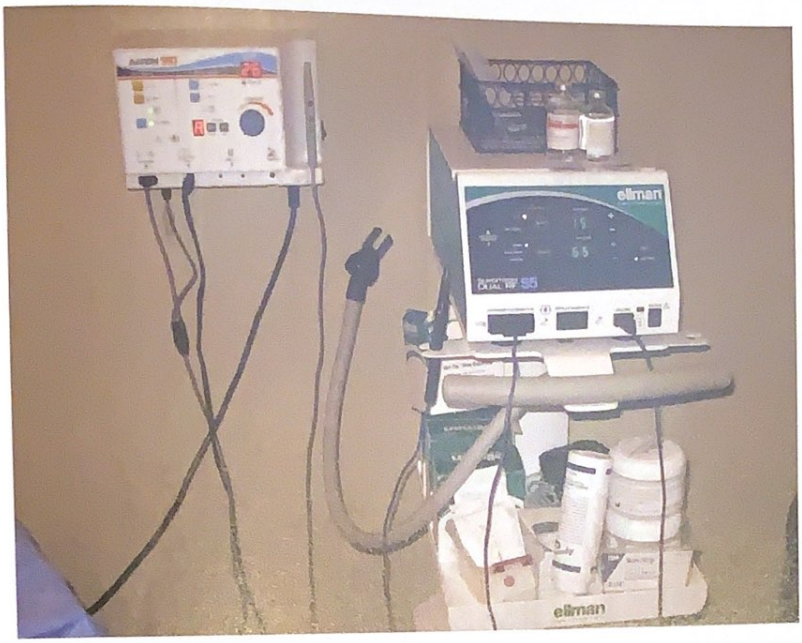


Figure 14.6 RF generator and cautery units.

Equipment and supplies

1 *Gynecological exam/surgical table.* Can be power or fixed, but must have drawers and ability to change out stirrups for either padded knee crutches or Allen-type leg rests. Knee crutches should be padded with foam, towels, and so forth and must have multi-positioning capability. A slide-out end is preferable for instruments and as a surgeon's arm rest; a mayo stand or the "cut-out Mayo" designed by Dr. Alinsod is elegant.

2 *Cutting and cautery capability.* Many choices are available for cutting and hemostasis, including scalpel, scissors, electrosurgical units for needle-point cutting, as well as cautery capability. Alternative power generators may be utilized if desired and are elegant and helpful for the precise scrolling work frequently required for cosmetic genital procedures. The author utilizes an RF generator for cutting and minor hemostasis and a separate Bovie™ or Valleylab™-type unit for hemostasis. Several manufacturers make RF generators. Requisites are bipolar pure cutting current, as well as fulguration or hemostatic capabilities. Many surgeons utilize laser equipment (see Chapter 8), which also is an excellent tool for these procedures. Both RF and laser are wonderfully precise cutting tools and, although both supply hemostatic options, neither has the capability for the cauterization requisite for safe genital plastic/cosmetic procedures.

3 *Smoke evacuator.* If utilizing RF, laser, or electrosurgical equipment, a small canister-type smoke evacuation system is mandated. The evacuation tip may be placed under the drapes just above the surgical field.

4 *Surgical lighting.* Many incandescent or halogen surgical lighting systems are available. These may either be ceiling mount, wall mount, or freestanding. The author uses an incandescent freestanding and a halogen wall-mount unit projecting light onto the surgical field from different angles.

5 *Draping.* One of several commercially available surgical drape kits with table covers, under-buttocks drape, leggings, and abdominal drape may be utilized. Most come with sterile surgical gowns, or these may be purchased separately.

6 *Surgical prep equipment.* Several different prep kits with iodine or other antiseptic soap and prep solutions are available. Prep must cover entire surgical field, buttocks, and distal one-third of vagina (vulvar surgery) and entire vagina for intra-vaginal tightening operations.

Surgical setup, instruments, and suture material (Figure 14.7)

1 *Back table* (e.g. Lakeside cart or equivalent). *Instruments/supplies*: 4 × 4 gauze sponges, draping supplies, sterile paper hand-drying wipes, gloves are

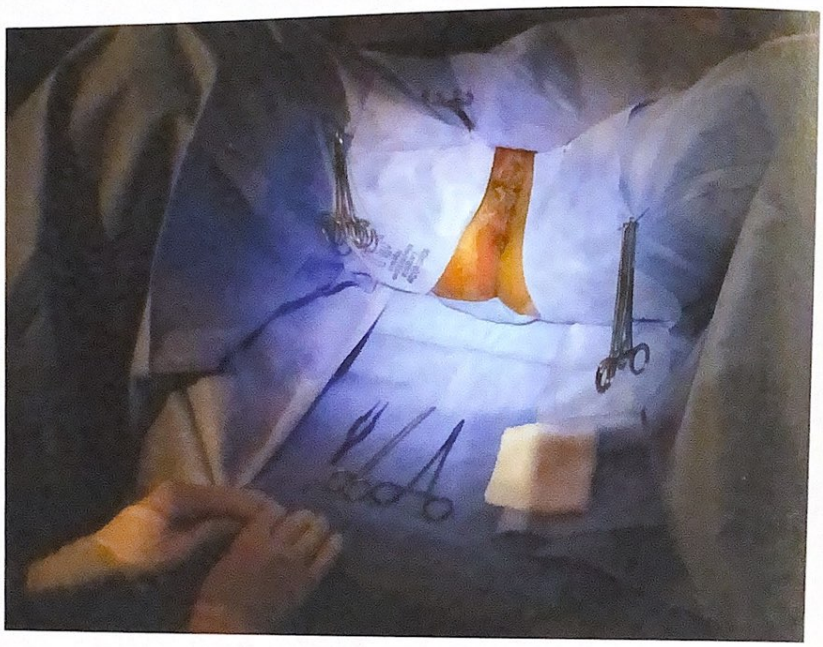


Figure 14.7 Op table setup. Source: M. Goodman. Reproduced with permission.

available on the "back table." The author's instrument set consists of (1) ~5" needle driver; (2) delicate (Addson- type) forceps; (3) baby Metzenbaum or Kaye scissors; (4) suture scissors; (5) two mosquito clamps; (6) two Allis clamps; (7) one Kelly or Mayo-type clamp to hold ancillary equipment (RF unit, cautery, etc.) to drape; (8) two towel clips or clamps to secure draping; (9) sterile fine-tipped marking pen; (10) ~50 ml medicine cup for drawing up anesthetic agent. Short-handled equipment (~5") is preferable.

For vaginal tightening procedures (PP; VRJ), *add*: 2–4 Allis-Adair or T-type clamps and heavier Metzenbaum or Mayo-type dissecting scissors. Heany-type curved jaw needle holder is preferable.

2 *Anesthesia supplies*: 0.25, 0.5% bupivacaine with and without epinephrine (multi-dose vial); sodium bicarbonate (multi-dose vial); 3–5 cc syringe with 18 or 20 ga. needle for drawing solution and 25 or 27 ga. needle for injecting; small (~50 ml) stainless steel medicine cup for mixing solution and drawing into syringe.

3 *Suture material*:

a *For labiaplasty, minora (LP-m); clitoral hood reduction (RCH)*: 5-0 Monocryl on PC-5 needle; 5-0 or 4-0 Vicryl on a SH-1 needle for sub-cutaneous closure; 5-0 Vicryl Rapide or 5-0 Vicryl on a PC-3 needle for skin (sub-cuticular or interrupted/mattress skin closure).

b *For labiaplasty, majora (LP-M)*: the author uses 4-0 Vicryl, 4-0 Monocryl, or 4-0 PDS on SH or SH-I needle for the cubcutaneous layer, and 5-0 Monocryl on a PC-5 needle for sub-cuticular closure, or 5-0 nylon on a PS-3 needle for skin closure. (Sutures removed in 7–8 days.)

c *For PP, VRJ*: the author uses 2-0 Monocryl on a CT-2 needle for deep layers (levators; perineal body); 3-0 or 4-0 Monocryl on an SH or CT-2 needle for second (rectovaginal fascia) layer; and 3-0 or 4-0 Vicryl on an SH-I needle for vaginal mucosa and perineal closure.

Medications, ancillary supplies

Pre-op sedation/analgesia and anesthesia supplies have been reviewed earlier. Extra instruments, singly packaged, should be available.

"Goodie Bag"

Our office supplies our patients with a supply bag containing many items they will need for their recovery, including:

a Medium-sized latex gloves
b Disposable panties
c 4 × 4s
d Telfa pads
e Arnica tablets

f 30 gm container of Cu-3 Hydrating Gel, a copper-based hydrating gel to be gently placed on the surface of the incision lines b.i.d.
g Canister of Dermaplast analgesic spray.
h Inflatable "doughnut" cushion.
i Two reusable small-sized soft ice packs.
j Angled sprayer squeezable peri-bottle for hygiene.
k Package of witch-hazel wipes for hygiene.

Personnel

Procedure room personnel may certainly vary with personal preference. The author prefers a surgical assistant (two office employees who have learned under his tutelage alternate) and an RN who acts as a "hand-holder" and circulating nurse, monitors the patient, manages emergency supplies, keeps the surgical record, helps position the patient, monitors any friend/family members present, recovers the patient, and cleans up/sterilizes equipment.

Estimated operative, post-op, and recovery time

Operative times of course vary with surgeon and patient, and there certainly is a learning curve, but a properly performed LP-m varies between 45 minutes–1.75 hours, depending on complexity and amount of hood and/or posterior commisure to be included; LP-M approximately 1–1.25 hours; simple PP approximately 1–1.25 hours, and PP/VP 1.25–2 hrs surgical time.

CHAPTER 21
Standards of care

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> Only the mediocre are always at their best.
>
> *Joan Giraudoux*

Standards of care (SOC) are the rules by which the consumer, in this case our patients, may be protected and guaranteed a minimal level of professional competence. Medical SOC are most often delineated by professional societies or organizations. In their absence, they may be forthcoming from hospitals via privileging guidelines, and even by legislation. Over time, "community standards" develop relating to the "usual custom and practice" of members of that community. One would hope that these are high standards, but unfortunately this is not always the case. Often, "standards of care" is a legal rather than a medical definition, a hard fact that physicians only viscerally understand after the papers for a professional liability action have been filed.

Why are standards of care needed?

The territory in which genital plastic and cosmetic procedures are performed is akin to the old "Wild, Wild West," namely, wide open and unregulated. Across the United States, across the world, and within the local community, there presently exists no comprehensive "standard" or cohesive training program for this distinct surgical discipline, part gynecology, part plastic and reconstructive surgery.

Training in women's genital plastic/cosmetic procedures, from labiaplasty (minora or majora) to hood reduction to hymenoplasty to vaginoplasty for reasons of vaginal tightening and improved sexual pleasure, are *not mandated* in gynecologic residency training programs in the United States and most foreign countries. In fact, *plastic technique* in regards to precise tissue handling, use of fine suture material, plastic closure techniques and procedure design oriented toward aesthetic outcome are not part of traditional gynecologic training. Plastic surgeons certainly are instructed in plastic technique, and receive training in vulvar anatomy, but not all programs teach vulvar surgical techniques, and very few contemplate intra-vaginal anatomy and procedures.

An informed SOC is imperative for patient protection, as there is certainly a difference between good outcome and poor outcome. It is intuitive that surgeons with training specific to genital plastic/cosmetic procedures will on average fare considerably better than surgeons untrained for the specific procedures discussed in this text. A pillar of the Hippocratic Oath is *primum non nocere*. It is within that oath that this chapter is rooted.

An approved OB/GYN residency program teaches its resident staff vulvar/vaginal/pelvic anatomy and extirpative procedures involving the vulva and vagina, most commonly for reasons of malignancy or pre-malignancy. It teaches vaginal wall surgery for reasons of symptoms from a variety of pelvic floor weaknesses. It does not teach plastic labial or clitoral hood procedures or technique. It most often does not take into account the

Female Genital Plastic and Cosmetic Surgery, First Edition. Edited by Michael P. Goodman.

potential effect of vaginal laxity on sexual activities and sexual satisfaction, and this eventuality rarely plays a part in pre-surgical planning. Pelvic floor procedures planned specifically for reasons of tightening to improve cosmesis, friction, and sexual pleasure are not a traditional part of either OB/GYN or plastic surgery programs.

Many plastic surgery programs incorporate labial and hood aesthetic/reconstructive procedures. Many do not. Very few teach vaginal and pelvic anatomy and the ins and outs of a vaginal floor repair. The "ideal" education is depicted in Table 21.1; the present-day reality in Table 21.2.

Precedent exists in both the gynecologic and plastic surgery communities. If we reasonably ask the questions (and certainly develop or imply SOC guidelines) regarding who is most qualified to perform a radical vulvectomy, general OB/GYN or gynecologic oncologist; who is most qualified to perform a laparoscopic pelvic floor repair, general gynecologist or urogynecologist; who should perform a difficult breast reduction or augmentation, general or plastic surgeon, then we certainly must ask the same question in regards to genital plastic/cosmetic procedures. Should there be training and qualification standards for individuals who claim to be able to perform a cosmetic labiaplasty, a clitoral hood reduction, a hymenoplasty, or a perineoplasty/vaginoplasty to tighten the vaginal barrel specifically for sexual-related reasons? One certainly can ask the proverbial but legitimate question: *If your family member was having an "XYZ procedure," whom would you want…"* More succinctly, what is, and what will be, the SOC to which the profession must adhere, if any?

Medical versus legal standards of care

Medically, for genital plastic/aesthetic procedures, the SOC *theoretically* demands:

1. Proper ("adequate") *training* in *patient selection*.
2. Proper *training* in *basic techniques* and individual *technique selection*.
3. Proper *training* in basic *plastic* technique.
4. Proper *training* in female *sexuality and body image issues* (so as to be able to know when to refer to a skilled therapist).
5. Proper *training* in giving *informed consent*.

Legally however, this is not necessarily the case. *There is no true MEDICAL definition for SOC*, although the term is firmly established in law [1] and legally defined as "the caution that a reasonable person in similar circumstances

Table 21.1 Ideal training for genital plastic/cosmetic procedures.

Taught in Residency / Practitioner	Female Genital Anatomy and Diagnostics and Technique	True Plastic Technique	Labiaplasty, Clitoral Hood Reduction–Specific Technique	Perineoplasty, Vaginoplasty Technique Specific for Tightening and Sexual Pleasure	Women's Sexual and Body Image Issues
OB/GYN	++	++	++	++	++
Plastic surgeon	++	++	++	++	++

Table 21.2 The reality re: genital plastic/cosmetic training.

Taught in Residency / Practitioner	Female Genital Anatomy and Diagnostics and Technique	True Plastic Technique	Labiaplasty, Clitoral Hood Reduction–Specific Technique	Perineoplasty, Vaginoplasty Technique Specific for Tightening and Sexual Pleasure	Women's Sexual and Body Image Issues
OB/GYN	++	O	O	+	±
Plastic surgeon	+	++	+	O	+

would exercise in providing care to a patient" [2]. This term (SOC) represents an essential component in a professional liability action in regards to proof that the defendant physician failed to provide the required SOC [1].

As far back as 1860, the Supreme Court of Illinois (in a case argued by none other than Abraham Lincoln) declared that "when a person assumes the profession of physician and surgeon, he [*sic*] must…be held to employ a reasonable amount of skill and care" [3].

"With no clear medical definition for SOC, it remains unclear how this mainly legal concept…compares in status to consensus statements or clinical guidelines that are secured in evidence-based medicine and produced by a representative organization or authoritative medical body" [4]. "Consensus statements should represent views from a broad-based, non-advocatory, balanced and objective panel of experts providing a collective agreement keeping in mind that variation is possible among individuals" (WIH Consensus Development Program) [4].

Clinical practice guidelines produced by specialty organizations, government agencies, and healthcare organizations can assist practitioners and patient decision making regarding appropriate healthcare decisions. A problem here of course is that biases of "experts" may inordinately shape these guidelines. "Modern and scientific healthcare should be firmly set in evidence-based medicine, defined as…best evidence in making decisions about the care of individual patients" [5]. "The term 'SOC' should be used with caution. Currently, it can be self-awarded by either a group of like-minded individuals or by a specialty society or organization and is a term which may be abused with the intention of providing impact and authenticity to a point of view" [5].

Strauss and Thomas [1] suggest that perhaps the term "SOC" should not be used without sufficient supporting evidence (e.g., randomized clinical or unchallenged meta-analyses). SOC is basically a legal term. Negligence in general is legally defined as straying from "the standard of conduct to which one must conform…[and] is that of a reasonable man under like circumstances" [6]. Legally, four elements must be met for a plaintiff to recover damages in a professional liability action: [1] Duty, [2] breach of duty, [3] harm, and [4] causation [7]. For example, in regards to genital plastic/cosmetic surgery, the surgeon has a *duty* to know how to perform the procedure; it is a *breach of duty* to operate without the proper training. In the absence of a poor outcome, this lack of proper training may be moot, but if there is *harm*, *causation* must be proven by linking surgery in the absence of proper training directly to the bad outcome (*harm*.) This second element, "breach of duty," implies conduct outside of the SOC [8].

Summing up, SOC medically is "the watchfulness, the attention, and the prudence that a reasonable practitioner in the circumstances would exercise" [9]. The problem is that the "standard" is often a subjective issue upon which reasonable people can differ.

Understanding the medical and legal disparities, what can be done to protect our patient from un-/undertrained individuals? Who should protect our patients? Whose duty is it? If we don't police ourselves, others (the tort system) will do it.

Who should perform specific surgical procedures: "credentialing" for genital plastics

Another means by which the consumers—our patients—may be protected and guaranteed a minimal level of professional competence is via credentialing or privileging. It is an ethical imperative that a healthcare practitioner perform only those procedures or therapies that she or he is trained in and familiar with (see "Freestanding Training Programs," below).

A large number of genital plastic procedures are performed in healthcare facilities by un- or undertrained healthcare providers. As it is also true that SOC is largely a retrospective legal rather than medical concept, how is one to proceed in the new field of female genital plastic/cosmetic surgery to assure consumer safety and physician competence?

"Credentialing" is a mechanism designed for protection both of the healthcare institution and the consumer. *Mosby's Medical Dictionary* [9] defines "credentialing" as "examination and review of the credentials of individuals *meeting a set of educational or occupational criteria* and therefore being licensed in their field. Strict credentialing is required by both hospital and managed care accreditation bodies. The process is conducted peridically because of the responsibility of the organization for any claims of malpractice by its staff."

Differing only slightly is *Segen's Medical Dictionary* [10], which defines credentialing as "The process of reviewing a health professional's *credentials, training, experience, or demonstrated ability,* practice history and medical certification or license to determine if clinical privileges to practice in a particular place are to be granted. A much less frequent use of the term applies to closed panels and medical groups and refers to examination of the credentials of a physician or other health care provider to determine whether that provider should be entitled to clinical privileges at a hospital or managed care organization.

The definitions are clear: *training, experience,* and *demonstrated ability* are prerequisites for credentialing, or the "privilege" of utilizing a hospital or outpatient facility to perform a (surgical) procedure.

It may be difficult to determine specific SOC within a given medical community. Who should determine SOC for genital plastic and aesthetic procedures? No distinct specialty organization speaks for practitioners who perform FGPS, and the self-serving nature of such organizations is often suspect. The procedures overlap the fields of gynecology, plastic surgery, urology, and sexual medicine, and no distinct organization presently speaks in a cohesive manner for genital plastic/cosmetic surgeons. Are standards to differ with community? State? Area of the country? Nation? In the present era of the Internet and Google, patients are educated and informed and are mobile, regularly crossing state lines and national boundaries to find qualified, experienced surgeons. In almost every state, or nearby, are trained surgeons with an increasing level of experience.

This confusion does not exist for credentialing; the lines are clearly drawn. Has the practitioner been *trained* (including self-training with evidence of continuing medical education (CME) and sufficient volume of procedures to satisfy credentialing, aka "grandfathering") in the procedure of cosmetic reductive labiaplasty, or for vaginal rejuvenation (VRJ), perineoplasty (PP), or vaginoplasty (VP) for reasons of vaginal tightening? Can the physician produce evidence of *training* and/or *experience* in these specific procedures either in his or her residency, a stand-alone training course, or via the performance of a minimum number of cases, *proven by a case list*? If he/she can, it is the responsibility of the credentialing institution to affirm, frequently by proctoring either from a staff member already privileged in the procedure specified or via video proctoring, the applicant's *demonstrated ability* to perform the procedure. Additionally, as credentialing is an ongoing process, as in other surgical privileges, the practitioner must affirm his or her continued experience and demonstrated ability by confirming a minimum number of cases ongoing every 2–3 years, as per the requirements of the institution. This is the present standard for surgical procedures. It is curious that this standard is not upheld in the area of plastic/cosmetic genital surgery, a standard made difficult secondary to the lack of an established board willing to take these procedures under its "umbrella."

Because a general surgeon has privileges to perform a mastectomy would not, at most hospitals and surgery centers, confer automatic breast augmentation or reduction privileges. Neither would an institution automatically grant radical vulvectomy/node dissection privileges to a practitioner who has proven experience with only wide local vulvar excision. Unfortunately, hospitals and surgical centers have not noticed that physicians at their institutions are performing labiaplasties and clitoral hood reductions under the false umbrella of "wide local excision, vulva" or "partial vulvectomy." In some cases, the procedure of "labiaplasty" may be included under this umbrella, but it is not the cosmetic procedure becoming the standard of care that is performed most often today.

Part of the credentialing process in many states is surgical proctoring. "Surgical proctoring is a peer review process governed by institutional bylaws and administered through a credentialing committee to objectively monitor, regulate, or oversee surgical privileging for its medical staff. Its primary purpose is to insure safety and quality of care for patients undergoing surgical procedures at the institution" [11]. The surgical proctor is an independent and unbiased monitor acting only to assess the required skills of the proctored physician. The proctor must be proficient in the skills being evaluated and may either hold privileges for the procedure in the same or another institution. Proctoring may be either immediate, on-site, or in the eventuality of unavailability of a suitable proctor, tele-proctoring, or remote evaluation through direct observation of a procedure is possible given the speed, bandwidth, and security of presently available Internet connections. Tele-proctoring may be the most cost-effective method for institutions unable to identify a local proctor for surgical privileging [12].

Suggested minimal standards

It is only a matter of time until hospitals are named in the burgeoning number of professional liability actions involving FGPS. Plaintiffs' attorneys are realizing that another set of deep pockets exist within their reach, namely the institutions that allowed a healthcare practitioner untrained in genital plastic/cosmetic procedures to perform these procedures.

Credible training in the relatively specialized field of genital plastics is difficult to come by. The procedure of cosmetic labia minoraplasty, reduction of excess clitoral hood epithelium, labia majoraplasty, release of a phimotic clitoral hood, hymenoplasty, and VRJ/PP/VP for enhanced sexual function is not presently a part of OB/GYN residency curriculums. Fortunately, there are a small handful of credible training programs around the United States where a surgeon can attend to learn technique, patient selection, equipment, sexual issues, risks, complications, and so forth. However, for patient and facility protection, more formal training programs, either freestanding or sponsored by specialty organizations, in addition to being taught in residency training programs, are necessary.

Post-graduate ("residency") training

It is the goal of post-graduate specialty training programs to instruct their trainees in order to maintain minimum competence in the procedures they are likely to encounter in their professional lives, and this training shifts over time with changes in practice patterns. Although use of an endoscope for diagnostic and minimal operative procedures was taught in OB/GYN residency programs in the 1970s and 1980s, it was not until the 1990s, a full 10 years after the original minimally invasive laparoscopic surgeons began their "operative gymnastics" (the term academicians gave to laparoscopic management of ectopic pregnancy, laparoscopic ovarian surgery, and laparoscopic hysterectomy in the 1980s), that residency programs began including minimally invasive endoscopic procedures into their instructional armamentarium. Similarly, the reality of female genital plastic/cosmetic surgery and the fact that it is community rather than academic surgeons who are qualified to perform these procedures will force residency training programs to incorporate both training in plastic technique and training in specific procedures into their programs. Each program will of course set its own standards. Box 21.1 broadly suggests minimum standards.

Box 21.1 Suggested minimum standards for residency training

Minimum standards, residency
- Didactic, anatomical, and experiential hours in patient selection, intra- and post-operative care of vulvar reduction patients (LP; CHR).
- Concept of adaptation of anterior and posterior colporrhaphy and perineoplasty for reasons of cosmesis and enhancement of sexual function.
- Sexuality and body image issues involved in genital plastic/cosmetic surgery.
- Observation and performance of a minimum number of procedures.

OB/GYN residents traditionally receive training in wide excision of vulvar lesions, a procedure that bears no resemblance (other than the fact that it is in the same anatomic area) to the plastic surgery–based aesthetic reductions mandated for cosmetic labiaplasty and redundant clitoral hood epithelium. Additionally, residents are taught site-specific repairs for prolapse and herniations of the pelvic floor and vagina, without understanding the sexual nature of many complaints, and technique for modifying these surgeries specifically for assuring vaginal tightening for increased sexual pleasure and the pelvic floor physical therapy techniques utilized to improve results. The plastic tissue–handling techniques mandatory for successful genital aesthetics are not presently taught in most all OB/GYN residencies. Vulvar plastic procedures are "hit or miss," and vaginal anatomy and procedures are only occasionally taught in plastic surgery residency programs.

Freestanding training programs

In the absence of training in residency programs, if a surgeon wishes to become competent in genital plastic/cosmetic procedures, she or he must either learn on his/her own in a hit or miss experiential fashion or attend one of a small handful of training programs or preceptorships available around the United States and Europe. Several well-experienced "mentors" either teach formal courses of 2–3 days in length or act as preceptors and mentors, specifically and personally explaining the specific surgical procedures, risks, patient selection, sexuality aspects, pre- and post-op care, and other aspects of genital plastics to their students.

Surgical courses and preceptorships are designed to provide surgeons with the requisite knowledge and

Box 21.2 Suggested minimum standards for freestanding training programs.

Minimum standards, training course (for OB/GYNs, plastic surgeons)

- Two-day minimum didactic and experiential training in external (LP, CHR) and internal (tightening) procedures.
- Observation of a minimum of two–three procedures, at least one of which is a vulvar procedure.
- Proctorship for first one or two LP-related cases.

Box 21.3 Suggested "grandfathering" standards.

Minimal standards, "grandfathered"

- Operative report evidence of ≥20 labiaplasty/RCH procedures and ≥10 tightening-related perineoplasty-related colporrhaphy/perineorrhaphy procedures.
- Minimum 25 units category 1 CME related to female genital/plastic procedures within the preceding 5 years.

Box 21.4 Suggested CME requirements.

Minimal standards, CME

- 25 units category 1 genital plastic-related CME q 5 years.
- 20 units CME in genital plastic-related literature or women's sexuality-related literature q 5 years.

skills to perform a surgical procedure prior to being proctored at their local institution, if so required. Preceptorships are a mechanism for acquiring the surgical skills to perform specific genital plastic/cosmetic procedures for surgeons already familiar with basic vulvar and vaginal anatomy and surgical technique. Short training programs and preceptorships must not attempt to substitute for lack of surgical training and familiarity with female vulvar and vaginal anatomy and should be available for previously trained and experienced surgeons, preferably board-certified or board-qualified gynecologists or urogynecologists, plastic surgeons, and, in some instances, cosmetic surgeons who have previously completed a general surgery residency. Box 21.2 suggests minimum standards for freestanding preceptorship training programs.

"Grandfathering"

In the absence of training in residency programs and, until recently, freestanding programs, many individuals have "trained" themselves. Similar to early pioneers in virtually all novel surgical disciplines (see early years of minimally invasive endoscopic surgical techniques), many surgeons, via reading the available literature re: technique, speaking personally with other surgeons already practicing genital plastics, and "trial and error," have become proficient in the performance of female genital plastic/cosmetic procedures and, in many cases, are presently training others. Certainly, in any discussion of SOC, credentialing, and minimal training recommendations, these many individuals must be recognized. For credentialing purposes, this may be accomplished by mandating evidence of a minimum number of cases and CME. Proctoring may be more difficult to mandate, as it may be these same individuals who may be called upon to be the proctors. Box 21.3 suggests "grandfathering" standards.

Continuing medical education

Any discussion of credentialing and privileging is incomplete without a parallel discussion of CME. Again, CME may not necessarily be considered part of SOC, but it certainly falls under the umbrella of ongoing privileging requirements. There presently are organizations (ACOG, AAPS, ASAPS, ASPS, AACS, ISCG, etc.) and individuals available to organize worthwhile CME activities for those surgeons wishing to begin, and for those presently holding privileges in female plastic/cosmetic genital procedures. Box 21.4 suggests CME requirements.

Experience and quality of care

Experience counts. The difference between a quality result and a disastrous result is obvious and is directly parallel with training and experience. Developing expertise takes a combination of exposure and practice along with a modicum of inherent luck, talent, or a combination of these [13].

To quote Barbara Levy, MD, in an editorial in the journal *Obstetrics and Gynecology*, "Our challenges in providing excellent surgical care for women are real. It will be critical for us to acknowledge variances in surgical performance and begin to define standard measures necessary to optimize outcomes for our patients. Quality initiatives—efforts to recognize and attempt(s) to reduce variance in outcomes—will, of necessity, involve assessment of both surgical volume and overall surgical experience. A commitment to professionalism

and dedication to teaching and promoting surgical intervention should be based on patient outcomes. Data and science, not marketing and expediency, are required if we are to provide optimal care" [13].

What are the goals of establishing minimal SOC, most likely via a process of privileging and credentialing? For the primary goal of protection of our patients' well-being (the expressed reason for SOC mandates), minimum training and experiential guidelines would be set in the privileging process. These guidelines and the credentialing process specifically will result in greater legal protection for both patient and surgeon. As procedures and qualified practitioners are identified and credentialed within medical communities, a workable horizontal and vertical referral process may be established, and clearer "community standards" will be set and available to all.

Equally, if not of greater import, would be the inclusion of vulvovaginal plastic and aesthetic techniques into both plastic surgery and—*especially*—OB/GYN training programs. It is time for residency directors and others responsible for GYN post-graduate education to recognize both the importance of these skills for their graduates and the rights of their patients to quality, experienced attendance. Taking this concept one step further, academic programs certainly could adopt community practitioners into their training programs and make this mainstream or at least begin teaching these procedures or accept their growing popularity.

Are any of these goals and mandates enforceable? As community standards, enforcement is unlikely, but as standards for individual licensed institutions they are eminently enforceable. A practitioner either is or is not allowed to perform a given procedure within an institutional setting via mandates in place for the protection both of the institution and the patients it serves. It is consumer-friendly as a mechanism for physician selection by patients and medical-legal importance related to SOC issues within the tort system.

Can this process be skirted by practitioners operating outside of the traditional licensed facility system? Of course it can; no system of medical checks and balances is foolproof. Facilities outside of the traditional hospital/surgical center model may not require a specific credentialing or privileging process. However, these facilities and practitioners operating within them must still medical-legally adhere to community standards, and if these are set in a manner discussed above, untrained and/or inexperienced practitioners certainly expose themselves to additional risk.

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EXHIBIT L

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REVIEW ARTICLE

Cosmetic

The Safe Practice of Female Genital Plastic Surgery

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Summary: The purpose of this article is to guide surgeons in the safe practice of female genital plastic surgery when the number of such cases is steadily increasing. A careful review of salient things to look for in the patient's motivation, medical history, and physical examination can help the surgeon wisely choose best candidates. The anatomy is described, with particular attention given to the variations not generally described in textbooks or articles. Descriptions are included for labiaplasty, including clitoral hood reduction, majoraplasty, monsplasty, and perineoplasty with vaginoplasty. Reduction of anesthetic risks, deep venous thromboses, and pulmonary emboli are discussed, with special consideration for avoidance of nerve injury and compartment syndrome. Postoperative care of a variety of vulvovaginal procedures is discussed. Videos showing anatomic variations and surgical techniques of common female genital procedures with recommendations to reduce the complication rate are included in the article. *(Plast Reconstr Surg Glob Open 2021;9:e3660; doi: 10.1097/GOX.0000000000003660; Published online 6 July 2021.)*

THE SAFE PRACTICE OF FEMALE GENITAL PLASTIC SURGERY

Female genital plastic surgery is growing in popularity. Labiaplasty in particular has increased 600% in less than a decade in the United States, from 2142 procedures in 2011 to12,903 in 2019.[1,2] These numbers are likely an underestimate because they do not account for the procedures that gynecologists perform.[3] This rise, which is global, has been attributed to several reasons, including functional, sexual, and appearance-related concerns; online access to information; the proliferation of photographs on the internet; depilation; negative comments; and cultural influences.[4–40]

Female genital plastic surgery includes labiaplasty, clitoral hood reduction, labia majoraplasty, perineoplasty, vaginoplasty, and monsplasty. Less common procedures, which are beyond the scope of this article, include hymenoplasty, anterior and posterior commissuroplaty, and labia minora reconstruction after iatrogenic amputation and female genital mutilation.[3,41] Nonsurgical procedure modalities, such as energy-based devices, PRP injection, the O-shot, and G-spot augmentation, are also beyond the scope of this article.

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EVALUATION

Establish Goals, Motivation, and Expectations

Patients interested in labiaplasty, the most commonly requested procedure, may complain of chaffing, itching, personal hygiene issues, dyspareunia, pain with exercise, tugging, exposure in a bathing suit, recurrent urinary tract infections, and deviation of urine stream.[7–40] Patients interested in vaginoplasty and perineoplasty after vaginal delivery may note loss of friction during intercourse and reduced sexual satisfaction.[42–44] Mons and labia majora concerns are generally cosmetic. Professional cyclists with labia majora hypertrophy may request a labia majora reduction to relieve pain and pressure.[45,46] Validated questionnaires can provide an objective measure of symptoms and motivations.[7,9,10,15,17,29,30,33,47,48]

As with any aesthetic procedure, the surgeon should vet patients for unrealistic expectations and body dysmorphic disorder. Body dysmorphic disorder is defined

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as a disproportionate dissatisfaction with the appearance of normal-appearing female genitalia, yet an *assumption* that a woman with normal-appearing anatomy desiring a female genital cosmetic procedure must be experiencing body dysmorphic disorder may indicate an evaluating physician's failure to understand the symptomatology and cosmetic concerns that can be associated with normal anatomy.[7,15,47] The marked drop in body dissatisfaction symptoms following female genital plastic surgery suggests that many of these patients likely have body dissatisfaction rather than true dysmorphia. Nonetheless, these patients should be carefully counseled and screened during consultation.[17] The patient may have already seen online images that may or may not convey an accurate impression of what surgery can accomplish, so a discussion with a review of before-and-after photographs can help establish realistic expectations.

If a vaginoplasty or perineoplasty is considered, a thorough obstetrical and gynecological history, including method of delivery, urinary incontinence, and pelvic maladies, is particularly important to elicit in vaginoplasty and perineoplasty patients.[49,50]

Body Mass Index

A high body mass index (BMI > 30) raises surgical risks in any patient, but it is a particular concern in patients interested in vaginoplasty and perineoplasty. Chronic pressure on the pelvic floor predisposes these patients to POP, urinary incontinence, rectocele, and cystocele.[51,52] Ninety percent of morbidly obese women experience pelvic floor disorders, compared with 23.7% of women in general.[53–55]

Parity

The trauma of vaginal childbirth, especially with the use of forceps or vacuum; multiparity; and high newborn birthweight can widen the vagina and injure both the pudendal nerve and the levator ani muscle complex, predisposing to POP.[56–61]

Menopause

The loss of estrogen production with menopause can result in atrophy of the genital tissues, leading to vaginal pain, vulvar pain, itching, discharge, and dyspareunia from loss of lubrication and narrowing of the vagina. Additionally, an increase in vaginal pH predisposes postmenopausal women to urinary tract infections.[61] Within a decade of menopause, half of women experience these symptoms, defined as the genitourinary syndrome of menopause.[62] Locally active estradiol cream, capsules, tablets, and rings can help increase vaginal mucosa thickness, reduce vaginal pH, improve moisture, and relieve dyspareunia.[63–65]

PHYSICAL EXAMINATION

The patient should be examined both standing and in the lithotomy position. An examination chair with retractable stirrups facilitates visualization and promotes patient comfort. In the standing position, the labia minora are noted for the degree of projection beyond the labia majora, and the labia majora are noted for ptosis, volume, and fullness.

Superficial Anatomy of the Vulva

The vulval complex can be divided into structured anatomical regions: the mon pubis, clitoral area, the labial-clitoral complex,[66] labia minora, labia majora, and perineal area (Fig. 1). As with facial aesthetics, surgery of the vulva should achieve "genital harmony."[66] Most textbooks and scientific articles illustrate the vulva with little variation, disadvantaging surgeons who may be unprepared for the anatomic variations they encounter[66–69] (Fig. 2).

Labia minora classification systems often focus on length, measured from introitus to edge; degree of protrusion beyond the labia majora; or the relationship of minora, majora, clitoral hood, and fourchette.[66,68–71] Dimensions help in operative planning but are poor determinants of a patient's candidacy for labiaplasty. Far more important is patient symptomatology.[7,15,47]

Instead of using absolute measurements, one of the authors (PEB) has described 3 main anatomical variants, based on the maximal projecting point of the labium: Type I projects maximally in the upper third, Type II in the middle third, and Type III in the lower third (Fig. 3). Contralateral sides can differ. These variants may influence choice of labiaplasty technique, trim or wedge, and the type of wedge[72] (Fig. 4).

Evaluation for Vaginal Laxity, Rectocele, and Cystocele

Candidates for vaginoplasty and perineoplasty should be evaluated for pelvic organ prolapse (POP), including rectocele and cystocele.[73–75] A cystocele is associated with urinary frequency, urgency, and incontinence; a rectocele is associated with constipation, including a history of digital manipulation to facilitate defecation.[73] Patients with POP, obstructed defecation, or urinary or anal incontinence should be referred to a gynecologist, urologist, or urogynecologist.[2,18,73–75] The short form Pelvic Organ Prolapse/Urinary Incontinence/Sexual Questionnaire (PISQ-12) aids in screening patients.[76]

In the standing position, the female perineum is typically located at a level within 2 cm of the ischial tuberosities. If the perineum lies below this level, at rest or with a Valsalva maneuver, the patient should be referred for an evaluation of POP.[42,44] In the lithotomy position, observation of attenuated mucosa with scant muscle bulk within the perineal body and proximity of the posterior fourchette to the anus should be noted. As the patient bears down and tightens, the surgeon can digitally assess the vaginal width and the levator ani muscles, each finger breadth of separation approximated 1 centimeter.[42] A rectovaginal examination is conducted to assess the integrity of posterior vaginal wall.[2,42,50] Lax, widely separated levator ani muscles are best addressed with a vaginoplasty.[42,44]

NERVE SUPPLY, VASCULATURE, AND MUSCLES

The pudendal nerve innervates the external female genitalia, splitting into the deep and superficial perineal

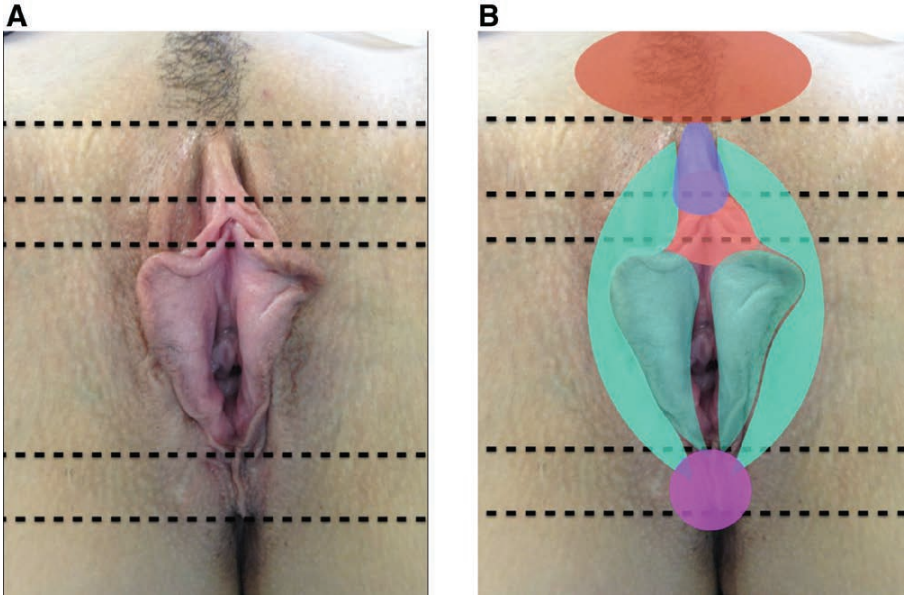

Fig. 1. A, Systematic assessment of the vulval complex. Dividing the vulval complex into 6 areas allows careful evaluation. B, Careful attention should be paid to each of these areas: labia minora, clitoral complex, labial-clitoral interface (complex), labia majora, pubic area, and perineal area. The quality of the tissues, rugosity, pigmentation and asymmetries should be noted. Reproduced with permission from Hamori CA, Banwell PE, Alinsod R. eds. *Female Cosmetic Genital Surgery. Concepts, Classification, and Techniques*. New York: Thieme; 2017.

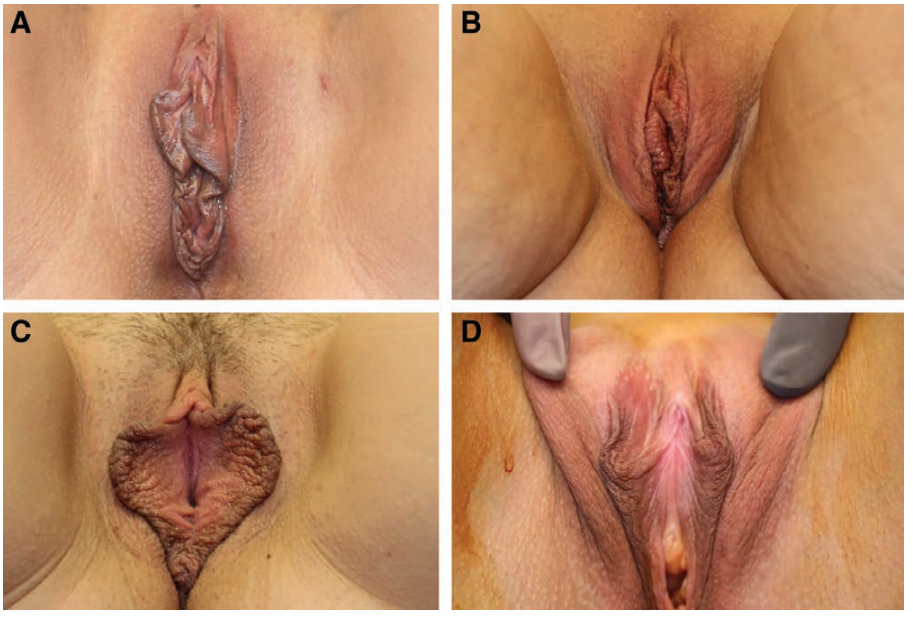

Fig. 2. Anatomic variations seen in clinical practice. Labia minora vary in pigmentation, texture (rugose or smooth), thickness, symmetry, shape, projection, and symmetry. Above left, This patient has a double clitoral hood, with an upper fold and lower fold. In this case, the lateral fold merges onto the superior aspect of the labia minora. Above right, In this patient, the lateral clitoral hood merges with the medial labia minora. The labia minora merge superiorly with the medial labia majora. The clitoris is recessed, and clitoral hood projects more laterally than centrally. Below left, In this patient, the thick mucosa of the fourchette merges with the raphe over an expansive area. Below right, In this patient, the clitoral hood merges onto the medial labia minora, and the labia minora merge superiorly onto the medial labia majora. Reproduced with permission from *Plast Reconstr Surg*. 2020;146:451e–463e. 10.1097/PRS.0000000000007349.[2]

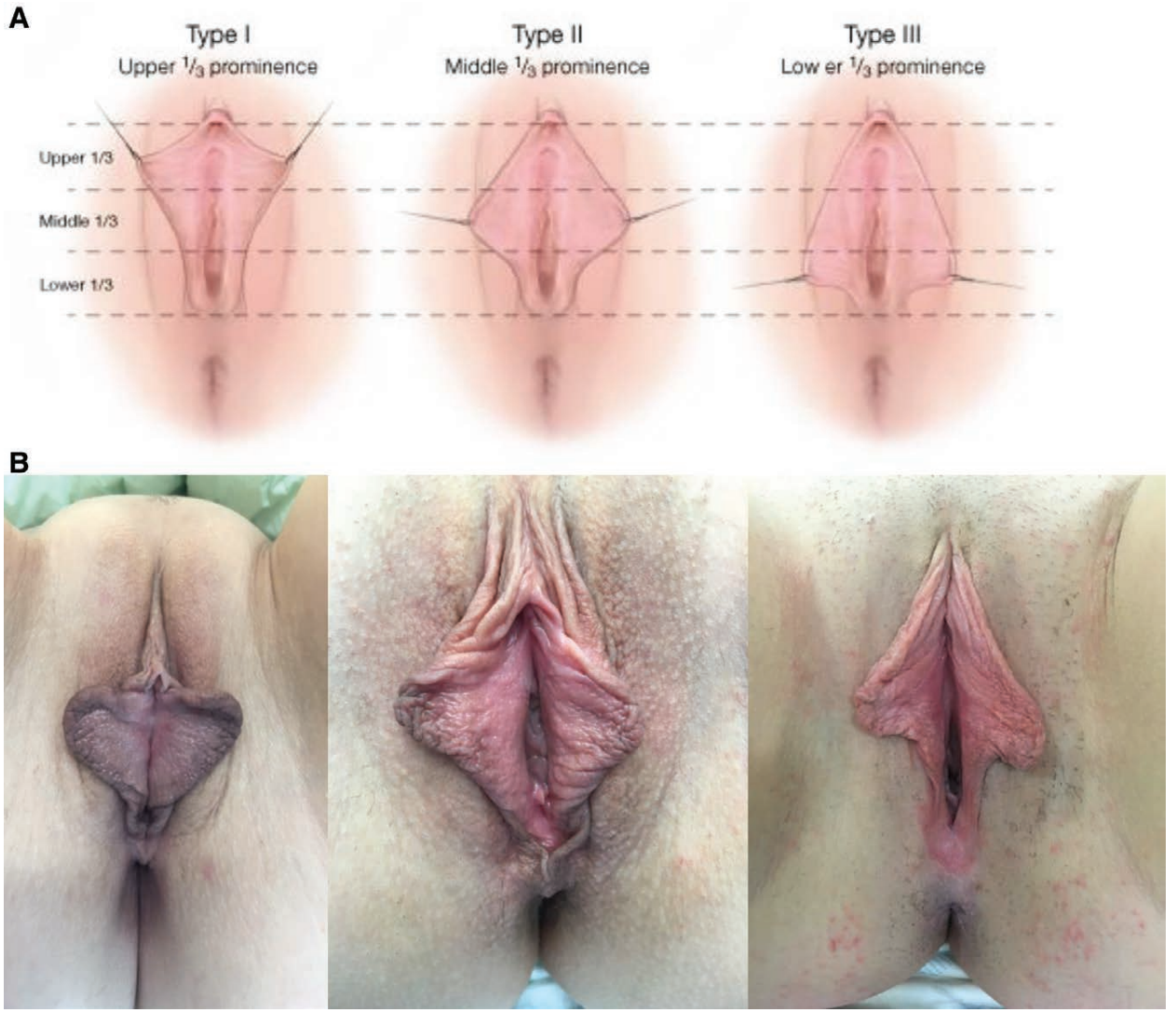

Fig. 3. The Banwell Classification. The labia minora are divided into three morphological types. Top left, center, and right, The most prominent point (width) of the labia may be seen in the upper third (Type I), middle third (Type II), or lower third (Type III). Example of Type I (lower left), Type II (lower center), and Example of Type III (lower, right). Reproduced with permission from Hamori CA, Banwell PE, Alinsod R. eds. *Female Cosmetic Genital Surgery. Concepts, Classification, and Techniques*. New York: Thieme; 2017.

nerves. The deep perineal nerve gives rise to the dorsal nerve of the clitoris, and the superficial perineal nerve gives rise to the posterior labial nerve, its sensory branches innervating the labia minora, with sparse branches to the labia majora.[2,66,77] Deep to the clitoral fascia, the tunica albuginea encapsulates the dorsal clitoral nerve and artery and erectile cavernosa.[78] The dorsal clitoral nerve travels deep, along the medial ischiopubic rami, emerging in its trajectory toward the glans. If the surgeon remains far from the glans and superficial to dartos fascia, injury to the clitoris is unlikely.[2,66,77]

The pudendal artery provides the blood supply to the labia majora and minora via the posterior labial and perineal arteries. The labia minora are supplied by a small anterior artery, a dominant central artery, and two moderate posterior arteries (Fig. 4). The external and internal pudendal arteries communicate through branches along the anterior labia minora and also through the frenulum arteries. When planning a wedge labiaplasty, the surgeon should remember that the anterior labium minus is the least perfused. A posteriorly based flap has a more reliable blood supply than one based anteriorly.[72] Of note, the nerves and vasculature of the labia minora travel within interstitial connective tissue, which is nonerectile.[79–81]

The bulbocavernosus muscles are positioned like parentheses deep to the labia majora, uniting posteriorly to form part of the bulk of the perineal body. The medial transverse superficial perineal muscles, arising from the ischial tuberosities, contribute the remaining bulk. The pubococcygeus, the iliococcygeus, and the puborectalis constitute the levator ani muscles. These broad, thin muscles that form a major part of the pelvic floor separate

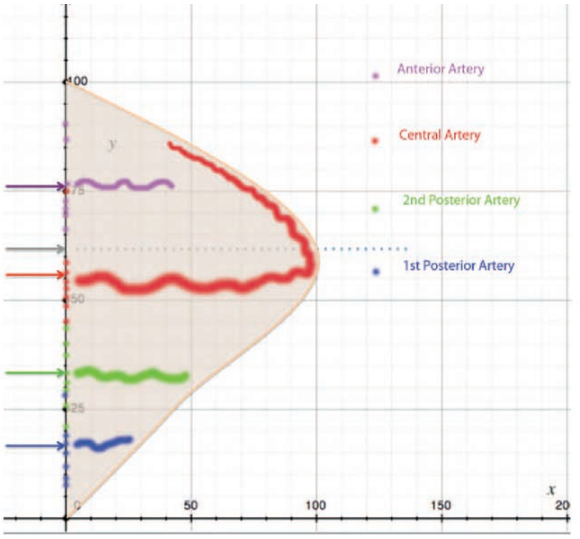

Fig. 4. Mapping of the labial arteries. On the y axis, emergence of the arteries found in every subject is noted. An arrow indicates the mean value of emergence for every artery as a distance from the posterior fourchette. The anterior artery is small, the central artery is dominant, and there are two posterior arteries. Reproduced with permission from *Plast Reconstr Surg*. 2015;136:167–178. doi: 10.1097/PRS.0000000000001394.[72]

with pregnancy and childbirth, predisposing to vaginal laxity[42,44] (Fig. 5).

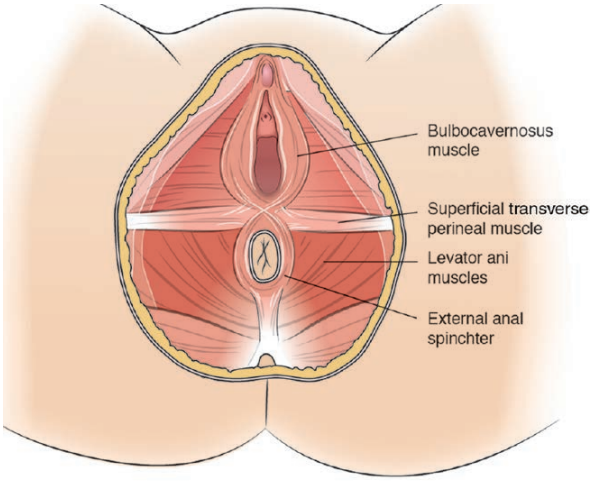

Fig. 5. Vaginal laxity results from the trauma and stretching associated with pregnancy and vaginal delivery. The stretching can attenuate the tissues and separate the levator ani, bulbocavernosus, and superficial transverse perineal muscles, similar to diastasis of the rectus abdominis. Reproduced with permission from *Plast Reconstr Surg*. 2020;146(4):451e–463e. doi: 10.1097/PRS.0000000000007349.[2]

ANESTHESIA

Types of Anesthesia

Local anesthesia with oral sedation is ideal for labiaplasty. Majoraplasty, perineoplasty, and mons liposuction can be done under local with oral or intravenous sedation, but general anesthesia may be preferred if the operative site is scarred, multiple procedures are being performed, or the surgeon anticipates difficulty. A vaginoplasty can be performed under general anesthesia or pudendal block.[2] Local anesthesia avoids potential complications associated with general anesthesia (like nausea, vomiting, and the rarer aspiration pneumonia, malignant hyperthermia, and thromboembolic events), but some patients are more comfortable under general anesthesia.[2]

Prevention of Deep Venous Thrombosis and Pulmonary Embolism

Risk factors for deep venous thrombosis and pulmonary embolism include age older than 35, BMI more than 25, hypercoagulability, family history, smoking, and estrogen therapy.[82] To lower those risks, patients can lose weight and temporarily cease taking exogenous estrogen 3–4 weeks before and after surgery. Sequential compression devices can be used during surgery and the stirrups positioned so the hips flex at 90 degrees in the lithotomy position, maximizing venous drainage. After surgery, patients should engage in early ambulation and hydrate themselves sufficiently.[83–86] The American Society of Plastic Surgeons and American Association of Plastic Surgeons advocate the Caprini scoring system for risk assessment, which should be filled out before surgery and guide intraoperative and postoperative prophylaxis.[87,88]

Prevention of Nerve Injury

The dorsolateral position, with the lower extremities in stirrups, can result in pressure or stretching of the femoral and lateral femoral cutaneous nerves. Hip flexion more than 90 degrees and knee extension can create tension along the sciatic nerve and compress the peroneal nerve against the head of the of the fibula.[89,90] Patients who are thin, diabetic, and/or alcoholic; and those who smoke; have peripheral vascular disease, or have subclinical neuropathies are at a higher risk for neuropraxia. Compressive and stretch mechanisms should be eliminated, and patients' legs should be removed from stirrups after 90 minutes.[89,91] "Candy cane" leg holders can place direct pressure on the nerves, whereas Allen YelloFin Elite Lift Assist stirrups have a boot fin design that limits points of contact and uncontrolled abduction. Fortunately, preventative measures lower injury rates to under 0.5%, and sensory nerve injuries typically resolve within 6 months.[89,92] Motor nerve injuries are possible, but rare.[93]

Prevention of Compartment Syndrome

The dorsolateral position creates hemodynamic changes that can result in compartment syndrome of the leg. Cases are rare, but the consequences are severe, including compromised limb function and muscle damage, leading to rhabdomyolysis, myoglobinemia, and acute tubular necrosis.[94] Signs and symptoms include pain on passive stretch, confirmed by compartment pressures more than 30 mm Hg or within 20 mm Hg of diastolic

blood pressure.[94,95] For complete recovery, release of the affected fascial compartment must be performed within 6 hours of onset.[91] Normalizing leg position every 90 minutes, avoiding hypotension, and limiting operative times drops the risk of compartment syndrome to under 0.3%.[96]

THE PROCEDURES

Labiaplasty (Labia Minoraplasty)

Several labiaplasty techniques have been described, but this article focuses on the most commonly performed: the trim and wedge labiaplasties. The patient's unique anatomy and personal goals should guide the choice of technique. The wedge is a good option for patient wanting to retain her natural labial edges, but if she dislikes her thick, rough, hyper-pigmented edge, she may prefer a trim technique.[97] Mastering more than one technique enables the surgeon to optimally address a variety of patients.[97,98]

Trim

The trim technique is also known as a linear, curvilinear, edge, direct excision, or amputation labiaplasty. The novice labiaplasty surgeon may discover too late how easy it is to over-resect the labia minora.[7,97,99] A running suture closure can permanently scallop the edge. If the suture is pulled too tight, the tension can strangulate the blood supply, scarring and shortening the surviving labium. Alter has described the use of clitoral hood flaps, wedge excisions, and YV flaps to reconstruct amputated labia minora.[100] In the absence of local tissue, reconstruction is difficult.

Thick labia can heal wide and flat without a tapered edge. If the posterior excisions are separated by less than a centimeter or are in continuity, the scar can contract across the fourchette, interfering with intercourse. An excision that extends too far cephalad can divide the frenulum, untethering the clitoris, allowing it to rotate anteriorly and subjecting the patient to chafing, irritation, and pain. Sensation has been shown to remain intact after a trim.[101] (**See Video 1 [online],** which demonstrates a trim labiaplasty and clitoral hood reduction. Part 1. The surgical technique is shown, and the steps are narrated with subtitles. Reproduced with permission from *Plast Reconstr Surg.* 2020;146(4):451e–463e. 10.1097/PRS.0000000000007349.) (**See Video 2 [online],** which demonstrates a trim labiaplasty and clitoral hood reduction. Part 2. The surgical technique is shown, and the steps are narrated with subtitles. Reproduced with permission from *Plast Reconstr Surg.* 2020;146(4):451e–463e. 10.1097/PRS.0000000000007349.)

Wedge

Dehiscence after a wedge labiaplasty can result from resecting an over-sized segment and closing under tension. Over-resection can pull the clitoral hood too far inferiorly and advance the fourchette, narrowing the introitus, resulting in discomfort during intercourse. Notching and color mismatch can occur along the incision line. Dehiscence can also occur with poor blood supply or if only the mucosal surfaces are sutured in the closure. (**See Video 3 [online],** which demonstrates a wedge labiaplasty. The surgical technique is shown, and the steps are narrated with subtitles. Reproduced with permission from *Plast Reconstr Surg.* 2020;146(4):451e–463e. 10.1097/PRS.0000000000007349.)

Poor labiaplasty results can result in amputation of the labia, dehiscence, scarring, pain, dyspareunia, reduced erotic sensation, deformity, and loss of self-esteem.[15,33,102] Dryness, painful scars, scar contracture, and deformity can result from over-resection and amputation of the labia.[99,100] These complications are minimized with appropriate patient selection, choice of procedure, and good operative technique.

Clitoral Hood Reduction

Failure to address a heavy clitoral hood at the time of a labiaplasty can result in patient complaints of a masculine, "penis-like" appearance.[100]

Majoraplasty (Labia Majora Reduction), Majora Liposuction, and Majora Augmentation

Labia majoraplasty consists of reduction and reshaping of the labia majora to address redundant, ptotic, full labia majora.[29,103,106] Professional cyclists may have functional concerns associated with vulvar lymphadenopathy.[45, 46] Redundant skin is excised medially, and adipose tissue can be excised directly in patients who desire reduced fullness and projection. The majora flap should not be precut, to avoid over-excision, but instead should be elevated from medial to lateral, and the redundancy confirmed before establishing the final incision line. Up to 50% of the majora skin is typically excised. A scar placed within the interlabial sulcus is less noticeable than one placed along the medial hairline.

Over-excision of the labia majora can result in a widened introitus that predisposes the patient to dryness and irritation.[103] Other potential complications include scarring, pain, impaired erotic sensation, increased vaginal secretions, dyspareunia, and diminished self-esteem.[103] Vulvar lymphadenopathy may limit the long-term results in intensive cyclists.[45, 46]

Minimal fullness without ptosis may be addressed with liposuction, which should be performed with a cannula under 3 mm in diameter to reduce the risk of bleeding and contour irregularities.[103]

Labia Majora Augmentation

Fat grafting is the most common technique to volumize flat or atrophic labia majora.[69,100,105] A volume of 10–25 ml injected with a 1-ml syringe is recommended, although injections of up to 120 ml have been reported.[105,106] It is far better to undertreat than to overtreat. The possibility of future weight gain should be considered, particularly in the younger patient.

Hyaluronic acid has been injected both subcutaneously and deep to the dartos fascia as a volume filler, with reports of injected volumes ranging from 2 to 6 ml.[105] Adverse sequelae include swelling, bruising, and palpable

nodules, which can be treated with light massage, intralesional corticosteroid, or hyaluronidase injection.[46,107,108]

Monsplasty and Mons Liposuction

The fatty mons with no ptosis can be treated by liposuction, but redundant skin and adipose tissue are best addressed with direct excision through a monsplasty.[103,109,110] Monsplasty candidates are often obese, adding to perioperative concerns,[111] but the surgery has been shown to improve urinary dysfunction and hygiene in massive weight loss patients.[112,113] After the redundant tissue has been excised, Scarpa's fascia should be anchored to the rectus abdominis muscle fascia to avoid descent.[109,110] Potential complications include bleeding, hematoma, and scarring.

Perineoplasty and Vaginoplasty

Vaginal tightening procedures, referred to variably as vaginoplasty, perineoplasty, colporrhaphy, and perineorraphy, have historically been performed for repairs after obstetrical delivery; only recently have they been performed to address sexual and aesthetic concerns.[18,114] Up to 76% of women experience decreased sensation, decreased friction during intercourse, and altered sensation associated with a generalized feeling of vaginal laxity.[14,50,115–119] Gaping of the vaginal vestibule with visibility of the vaginal mucosa, excessive vaginal secretions due to mucosa exposure, altered ability to achieve orgasm, and vaginal air entrapment resulting in embarrassing sounds during sexual intercourse are other sequelae women may experience from vaginal laxity.[50,120,121]

Because sexual satisfaction is impacted by multiple factors, patients hoping for improvement may not achieve what they wish, and patients should be screened and counseled so their expectations are realistic.[17,50] A history of vulvodynia, dyspareunia, or chronic pelvic pain are relative contraindications to vaginal tightening surgery.[48,50]Postmenopausal patients considering vaginoplasty should be on estrogen to thicken their vaginal tissues before surgery.[63–65]

Indications for a perineoplasty include aesthetic concerns, laxity of the introitus, and decreased sexual satisfaction after vaginal delivery.[43,117] Redundant, atrophic perineal mucosa is excised up to the hymen ring, and the bulbocavernosus and the medial transverse superficial perineal muscles are reapproximated to reestablish the pre-delivery anatomy of the perineal body and introitus. After perineoplasty, nearly 90% of patients experience improved rates of sexual intercourse satisfaction.[122] A perineoplasty without muscle plication can be performed for aesthetic reasons in the nulliparous patient.

A vaginoplasty can be done by tightening the anterior vaginal wall by plicating the vesicovaginal fascia. Some surgeons favor tightening the lateral wall to avoid a posterior scar where the pressure and sensitivity are the greatest.[115,123–125] More commonly, the posterior vaginal wall is tightened by plicating the rectovaginal fascia and approximating the levators up to 7–10 mm proximal to the hymen ring. Even without muscle plication, a wedge excision of the vaginal epithelium and rectovaginal fascia shows favorable results in narrowing the vagina.[74,115,126] (**See Video 4 [online],** which demonstrates vaginoplasty. The surgical technique is shown, and the steps are narrated with subtitles. Reproduced with permission from *Plast Reconstr Surg.* 2020;146(4): 451e–463e. 10.1097/PRS.0000000000007349.)

Risks include bleeding, hematoma, injury to bowel or bladder, and rectovaginal fistula scarring, vaginal stenosis, dyspareunia, and altered sensation.[14,43,50,53] Since no objective, reproducible method of measuring vaginal

Table 1. Postoperative Instructions after Female Genital Plastic Surgery (Specific Procedures Are the Details Contained within Female Genital Plastic Surgery)

	General Instructions after Female Genital Plastic Surgery
Voiding	Patients should be straight catheterized at the end of multiple procedures, perineoplasties, or vaginoplasties performed under general anesthesia. At home, patients should void in the shower or with the use of a bidet or squirt bottle and avoid wiping for the first week.
Bathing	Patients can shower right away. During the first week, sitting in a hot bath for a long time should be avoided to minimize venous pressure and vasodilation in the operated area and avoid the chance of bleeding.
Dressings	Antibiotic ointment and peri-pad can be used during the first week for oozing and padding. Some surgeons prescribe topical Estrace to place on the incisions, especially within the vaginal canal after perineal and vaginoplasty.
Pain relief	These procedures are associated with mild to moderate pain. The surgeon's nonopioid pain regimen may be sufficient, but a backup opioid may be prescribed.
Icing	Patients should place a cold pack between their underpants and stretchy outer pants, 20 minutes on, 20 minutes off. The cold pack should not contact the skin directly.
Elevation	Minimize sitting, which puts pressure on the operated area. Unless contradicted by other procedures, patients should get on their elbows and knees and raise their bottom in the air for 10 minutes, 5 times a day for the first week.
Exercise	To reduce the risk of bleeding, patients should take it easy for 2 weeks. Low-impact exercise may be resumed, if comfortable, at 4 weeks, and high-impact exercise begun to 6 weeks. No saddles (bicycle, horseback, motorcycle) for 8 weeks or longer, depending on comfort and duration.
	Instructions after Specific Procedures
Labiaplasty, clitoral hood reduction	No tampons or intercourse for 4 weeks (trim) and up to 6 weeks (wedge), depending on healing.
Monsplasty, majoraplasty	Patients should delay demanding, high-impact aerobic exercise for 6 weeks, and avoid straddling a saddle for at least 8 weeks.
Perineoplasty, vaginoplasty	Tampons and intercourse are avoided for 6–8 weeks. If the vaginal diameter is smaller than desired, the patient can be instructed to use dilators.

laxity has yet been developed, the measure of surgical outcome is limited to physical examination and patient questionnaire.[116]

Clinical Case Studies

A series of clinical case studies of female genital plastic surgery appear in Video 5 (**See Video 5 [online]**, which demonstrates clinical cases of female genital plastic surgery. This narrated video shows different surgical cases with anatomical variations. The cases shown through preoperative and postoperative photographs include trim and wedge labiaplasties, clitoral hood reduction, majoraplasty, and perineoplasty. Reproduced with permission from *Plast Reconstr Surg.* 2020;146(4):451e–463e. 10.1097/PRS.0000000000007349). Postoperative instructions for all patients are listed in Table 1.

OUTCOMES

Overall satisfaction rates after labiaplasty are high, mostly more than 90%.[3–35,40] Labiaplasty is associated with a significant improvement in self-esteem and a significant drop in the labia's negative impact on intimacy, twisting, physical discomfort, clothing restriction, pain, exposure in a bathing suit, and visible outline in tight pants.[3,7] In a prospective study of 62 patients, all patients had symptomatology before labiaplasty; after surgery, 93.5% were symptom-free.[7] Patient outcomes studies after vaginal tightening show an associated improvement in sexual function, sexual satisfaction, desire, and orgasm. Complication rates include 2% inadvertent rectal entry and a low rate of minor complications without long-term sequelae.[18,114,118,127,128]

THE CONTROVERSY

In 2019, the American College of Obstetricians and Gynecologists reaffirmed their 2007 Committee Opinion 378, calling these procedures "untenable" due to the absence of established safety and efficacy.[129] In January 2020, Committee Opinion 795 replaced 378 with softer language that still maintains that vulvovaginal surgery for appearance and sexual function reasons is not medically indicated and poses substantial risk, and women interested in surgery should instead be reassured of the normalcy of their anatomy. The opinion further states that studies demonstrating patient satisfaction with these procedures "should not serve as evidence that these procedures are clinically effective."[130,131] This recommendation ignores the negative impact of *not* performing a cosmetic procedure that can improve quality of life.

Unlike gynecologists, plastic surgeons perform cosmetic procedures on normal anatomic structures and regard a patient's satisfaction to be an important measure of success.[132] Committee position statements published by the American College of Obstetricians and Gynecologists have indicated that physicians who perform cosmetic gynecological procedures are pathologizing the normal vulva and vagina, contributing to women's sexual dysfunction and distress.[133] The stance that women seeking these procedures are victims of a patriarchal ideal is unique among cosmetic procedures.[134] The surgeon performing *any* cosmetic procedure must ensure that the patient is internally motivated to have surgery. Physicians listening to patient requests for female genital cosmetic surgery may themselves be unaware of their own cultural biases.[19,47,135–141]

Teaching these procedures in training programs will help reduce the complications that the American College of Obstetricians and Gynecologists' opinion warns of, and developing more validated questionnaires specifically for female genital cosmetic surgery will expand our understanding of the impact these procedures have on women's lives. When practiced safely, female genital plastic surgery can improve the quality of life for women seeking relief.

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EXHIBIT M

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Vaginal laxity: which measure of levator ani distensibility is most predictive?

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KEYWORDS: 3D/4D ultrasound; pelvic floor; translabial ultrasound; vaginal laxity

CONTRIBUTION

What are the novel findings of this work?
Our results show a clear, statistically significant increase in measures of pelvic floor distensibility in women complaining of vaginal laxity, supporting the growing evidence of an association between vaginal laxity and pelvic floor hyperdistensibility, and contributing to a method for objectively defining this condition.

What are the clinical implications of this work?
Since vaginal laxity is likely to be under-reported by patients, and given its association with pelvic floor hyperdistensibility, gynecologists should be sure to investigate sexual function, especially in women with a clinically wide hiatus or hiatal 'ballooning' on translabial ultrasound.

ABSTRACT

Objective *To assess the predictive value of measures of levator hiatal distension at rest and on maximum Valsalva maneuver for symptoms of vaginal laxity.*

Methods *This was a retrospective study of women seen at a tertiary urogynecological unit. All women underwent a standardized interview, clinical examination and four-dimensional translabial ultrasound examination. Area, anteroposterior diameter (APD) and coronal diameter (CD) of the levator hiatus were measured at rest and on maximum Valsalva maneuver in the plane of minimal hiatal dimensions using the rendered volume technique, by an operator blinded to all clinical data. The association between levator hiatal measurements and vaginal laxity was assessed, and receiver-operating-characteristics (ROC)-curve analysis was used to determine their predictive value.*

Results *Data from 490 patients were analyzed. Mean age was 58 (range, 18–88) years, and vaginal laxity was reported by 111 (23%) women. Measurements obtained on maximum Valsalva were significantly larger in women who reported vaginal laxity than in those who did not, with mean levator hiatal area, APD and CD of* $30.45 \pm 8.74\,cm^2$, $7.24 \pm 1.16\,cm$ *and* $5.60 \pm 0.89\,cm$, *respectively, in the vaginal-laxity group, compared with* $24.84 \pm 8.63\,cm^2$, $6.64 \pm 1.22\,cm$ *and* $5.01 \pm 0.97\,cm$ *in the no-laxity group (*$P < 0.001$ *for all). Measurements obtained at rest were not significantly different between the groups. Multiple logistic regression analysis controlling for age, body mass index, vaginal parity and levator avulsion confirmed these results. The best regression model for the prediction of vaginal laxity included age, vaginal parity and levator hiatal area on maximum Valsalva. ROC-curve analysis of levator hiatal measurements on maximum Valsalva in the prediction of vaginal laxity demonstrated areas under the curve of 0.68 (95% CI, 0.63–0.73) for area, 0.63 (95% CI, 0.57–0.68) for APD and 0.68 (95% CI, 0.62–0.73) for CD.*

Conclusions *Levator hiatal area on maximum Valsalva seems to be the measure of levator ani distensibility that is most predictive of symptoms of vaginal laxity.* © *2019 The Authors. Ultrasound in Obstetrics & Gynecology published by John Wiley & Sons Ltd on behalf of the International Society of Ultrasound in Obstetrics and Gynecology.*

INTRODUCTION

Vaginal laxity is a poorly investigated symptom of pelvic floor dysfunction. It has been identified only recently as a symptom of sexual dysfunction that is related to pelvic organ prolapse (POP), and has been defined as a complaint of excessive vaginal looseness[1]. It is experienced mostly as reduced vaginal sensation during sexual intercourse, carrying physical and emotional consequences[2].

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There is no objective, standardized diagnostic test for vaginal laxity[3]. In the literature, it has been defined as a self-reported symptom that can be elicited by interviews or questionnaires[1–8]. In a survey of urogynecologists, 83% of 563 respondents stated that vaginal laxity is under-reported by their patients[4]; this implies that there is a high number of affected women who are undiagnosed. Some studies have investigated its presence among women attending a urogynecology clinic, documenting a prevalence of 24–38%[5,6], but no information is available regarding its incidence in the general population.

There is a consensus on the association of vaginal laxity with pregnancy and childbirth[7–9]. However, its pathophysiology is not completely understood. While one proposed mechanism involves overstretching of the vaginal walls and the introitus during vaginal delivery, an alternative pathophysiological process may be related to an increase in levator ani hiatal dimensions resulting from trauma to the levator ani muscle via frank avulsion (macrotrauma) or overdistension (microtrauma)[10,11].

An association between vaginal laxity and measures of levator ani hyperdistensibility (genital hiatus (Gh) plus perineal body (Pb), and levator hiatal area on Valsalva maneuver) has been demonstrated in a previous study[5]. On the basis of these results, we designed the current retrospective study to assess the predictive value of different measures of levator hiatal distension, obtained at rest and on maximum Valsalva maneuver, for symptoms of vaginal laxity and symptom bother, in order to identify which measure of levator ani distensibility is most predictive of the symptoms of vaginal laxity.

METHODS

This was a retrospective study based on archived datasets of women with symptoms of pelvic floor and lower urinary tract dysfunction, examined between 26 May 2016 and 20 July 2017 at a tertiary urogynecological center. All patients underwent a locally developed standardized interview, clinical examination and four-dimensional translabial ultrasound (4D-TLUS) examination. During the interview, symptoms of vaginal laxity were elicited by asking: 'Have you noticed vaginal laxity or looseness?', and subjective vaginal laxity symptom bother was assessed using a visual analog scale from 0 (no bother at all) to 10 (worst conceivable bother). Clinically significant POP was defined as stage ≥ 2 in the anterior and posterior compartments, and ≥ 1 centrally, on the POP quantification system[12].

4D-TLUS was performed using a Voluson 730 Expert or Voluson S6 machine with 4–8-MHz curved array volume transducers (GE Healthcare, Zipf, Austria) with the woman in the supine position, after emptying her bladder, at rest and on maximum Valsalva maneuver. Ultrasound volumes were assessed by the first author (C.M.) at a later date using proprietary software (4D view v. 10, GE Healthcare), blinded to all other data.

As described previously[13], levator hiatal area, anteroposterior diameter (APD) and coronal diameter (CD) at rest and on maximum Valsalva maneuver were measured in the plane of minimal hiatal dimensions using the rendered volume technique (Figure 1). The change in those parameters from rest to maximum Valsalva (delta value) was calculated using the formula: $100(X_{Valsalva} - X_{rest})/X_{Valsalva}$. Significant POP on TLUS was defined as a bladder and rectal ampulla descent to ≥ 10 mm and ≥ 15 mm below the pubic symphysis, respectively, and descent of the uterus to ≤ 15 mm above the pubic symphysis.

A test–retest series for all investigated measures of levator ani distensibility was undertaken by two observers (C.M., F.T.). Interobserver reliability was determined using the intraclass correlation coefficient (ICC) (single measure, absolute agreement).

Statistical analysis was carried out using IBM SPSS software v. 22 (IBM Corp., Armonk, NY, USA). Mean values were compared using an independent samples *t*-test. Logistic regression and Pearson's correlation were used to assess the association between levator hiatal distension parameters and vaginal laxity and symptom bother, respectively. To identify the best regression model for the prediction of vaginal laxity, a forward selection procedure was used, in which explanatory variables were retained or removed from the model based on the

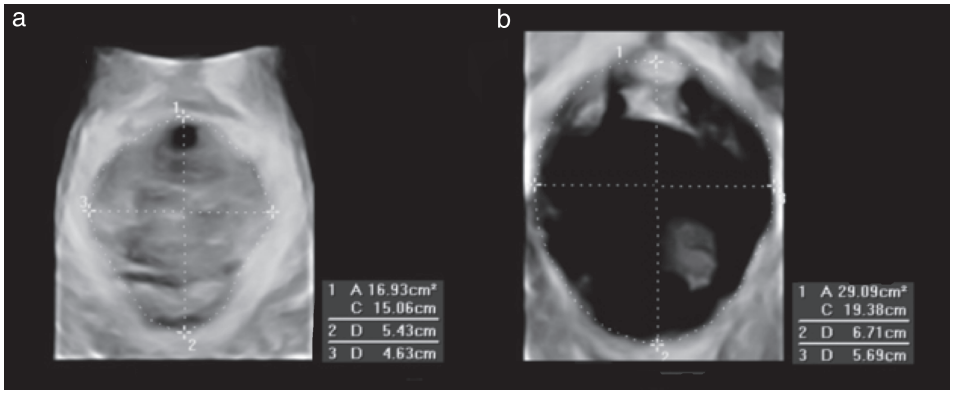

Figure 1 Ultrasound images of levator hiatus at rest (a) and on maximum Valsalva maneuver (b), on which area, anteroposterior diameter and coronal diameter were measured.

likelihood ratio test, using $P < 0.05$ as the entry criterion and $P > 0.1$ as the exit criterion. As there were more than three times the number of women in the no-laxity group than in the vaginal-laxity group, in order to avoid class imbalance, we included all patients with vaginal laxity as well as a random selection of patients from the no-laxity group, so that the two groups were equal in size. Parameters tested as explanatory variables were age, body mass index (BMI), vaginal parity, levator avulsion and levator hiatal area, APD and CD on maximum Valsalva. Receiver-operating-characteristics (ROC) curves were constructed for measures of levator hiatal distension on maximum Valsalva in the prediction of vaginal laxity.

This retrospective study was approved by the local Human Research Ethics Committee (NBMLHD HREC 13-70).

RESULTS

Of the 515 women seen during the study period, 25 were excluded owing to missing clinical or ultrasound volume data, leaving 490 patients for the analysis. Mean age was 58 ± 13 (range, 18–88) years, and mean BMI was 30 ± 7 (range, 15–68) kg/m^2. There were 318 (65%) postmenopausal women, of whom 13% (40/318) were on hormone replacement therapy. 434 patients (89%) had a history of vaginal delivery, of whom 32% (138/434) had a history of forceps delivery. Of the women, 151 (31%) had previously undergone a hysterectomy, 80 (16%) had undergone prolapse surgery and 58 (12%) had a history of incontinence surgery. Symptoms of prolapse were reported by 240 patients (49%), those of stress incontinence by 351 (72%), those of urge incontinence by 360 (73%), those of urinary frequency by 148 (30%), those of nocturia by 187 (38%) and those of vaginal laxity by 111 (23%), with a mean vaginal-laxity symptom bother score of 5.8/10. Clinically significant POP was detected in 360 (74%) patients, including 266 (54%) cases of cystocele, 121 of uterine prolapse (36% of 339 women who did not have a hysterectomy) and 281 (57%) of posterior compartment prolapse. On TLUS, significant cystocele, uterine prolapse, rectocele and enterocele were identified in 183 (37%), 112/339 (33%), 204 (42%) and 36 (7%) cases, respectively (Table 1). There were 110 patients (22%) with an avulsion and 253 (52%) showed abnormal distensibility of the levator hiatus (hiatal area on maximum Valsalva of ≥ 25 cm^2).

In a test–retest series of 20 patients, measurements of levator hiatal area, APD and CD demonstrated good to excellent interobserver repeatability, with respective ICC values of 0.86 (95% CI, 0.57–0.95), 0.85 (95% CI, 0.55–0.94) and 0.61 (95% CI, 0.25–0.83) for measurements obtained on maximum Valsalva, and 0.79 (95% CI, 0.53–0.91), 0.74 (95% CI, 0.45–0.89) and 0.86 (95% CI, 0.69–0.94) for those obtained at rest.

Table 2 provides mean values of hiatal area, APD and CD obtained at rest and on maximum Valsalva in women who reported vaginal laxity and those who did not. Measurements obtained on maximum Valsalva were significantly different between groups, while those obtained at rest were not. On univariate analysis, measurements of levator hiatal distension on maximum Valsalva had a strong significant association with vaginal laxity ($P < 0.001$), and a multiple logistic regression analysis controlling for age, BMI, vaginal parity and levator avulsion confirmed these results.

The best regression model for the prediction of vaginal laxity included as explanatory variables age, vaginal parity and levator hiatal area on maximum Valsalva, classifying

Table 1 Demographics, symptoms at presentation and pelvic organ prolapse (POP) assessment of 490 women with pelvic floor and lower urinary tract dysfunction examined at a tertiary urogynecological unit

Variable	*Value*
Age (years)	58 ± 13 (18–88)
BMI (kg/m^2)	30 ± 7 (15–68)
Postmenopausal	318 (65)
Parous (vaginal)	434 (89)
Previous forceps delivery	138 (28)
Previous hysterectomy	151 (31)
Previous POP surgery	80 (16)
Previous incontinence surgery	58 (12)
Prolapse symptoms	240 (49)
Vaginal laxity	111 (23)
POP-Q assessment	
Significant cystocele	266 (54)
Significant uterine prolapse*	121/339 (36)
Significant posterior compartment prolapse	281 (57)
TLUS assessment	
Significant cystocele	183 (37)
Significant uterine prolapse*	112/339 (33)
Significant rectocele	204 (42)
Enterocele	36 (7)

Data are given as mean ± SD (range), *n* (%) or *n*/*N* (%). *Measured for 339 patients who did not have hysterectomy. BMI, body mass index; POP-Q, POP quantification system; TLUS, translabial ultrasound.

Table 2 Measurements of levator hiatal area, anteroposterior diameter (APD) and coronal diameter (CD) obtained at rest and on maximum Valsalva maneuver in 490 women with symptoms of pelvic floor and lower urinary tract dysfunction, according to whether they reported vaginal laxity

Levator hiatal variable	*No vaginal laxity (n = 379)*	*Vaginal laxity (n = 111)*	P*
Hiatal area (cm^2)			
At rest	15.49 ± 4.47	16.29 ± 3.78	0.088
On Valsalva	24.84 ± 8.63	30.45 ± 8.74	< 0.001
Delta (%)	33.68 ± 18.09	44.02 ± 14.19	< 0.001
APD (cm)			
At rest	5.64 ± 0.87	5.79 ± 0.74	0.117
On Valsalva	6.64 ± 1.22	7.24 ± 1.16	< 0.001
Delta (%)	13.71 ± 11.72	18.84 ± 11.62	< 0.001
CD (cm)			
At rest	4.09 ± 0.69	4.24 ± 0.76	0.053
On Valsalva	5.01 ± 0.97	5.60 ± 0.89	< 0.001
Delta (%)	16.86 ± 13.72	23.54 ± 11.81	< 0.001

Data are given as mean ± SD. *Independent samples *t*-test.

Table 3 Correlation of measurements of levator hiatal area, antero-posterior diameter (APD) and coronal diameter (CD) obtained at rest and on maximum Valsalva maneuver, with vaginal laxity symptom bother score in 471 women* with symptoms of pelvic floor and lower urinary tract dysfunction

Levator hiatal variable	r	P
Area		
At rest	0.082	0.076
On Valsalva	0.232	< 0.001
APD		
At rest	0.072	0.117
On Valsalva	0.185	< 0.001
CD		
At rest	0.097	0.035
On Valsalva	0.228	< 0.001

Analysis performed using Pearson's correlation. *Symptom bother scores missing for 19 women.

correctly 67% of cases compared with 50% using the null model (model without explanatory variables in which all cases are assigned to the no-laxity group). Levator hiatal APD and CD on maximum Valsalva were not included in the final model, which confirms that levator hiatal area on maximum Valsalva is the measure of levator ani distensibility with the best predictive value for vaginal laxity.

Table 3 shows the correlation between measurements of levator hiatal distension and vaginal laxity symptom bother score. All measurements on maximum Valsalva and CD at rest were correlated with symptom bother score ($P < 0.001$ and $P = 0.035$, respectively).

ROC curve analysis of levator hiatal measurements obtained on maximum Valsalva in the prediction of vaginal laxity demonstrated areas under the ROC curve of 0.68 (95% CI, 0.63–0.73) for area, 0.63 (95% CI, 0.57–0.68) for APD and 0.68 (95% CI, 0.62–0.73) for CD. ROC curves for the delta values (change from rest to Valsalva) of levator hiatal measurements did not significantly increase the predictive power; hence, calculating delta values is not likely to be clinically useful.

For levator hiatal area on maximum Valsalva, the best cut-off for the prediction of vaginal laxity was 26 cm^2, with sensitivity of 0.64 and specificity of 0.60.

DISCUSSION

Vaginal laxity is a poorly investigated and probably under-reported symptom of pelvic floor dysfunction[4], which is defined as a complaint of excessive vaginal looseness[1], meaning that the vagina is not firmly held in place, often with consequent reduced vaginal sensation during sexual intercourse[2]. As there is no objective, standardized diagnostic test for vaginal laxity[3], it is a self-reported condition and, having been neglected for a long time, it clearly deserves further study.

One of the most important results of the current study is the clear, statistically significant increase in measurements of pelvic floor distensibility in women complaining of vaginal laxity. Our findings support the growing evidence of an association between vaginal laxity and pelvic floor hyperdistensibility[5], and contribute to a method for objectively defining this condition. Of note, for levator hiatal area on maximum Valsalva, the best cut-off for the prediction of vaginal laxity was 26 cm^2, confirming the standard definition of 'ballooning' or excessive distensibility of the levator hiatus, which is ≥ 25 cm^2 [14].

The best regression model for the prediction of vaginal laxity included as explanatory variables age, vaginal parity and levator hiatal area on maximum Valsalva, which confirms that levator hiatal area on Valsalva is the measure of levator ani distensibility with the best predictive value for vaginal laxity, given that levator hiatal APD and CD on maximum Valsalva were not included in the final model. As suggested previously[5], the association with age implies that this complaint may primarily affect younger women, probably because it is commonly perceived during sexual intercourse. The association with vaginal parity confirms the role of vaginal delivery in the pathophysiology of the symptoms.

Interestingly, women who reported vaginal laxity had statistically significantly larger hiatal dimensions on maximum Valsalva, but not at rest. These results confirm a previous finding of an association between vaginal laxity and levator ani hiatal area on maximum Valsalva[5]. The fact that measurements obtained at rest are not significantly different between the two groups may seem surprising. However, measurements obtained on maximum Valsalva are likely to be more indicative of the biomechanical properties of the muscle than those obtained at rest and with the woman in the supine position, i.e. without loading of the structures in question, since loading occurs constantly during normal (awake) life.

Abnormal biomechanical properties may have a number of causes, and some of those are clearly anatomical, such as avulsion. Hence, no firm conclusions can be drawn with regard to the treatment of this condition. However, we can conclude that interventions targeting vaginal tissue are likely to overlook one of the main pathophysiological factors, i.e. pelvic floor hyperdistensibility.

We found a statistically significant positive correlation between levator hiatal dimensions on maximum Valsalva and the degree of vaginal-laxity symptom bother, which means that the larger the levator hiatus is, the greater the bother experienced from this symptom. Having said that, this correlation was weak, probably owing to the fact that the degree of symptom bother is confounded by a number of other factors such as, for example, the quality of any sexual relationship and the importance of coitus in the patient's sexual life.

Aydin *et al.*[15] explored the association between levator hiatal biometry and female sexual function, assessed using the Female Sexual Function Index. Statistically significant differences in delta-area and delta-APD (delta being the difference between hiatal dimensions on maximum Valsalva and those at rest) of the levator hiatus were found between a low-sexual-function group and a normal-sexual-function group. No significant difference was found between the groups in measurements obtained at rest, nor those obtained on maximum Valsalva.

The discrepancies between these results and ours can be explained by several factors. The study populations differed substantially, as the study of Aydin *et al.* included only patients asymptomatic for pelvic floor disorders, while our study population was recruited from a urogynecology clinic. Moreover, Aydin *et al.* investigated female sexual function in general, which involves not only physical, but also psychological, aspects. However, it is interesting that, despite differences in study design, both studies found a correlation with delta values of levator ani distensibility measurements, supporting the role of levator ani distensibility in female sexual function.

In another study, Thibault-Gagnon *et al.*[16] investigated the impact of childbirth-related levator trauma on pelvic floor and sexual function using 4D-TLUS and an in-house validated questionnaire in women on average 5 months after childbirth. Interestingly, the presence of levator avulsion was correlated with a lower perception of pelvic floor muscle integrity and function, but levator ani overdistension was not. An explanation may be that the effect of levator avulsion is perceived earlier after delivery than is the effect of hyperdistensibility, as the patients were seen on average 5 months postpartum.

We acknowledge that this study has some strengths and weaknesses. A strength lies in the assessment of the sonographic parameters, which was performed blinded to all other data including symptoms and clinical findings. Another strength is its large population size. A major limitation is the composition of our study population, which consisted largely of Caucasian women recruited from a urogynecological clinic. This implies that our results may not be applicable to the general population. In our population, 93% of women in the vaginal-laxity group also had significant prolapse, which is unlikely to be representative of the general population and can be explained by the fact that both conditions are associated with pelvic floor hyperdistensibility. Women with vaginal laxity without symptoms of prolapse may not seek medical help. However, if examined, we expect that a non-negligible proportion of them would probably have early-stage prolapse (not yet causing any typical prolapse symptoms) and an enlarged levator hiatal area on maximum Valsalva on TLUS. Another limitation of this study is its retrospective design and the fact that imaging data were obtained in clinical practice by multiple subspecialty trainees, albeit under the direct supervision of the senior author. However, this may also be considered as a strength rather than a weakness, given that it would tend to increase the general applicability of our results.

In conclusion, this retrospective study showed a statistically significant association between vaginal laxity and measures of levator ani hiatal distensibility obtained on maximum Valsalva maneuver, with levator hiatal area providing the highest predictive value.

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EXHIBIT N

EXHIBIT N

Original Article on Transgender Surgery

The strategy for vaginal rejuvenation: CO_2 laser or vaginoplasty?

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Background: Vaginal laxity may result from trauma to the pelvic floor muscle, which may affect patients' sensation and quality of life. Vaginal rejuvenation, including surgical or nonsurgical interventions, aims to improve laxity. In this study, we aimed to establish a strategy for vaginal rejuvenation by comparing surgical and nonsurgical methods.

Methods: A retrospective clinical study was performed on patients who complained about vaginal laxity from 2017 to 2019. The degree of vaginal laxity severity was evaluated by vaginal examination in each patient. The patients were categorized as having a light, moderate or severe degree of vaginal laxity, and different correction methods were chosen accordingly. The Female Sexual Function Index (FSFI) questionnaire was administered to the patients preoperatively and at three months and one year after treatment.

Results: Seventeen patients with severe-degree vaginal laxity were treated with vaginoplasty. The total FSFI score was 23.21±2.57 before the operation and significantly increased to 29.36±1.84 ($P<0.01$) at one year after surgery. Eleven patients with moderate-degree vaginal laxity were treated with vaginoplasty and had a significant improvement in the total FSFI score at one year after surgery (29.86±1.74, $P<0.01$) compared with the FSFI score before surgery (23.41±2.84). Three patients with moderate-degree vaginal laxity were treated with a CO_2 laser and tended to have increased FSFI scores but did not show significant improvement after the operation. CO_2 laser treatment was performed on 16 patients with light-degree vaginal laxity. The total FSFI score improved from 23.76±2.35 to 26.16±2.58 at one year ($P<0.05$).

Conclusions: The strategy for vaginal rejuvenation should be selected based on the degree of vaginal laxity severity. Surgical treatment is suitable for severe- and moderate-degree vaginal laxity while nonsurgical treatment is suitable for light-degree vaginal laxity.

Keywords: Vaginal laxity; vaginal rejuvenation; vaginoplasty; nonsurgical vaginal rejuvenation

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Introduction

Sensation loss caused by vaginal laxity is a common problem for women after childbirth. Although the etiological relationship between vaginal laxity and childbirth is not well clarified, it is now generally accepted that vaginal delivery may result in trauma to the levator ani muscle along the pelvic floor (1). It was also found that vaginal delivery is associated with an increased diameter of the hiatus of the

levator ani muscle (2,3). Women with vaginal laxity may complain of decreased friction during coitus and diminished sexual satisfaction (4), and sexual dysfunction due to vaginal laxity has also been confirmed by questionnaires such as the female sexual function index (FSFI) (5). Therefore, vaginal laxity not only physically stretches the perineum but also has a large effect on sexual satisfaction (6).

It was reported that 48% of patients who experienced vaginal delivery reported vaginal laxity, but 62% never discussed vaginal laxity with anyone despite 50% feeling that improving tightness would increase sexual satisfaction (7). In an international survey of urogynecologists, 83% of the 563 respondents described vaginal laxity as underreported by their patients (8). Therapies available to these patients have included a range of options that are often minimally effective, such as Kegel exercises. On the other hand, vaginal plastic surgery or vaginal rejuvenation has been shown to be an effective treatment for vaginal laxity caused by childbirth, aging or estrogen deficiency (7). From 2014 to 2019, vaginal rejuvenation, including surgical or nonsurgical interventions, increased nearly 220% and is currently practiced by over 25% of plastic surgeons (9).

Surgical methods such as vaginoplasty and perineoplasty have historically been used for wound repair after delivery, but now, they have been increasingly used for vaginal laxity and aesthetic concerns (10). Meanwhile, the use of energy-based devices as nonsurgical treatments for vaginal laxity has currently become popular in the community and medical fields. However, the idea that nonsurgical treatment, including fractional laser and radiofrequency (RF) devices, can deal with vaginal laxity is difficult to accept according to the plausible mechanism or several studies supported by manufacturers. This prompted the U.S. Food and Drug Administration to issue a press announcement stating that the safety and effectiveness of energy-based devices have not been established (11).

In this study, we performed a retrospective clinical study on patients who complained about vaginal laxity. According to the degree of vaginal laxity severity, different strategies were selected to meet the medical requirements of the patients. Based on the characteristic treatment of vaginal laxity in our study, we aimed to establish a strategy for vaginal rejuvenation.

We present the following article in accordance with the STROBE reporting checklist (available at http://dx.doi.org/10.21037/atm-20-5655).

Methods

A retrospective study was performed between 2017 and 2019 in Shanghai Ninth People's Hospital. The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013) and was approved by the Ethics Committee of Shanghai Ninth People's Hospital (No. 2017-302-T222). All patients signed informed consent forms.

The inclusion criteria were as follows: female patients aged 25 to 40 years who complained about vaginal laxity and had a history of vaginal delivery. The exclusion criteria included menopause; history of urogynecologic operations; symptomatic genital prolapse; and estrogen, anticholinergic medication or antihistamine use. All patients who met the inclusion criteria from 2017 to 2019 were included in this study.

Vaginal laxity was confirmed through vaginal examination, which had been described in Abedi's study (12). The degree of vaginal laxity severity was evaluated in this examination process. In the lithotomic position, patients were asked to squeeze the examiner's two fingers with the vagina. If the pressure was strong and could last more than 3 seconds, the patients were regarded as having a light degree of vaginal laxity. Less pressure lasting from 1–3 seconds was regarded as a moderate degree of vaginal laxity. Nearly no pressure on 2 fingers and only a little pressure on 3 or more fingers was regarded as severe vaginal laxity.

For patients with severe laxity, surgical vaginal rejuvenation was suggested, and all patients in the severe group chose vaginoplasty. The vaginoplasty performed was similar to Abedi's technique (12). Briefly, the vaginal mucosa is elevated to expose the levator ani muscles, and stitches are started from the upper triangle of the vagina to the edge of the hymen to tighten the muscles. The perineal gap was also repaired if needed. The size of the vagina was considered normal if no more than two fingers could be tightly inserted into the vagina after repair. All operations were performed by one surgeon (YL) under local anesthesia.

Patients with light laxity were advised to receive CO_2 laser treatment. The CO_2 laser (SmartXide2, DEKA, Florence, Italy) was set with a DOT (microablative zone) power of 30 W, a dwell time of 1,000 usec, and a DOT spacing of 1,000 μm. In total, three treatments within a one-month interval were performed for each patient. All laser treatments were performed by one surgeon (S-X.M). Patients with moderate laxity were also advised to have vaginoplasty, but some chose the laser treatment.

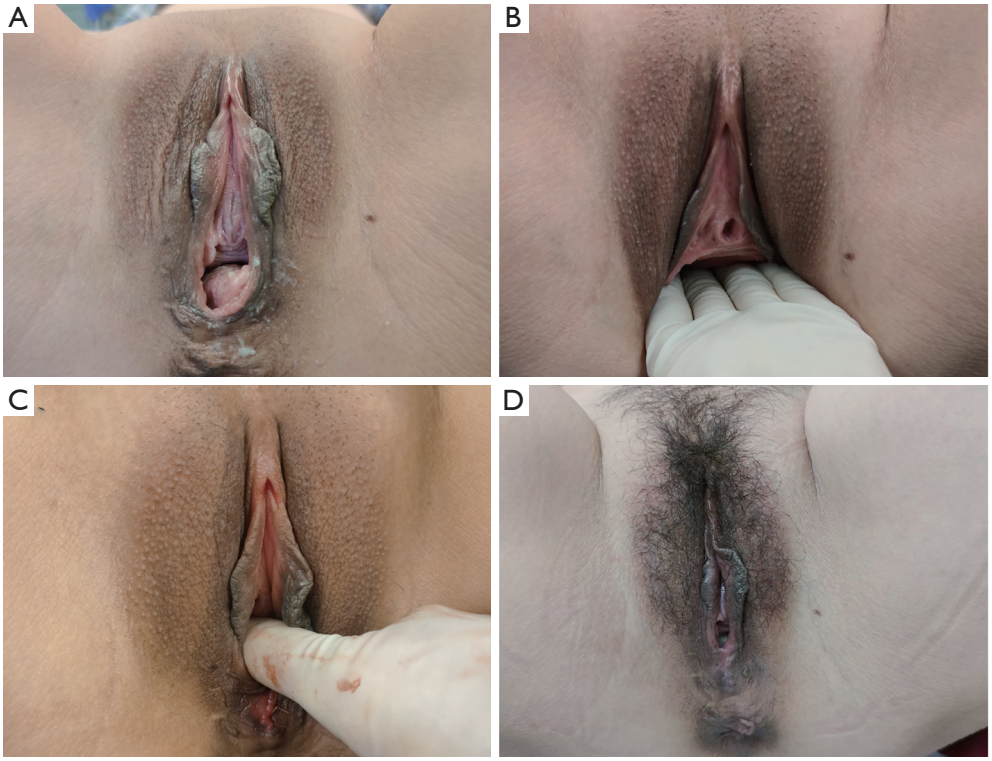

Figure 1 A typical case of severe vaginal laxity treated by surgery. The patient was 35 years old and had a history of vaginal delivery. (A) The appearance before surgery, (B) on vaginal examination, four of the surgeon's fingers could be held, (C) only one of the same surgeon's fingers could be held after surgery. (D) The appearance at 3 months after surgery.

The FSFI questionnaire was administered to the patients preoperatively and at three months and one year after treatment. The FSFI questionnaire addresses six different domains (desire, arousal, lubrication, orgasm, satisfaction, and pain/discomfort) ranging from 0 (no sexual activity in the past 4 weeks) or 1 (very dissatisfied) to 5 (very satisfied). The sum of the 6 final domain scores was reported as the total FSFI score. The evaluation of patient satisfaction rates and vaginal examinations were also performed at the one-year follow-up. To minimize variability, one surgeon performed the vaginal examinations to evaluate the degree of laxity before and after the operations. The data from same surgeon was used for data analysis.

Statistical analysis

The results are expressed as the mean ± SD (standard deviation). Statistical analysis was conducted with Statistical Package for Social Sciences (SPSS) 10.0. (IBM Corporation, NY, USA). One-way ANOVA was used to determine the probability of significant differences, and a P value <0.05 was considered to be statistically significant.

Results

In total, 47 patients with vaginal laxity confirmed by vaginal examination were included in the study. Seventeen patients with severe-degree vaginal laxity were treated with vaginoplasty. In the vaginal examination, the tightening effects of vaginoplasty resulted in the ability to hold no more than two fingers after surgery. One typical case was present in *Figure 1*. The total FSFI score was 23.21±2.57 before the operation and significantly increased to 30.14±1.2 (P<0.01) at three months after surgery. The FSFI was 29.36±1.84 (P<0.01) at one year after surgery. The satisfaction rate in this group of patients was 88.23% (15/17).

Fourteen patients with moderate-degree vaginal laxity were referred for surgical treatment, but 3 patients preferred nonsurgical methods. These 3 patients were treated with a CO_2 laser and had a trend of increasing FSFI scores but did not show significant improvement after the operation (23.83±1.86 *vs.* 25.5±1.04, P>0.05). These 3 patients were

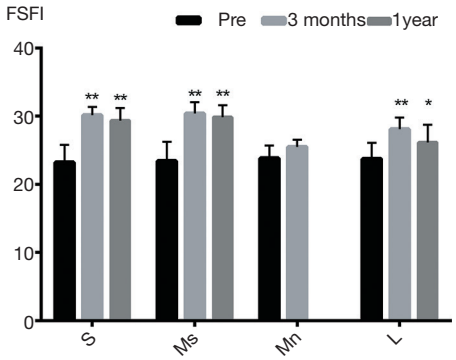

Figure 2 The total FSFI scores before and after treatment. S: severe vaginal laxity with surgical treatment; Ms: moderate degree of vaginal laxity with surgical treatment; Mn: moderate degree of vaginal laxity with nonsurgical treatment; L: light degree of vaginal laxity with nonsurgical treatment. (**, P<0.01; *, P<0.05).

not satisfied with the results and decided to have further surgical treatment within 1 year, so the long-term FSFI data were missing among these patients. The other 11 patients with moderate-degree vaginal laxity were treated with vaginoplasty and had a significant improvement in the total FSFI score at three months (30.38±1.7, P<0.01) and one year after surgery (29.86±1.74, P<0.01) compared with the FSFI score before the operation (23.41±2.84). In the vaginal examination, the tightening effects of vaginoplasty would resulted in the ability to hold one or two fingers after surgery. A total of 90.9% of the patients (10/11) with moderate-degree vaginal laxity treated with surgery were satisfied with the outcome. CO_2 laser treatment was suggested to and performed on 16 patients with a light degree of vaginal laxity. The total FSFI score improved from 23.76±2.35 to 28.09±1.7 (P<0.01) at three months and 26.16±2.58 at one year (P<0.05) after the last CO_2 treatment (*Figure 2*). In the vaginal examination, the tightening effects of CO_2 treatment would resulted in the ability to hold two fingers. The satisfaction rate of these patients was 87.5% (14/16).

Discussion

Vaginal laxity means different things to different patients (13), but the most common complaint from patients was actually the effect of genital sensation and sexual function instead of the laxity itself. There are many options provided by surgeons and aesthetic practices for improving vaginal laxity; however, the degree of laxity has seldom been mentioned. Ostrzenski's 4-degree classification (14) mainly focused on the mucosa and appearance, and an objective evaluation of the degree of vaginal laxity is still missing. In our study, patients with vaginal laxity were included, and suitable treatment was suggested according to the degree of laxity measured by vaginal examination. We mainly focused on the pressure from the pelvic floor muscle since the separable muscle should be the most important target in vaginoplasty. Therefore, patients with poor pressure were classified as having severe-degree vaginal laxity, and surgical treatment was suggested. If the pressure was acceptable, the pelvic floor muscle may still be functional and should not be operated on. The patient would be regarded as having light-degree vaginal laxity, and a nonsurgical treatment, i.e., the CO_2 laser, was preferred by both doctors and patients.

Many clinical studies have proven that vaginoplasty or colpoperineoplasty can increase sexual function in reproductive-aged women (15-17). In our study, patients who underwent surgical treatment had a significant increase in FSFI scores and higher satisfaction. In the follow-up, improvement in vaginal pressure remained. It was implied that the levator ani muscle plays an important role in regulating the motor response of the vagina and orgasm (16). In those who underwent surgery, the tightening effects were mainly based on the levator ani muscles, which can well explain the significant and stable improvement resulting from the surgery. In our one-year follow-up after vaginoplasty, several patients' husbands gave us feedback that sexual satisfaction was significantly improved.

On the other hand, surgical treatment is a more invasive operation than nonsurgical methods such as CO_2 lasers. Although research on nonsurgical vaginal rejuvenation has increased greatly in recent years, there is still a lack of solid evidence that any energy-based device could effectively tighten the levator ani muscle. The main effect of energy-based devices, including CO_2 lasers, are to induce the production and remodeling of collagen and elastin; they may also stimulate neovascularization (18). Histologically, biopsies after treatment revealed increased epithelial thickness, restoration of epithelial structures, and enhanced collagen deposition (19,20). All these beneficial changes would help to restore normal vaginal physiology and improve sexual function. In our study, if the patients did not have much vaginal pressure loss at the examinations, the function of pelvic floor muscle was considered acceptable. These patients were regarded as having a light degree of vaginal laxity, and CO_2 laser treatment was suggested. The satisfaction rates among these patients were also high (13/16), mainly because the treatment was minimally

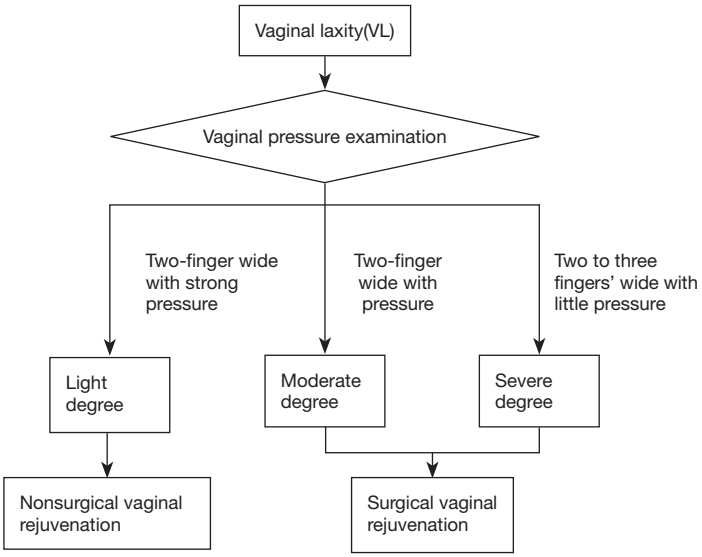

Figure 3 The strategy for vaginal rejuvenation.

invasive and the effectiveness was distinct as well. It is not surprising that several patients with moderate-degree vaginal laxity did not show much improvement with only CO_2 laser treatment because the beneficial effects of this method are on epithelial structures rather than muscles, which would not be sufficient to restore vaginal function in these cases. Additionally, surgical treatment of patients with moderate-degree vaginal laxity achieved good improvement in FSFI and the highest satisfaction rates (10/11).

Vaginal laxity also means different things to different doctors. Surgical and nonsurgical treatments have their own advantages and disadvantages. Surgeons who use a single treatment method as a "one fits all" solution would no longer be regarded as experts in this field.

Based on our clinical observations and available evidence to date, the degree of laxity severity based on vaginal pressure should be measured before any treatment. For patients with a large loss of vaginal pressure, vaginoplasty should be performed to restore muscle tension, which would effectively improve vaginal function. For patients with acceptable vaginal pressure, surgery could be helpful, but it is a more invasive procedure. Nonsurgical treatments, such as CO_2 lasers, are more suitable and should have more beneficial effects on the vaginal mucosa. Therefore, the strategy for vaginal rejuvenation should be properly selected by doctors, as we have suggested (*Figure 3*).

The limitation of this study was that RF therapy was not included. As another popular nonsurgical treatment, RF can also restore vaginal tissue and improve sexual function (21). The mechanism of RF is similar to that of lasers in that RF mainly contributes to stimulating mucosal tissue activation and revitalization (21). In addition, the results of this study came from a single institution and involved a limited number of cases. Additional cases are needed in future clinical studies to further confirm our proposed approach. A multicenter study should be performed to increase the credibility of our research.

Conclusions

Vaginal rejuvenation can restore sexual function for women after childbirth. The strategy for vaginal rejuvenation should be selected based on the degree of vaginal laxity severity, which is measured by vaginal pressure. Surgical treatment, such as vaginoplasty, is suitable for severe- and moderate-degree vaginal laxity, while nonsurgical treatment, such as CO_2 laser treatment, is suitable for light-degree vaginal laxity.

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Footnote

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Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013) and was approved by the Ethics Committee of Shanghai Ninth People's Hospital (No. 2017-302-T222). All patients signed informed consent forms.

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EXHIBIT O

EXHIBIT O

Fisting—What is it and why should I have a high index of suspicion?

By Susan Short, RN, SANE-A, Forensic Nurse Examiner, British Columbia

Introduction

This article will define the sexual act of fisting; review the anatomy and physiology of the vaginal and anorectal areas; characterize sharp versus blunt force injuries; and highlight selected case studies. Fisting is also known as 'handballing' or 'fist fucking', 'brachiovaginal' or 'brachioproctic' insertion. Fisting can cause laceration or perforation of the vagina, perineum, rectum, and/or colon, with the potential for death.

The late 1960s/early1970s is when fisting first appeared on the homosexual club and party scene. Crisco was a common lubricant until other commercially prepared lubricants were available. Unprotected fisting may have been a causative factor in the transmission of HIV due to the micro-lacerations from penetration in the anal area. In the 21st century it has become more commonplace in heterosexual intercourse.

Accordingly it is useful to learn about this sexual practice.

Fisting definition

Fisting is a sexual act that involves using the whole hand to penetrate the body. People engage in both vaginal fisting, inserting the hand inside the vagina, and anal fisting, inserting the hand into the anorectal canal. The label fisting is deceptive, as the hand may not be made into a fist, if ever, until it has been fully inserted.

Two techniques recognized as the most commonly practised are the duck and the praying hands.

With the first technique, the fingers are extended and arranged to be overlapping; the thumb is positioned against the palm/base of the fingers. In this formation it resembles a bird's beak and is often called the 'silent duck' or 'duck billing'. The hand is then slowly inserted into the orifice of choice. Once insertion is complete, the fingers either naturally clench into a fist or remain straight.

The second technique is considered advanced and for the more experienced fistees. The hands are placed palm to palm, resembling a position of prayer. The hands are turned parallel to the floor with fingers again pointing to the orifice of choice for insertion.

Typically, fisting does not involve forcing the clenched fist into the vagina or rectum. In more vigorous forms of fisting, such as "punching," a fully clenched fist may be inserted and withdrawn slowly.

Anatomy and physiology

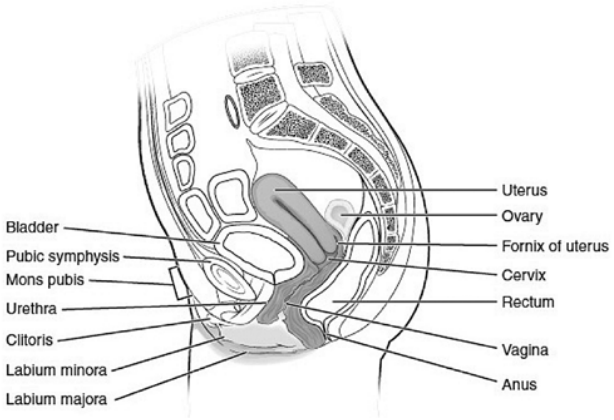

Figure 1. Vagina
https://commons.wikimedia.org/wiki/File:Female_Reproductive_Lateral.JPG
Share Alike - Created by CFCF

The vagina is a thin-walled fibromuscular tubular structure that extends from the cervix to the vulva and measures 7–10 cm in length. The inner walls of the vagina are covered with rugae, which are ridges of tissue that allow for stretching and expansion. Normally, the vaginal walls are collapsed and in contact except at the upper end where the cervix keeps them separate. The elastic structure of the vagina allows it to stretch in both length and diameter to accommodate the penis and fetus. Glands near the opening of the vagina secrete mucus to keep the surface moist.

The vagina does change anatomically in response to stimuli. A person can be sexually aroused by a variety of factors, both physical and mental, which causes a number of physiological responses to occur in the body. These responses in the female can include vaginal lubrication, engorgement of the external genitalia and internal enlargement of the vagina.

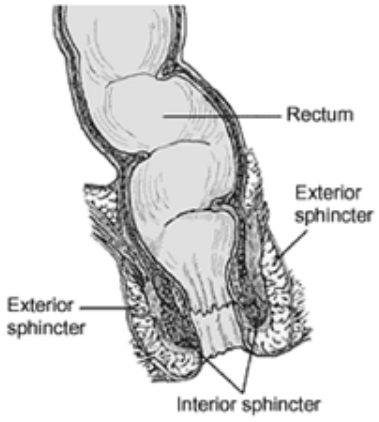

Figure 2. Anorectum
https://upload.wikimedia.org/wikipedia/commons/7/75/Anorectum.gif
Public domain

The anorectal area is the outlet of the gastrointestinal (GI) tract. The anal section is lined with skin that has no hair or sebaceous glands and merges with the rectal mucosa approximately 4 cm within the canal.

Innervation of the rectum is by autonomic nerves, but the anus and anal canal have numerous somatic sensory nerves. The sphincter muscles of the anus are quite sensitive and also are composed of numerous nerve endings. They facilitate pleasure or pain during anal intercourse. For the male, the pleasurable sensation is due to the contact with the prostate gland through the anal wall. For the female, the indirect stimulation of the clitoral nerve endings through the anal wall achieves the same outcome.

Injuries—Sharp versus blunt force

Sharp force trauma

Injuries produced by pointed objects or objects with sharp edges. These are characterized by a relatively well-defined traumatic separation of tissues, occurring when a sharp-edged or pointed object comes into contact with the skin and underlying tissues. These are commonly known as cuts or incisions.

Blunt force trauma

Injuries resulting from an impact with a dull, firm surface or object. Individual injuries may be patterned (e.g., characteristics of the wound suggest a particular type of blunt object) or non-specific. Blunt force trauma may cause contusions or bruises and lacerations.

Lacerations are often confused with cuts. The differentiation is based on the appearance of the separated tissues. With a laceration there is tissue bridging such as seen when there is tearing or pulling apart the tissue. The edges of the injury are not as well defined as in a cut.

Principles of why blunt force injuries occur

The amount of kinetic energy transferred and the tissue to which the energy is transferred will determine the severity of the injury.

The characteristics of the blunt object and the surface that is in impact will also determine severity. Impacts involving a large surface area—either with regard to the impacting object or with regard to the tissues being impacted—will result in a greater dispersion of energy over a larger area and, therefore, less injury to the impacted tissues.

The composition, or plasticity, of the tissues impacted also affects the resultant injuries.

Another factor is the amount of time that the body and the impacting object are in contact. A longer period of contact allows kinetic energy to be dissipated over a prolonged period, resulting in less damage to the tissues than an equally forceful impact with dispersion of energy over a brief period.

It has been simply said "an injury occurs when the force applied to a body surface exceeds the ability of that surface to stretch." (Lecture notes, Sheila Early, BCIT Forensic Program, circa 2005).

Selected case studies

Case 1

In 1989, Fain et al. wrote that the death of a 16-year-old female occurred in relation to a fisting incident. The male involved in the event did admit to having his entire fist and most of his forearm in the female's vagina. The autopsy findings include an 8 cm vaginal laceration that was surrounded by a contusion. It was located posterior to the cervix and extended through the posterior vaginal wall. Also present was a bladder and rectum contusion that extended into the rectal musculature without laceration. There were also numerous smaller lacerations on the lateral surface of the vaginal walls. Within the wall of the female's abdominal cavity there was 75–100 cc of blood. There were also two pubic hairs collected that were matched to the male in question. The cause of death was attributed to shock from blood loss due to 8 cm vaginal laceration.

Case 2

Cohen et al. (2004) described the following case of a 39-year-old male who presented to the ER 14 hours post consensual anal fisting. The male gave a history of ketamine use, which included him snorting and inserting it rectally. He reported that during fisting, he heard a 'pop', and his partner stopped the activity. Rectal bleeding did start following, but it was the increasing abdominal pain and bloating that brought him to the hospital. He presented with a distended abdomen and guarding of the left lower abdomen. A chest x-ray revealed free air under his diaphragm. A laparotomy revealed 550 ml of blood in his peritoneal cavity and a 1 cm full thickness laceration of the lower sigmoid colon.

Case 3

Anorectal penetration by forearm that resulted in a rectal perforation is the last case. Delacroix et al., in 2011, described the following case. A 16-year-old female patient presented to the ER with complaints of vaginal bleeding, rectal incontinence and chest pain. She also indicated that she had lethargy, epigastric pain, nausea and vomiting and rectal pain. She gave history of ingesting a large amount of alcohol and engaging in vaginal and anal intercourse with a male. Although she could not recall all the events of the day, she did insist that there was only penile penetration. Also of note is that the patient was intoxicated when presenting to the ER. She also had been diagnosed with a major depressive disorder with psychotic features and was on appropriate medications. On examination in the ER, an anal inspection revealed a superficial laceration at the anterior aspect, no active bleeding and intact sphincter tone. A vaginal speculum exam revealed no vaginal lesions, and a small amount of menstrual-type blood in the vault. A forensic examination was done; the speculum examination was deferred, as it had already been done. The findings were bleeding from the vagina and rectum; redness and a laceration to the left thigh; bilateral edema to the labia minora; and a laceration to the posterior fourchette (area just outside of the vaginal opening). The patient was kept in the ER overnight for observation. In the morning her condition had deteriorated and a CAT scan of her abdomen revealed free air and fluid in the abdominal cavity. An exploratory laparotomy was done. The anus was noted to have erosion and a laceration; the abdomen had large quantities of fecal matter and fluids with resulting diffuse peritonitis and the rectum had a linear tear. The tear was sutured and the patient received a colostomy, which was reversed nine months later to ensure healing of the tear occurred.

Clinical considerations

A high index of suspicion with fisting must be encouraged due to the potential serious consequences if these injuries are not identified.

We should bear in mind that regardless of whether the sexual activity was consensual or non-consensual, our patient may have difficulty verbalizing what has happened, and they may not remember the details, even in the absence of inebriation. With the disclosure of fisting activity, take into account that there is an increased risk of perforation. Combine that knowledge with the patient complaining of anal and/or vaginal bleeding, abdominal pain and/or genital injuries, and act accordingly.

About the author

Susan Short has been a registered nurse for 25 plus years with the majority of her career in the emergency department. She has specialized in forensic nursing and is currently the Coordinator of the Fraser Health program at the Abbotsford Regional Hospital, BC. Susan was the first student to complete the BCIT Advanced Specialty Certificate in Forensic Science Technology – Forensic Health Sciences Option, with Distinction. Building on that certificate, she has completed the courses for a BCIT Bachelor of Technology in Forensic Science. Susan has also been teaching for BCIT since 2006. She is the past president of the Canadian Forensic Nurse's Association and a lifetime member of the International Association of Forensic Nurses.

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EXHIBIT P

EXHIBIT P

Shared Decision Making During the Informed Consent Process

November 13, 2018

The informed consent process is an excellent time to engage patients. Ideally, an informed consent to treatment is the end result of a shared decision making process between a clinician and patient. This process, when executed appropriately, can have many benefits. It can decrease liability exposure, increase patient adherence, protect the patient's right to self-determination and increase patient satisfaction.[1]

During shared decision making (SDM), the patient weighs the risks, benefits, and alternatives against their preferences and values in collaboration with the clinician. The process is frequently facilitated by the use of decision aids, which are designed to help the patient understand the risks, benefits, and alternatives (RBA) of the proposed treatment.[1] In SDM, the physician is responsible for aligning the risks, benefits, and alternatives with the patient's values and preferences.[2] Because SDM strengthens the therapeutic alliance, it can also help the surgeon and patient work through treatment complications.[1]

Unfortunately, many surgeons (and other physicians) regard the informed consent process as one of many administrative tasks — an authorization to perform surgery. For these clinicians, informed consent is completed with little or no input from the patient and little effort to determine whether the patient has understood or retained any of the risks, benefits, or alternatives.[3] When informed consent is only an authorization for treatment, it does not satisfy legal and ethical informed consent requirements[4] and does little to engage the patient in their healthcare, which is unfortunate, because the period leading up to the patient's consent to undergo surgery is ideal for rapport building.

Patients and surgeons can fall victim to overly optimistic expectations.[5] Frequently, patients undergoing surgical procedures have a difficult time understanding that adverse outcomes are not necessarily the result of negligence. It is the surgeon's job to help the patient understand that uncertain outcomes are an inherent aspect of surgery. When a patient doesn't adequately understand the degree of risk and weigh the possibility of an unexpected outcome against the benefits of undergoing a proposed surgery, an unexpected adverse outcome is more likely to result in anger and frustration, which is more likely to prompt litigation.

Topics

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Recently Added

Opioid Prescribing for Chronic Pain: Case Studies and Best Practices

Strategies for Tapering Patients off Long-Term Opioid Therapy

Optimizing Opioid Therapy for Patients with Behavioral Health Disorders

Reducing Opioid Overdose Risk in Patients with Opioid Use Disorder

Telehealth Offers Advantages for Practices, But Liability Risks Remain

The following case involves a patient who was desperate for relief of chronic pain. Consider how her response to the unsuccessful outcome might have been different if she had truly understood that pain relief was not a guaranteed outcome of surgery. Consider also how the defense of the surgeon might have been facilitated by appropriately documented shared decision making.

Allegation

Because the surgeon failed to address the potential for chronic pain following surgery, the patient did not give an informed consent.

Case File

A 45-year-old woman was referred to a general surgeon for the repair of a small inguinal hernia with surgical mesh. The patient had been suffering from long-term chronic pelvic pain. Hernia repair was proposed for pain relief. The surgeon presented the risks, benefits, and alternatives of the procedure as three options:

1. Doing nothing
2. Doing a laparoscopic hernia repair
3. Doing an open procedure

He explained that an open procedure had a lower hernia recurrence rate, but a longer recovery period, a higher infection rate, and greater postoperative pain potential than a laparoscopic procedure. For these reasons, the patient chose the laparoscopic option. The surgeon did not document the discussion with the patient in the medical record other than to note "RBA discussed." He did not use an informed consent form.

More Information About Patient Engagement Along the Continuum of Care

- Overview: Patient Engagement Along the Continuum of Care: Case Studies and Best Practices
- Closed Claim Case Study: Poor Patient Activation Leads to Claim of Inadequate Discharge Instructions
- Closed Claim Case Study: Poor Patient Activation Leads to Claim of Negligent Disease Management

The hernia repair was completed with no apparent complications. However, the patient's pain gradually became worse than it had been before the hernia repair. The mesh was eventually removed, but the patient's pain continued at the same level. The patient filed a malpractice lawsuit against the surgeon, which included a claim for lack of informed consent.

Discussion

Defense experts believed there was no surgical malpractice. They believed the patient was one of a small percentage of patients who develop chronic post-hernia surgery pain. The plaintiff's experts had various criticisms of the surgery, including the use of mesh, the mesh weight and position, method of attachment and apparent lack of consideration for the surrounding nerves. They questioned whether the surgery was necessary, as the hernia was small and possibly unrelated to the patient's chronic pelvic pain. The plaintiff's experts also believed the patient should have been informed of the potential for chronic pain and should have been offered a non-mesh surgical alternative.

Although the defense team felt the technical aspects of the surgery were defensible, they believed defending the lack of informed consent claim would be complicated by a number of issues. For example, the patient convincingly testified in deposition that she was not informed of the risk of increased pain, particularly because of her preexisting chronic pelvic pain. She denied receiving any information about the materials (e.g., mesh and tacks) that would be used in her surgery. She was encouraged by the surgeon's description of the laparoscopic procedure as "simple" and further by his assertion that her recovery would take three to five days. She claimed she would have forgone surgery if she had known it might result in worse pain.

Unfortunately, the surgeon had no memory of the patient. Because his documentation of the informed consent process was very limited, his testimony was limited to what his general practice was for obtaining an informed consent for hernia repair. The surgeon's limited proof of an informed consent process was expected to be used against him at trial.

Medical Liability Risk Management Recommendations

The following recommendations include the U.S. Department of Health & Human Services Agency for Healthcare Research and Quality (AHRQ) Essential Steps of Shared Decision Making, known as the SHARE Approach. An expanded discussion of the SHARE Approach, including conversation starters, is available on the AHRQ website, as is a shorter "Quick Reference Guide."

Specialty society websites also offer disease-specific patient education materials and consent information.

Consider using the following strategies during the informed consent process:[1,5,6,7]

- Include shared decision making strategies in your informed consent policies and procedures. Emphasize the importance of the patient's participation in decision making.
  - Help your patient express what matters most to them (e.g., recovery time, cost, pain relief, functionality level, etc.)
    - Patients with very low patient activation levels may find shared decision making difficult or impossible. These patients may need extra help to prepare for shared decision making.
- Acknowledge and agree on what is important to your patient.
- Tell the patient about the options.
  - Assess what your patient already knows about the options.
  - Inform the patient about the benefits and risks of non-surgical options and surgical options utilizing different techniques and materials and the likely success of these alternatives.
  - Write down the options for the patient and describe them in plain language.
- Be supportive, but present risks realistically. Inform the patient about how unintended outcomes can affect quality of life.
- Utilize evidence-based educational materials to facilitate patient comprehension of the risks, benefits and alternatives to proposed treatment.
  - Provide materials written at about a sixth-grade level.
  - Present numbers in an understandable way by using graphs, charts and pictographs.
- Create your own educational materials. For example, sketch the surgery with simple notes of the various risks, benefits, and alternatives; scan the page into the electronic record and give the sketch to the patient. Not only does this personalize the consent process, it can help patients explain their upcoming surgery to family members.
- Review educational materials with patients.
  - Circle or highlight the most important points as you talk about them.
  - Personalize the material by adding the patient's name, medications, and specific care instructions as appropriate.
- When a patient appears to be having difficulty grasping concepts during the informed consent process:
  - Slow down. Speaking more slowly can give a struggling patient a greater opportunity to understand not only the words, but also the implications of what is being said.
  - Use meaningful language. For example, instead of describing a procedure as "complex and challenging," describe what makes it so – scar tissue, previous surgeries, anatomy that may be different from the norm, the extent of the patient's disease, etc.
  - Cluster related concepts. After presenting a cluster, pause, interact, and confirm patient understanding.
    - See Patient Engagement Along the Continuum of Care: Case Studies and Best Practices for a discussion of this "teach-back" method.
  - Use examples that put things into the context of everyday life. For example, explain how nerve damage could affect driving a car, exercising, or work-related activities.
  - Use pictures and models, particularly if a patient struggles with reading comprehension.
  - Include the patient's family or caregivers in the informed consent process when appropriate.
- Give patients a copy of the consent form, pictures, diagrams, and educational written materials to take home.
  - Emphasize the importance of the materials by referring to them during follow-up.

Informed Consent Documentation

Informed consent litigation usually pits the memory of the patient against the documentation of the clinician. Clinicians often cannot recall informed consent details and must prove that an appropriate informed consent occurred based on a generic informed consent form in the patient's record and testimony about their standard practice. Additional documentation in the medical record increases the defensibility of the claim.

Consider including the following in the patient's record in addition to the consent form:

- Confirmation that the informed consent discussion took place and that the patient either consented or did not consent to the procedure.
  - A patient's refusal of any treatment should be documented in the medical record, and the patient should be asked to sign a refusal of treatment form.
- Notation of the specific questions the patient had about the procedure, how the questions were answered, and any other issues that received special emphasis during the shared decision making process.
- Copies of written material given to the patient, including educational handouts and information sheets.
  - Educational materials, even if no longer in use, can be a valuable defense tool in the event of litigation.
- Descriptions of DVDs, websites, and other electronic materials used during the educational process.
- Notation of the patient's language, if not English, and the name and relationship of the translator or other steps taken to facilitate communication, if applicable.

Documentation of the informed consent process, including shared decision making and efforts to ensure patient comprehension can also be used as a guide for providers in post-surgical discussions about an unintended outcome. For example, the informed consent notes in the medical record can be used as a reference in a discussion with a patient that might start, "Do you remember when we discussed that a risk of ACL reconstruction is nerve damage? Unfortunately, during the procedure it happened. This is what we need to do..."

If an appropriate shared decision making process had been documented in the foregoing case, the surgeon could have gone back to the informed consent documentation to gently remind the patient that she was informed of the risk of post-surgical chronic pain and she was willing to take that risk.

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Filed under: Patient Relationship, Patient Communication, Case Study, Physician

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EXHIBIT Q

EXHIBIT Q

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 795

(Replaces Committee Opinion Number 378, September 2007)

Committee on Gynecologic Practice

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice in collaboration with committee members Peter F. Schnatz, DO and Lori A. Boardman, MD.

Elective Female Genital Cosmetic Surgery

ABSTRACT: "Female genital cosmetic surgery" is a broad term that comprises numerous procedures, including labiaplasty, clitoral hood reduction, hymenoplasty, labia majora augmentation, vaginoplasty, and G-spot amplification. Both patient interest in and performance of cosmetic genital procedures have increased during the past decade. Lack of published studies and standardized nomenclature related to female genital cosmetic surgical procedures and their outcomes translates to a lack of clear information on incidence and prevalence and limited data on risks and benefits. Women should be informed about the lack of high-quality data that support the effectiveness of genital cosmetic surgical procedures and counseled about their potential complications, including pain, bleeding, infection, scarring, adhesions, altered sensation, dyspareunia, and need for reoperation. Obstetrician–gynecologists should have sufficient training to recognize women with sexual function disorders as well as those with depression, anxiety, and other psychiatric conditions. Individuals should be assessed, if indicated, for body dysmorphic disorder. In women who have suspected psychological concerns, a referral for evaluation should occur before considering surgery. As for all procedures, obstetrician–gynecologists who perform genital cosmetic surgical procedures should inform prospective patients about their experience and surgical outcomes. Patients should be made aware that surgery or procedures to alter sexual appearance or function (excluding procedures performed for clinical indications, such as clinically diagnosed female sexual dysfunction, pain with intercourse, interference in athletic activities, previous obstetric or straddle injury, reversing female genital cutting, vaginal prolapse, incontinence, or gender affirmation surgery) are not medically indicated, pose substantial risk, and their safety and effectiveness have not been established.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions regarding the use of and indications for female genital cosmetic surgery.

- Patients should be made aware that surgery or procedures to alter sexual appearance or function (excluding procedures performed for clinical indications, such as clinically diagnosed female sexual dysfunction, pain with intercourse, interference in athletic activities, previous obstetric or straddle injury, reversing female genital cutting, vaginal prolapse, incontinence, or gender affirmation surgery) are not medically indicated, pose substantial risk, and their safety and effectiveness have not been established.
- Women should be informed about the lack of high-quality data that support the effectiveness of genital cosmetic surgical procedures and counseled about their potential complications, including pain, bleeding, infection, scarring, adhesions, altered sensation, dyspareunia, and need for reoperation.
- Obstetrician–gynecologists should have sufficient training to recognize women with sexual function disorders as well as those with depression, anxiety, and other psychiatric conditions. Individuals should be assessed, if indicated, for body dysmorphic disorder. In women who have suspected psychological concerns, a referral for evaluation should occur before considering surgery.
- In responding to a patient's concern about the appearance of her external genitalia, the obstetrician–gynecologist can reassure her that the size, shape,

and color of the external genitalia vary considerably from woman to woman. These variations are further modified by pubertal maturity, aging, anatomic changes resulting from childbirth, and atrophic changes associated with menopause or hypoestrogenism, or both.

- As for all procedures, obstetrician–gynecologists who perform genital cosmetic surgical procedures should inform prospective patients about their experience and surgical outcomes.
- Advertisements in any media must be accurate and not misleading or deceptive. "Rebranding" existing surgical procedures (many of which are similar to, if not the same as, the traditional anterior and posterior colporrhaphy) and marketing them as new cosmetic vaginal procedures is misleading.

Background

Female genital cosmetic surgery, when referred to in this Committee Opinion, is defined as the surgical alteration of the vulvovaginal anatomy intended for cosmesis in women who have no apparent structural or functional abnormality. Genital cosmetic surgery will not refer to procedures performed for clinical indications (eg, clinically diagnosed female sexual dysfunction, pain with intercourse, interference in athletic activities, previous obstetric or straddle injury, reversing female genital cutting, vaginal prolapse, incontinence, or gender affirmation surgery). The goals of this Committee Opinion are to provide the following three items: 1) potential reasons for the increase in the number of cosmetic genital surgical procedures; 2) a brief overview of cosmetic vaginal procedures and outcomes data associated with them; and 3) an opinion on their use for the sole purposes of cosmesis, sexual function augmentation, or both. This Committee Opinion has been updated to include new data on elective female genital cosmetic procedures and their outcomes, as well as guidance on patient counseling. For guidance on labial surgery in adolescents, see Committee Opinion No. 686, *Breast and Labial Surgery in Adolescents* (1).

Both patient interest in and performance of cosmetic genital procedures have increased during the past decade. For example, labiaplasty rates in the United States increased more than 50% between 2014 and 2018 (2). At the same time, ethical and, more recently, safety concerns have been raised about the performance of cosmetic genital surgery. In July 2018, the U.S. Food and Drug Administration (FDA) issued a warning against the use of energy-based devices (most commonly, radiofrequency or laser) outside of standardized research protocols for cosmetic vaginal procedures or vaginal "rejuvenation," citing their potential for serious adverse events, including vaginal burns, scarring, pain during sexual intercourse, and recurring or chronic pain (3). The FDA has not cleared or approved any energy-based medical device for vaginal "rejuvenation" or vaginal cosmetic procedures, or for the treatment of vaginal symptoms related to menopause, urinary incontinence, or sexual function.

Potential Reasons for Increased Interest in Genital Cosmetic Surgery

Shaving, waxing, electrolysis, and laser removal of pubic hair may allow a better view of the external genitalia for both women and their partners. In a cross-sectional study of more than 2,400 women aged 18–68 years living in the United States, 79% had partially or totally removed their pubic hair or were hair-free in the past month (4). One consequence of this procedure may be to draw more attention to asymmetries and differences in the external genitalia, potentially contributing to an increased desire for surgical alteration (5).

The perception of having aesthetically inferior external genitalia, augmented by the internet, online pornography, and other media sources, may drive women to seek surgical alteration (6). Women who explore cosmetic surgery often turn to internet searches. This is particularly important because the internet may be their only source of information (6). A systematic review of online content that promoted female genital cosmetic surgery found that sites that promoted cosmetic genital surgery regularly described the wide variation of normal vulvar appearance as unnatural or diseased and implied that variation beyond the prepubescent-looking vulva (eg, no visible labia minora, narrow vaginal opening) results in distress and sexual dysfunction (6). In a cross-sectional survey of 395 participants, older women (45–72 years of age) were more likely to consider cosmetic genital surgery than a cohort of younger women (18–44 years) (7); this is not surprising given the societal emphasis on reversing the effects of normal aging. In a prospective study of 33 women who sought labial reduction surgery at a London gynecology clinic, dissatisfaction with appearance was most commonly reported. For the entire cohort, however, the dimensions of the labia minora measured within the range of typical variability (8).

Of equal importance are marketing claims that genital cosmetic surgery treats cosmetic and functional issues and enhances sexual satisfaction. Much of the increase in popularity seen in vulvovaginal procedures for nonmedical indications is associated with the success of direct-to-consumer marketing in the 1990s (9, 10). In 2013, the Royal College of Obstetricians and Gynaecologists recommended, and the American College of Obstetricians and Gynecologists agrees, that women should be given accurate information about normal variations in genital anatomy and that advertisement of female genital cosmetic surgery should not mislead women on what is considered to be normal or what is possible with surgery (11). Characterizing normal anatomic variation as necessitating medical intervention exposes otherwise healthy women to unnecessary surgery with the potential for serious complications. Additionally, industry-generated conditions and diagnoses, where a proprietary device is deceptively marketed as a proven treatment, are concerning (12, 13).

Outcomes of Cosmetic Gynecology Surgery

"Female genital cosmetic surgery" is a broad term that comprises numerous procedures, including labiaplasty, clitoral hood reduction, hymenoplasty, labia majora augmentation, vaginoplasty, and G-spot amplification; see Table 1 for descriptions of surgical techniques and complications. Aside from labiaplasty, it is difficult to know how often these procedures are being performed. Lack of published studies and standardized nomenclature related to female genital cosmetic surgical procedures and their outcomes translates to a lack of clear information on incidence and prevalence and limited data on risks and benefits. In general, the safety and effectiveness of these elective procedures have not been well documented, and evidence largely is restricted to clinical case reports and retrospective studies. Measures used to assess outcomes, such as patient questionnaires, are rarely comparable across studies, and follow-up rates vary widely (14). Reports of patient satisfaction should not serve as evidence that these procedures are clinically effective (15).

Table 1. Cosmetic Genital Procedures

Type of Procedure	Purported Benefit*	Procedures Used	Reported or Potential Complications
Surgical Procedures			
Clitoral hood reduction	To improve sexual function by increasing sensitivity and allowing more direct clitoral contact	Hoodectomy Note: Often combined with labiaplasty to create labia minora symmetry and prevent clitoral hood sagging	• Scarring • Infection • Hematoma • Hypersensitivity • Damage to the glans
Labiaplasty	To eliminate unwanted tissue of the labia minora or labia majora	• Trim or edge resection • Wedge resection using a V-shaped or Y-shaped incision • Z-plasty • De-epithelialization	• Scarring • Infection • Hypersensitivity or loss of sensation • Dyspareunia • Wound dehiscence
Labia majora augmentation	To create a full, symmetric look	• Autologous fat transplantation • Injectable fillers (hyaluronic acid)	Palpable fatty cysts
Hymenoplasty	To recreate the virginal state of the hymen; has cultural roots in regions that place a value on an unmarried woman's virginity	Reconstruction of hymenal remnants, vaginal mucosal flaps, or both	Wound dehiscence
Vaginoplasty	To tighten vaginal contour and increase sexual satisfaction	• Anterior, posterior, or lateral colporrhaphy • Rugation restoration† • Energy-based devices	• Infection • Dyspareunia • Dehiscence • Fistula
Energy-Based Interventions			
Energy-based vaginal procedures†	To tighten vaginal contour and increase sexual sensation	Laser radiofrequency	• Burns • Scarring • Pain during sexual intercourse • Recurring or chronic pain
Injections			
G-spot amplification	To augment G-spot and heighten sexual satisfaction	• Autologous fat transfer • Hyaluronic acid	• Urinary tract infection • Infection

*This may not be the patient goal, but these procedures are often marketed with these outcomes.

†U.S. Food and Drug Administration. FDA warns against use of energy-based devices to perform vaginal 'rejuvenation' or vaginal cosmetic procedures: FDA safety communication. Silver Spring (MD): FDA, 2018. Available at: https://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm615013.htm. Retrieved August 26, 2019.

Labiaplasty is the most commonly performed cosmetic genital surgical procedure, and a variety of techniques have been described (Table 1). Clitoral hood reduction frequently is performed at the time of labiaplasty to reduce the occurrence of clitoral hood sagging after labiaplasty alone. In a multicenter retrospective cohort study of 258 women who underwent 341 cosmetic genital procedures, 177 underwent labiaplasty, clitoral hood reduction, or both (16). Although this study reported high patient satisfaction and enhancement in sexual function, these results should be interpreted with extreme caution given the lack of a comparison group and use of poorly constructed questionnaires, none of which were validated. Although validated scales were used in the same author's 2016 prospective cohort case-controlled study of 120 individuals, only 54% of the women having genital cosmetic surgery chose to complete the scale at entry, versus 76% of controls (17). Even with greater use of validated scales in more recent literature, comparability remains difficult with the rare use of the same scale in more than one study.

Procedures that focus on the vaginal canal are marketed to improve sexual function. One of the most controversial female genital cosmetic surgical procedures, vaginal "rejuvenation," is a proprietary term meant to encompass perineoplasty, vaginoplasty, or both, as a technique to reduce the diameter of the vagina, strengthen the perineal body, and enhance sexual function (18). The surgical technique used is very similar, if not identical, to anterior or posterior colporrhaphy and often is combined with perineoplasty. Another method for treating vaginal laxity, described as vaginal rugation restoration, involves use of the CO_2 laser to create vaginal rugae in women in whom absent or decreased vaginal rugation has been diagnosed. Scant information on the outcomes (risks and benefits) of laser assistance, rugation restoration, or G-spot amplification exists in the peer-reviewed literature, and the published data are mostly restricted to expert opinion, case reports, or small case series (19). A 2012 prospective observational study of vaginal rugation restoration included only 10 women who underwent the procedure, making it difficult to draw conclusions (20). The FDA's 2018 Safety Communication warned against the use of energy-based devices (commonly radiofrequency or laser) to perform vaginal "rejuvenation," cosmetic vaginal procedures, or nonsurgical vaginal procedures to treat symptoms related to menopause, urinary incontinence, or sexual function (3). Prospective studies that used validated measures of quality of life, body image, and sexual function are needed to understand the true benefits and harms of these procedures. Research should be conducted by those without a financial interest in the outcomes (14).

Patient Counseling

Understanding a woman's motivation for cosmetic surgery requires careful and sensitive exploration to ensure her autonomy and rule out the possibility of coercion or exploitation by another person, such as a partner or family member. See ACOG Committee Opinions No. 578, *Elective Surgery and Patient Choice*, No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, and No. 787, *Human Trafficking* (21–23).

Labiaplasty in girls younger than 18 years should be considered only in those with significant congenital malformation, or persistent symptoms that the physician believes are caused directly by labial anatomy, or both. Surgical alteration of the labia that is not necessary to the health of the patient, who is younger than 18 years, is a violation of federal criminal law (24) (Box 1). At least one half of the states also have laws criminalizing labiaplasty under certain circumstances, and some of these laws apply to minors and adults. Obstetrician–gynecologists should be aware of federal and state laws that affect this and similar procedures in adolescents (1) and adults.

Box 1. Female Genital Mutilation 18 U.S.C. § 116 (2017)

(a) Except as provided in subsection (b), whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both.

(b) A surgical operation is not a violation of this section if the operation is—

(1) necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner; or

(2) performed on a person in labor or who has just given birth and is performed for medical purposes connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife, or person in training to become such a practitioner or midwife.

(c) In applying subsection (b)(1), no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual.

(d) Whoever knowingly transports from the United States and its territories a person in foreign commerce for the purpose of conduct with regard to that person that would be a violation of subsection (a) if the conduct occurred within the United States, or attempts to do so, shall be fined under this title or imprisoned not more than 5 years, or both.

Reprinted from Female genital mutilation 18 U.S.C. § 116. (2017). Available at: https://www.govinfo.gov/app/details/USCODE-2017-title18/USCODE-2017-title18-partI-chap7-sec116. Retrieved September 4, 2019.

Obstetrician–gynecologists should have sufficient training to recognize women with sexual function disorders as well as those with depression, anxiety, and other psychiatric conditions. Individuals should be assessed, if indicated, for body dysmorphic disorder, criteria for which, according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, include a preoccupation with an imagined physical defect or exaggerated concern about a physical defect that would not be apparent to the casual observer, or a history of repetitive or obsessive behaviors (such as repeated examination or attempts to conceal the flaw, or continually seeking reassurance from others) (25, 26). In women who have suspected psychological concerns, a referral for evaluation should occur before considering surgery (27).

In responding to a patient's concern about the appearance of her external genitalia, the obstetrician–gynecologist can reassure her that the size, shape, and color of the external genitalia vary considerably from woman to woman. These variations are further modified by pubertal maturity, aging, anatomic changes resulting from childbirth, and atrophic changes associated with menopause or hypoestrogenism, or both. Although labia minora longer than 30–40 mm is currently marketed as hypertrophic, in a study of 657 adolescent and adult females, the mean length of the labia minora (measured from clitoris to the lower margin of the labia) exceeded that estimate in more than 50% of the individuals (28). Measurements of the external genitalia must be interpreted on an individual basis, and age-related differences in the length of the labia minora vary widely (28). Table 2 provides information on the variability of female genitalia that can be used to counsel patients; however, the values should not be used to determine surgical appropriateness. Although patients often believe female genital cosmetic surgery will improve sexual function, current evidence does not support improvement in body image, libido, or sexual satisfaction. Concerns regarding sexual satisfaction may be addressed by careful evaluation for any sexual dysfunction, relationship issues, and an exploration of nonsurgical interventions, including counseling. For more information, see Practice Bulletin No. 213, *Female Sexual Dysfunction* (29).

It is important to review patients' expectations about the results of surgical intervention. Women should be informed about the lack of high-quality data that support the effectiveness of genital cosmetic surgical procedures and counseled about their potential complications, including pain, bleeding, infection, scarring, adhesions, altered sensation, dyspareunia, and need for reoperation. The possibility of dissatisfaction with cosmetic results, including potential adverse effects on sexual function, also should be discussed.

As for all procedures, obstetrician–gynecologists who perform genital cosmetic surgical procedures should inform prospective patients about their experience and surgical outcomes. Advertisements in any media must be accurate and not misleading or deceptive (30). "Rebranding" existing surgical procedures (many of which are similar to, if not the same as, the traditional anterior and posterior colporrhaphy) and marketing them as new cosmetic vaginal procedures is misleading.

Training

Obstetrician–gynecologists who perform cosmetic procedures should be adequately trained, experienced, and

Table 2. Variability of Female Genitalia*

	Mean (in mm)	Standard Deviation	Minimum (in mm)	Maximum (in mm)
Width of clitoris	4.62	2.538	1	22
Length of clitoris	6.89	4.965	0.5	34
Distance clitoris–urethra	22.63	7.661	3	65
Introitus opening	27.91	10.36	6	75
Length of perineum	21.34	8.544	3	55
Length of labia majora (right)	79.71	15.25	12	180
Length of labia majora (left)	79.99	15.44	20	180
Length of labia minora (right)	42.1	16.35	6	100
Length of labia minora (left)	42.97	16.29	5	100
Width of labia minora (right)	13.4	7.875	2	61
Width of labia minora (left)	14.15	7.643	1	42

*Measurements were taken of the clitoral gland, distance from the base of the gland to the urethral orifice, length of introitus, length of perineum, length of labia majora, and length and width of labia minora. Measurements outside of these ranges do not indicate abnormal anatomy.

Modified from Kreklau A, Vaz I, Oehme F, Strub F, Brechbuhl R, Christmann C, et al. Measurements of a 'normal vulva' in women aged 15–84: a cross-sectional prospective single-centre study. BJOG 2018;125:1656–61.

clinically competent to perform the procedure (31). Extensive familiarity with appearance and function, as well as the ability to manage complications, are expected from obstetrician–gynecologists who perform these procedures.

Conclusion

Obstetrician–gynecologists may receive requests from adolescents and adults for cosmetic genital surgery. For those choosing to provide cosmetic services, patient counseling (including definitions of normal range of anatomy and sexual function), shared decision making, and informed consent are paramount. Patients should be made aware that surgery or procedures to alter sexual appearance or function (excluding procedures performed for clinical indications, such as clinically diagnosed female sexual dysfunction, pain with intercourse, interference in athletic activities, previous obstetric or straddle injury, reversing female genital cutting, vaginal prolapse, incontinence, or gender affirmation surgery) are not medically indicated, pose substantial risk, and their safety and effectiveness have not been established.

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Elective female genital cosmetic surgery. ACOG Committee Opinion No. 795. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;135:e36–42.

EXHIBIT R

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Dr MICHAEL GOODMAN MD
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About

Michael P. Goodman MD, FACOG, IF, AAACS

Michael Goodman MD has been practicing women's healthcare since finishing his OB/GYN residency at Stanford University in 1972. Following a transition from his full-time OB practice in 1988, he began devoting his career to Women's Integrative Health and emerged as a pioneer in the development and advancement of Minimally Invasive Gynecologic Surgery.

Since 1998, Dr. Goodman has focused primarily on menopausal and sexual medicine and Female Genital Plastic/Cosmetic Surgery. He specialized in difficult gynecologic issues, peri-menopausal medicine, lifestyle enhancement, facial aesthetics, sexuality issues, bone densitometry, pelvic ultrasound, labiaplasty and other vulvovaginal aesthetic surgeries. Since 2000 Dr. Goodman has performed > 1000 genital plastic/cosmetic procedures, among the most of any surgeon in the world. In 2013 Dr. Goodman was elected to be a "Fellow" of the International Society for the Study of Women's Sexual Health (IF). He has been active in educating and training, on the Scientific Committee of the Annual International Society of Cosmetogynecologists (ISCG) meetings

Dr. Goodman was among the first members of the North American Menopause Society and is involved in its Consumer Education Committee

As a well-known expert in his field, Dr. Goodman has been a guest at numerous seminars and symposiums nation-wide and has made appearances on area network TV and talk radio. He has many citations in peer-reviewed literature in Hormone therapy, endoscopic surgery, and especially in the field of genital plastic/cosmetic surgery In 2020 he retired from clinical practice of Gynecology and Menopausal and Sexual Medicine, devoting his attention to his genital plastics practice and teaching. Dr. Goodman serves as a frequent peer-reviewer for the Journal of Sexual Medicine, Plastic and Reconstructive Surgery, and the Aesthetic Surgery Journal, and is an *ad hoc* reviewer for several additional medical journals

A critically-acclaimed author, Dr. Goodman has published two consumer-oriented books on menopause: "The Midlife Bible—A Woman's Survival Guide" and "MEN-opause: The Book for Men." His new book, "You Want to do WHAT? Where? A Guide to Women's Genital Plastic and Cosmetic Surgery" is **available as an e-Book on Amazon**, He is the Executive Editor and author of several chapters of the Wiley-Blackwelll Medical Textbook, "*Female Genital Plastic/Aesthetic Surgery*" released in 2016. Dr. Goodman was invited to write the chapters on "*Revision Labiaplasty*" and "*Complication Avoidance*" for the new 3rd Edition of Nahai et al's classic Plastic Surgery textbook, "*The Art of Aesthetic Surgery: Principals and Practices*"

Dr. G is an educator. He has been a Clinical Instructor at U-C San Francisco and U-C Davis, as well as an Assistant Clinical Professor at California Northstate University School of Medicine since 2015.

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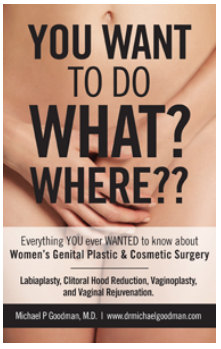

Sign up below for the first chapter of his latest book. You'll receive Chapter 1: The Anatomy and Rationale for Surgery, as well as an article he wrote for The Journal of Sexual Medicine titled, "Female Genital Plastic/Cosmetic Surgery".

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Since 2010 he has trained surgeons in his techniques via both formal in-office mini-Fellowship training programs, and through his traiing entity, "The Labiaplasty and Vaginoplasty Training Institute of America, Inc. ™

Dr. Goodman has practiced in the University community of Davis, CA (between Sacramento and the San Francisco Bay area) since 2000. Dr. Goodman lives on 5 acres of ridgetop outside of Winters, CA, and enjoys writing, gardening, tennis and fitness as well as spending time with his four children, Gabriele, Lauren David, Caleb, and Sam.

Dr. Goodman and his Fellow and new Associate, Dr. Michael Reed, MD

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SUBMIT

What is the new "Labia Majora Lift" and what does it accomplish?

Labia Majora Lift ("LML"), aka "Smile Lift," is a brand new minor surgical procedure designed and brought to market by renowned genital plastic/Cosmetic surgeon, Dr. Michael Goodman. Based on the so-called "double hockey-stick" labia majora incision first described by Polish surgeon Dr. Dawid Serafin, it is an inexpensive, easy-to-recover-from procedure where a horizontal "chevron-shaped" portion […]

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READ DR. GOODMAN'S INVITED COMMENTARY ABOUT THE STIGMA WOMEN ENDURE REGARDING SURGERY ON THEIR "PRIVATE PARTS."

Dr. Goodman was recently asked by Foad Nahai, MD, the Editor of the Aesthetic Surgery Journal, one of the top Plastic Surgery journals, to comment on a recently accepted and fascinating article entitled "**Labiaplasty: The Stigma Persists**," original research which discussed women's negative attitudes regarding their genitalia, as compared with breasts and other areas of their bodies.
Dr. Goodman's insightful commentary will be of interest to all women, especially those considering female genital plastic/cosmetic surgery. **For the free Full**

Text of Dr. Goodman's Commentary, **click here.** For an Abstract of the original article, **click here.**

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Sitemap

Professional Accomplishments

Dr. Goodman was educated in Michigan at Kalamazoo College and Wayne State University School of Medicine. He moved to California in 1968 to finish his training in the San Francisco Bay area.

After residency training at Stanford University and a short time with Kaiser in the Bay Area, Dr. Goodman moved to the Mendocino Coast in 1973 to become the first OB-GYN on the North Coast between Sonoma and Eureka. He moved with his family from Mendocino to Davis, CA., a small University town located between Sacramento and the San Francisco Bay Area, in 2000

I. Education and Training:

College: BA, Kalamazoo College 1964
Medical School: MD Wayne State University 1968
Internship: Highland Alameda Co. Hospital, 1968-69
OB-GYN Residency: Stanford University and affiliated hospitals, 1969-1972 (Chief Resident, 1971-1972)
Post-grad Training includes: IVF, advanced operative laparoscopy and hysteroscopy,endo-vaginal ultrasound, menopausal medicine, bone densiometry and women's and men's sexuality

II. Professional Practice:

Private Practice of OB-GYN and Infertility Fort Bragg and Willits, CA 1972-1988
Private practice of gynecology, advanced operative laparoscopy and menopausal medicine, Fort Bragg and Willits, CA.1989-1999
Hospital Consultant and Locum Tenens physician: High risk hospital-based OB, practice management, clinic-based OB-GYN and menopausal medicine for Permanente Medical Group (Kaiser), Sutter Health, East Bay Perinatal Medical Associates, and others; 1989-2006
Present practice of Gynecology, Perimenopausal Medicine, Bone Densiometry, Vitality and Health Enhancement, Sexual Medicine and Gynecologic and Vulvo-Vaginal Aesthetic Surgery in Davis, CA since 2000. Present primary practice focus: Vulvo-vaginal aesthetic and plastic surgery, integrative women's health, peri-menopausal and sexual medicine, and difficuly gynecologic decision-making.

III. Professional Organizations:

Fellow, American College of Obstetrics and Gynecology
Elected Member, Society of Reproductive Surgeons
Member, International Society for Sexual Medicine (ISSM) since 2015
Member, California Medical Association and Sierra-Sacramento Co. Medical Society
Member, American Association of Gynecologic Laparoscopists
Member, American Institute of Ultrasound in Medicine
Member, North American Menopause Society
Member, California Medical Review, Inc.
Member, Northern California Ob-Gyn Society
Member, Traditional Practice Alliance
Member, Northern California OB-Gyn Society

Member, International Society of Clinical Densiometry
Member of the Consumer Education Committee of the North American Menopause Society and Past Project Chair of the Consumer Booklist Committee.
Associate, American Academy of Cosmetic Surgery.
Fellow, International Society for the Study of Women's Sexual Health

IV. Accreditations and Certifications:

Board certified and re-certified, American Board of Obstetrics and Gynecology
Accredited in Advanced Operative Laparoscopy, Accreditation Council of Gynecologic Endoscopy
Certified Menopauseal Clinician and Menopausal practitioner by the National Certification Corporation of Ob-Gyn/Ob-Gyn Nursing Specialties and the North American Menopause Society
Certified Clinical Bone Densiometrist (International Society of Clinical Densiometry)
Fellow, Intentional Society for the Study of Women's Sexual Health

V. Teaching Activities and Publications:

Dr. Goodman has presented numerous papers at hospital training sessions and clinical meetings on menopause and hormone replacement therapy, female genital plastic/cosmetic surgery, vaginitis, advanced operative laparoscopy, pelvic ultrasound, pelvic pain and risk management. He has published papers on obstetrical care, nurse-monitrices, advanced laparoscopy, risk management and recovery and sexuality issues surrounding hysterectomy and UAE, as well as six separate research papers, reviews and commentaries on vulvo-vaginal aesthetic and reconstructive surgery.

Dr. Goodman was the lead author of a large, multi-center outcome study on vulvo-vaginal aesthetic surgery published in the prestigious *Journal of Sexual Medicine* and is the author of a full review on the subject of vulvo-vaginal aesthetics, as well as a study of the sexual effects of vulvo-vaginal plastic/cosmetic surgery. A major paper on body image and sexuality in women receiving genital plastic/cosmetic modification is in preparation for publication. Dr. Goodman is the Editor-in-Chief and major chapter contributor to the first major medical textbook on genital plastics, *Female Genital Plastic and Aesthetic Surgery* presently in production at Wiley Blackwell, Oxford, UK, for a February 2016 release.

Dr. Goodman presents frequently at women's health seminars in California and elsewhere and has written three popular books about menopause and midlife transitions: **The Midlife Bible: A Woman's Survival Guide**; **MEN-opause: The Book for Men (2007)**; and his newest popular book, **You Want to Do WHAT? WHERE??** (All You Wanted to Know About Women's Genital Plastic and Cosmetic Surgery, Written by an Expert), which is now available on Amazon.

VI. Special Professional Activities:

Ad. hoc. reviewer for the " Journal of the American Association of Gynecologic Laparoscopists."
Peer reviewer for the "Journal of Sexual Medicine."
Reviewer for the International Society for the Study of Women's Sexual Health.
Ob-Gyn reviewer for the Medical Board of California
Peer reviewer for the journal, "Menopause Management."
Peer Reviewer, British Journal of Obstetrics and Gynecology
Peer Reviewer, World Journal of Obstetrics and Gynecology
Peer Reviewer, World Journal of Urology

What is the new "Labia Majora Lift" and what does it accomplish?

Labia Majora Lift ("LML"), aka "Smile Lift," is a brand new minor surgical procedure designed and brought to market by renowned genital plastic/Cosmetic surgeon, Dr. Michael Goodman. Based on the so-called "double hockey-stick" labia majora incision first described by Polish surgeon Dr. Dawid Serafin, it is an inexpensive, easy-to-recover-from procedure where a horizontal "chevron-shaped" portion […]

The Very Latest About Revision Surgery for Botched Labiaplasty

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Dr. Goodman's insightful commentary will be of interest to all women, especially those considering female genital plastic/cosmetic surgery. **For the free Full**

Text of Dr. Goodman's Commentary, **click here.** For an Abstract of the original article, **click here.**

GET MORE INFORMATION

What is the normal size of a woman's labia?

What are the surgical techniques for Labiaplasty? **CLICK HERE** to find out the answer to these, and other, questions

CONTACT DR. GOODMAN'S OFFICE

Phone: (530) 753 2787

Fax: 530-302-8042

Contact Dr. Goodman

Sitemap

More About Dr. Goodman

World-renowned genital cosmetic surgeon, teacher and author

If you are considering genital cosmetic surgery, you deserve the best and most qualified surgeon.

Dr. Goodman trains other cosmetic genital surgeons, lectures around the world and is recognized for having the "Best Aesthetic Results in Cosmetic Genital Surgery" in 2017 and 2018. He received the 2019 award for "Teaching Excellence" and the 2020 award for "Best Combined Labia Majoraplasty and Minoraplasty."

I'm Ready to Get Started

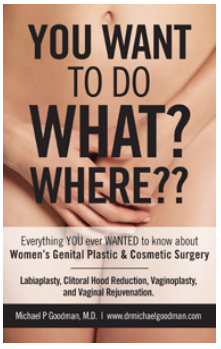
ISCG, the International Society of Cosmetogynecology, is the international spokes-organization for female genital plastic and cosmetic medicine and surgery. It was the first organization to promote an exchange of ideas, new techniques, debate and comradery among the fastest emerging sub-specialty of Gynecology since the millennium, *"Cosmetic Gynecology."* Their annual Congresses, by far the largest in the field of women's intimate wellness and surgery draws participants from over 20 countries and the majority of U.S. states.

Dr. Goodman for years has been an invited attendee, lecturer, and Scientific Committee Co-Chair. He delights in their annual meetings, at which he learns as much as he teaches. He has been honored by ISCG in several different areas. Since their 2016 Congress, ISCG annually invites its members and Congress attendees to submit "Before and After" photos, and honors the best work in several categories. In 2017 ("*Best Combined Labiplasty with Clitoral Rood Reduction*"), 2018 ("*Best Revision*

Search this website

Fields marked with an * are required

Would you like to learn more about what Dr. Goodman does and how he can help?



Sign up below for the first chapter of his latest book. You'll receive Chapter 1: The Anatomy and Rationale for Surgery, as well as an article he wrote for The Journal of Sexual Medicine titled, "Female Genital Plastic/Cosmetic Surgery".

Fill in the fields below:

First Name *

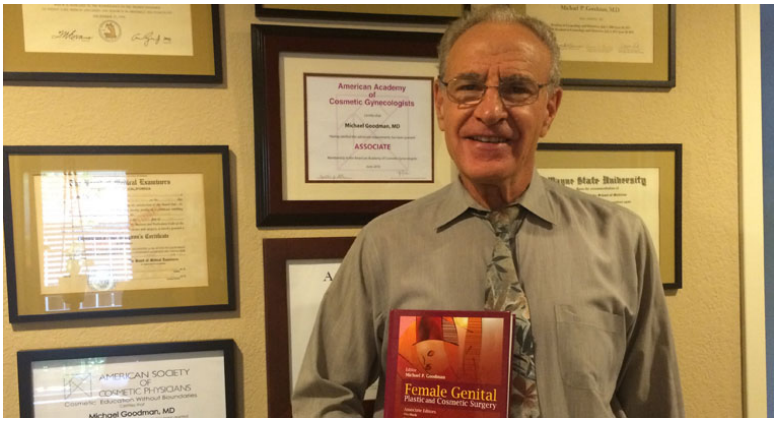
Last Name *

Email *

Labiaplasty"), 2020 ("*Best Labia Majoraplasty*") he has received awards. In 2019 he was awarded ISCG's Best Educator Award.

At this writing, April 2021, Dr. Goodman has recently returned from ISCG's 14th Annual Congress, where in addition to picking up another "Best Of" clinical award ("*Best Vaginal Rejuvenation*"), he was honored with ISCG's highest award, the ***2021 ISCG Award For Outstanding Contributions To Cosmetic Surgery***. At the meeting Dr. Goodman, one of the Scientific Program Committee's Co-Chairs, delivered two invited addresses, 23 "Pearls" for 23 Years of Genital Plastics: Labiaplasty," and "23 "Pearls" for 23 years of Genital Plastics: Vaginoplasty," honoring Dr. Goodman's long tenure as a female genital plastic/cosmetic surgeon, one of the longest and most experienced in the world.

Dr. Goodman has written the preeminent textbook Female Genital Plastic and Cosmetic Surgery



SUBMIT

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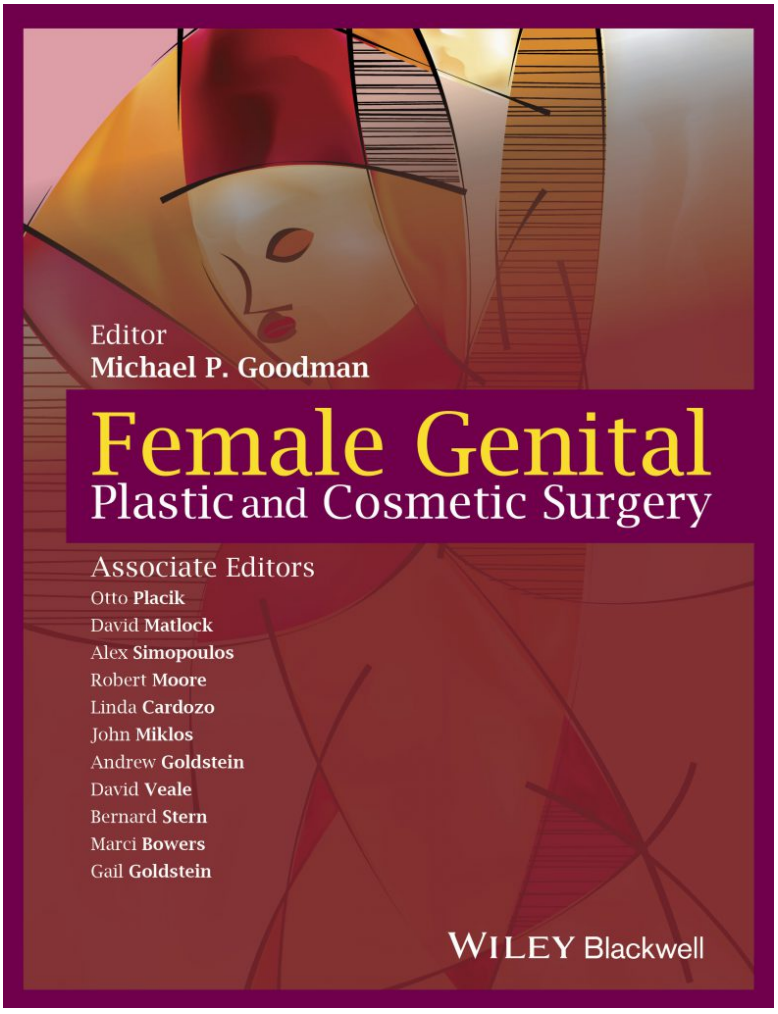


Female Genital Plastic and Cosmetic Surgery English Edition

Dr. Michael Goodman lecturing at the International Continence Society

Dr. Goodman lecturing internationally

Text of Dr. Goodman's Commentary, **click here.** For an Abstract of the original article, **click here.**

Cartagena, Colombia

Bali, Indonesia

Dr Goodman teaching other doctors genital cosmetic surgery.

I'm Ready to Get Started

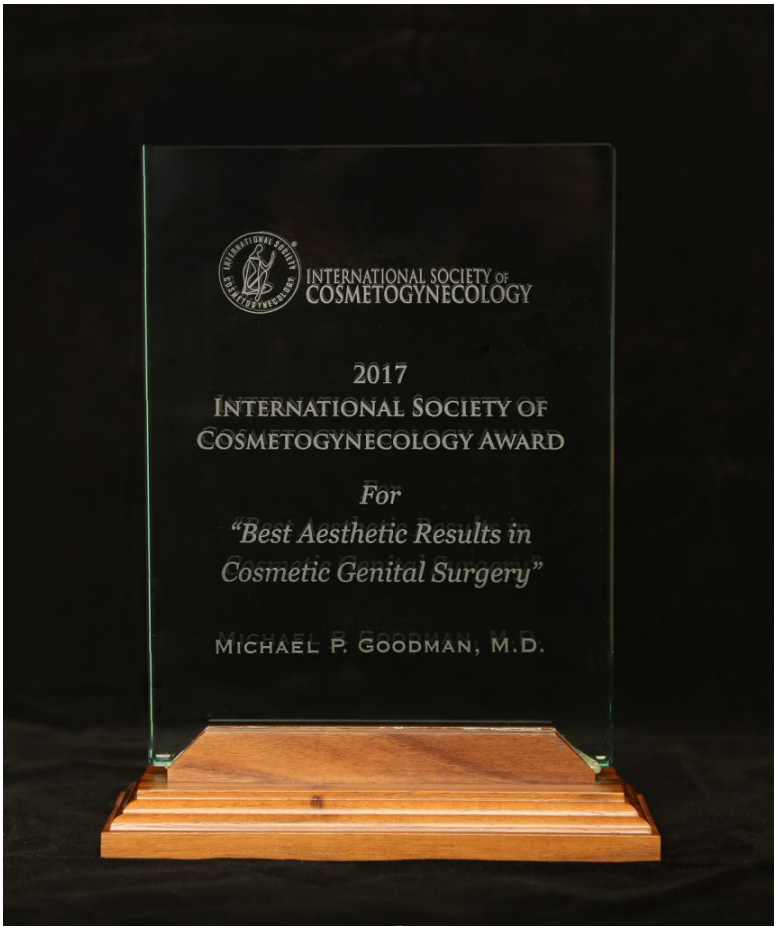
Training new associate

Dr. Goodman's Numerous Awards

2020 Award for "Best Combined Labia Majoraplasty and Minoraplasty

2019 Award for “Teaching Excellence”

International Society of Cosmetogynecology Award 2018



International Society of Cosmetogynecology Award 2017

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Sitemap

EXHIBIT S

EXHIBIT S

VAGINOPLASTY

Cases: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |

CASE 1

Click Image for enlarged viewing

Front View Gaping

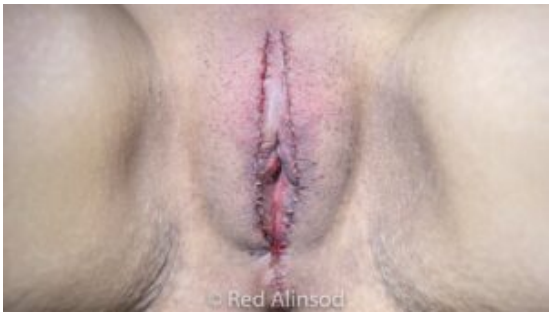
Side1 View Gaping

Side 2 View Gaping

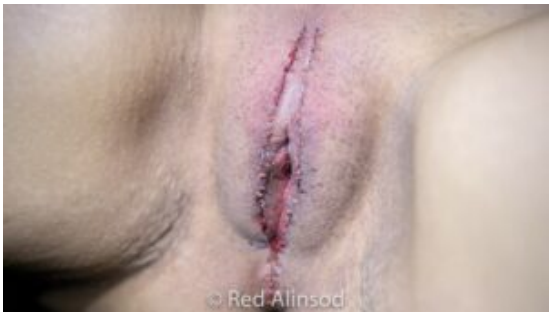
Front View Relaxed

Side 1 View Relaxed

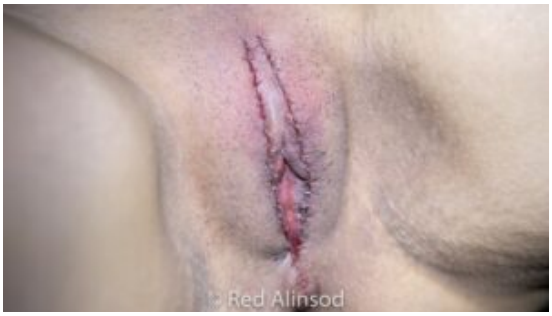
Side 2 View Relaxed



Front Immediately After



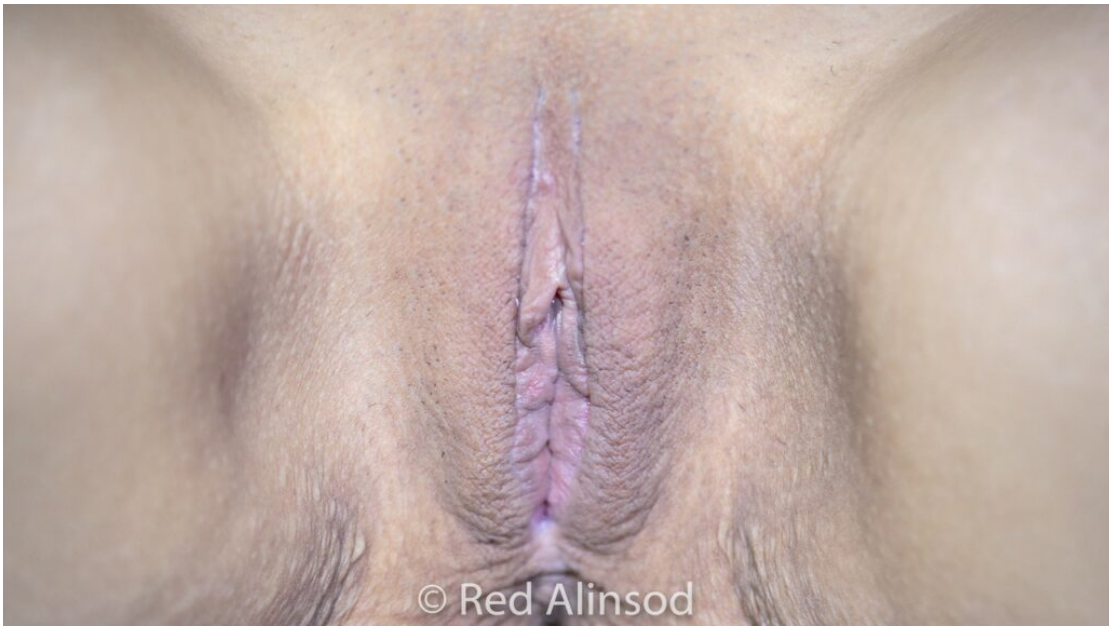
Side 1 Immediately After



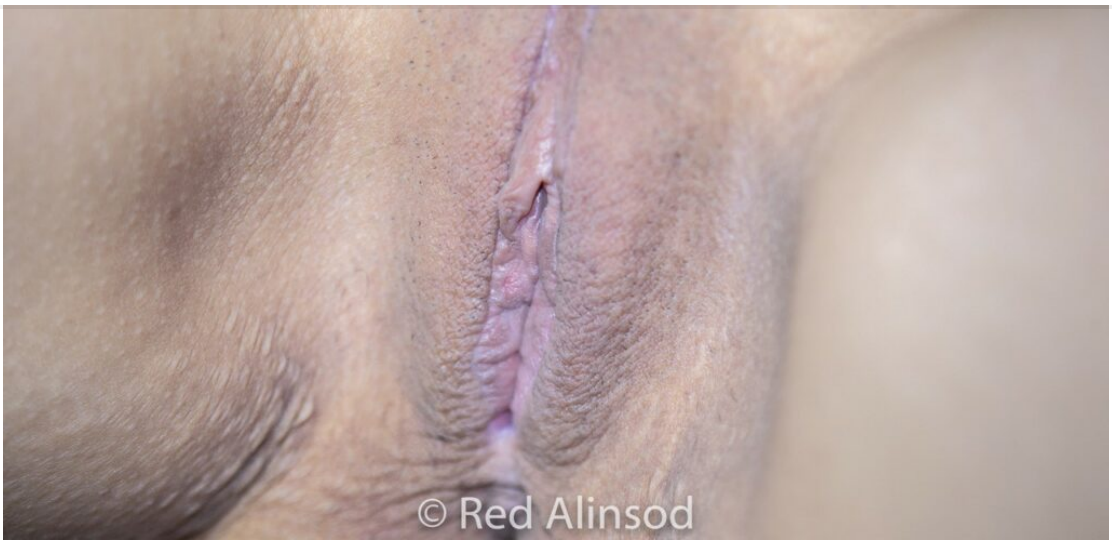
Side 2 Immediately After

Side 1 – 2 Weeks After

Side 2 – 2 Weeks After



Front View – 6 Weeks After



Side 1 – 6 Weeks After

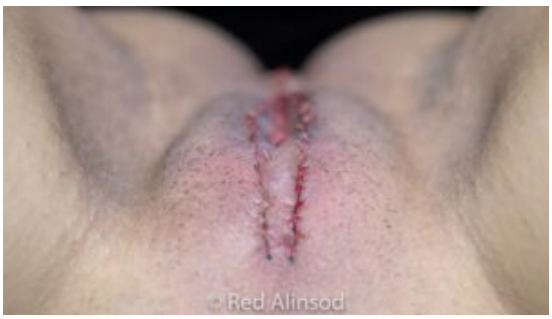
Side 2- 6 Weeks After

Oblique – Before

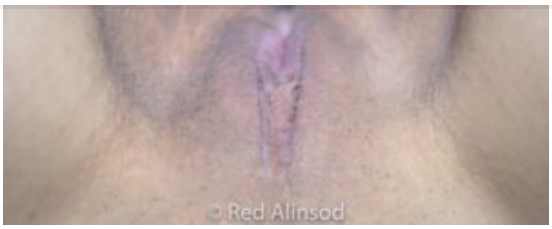
Oblique – Immediately After

Oblique – 2 Weeks After

Patient View – Before

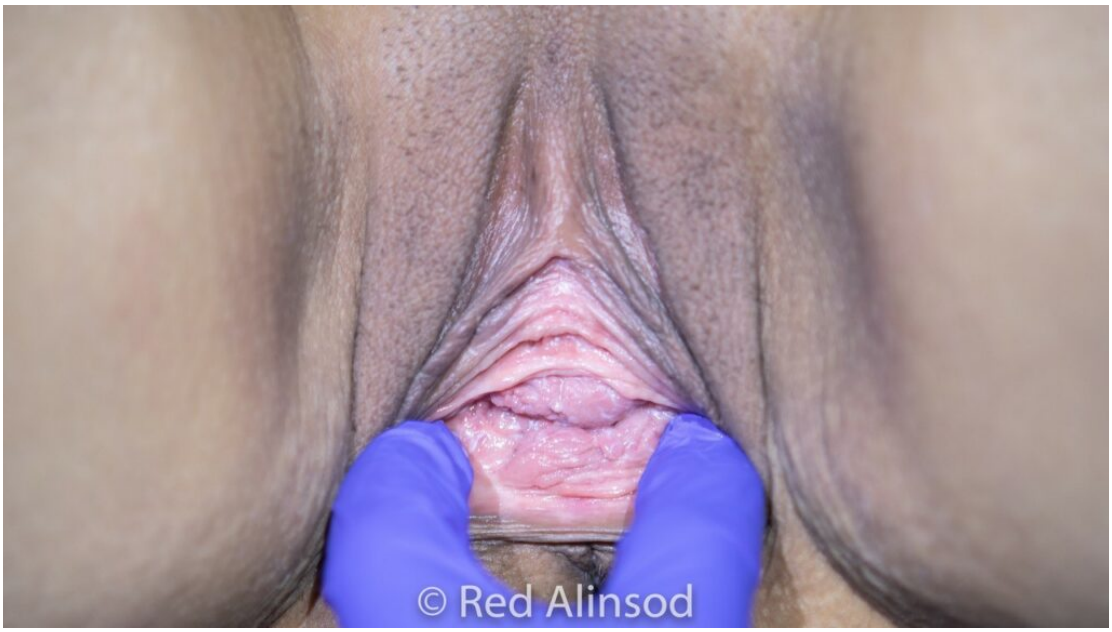


Patient View – Immediately After

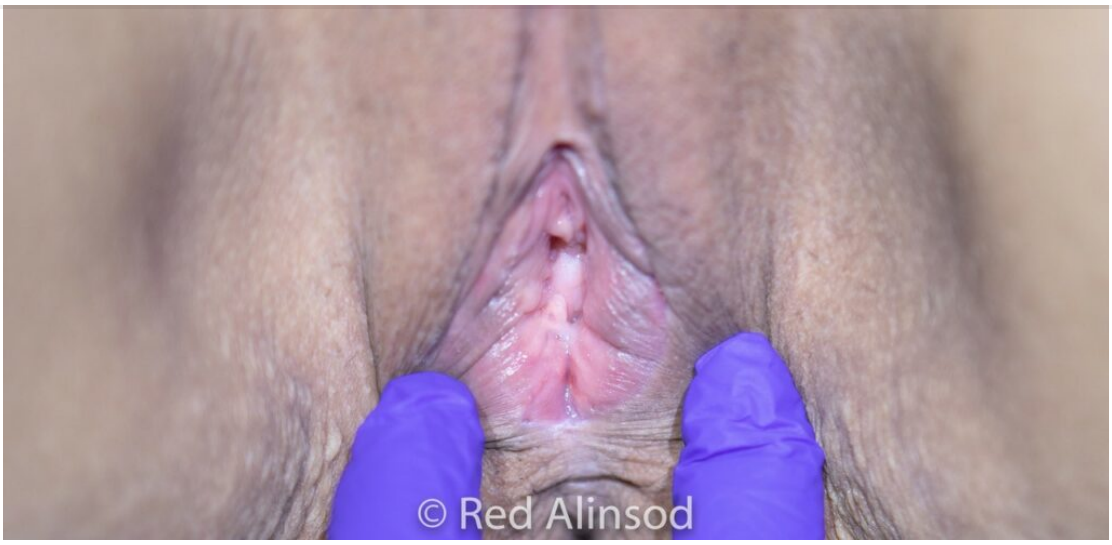


Patient View – 2 weeks after

PUSHING / SIZING

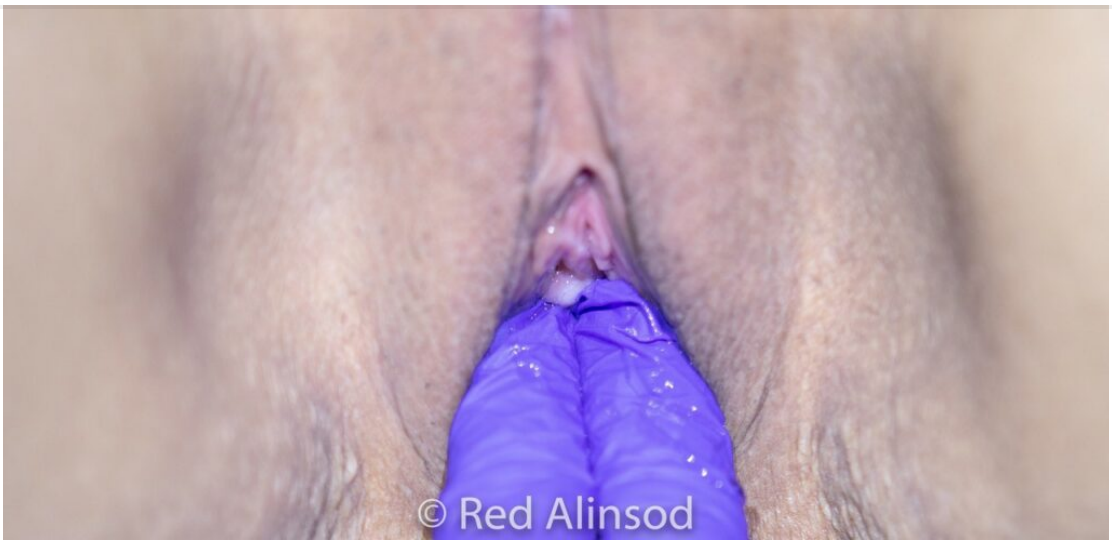


Pushing View Before



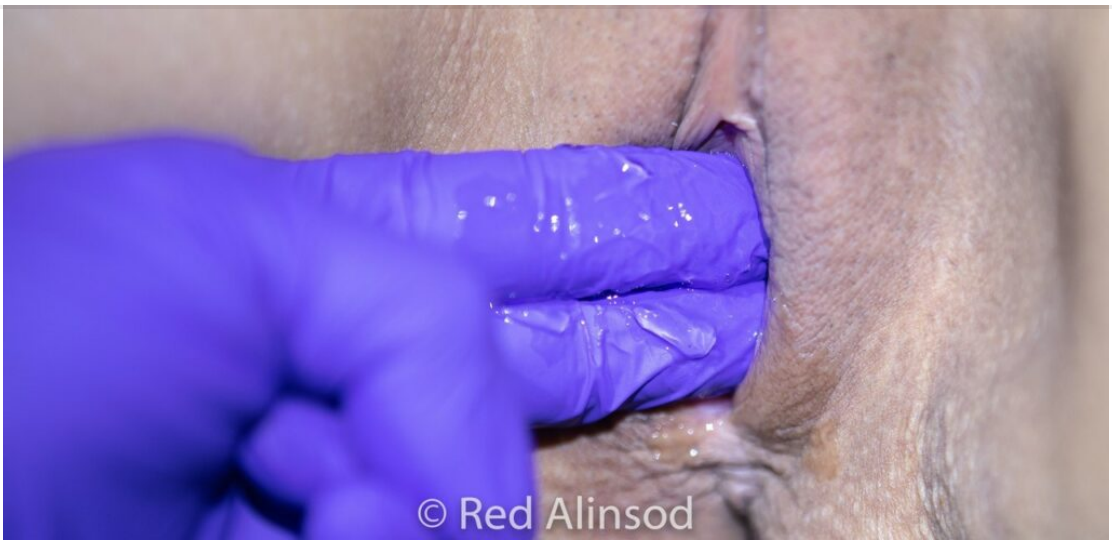
Pushing View – After

Sizing Horizontal – Before



Sizing Horizontal – After

Sizing Vertical – Before



Sizing Vertical – Before

LINKS

- Home
- Photos / Case Studies
- ThermiVa™
- Vaginoplasty (vaginal rejuvenation)
- Perineoplasty (Perineorrhaphy)
- Labia Minora Plasty (Labial Reduction)
  - Barbie Look
  - Hybrid Look
  - Rim Look
- Labia Majora Plasty

- Clitoral Hood Reduction
- Labiaplasty Revisions
- Laser Resurfacing
- Hymenoplasty
- Incontinence: Non-surgical Treatment
- Incontinence Sling
- Cystocele Repair (Bladder Repair)
- Rectocele/Enterocele Repair (Rectal Repair)
- Vaginal Vault Suspension
- Uterine Suspension
- Endometrial Ablation

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VAGINOPLASTY

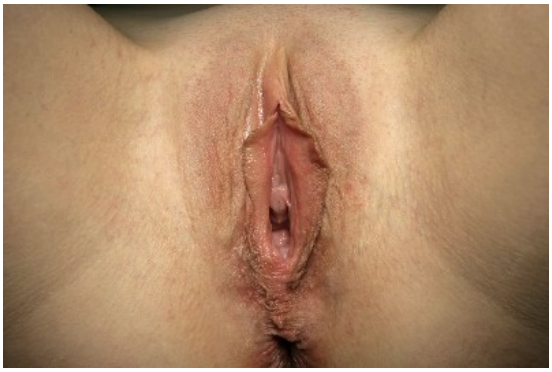
Cases: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |

CASE 6

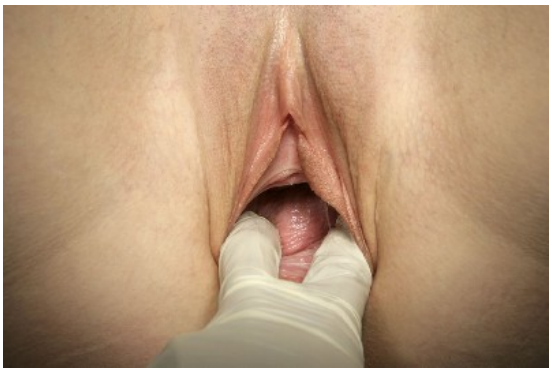
History: A lady in her late 30s complained of a loose feeling vaginal vault and lack of sensation during intercourse. She also suffered from a large rectocele that bulged out of her vagina that gave a chronic feeling of constipation. She leaked urine with coughing and sport activities and wanted to have a sling placed to resolve this problem. She wanted a more youthful appearance to her vulva and requested a labiaplasty with a clitoral hood reduction as part of her repair.

Surgery: Vaginoplasty and perineoplasty, transobturator sling, rectocele repair, vaginal vault suspension, vaginoplasty, labia minora plasty, labia majors plasty, clitoral hood reduction.

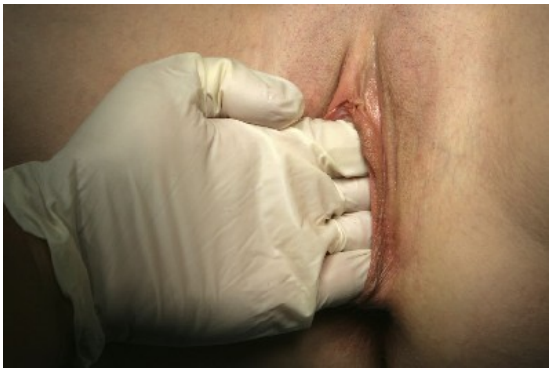
Results: Return to full function. Dry with no leakage, more satisfying sex life.



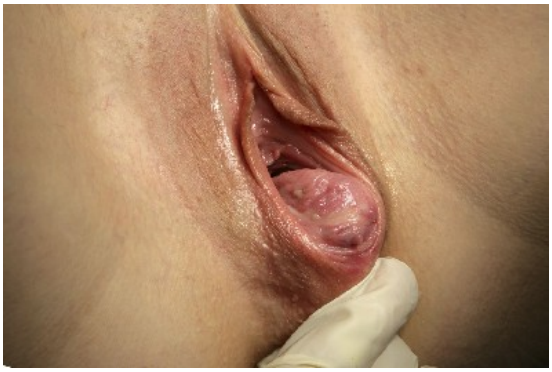
Before Surgery



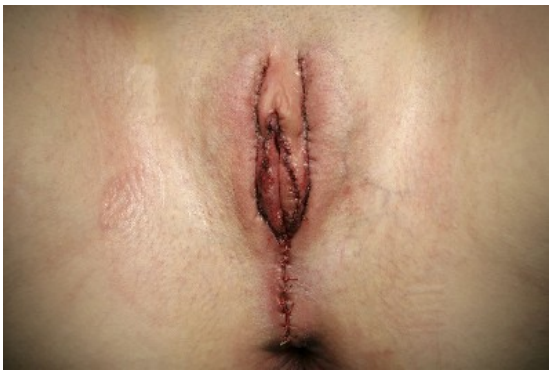
Before Surgery



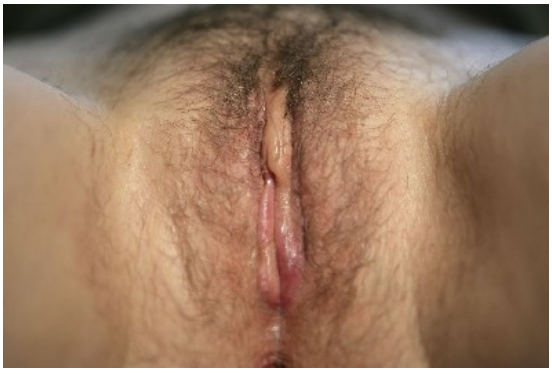
Before Surgery



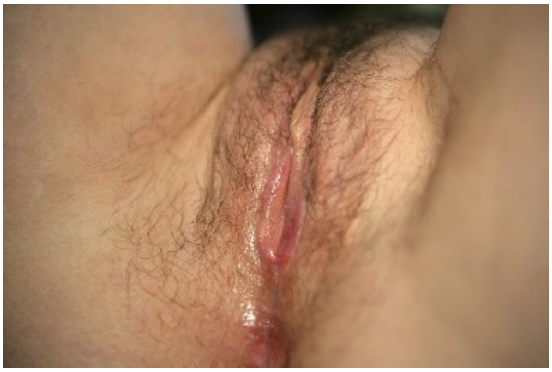
Before Surgery



Immediately After Surgery



After Surgery



After Surgery

After Surgery

LINKS

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VAGINOPLASTY

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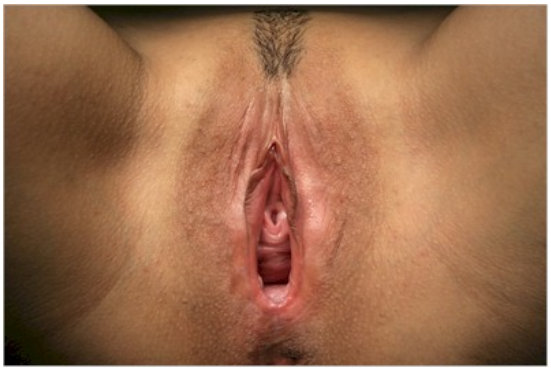
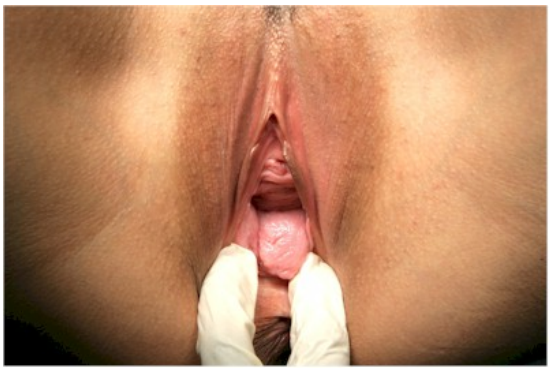
CASE 7

History: A lady in her mid 30s complained of pelvic pressure and a loose feeling vaginal canal with lack of sensation during intercourse. She also suffered from a moderate bladder prolapse and a large rectocele that bulged out of her vagina and gave a chronic feeling of constipation. She leaked urine with laughing, sneezing, coughing, and sport activities. She wanted a return to a more active physical and sexual lifestyle after living with the symptoms for several years.
Surgery: Vaginoplasty, Perineoplasty, Total Vaginal Hysterectomy, Incontinence Sling, Pelvic Reconstructive Surgery with Ultra Lightweight Mesh.



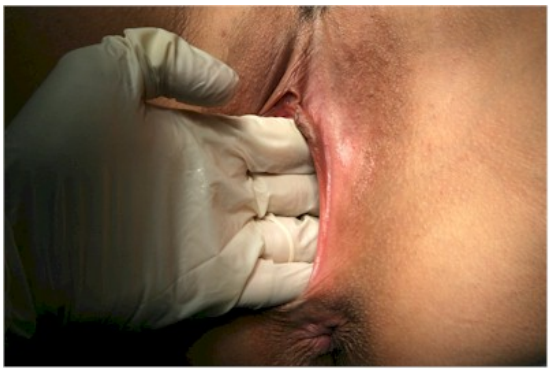
Before Surgery



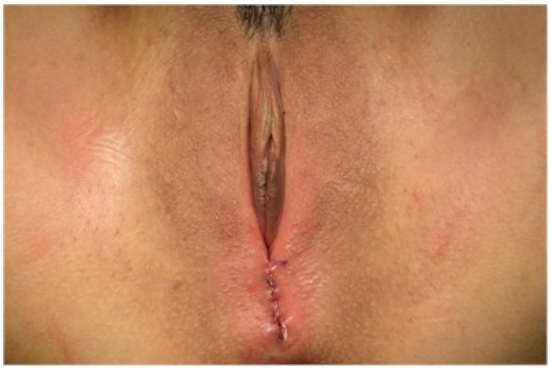
Prolapsed Rectum

Prolapsed Bladder

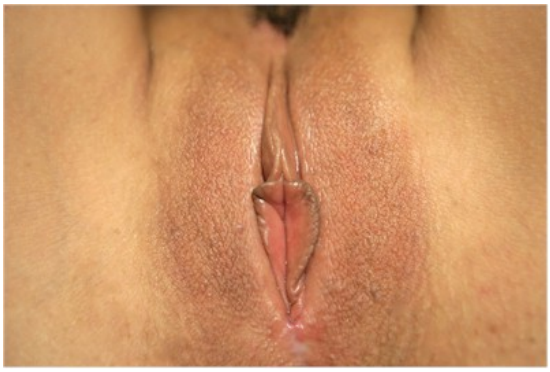
Vaginal Looseness



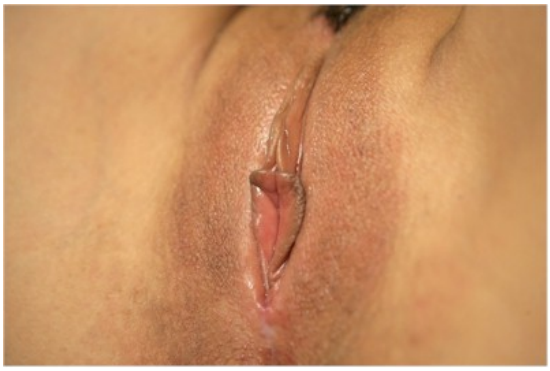
Vaginal Looseness



Immediately After Surgery



2 months After Surgery



2 months After Surgery

LINKS

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- Photos / Case Studies
- ThermiVa™
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  - Hybrid Look
  - Rim Look
- Labia Majora Plasty
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- Uterine Suspension
- Endometrial Ablation

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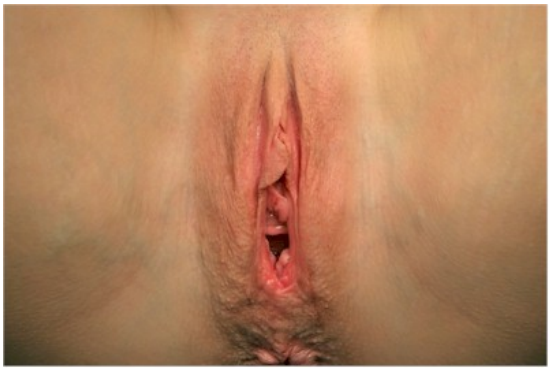
VAGINOPLASTY

Cases: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |

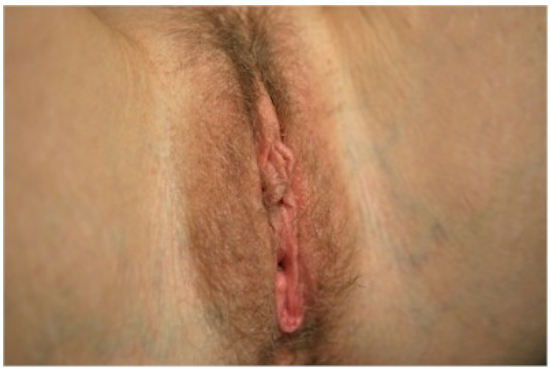
CASE 9

History: A young mother in her early 30s complained of vaginal bulges and pelvic pressure and a loose feeling vagina with lack of sensation during intercourse. She felt chronic constipation even though her stools were soft and she was taking fiber supplements. She leaked urine with any sporting activity and was unable to stay dry during her yoga classes. She wanted a pelvic prolapse and incontinence repair with vaginal tightening.
Procedures Performed: Vaginoplasty, Perineoplasty, Incontinence Sling, Pelvic Reconstructive Surgery with Ultra Lightweight Mesh. She also underwent a Mommy Makeover abdominoplasty

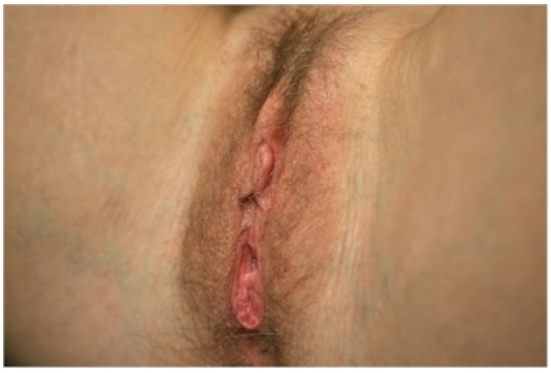
Results: Return to a full and active lifestyle and ability to wear her bikini again.



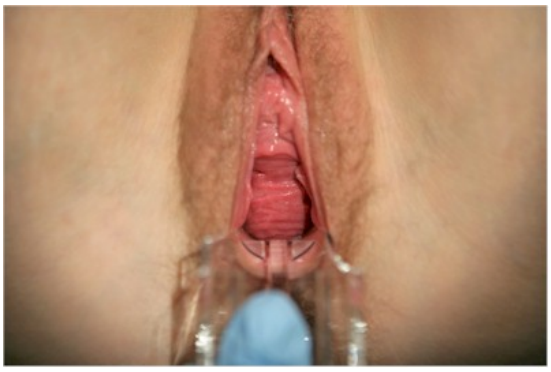
Before Surgery



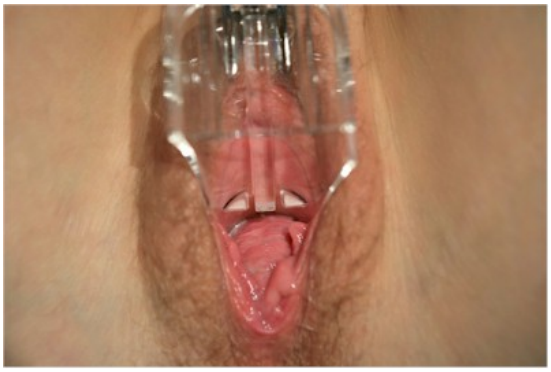
Before Surgery Side 1



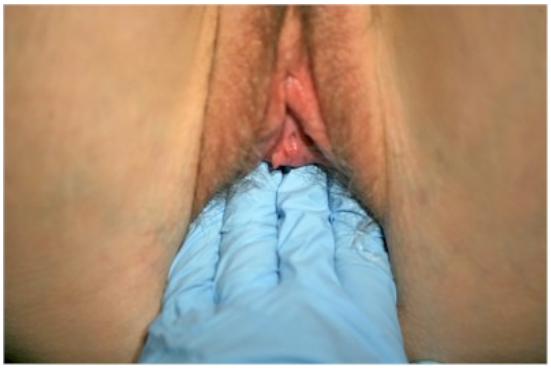
Before Surgery Side 2



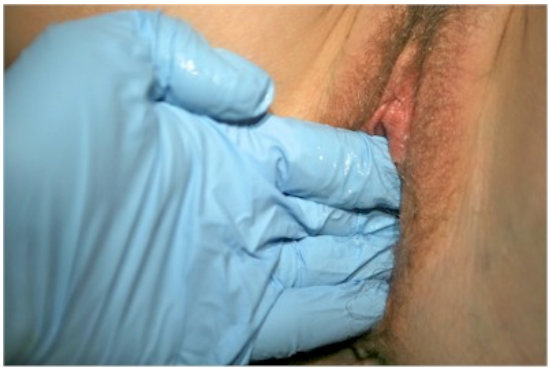
Before Surgery Cystocele



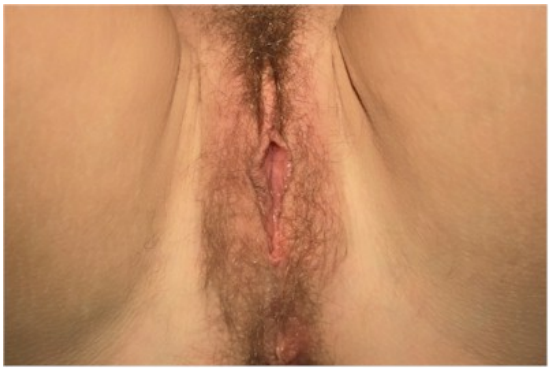
Before Surgery Rectocele



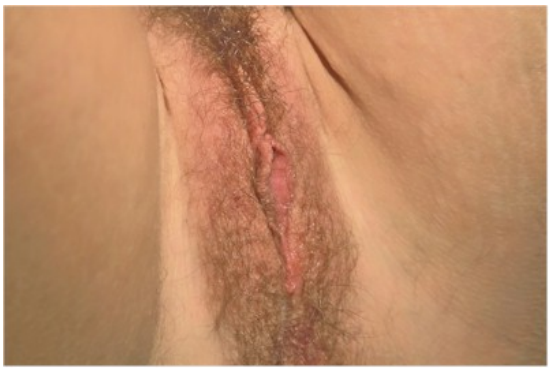
Sizing Before Surgery



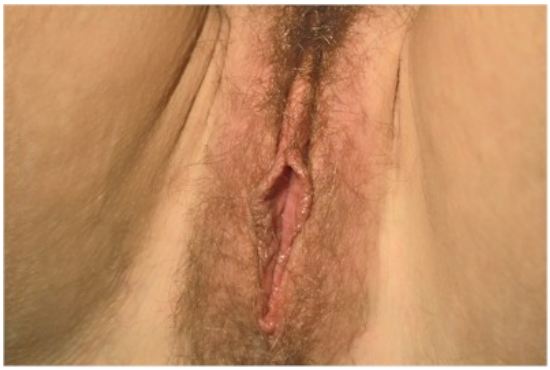
Sizing Before Surgery



After Surgery Front



After Surgery Side 1



After Surgery Side 2

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VAGINOPLASTY

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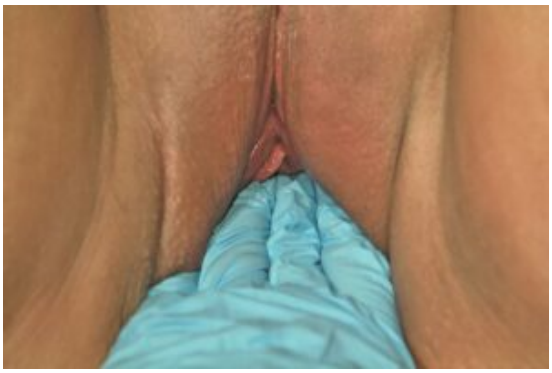
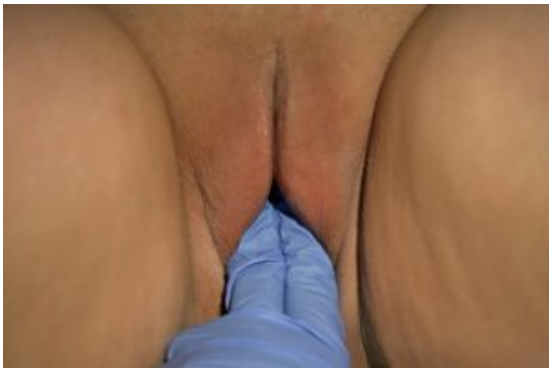
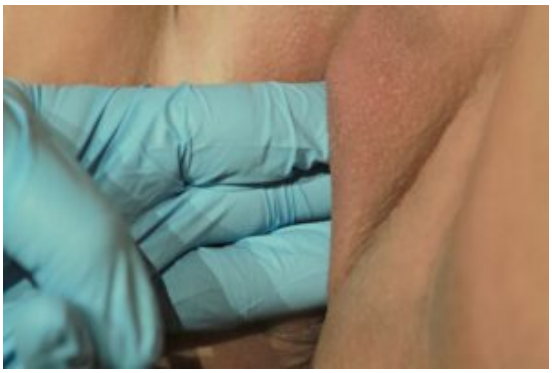
CASE 10



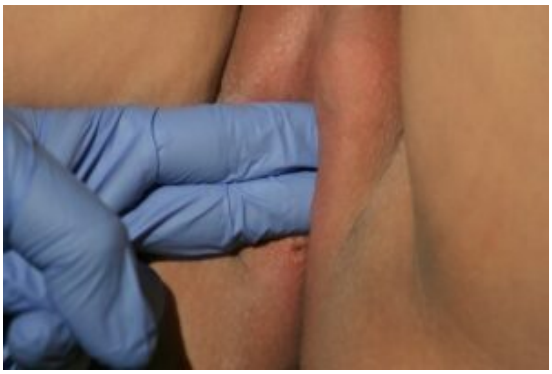
Sizing – Before Vaginoplasty



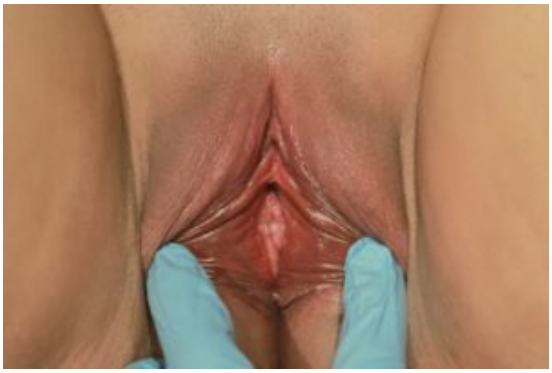
Sizing – After Vagnoplasty



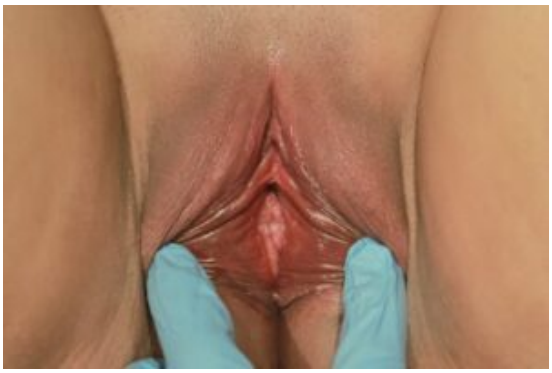
Sizing – Before Vagnoplasty – side



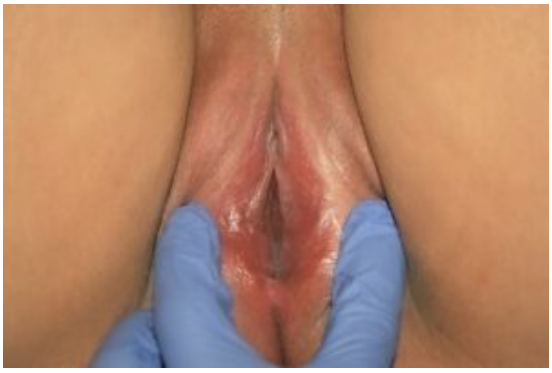
Sizing – After Vagnoplasty – side



Before Vaginoplasty



Before Vaginoplasty



After Vaginoplasty

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- Endometrial Ablation

EXHIBIT T

EXHIBIT T

Patient Information Booklet

AESTHETIC VULVOVAGINAL SURGERY AT SOUTH COAST UROGYNECOLOGY

2018

Red M. Alinsod, M.D., FACOG, FACS, ACGE

949-499-5311 • info@urogyn.org
www.urogyn.org
Pacific Coast Highway, Laguna Beach, California

ALINSOD INSTITUTE
for AESTHETIC VULVOVAGINAL SURGERY

Contents

Introduction to The Alinsod Institute for Aesthetic Vaginal Surgery

Dr. Red Alinsod and South Coast Urogynecology serve a dual role for Orange County and all of California. First and foremost is to provide urogynecologic and gynecologic services in the envelope of a Women's Center. Its second role is to educate physicians and surgeons in the art and science of pelvic and vaginal surgery.

We offer highly specialized surgery to restore and enhance the appearance of the vaginal area. These procedures, frequently referred to as "Vaginal Rejuvenation," "Aesthetic Vaginal Surgery," "Cosmetic Vaginal Surgery," or "vaginoplasty," resurfaces and tightens the tissues to reclaim the youthful appearance and function of the vulvar and vaginal area. In ordinary terms, the procedure is esssentially a "face lift" for the vulva and vagina.

Dr. Alinsod has developed and pioneered many innovative techniques in this newly evolving field of cosmetic surgery and is happy to offer these services to his patients.

Due to the effects of childbirth, aging, trauma, and/or genetics, the vaginal tissue and surrounding muscles can become stretched and lose their strength and tone. The loose and unsatisfying feeling that many women feel can also be felt by their male partner during intercourse. Labial enlargement, unevenness, or traumatic tears from childbirth can also affect the labia to make it look unappealing. This can result in discomfort with intimate contact, chronic rubbing, a pulling sensation, vulvar pain, and an inability to wear certain types of clothes such as tight jeans or swimsuits. Most women simply live with these symptoms but now help is available. Femininity can be restored.

These surgical procedures can increase friction during intercourse and can enhance intimacy. Furthermore, labial contouring, commonly referred to "labiaplasty," can be performed in the office in an outpatient setting. Many patients have flown in to Southern California and have received the highest of care, personalized service, and outstanding results.

Dr. Alinsod has the distinct advantage and experience as a reconstructive pelvic surgeon enabling him to tackle even the most difficult of cosmetic vaginal/vulvar cases. Unlike a plastic surgeon, who typically has no training in the art of reconstructive pelvic surgery, or a general gynecologist, who has little to no training in aesthetic vaginal/vulvar procedures, Dr. Alinsod is able to treat the whole woman in terms of her aesthetic, gynecologic, and urologic health by addressing any incontinence and pelvic prolapse that may be present at the time of the cosmetic procedure.

This broad base of knowledge and experience combined with a sharp focus on aesthetics makes Dr. Alinsod the surgeon of choice. He welcomes your inquiries.

Dr. Alinsod is able to treat the *whole woman* in terms of her aesthetic, gynecologic, and urologic health by addressing any incontinence and pelvic prolapse that may be present at the time of the cosmetic procedure.

About Dr. Red Alinsod

Dr. Red Alinsod is director and owner of *South Coast Urogynecology, The Alinsod Institute for Aesthetic Vaginal Surgery,* in Laguna Beach, CA. He is a world renowned Urogynecologist and Aesthetic Vaginal Surgeon and the founder of the first CME approved Aesthetic Vaginal Surgery Workshops sponsored by The American Academy of Cosmetic Gynecologists.

Dr. Red Alinsod completed medical training at Loma Linda University Medical Center in 1990. He served a 12-year Air Force career with 4 active duty years at George and Nellis Air Force Bases. Now in solo private practice, Red has built a large and successful urogynecology, pelvic reconstructive surgery, and aesthetic vaginal surgery following. He is the Director and founder of South Coast Urogynecology and The Alinsod Institute for Aesthetic Vulvovaginal Surgery. His International teaching program is the first of its kind to combine both pelvic reconstructive and aesthetic principles together. He has trained many of the world's leading doctors and instructors in cosmetic gynecology and has presented his techniques worldwide. He is co-editor of Female Cosmetic Genital Surgery, Concepts, Classification and Technique, the seminal textbook for plastic surgeons and gynecologists in this rapidly growing field. He is the Founder and Chairman of CAVS (Congress on Aesthetic Vulvovaginal Surgery), the oldest and longest running Congress dedicated to Aesthetic Vulvovaginal Surgery and Female Cosmetic Genital Surgery. He is the inventor of the "Barbie Look" and "Hybrid Look" Labiaplasty, Medial Curvilinear Labia Majoraplasty, Central and Lateral Clitoral Hood Reduction, In-office No-IV Labiaplasty, Perineoplasty, Vaginoplasty, Pudendo-Levator Block. He is the inventor and patent owner of the Lone Star APS Vaginal Retractor, APS Surgical Table, Alinsod Scissors, and various pelvic reconstructive devices and techniques such as Sling with Bladder Support and Implants and Procedures for Treatment of Pelvic Floor Disorders. Dr. Alinsod is the inventor of ThermiVa, a radio frequency device for dermatologic conditions with specific use in feminine tissues. He heads Thermi's Clinical Advisory Committee for Women's Health and the ThermiVa Center for Physician Education. Dr. Alinsod also specializes in non-surgical labial and vaginal tightening, treatment of stress incontinence, non-drug treatment of overactive bladder, atrophic vulvovaginitis, orgasmic dysfunction, and vulvar dystrophy. These disruptive and safer methodologies of treatments, developed by Dr. Alinsod, are changing the face of gynecology for the benefit of women worldwide. Dr. Alinsod welcomes your calls, emails, and inquiries.

Maria, Dr. Alinsod's trusted Medical Assistant, is a kind-hearted and excellent patient advocate. She will do just about anything to ensure that your stay in our office is full of smiles and cheer.

PATENTS AND EQUIPMENT DEVELOPED

1. Lone Star APS Retractor
2. Implantable Sling with Bladder Support
3. Implants and Procedures for Treatment of Pelvic Floor Disorders
4. Brought first Ultra Lightweight Mesh to USA in 2005 (Restorelle)
5. Alinsod Urogyn Table
6. Alinsod Scissors, Pickups, Clamps
7. ThermiVa – Patent Pending

PROCEDURES DEVELOPED

1. Radiofrequency Surgical Techniques for Aesthetic Gynecologic Surgery In-Office
    a. First to treat vulvovaginal tissues with non-surgical RF energy
    b. Feathering Technique for Resurfacing Revision surgery
    c. Pudendal-Levator Block
2. In-Office RF Labiaplasty a. Barbie Look
    b. Hybrid Look
    c. Vertical Clitoral Hood Reduction
    d. Lateral Curvilinear Clitoral Hood Reduction
3. In-Office Vaginoplasty and Perineoplasty
4. Medial Curvilinear Labia Majoraplasty
5. Thermi-O (ThermiVa + O-Shot)
6. ThermiVa Research on
    a. Tightening of vulva and vagina
    b. GSM
    c. SUI
    d. OAB
    e. Orgasmic Dysfunction
7. Gynecologic Dermoelectroporation for local anesthesia and vulvar lightening and plumping

Introduction to South Coast Urogynecology

Who We Are:

We are surgical sub-specialists for women's health issues such as urinary leakage, fallen bladder/rectum/vagina/uterus, abnormal vaginal bleeding, pelvic pain, failed prior surgeries, and unappealing vaginal appearance or function.

What We Do:

We specialize in gynecology, urogynecology, pelvic surgery, and aesthetic vaginal surgery or vaginal rejuvenation.We perform complete workups for referring doctors and private patients. Most of our surgeries are quick, outpatient, or just overnight stays.

Why We Are Unique:

Our surgical sub-specialty is unique in that it enables one physician to integrate the skills of a gynecologist, urologist, and aesthetic surgeon. Our practice is one of the very few internet based practices that offers secure communications with patients along with rapid response. We use Blackberry and iPhones to provide instantaneous, secure, and timely responses. "Phone tag" is eliminated. We are a one stop Women's Health Center.

Care Philosophy:

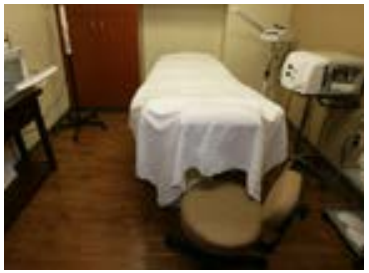
Our staff offers timely, compassionate and personalized care. We strive to provide you with answers and options, as quickly as possible, and to assist you in understanding the personal solutions best suited to meeting your individual needs. We are one of only a very few West Coast practices to offer the convenience of advanced endoscopic procedures and aesthetic vaginal procedures in the office and without IVs. inside the office. This resource reflects our ambitious efforts to cater to your desires and diligently meet your personal needs.

For more photos of South Coast Urogynecology go to:

Office Photos








Laguna Beach offers year-round excellence in both weather and amenities. Many travel here to have surgery and a pleasant vacation break from the everyday world. Our entire staff aims to pamper you from the minute we hear from you.

http://www.lagunabeach.com/

Meet Our Staff

Dr. Red M. Alinsod

Physician, Surgeon, Teacher, Photographer, Boss

He is the heart and soul and keeps us on our toes. Does he ever sleep? The patients love our office because of Dr. Alinsod and his vision. Patients have said that he has the best bedside manner they had ever encountered and the comfort level he provides is also second to none. He covers everything mentioned above and even answers his own email, sometimes a nice surprise to his patients. He is an educator, teaching patients and surgeons the world over about his expertise in pelvic reconstruction, vaginal rejuvenation and even medical photography.

red@urogyn.org

Maria Islas

Medical Assistant and Urodynamic Specialist

Maria, Medical Assistant and Urodynamics Specialist - Dr. Alinsod's right hand, Maria's compassionate and outgoing personality puts the patients at ease, starting with the initial appointment to the post-op visits. She is attentive to the patient's emotions of coming to the office, in discussing their issues, including post-op care and getting back on their feet. She is the number one person in individualized patient care and assisting Dr. Alinsod in all office procedures. ~Maria

maria@urogyn.org

Marisol

Medical Assistant

Marisol was born and raised in sunny Southern California. She joined the South Coast Urogynecology staff in 2012 and has been a wonderful edition to the team. She works meticulously with Dr. Alinsod, making sure all surgical needs are met in a timely, efficient, and caring manner. Above all else, her main priority is exceptional patient care. When she's not tending to patients, she enjoys spending time with her beautiful family.

Email: marisol@urogyn.org

Meet Our Staff

Diane Watson *Front Office Coordinator*

I was born and raised in Southern California and have a beautiful daughter who is my best friend. I have worked in the medical field in different specialties for over 25 years and have always enjoyed gynecology. Working for Dr. Alinsod has been challenging, rewarding, and a learning experience for me. I truly love coming to work every day and enjoy the interaction with our patients. My hobbies include walking, going to the beach, riding my bike and reading suspense novels. Spending time with my friends is also very important to me.

Email: diane@urogyn.org

Eunice *Medical Biller*

Eunice, Medical Biller - After all is said and done, Eunice works with the patient on their final step, insurance and patient payments. Not an easy task, Eunice has worked in medical billing for over 20 years. She reviews the patient's explanation of benefits and makes sure all appointments and procedures are billed correctly and in a timely manner. She certainly cracks the proverbial whip when it comes to correctly inputting patient data and marking all appropriate procedure codes.

Email: info@urogyn.org,

Medical Treatments

Specialty Descriptions for SCU

Gynecology

We excel in the diagnosis and treatment of all gynecologic conditions ranging from pelvic pain, abnormal bleeding, fibroids, and infections. Endometrial resection and ablation are just some of the advanced skills offered. We also have the most up-to-date diagnostic equipment available.

Urogynecology & Reconstructive Pelvic Surgery

We specialize in diagnosis and treatment of incontinence and pelvic organ prolapse. State-of-the-art minimally invasive treatments are our forte. We have some of the most extensive and successful experience on the use of tissue and mesh in vaginal reconstruction. We also have helped pioneer the use of transobturator slings and Posterior IVS vaginal suspension surgeries on the West Coast. Renowned surgeons from all areas of the country have flown in and have been trained by Dr. Alinsod in modern reconstructive pelvic surgery.

Aesthetic Vaginal Surgery

Highly specialized surgery is available to restore and enhance the appearance of the vaginal area. This is frequently referred to as "Vaginal Rejuvenation" and "Aesthetic Vaginal Surgery." Lasers are used to incise and resurface the skin and to tighten and restore the youthful appearance and function of the vulvar and vaginal area. In ordinary terms, the procedure is esssentially a "face lift" for the vulva and vagina. Dr. Alinsod has developed and pioneered many innovative techniques in this newly evolving field of cosmetic vaginal surgery.

Aesthetic Laser Center

Available to you at our Laguna Laser Center is a complete array of light based and radio frequency therapies to improve the look, feel, and touch of your skin. Hair and vein reduction therapies are at the forefront of technology. The safest, most comfortable lasers and Intense Pulsed Light (IPL) systems as well as the most effective radiofrequencyt devices on the market are up and running and giving amazing results to our patients.

We carry the Palomar/Cynosure line as well as the newest Thermi machines. We have Fractional Erbium lasers of the highest order for that gentle lunch time peel to the most aggressive deep resurfacing for acne scars, and wrinkles. We are a Center of Excellence for deep Radio Frequency Skin Tightening for loose and saggy skin, wrinkles, stretch marks. Dr. Alinsod is the first surgeon able to incorporate these technologies into his aesthetic vaginal surgeries to give that smooth and natural look.

Packages are available at very reasonable prices that can incorporate all the technologies into one comprehensive plan of care. For example, stretch marks can be treated with fractional lasers to reduce the prominence and coloration of stretch marks ($1500/treatment) then radiofrequency tightening of skin ($1500/treatment) then Platelet Rich Plasma $1800) to aid healing, then have Radiofrequency with laser body countouring ($4,000) to reduce the local fat all for $5,000 instead of $15,000! It is the best value for stretch marks reduction in Southern California.

The Laguna Laser Center has a complete line up of powerful light based technologies available to its customers.

High Frequency (No Scalpel) Surgery vs. Laser Surgery *by Edward Jacobson, MD*

If you have visited the many vaginal rejuvenation and labia reduction websites on the Internet you have probably discovered several different techniques promoted as the best for restorative vaginal reconstruction, especially laser surgery. As someone who was personally trained by the two top two pioneers in the specialty and who has over eight years experience with restorative vaginal surgery, let me share with you my thoughts on this subject.

For the first five years working in this subspecialty I used the laser for all of my vaginal rejuvenation and labia reduction procedures. The laser was highly marketable and well known to the public, literally and figuratively the 'cutting edge' of medical technology, and achieved very good results. Even today, many women believe if their surgeon isn't using a laser he is behind the times. Well, if the laser is so outstanding, what convinced me to switch to high frequency surgery to perform the same procedures?

Before we go there, let's talk about the laser first. This is a device that focuses and concentrates light energy into a very precise cutting instrument. The type of laser used for vaginal rejuvenation uses a wavelength designed to seal small blood vessels as it cuts. The result: a precision incision with virtually no bleeding. However, there is a significant downside. The laser generates intense heat. The remaining tissue edges that need to be stitched together sustain a lot of thermal damage, resulting in swelling, peeling and inflammation that lasts for days or even weeks. A significant amount of post-operative discomfort persists and it takes a long time to heal, especially after vaginoplasty. During labiaplasty, if the inner labia are thin the residual heat damage can be very traumatic and result in distortion and prolonged discomfort, even it the best of hands.

High frequency surgery provides the best of all worlds. It generates a radiowave emitted by a fine wire. This cool tip doesn't even touch the skin as it cuts. As a result there is virtually no thermal effect, charring, swelling or inflammation. In fact the cut edges are 'cleaner' compared with a scalpel or knife because the width of the incision is so fine. Patients who waddled into my office the day after laser surgery now walk in with minimal discomfort, whether they had undergone vaginoplasty or labia reduction. Where I previously ordered Percocet and Oxycontin for post operative pain

with laser surgery I now only use a mild narcotic such as Vicodin, and even then only as a backup medication. Needless to say, you can be up and about and can return to normal activities faster and with greater comfort compared with the laser.

The problem with high frequency surgery is that women don't know about it and not many surgeons are trained in its use. It's actually been around for a long time and has been used by neurosurgeons, ENT surgeons and dermatologists. This is simply a new application of a well established instrument. It may not be sexy but it makes for a wonderful marriage of technology and restorative vaginal surgery.

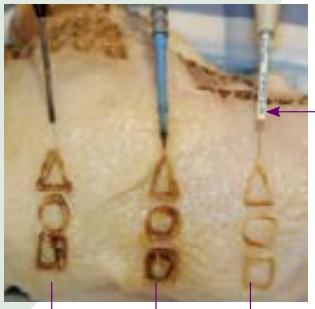
Ellman Surgitron versus Lasers: Which is Best?

I am glad you have done your homework and have asked this important question about the use of lasers in aesthetic vaginal surgery. I have performed labiaplasty many ways. **I have switched from the lasers to a more precise instrument called the Ellman Surgitron.** I did this because of the gorgeous results, increased precision, and decreased tissue damage when compared to a knife, laser, or regular cautery unit. The magnitude of safety is superior. There are no stray laser beams that may burn you. The tip is "cool" and precise. The Ellman Surgitron measures tissue destruction at the micron level unlike the Yag or 980 Diode laser that measures it in millimeters. Because it is such a safe and precise instrument I am able to perform labiaplasties in my office, under local anesthesia, quite successfully. That saves you thousands of dollars! There is no hospital cost, no anesthesiologist to pay. Although the term "laser vaginal rejuvenation" sounds quite catchy, it is strictly a marketing term.

There is no advantage to the use of lasers in vaginal surgery in general. In fact, many who advertise the term "Laser Vaginal Rejuvenation" rarely use the laser doing a labiaplasty or vaginoplasty.

Please go to *www.ellman.com* and read about their Surgitron units. It is impressive. I am Ellman's pioneer in the use of their device for for beautiful aesthetic vaginal surgery.

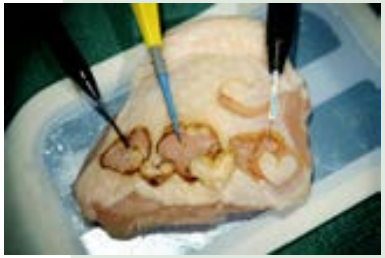
Previously, it was used in cosmetic surgery, dermatology, ENT, spine, and neurosurgery. In fact, this unit was the device used to separate the conjoined twins that were attached in the head just a few years ago! **In my humble opinion, lasers in vaginal surgery have seen their best days in the past. Aside from resurfacing the vulva or vagina, it has no advantage over the Ellman but carries distinct disadvantages such as hot and damaging tips.** Another disadvantage of the laser is cost. A good CO2 or Yag laser costs $30-$110,000. You can imagine the cost passed on to you. The Ellman costs much less, gives dramatic savings, enables office surgery, increased safety, increased precision, minimal tissue destruction, and rapid recovery. It is a difficult technology to beat. ~ *Red M. Alinsod, M.D.*



980mm Diode Laser | ConMed System5000™ | Ellman Surgitron Dual 4.0

Ellman Surgitron Dual RF

The Ellman Pelleve: The Best RF Device in the world.



The Ellman is extremely precise with minimal heat damage as seen on the far right. Compare the edges of the incisions.

Ellman/Laser Lab: Seeing is believing

The Switch is On

News is spreading like wildfire through the medical grapevine.

More and more plastic surgeons, gynecologists, urologists, and urogynecologists are hearing about Dr. Alinsod's consistent results and safety record using the Ellman Surgitron and SurgiMax. Many laser trained aesthetic gynecologists and plastic surgeons have quietly retired their 980 Diode lasers and have purchased an Ellman in hopes of mimicking Dr. Alinsod's results. Several renown and prominent laser vaginal surgeons have taken Dr. Alinsod's Master Course in Aesthetic Vaginal Surgery after spending $50-60,000 in a laser vaginal course. After initial impressions that lasers were effective in shrinking the vagina, surgeons soon realized that the 980 Diode laser was simply a very expensive cutting instrument with no significant advantage other than the glamorous marketing it was associated with. The lasers were found to be temperamental and tissue destructive with charred labias and vaginas resulting. Edge healing was compromised. The bubbling of the wound edges due to the immense heat the laser produced caused 2nd degree burns. Totally unacceptable to these fine surgeons. From New York to California, the switch to superior technology is on and a new Gold Standard is developing.

Dr. Red Alinsod is responsible for the advancement of Radiosurgery in vulvar and vaginal surgery. His work in developing RF sculpting and resurfacing techniques are far ahead of his time.

Precision excisions are taught and compared to enable the surgeon to objectively choose his or her device of choice. At our Institute we choose the most precise technology available, the Ellman Surgitron, SurgiMax, and the newest Pelleve.

What is Vaginal Rejuvenation?

One of the fastest growing segments of cosmetic surgery is female genital surgery. Many phrases are used to describe what is surgically done and the catch-all phrase lay people have seen with increasing regularity is "vaginal rejuvenation."

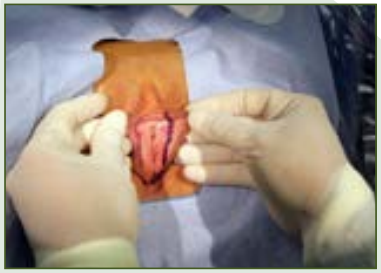
The branded name "Laser Vaginal Rejuvenation" has even gained national attention in print and television. In reality, vaginal rejuvenation is a marketing term referring to vaginoplasty, or the surgical tightening of the vagina. Vaginoplasty usually entails a modification of a standard "posterior repair" along with rebuilding of the perineum (the space between the vagina and rectum). This procedure was traditionally performed for a fallen or prolapsed rectum or rectocele. Lasers, scissors, cautery units, knives are used. Another surgery rapidly gaining social acceptance and widespread growth is labiaplasty. This is when the labia minora (the "minor lips") or the labia majora (the larger outer lips) are sculpted to look more pleasing and less prominent. Labiaplasty and vaginoplasty have been referred to as a vaginal face-lift. Gynecologists on an occasional basis have performed these procedures for years with plastic surgeons recently showing interest in this rapidly growing ultra-sub-specialty. In recent years reconstructive pelvic surgeons and urogynecologist, with specific training in pelvic and vaginal surgery, have popularized these aesthetic genital procedures and have helped provide it with legitimacy. It was only several years ago when cosmetic vaginal surgery was attacked vigorously by many medical practitioners as barbaric, unnecessary, and frivolous. However, baby boomers drove the acceptance of these procedures and fueled the growth of this very small niche. Women no longer wanted to live with unflattering, sagging, and large labias, nor did they want to live with gaping open vaginas and lack of sensation when having sexual relations. Both young women wanting a sleeker appearance of their genitals and older women wanting to repair the ravages of childbirth and time are in the forefront of demand to look and feel young again. Southern California, where many trends start, became the birthplace of this movement.

There are only a handful of surgeons who perform these surgeries in adequate volumes to be proficient and adept. Technical skill is of paramount importance for the surgeon but having an artist's eye is of equal value.

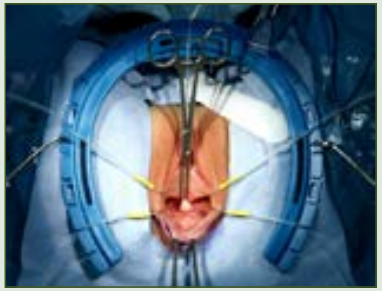
What is the difference between Labiaplasty and Vaginoplasty?

Many people ask me this very question. It is probably one of the most common ones I answer on a daily basis. Even established doctors have a hard time differentiating between the two surgeries. It is actually quite simple if you think of what you see and what you don't see.

First, what you see in a woman's pelvic area is called the "vulva." This includes the clitoris, inner smaller lips (labia minora), larger outer lips (labia majora), and the perineum (space between the vaginal opening and the anus. Some even include the anal area, inner thighs, and the fat pad above the pubic bone as part of the vulva since it is visible. Remember, this is the stuff you can see with your own eyes without the aid of retractors, microscopes, or other devices. This is the area where labiaplasty surgery is done. Specifically, labiaplasty usually involves the surgical trimming, reduction, or re-sculpting of the inner smaller lips. However, it can also refer to the surgical procedure to reduce the saggy skin of the larger outer lips. Together, the inner and outer lips are called the labia, hence labiaplasty. One more thing, if you have a flap of excess skin on the sides of your clitoris that is large and floppy, pulls, or is constantly irritated then a clitoral hood reduwction (also called prepuce reduction) is often done as part of the labiaplasty surgery.



Labiaplasty is surgery on the "outside" structures for labial sculpturing.



Vaginoplasty is surgery on the "inside' structures for tightening.

Next, what you don't see is the inside of the vagina. This is the canal where tampons are placed, where babies pass through, where vibrators are placed internally. This is the inside of the vagina that is stretched over ten times its normal size when a child is born through the

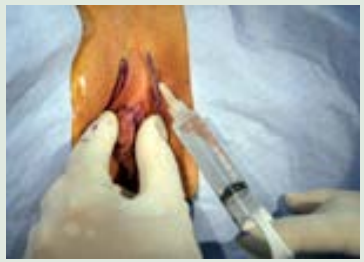
What is Vaginal Rejuvenation?

vagina. Even with a C-Section this inside space of the vagina can be severely stretched. When this happens, the walls of the vagina become loose and saggy on the inside, the part you don't see. This is the area where vaginoplasty surgery is done. Specifically, vaginoplasty usually involves the surgical tightening of the unseen inside of the vagina to narrow its size by both suturing together inner deeper tissues and trimming more inner superficial vaginal skin. When you have to do surgery on the space in between the vagina and the anus it is called a perineoplasty or perineorrhaphy. This is done if there is a bulging structure in this space or if a prior delivery messed up the appearance of this region. Prior tears or episiotomies are the most common cause of looseness in this entry point into the vagina.

One thing you should remember is the way most plastic surgeons do their vaginoplasty surgeries. During a plastic surgeon's residency program, and even in their fellowship programs, most will only get a couple of months of surgical time with the gynecology department. During these two months the plastic surgery resident typically assists the gynecology resident or fellow doing the vaginal surgery. The only other time most plastic surgeons get any vaginal surgery experience is during their two to three month rotations as medical students in the obstetric ward. During this time, they may get a few deliveries in which they repair superficial lacerations and tears in the perineum. It is rare that the plastic surgeon will be given the responsibility of repairing deep damage since the anatomy is difficult and rips into rectum, bowel, or bladder may occur during the repairs. In their gynecology rotations a medical student is never the primary surgeon doing deep pelvic repairs. As a plastic surgery resident or fellow it is rare that they do the primary deep pelvic repairs since they have to battle with the gynecology resident or fellow for these precious learning experiences. This usually means that a plastic surgeon advertising that they do vaginoplasty is really doing a perineoplasty and only tightening the opening into the vagina and doing little to no tightening of the deeper inner canal. To be fair, most gynecologists have absolutely no training in cosmetic surgeries such as breast implants, tummy tucks, and Brazilian Butt Lifts. In fact only a very few actually do these cosmetic procedures. In almost all cases these skills were learned after graduating from their formal residencies and fellowships and were learned in seminars or as an "apprentice" to a plastic surgeon. Few gynecologists are formally trained to do labiaplasty surgeries and even fewer plastic surgeons have the training to do them safely.

What is Micro Tumescent Vaginal Rejuvenation (MTVR)?

MTVR is the safest and most tailorable manner in which to perform aesthetic vaginal surgery. The original art of tumescent anesthesia involved placement of large volumes of local anesthetics under the skin to provide numbing before liposuction surgery. This volume infused distorted the anatomy. Our tried and true protocols, refined over a decade, have enabled us to perform labial and vaginal surgeries while you are comfortably awake, able to express your desires and preferences in appearance and fit, all without an I.V. having to be used. Very small volumes of local anesthetic, precisely placed in strategic locations, enable us to safely sculpt the labial appearance you want and the precise vaginal tightness you desire. For example, labial surgery averages only 4 to 7 cc of local anesthesia. Clitoral Hood Reduction a miniscule 1 to 2 cc. Perineoplasty needs about 10 cc. Hence the term "Micro Tumescence." VaginalRejuvenation/Tightening requires 30 to 40 cc due to the depth of surgery and density of nerve supply in the deep pelvis. You are able to watch TV, listen to your iPod, read a magazine, or nap during the surgery then give your opinion on the surgery as it proceeds. With the patient's use of mirrors it allows real-time evaluation of the surgery and enables adjustments as you go. You cannot do this when you are asleep in a surgery center or operating room. You cannot do this with a spinal or epidural in almost all cases. MTVR avoids the risks of a general anesthesia, spinal, or epidural, and saves significant dollars in doing so. There are no anesthesiologists or surgery center bills if you choose to have Micro Tumescent Vaginal Rejuvenation with Dr. Alinsod.



Micro Tumescent Vaginal Rejuvenation uses very little local anesthesia and is the safest and least costly technique available.

Frequently Asked Questions about Vaginal Surgery

Why choose Dr. Alinsod to do my surgery?

Dr. Alinsod has the distinct advantage and experience as a reconstructive pelvic surgeon enabling him to tackle even the most difficult of cosmetic vaginal/vulvar cases. Unlike a plastic surgeon, who typically has little to no training in the art of reconstructive pelvic surgery, or a general gynecologist, who has little to no training in aesthetic vaginal/vulvar procedures, Dr. Alinsod is able to treat the whole woman in terms of her aesthetic, gynecologic, and urologic health by addressing any incontinence and pelvic prolapse that may be present at the time of the cosmetic procedure. This broad base of knowledge and experience combined with a sharp focus on aesthetics makes Dr. Alinsod the surgeon of choice. Dr. Alinsod has trained hundreds of surgeons in the art and science of Aesthetic Vaginal Surgery. He is the National Instructor in Aesthetic Vaginal Surgery for The American Academy of Cosmetic Gynecologists and gives talks, seminars, and workshops in this rapidly evolving subspecialty.

What is Aesthetic Vaginal Surgery?

The term Aesthetic Vaginal Surgery is also known by other names such as Vaginal Rejuvenation, Laser Vaginal Rejuvenation, Labiaplasty, Vaginoplasty, Designer Laser Vaginoplasty, Perineoplasty, and Hymenoplasty. Aesthetic Vaginal Surgery is a broad term that includes the individual procedures. Since it is a rather new field dealing with the appearance and function of a woman's private parts the terminology has not been standardized. In simple terms, Aesthetic Vaginal Surgery and its many names deal with cosmetic surgery of the vulvar and vaginal region. It is cosmetic surgery of the "Private Parts."

What causes labias to be so enlarged or asymmetric?

Genetics plays a key role and is probably the major determinant in how large and what shape your labia will be. Exposure to estrogen or testosterone can also be a significant factor. Don't forget that physical trauma (e.g. labial tear from childbirth or bicyle injury) occasionally plays a role in the appearance of the labia.

What causes the vagina to be so cavernous at times?

The most likely culprit is childbirth. The passage of an average seven pound baby causes a great deal of muscle and tissue stretching that does not go back to its original tautness. Furthermore, vaginal lacerations, episiotomies, tears of the perineum and widen the vaginal opening and deeper canal even more. Other rare causes of vaginal laxity include a genetic predisposition to stretchy skin such as Marfan's Syndrome. Excess weight, chronic cough, chronic bronchitis can weaken the vaginal tissues and cause a downward and outward travel of the vaginal tissues.

Why is vaginal correction important?

Surgery to improve the appearance and function of a woman's vaginal tissues is important for both personal esteem and physiologic function. Childbirth is often traumatic resulting in lacerations and healing process that is not personally satisfying. The use of forceps or vacuum assisted delivery and the increasing weight of babies today result in more prolapse of pelvic organs, more incontinence, and more looseness of vaginal tissues or unappealing appearance of labial tissue. Many who have finished their childbearing years are now concerned about their personal appearance and are looking for ways to deal with this problem. Some feel that they have lost a great deal of sexual sensation due to looseness of the vagina. Vaginoplasty can increase friction during intercourse and can enhance intimacy.

Who does Aesthetic Vaginal Surgery?

Gynecologists, urogynecologists, and a few plastic surgeons do most of these types of surgeries. Gynecologists are trained specifically in repair of fallen bladders and rectums, fallen uterus or vagina, and repairing tears in the vaginal region as part of their everyday work. Urogynecologists usually are highly sub-specialized and focus primarily on the worst incontinence and pelvic organ prolapses encountered. Plastic surgeons are generally trained in cosmetic surgery on men and women and very few are trained in vaginal surgery. Some plastic surgeons are highly trained in totally reconstructing new vaginas in transsexuals, transvestites, and pelvic cancer patients. With experience and training all specialties mentioned above can perform aesthetic vaginal surgery.

Is the use of Lasers important?

The laser is an important surgical tool that has many advantages. Certain lasers are very precise and are used as scalpels. Some lasers are ablative (destructive) and used more to destroy abnormal tissue or to resurface the skin. Many dermatologist and plastic surgeons use this type of laser. However, there is no magic in the use of lasers. In fact, other modalities such as radiofrequency cautery units can give more precise cuts and less tissue destruction by a factor of ten or more. Other surgeons will avoid electrical units altogether and use highly precise

Frequently Asked Questions about Vaginal Surgery

scissors or scalpel units. Another way to look at lasers is to realize that it is a tool in the doctor's bag but that it is not ultimately any better than a cold knife. However, it is undeniable that using the term "laser" adds glamour and a sense of prestige to a procedure. Please see pages 8 and 9 of this Brochure for details.

What is the procedure like?

Almost all of the cosmetic surgeries are outpatient. Labiaplasty and vaginoplasty cases are typically finished within an hour. If a repair of the bladder, rectum or bowel is needed then a 23 hour overnight stay may be needed. If a hysterectomy is needed than it is typical to stay one to two days. Placement of a sling to help with incontinence does not prolong the hospital stay. Many patients feel the pain involved is similar to the discomfort AFTER a baby has been born. They are somewhat sore but not in agony. Pain control is excellent in the large majority of cases.

What and how are the actual procedures done?

Labiaplasty is the cosmetic reshaping of the inner folds of tissue, called the labia minora, or smaller inner lips of the vagina. Various instruments are used such as pinpoint cautery, Yag lasers, fine scissors, or a knife. The edges are then sewn together with delicate absorbable sutures. A vaginoplasty (commonly referred to as vaginal rejuvenation) is when a diamond shaped section of tissue is excised from the inside of the vagina and brought down to the outside of the vagina. Often times a small triangular area is also excised from the perineum (the area right below the vaginal opening). This is called a perineoplasty or perineorrhaphy. The size of the tissues removed rarely are larger than a domino block. If needed, sutures that bundle loose muscles together are used to narrow the vaginal opening. At the very end of the procedure, a CO2 laser may be used to smooth out any skin irregularities and further tighten the vaginal opening. The laser provides for growth of new, softer, smoother, and tighter skin just as it would when used on a face.

What does surgery actually do to me physically?

Surgery can trim excessively large labia minora, it can also reduce a labia majora. We can also trim the excess bulge of skin in the vagina and tighten the entrance to the vagina. We can make the whole vagina tighter by excising this loose vaginal skin and reapproximating the stretched tissues from vaginal births. Surgery alone will not improve the tone of your vaginal muscles. You need pelvic floor exercising for that similar to Kegel's exercises. Surgery can also add support to your fallen bladder, rectum, bowel, or vagina. We often use a mesh made of polypropylene, or skin tissue from a donor, or tissue from a pig or cow to act like a patch for the herniation of organs into and out of the vagina. This is a highly specialized skill very few surgeons perform. Again, in some instances lasers are used to smoothen out wrinkled vaginal skin to make it new and young looking again. Many women tell us that they are happy to be able to wear jeans, bathing suits, and form-fitting outfits again because the rubbing and irritation have disappeared. Women can also regain the confidence in appearance that enable them to wear leotards, bikinis, and tighter clothing.

Where is the procedure done?

The procedure is usually done in the office procedure room. Surgery can also be done in the surgery center or operating room with additional charges involved. If a simple labiaplasty or vaginoplasty is performed then the option of performing the surgery in the office under local anesthesia and oral and injectible medication can be considered. We tailor the surgery to the patient's projected pain tolerance, anxiety level, and health status.

Frequently Asked Questions about Vaginal Surgery

What type of anesthesia is used?

You can have a short nap or be fully awake. General anesthesia is the most common anesthetic used because of the patient's desire not to know or feel anything. Then there is the spinal or epidural anesthetic that allows you to be awake. This is ideal for those who have a fear of going to sleep or have other major medical problems. Sedation and use of local anesthetics is the least invasive of anesthetic options. This is our practice preference. Many choose this so that recovery is almost immediate and the down time is minimal. If the case involves bladder, rectum, or bowel repair of if a hysterectomy is performed then general anesthesia is the standard.

What are the logistics involved?

A patient interested in aesthetic vaginal surgery usually calls or emails us to set up an initial appointment for evaluation. If at the time of evaluation the patient and physician agree that surgery is the correct choice then a surgical date is finalized. If the individual is an established patient then I will usually see her within a week of surgery to perform a pre-op evaluation. They may also have this pre-op evaluation with their primary care physician for surgical clearance. This is where blood work, X-rays, EKGs are done if needed. The majority of the time a simple blood count and pregnancy test are all that is needed.

For women who are from outside the area and choose to fly in, we recommend using John Wayne International Airport. It is about 30 minutes away from beautiful Laguna Beach where our office is located. One trip to Southern California is all that is needed. We can arrange the initial examination to be the day before planned surgery, do the surgery the next day, and go home the day after in most cases. We want to evaluate your tolerance and response to surgery before you fly off for home.

Frequently Asked Questions about Vaginal Surgery

What are the advantages of having surgery in Laguna Beach?

We have some of the finest resort lodging available in California. The Monarch Beach Resort and Montage Resorts are within minutes of our office. You can choose to have your recovery at one of these world-class resorts with a home health nurse visiting you or even staying in an adjoining room for total care. Of course you can also stay in the hospital for about the same room rates as these hotels. Believe or not, the views from the hospital rooms compete very well with the resorts!

What are the advantages of having surgery by Dr. Alinsod?

Dr. Alinsod has performed beautiful aesthetic vaginal surgery for thousands of women over the past 18 years. He has concentrated his skills in the art of aesthetically pleasing vaginal repairs and has taught hundreds of gynecologists, urogynecologist, and urologists. Fellow physicians, physician wives, nurses, operating room technicians have sought out Dr. Alinsod to perform their surgeries. Furthermore, Dr. Alinsod is always in the forefront of his field and travels extensively to meet and discuss with other prominent surgeons what is new and better for the patient. Dr. Alinsod truly cares for his patients and it is this commitment to service that drives his entire team. Dr. Alinsod is the Principal Instructor in Aesthetic Vaginal Surgery for the American Academy of Cosmetic Gynecologists.

How do I get a consultation scheduled?

Call us at 877-4-UROGYN or 949-499-5311. We have office hours to meet your needs ranging from early 8 AM appointments to 3:30 PM appointments in Laguna Beach. We can see you for consultations in Laguna Beach and Burbank with collegues.

I live far away. Can I get an Internet consultation?

Yes. For the price of a co-pay, you can have Dr. Alinsod respond to your questions in a personal and secure manner via his On-Line Consultations at www.urogyn.org. He answers his emails usually on the same day. You can also send unsecured email for general questions that are not patient specific. We do this to protect an individual's privacy.

What are the risks of surgery?

Anesthesia is a risk factor because of the very rare possibility of a reaction to either the injected medication or inhaled agents. High temperatures and fevers from "Malignant Hypertension" can occur. I have personally never seen this in 19 years of clinical practice. You can also aspirate food or fluid that can obstruct your breathing tube or even cause a pneumonia. There is risk of infection of the surgical site, there is a possibility of bleeding and hemorrhage and a need to have a transfusion. With transfusions there is risk of HIV, Hepatitis, and perhaps other unknown viruses. There is even the risk of death. If tissue or mesh augmentation is needed then there is the risk of rejection of these grafts. Again, these complications are exceptionally rare and the huge majority of cases go quite smoothly. A risk you should also consider is one similar to "buyer's remorse" when one is not fully happy with the result of surgery. Perfect symmetry is impossible to achieve and the exact look you want may be unattainable. The risk of having the surgery redone or amended is present but fortunately is very rare. We will fully review the risks of surgery before the case is even scheduled and give you every opportunity to have your questions answered.

What restrictions do I have after surgery?

We advise "Pelvic Rest" for six to eight weeks. This means nothing goes inside the vagina, such as tampons or vibrators, and no sexual intercourse for that length of time. The only thing allowed in the vagina is the applicator full of estrogen cream we give you to aid in the healing process. We also recommend loose clothing and no tight underwear, thongs, or jeans that may cause rubbing and discomfort. We advice against lifting of objects or activities that can cause you to strain or bear down. We do not want tension on our suture line nor do we want to stretch tissues we have just tightened. Basically, treat yourself like a princess during this healing phase.

Frequently Asked Questions about Vaginal Surgery

How soon can I go back to work?

If you had a labiaplasty or vaginoplasty you can return to work or normal activity within 1-4 days. If you had both a labiaplasty and vaginoplasty then it may take you a whole week before you feel comfortable to go back to work. Much depends on the type of work you do. For example, a woman who has a desk job will return to work sooner than one who has to walk or run and carry objects from place to place. We will need to individualize your return to work date. In any event, you are usually healed by six weeks although complete healing takes up to three months.

When can I resume sexual activities after surgery?

We recommend that you wait at least six weeks before resuming sexual intercourse. If you had a vaginoplasty it is also recommended that some softening exercises of the surgical site start at six weeks to soften any scarring that may occur and to make the sexual experience more comfortable after surgery. Softening exercises take two to four weeks. This stretching exercise is not needed if you had a labiaplasty alone.

Can you talk about how surgery will affect my sex life?

There are many sites on the Internet that address the topic of sexual gratification and surgeries that may enhance this experience. In summary, there is an opinion that aging and the trauma of childbirth results in looseness of vaginal tissue, weakening of vaginal muscles, and resultant decrease in friction, hence, decreased sexual gratification for both men and women. Unfortunately, this topic is much more complex than simply tightening a vagina to increase frictional forces for both sexes. Surgery can indeed result in tightening of the vagina but there is no guarantee that your sex life will be better or that your orgasms will be more pronounced. You must weigh carefully the claims of an improved sexual experience. Sexual response is multifactorial and it is often the case that a person's personal relationship with his or her partner is the primary determining factor in the happiness of an intimate relationship. Surgery is no panacea but it certainly can improve appearances and increase friction involved. A positive body image is priceless. One more thing, surgery does not affect a woman's ability to become aroused or her ability to become moist prior to having intercourse.

Will my partner feel any changes when we have sex?

If you had a labiaplasty there will probably be a dramatic decrease in the interference of tissue that will be felt by both you and your partner. The same goes for vaginoplasty or vaginal rejuvenation since frictional forces are increased. You may need to perform some stretching exercises of your vagina after surgery to allow comfortable intercourse. This is even more important if your partner is large in size.

Can I combine the vaginal surgeries with other surgeries?

Yes. We do "North-South Face Lifts" quite often. We have an excellent and highly respected Aesthetic Plastic Surgeon, Dr. Dan Mills, who is able to perform anything from liposuction, tummy tucks, to breast implants or facial reconstruction. He welcomes your inquiries. Please visit his website at *www.danmillsmd.com* or call him at 949-499-2800.

Other well respected plastic surgeons Dr. Alinsod works with include Daniel Kim, M.D. (*http://www.psaoc.com/dr_kim.cfm*), Robert Kachenmeister, M.D.(*http://www.psaoc.com/dr_kachenmeister.cfm*), and Daniel Mills *https://www.danmillsmd.com*

What other services are offered in Dr. Alinsod's practice?

The Women's Health Center specializes in total care for women. It is more than a Med Spa, more than a plain Laser Center. It is more than a cosmetic dermatology practice and more than a plastic surgery laser service. Nowhere else can you come in for your annual physical examination, Pap smear, mammogram, birth control, hormone check, vaginal rejuvenation, Botox/Fillers, and total laser skin care. Availability to you 24 hours a day, 7 days a week, by phone and by email, at your fingertips, direct to a doctor, to provide answers to your questions and care for your feminine needs. We are the new model for Women's Healthcare Services.

The Laguna Laser Center is available to you now. It provides a broad array of light based therapies to improve the look, feel, and touch of your skin. We also offer a tattoo removal service. The safest, most comfortable lasers and Intense Pulsed Light (IPL) systems on the market are up and running and giving amazing results. The newest Palomar Starlux system, the most powerful of all aesthetic laser/IPL

Frequently Asked Questions about Vaginal Surgery

machines available, has become the standard by which all others compare to. With the addition of Southern Orange County's top medical aesthetician and Clinical Nutritionist to our team you now have choices and solutions in total aesthetic skin care. Whether it is an intensive six-month series of skin therapies or a single lunchtime peel the Laguna Laser Center will be here for you at your convenience. Dr. Alinsod and South Coast Urogynecology will continue to bring integrated and comprehensive services to Orange County. From annual exams and bio-identical hormones, to complex gynecologic problems, from skin rejuvenation to vaginal rejuvenation, you are covered.

Does insurance cover the surgeries?

Aesthetic Vaginal Surgery is not covered by most health plans since it is cosmetic in nature. However, if you have a fallen bladder, fallen rectum, fallen vagina or uterus, or incontinence, then those surgeries are generally covered if you are symptomatic enough to desire surgery.

How much does it cost for an initial consultation?

There is a consultation fee but it is deducted from the cost of surgery. During this initial consultation we will discuss the risks/benefits/options of surgery, do a private examination, discuss costs, and give you every chance to ask questions that are vital to you. On-Line Consultation is also available at a very modest cost of a co-pay. Find this link at the left hand side of the web page or at the top of the Aesthetic Vaginal Surgery site. I personally answer the emails with the goal of a 24 to 28 hour turnaround.

How much does surgery itself cost?

Repair of a fallen bladder/rectum/vagina/or uterus is usually covered by your insurance. Incontinence surgery is also covered by your insurance. The prices quoted do not include anesthesia or facility fees nor do they include the hotel costs. We are able to do labiaplasty in our office under local anesthesia and the facility fee is very low. This can save you a great deal of money.

I cannot afford this right now. Do you have financing?

Yes we do. We have very competitive rates provided by CosmeticSurgeryFinancing.com and Cosmeticredit. You can even apply online. On special occasions, such as training days for surgeons. Dr. Alinsod is able to give a discount on surgery costs if you are willing to participate in his teaching programs.

Additional information:
http://urogyn.org/survey.pdf
http://www.makemeheal.com/answers/viewExpert.do?username=redalinsod
http://www.realpatientratings.com/Red-Alinsod/
https://www.realself.com/find/California/Laguna-Beach/OB-GYN/Red-Alinsod

ThermiVa: Non-Surgical Vaginal Tightening

Vaginal And Labial Looseness After Babies

For those with labial and vaginal looseness or unsatisfying gaping appearance we now have Dr. Alinsod's invention, called ThermiVa.This is a device that tightens the labia and vagina without surgery.

Thermi Aesthetics received approval to initiate an Investigational Review Board (IRB) study assessing the potential benefit of Temperature Controlled Radiofrequency for the Treatment of Vulvovaginal Laxity. It specifically investigates the non-surgical approach to vulvar and vaginal tightening as well as evaluate effects on incontinence, vaginal dryness, and orgasmic response. The study will be lead by Red Alinsod, MD, FACOG, FACS, ACGE, and Chairman of the ThermiAesthetics Women's Health Advisory Clinical Board.

The study will evaluate the clinical efficacy of Temperature Controlled Radiofrequency for the Treatment of Vulvovaginal Laxity. Up to 500 subjects will be recruited nationwide over the next 12 months to participate in this important study. All patients will be treated utilizing the ThermiVa Temperature Controlled Radiofrequency system and hand piece. Dr. Alinsod's office will be the primary center for treatments in the United States with several other sites scattered across the country. Treatments are warm and comfortable without the need for anesthesia. There is absolutely no downtime and effects can be immediate with improvement seen over three months.

Damage from vaginal birth and aging can diminish sensation during intercourse, reduce sexual satisfaction, and change the relationship between partners. Radiofrequency heat has become a standard for promoting collagen remodeling and healing, which helps strengthen the structural support columns for the skin, improving the integrity & tightness of the skin. ThermiVa has mastered the delivery of controlled-heating in these intimate regions. Primary endpoints of the study include evaluation of non-surgical vulvar and vaginal tightening effects as it relates to sexual satisfaction. Secondary endpoints will look at the remarkable ability of radiofrequency to improve skin texture and tone to reduce urinary urgency and leakage, change vulvovaginal tissues to reverse the effects of atrophic vaginitis, and lastly, RF's effects on nerves responsible for normal sexual response and orgasms. For a limited time during the study process the three treatments are being offered for $1,500, or $500 per treatment. This is less than one third the standard costs. You must meet qualifying criteria.

Surgical vaginal rejuvenation and labiaplasty done in the office are also available from Dr. Alinsod.

For more information on ThermiVa please go to *www.thermiva.org* or call *949-499-5311* and speak with Diane.

ThermiVa: Non-Surgical Vaginal Tightening

What Is Thermiva?

ThermiVa is an in-office, non surgical procedure for labia and vaginal tightening. A radio frequency generator, made by Thermi Aesthetics powers an "S" shaped hand piece that tightens external and internal vulvovaginal tissue via a thermistor top which is able to control heat delivered. The top has gentle curves that provide comfort.

Is It Safe?

ThermiVa and ThermiSmooth Treatments have been very very safe with no known serious side effects found. There is a potential for blister and burns but none have been found in our clinical trials. The ability for treatment tips to have Thermistor tips able to monitor skin temperatures real-time make the procedure both comfortable and exceptionally safe.

How Many Treatments Will I Need?

Results are seen after only 1 treatment but there is more improvement when a series of 3 are completed. Each treatment is spaced at 4-6 weeks apart.

How Long Will Each Treatment Last?

ThermiVa for the labial tightening takes about 10-15 minutes to complete while ThermiVa for vaginal tightening takes 15-25 minutes. Treating both the labia major and vaginal canal averages about 25-30 minutes.

How Long Will The Results Last?

Durable results continue for an average of 9-12 months with tightness lasting up to 15 months. Once to twice yearly maintenance treatments are recommended. After the initial series of 3 treatments I recommend touch ups 6-12 months after the last treatment.

When Will I See Results?

Softening and smoothing results on the labia major can be felt at about two weeks out. Tightening effects on the labia majora can be seen immediately after ThermiVa treatment #1 with progressive tightening over the next month. Maximum tightening effects are seen about a month after treatment. #3. The vaginal tissues respond even better than face or neck skin due to its higher moisture content and more dramatic mucosal effects.

ThermiVa: Non-Surgical Vaginal Tightening

ThermiVa: Non-Surgical Vaginal Tightening

PRWeb
Online visibility from Vocus

ThermiAesthetics Welcomes Red Alinsod, MD as Chairman of Its Women's Healthcare Clinical Advisory Board

New Appointment Promises to Further Develop Clinical Validation for Treatment of Vaginal Laxity

Dallas, TX (PRWEB) February 28, 2014 – ThermiAesthetica™, creator of the ThermiRF™ temperature controlled radiofrequency system, is pleased to announce the appointment of Red Alinsod, MD, FACOG, FACS as Chairman of the ThermiAesthetics Women's Health Advisory Clinical Board. Dr. Alinsod will help develop therapeutic strategies and devices to treat specific gynecological conditions.

"We are privileged to have a world renowned urogynecologist, with an outstanding clinical experience in treating women for vaginal laxity, join ThermiAesthetica as Chairman of our Women's Healthcare Advisory Board," says Paul Herchman, Chief Executive Officer of ThermiAesthetica. "Dr. Alinsod's experience is an excellent fit for the strategy and vision of our company as we transition from the development of products and treatments into offering a commercialized procedure and product line. We believe that Dr. Alinsod's clinical and strategic insights across core women's health issues will be a significant asset to ThermiAesthetica as we continue to execute on our strategic plans."

Dr. Alinsod commented, "I am honored to chair the ThermiAesthetica's Women's Clinical Advisory Board and work with such a talented team of industry executives and physician members of the clinical advisory council. ThermiAesthetica's clinical assets and its unique temperature controlled radiofrequency platforms, hold remarkable potential for groundbreaking therapies."

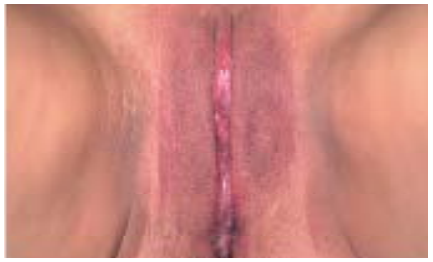
In addition to the Clinical Advisory Board, Dr. Alinsod will serve on the ThermiAesthetica Clinical Advisory Council, an independent body consisting of hundreds of physicians who are actively collaborating to advance the science of thermistor-regulated energy delivery and refine treatment protocols for a myriad of cosmetic applications. A number of additional applicators and studies are planned and underway to further demonstrate the safety and effectiveness of ThermiRF for a number of cosmetic conditions, such as skin laxity of the face and body, axillary hyperhidrosis, cellulite and snoring. The company plans to continue to expand the size and role of the Clinical Advisory Council over the next year.

About Red Alinsod, MD
Dr. Red Alinsod graduated from Loma Linda University School of Medicine and completed his OB/GYN residency at Loma Linda University Medical Center. His focus in those early years was pelvic surgery. He was the first Rutledge Fellow at MD Anderson Cancer and Tumor Institute and was also selected as a Galloway Fellow at Memorial Sloan Kettering Medical Center. Dr. Alinsod was accepted to Yale's Gynecologic Oncology fellowship but was unable to attend due to a military commitment with the US Air Force. He headed the Gynecologic Services at George Air Force Base, CA, and Nellis Air Force Base, NV, as he concentrated on benign gynecology, urogynecology and pelvic surgery.

Dr. Alinsod is instrumental in the development of aesthetic vulvovaginal surgery. He founded "CAVS" (Congress for Aesthetic Vulvovaginal Surgery) in 2005 and is considered one of the pioneers of this evolving field. He is responsible for the current techniques in radiofrequency labiaplasty of the minora, the "Barbie" and Hybrid Look labiaplasty, invented the Medial Curvilinear Labia Majoraplasty, and the central and lateral clitoral hood reductions. He developed the combination Pudenal-Levator Block for In-Office Awake/No IV

Before and After ThermiVa: Non-Surgical Vaginal Tightening

BEFORE



AFTER

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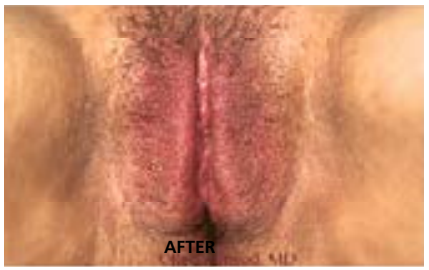

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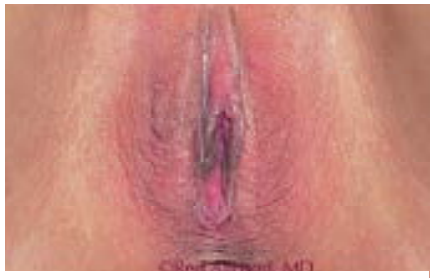

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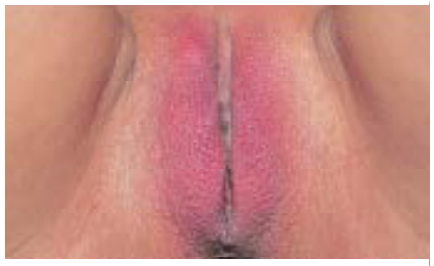

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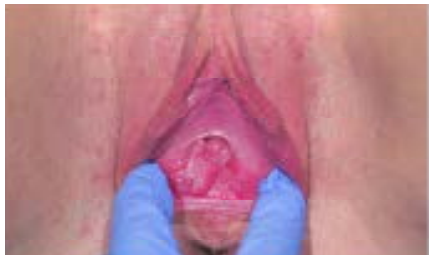

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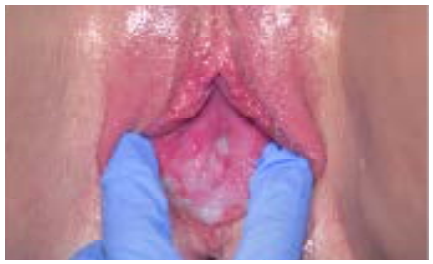


AFTER

ThermiVa: Patient Testimonials, Patient #1

Dear Dr. Alinsod,

I am a 53 year old woman who has had two children. My labia had become loose and a bit saggy and no matter how many Kegels I did, my vagina felt large and loose. Sex was ok, but I had lost some confidence in myself and ability to please my partner. I didn't really know what to think about "the procedure performed", but there was no down side to it. There was no pain during or after, no burning, no discharge, no mess. After the first treatment in a series of three, I was surprised that my labia seemed closer to my body and there also was some vaginal tightening.

It was after the second treatment that I noticed a significant difference. My labia were fuller and softer and my vagina was noticeably tighter. Sex was very good. I had not told my partner that I was having the procedure. He is ten years older than me and has difficulty ejaculating during intercourse. So I was surprised when my new tightness created enough friction for him to alleviate that issue. Sex became better for both of us I could feel him more and sex was more pleasurable for both of us.

I did not think things could get tighter or sex better, until after the third treatment. But they did and I am so thankful to Dr. Alinsod for recommending this procedure to me. I feel better about myself, more youthful and sexier. My partner is a happy man and our sex life, which was good, is now better than ever.

Thank you again Dr. Alinsod

A Very Happy Wife

ThermiVa: Patient Testimonials, Patient #2

Dear Dr. Alinsod,

Now that I have completed all my treatments I wanted to give you my impression on ThermiVa. The treatments have really been wonderful and quite easy. I had no blisters, no burns, no discharge, and not a single complication. I had sex the same day of my treatments and I went to my gym immediately and it's as if no procedure had been done. It's crazy! Your design for ThermiVa handle so comfortable and very slim that I barely felt it being inserted and I felt just gentle pressure. All I felt was pleasing warmth on my labia and my vagina. It really helped that you were gentle and slow and did not rush. Putting a tampon inside is probably more uncomfortable than using your device. Your device was smooth and rounded and not scary at all.

So Dr. Alinsod, let me summarize how I felt immediately after your treatments and how it is now that I am months done. The first treatment definitely got me tighter and my husband and I loved it. It wasn't' immediate for me and it took me two weeks before I felt significantly tighter. I got tighter more after the second treatment and then even more after the third treatment. My husband said that my muscles felt stronger and that I had better grip and more noticeable friction. He loved the way the outside labia looked and he said it made a big difference visually. My husband said I look more youthful and pretty and appealing. Men are so visual. Appearance and comfort was so much better in both our eyes. Now I can wear my tighter clothing without the rubbing or at least not feeling irritated anymore. There was no difference in my vaginal moisture or how I got wet but that had never been a problem for me. My orgasms come quicker now with the same intensity and there's been no change in the frequency of my orgasms. I'm not sure why my orgasms are better but perhaps it can be because of my improved appearance giving me more confidence and less self consciousness worries. For sure I can feel my husband more and I'm definitely tighter.

I couldn't have multiple orgasms in the past now I'm able to have multiple orgasms for the first time in my life. I have more sensitivity. The strength of my orgasms are about the same as before but it feels better for some reason I can't really explain. Anyway this is probably the best lunchtime rejuvenation available out there! I'd pay for this procedure over and over and over!

I'm so glad you included me in your study. This is really going to help so many women around the world. I hope you get this out in the market soon and train doctors from all over the world.

With sincere thanks,

A Loving Wife and Mother

ThermiVa: Patient Testimonials, Patient #3

Dear Dr. Alinsod,

You asked me to write about my experience so I hope you don't mind that I am writing you not a very formal letter. I think it's better if I write from my heart. Thanks so much for taking care of me this past year. It has really changed my life in so many different ways. You have been so kind and open with me. You understood my needs and insecurities as a dancer and adult entertainer. So you knew how important this whole ThermiVa treatment was for me.

When you first started ThermiVa early last year I noticed immediately how the texture and tightness of my labia majora improved. Super dramatic changes for sure which got rid of my camel toes. Gave me lots more confidence when I performed. On the inside I had more vaginal tightness and it just kept getting tighter. My boyfriend loved the way it looks and how I was suddenly able to have orgasms one right after another when in the past I had none before treatments. My two kids really messed up my vagina and I thought I would never have orgasms again! It had been over 5 years since I had one before you treated me. Now I have multiple orgasms and they are super intense since the treatments. They are the "good kind" of orgasms and they come within seconds of each other to about three minutes apart. At one time I had seven in a row, which was completely unbelievable. I used to have only orgasms with oral or manual stimulation but now I'm able to have orgasms with penetration. This is really important to me. When you first treated me I was a little bit worried that you got me too tight because I couldn't insert my vibrators anymore. But now I don't need them because I can have great sex with my boyfriend and have orgasms without the toys. I notice I am more aroused and more wet and don't need lubrication anymore. I don't know how ThermiVa has done this whether it helped heal some of my nerves or if it's all in my head because now I feel healthier and sexier. I know the radiofrequency has helped both the inside and outside my vagina.

Doesn't really matter if it is mental or physical healing with me, it helped!

You asked me also if there were any areas I thought it didn't help at all. Well, it didn't help me with my urination because I really had no problems with it before treatments. I don't leak when I cough or sneeze or jump around and exercise. I do have less feeling that I have to go all the time after the treatments. I don't know what that's about. One thing I did notice was that I had more control of my urine stream. My urination muscles are stronger and I can start and stop anytime I want now. Some other things I noticed where that my labia majora were softer and smoother but also more full feeling. I said earlier they feel more comfortable when I'm in tight clothes like jeans or bikinis.

So Dr. Alinsod, I will definitely be a regular customer coming to your office every six months. There is no way I want to lose what I have gained from your treatments. Have told all my close friends about you. Seeing you is so worth the drive.

A Happy Hot Mom from the Inland Empire

ThermiVa: Patient Testimonials, Patient #4

Dear Dr. Alinsod,

I have now finished all three of the ThermiVa treatments and am still in awe of the results I have gotten. I can't believe all this has happened to me without the need for surgery and with treatments that were comfortable, felt actually good, and were totally relaxing. And having absolutely no downtime was great. I could have sex the same day as the treatment, had no blisters, burns, or complications.

I was pessimistic at first after Dr. Alinsod did my first ThermiVa treatment. It only took half an hour and I was relaxed during the treatment of both my labia majora and my outer and inner vagina. I noticed some tightness immediately on the majora but did not feel a huge change inside my vagina during the first two weeks. I thought I was the failure for his treatments. So many other women had amazing and lasting results and here I was thinking "Great, it would be me that does not respond!" Then 10 days after the first treatment my vagina got really really tight! Significantly tighter! I felt better muscular control and increased strength in my vagina and urinary muscles and my husband sure felt that benefit! He also liked the tightness and softness of my labia majora and the moist smoothness inside my vagina. One thing I really liked was that my labia majora did not sag anymore and I got rid of the "Camel Toes." Never thought that would happen without surgery.

I used to have this pain on the left side of my vagina, for decades in fact. It was always tender when hit. The wand that Dr. Alinsod used treated that area on the floor of my vagina, a very sore muscle probably, and now the muscle is not sore at all! There is no more pain, as if my muscles were healed. That sure makes a world of difference not and both Dr. Alinsod and I can't really explain how a painful and sore area of muscle is now non-painful and working more strongly and more coordinated. I know radiofrequency treatments are used for sore and damaged muscles for professional athletes and physical therapy offices so now I can related to others who have had relief of muscle pain due to the healing effects of radiofrequency. Dr. Alinsod told me that it does encourage new collagen to form does help with tissue healing. I am a prime example.

There is one other wonderful thing I have noticed that got better with each ThermiVa treatment and that is the control of my urine. Dr. Alinsod did not do the treatments on me for the control of urine but simply to tighten my labia and vagina. When I reported to him that I leaked less urine, in fact I don't leak at all now since after the first treatment, he told me that it was a pleasant result of tightening the "pubocervical fascia" that help with urine control and fallen bladders. I can hold my urine longer now, can produce a stronger squeeze to prevent accidents, and can make it to the bathroom in plenty of time.

Lastly, I also noticed that after treatment around my clitoral nerves and the supposed G-Spot, my orgasms are now easier to achieve. I can't have multiple orgasms and my orgasms are about the same intensity but now it does not take me all night to get there! What a wonderful thing! I did not even have many orgasms before treatment and now it seems like I can get one on any lovemaking with my husband. I enjoy the lovemaking between my husband and I more and the stress and anxiety of getting that orgasm is gone. It is just a pleasure now being with my husband. That is worth everything. ThermiVa has really been a blessing for us. I hope it becomes available to all my friends and family.

With hope and happiness,

Reborn in OC

Thermi: Non-Invasive Body Contouring & Tightening

Description of Thermi Procedures

* ThermiTight

Controlled Subdermal Tissue Heating

During the ThermiTight® application, a tiny probe is used to gently heat specific tissues to a physician selected therapeutic temperature. After the application, a gentle wrap is applied and you may resume normal activities the next day..

Areas ThermiTight treats:

- Neck
- Breasts
- Arms
- Abdomen
- Thighs/Knees

* ThermiSmooth - Body

Temporary Reduction of Cellulite

ThermiSmooth® Body is performed by targeting the areas under the skin, providing a temporary reduction of cellulite. There are a series of applications over 6-8 weeks that are gentle, and patients often say it feels like receiving a warm massage. .

Areas ThermiSmooth Face treats:

- Chest • Breast • Arms
- Abdomen • Planks • Back
- Hips • Buttocks • Thighs
- Knees • Calves • Ankles

* ThermiSmooth - Face

Controlled Non-Invasive Tissue Heating

ThermiSmooth® Face is performed using a specially designed temperature controlled hand piece. The hand piece gently heats the skin's surface using dermal heating.

Areas ThermiSmooth Face treats:

- Forehead
- Eyes
- Cheeks
- Mouth
- Neck

Thermi250

Temperature Controlled Radiofrequency

Thermi250™ is a high powered, temperautre controlled radiofrequency system emitting at 470 kHz, the most studied RF radiofrequency in aesthetic medicine. This platform is designed with a unique feature set and user-friendly graphic interface, which enables maximum versatility for targeting cellulite from eyes to thighs.

Uro Chair: Stress Incontinence and Overactive Bladder

What is the Uro Chair?

The Uro Chair is a revolutionary FDA approved, non-invasive and painless treatment for all types of urinary incontinence, pelvic floor prolapse and vaginal relaxation. The Uro Chair strengthens the pelvic floor muscles by focusing electromagnetic waves causing the muscles to contract and relax, exercising them in a similar way to Kegel exercises.

Description of Surgical Procedures

Description of Surgical Procedures

http://urogyn.org/cases/vaginoplasty_case5.html

Patient History: The pictures below show a successful professional in her mid 50s who was recently divorced a year earlier. She had suffered traumatic childbirths with lacerations and torn episiotomy, had symptoms of incontinence and pelvic fullness and pressure, and a feeling of constant constipation. Bowel movements gave her a bulge she could both see and feel. She had to push on this bulge coming out of her vagina to complete the emptying of her bowels. Quite bothersome to this lady was the lack of sensation and a very loose feeling during intercourse. She could not feel her partner. Bladder studies showed her to have stress incontinence. She requested pelvic reconstruction and vaginoplasty. For more photos please visit http://urogyn.org/galleryvaginoplasty.html

Surgery Performed: Vaginoplasty, Perineoplasty, Transobturator Sling, Cystocele Repair, Rectocele Repair, Vaginal Vault Suspension, Rim Labiaplasty, Clitoral Hood Reduction

Patient Testimonial:

Dear Dr. Alinsod,

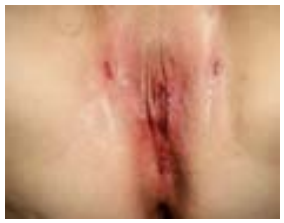
I recently came to your office to have the "vaginoplasty" procedure performed. I spent years wondering if there was anything that could be done to tighten up my vaginal area. I asked my gynecologists for help, but was told there was no procedure to help me. I finally went online and did a search and your office was the first on the list.

From the very beginning I was so impressed, there were links for everything, there were clear explanations of procedures and of what to expect from each. There was even a place that I could ask confidential questions directly to you...of course I was sure that the answers would come from an assistant. Well, it was already about 8 pm, but I emailed my questions anyway, and by 7am the answers to those questions were in my mailbox and they came directly from you. It made me feel important even though you had never met me. Satisfied with the answers, I call in to your office and spoke with Dianne, what a wonderful person, upbeat, open, detailed and wanting to make me feel at ease about the process. So, I get scheduled in for the assessment and procedure, that's when I met you.....What a kind and gentle man. You were able to immediately put me at ease, (as it's not the easiest think to discuss the procedure with a male stranger). You showed compassion and confidence. You quickly suggested a direction for the process. So then comes the procedure, your nurse Maria could not have been more attentive, every little step was explained and everything happened just as it was explained. I went home that same day and started my recovery and in wanting to get thru the healing as fast as I could, I rushed and ended up injuring myself. When I called I expected that I would be yelled at for not following all the instructions to the letter, but that was not the case, as a matter of fact you and your staff, scheduled me in to the office for 7 am. the next morning, what Dr. does that? I am now healed, and feel so much better about myself and my boyfriend of over 8 years cannot believe the difference in our sexual intercourse. As a matter of fact it's made a huge difference for me as well. Thank you so much, not just for being a first class Physician with a first class office and great staff, but for providing an environment that feels warm and comfortable, a place to come for the most sensitive of procedures knowing that we will be respected and treated in a confidential and caring manner. Thank you ...I would recommend anyone even considering this procedure to speak with you and your staff, they won't want or need to go any further.

Best of wishes for your continued success! Sara from Southern California

Before Surgery

Before surgery showing the cystocele and rectocele with significant vaginal looseness



Immediately after surgery

Two months after surgery

Vaginoplasty (vaginal rejuvenation)

As we get older our bodies get worn, torn, stretched and some of our youthful resilience is reduced. The same happens to the vaginal tissues and pelvic floor, especially after pregnancy and childbirth, menopause and aging, or simply from increased abdominal pressure from excess weight or weight bearing over time. The vaginal vault and pelvic floor are stretched, dilated, pelvic muscles become too relaxed, loose strength and tone, and you loose some or all support and control. The vaginal vault becomes stretched and weakened and it looses the constricting effect during sexual intercourse. As a result you no longer have the ability to contract, squeeze and relax your vaginal muscles at will. The loose feeling that many women feel can be noticed even more by their male partner during sexual intercourse.

This aesthetic vaginal surgery aims to tighten lax muscles and tissues and remove excess vaginal skin to narrow the diameter of the vagina resulting in a smaller and tighter opening and vaginal canal. The tightening is done in the entire length of the vagina and not merely the opening few centimeters. Dr. Alinsod does full depth repairs unlike the superficial perineoplasty repairs done by most plastic surgeons and gynecologists. This can be done in the surgery center under general or spinal anesthesia or under local anesthetic with some sedation. However, Dr. Alinsod has refined the in-office vaginal rejuvenation surgery that does not require an IV and is done under mild sedation and local anesthesia.

Dr. Alinsod uses the Ellman Surgitron Radiofrequency device to make exceptionally precise and minimally traumatic incisions. This method is dramatically less destructive than the use of Yag lasers. It takes about 60 minutes to perform. Many advertise this procedure for the "Enhancement of Sexual Gratification" as well as a cosmetic procedure. For costs please *click here.*

Description of Surgical Procedures - Perineoplasty

Perineoplasty (Perineorrhaphy)

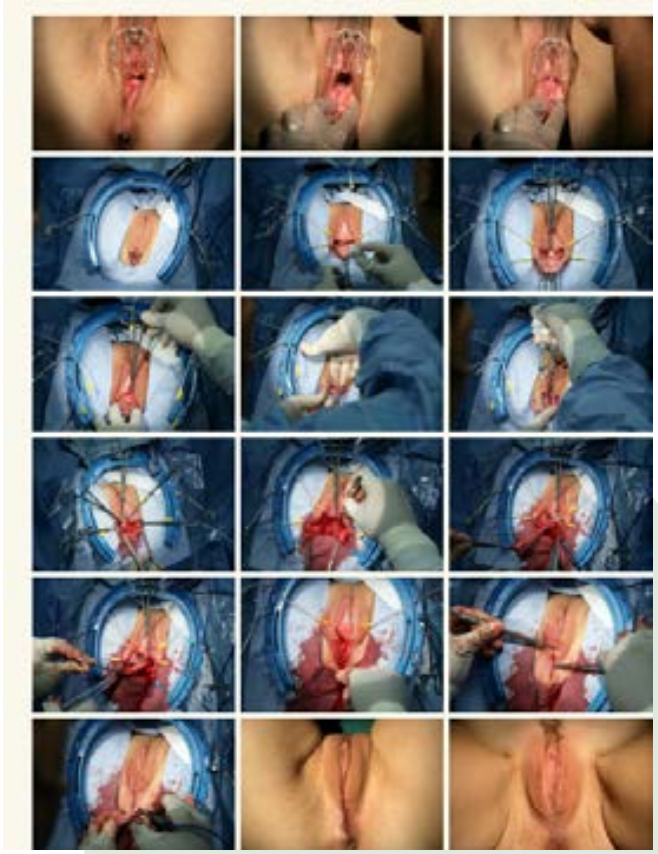
The visible area between the vagina and the rectum is called the perineum. This is the region where episiotomies are cut and where tears during childbirth are most common. Perineoplasty (or Perineorrhaphy) aims to make this region appear normal by excising excess skin, loose skin tags, and suturing the underlying muscles or the perineal body closer together to give a more snug feeling in the introitus or vaginal opening. Most plastic surgeons who perform vaginoplasty surgery are actually performing perineoplasty surgery, a more superficial procedure that does not tighten the entire depth of the vaginal canal. This procedure has been advertised by many to "Enhance Sexual Gratification." The procedure almost always accompanies vaginoplasty since you are working in the same area. This procedure takes 30 minutes to perform. For cost of surgery, *click here*.

Patient History: This professional young woman in her mid 40s complained of vaginal laxity and pelvic pressure. Bowel movements were sometimes difficult. She had multiple vaginal deliveries with the usual episiotomies and tearing. She complained of bulging of her perineal body (the space between the vagina and the rectum) when having bowel movements and found that pushing on this bulge helped get the stools out.

Surgery Performed: Posterior Compartment Repair, Vaginoplasty, Extensive Perineoplasty

Shown in the photographs are the steps performed in surgery. This surgery was done in our office under mild sedation, local anesthesia, and no IVs! You can see the vaginal mucosa at rest and with the patient pushing to illustrate the protruding rectocele. The perineum was rebuilt with multiple layers of sutures and the perineal bulging was eliminated. The entire length of the vaginal was also rebuilt by perfoming a vaginoplasty. The Post-Op pictures at the end of the series shows excellent healing just six weeks after surgery. The small scar will fade within weeks to months and a smooth perineum will be seen.

Many plastic surgeons and general gynecologist perform simple perineoplasty with excision of triangular pieces of vaginal and perineal skin and mistakenly label it as a vaginoplasty. What is shown here is a more extensive and definitive approach to the problem of vaginal looseness. Simply performing a perineoplasty will not give the vaginal tightness deeper into the vagina. **Perinoplasty surgery does not go deep into the vagina but intends to repair the damage of childbirth right at the opening of the vagina.**



Outcome:

She had pain and pressure for the first two weeks of surgery that slowly resolved. Her bowel movements improved dramatically and no bulging of the perineum occured. She started the vaginal softening exercises six weeks after surgery and resumed a normal and active lifestyle.

Description of Surgical Procedures - Labia Minora Plasty

Labia Minora Plasty

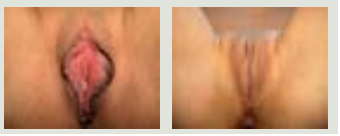
This surgery is for the removal of excess, floppy, or uneven labia minora (smaller interior vaginal lips) that often causes chronic irritation, rubbing, or discomfort during sexual intercourse. Many request this surgery to eliminate the appearance of a bulge with certain clothing such as wet swimsuits or leotards. The term "Labiaplasty" can also relate to the cosmetic surgery of the labia majora (larger outer lips) to make it less prominent and saggy. Labias can grow large with estrogen stimulation at puberty and pregnancy and with the effects of gravity with aging. Labiaplasty is done in the operating room and in the office under local anesthesia at dramatically decreased costs. The Ellman Surgitron is also the tool of choice. It is dramatically less destructive than lasers often advertised. This procedure takes 60 minutes to perform. *For cost of surgery click here*.

Patient History: This beautiful young mother of three had suffered from traumatic deliveries and tears insider her vagina and perineum. She was in her early thirties but felt looseness in her vagina canal from the large babies delivered. She also wanted to reduce the size of her labia minora to reduce the discomfort when wearing tighter clothing.

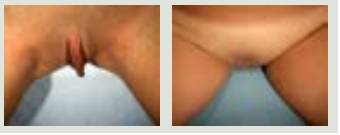
Surgery Performed: Labia Minora Plasty, Vaginoplasty, Perineoplasty

Outcome: Resumption of a normal active lifestyle at eight weeks post-op.

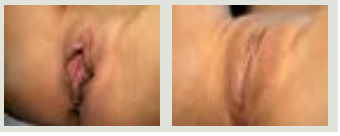
BEFORE AFTER



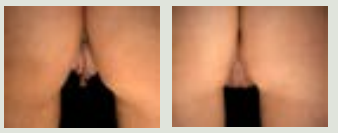
Lying BEFORE Surgery | Lying AFTER Surgery



Sitting BEFORE Surgery | Sitting AFTER Surgery

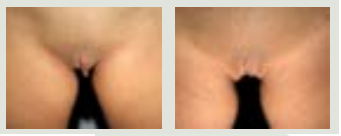


Side View BEFORE Surgery | Side View AFTER Surgery

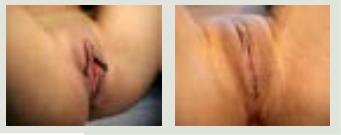


Rear View BEFORE Surgery | Rear View AFTER Surgery

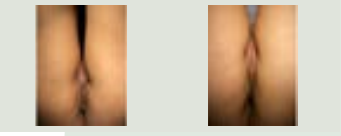
BEFORE AFTER



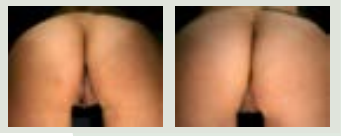
Standing BEFORE Surgery | Standing AFTER Surgery



Side View BEFORE Surgery | Side View AFTER Surgery



Vertical View BEFORE Surgery | Vertical View AFTER Surgery



Rear View BEFORE Surgery | Rear View AFTER Surgery

Patient Testimonial:

When I decided that labiaplasty was a procedure that I wished to pursue, I carefully researched the credentials of many physicians that offered this procedure and I quickly recognized that Dr. Alinsod was clearly highly and uniquely qualified (being both board certified in gynecology and trained in this type of an aesthetic procedure). I had the procedure in early January. Prior to the surgery I met with Dr. Alinsod and his extremely kind and professional staff. As soon as I met each of them and Dr. Alinsod, I realized that there was a sincere kindness and professionalism in how they treated their patients, and that I was in very good care. Even then, however, I did not realize how skilled my surgeon actually was. I have had many dental procedures that I only wish could have gone so well. Pain and swelling were minimal and medications that Dr. Alinsod prescribed for pain management were highly effective. My recovery was very quick. The improvement in appearance and comfort is striking. I am quite sure that no one (even another surgeon) would not be able to recognize that I had the procedure done, as there is no scar at all. I truly cannot thank Dr. Alinsod enough for the quality of surgery and care that I got. -- MB

Description of Surgical Procedures - Labia Majora Plasty Cont.

Labia Majora Plasty

The broader outer lips of the vulva can be enlarged with excess skin and tissue. This enlargement can cause an embarrassing bulge in pants, swimsuits, or leotard. It can also increase the discomfort of sweating in the vulva. The labia majora may be enlarged from birth, secondary to childbirth, or due to aging. Many women also find quite a large and droopy labia majora after major weight loss such as post bariatric surgery. Dr. Alinsod has refined his technique over the years to safely reduce the size of the labia majora by exicing a crescent shaped portion of the inner portion of the labia majora. The scar is hidden in the crease between the inner and outer labia. Labiaplasty is done in the operating room and in the office under local anesthesia at dramatically decreased costs. This procedure takes 60 minutes to perform.

For cost of surgery *click here*.

Patient History: After having several childbirths this lady in her mid-30s found looseness in her vagina and a loss of friction when having sex. She was also self-conscious of her vaginal appearance due to the sagging of her labia majora. She did not have incontinence or prolapse.

Surgery Performed: Labia Majora Plasty, Vaginoplasty, Perineoplasty

Outcome: Resumption of a normal active lifestyle at eight weeks post-op.

Before Surgery

After Surgery

Patient Testimonial:

I finally did it!!! I had a vaginoplasty and labia majora plasty done--ten years after my youngest child was born, and after researching it extensively for 2 years. Now, four months later, I feel it's one of the best decisions I have ever made. The results are amazing! I gave birth to two children--both deliveries were very difficult. I'm an extremely petite, small boned woman and the delivery with my second child included 18 hours of labor and 3 hours of pushing.

After delivery, when my OB was stitching me up (for 2 hours) she said "Your poor, virgin vagina." She was right!! It never felt the same-- urinating, having bowel movements, and of course during sexual intercourse. The looseness was almost a numb feeling. I felt un-plumbed and looked loose and crooked with the birth trauma and aging.

I met Dr. Red Alinsod after interviewing several other prominent doctors often seen on TV. Dr. Alinsod was very professional, understanding, and a gentle soul. He knew exactly how I felt and what I wanted to accomplish. His credentials as a vaginal surgeon was unmatched by his more famous TV doctors. He gave me the confidence to go forward with a procedure that I really needed. His recommendations were nothing more and nothing less than what I needed. Surgery went smoothly and everything turned out to be great!!! It's all back in working condition--all operations make me feel young again. I am very very happy with my decision and I feel every woman should be given this opportunity if she feels the need. I highly recommend Dr. Alinsod and am thankful I found him in. --LLW

Description of Surgical Procedures - Clitoral Hood Reduction

Clitoral Hood Reduction

Excess skin on the sides of the clitoris often causes the clitoris to look enlarged or uneven. Genetics, estrogen, and testosterone exposure can make significant changes in the way the clitoral area appears. A labiaplasty itself may result in the appearance of a relatively larger clitoral area since the excess labia have been removed drawing the eyes to the clitoral region. Dr. Alinsod offers an exceptionally precise surgery for women seeking to improve the aesthetic appearance of their genital area by excising the extra folds of skin lateral to the clitoris. The clitoris itself and its nerves are never touched. This is NOT clitoral mutilation or clitoral un-hooding. Clitoral Hood Reduction is done in the office under local anesthesia. The procedure takes 30 minutes to perform.

For cost of surgery *click here*.

Surgery Performed: all the photos show labiaplasty WITH clitoral hood reduction.

Clitoral Hood Reduction and Hymenoplasty are best performed with the Ellman Surgitron. Because of its "cool" tip there is no damage to the clitoral nerves from stray energy. Because of its extremely small pinpoint tip there is precision. You cannot do this type of surgery with the current medical lasers available, including the 980 Diode.

Patient 1
BEFORE

AFTER

Patient 2
BEFORE

AFTER

Patient 3
BEFORE

AFTER

Patient 4
BEFORE

AFTER

Patient 5
BEFORE

AFTER

Patient 6
BEFORE

AFTER

Patient Testimonial:

I would highly recommend Dr. Alinsod! He is incredibly detailed and it's obvious that he takes great pride in his work and loves what he does. His staff is fantastic, they always made sure I was comfortable and they were all very nice and answered all my questions with great detail. He's extremely personable and makes you feel at ease right away….. something most surgeons don't do. "I'm extremely happy with the outcome and I would recommend Dr. Alinsod without hesitation." - C

Description of Surgical Procedures - Hymenoplasty

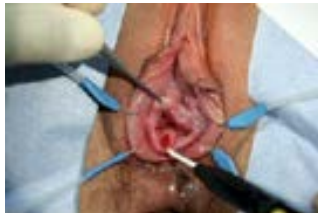
Hymenoplasty

This surgery is the reconstruction of the hymen. Cultural, religious, or social reasons predominate when this surgery is contemplated. Hymenoplastyis performed to make the patient appear virginal. It works for women who have not had vaginal deliveries, and preferably, in those who have never been pregnant. We take advantage of the Ellman Surgitron to make extremely precise incisions into the vagina and remnants of the hymeneal ring to bring them into close approximation to allow delicate sutures to hold the tissues in place. Once healed, the act of sexual intercourse can result in bleeding when the hymen is torn or stretched. Hymenoplasty is done in the office under local anesthesia. This procedure takes 60 minutes to perform. For cost of surgery, *click here*.

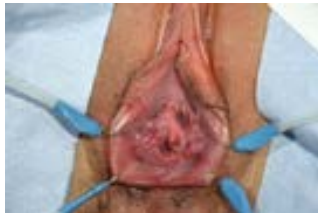
Patient History: This young lady, in her early 20s, flew in from out-of-state and requested a hymenoplasty surgery prior to her wedding in the Middle East. She was foreign born but American raised and had an arranged wedding scheduled in two months. She feared for her life because of the cultural need to show bleeding on a special sheet on her wedding night. Her husband-to-be was also from the same country and was raised a Muslim. If no bleeding occurred during intercourse she feared that a young and underaged male family member would kill her to maintain the family honor. She trembled in fear as she requested this potentially life-saving procedure.

Outcome: The patient had a successful trip to the Middle East and enjoyed her wedding. She had painful intercourse on her wedding night but was ecstatic that she bled and was able to prove her virginity to her new husband and family.

Before hymenoplasty



During hymenoplasty



After hymenoplasty

Patient Testimonial:

I am originally from the Middle East and in my mid-twenties. After my child was born, some things just weren't the same (ladies you know what I mean!). But of all the changes my body was going through, this was one that I couldn't stand. I eventually got the guts to say enough, and do something about it (after trying a billion Kegels with no results!) I had a consultation with Dr. Alinsod and shortly after I decided to go with the vaginoplasty, and perineoplasty. The first week after the procedure was tough, but then it just healed nicely and really changed my life! My partner feels a great difference and the procedure was definitely worth it for the both of us.

Dr. Alinsod is very professional and experienced and really did a wonderful job making me feel more like my pre-baby self again - EM, from Cairo

The Process: What happens when you finally decide to have surgery

Once we have answered all your questions to your satisfaction and you have decided to proceed with aesthetic vaginal surgery we then try to make your experience as pleasant and stress-free as possible. We offer a concierge service that can take the worries off your shoulder. Please call us for details.

We will work with you to choose a time and date that is convenient once you have decided on surgery. You will then go to our website at www.urogyn.org, click on the "Office Information" tab, click on "Patient Forms" and download the History and Physical PDF file. Print this out and fill it out to the best of your abilities and fax it back to us. This will be our initial screen on your health. If you wish, we can fax this form to you. I will review your History and Physical and call you if I have any concerns. You will also download the files called "Essential Pre-Op Instructions" and Post-Op Aesthetic Vaginal Surgery." These are very important files that detail your preparations prior to surgery and your instructions after surgery. It helps to review these so that there will be no surprises. If you have significant incontinence or pelvic organ prolapse then you will also need to download and fill out the files called "Pelvic Pain & Urinary Frequency Scale," "Quality of Life – Urinary Distress Inventory," and "Intake & Voiding Diary." Having these filled out and faxed to us ahead of time makes your office experience even more streamlined and efficient. One more thing, if you have the capability of obtaining a digital photograph of your vulvar area you can send this to me securely and we can discuss by phone or email what it is you do not like and what it is you are aiming for in terms of appearance and function.

Prior to your departure to California you must ensure that you are not pregnant. Please check a pregnancy test before you fly. We will do one also in the office to confirm you are not pregnant. We cannot do your procedure if you are pregnant. You will fly into John Wayne International Airport and will travel to the office typically by taxi, shuttle, or limousine. We can arrange your transportation. We recommend coming into our office in the morning to meet Dr. Alinsod, review your history, perform a physical examination, and be evaluated for surgery. You can then specifically tell us your wishes and desires and expectations for surgery. You can bring in a photo to show us the appearance you are looking for. You can also tell us how tight a vagina you are wanting. After the examination, if you wish to proceed with surgery, this is when you will pay your fee. We accept cash, credit cards, and cashier's check. You will need to arrange for financing if you wish. We can help you with that. It is best to arrange for financing well ahead of time. We cannot perform your surgery if financing has not been completed.

We then decide on a time for surgery in our office. We require that you eat a large meal prior to surgery. One hour prior to this time you will need to place an anesthetic cream on the surgical site (EMLA Cream) to start the anesthetic process. We will also give you an anti-anxiety medication and oral pain medication. About 15 to 30 minutes prior to surgical "cut time" we will give you an injection to ease your surgical discomfort. We will go ahead and take your "Before" pictures immediately before surgery. When we are satisfied with your level of comfort we will proceed with surgery. This is when you get your local injection of Marcaine and the actual surgery starts. We monitor your vital signs, ask you to tell us of your comfort level, and allow you to nap if you wish. Surgery takes 1-3 hours. We have soothing music for you to listen to and relax as we complete your surgery.

After surgery is finished you will go to our recovery room for approximately 30-60 minutes, or longer if necessary, to recover, relax some more, view beach scenes on the TV screen until you feel fit to go leave. We will check your vital signs several times during

The vibrant city of Laguna Beach is filled with stunning sunsets and that relaxed atmosphere Southern Orange County is known for. A small town with big time services and with all the privacy and discretion not found up the road in Newport Beach or Beverly Hills. This is Southern California's little secret hideaway for aesthetic vaginal surgery.

The Process cont.

this time period. We will examine you one more time for bleeding and release you when appropriate. Your ride will take you home or to your hotel where you will be checked in expeditiously and with privacy. If you had requested it we will arrange for a home health specialist to visit you in your suite. If you had requested it we can even arrange for a nurse to stay in an adjoining suite ready to assist you in any way. You can have room service or visit one of the fantastic restaurants if you stay at Monarch Beach Resort and Spa. You can be pampered to your heart's desire at one of the five-star resorts or you can choose a less expensive hotel and let your partner pamper you! Be sure to have ice packs, Dermoplast Spray, your pain medication, antibiotics, estrogen cream, and any other medication already in hand BEFORE you go to the hotel since most hotels do not have a pharmacy. The most convenient thing to do for your prescriptions is to use the pharmacy on the first floor of our office and get your meds prior to surgery. We can even call in medications for you at the pharmacy of your choosing if you live in California. Now you can sleep. If needed, we will give you a sleep aid. You can use 50 mg of over-the-counter Benadryl to help you sleep if you have no contraindications.

The next day, you will most likely check out of the hotel and visit our office for an exam prior to your departure for home. If you have no bleeding, you have good pain control, no excessive puffiness, no signs of infection then you can even skip the appointment and just fly or drive home. Again, we can help arrange your transportation. We want you to keep in close contact with us during the first couple of weeks so we will either call or email you to check on your progress. Do not evaluate the results of your surgery at this time because you will often be disappointed. This is the time when bruising, puffiness, discomfort, discharge and bleeding occurs. Read the Post-Op Aesthetic Vaginal Surgery sheet again to evaluate whether your symptoms are normal or not. Be sure to be compliant with "Pelvic Rest" in the first 6 – 8 weeks to ensure proper healing. Call or email us if you have any questions or concerns. A digital photograph may be helpful if you are able to send one securely. We usually answer our emails within a few minutes. Dr. Alinsod and staff are available 24/7.

Plan to see us 6 – 8 weeks after surgery to ensure that healing has been proper and complete. Now you can use a mirror and judge the results yourself. If you are happy and have no problems you will be released to resume normal activities including sexual intercourse. If needed, we will teach you how to perform vaginal stretching exercises to soften any scaring that may occur and to ensure an adequate sized vagina. Many who live far away will take the "After" pictures of their vulvar region and email it to me. It is important to me to receive these pictures to keep track of our cosmetic results and ensure a complete patient file. If you are happy with the results and have no other concerns then the follow-up visit is elective. We can do a phone or email follow-up. If the occasional minor revision is needed then we will do this in the office at a minimal fee. There is no charge for any of the postoperative appointments.

In closing, be sure to take your antibiotics and use your estrogen cream. We do not want any infections and we do want rapid healing with softened tissues and skin. Outstanding service and excellent results are our goals.

Procedure Details for Labiaplasty in the Office

"How do you do a labiaplasty" is question I answer everyday. Although it is not rocket science it takes the precision of an engineer, the eye of an artist, and the hands of a drummer. The steps are simple but the execution of the steps can be daunting. If you are healthy, with no major medical problems, and do not have extreme anxiety, you can choose to have your procedure in our comfortable office. Let me give you an overview of the whole series of steps once you have decided on getting a labiaplasty in the office.

Before you came in for your surgery, my staff had already given you pre-op instructions days before. You would have known to eat a large meal prior to surgery. You would already have the anesthetic cream. You would already have picked up the pain pills, antibiotics, and estrogen cream from your pharmacy. You would have taken your first antibiotic pill the morning of your surgery. You would have placed the numbing cream over the labia and maybe into the vagina a bit. You would have covered the cream with Saran wrap and worn your panties or panty hose over the Saran wrap to prevent messiness and loss of anesthetic medication.

My staff will welcome you and bring you into your own private room where you can relax a bit away from the rest of the world. My medical assistants and nurses will make sure you have had all your questions answered and will ask you the basics such as what time did you eat last and are you pregnant? They will check your vital signs, make sure your bladder is empty, and check a pregnancy test. This is typically the time I come in and welcome you, explain the procedure in detail, and go over the risks, benefits, and options one more time. Finally, you sign your consent once comfortable and knowledgeable that your questions are fully answered and that you indeed want to continue.

We then go to our photography room and take your "Before" pictures. We are fanatical about taking quality photographs for you. You will appreciate the efforts exerted in our quest for quality. Weeks later when you look at your own "After" pictures and compare the two you will understand our fanaticism. Usually we give you an oral anti-anxiety drug, like Ativan or Valium, right after your consent is signed. We also give you an oral nausea medication right at the beginning to fend off any nausea during the procedure. Next come a few injections in your upper arm or buttock to reduce the pain and the possible cramping or salivating. The pain medication we use can be Demerol, Morphine, Dilaudid, and Toradol. The medication preventing excess salivation is called Atropine. These injections also help keep you from feeling woozy or lightheaded. Notice we do not give you an I.V. at all. It is such a safe protocol I developed and modified over the past ten years.

After you receive all our shots you will go to the procedure room and lay in a comfortable bed. We put monitors on you and just watch you for several minutes to see how you react to the medications before we actually start doing surgery. This is probably the time you feel like you just had a couple of Margaritas or Martinis! "Comfortably Drunk" is what we call it. You are easily talking to me, responding to questions, watching FOX News on TV, listening to your iPod, or even reading a magazine. If you are a "cheap date" and feeling tired and comfortable after one set of shots then we start with surgery. However, if you are fully awake and not showing any signs of being "Comfortably Drunk" we may choose to give you a second dose of narcotics. By the way, for those who do not like shots at all, we can give all but one of the medications orally. You have to plan a bit ahead because the oral meds take a bit longer to take effect.

Now is the time I place your legs in its proper position just like you were getting a Pap smear. I wipe off all the numbing cream and use my markers to draw and outline the surgical plan. Since your vulva is numb it usually feels a bit strange to see someone touching you but you can't feel it. We would have already talked about the look you want and how much or how little labia minor or majora to remove. You have a hand mirror during this process to help me define and draw out the plan of action. Next is the cleaning and prep work with betadine or chlorhexidine to sterilize the surgical field. Soon to follow is the covering blue drape that ensures a sterile field. You are now ready for the actual start.

This next step is the most uncomfortable but also the shortest and quickest. I have to place local anesthesia with a very small needle on the areas I am working on. Typically, this is the labia minora or majora, clitoral hood, and maybe the introitus (the very beginning lower region of the entry into the vagina). You are allowed to cuss

Procedure Details for Labiaplasty in the Office cont.

and swear during this minute! Go ahead, I won't take it personal. If you are having a vaginoplasty also then I have to numb up the inside of your vagina. That is an extra thirty seconds. This is when I get compared to a dentist and my maternal heritage is put into question. I then check all areas to make sure you are completely numb. If you are not feeling anything sharp then we go to the next step.

Next, you hear the whirl of the smoke evacuator or the increase volume of the TV or stereo. I go ahead and start the delicate and carefully planned surgery. I follow the surgical markings on your labia with the minimally traumatic Ellman Surgitron. It is such a fantastic tool because it is a relatively cool tip that has lateral thermal damage measured in microns instead of in millimeters when one uses a 980 Diode laser you read about when a surgeon does "laser" surgery to rejuvenate a vagina. The Ellman is without comparison in its finesse. Since I first started using the Ellman several years ago I have noticed more plastic surgeons and gynecologists using the Ellman (also known as RF or Radio Frequency) when doing labial/vaginal work. To help me with certain bleeding sites I a There are two basic techniques to labiaplasty of the labia minora. I am partial to one and avoid the other like the plaque. The "V" technique discussed on some reality TV shows is one preferred by many plastic surgeons. Unfortunately, it is wrought with complications in my opinion. The edges of the V are brought together with fine sutures but they unfortunately pull apart often enough for me not to feel comfortable with the technique. There is too much tension and not enough suture strength; too much tension and a variable blood supply to regenerate the edges together. I have to repair these "labiaplasty-gone-bad" cases from other surgeons often enough to realize the faults of this technique. Most gynecologists use the technique that sculpts the edges to the size desired without the high-tension "V" incision. There is less wound breakdown and fewer problems with restoration of blood flow. I personally favor this sculpting technique because of its precision and flexibility. You do not have to guess how the top will line up with the bottom. The edges always line up. The knock on this technique is that there are the color discrepancies of the inner labial lips as compared to the outer labial skin. This is true in the short term but over the long term the color issues are nonexistent because nature has a way for the edges to eventually match in color.

Once all undesired labial tissues are removed the suturing begins. Fine but strong sutures are used in several layers to ensure proper wound healing. Many various suturing methods can be used but I prefer to stay with a tried-and-true technique I have developed over the years. This multi-layer approach is the technique I teach all my trainees. It is the safest method of all to ensure wounds do not open up and at the same time preserving the most natural of looks.

So now you are pretty much done. You are comfortable and awake. I will take off the drapes, clean you up, and give you a mirror to view your new you. A few pictures follow, you go to your private room and change, have a glass of water if you wish, then go home with your driver. Your post-op instructions and handouts will be reviewed just one more time before you leave and go off painlessly into the outside air. Your post-op appointment will be set and my personal cell phone number will be given to you so that you always feel that I am available. You will be numb for another couple of hours but be sure to use your pain meds and ice packs for your comfort. Be a princess and don't do too much. You can walk and eat what you like. You can drive the next day. Read the section on "Recovery Time" and you will get a good feel of what to expect in the weeks to come.

Essential Pre-Op Instructions

- *If your surgery is scheduled for early in the morning, eat a hearty breakfast and drink plenty of water.. In the morning you may shower and brush your teeth, If your surgery is planned for the early afternoon then please eat a hearty lunch about 8 hours prior to your surgical time and sip water all day. We encourage sipping water, not gulping, all day before surgery to prevent dehydration. This is very important specially for those who need a bowel prep. These are new recommendations from the Anesthesiology Associations. You must make arrangements prior to surgery for a responsible adult to drive or accompany you home. No one will be discharged from the surgicenter alone.*
- *Please leave all valuables, jewelry and contact lenses at home.*
- *You should wear comfortable clothing that you can easily put on after surgery.*
- *Remove nail polish from either your left or right index finger.*
- *If you have received a prescription for pain relief prior to your surgery, be sure to have it filled so it will be immediately available to you.*
- *If ordered, please have your blood tests completed ten days before surgery and have the results forwarded to our office.*
- *Do not drink alcohol or smoke cigarettes ten days before or after surgery.*
- *Do not take any of the following medications for a week prior to your surgery, which may effect bleeding: Vitamin E, ginkgo, aspirin, Empirin, Anacin, Excedrin, Bufferin, Ibuprofen, Motrin, Advil, Coumadin, Elmiron, Heparin or Aleve. If you need pain relief, Tylenol products are fine*
- *Do not undertake any strenuous exercise 24 hours before surgery.*
- *Print out these instructions for future reference.*

Post-Operative Care Instructions

Congratulations on having aesthetic vaginal surgery.

It is now up to you to ensure that healing occurs properly by protecting the tissues and not allowing them to become stretched or pulled. For the next six to eight weeks, these instructions should be followed as carefully as possible. Please contact the office if you have any questions or would like clarification of these post-op instructions.

PLEASE REVIEW AND FOLLOW THESE INSTRUCTIONS:

Pamper yourself and take it easy, especially the first couple of days. Please be aware that you may experience some pain or discomfort in the vaginal area. You may spot blood or have a small to moderate amount of discharge. This is normal and will lessen within a few days. You may initially experience some irritating symptoms, such as rubbing and sticking, puffiness, and bruising. This is not unusual during the early phases of healing and will resolve with time. Wear loose clothing for comfort and keep your vaginal area clean and dry. Use soap and water daily. A hand sprayer is helpful to keep discharge and debris from accumulating in your vaginal region. If you had a laser procedure or resurfacing, clean off the whitish discharge often. You want the healthy pink skin to show.

For the first week, you should relax and take it easy. Limit your activities to light work or deskwork. This is a great time to catch up on your reading, television programs or other similar activities that you rarely have time for. You can walk up and down stairs, drive, cook, go to movies but avoid activities such as vacuuming, heavy gardening, carrying heavy objects, lifting your children, swimming. You may drive once you feel comfortable and able. Use pain medicine, such as Ibuprofen and Darvocet, when needed and use ice packs and Dermoplast Spray for comfort.

Do not use a tampon or put anything into the vagina except the estrogen cream. Avoid vaginal sexual activity for the first 6 to 8 weeks. You can start vaginal stretching exercises at 6 to 8 weeks post-op if you had a vaginoplasty or perineoplasty or posterior repair. Use your estrogen cream daily to aid in healing and regeneration of new skin. This will also prevent erosions. Finish your antibiotics.

Take a vitamin every day for 3 months following surgery to ensure you have excellent nutrition. Take a stool softener such as Colace to reduce the risk of straining during elimination. Whether you use the softener or not, it is very important not to strain these tissues. We recommend the use of Colace, Milk of Magnesia, Fibercon, Metamucil, Prunes, and Prune Juice. Use Dulcolax Suppositories and Fleets enemas as needed.

Weeks 2 – 4 gradually increase your physical activities, but specifically you should still not lift heavy objects (one (1) gallon of liquid or more). Walking or strolling is acceptable – just no power walking, impact exercises, jogging or aerobics. If your wound edges have healed well and you have sutures dangling or irritating you then please come into the office and we can trim them off. Most will just melt away or fall off because we use absorbable sutures only.

Weeks 5 – 8 gradually resume normal activities. If you are still sore or certain activities are still uncomfortable, wait an additional week or two before resuming. If you had laser resurfacing it may take weeks to months for normal coloration to come back. If you are bleeding more than expected, have an odorous discharge, have a fever, have increased swelling of your labia or vulva, or have any other concerns, please contact the office immediately. If you live outside the area please contact us via email or phone at any time. Feel free to use photographs on our secure website to show us any areas of concern. We will respond rapidly.

Before and After Photos

Before and After Photos

http://www.urogyn.org/vaginal_surgery-photos.html

We pride ourselves in providing our patients with the the highest quality photographs of Aesthetic Vaginal Surgeries that are found anywhere on the web. You can often judge the skill level and experience of the surgeon by examining the quantity and quality of their unaltered photos of their surgical procedures. Please visit our website to view the most extensive set of medical photographs available on the internet. Dr. Alinsod has spent two decades collecting and preparing them for his patients. The links may be shared with others but no reproduction of any kind is permitted. These photos are updated on a regular basis.


Rim Look


Barbie/Smooth Look


Hybrid


Labia Majora Plasty


Labia Majora Pelleve


Revisions/Resurfacing

Vaginoplasty
Labiaplasty and Vaginoplasty
Reconstructive Pelvic Surgery
Clitoral Hood Reduction
Hymenoplasty

Dr. Alinsod's passion for photography has been directed towards the collection and dissemination of helpful teaching aids for the medical field. He has freely made available his two decades worth of photographs for medical professionals and patients alike in helping understand the conditions of interest. Dr. Alinsod teaches medical photography at his local Preceptorships and at National Meetings. His photographs have been used Internationally in educational materials, publications, advertisements, research, and technical bulletins.

By Category

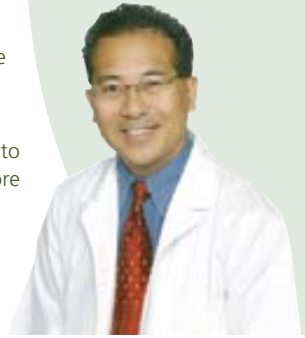
Labiaplasty RIM Look

The **RIM Look** is the most requested look patients ask for. Precise labial reduction leaves a small rim of labia minora below the level of the labia majora to reduce its prominence and increase patient comfort.

Labiaplasty Barbie/Smooth Look

The **Barbie/Smooth Look** is a more aggressive reduction of the labia minora to the point of complete excision. It leaves a refined look and elliminates the pulling and tugging sensations women often encounter.

Dr. Alinsod's personal preference is the **Hybrid Look**. This combines the RIM and Barbie appearance to leave a very fine and natural looking rim around the vaginal opening. This Hybrid Appearance is more technically difficult to achieve and requires extreme precision techniques and tools.



Case Studies of Dr. Alinsod's Vaginal Surgeries

http://urogyn.org/cases/case_index.html

Please click on the Case Numbers below.

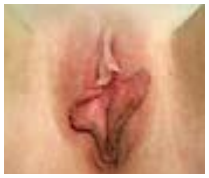

Case 1


Case 2


Case 3

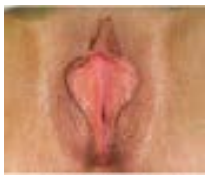

Case 4


Case 5


Case 6


Case 7


Case 8


Case 9


Case 10


Case 11


Case 12


Case 13


Case 14


Case 15

Dr. Alinsod's International Training Program at the Alinsod Institute for Aesthetic Vaginal Surgery teaches the surgeon how to manage the most simple request for a labial reduction to the most complex repair of childbirth trauma, incontinence, and prolapse. This unique and integrated approach to beautiful vaginal surgery can be learned by gynecologists, urologists, urogynecologists, and interested plastic and cosmetic surgeons.

The intricate details of surgical order, labial size management, clitoral hood reduction, skin resurfacing techniques, perineal reconstruction, vaginal size evaluation, and prolapse repairs are given in a comprehensive multi media manner using print, photos, PowerPoints, videos, and live surgery. It is a transformational learning experience for the surgeon.

Office Photos

South Coast Urogynecology provides its patients a warm and calming atmosphere conducive to precision surgery in a Southern California setting of serenity and beauty.

Costs and Financing, Patient Forms

Costs and Financing

(Go to http://www.urogyn.org/costs.html to see details)

The Surgery Costs:

Contact the Office for Appointments and Pricing

Labiaplasty	In Office
Vaginoplasty	In Office
Labiaplasty & Vaginoplasty	In Office
Labiaplasty/Vaginoplasty/Perineoplasty	In Office
Vaginoplasty & Perineoplasty	In Office
Hymenoplasty	In Office
Labiaplasty, Labia Minora	In Office
Labiaplasty, Labia Majora	In Office
Labiaplasty, Labia Minora and Labia Majora	In Office
Laser Resurfacing	In Office
Clitoral Hood Reduction	In Office
Perineoplasty	In Office
Transobturator Sling	Hospital
Anterior Compartment Repair w/ Mesh	Hospital
Posterior Compartment Repair w/ Mesh	Hospital
Vaginal Vault Suspension	Hospital
Uterine Suspension	Hospital

**Note : Remember that the procedures done in the Hospital Operating Room will add about $1,500 to the cost for the patient over the quoted professional fee. Also, incontinence and pelvic prolapse repairs can be done in conjunction with aesthetic repairs and are usually covered by one's healthcare insurance. Please call us for special pricing on our Teaching Days.*

Participation in Dr. Alinsod's active teaching program may qualify you for discounted surgical fees. Dr. Alinsod performs all the surgeries and surgeons worldwide come to Laguna Beach to learn of his advanced and innovative techniques.

Financing Options:

http://www.cosmeticsurgeryfinancing.com/
http://www.carecredit.com/webtoolkit/cosmetic/
http://www.cosmeticredit.com/

Patient Forms

http://www.urogyn.org/ptforms.html

History and Physical Forms Kit:

http://www.urogyn.org/ptforms/HPForms.pdf
Please fill this out and fax or email it back.

Surgical Informed Consent:

http://www.urogyn.org/ptforms/SCU_Surgical_Informed_112607.pdf

Photography and Video Consents:

http://www.urogyn.org/ptforms/Photo_Video_Consent_Nov07.pdf

Pre-Op Instructions:

http://www.urogyn.org/ptforms/Pre-Op_Instructions.pdf

See page 27

Post-Op Instructions:

http://www.urogyn.org/ptforms/Post_Op_AVS.pdf

See page 28

Concierge Service:

http://urogyn.org/concierge.html

Hotels:

http://urogyn.org/hotel.html

We have markedly reduced corporate rates for our quests. Please call us for details.

Patient Testimonials

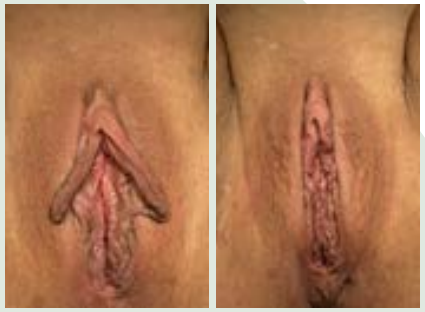
Patient Testimonials *http://urogyn.org/ptletters.html*

FOR MANY YEARS I RESEARCHED LABIAPLASTY SURGERY and had numerous consultations, asked questions, and finally went to a plastic surgeon in La Jolla, CA. The plastic surgeon claimed to have done "many" labial surgeries among with her tummy tucks, faces, and breasts.

Two weeks after surgery, I felt some stitches had come out and that something was terribly wrong. I should have trusted my gut instinct and went with a full time vaginal surgeon instead of a part time vaginal surgeon. The nurse at the plastic surgeons' office gave me some instructions, which I followed completely, but I kept insisting something was amiss. Two weeks later a revision was done under a poorly done local anesthesia and I felt the entire procedure and was in pain. After the revision healed my labia were like flaps and were barely attached by thin strands. Now the well-known La Jolla surgeon changed from a nice professional to one with attitude and indifference. It was hurtful. I was terrified to try and find the right surgeon to fix this bad result. There are many doctors who advertised performing labiaplasty but not fixing or revising them. It makes you wonder who are actually formally trained in labial surgery? I was very fortunate to find Dr. Red Alinsod as the expert in labial revision surgery. His credentials are as a vaginal surgeon first and foremost, not a breast or face or tummy expert but simply a world renowned vaginal surgeon. He responded immediately to emails and even gave his opinion on photos of my result without charge. He was a very compassionate person which made a huge difference. During my consultation with Dr. Alinsod he could not understand why I had been sutured the way I was or why the plastic surgeon approached the surgery in the manner she did. He spent a great deal of time with me to ease my fears and give me the options of how to go about fixing the labia. He told me how the blood supply to the labia minora varies greatly and how Wedge or Z-Plasty labiaplasties and skin removal techniques are prone to improper healing and "holes" and dangling tissues. After many discussions and emails I finally had Dr. Alinsod re-do my labiaplasty and I have not looked back with any regrets. I chose to have the "Barbie" technique, which Dr. Alinsod developed and perfected, as my revision procedure. I just wished I had gone to him first and not for the revision. It was a long and painful procedure to remove the old stitches and scar tissue left by my original surgeon but it has been worth the effort. My labia now are beautiful and natural looking. You cannot tell anyone had done surgery on me. My own doctors cannot tell. My original labiaplasty and time of revision were two years apart and that time in between was very trying for me, emotionally and physically. Not only was Dr. Alinsod compassionate but he was professional as well. He never rushed me. My situation was not passed off as "No Big Deal." I loved Dr. Alinsod's care for me and think the world of him. I am now very happy with my labial appearance and feel a great deal of confidence to move forward with my life. Thank you Dr. Alinsod for not only your professionalism and expert hands but for your empathy and understanding.

Like many of his patients who travel many miles and over many states to see him, I now travel more than an hour to see him for my routine gynecology and aesthetic needs and I do so with a smile. Save time, money, and personal grief and have Dr. Alinsod as your surgeon. I am willing to speak with you personally about Dr. Alinsod and his team.

A Very Happy and Very Sincere Holly from So Cal



Before Surgery *After Surgery*

Patient Testimonials http://urogyn.org/ptletters.html

I COULDN'T BE HAPPIER WITH THE RESULTS OF MY LABIAPLASTY with the beautiful transformation done on me by Dr. Red Alinsod at South Coast Urogynecology. It has made a huge difference in my everyday comfort (no more rubbing and chafing!) and I must say, I do think my vulva looks beautiful; a definite added bonus to a procedure I saw primarily as a physiological necessity rather than an aesthetic choice. The result is symmetrical, pretty, and totally natural looking. There is no scarring, and no loss of sensation of any kind.

I'm really glad I flew out to California all the way from Boston, Massachusetts just to have Dr. Alinsod do this procedure. The added expense was well worth it. I had spent many months researching doctors doing this procedure and found that Dr. Alinsod's web site conveyed an unparalleled professionalism, the best "before" and "after" pictures, the friendliest staff, and comforting photos of the clinic offices. I was especially impressed by the on line patient information and handouts, and detailed description of what to expect before, during and after the procedure. It was obvious to me that he really cares about his patients, has a high level of perfectionism, and understands that this is a bit of a scary decision to make. I knew right away that this was the place to go to be treated with respect, kindness and to get the best care and excellence. Also, I wanted the procedure to be done using the Ellman Surgitron Radio frequency device, rather than with the lasers used in most other clinics. After reading about it, it became clear that Dr. Alinsod is a leader in his field and that the Surgitron is the best tool.

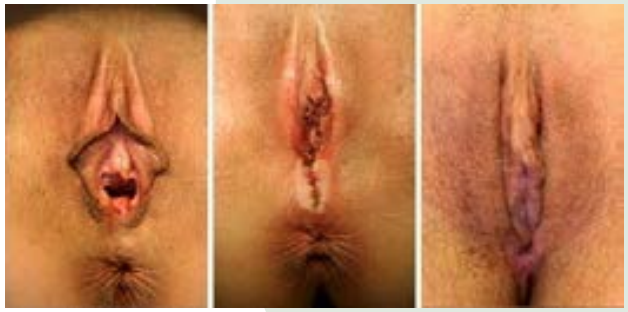
In person, Dr. Alinsod's bedside manner is kind, gentle, sincere and immediately puts you at ease—completely professional. And his wonderful assistant, Maria, was there to hold my hand in every way. I felt confident that I was in the best of hands and that everything would go well, as it did! I was also given every opportunity to talk with Dr. Alinsod directly at any point in the following weeks and months when I had concerns or questions about the healing process. My emails and phone calls were always returned immediately or within hours by Dr. Alinsod himself. I have never been so well cared for during a surgical procedure. If any gynecological issues should come up in my future, I will definitely go directly to Dr. Alinsod and his staff. --Catlin, Boston, MA

DEAR DR. ALINSOD, I WILL TRY MY BEST TO EXPLAIN IN WORDS HOW I FEEL ABOUT MY VAGINOPLASTY AND PERINEOPLASTY SURGERY. I would of never considered plastic surgery vaginal rejuvenation, until I needed bladder and rectal repair. My organs were no longer where they belonged. My first feeling that something was not quite right was a wideness in my pelvic area and feeling of separateness. Then a difficult and long time to urinate. It wasn't until my organs fell into my pelvic anatomy and sex with my husband was extremely emotional. My condition went from moderate to severe.

I felt my vaginal anatomy was ruined and knew just fixing my organs would not be enough. I am not your plastic surgery type nor do I believe it should be in this category. These issues are at the core of a women's sensuality. Us women at the age of 50 and over don't realize the change in that area since it is so gradual or until something serious like your organs falling.

I gave your card to 2 of my friends that called and asked re: vaginoplasty, etc. After, I told them how perfect I feel from the reconstruction as well as if I had a butt lift my buddies want a new vagina as well. Two days after surgery, while in the hospital, I showed my girlfriend and she said it looked just like a 21 year old. She couldn't believe how good it looked on the 2nd day or recovery. I told her the advertisement indicates you will look like a 21 year old again. A bonus is the 21 year old vaginal canal. I feel renewed and restored as well as empowered and somewhat young again. I could be a spokeswoman for these procedures in the enlighten state I feel. Thank you once again. I hope your creative future restoring a woman's core being her sensuality and sexuality grows big and bright. Further, the wonderful women employed by Dr. Alinsod are the best, without them I could not of gone through this surgery.

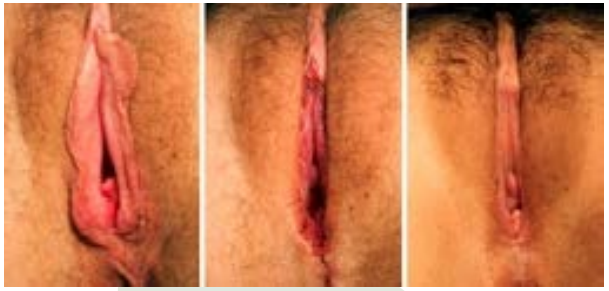
Love and Light E



Before Surgery *Immediately After Surgery* *8 Weeks After Surgery*

Patient Testimonials *http://urogyn.org/ptletters.html*

I DECIDED TO HAVE LABIAPLASTY BECAUSE I WAS EMBARRASSED ABOUT THE SIZE OF MY LABIA MINORA, they were too big. I wanted to feel sexy, and I could not feel that way with my inner lips the way they were. I don't have a lot of money, so when I saw an ad for this very inexpensive place called San Dimas Surgical Center, I thought this sounded like a good choice. The first thing that should have raised a red flag that this wasn't the ideal place to have surgery was the fact that on the website there wasn't any information about the doctor who would be performing my surgery, namely his expertise, which should never be the case with any surgical procedure. To be honest, I just thought this was a common procedure often performed, and it never crossed my mind that anything could go so terribly wrong. After the surgery, I noticed a difference between my two inner lips immediately, but I thought maybe it was just the swelling and it would all end up looking normal after a couple of months. Well, a couple of months passed, and it just ended up looking worse. One side was still very big, and the other side was very short and bumpy, with notches of skin through out. I felt totally scarred and deformed, and what's worse I thought it would be a permanent problem. I even thought I might have to give up sex because it looked so awful. I was very depressed and worried. This is were I started doing some research and I wanted to find, this time, the best in the business. I came across South Coast Urogynecology, and took a look at Dr. Alinsod's work. His pictures of labiaplasty procedures were the best I'd ever seen, so smooth, so natural. Based on his pictures, I thought if anybody can help me, it has to be him. And sure enough, when I met Dr. Alinsod he made me feel so at ease, he is such a gentleman, and so in touch with what a woman needs. He assured me that he could help me, and those news, to a woman who felt so incredibly hopeless up to that point, were music to my ears. My final results are incredible. I am so smooth down there, that I don't even think any man would ever notice I had anything done! I'm very satisfied with my results. If I could do this procedure over again, I would never again choose a doctor based on price. I would, without a doubt, choose Dr. Alinsod. He is very experienced at what he does, and has a great staff, most noticeably, Maria, his assistant, who was always so nice and reassuring. If you are considering labiaplasty, please choose wisely, this is such a complex procedure, and you should only let the most experienced surgeon work on such a delicate and important area to us women.
Thank You Dr. Alinsod!!! – C



Before Surgery *Immediately After Surgery* *8 Weeks After Surgery*

Patient Testimonials *http://urogyn.org/ptletters.html*

SINCE THE BIRTH OF MY 3RD CHILD, I SEARCHED FOR A PHYSICIAN WHO WOULD HELP ME CORRECT WHAT I WAS TOLD TO BE "NORMAL" BY NUMEROUS OBSTETRICIANS / GYNECOLOGISTS. I thought I had stress incontinence, and knew I had large, uncomfortable labia, and a stretched vagina. I felt helpless until I met Dr. Alinsod. It was last year when I discovered Dr. Red Alinsod by searching the Internet. I contacted him via email and to my surprise was contacted the next day, which happened to be on a Saturday. I could not believe the quick response and his sincerity and loyalty to his patients. I immediately knew he was a genuine person and very experienced by our phone conversation. He understood my needs and scheduled a consult.

Dr. Alinsod performed a labiaplasty with unbelievable results. I was so impressed. I went back and within two months had a vaginoplasty, rectocele repair, and stress incontinence sling. My quality of life is 110% better.

I travel from North County, San Diego area to Laguna to see Dr. Alinsod. I highly recommend traveling across the states to anyone seeking the highest quality, state-of-the-art treatment. Dr. Alinsod is compassionate and truly takes pride in his profession. He is professional and kind with communication being one of his best qualities. I recommend Dr. Alinsod to all of my family and friends. I truly wish that all physicians practiced medicine in the same manner as Dr. Alinsod. He is simply amazing. -- DM I am originally from the Middle East and in my mid-twenties. After my child was born, some things just weren't the same (ladies you know what I mean!). But of all the changes my body was going through, this was one that I couldn't stand. I eventually got the guts to say enough, and do something about it (after trying a billion Kegels with no results!) I had a consultation with Dr. Alinsod and shortly after I decided to go with the vaginoplasty, and perineoplasty. The first week after the procedure was tough, but then it just healed nicely and really changed my life! My partner feels a great difference and the procedure was definitely worth it for the both of us.

Dr. Alinsod is very professional and experienced and really did a wonderful job making me feel more like my pre-baby self again! **--***EM, from Cairo*

Dr. Alinsod. Now that I am on the recovery side of my surgery, I had to write to tell you how much your compassionate care for me made the process of my bladder surgery possible. I couldn't have gone through this without the help of you and your staff. As you know, I was terrified at the prospect of undergoing bladder surgery and when you added the other procedures to the picture, I was very nervous about the outcome. My recovery has been manageable and now I'm looking forward to getting back to my active lifestyle with no worries whatsoever.

I can't thank you enough for all that you have done. Your communication skills are terrific and that made it easier to understand the procedures that I was having. In addition, ***your nurse Maria is really a saint.*** I put her to the test with my concerns about my bladder and she shouldered them all with that loving way she treats your patients. I feel blessed to be a part of your medical family and have already recommended you to two of my friends who are as afraid as I was to address my bladder issues. Lucky am I to have you in my world. - *Anonymous*

ELEVEN YEARS AGO, I HAD A VERY ROUGH DELIVERY WITH MY SON. I HAD A BEAUTIFUL BABY BOY; HOWEVER, MY BODY WAS LEFT PRETTY TORN UP. THE YEARS THAT FOLLOWED PROVED TO BE CHALLENGING FOR ME. Whenever I had a bowel movement, I had to sit a certain way…it was disturbing to me. Also, when I would sit down, I always had to adjust my internal organs. I am very active and work out everyday and "my problem" just continued to get worse. I began to get depressed about it, thinking I could never change it. I felt like "damaged goods" and certainly forgot what it was like to feel normal. I had consultations with different doctors who either were not qualified to do what I needed done, or I did not feel comfortable having them do surgery on me. Just when I thought that this condition would be with me for the rest of my life….I found Dr. Alinsod! Dr. Alinsod and his staff are warm, compassionate and caring. I emailed Dr. Alinsod to ask if he could help me and he emailed me back within and hour! Who does that? And it just got even better from there! I set up a consultation with Dr. Alinsod and he answered EVERY question I had. I decided that he was THE ONE who could fix me…and boy was I right! He performed a transobturator sling and pelvic reconstruction with vaginoplasty and perineoplasty on me. My leakage and my pelvic pressure are gone and I am as if I never had a baby! I am a CHANGED WOMAN!!! I am back to being me and excited about my life again! Dr. Alinsod and his staff are AMAZING! They are ALL kind and caring and most importantly know EXACTLY what they are doing! Dr. Alinsod gave me my life back! THANK YOU, Dr. Alinsod!With MUCH Gratitude… *CP, all the way from Utah!*

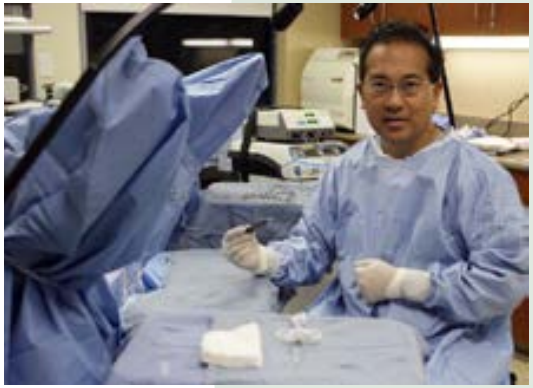
Patient Testimonials *http://urogyn.org/ptletters.html*

I HAVE BEEN ABLE TO OBSERVE DR. ALINSOD'S CAREER FOR OVER SEVEN YEARS AS BOTH HIS PATIENT AND AS A MEDICAL PROFESSIONAL. I have the utmost trust and confidence in his surgical skills and abilities and have been fortunate enough to have been under his care. His incontinence surgery have kept me dry and feeling refreshed. The cosmetic vaginal surgeries have enhanced my sexual experience and have improved my self image. Dr. Alinsod is able to make me feel relaxed and open in my personal discussions and I feel quite fortunate to have a physician I can confide in. -- *LA*

WHEN I DECIDED THAT LABIAPLASTY WAS A PROCEDURE THAT I WISHED TO PURSUE, I CAREFULLY RESEARCHED THE CREDENTIALS OF MANY PHYSICIANS that offered this procedure and I quickly recognized that Dr. Alinsod was clearly highly and uniquely qualified (being both board certified in gynecology and trained in this type of an aesthetic procedure). I had the procedure in early January. Prior to the surgery I met with Dr. Alinsod and his extremely kind and professional staff. As soon as I met each of them and Dr. Alinsod, I realized that there was a sincere kindness and professionalism in how they treated their patients, and that I was in very good care. Even then, however, I did not realize how skilled my surgeon actually was. I have had many dental procedures that I only wish could have gone so well. Pain and swelling were minimal and medications that Dr. Alinsod prescribed for pain management were highly effective. My recovery was very quick. The improvement in appearance and comfort is striking. I am quite sure that no one (even another surgeon) would not be able to recognize that I had the procedure done, as there is no scar at all. I truly cannot thank Dr. Alinsod enough for the quality of surgery and care that I got. – *MB*

DR. RED ALINSOD IS A CARING AND COMPASSIONATE PHYSICIAN THAT HAS HELPED CHANGE MY PERSONAL OUTLOOK ON LIFE. For years I suffered low self-esteem due to the appearance of my vaginal area brought on by the ravages of childbearing. Not only did I leak urine but my labia were quite enlarged and caused irritation and pain. I could not wear jeans or tight clothing and wearing a swimsuit made me feel very self-conscious. I asked friends and family and medical professionals who I should see and all suggested I get in contact with Dr. Alinsod. I have never regretted my decision to seek out his opinion and to go ahead with my aesthetic surgery. I underwent a labial reduction, laser perineorrhapy, and vaginal tightening that has resulted in my renewed sense of youth. Some would call this "vaginal rejuvenation." I am in my mid 40s and but my private areas are 21 years old again! I am so pleased and happy even more so than my husband who is quite impressed with the surgical results. I feel like a new woman not afraid to dress any way I please and no longer am I self-conscious because I have made the right decision to choose Dr. Alinsod to be my personal aesthetic surgeon for my most private of parts. -- *NR*

THIS WAS ONE OF THE BEST THINGS THAT I COULD HAVE EVER DONE FOR MYSELF… AND MY HUSBAND!! The procedure was incredibly easy with relaxing music and Dr. Alinsod and his staff explaining everything and keeping me comfortable every step of the way. I look and feel INCREDIBLE and can't believe how perfect everything went. Thank you Dr. Alinsod. You've made me sooo happy!!" You guys are the Best!
- P from San Diego



Patient Testimonials http://urogyn.org/ptletters.html

ABOUT 4 YEARS AGO I NOTICED A MARKED VAGINAL LOOSENESS. THIS BECAME A VERY BOTHERSOME PROBLEM FOR ME.

I spoke with my primary care doctor who prescribed kegel exercises. This obviously did not work, as it does not work for most women unless they are 20 years old and never had children. I then spoke with my gynecologist who told me that the surgery to tighten my vagina was possible with a price tag of about 27,000 dollars. I was very upset. If you are reading this and considering this surgery, you already know my frustrations. I started Googling "vaginal tightening" and luckily found and clicked on Dr. Alinsod's website. I called and spoke to Diane who immediately was able to set up an appointment for a consultation and surgery the same day because I would be on vacation down in southern California at the time. I live in the Northeast and had to fly in.

I was met at the door by Maria who is wonderful, very understanding and down to earth. She made me feel very relaxed. Dr. Alinsod walked in and I was so impressed. He mixed professionalism with humor and understanding. He made me feel instantly relaxed. The vaginalplasty surgery went wonderfully. At this time Dr. Alinsod said I was also a good candidate for labia plasty. At the time this was not important and I choose not to do it.

I can honestly say I did not follow the "healing plan". The next day I went to Universal Studios with my family and went on a lot of rides. This was not a good idea. I caused some stitches to rip. Within 3 weeks I had to go back to see Dr. Alinsod and have him re-stitch me. He did this happily and free of charge. After 6 weeks I questioned how I was healing and went back down to Southern California to see him. Dr. Alinsod believed I was healing great and told me I was fine. After a few more weeks I emailed Dr. Alinsod and told him I was not as "tight" as I had hoped to be. He told me if I was unhappy, he would make me "good as new" and would also perform labiaplasty on me free of charge because it was a training day for him. It was extremely nice of him to do the extra surgery for me. I am now a couple weeks into the healing process and I am doing great. The surgery site looks terrific! This time I am taking it easy.

I have never met a more professional and kind doctor. He responds to all emails lightening fast and always is patient and kind. He is a true gift to his profession. He gives women a fresh start where others cannot. He is a pioneer in vaginal plastic surgery and goes where 99% of all other doctors will not. His staff is understanding, patient and kind. I would recommend him to ANY woman who wants a fresh start and who wants to feel like the woman she once was or had always wanted to be. Thank you Dr. Alinsod, you are a diamond on a beach of stones. ***Sincerely, TA from the Great Pacific*** Northwest

I finally did it!!! I had a vaginoplasty and labia majora plasty done--ten years after my youngest child was born, and after researching it extensively for 2 years. Now, four months later, I feel it's one of the best decisions I have ever made. The results are amazing! I gave birth to two children--both deliveries were very difficult. I'm an extremely petite, small boned woman and the delivery with my second child included 18 hours of labor and 3 hours of pushing.

After delivery, when my OB was stitching me up (for 2 hours) she said "Your poor, virgin vagina." She was right!! It never felt the same-- urinating, having bowel movements, and of course during sexual intercourse. The looseness was almost a numb feeling. I felt un-plumbed and looked loose and crooked with the birth trauma and aging.

I met Dr. Red Alinsod after interviewing several other prominent doctors often seen on TV. Dr. Alinsod was very professional, understanding, and a gentle soul. He knew exactly how I felt and what I wanted to accomplish. His credentials as a vaginal surgeon was unmatched by his more famous TV doctors. He gave me the confidence to go forward with a procedure that I really needed. His recommendations were nothing more and nothing less than what I needed. Surgery went smoothly and everything turned out to be great!!! It's all back in working condition--all operations make me feel young again. I am very very happy with my decision and I feel every woman should be given this opportunity if she feels the need. I highly recommend Dr. Alinsod and am thankful I found him in. --*LLW*

Labia Majora Plasty

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I AM FROM A LARGE METROPLEX IN TEXAS AND WE HAVE SOME OF THE BEST DOCTORS AND HOSPITALS IN THE WORLD. I chose the best doctor in my city to perform my surgery and didn't think twice that I may have complications. My surgeon is held in the highest regard and has won several top doc awards. After surgery, everything looked great, but the pain was unbearable. There was a rare complication with my sutures and my doctor was too inexperienced to recognize and remedy my situation. Months went by and there was little relief from the pain. Words cannot describe the desperation you feel when an elective surgery can leave you in chronic pain. I knew I needed a revision. Ladies, these are your genitals, and you simply cannot mess around with your choice of surgeon. You must go to the best regardless of cost or location. I began my research again in search of the TOP doc, and before long ended up on www.urogyn.org. When I saw the photos of Dr. Alinsod's work, I knew the skill of this surgeon was unparalleled. Dr. Alinsod also trains other doctors in several types of procedures. Why go to someone who's been trained by Dr. Alinsod when you can go to Dr. Alinsod himself? I started reading his patient's testimonials and learned of how nice he truly is as a person. His entire staff is personable, knowledgable and very comforting as well. Dr. Alinsod truly does care about his patients in every way. He will personally answer your emails and return your phone calls very quickly. As an out of town patient, his excellent lines of communication were key to my piece of mind both before and after my surgery. Laguna Beach is a beautiful city and it is very easy to get around in and get to from John Wayne airport. I am so pleased with my results physically, but I am also happy to report that I am now pain free. A huge thanks to Dr. Alinsod and his staff!!!! *--Ecstatic in the heart of Texas*

TO WHOM IT MAY CONCERN: DR ALINSOD IS THE BEST!!! HE IS TRULY A PROFESSIONAL. It was unfortunate for me that my vagina was totally ruined after having a baby. It was loose, ugly and no sensation during sex! I hated it. My sexual well being is something that I reguard highly, a nessecity, my livelihood! I also had less than perfect labia which I really wanted to make georgous. Dr. Alinsod was not the first doctor I went to. The first doctor I went to mutilated me and took my money. My labia was so unnatural looking and full of scar tissue. My vagina was still just as loose as before the operation. I was devastated. I found Dr. Alinsod online. He answered all my questions, basically consoled me for two months before I decided to go and have a revision. His nursing staff is excellent, (tasha and janet)I love them! They are amazing women. I am just about six weeks now, three days from it and so excited. My surgery took over four hours. Dr. Alinsod is a perfectionst. I never thought my labia could be this georgous! I love it! I feel like a new woman. When doctor alinsod asked me how tight I wanted to be, I said two fingers tight. I know that he did a good job. I can no longer see my insides like I had been able to in the past. I can no longer see my vaginal wall hanging down. All I can see now is georgous, pink, tight vagina!! Dr alinsod has coached me every step of the way. He has been very supportive. He always gets back to me within an hour or two at the most! He really cares about his patients. He is very curteous. I couldn't say enough about him because he is really fantastic. I am ready to start my new life now!!! No woman should ever accept the ravages done to their body after childbirth!! There are professionals out there who can help us. We must take advantage of this!! --Ecstatic in the Great Pacific North West

ELEVEN YEARS AGO, I HAD A VERY ROUGH DELIVERY WITH MY SON. I HAD A BEAUTIFUL BABY BOY; HOWEVER, MY BODY WAS LEFT PRETTY TORN UP. The years that followed proved to be challenging for me. Whenever I had a bowel movement, I had to sit a certain way…it was disturbing to me. Also, when I would sit down, I always had to adjust my internal organs. I am very active and work out everyday and "my problem" just continued to get worse. I began to get depressed about it, thinking I could never change it. I felt like "damaged goods" and certainly forgot what it was like to feel normal. I had consultations with different doctors who either were not qualified to do what I needed done, or I did not feel comfortable having them do surgery on me. Just when I thought that this condition would be with me for the rest of my life….I found Dr. Alinsod! Dr. Alinsod and his staff are warm, compassionate and caring. I emailed Dr. Alinsod to ask if he could help me and he emailed me back within and hour! Who does that? And it just got even better from there! I set up a consultation with Dr. Alinsod and he answered EVERY question I had. I decided that he was THE ONE who could fix me…and boy was I right! He performed a transobturator sling and pelvic reconstruction with vaginoplasty and perinoeplasty on me. My leakage and my pelvic pressure are gone and I am as if I never had a baby! I am a CHANGED WOMAN!!! I am back to being me and excited about my life again! Dr. Alinsod and his staff are AMAZING! They are ALL kind and caring and most importantly know EXACTLY what they are doing! Dr. Alinsod gave me my life back! THANK YOU, Dr. Alinsod! *With MUCH Gratitude. P, all the way from Utah!*

WHEN CONSIDERING SURGERY, HANDS-DOWN WITHOUT A DOUBT, YOU CAN TRUST DR. ALINSOD. TO SAY HE'S A PROFESSIONAL AND A MASTER IN THIS FIELD IS AN UNDERSTATEMENT. I never dreamed outstanding results were possible for me. I am thrilled and relieved. My problem was I felt "that part" of my body never matched the rest of me, it looked 15 years older. Being in the entertainment industry, often times I have to change in front of people or wear minimal clothing, and I don't fear or dread those moments anymore. I'm happier overall, more confident, and completely comfortable in my own skin. My only regret is not finding Dr. Alinsod 10 years ago before my original surgery. --Happy in California

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I AM ORIGINALLY FROM THE MIDDLE EAST AND IN MY MID-TWENTIES. AFTER MY CHILD WAS BORN, SOME THINGS JUST WEREN'T THE SAME (LADIES YOU KNOW WHAT I MEAN!). But of all the changes my body was going through, this was one that I couldn't stand. I eventually got the guts to say enough, and do something about it (after trying a billion Kegels with no results!) I had a consultation with Dr. Alinsod and shortly after I decided to go with the vaginoplasty, and perineoplasty. The first week after the procedure was tough, but then it just healed nicely and really changed my life! My partner feels a great difference and the procedure was definitely worth it for the both of us. Dr. Alinsod is very professional and experienced and really did a wonderful job making me feel more like my pre-baby self again! *--EM, from Cairo*

WHEN CONSIDERING SURGERY, HANDS-DOWN WITHOUT A DOUBT, YOU CAN TRUST DR. ALINSOD. TO SAY HE'S A PROFESSIONAL AND A MASTER IN THIS FIELD IS AN UNDERSTATEMENT. I never dreamed outstanding results were possible for me. I am thrilled and relieved. My problem was I felt "that part" of my body never matched the rest of me, it looked 15 years older. Being in the entertainment industry, often times I have to change in front of people or wear minimal clothing, and I don't fear or dread those moments anymore. I'm happier overall, more confident, and completely comfortable in my own skin. My only regret is not finding Dr. Alinsod 10 years ago before my original surgery. *-Happy in California*

I truly cannot tell you how grateful I am for this entire experience. Your work is impeccable. I'm so happy that you chose to do this, and to share it!! And its been a pleasure visiting with you and the staff! Thank you thank you thank you!!! Have a great weekend!!! *--Grateful in Southern California*

DEAR DR. ALINSOD, I REALLY CANNOT THANK YOU AND YOUR STAFF ENOUGH FOR THE SUPERB CARE YOU GAVE TO ME BEFORE, DURING AND AFTER MY TREATMENT ON SEPTEMBER 13, 2010. I couldn't have been more aprehensive regarding this very extensive surgery and you gave me the confidence to go forward by outlining the rational for treatment, sharing your expertise in this area, the thorough preparation and evaluation, and for taking the time to reassure me from start to finish. It is very apparent that you are not only a great surgeon by your many successes but more importantly a genuine caring human being that values the patient docter relationship. I can say this with great confidence because I am in dentistry and deal with nervous people all day long. As health care providers we must always adminster patience, empathy, sympathy and deep commitment to quality patient care. It is obvious that you and your staff practise these principals. I have and will always refer many women to you because of your special ability to work in this delicate area with the skill of a professional. Many many thanks to you and your entire staff. Please feel free to give my number to anyone wishing to be additionally reassured. *Sincerely yours, Christine Jenkins*

I WAS A PATIENT OF DR. ALINSOD'S ABOUT TWO YEARS AGO, IN 2009. I had a vaginal delivery in November of 2007, which resulted in a tremendous amount of tearing. I had undergone three revision surgeries, all which did not correct the problem. My HMO insurance wanted me to continue seeing the same gynecologists who performed the three revision surgeries. After a year and a half of the birth of my child and still not getting better, I decided to do some research. Thankfully, I found Dr. Alinsod online.

When I first contacted his office, I began speaking with Diane. She was absolutely fantastic and made me feel so comfortable. Dr. Alinsod's staff has been nothing but sympathetic, helpful, sensitive, and compassionate to me. Dr. Alinsod, as well as his staff, responds to emails and phone messages very promptly, which is wonderful. Dr. Alinsod and his staff are in communication with one another so everyone knows what needs to be done. Dr. Alinsod is highly trained in vaginal surgery and even has doctors from all over the world come to learn from him. Dr. Alinsod was very understanding and offered me a cash patient price, since my HMO wouldn't help out with costs. Any prescriptions or items that I needed mailed to me was done immediately as well.

Dr. Alinsod is located in Laguna Beach and I live in the San Fernando Valley. It was very convenient that I could see Dr. Alinsod at his Burbank office for my consultation and post surgical follow-up. Dr. Alinsod was able to work around my work schedule for both office appointments and the date of surgery. I only had to drive to Laguna Beach for the surgery.

I trusted Dr. Alinsod and am so happy that I did. He was able to fix my problem, which in turn helped me personally and also my marriage. Even though my surgery was two years ago, Dr. Alinsod will still reply to my updates on email and answer any questions that I have. After surgery with Dr. Alinsod, I had vaginal physical therapy for fourteen months. Dr. Alinsod and my physical therapist were in contact as to how my progress was going.

I will be forever grateful to Dr. Alinsod for helping me so much. I am grateful for finding him, putting my faith in him, and being able to have an intimate relationship with my husband again. Forever grateful patient. *- Andrea*

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I AM WRITING THIS LETTER TO PLEDGE MY UTMOST THANKS TO THE TRULY INCREDIBLE DR ALINSOD AND HIS AMAZING TEAM AT SOUTH COAST UROGYNOCOLGY. After 5 years of research and decision making in whether or not to have labiaplasty, I recently decided to go ahead and take the plunge. My reasons for wanting the operation were like so many in the same boat: I'm very sporty (horse and bike riding), active (hiking, jogging) and yes, like to look good in well-fitting clothing. My labia was unfortunately getting in the way of all of those things and so the time had come to change this.

There are many excellent doctors throughout Southern California (where I live) and the country who are well-known in the field of vaginal surgery. I looked into each and every one of them because quite honestly, if I was going to make a fairly large financial and life changing decision, I only wanted the best.

I had read about Dr Alinsod on various message boards and thoroughly looked over his website. One of the factors that appealed to me was that he had attended the Loma Linda School of Medicine, which is extremely well known in California and beyond for producing not just excellent doctors, but individuals who have a warm, compassionate and sensitive approach. Ladies, let's face it – if we're taking cutting your labia, then you will want a doctor with these traits!

I made an appointment to see Dr Alinsod for an initial consultation and from the moment he walked through the door, I could have cried with relief. In fact, I did cry as it was pretty powerful to share my secret problem that I had been suffering with for so long with someone who both understood and helped lift years of worry away in a matter of minutes. Dr Alinsod has the kind of personality that make you feel as if you have known him for many years. Nothing you tell him or ask him about will shock, surprise or worry him as he has seen it all. To sort of explain how he makes you feel, it's like a reassuring dad, protective older brother and mentor/counselor all in one. During my consultation, Dr Alinsod examined me with the utmost of care, taking his time to listen to each and every concern I had. That was very important to me. We talked about what the operation would involve, the look and feel of the area during and after the day and what the healing process entailed. My mind was immediately made up that Dr Alinsod was going to be my surgeon.

I am lucky to live in Los Angeles, so traveling to Dr Alinsod's surgical office in Laguna was not a major problem for me. For anyone who has seen the show "Laguna Beach" or "The Hills" and think the area is 'millionaires paradise', well, it is (!) but it's also of course an area where regular folk live and work. I was not going to be driving back to LA after my operation as I knew I needed to sleep off the meds and so I booked a room at one of the very inexpensive hotels that are within half a mile of the clinic – my bill came to less than $75 for a really great room.

I wasn't too nervous on the day of the operation as I had been thoroughly prepared and reassured by Dr Alinsod in the days leading up to it - plus I had taken valium! But further great things were about to happen: I was about to meet Dr Alinsod's incredible team. Diane, Dr Alinsod's office manager who conducted my initial intake was like mommy. She gave me the biggest hug when we met and could not have been more warm, welcoming and wonderful. She was with me from the moment I walked in, till after my operation when I walked out and was my mental strength throughout. Then I met Maria, Dr Alinsod's operating room nurse. If I could kidnap Maria and bring her to live with me, I would. She is like your fairy godmother. When you meet her, you will know what I mean. She literally held my hand throughout the entire time I was there, from when I was given my meds, to when I was in surgery, to walking me back to the post operative room – she was right by my side the whole time, letting me know she wasn't going anywhere and that it was going to be over before I knew it (she was right!). Then there is Tasha, another of Dr Alinsod's nurses. Tasha is like the amazing, cool, big sister you always wanted. I can't gush enough about her. Tasha's best quality is her ability to reassure you that no question you ask her is too big, small or ridiculous. As with everyone else, of course, she really knows her stuff and trust me, I had some ridiculous questions to ask her about what looked normal and what didn't in the days after my op and she was always available immediately or as close to immediately with the right answer every time. (Tasha – thank you again). Of course, Dr Alinso d is always available too and is incredible at getting back to you in his warm manner, if you need to speak to him specifically.

As for the operation itself, even though it is elective surgery, nothing really prepares you for facing the operating room. I had been planning this day for literally years and when the day comes, it does feel a little surreal. I'll be honest: the concept of 'pain' was my biggest worry! As it turned out, I needn't have bothered spending time thinking about that. Dr Alinsod, Diane, Maria and Tasha fully prepare you ahead of time. I had a mix of valium for anxiety, and rubbed topical numbing cream down below to help with the injections of local anesthetic. Thus, when the operation started, I felt barely a pinprick in that area. I will say I have quite a high pain tolerance and in my case, didn't want or need any narcotic pills, but that is an option for people. I had a combination of labiaplasty and hood reduction and honestly, did not feel a thing. I remember feeling a little woozy from the valium but spent my whole time in the operating chair chatting away to Maria and Dr Alinsod and watching CNN! It's pretty hilarious talking with Dr Alinsod because you forget he is actually this world class surgeon and expert who trains hundreds of doctors around the world. He

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was so down to earth, genuine and funny the whole time and barely an hour later, the whole thing was all over.

LADIES, NOTHING PREPARES YOU FOR THE HIGH OF LOOKING IN THE MIRROR AFTER THE EVENT. In my case, the transformation was incredible. Dr Alinsod takes before and after pictures of his work (focusing SOLELY on the vaginal area) which I signed a consent to and it goes without saying that privacy is of the utmost importance to the team, so I was not therefore worried in the slightest. Within 30 minutes of my operation, after saying my goodbyes, I was back in my hotel room admiring the new 'me' until I fell asleep. I had no bleeding, some very minor spotting the following morning but most surprising of all, no pain, which, I'll be honest was weird because you think 'cuts', stitches', 'trauma', 'how am I going to pee' etc etc: I can't explain it but the methodology used is so precise that healing begins immediately and you genuinely feel very little discomfort. The only 'irritation' I had over the next few weeks was quite bad itching due to the stitches dissolving (Dr Alinsod uses dissolvable stitches as oppose to ones that need removing – trust me that's preferable!). The itching IS uncomfortable, I can't lie but again, it's not 'painful', merely, annoying. But it's nothing that Dermablast from Rite Aid can't solve, though.

With this type of operation too, Dr Alinsod and his team give you very detailed 'aftercare' notes so you know exactly what to do in the ensuing weeks, how to wash the area, what to avoid etc etc. They also can't reassure and advise you enough that if you are experiencing any issues (which you won't be) to CALL them immediately. Dr Alinsod can always be paged and will always make himself available to you as soon as he can. You will also have a 2 week follow up with him which is reassuring to know and I guarantee he will say to you (as he did to me) 'the area is healing incredibly'. I think in total, I had four days off work which I spent lying down in bed, and then the next few weeks taking it very easy. It was a tiny sacrifice to make all things considered.

I'm a changed woman thanks to this operation. The difference that it's made to my life is unquantifiable. What was the icing on the cake was having one of the world's top doctors in this field as my surgeon. And not only that, but Dr Alinsod and his team truly made me feel like family. I cannot recommend South Coast Urogynecology enough. My heartfelt wishes to the fantastic team. ***Yours, Ecstatic, in Los Angeles***

LOOK NO FURTHER, DR. ALINSOD IS AN ANGEL! Before I found Dr. Alinsod I was living in a shell of self consciousness and pity. For years after a certain event at a young age, I couldn't get the idea out of my head that there must be a solution to my insecurities. After a couple years, I discovered certain doctors advertising for the procedures but after consulting with them, did not feel confident about the surgeries. Whether it be for lack of information received or an apparent disregard for my concerns and preferences, I did not feel it was worth it to take a chance of going from bad to worse. Finally after I had almost given up I found Dr. Alinsod while aimlessly browsing the internet. I immediately had a good feeling after reading reviews and decided to call. The service on the call was wonderful, although he is always booked he was often willing to make it work before or after normal hours. After I met with him though, I was ECSTATIC! (NO JOKE, ALL MONTH I HAD A SMILE ON MY FACE. NOTHING COULD GET ME DOWN!) and that was only the consultation. All of my insecurities or negative thoughts seemed to float away when I met with Dr. Alinsod. He took his time and explained everything, answered all of my questions, and even gave me suggestions from low to high pricing scales when I asked!!! The nurses are a huge part of the positive energy that is always flowing. They provide first class service by always anticipating personal needs and providing empathetic, efficient service. Most of all they all have great humor. Now having completed and healed from my surgery I am still in heaven. I am extremely confident in myself. My new confidence seems to find me time to have fun instead staying in and wallowing. Funny how that works. I can also say that I have witnessed Dr. Alinsod teaching other experienced surgeons, but honestly, they have a lot to learn to get near his talent and amazing personality!!!!! I believe IT WOULD BE A MISTAKE TO GO ANYWHERE ELSE. ***Ecstatic in Sol***

WHEN CONSIDERING SURGERY, HANDS-DOWN WITHOUT A DOUBT, YOU CAN TRUST DR. ALINSOD. TO SAY HE'S A PROFESSIONAL AND A MASTER IN THIS FIELD IS AN UNDERSTATEMENT. I never dreamed outstanding results were possible for me. I am thrilled and relieved. My problem was I felt "that part" of my body never matched the rest of me, it looked 15 years older. Being in the entertainment industry, often times I have to change in front of people or wear minimal clothing, and I don't fear or dread those moments anymore. I'm happier overall, more confident, and completely comfortable in my own skin. My only regret is not finding Dr. Alinsod 10 years ago before my original surgery. ***--Happy in California***

I TRULY CANNOT TELL YOU HOW GRATEFUL I AM FOR THIS ENTIRE EXPERIENCE. Your work is impeccable. I'm so happy that you chose to do this, and to share it!! And its been a pleasure visiting with you and the staff! Thank you thank you thank you!!! Have a great weekend!!! ***--Grateful in Southern California***

I AM ORIGINALLY FROM THE MIDDLE EAST AND IN MY MID-TWENTIES. After my child was born, some things just weren't the same (ladies you know what I mean!). But of all the changes my body was going through, this was one that I couldn't

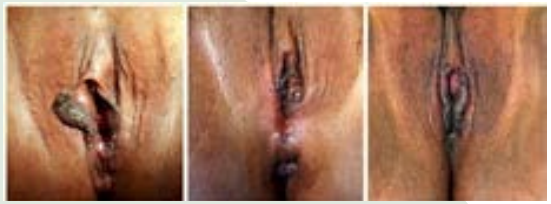
Patient Testimonials http://urogyn.org/ptletters.html

stand. I eventually got the guts to say enough, and do something about it (after trying a billion Kegels with no results!) I had a consultation with Dr. Alinsod and shortly after I decided to go with the vaginoplasty, and perineoplasty. The first week after the procedure was tough, but then it just healed nicely and really changed my life! My partner feels a great difference and the procedure was definitely worth it for the both of us. Dr. Alinsod is very professional and experienced and really did a wonderful job making me feel more like my pre-baby self again! ***--EM, from Cairo***

Patient Testimonial:

FOR YEARS I KNEW I WASN'T THE SAME AS BEFORE I HAD MY CHILDREN. BUT I THOUGHT IT WAS SOMETHING THAT ALL WOMEN FACED. My husband always said I was just fine, but I just felt too "loose". My husband and I have alot of fun years ahead of us and I knew I wanted to do something. I started to research Vaginalplasty and all the different Physicians andw clinics in the U.S. But when I spoke to to Dr. Alinsod for the first time I felt very sure I was making the right choice. The day I was scheduled for surgery, his office staff did everything they could to make me feel comfortable, and Dr. Alinsod made sure that all my questions were answered which totally put me at ease. 6 weeks after the surgery, I can't believe how great I feel and how my husband is more than ecstatic. Our sex life is great, and the only regret I haveis that I didn't do this sooner. Thank you Dr. Alinsod! -- ***ML***

Patient History: This pleasant lady was in her late 30s, had completed her childbearing, and wanted to renew her intimate relationship with her husband. She did not like the uneven appearance of her labia and the laxity of her vaginal canal. She underwent an in-office labia minora plasty, vaginoplasty, and perineoplasty under local anesthesia and without an IV.



Before Labiaplasty/ Vaginoplasty | *Immediately After Surgery* | *6-8 Weeks After Surgery*

Outcome: Patient resumed a normal and active lifestyle both professionally and personally. She was able to resume intimate relationships about three months after surgery. She felt more friction during intercourse and had a satisfying sex life.

Patient Testimonials http://urogyn.org/ptletters.html

HI DR. ALINSOD! I HAVE BEEN MEANING TO SEND YOU THIS LETTER AND I AM SORRY THAT IT HAS TAKEN ME SO LONG TO WRITE THIS! I guess I have been so busy getting on with life and so thrilled with the results, that I no longer think about it on a daily basis! I just want to say thank you so much for everything you and your staff have done for me! The entire experience from start to finish was excellent! It far exceeded my expectations!!:) Even though I was coming to Laguna Beach to have surgery, this was one of the best experiences of my life. Both Diane and Laureen were very helpful to me over the phone with any questions that I had, including helping me find a wonderful place to stay post-op. I could not have been any more comfortable there and I honestly cannot remember a time that I felt more at peace during my stay. Also, Maria and Marisol helped me feel very comfortable from start to finish with the entire surgical procedure. Maria is one of the most caring people I have ever met. She treated me like a princess and made me feel so special while I was in her care. I will remember her forever! Thank you Dr. Alinsod for caring about me and my outcome so much! In my opinion it is a rare find to discover such a Dr. like yourself that cares more about the final result than the financial gain. You have truly changed my life and I am grateful now and forever with any personal relationships that I have, for I now feel more confident than ever before! I no longer hold back because of those previous insecurities! :) Thank you again to you and your staff, you guys truly made a huge difference in my life! I cannot express my gratitude enough! I hope that I can come back in the future and visit such a beautiful place!! THANK YOU. *--A grateful and changed woman*

TESTIMONIAL FOR DR. ALINSOD FROM A HAPPY EUROPEAN PATIENT. After having botched labiaplasty surgery in Eastern Europe, from a supposed expert, I began contacting several American revision specialists as no one in Europe specializes in labia revisions. After consulting with several renowned and world famous surgeons, I decided on Dr. Alinsod who immediately made me feel comfortable and confident that he was the right surgeon. His extensive revision and reconstructive surgical experience convinced me to choose him and I'm so happy I did. Unlike my original surgeon, who had very very few photographs of their work, Dr. Alinsod provided me with dozens and dozens of patient photos of his actual patients. His website had amazing details. The radiosurgery revisions he performed were several levels above what other surgeons could achieve. Plus he invented those techniques himself. So I flew out to Laguna Beach, California. I wish I had seen Dr. Alinsod for my original labiaplasty. I found Dr. Alinsod's bedside manner and personality engaging and professional. I felt very well-informed about all my choices, options on different appearances my surgery could achieve, and on how to care for myself after surgery. Dr. Alinsod takes all the time you need to discuss the procedure and answers any questions you might have. He's patient and walked me through every step of the process. I found that very comforting. He provided me with 24-hour email, Skype, and phone access and answered all my questions so rapidly.

My experience with Dr. Alinsod and his staff was absolutely wonderful. Not only is Dr. Alinsod incredibly talented; he's the nicest, most caring surgeon I have ever met. He was very easy to talk to and non-judgmental at all. His staff was extremely friendly and helpful, especially Maria who made me feel comfortable and safe throughout the entire process. She always held my hand with empathy. I felt very well taken care of. After surgery I was able to enjoy the warmth and beauty of Southern California.After returning home I've kept in contact with Dr. Alinsod via e-mail, sending him updates on my healing process. He kept a close eye on my healing progress. Whenever I have had any worries, he always puts me at ease and I find it very reassuring that he still cares about my well being even though I'm in another continent. Now I understand why patients from all parts of the world travel to Laguna Beach to see Dr. Alinsod.Needless to say, I'm very happy with the results! I'm so grateful I found Dr. Alinsod and can't speak highly enough of him and his staff. It was beyond worth it to fly overseas to see Dr. Alinsod and I would highly recommend him to anyone who is interested in having labiaplasty or aesthetic gynecologic surgery. From Eastern Europe with thanks, - *Anonymous*

MY EXPERIENCE AT YOUR OFFICE WAS ABSOLUTELY AMAZING. I have never felt so welcomed at an office. And when I say that, I don't just mean welcomed by you, I mean by you and your ENTIRE STAFF. Everyone at your office is amazing, and incredibly comforting. You weren't the first doctor I considered, but you were the last. I knew the moment I walked in, saw your results, and received the warm welcome you and your staff gave me. Everyone treated me as if I were their own daughter going into surgery. My mom was with me, and to be honest, I though I was blessed to have her there, she didn't need

Patient Testimonials *http://urogyn.org/ptletters.html*

to be. Thats how truly great everyone made me feel.I cried after the surgery, I cried tears of joy due to my amazing results. I was so uncomfortable, for so many years. I don't mean to sound vain, but I was afraid to do anything sexually, I was embarrassed, I was uncomfortable, and 10 months after the surgery, I can tell you I feel GREAT. The results are remarkable. Especially considering the little time frame I experienced some pain and discomfort. After a month I was pretty much completely back to normal in every way. And after 3 months, I was back in the gym, had a boyfriend (which I was afraid to have prior to the surgery), and CONFIDENT. I never, ever, in my life thought I would be confident enough to have sex. My life changed after this surgery, for the better. I was so afraid to move forward in life and nearly haunted by my outer lips. I know it sounds dumb but what can I do? It's how I feel. There's nothing I can do about how I genuinely feel and have felt since i was about 13. I am 21 and was 21 going into the surgery. I was terrified. But EVERYTHING went great. Like I said, I was thoroughly taken care of by you and your staff before and after the surgery. If results aren't exactly what you want them to be, post op, you will help to get us there. It's not an easy surgery, and nothing will ever be perfect, but your team will not stop until I am happy.

I can't thank the office and you, Dr. Alinsod, enough for what you've done for me. I am so fortunate to have had a great experience and I wouldn't recommend another surgeon to do my labial surgery anywhere else. I If I lived far I would fly to Los Angeles to get it done with you if necessary. You are the best. Your staff is the best. Like any surgery, this is a serious one and not to be messed with. Nobody should walk into any office and rush into it. I don't want to mention any names but I did sit down with a big Beverly Hills doctor prior to meeting you and I'll tell ya, I left hysterical and in tears. The meeting made me extremely uncomfortable. I felt like the staff and the doctor didn't give 2 craps about who I was, the meeting was the least bit personable, and I was just another young girl getting vagina surgery done. That's honestly how I felt. I was devastated! Here I was, at the so called best office in LA, and I had a gut feeling something was off. I did my research and met with you and was immediately comfortable. I drove from LA to Laguna Beach to meet with you, and eventually get my surgery done, and boy, it was worth it. I want to thank you, Dr. Alinsod, and your staff because they are truly amazing. This isn't an easy process, but 3 months down the road, my life has changed for the better. I am not encouraging surgery but if it's something other women must do, as I have done, I am encouraging all to go to you, Dr. Alinsod. Go ahead and let others read this heart felt letter.
Sincerely, anonymous and grateful

Patient Testimonials http://urogyn.org/ptletters.html

Patient Testimonial:

For years I knew I wasn't the same as before I had my children. But I thought it was something that all women faced. My husband always said I was just fine, but I just felt too "loose". My husband and I have alot of fun years ahead of us and I knew I wanted to do something. I started to research Vaginalplasty and all the different Physicians andw clinics in the U.S. But when I spoke to to Dr. Alinsod for the first time I felt very sure I was making the right choice.

The day I was scheduled for surgery, his office staff did everything they could to make me feel comfortable, and Dr. Alinsod made sure that all my questions were answered which totally put me at ease. 6 weeks after the surgery, I can't believe how great I feel and how my husband is more than ecstatic. Our sex life is great, and the only regret I haveis that I didn't do this sooner.
Thank you Dr. Alinsod! -- ***ML***

Comparative Chart

Micro Tumescent Vaginal Rejuvenation (MTVR) compared to Laser Vaginal Rejuvenation and Designer Laser Vaginoplasty (LVR and DLV)

	MTVR	LVR AND DLV
Years Of Experience	20+	Highly Variable
International Training Program	Yes	Yes
Advanced Pelvic Reconstruction	Yes	Not Available In Most
Ellman Radiosurgery	Yes	No
Cool Tip	Yes	No
Laser Skin Resurfacing	Yes	Not Available In Most
IR and RF Skin Tightening	Yes	Not Available In Most
IPL Fotofacials and Hair Reduction	Available	Not Available In Most
980 Diode Laser	No	Yes
Hot Tip	No	Yes
Lateral Heat Damage	Microns	Milllimeters
Tissue Damage	Minimal	2nd Degree Burns
Surgical Location	Office In Most	Surgery Center/O.R.
Surgical Suite Fee	Included	Additional Fee
Anesthesiology Fee	Included	Additional Fee
Airline Ticket Refund	One Way Only Up To $200	Not Available In Most
Average Savings	$2,500 And Up	-----
Anesthesia	Topical / Local	General in Most
Awake	Yes	No
Need For I.V.	No	Yes
Post Op Recovery	15 Minutes	1-2 Hours
Post Op Pain For The First 8 Hours	Minimal To None	Mild To Moderate
Post Op Pain For The First Two Weeks	Mild To Moderatel	Mild To Moderate
Full Recovery	Six Weeks	Six Weeks
Beach Resorts	Laguna Beach Area	Not Available In Most
Five-Star Resort	St. Regis	Not Available In Most
Airport Service	Taxi or Limo	-----
Concierge Service	Available	Not Available In Most

Outstanding surgeons who are leaders in their fields come to train with Dr. Alinsod every month. The Alinsod Institute for Aesthetic Vaginal Surgery, a division of South Coast Urogynecology, has twin goals of excellence in surgical repairs and excellence in surgical training of doctors. This free flow of ideas generates innovation and cutting edge care.

IN THE NEWS!

In the News


10
2005
2015
SOUTH COAST
UROGYNECOLOGY
THE ALINSOD INSTITUTE FOR
AESTHETIC VAGINAL SURGERY

In the News- Recent Awards

APRIL 2016
Award of Innovations in Cosmetic Gynecology,

JULY 2015
Best Feminine Rejuvenation, The Aesthetic Show, Las Vegas, NV

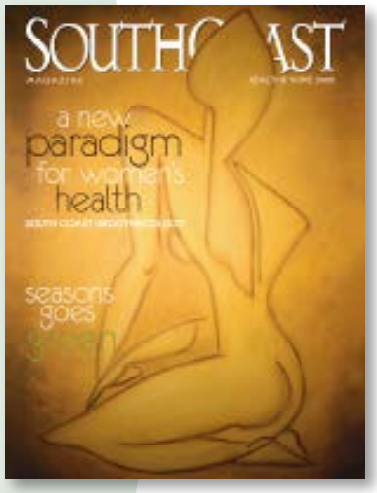
FEB 2017
Outstanding Contributions to Cosmetic Surgery 2017,
International Society of Cosmetogynecology, San Diego, CA

In the News- Recent Awards

MAY 2017

Award of Lifetime Contribution in Cosmetic Gynecology, European Society of Aesthetic Gynecology, Madrid, Spain

In the News



Click to download Dr. Alinsod's recommended reading

In the News

CONGRESS ON AESTHETIC VULVOVAGINAL SURGERY
Founded 2006

Dr. Red Alinsod founded CAVS over eight years ago. He was instrumental in developing the first Continuing Medical Education (CME) conference in Aesthetic Vaginal Surgery in 2006 and the first CME surgical preceptorship program for the specialty in 2007. Each year he brings together the brightest and most innovative minds to teach surgeons the safest and best techniques from around the world. Surgeon education, patient safety, and excellent surgical results are the goals of the conference. His Congress has been reproduced worldwide from Europe to Asia to South America.

Dr. Alinsod brings together a dynamic group of individuals who are acknowledged leaders in their respective fields. A global span of specialty experience is represented from gynecology, urogynecology, plastic surgery, cosmetic surgery, genital mutilation dermatology, medico-legal, marketing, to Search Engine Optimization. This brings balance and a broad perspective of the specialty that goes beyond simple marketing or self-promotion. A truly educational experience is sought. All speakers are welcoming and eager to share their experience. All speakers are uncompensated and are present because of their passion in advancing the specialty of Aesthetic Vaginal Surgery.

Past conferences have been held in Las Vegas, Tucson, and next in Orlando in conjunction with the annual meeting held by The American Society of Cosmetic Physicians. The conference usually takes place in November and is sponsored by the ASOCP. ASOCP is an open society that welcomes attendance and membership from all specialties, both national and international, without competitive aims or restrictive covenants. Each member enjoys the freedom to participate in any activities or societies and to teach others in any venue they choose.

Groundbreaking innovations and discoveries have been presented at this conference relating to aesthetic gynecology. These include radiofrequency labial surgery, the Barbie Look labiaplasty, curvilinear labia majoraplasty, radiofrequency labial tightening, non-surgical radiofrequency vaginal tightening, dermoelectroporation for vulvar lightening, G-Spot discovery in a cadaver dissection, PRP and Growth Factors for gynecology, levator-pudendal blocks, In-Office Awake Vaginal Rejuvenation, and many more.

Physicians from all parts of the world attend this annual conference prepared by Dr. Alinsod.

Please visit cosmeticphysicians.org for more details.

CAVS 2012 AGENDA: http://urogyn.org/pdfs/cavs_2012.pdf
CAVS 2011 AGENDA: http://urogyn.org/pdfs/CAVS_2011_Agenda.pdf
CAVS 2010 AGENDA: http://urogyn.org/pdfs/cvs.pdf

Contact Us

Practice info found in *http://www.urogyn.org/office.html*

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Burbank, CA 91505
Wednesday Afternoons/Evenings Only

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Fax: (949) 499-5312

www.urogyn.org
red@urogyn.org
Vaginal Rejuvenation Blog:
http://vaginalrejuvenation.blogspot.com/

For more photos South Coast Urogynecology go to:


ALINSOD INSTITUTE
for AESTHETIC VULVOVAGINAL SURGERY
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EXHIBIT U

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2016 AVN Awards Ad

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AVN Award 2019

For our January AVN S... Advertisement

All results in mail

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Chambers, Jr., M.D. - Case No. 22-27...

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me, Michael 4 Mar 23

Complaint against Dr. Chambers

Good morning Dr. Goodman, Pl... Inbox

Sara, me 6/14/19

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placing an ad in one of... Advertisement

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AVN Award 2019

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Sara Harter 7/12/17

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> *AVN Magazine - May... Advertisement

Sara, me 5 2/5/14
FW: Awards Program - Dr Chambers
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XO Chanel Preston

AVN AWARDS SHOW 2014

January 18, 2014

Hosted by **Chanel Preston** and **Wicked Pictures** Contract Star **Samantha Saint**

2014 NOMINEES

BEST MEMBERSHIP WEBSITE
21Sextury.com | AbbyWinters.com | BangBros.com | Brazzers.com | BurningAngel.com | DorcelClub.com | ElegantAngel.com | EvilAngel.com | JulesJordan.com | LifeSelector.com | NaughtyAmerica.com | PornFidelity.com | RealityKings.com | Saboom.com | TeamSkeet.com

PLEASURE PRODUCTS

BEST CONDOM MANUFACTURER
Billy Boy | Caution Wear | Coripa Condoms | Crown | Durex | Glyde | Kimono | LifeStyles | One Next Generation Condoms | 000 Boutique | Trojan | Sir Richard's Condom Company

BEST PLEASURE PRODUCT MANUFACTURER – SMALL
Adult Brand Concepts | A.L. Enterprises | Aneros | BSwish | Crave | Heeldo | Je Joue | Jimmyjane | Laid | Marc Dorcel Sex Toys | njoy | OhMiBod | Rianne-S | Shiri Zinn | Toyfriend

BEST PLEASURE PRODUCT MANUFACTURER – MEDIUM
Big Teaze Toys | BMS Factory | Crystal Delights | JOPEN | LELO | Lovehoney | Perfect Fit Brand | Pleasure Works Wholesale | The Screaming O | Tantus | Vibratex | Xgen Products

BEST PLEASURE PRODUCT MANUFACTURER – LARGE
California Exotic Novelties | Doc Johnson | Evolved Novelties | Fleshlight | Ovo | Fun Factory | Icon Brands | Nasstoys | NS Novelties | Pipedream Products | Sportsheets | Topco Sales

BEST LUBRICANT MANUFACTURER
Adam & Eve | Astroglide | Empowered Products | Intimate Organics | Nature Labs | Pjur USA | Sliquid | System Jo | Slyd | Tiger Lube | Uberlube | Westridge Labs | Wet International | Wicked Sensual Care | Zero Tolerance Toys

BEST ENHANCEMENT MANUFACTURER
Adventure Industries | Beamonstar | Classic Erotica | DTD Products (DonkeyMale.com) | Earthly Body | GoldReallas | Jelique | Kama Sutra | Masque Sexual Flavors | Priced-Right-Products | Rizer XL | Sobo Products | Sensuva | Shunga Erotic Art | Viamax

BEST FETISH MANUFACTURER
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BEST PRODUCT LINE FOR MEN
Jack-Aide Line, ZT Toys | Zolo Cups, Adult Brand Concepts | Ego, Jopen | PrimO, Screaming O | Create-A-Mate, PepRuss Creative | Cockslings, OxBalls | Fleshlight Girls, Fleshlight | MILF in a Box, Doc Johnson | RAM Collection, Nasstoys | Roto-Bators, Pipedream Products | Renegade, NS Novelties | Penthouse Pet Cyberskin Collection, Topco Sales

BEST PRODUCT LINE FOR WOMEN
Average Joe Collection, Topco Sales | B Classic Line, Bswish | Bodywand, Xgen Products | Diamond Collection, Adam & Eve | Entice, California Exotic Novelties | Envy, Jopen | Iroha line, Tenga | Le Réve, Pipedream Products | Love Candy By Kendra Vibrators, Evolved Novelties | Masquerade Masks, Baci Lingerie | Marc Dorcel Sextoys, Marc Dorcel | Ohm, Blush Novelties | Ovo Rabbits, Ovo | Smart Wands, LELO | Stronic Pulsators, Fun Factory USA

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BEST WEB RETAIL STORE
AdamEve.com | AdultDVDEmpire.com | AsYouLikeItpdx.com | DallasNovelty.com | EdenFantasys.com | Gamelink.com | HustlerStore.com | MyPleasure.com | Onjenoo.com | TLAVideo.com | PenthouseStore.com | PinkCherry.com | SexToy.com | Vibrator.com

BEST RETAIL CHAIN – SMALL (2-9 STORES)
Babeland | Carmen's Love Boutique | Crypto Techonology | Dreamers | Entice Couples Boutique/Sexy Suz | Eros 1207 | Exotica Superstore (Indiana) Fairvilla Megastore | Good Vibrations | Northwest Galaxy/Taboo | The Pleasure Chest | Pleasures Entertainment Centers | Pleasures (Alabama) Sara's Secret/Condoms to Go Sex World | VIP (Very Intimate Pleasures)

BEST RETAIL CHAIN – LARGE (10 STORES OR MORE)
Adam & Eve Stores | Amazing Superstores | Castle Megastores | Cirilla's | CW Whitewater | Déjà vu Love Boutique | Fascinations | Hustler Hollywood | Lion's Den | Lover's Lane | LSMT/New Fine Arts | Peekay (Lovers, ConRev, A Touch of Romance) | Priscilla McCall's | Romantix | Starship Enterprises

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Sales Rep	SH

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to Teri

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Thank you.

VIEW ENTIRE MESSAGE

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me Nov 4, 2013

to Teri

Hi Ms. Hernandez,
I just received the November 2013 issue of AVN magazine. Please forward a corrected invoice so that I may make my quarterly payment. Thank you.

VIEW ENTIRE MESSAGE

AVN ADULT ENTERTAINMENT EXPO 2016

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Phone: 702-463-0800 Fax: 702-463-0801

Email: drcobg@gmail.com

The reservation of a Sponsorship/Advertising Opportunity is based upon the terms set forth on this page and on the next page hereof and will become effective and binding upon acceptance by Show Management. The individual signing this contract warrants that he/she has been duly authorized to execute this binding agreement on behalf of the advertising/sponsoring company, if applicable, by his/her signature below. We agree to the Terms & Conditions of this Contract as stipulated here and within this document.

Accepted for Advertiser/Sponsor	**Accepted for *AVN Adult Entertainment Expo***
Authorized Signature	Authorized Signature
George P. Chambers, Jr., MD	
Print Name	Print Name
12/30/2015	
Date	Date

THIS FORM MUST BE RETURNED TO SHOW MANAGEMENT BY: **12/30/2015**

15:34

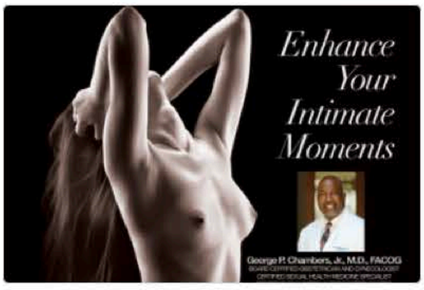
Dr George ad Advertisement

J

Jesse Dena Jan 4, 2016

to me, Sara

Hi, here is a lo rez copy of the ad please proof and let me know if it's ok to send.
Thank you!,
-jesse



G

me Jan 4, 2016

I love it! Cheers!

4

G

me Jan 4, 2016

Will do.

J

Jesse Dena Jan 5, 2016

to me

Thanks Doc!
Hope to see you at the show!!

Reply Forward

me Jan 29, 2016
to Sara

From George Chambers drcobg@gmail.com
To Sara Harter sara.harter@avn.com
Date Jan 29, 2016 at 10:11

Hi Sara,

Please remember to send me a copy of the AVN 2016 show guide to my office located at:

7220 S. Cimarron Rd. , Ste 200, Las Vegas, Nevada 89113.

Thank you,
- Dr. Chambers

Sara Harter Jan 29, 2016
to me

Hi George,

We're just waiting on our shipment to get back from the Show and I'll get it sent out asap.

Sara

me Jan 29, 2016

AVN Show 2017 - last chance!

Advertisement

Sara Harter Oct 31, 2016

to me

Good afternoon George,

We are almost sold out of booth space/sponsorships for the 2017 AVN Show; the largest adult event that takes place in Las Vegas, January 18-21, 2017 at the Hard Rock Hotel in Las Vegas. This convention features over 27,000 consumers, 6,000 trade and over 1,700 media. Reserve your space today before it's too late! The exhibit areas are split up as follows:

FESTIVAL HALL – (*ANE*) – January 18-20, 2017 – this is the only area designated for TRADE ONLY, no consumers/fans will be allowed to enter this portion of the hotel. This is an intimate area for manufacturers, retailers and distributors to network and write orders. The *ANE* portion of the event also offers private meeting rooms, pool villas and special sponsorship opportunities to reach your target audience. We also have a new exclusive event for ANE Exhibitors for a special meet-and-greet with mainstream media!

MUSE HALL – (*AEE*) – January 18-21, 2017 – this hall is primarily for production studios, but open to everyone. You may sell product(s) with show approval to the public, and must pay Nevada State tax (cash/check only). SOLD OUT

soon.

Sara

UPCOMING DEADLINES:

AVN Magazine – December issue

Artwork deadline: November 5, 2016

Intimate – Winter "LUBE" edition

Extra distribution at the AVN Show, AVN Novelty Expo, ANME

Artwork deadline: December 5, 2016

Sara Harter

Director of Sales

818-718-5788 ext 109

818-671-3917 direct

818-396-3154 fax

AIM: Sara2AVN

Sara.Harter@AVN.com **best way to reach me*

www.facebook.com/AVNSara

www.instagram.com/OfficialSaraHarter

G

me Jun 14, 2019

to Sara

Hello Ms. Harter,

I am interested in placing an ad in one of the 2020 AVN award program. Would you please send me information regarding my options. Thank you.

Reply Forward

EXHIBIT V

EXHIBIT V

14:07

New iMessage

Cancel

To: Casey Carden

No problem

Dec 13, 2021 at 10:35

Good morning Dr. C! So Hazel tested positive for Covid. I am negative according to home test but I wanted to let you know in case you want me to reschedule tomorrow

Yes, let's reschedule to 2

5

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, M.D., Respondent.**	**Case No. 22-27891-1**

FILED
SEP 27 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

AFFIDAVIT OF SERVICE

I, GEORGE J. TUIOTI, an employee of the Nevada State Board of Medical Examiners, being first duly sworn, declare under penalty of perjury under the laws of the State of Nevada that the following assertions are true to the best of my knowledge; and

I personally served on **September** 26, **2022 at** 2 : 10 ~~a.m.~~ / p.m. the following:

1. COMPLAINT and PATIENT DESIGNATION on Respondent, George Peter Chambers, M.D. at:

[redacted]

Further your Affiant sayeth naught.

GEORGE J. TUIOTI

STATE OF Nevada)
) ss. Las Vegas
COUNTY OF Clark)

SUBSCRIBED and SWORN to before me by George Tuioti on this 26th day of September, 2022.

Notary Public

ROSEMARY CHAMPLAIN
Notary Public, State of Nevada
Appointment No. 18-3930-1
My Appt. Expires Oct 12, 2022

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, M.D., Respondent.**	**Case No. 22-27891-1**

FILED

OCT 17 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

PROOF OF SERVICE

I, Mercedes Fuentes, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on September 27, 2022, I sent the required fingerprinting packet contating the card with instructions to:

GEORGE PETER CHAMBERS, M.D.

[redacted]

via USPS Certified Mail, tracking number 9171969009350254761686. Due to issues with the certified mailing not being able to be delivered or picked up from the local post office, another fingerprinting packet was re-sent to the office of Maria Nutile, Esq., counsel for Respondent on October 11, 2022, via Fed Ex 2-Day with adult signature, and was delivered on October 12, 2022. *See* **Exhibit 1**.

DATED this 17th day of October, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT 1

EXHIBIT 1

FedEx

October 17, 2022

Dear Customer,

The following is the proof-of-delivery for tracking number: 770172582295

Delivery Information:			
Status:	Delivered	**Delivered To:**	Receptionist/Front Desk
Signed for by:	M.BRIDGET	**Delivery Location:**	
Service type:	FedEx 2Day		
Special Handling:	Deliver Weekday; Adult Signature Required		LAS VEGAS, NV,
		Delivery date:	Oct 12, 2022 09:41

Shipping Information:			
Tracking number:	770172582295	**Ship Date:**	Oct 11, 2022
		Weight:	0.5 LB/0.23 KG

Recipient:	**Shipper:**
LAS VEGAS, NV, US,	Reno, NV, US,

Signature image is available. In order to view image and detailed information, the shipper or payor account number of the shipment must be provided.

Thank you for choosing FedEx

Maria Nutile, Esq.
Nevada Bar No.: 7847
Bridget Kelly, Esq.
Nevada Bar No.: 14388
NUTILE LAW
7395 S. Pecos Rd., Suite 103
Las Vegas, Nevada 89120
Telephone: (702) 307-4880
Facsimile: (702) 307-4881
Email: maria@nutilelaw.com
bridget@nutilelaw.com

Attorneys for George Peter Chambers, Jr., M.D.

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.,** **Respondent.**	**CASE NO.: 22-27891-1** **ANSWER AND NOTICE OF DEFENSE**

Respondent above named, in answer to the Complaint filed in the above-titled matter before the Nevada State Board of Medical Examiners (the "Board"), admits, denies, and alleges as follows:

a. With regard to Paragraph 1, Respondent admits that the Board has jurisdiction over this matter, that Respondent held and still holds License No. 10476 issued April 30, 2003, and that Respondent specializes in obstetrics and gynecology.

b. Paragraphs 2 through 4 do not contain allegations against the Respondent. To the extent an answer is required, the Respondent denies the allegations in these paragraphs.

PATIENT A

d. Paragraphs 5 and 6 do not contain allegations against the Respondent. To the extent an answer is required, the Respondent denies the allegations in these paragraphs.

e. With regard to Paragraph 7, Respondent admits the allegations in this paragraph.

f. With regard to Paragraph 8:

1. Respondent admits he used Patient A's cellular telephone to take photographs of Patient A's vaginal and anal areas during the course of his examination; but

2. Respondent is without sufficient knowledge as to the total number of photographs he took with Patient A's cellular telephone upon which to base a belief as to the truth of the allegation that he took approximately twelve (12) such photographs during the course of his examination, and therefore denies such allegation contained in this paragraph.

g. With regard to Paragraph 9, Respondent is without sufficient knowledge upon which to base a belief as to the truth of the allegations contained therein, and therefore denies each and every allegation contained therein.

h. With regard to Paragraph 10, Respondent denies the allegations in this paragraph.

1. Respondent admits he requested Patient A to send two (2) of the photographs he took with her cellular telephone to his cellular telephone via text message.

2. Respondent is without sufficient knowledge as to the total number of photographs he took with Patient A's cellular telephone upon which to base a belief as to the truth of the allegation that he took approximately twelve (12) such photographs during the course of his examination, and therefore denies such allegation contained in this paragraph.

i. With regard to Paragraph 11, Respondent denies the allegations in this paragraph.

1. Respondent admits neither of the two (2) photographs he requested Patient A to send to his cellular telephone via text message was a photograph of Respondent inserting four (4) fingers into Patient A's vagina.

2. Respondent is without sufficient knowledge upon which to base a belief as to the truth of the allegation that one of the photographs he took with Patient A's cellular telephone was a photograph of Respondent inserting four (4) fingers into Patient A's vagina, and therefore denies such allegation contained in this paragraph.

j. With regard to Paragraph 12:

1. Respondent is without sufficient knowledge upon which to base a

belief as to the truth of the allegations contained therein, and therefore denies each and every allegation contained therein; and

2. Respondent OBJECTS to each and every allegation contained therein as irrelevant to support any of the charges against Respondent; and/or as presenting a danger of unfair prejudice against Respondent, confusion of the issues, and/or misleading the adjudicators in this matter.

k. With regard to Paragraphs 13 and 14, Respondent admits the allegations contained in these paragraphs.

l. With regard to Paragraph 15:

1. Respondent admits he did not document in the medical record, nor inform the IC during its investigation, that during the November 17, 2020 encounter with Patient A he inserted four (4) fingers into her vagina; but

2. Respondent is without sufficient knowledge upon which to base a belief as to the truth of the allegation that he did insert four (4) fingers into Patient A's vagina during the November 17, 2020 encounter with Patient A, and therefore denies such allegation contained in this paragraph.

m. With regard to Paragraph 16, Respondent denies the allegations in this paragraph.

n. With regard to Paragraph 17, Respondent admits the allegations contained in this paragraph.

o. With regard to Paragraph 18:

1. Respondent is without sufficient knowledge upon which to base a belief as to the truth of the allegations contained therein, and therefore denies each and every allegation contained therein; and

2. Respondent OBJECTS to each and every allegation contained therein as irrelevant to support any of the charges against Respondent; and/or as presenting a danger of unfair prejudice against Respondent, confusion of the issues, and/or misleading the adjudicators in this matter.

n. With regard to Paragraphs 19 and 20, Respondent denies the allegations in these paragraphs.

p. With regard to Paragraph 21:

1. Respondent denies the allegations in this paragraph; and

2. Respondent OBJECTS to each and every allegation contained therein as irrelevant to support any of the charges against Respondent; and/or as presenting a danger of unfair prejudice against Respondent, confusion of the issues, and/or misleading the adjudicators in this matter.

q. With regard to Paragraph 22, Respondent respectively admits, denies, and/or objects to each of the preceding allegations as set forth above.

r. With regard to Paragraph 23, Respondent states this paragraph requires no response.

s. With regard to Paragraph 24, Respondent denies the allegations in this paragraph.

t. With regard to Paragraph 25, Respondent states this paragraph requires no response.

u. With regard to Paragraph 26, Respondent respectively admits, denies, and/or objects to each of the preceding allegations as set forth above.

v. With regard to Paragraph 27, Respondent states this paragraph requires no response.

w. With regard to Paragraph 28, Respondent denies the allegations in this paragraph.

x. With regard to Paragraph 29, Respondent states this paragraph requires no response.

y. With regard to Paragraph 30, Respondent respectively admits, denies, and/or objects to each of the preceding allegations as set forth above.

z. With regard to Paragraph 31, Respondent states this paragraph requires no response.

aa. With regard to Paragraphs 32, 33, and 34, Respondent denies the allegations in these paragraphs.

bb. With regard to Paragraph 35, Respondent states this paragraph requires no response.

cc. With regard to Paragraph 36, Respondent respectively admits, denies, and/or objects to each of the preceding allegations as set forth above.

dd. With regard to Paragraph 37, Respondent states this paragraph requires no response.

ee. With regard to Paragraph 38, Respondent denies the allegations in this paragraph.

ff. With regard to Paragraph 39, Respondent states this paragraph requires no response.

PATIENT B

gg. Paragraphs 40 and 41 do not contain allegations against the Respondent. To the extent an answer is required, the Respondent denies the allegations in these paragraphs.

hh. With regard to Paragraphs 42, 43, 44, and 45 Respondent denies the allegations in these paragraphs.

1. Patient B asked Respondent about a flyer posted in Respondent's patient lavatory seeking models for a print advertisement promoting Respondent's practice, particularly cosmetic gynecology and sexual health medicine services, within the adult entertainment industry. Specifically, the advertisement would run in the program for the 2019 Adult Video News (AVN) Awards, a ceremony held annually in Las Vegas.[1]

2. Respondent responded to Patient B that the advertisement would utilize nude photographs taken by a professional photographer, for which the model would be compensated $1,000 and provided copies of the photographs.

3. Patient B had the opportunity to serve as a model for the advertisement if she so desired. Patient B was not required, expected, or coerced to model for the advertisement, nor was Patient B's medical care conditioned in any way upon her choosing to serve as a model for the advertisement. Patient B decided not to serve as a model for the advertisement.

ii. With regard to Paragraph 46, Respondent states this paragraph requires no response.

jj. With regard to Paragraph 47, Respondent denies the allegations contained in this paragraph.

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[1] https://en.wikipedia.org/wiki/36th_AVN_Awards. The 2019 AVN Awards show was held at the Hard Rock Hotel, broadcast on Showtime, and Cardi B. made history as the AVN Awards' first female musical performer. https://www.rollingstone.com/music/music-news/cardi-b-2019-avn-awards-785104/

kk. With regard to Paragraph 48, Respondent states this paragraph requires no response.

PATIENT C

ll. Paragraphs 49, and 50 do not contain allegations against the Respondent. To the extent an answer is required, the Respondent denies the allegations in these paragraphs.

mm. With regard to Paragraph 51, Respondent denies that Patient C was seen on October 15, 2019. Patient C's medical record indicates she was seen, in pertinent part, on September 24, 2019; October 8, 2019; and November 11, 2019.

nn. With regard to Paragraph 52, this allegation lacks specificity as to the date, location, mode, or other context to the alleged communication. Respondent is therefore without sufficient knowledge upon which to base a belief as to the truth of the allegations contained therein, and therefore denies each and every allegation contained therein. Patient C asked Respondent about a flyer posted in Respondent's patient lavatory seeking models for a print advertisement promoting Respondent's practice.

oo. With regard to Paragraph 53, Respondent is without sufficient knowledge upon which to base a belief as to the truth of the allegations contained therein, and therefore denies each and every allegation contained therein.

pp. With regard to Paragraphs 54 and 55, Respondent denies the allegations in these paragraphs.

qq. With regard to Paragraph 56, Respondent respectively admits, denies, and/or objects to each of the preceding allegations as set forth above.

rr. With regard to Paragraph 57, Respondent states this paragraph requires no response.

ss. With regard to Paragraph 58, Respondent denies the allegations in this paragraph.

tt. With regard to Paragraph 59, Respondent states this paragraph requires no response.

PATIENTS A, B, AND C

uu. With regard to Paragraphs 60, 61, and 62, Respondent denies the allegations in this paragraph.

vv. With regard to Paragraph 63, Respondent respectively admits, denies, and/or objects to each of the preceding allegations as set forth above.

ww. With regard to Paragraph 64, Respondent states this paragraph requires no response.

xx. With regard to Paragraph 65, Respondent denies the allegations in this paragraph.

yy. With regard to Paragraph 66, Respondent states this paragraph requires no response.

zz. With regard to Paragraph 67, Respondent respectively admits, denies, and/or objects to each of the preceding allegations as set forth above.

aaa. With regard to Paragraph 68, Respondent states this paragraph requires no response.

bbb. With regard to Paragraph 69, Respondent denies the allegations in this paragraph.

ccc. With regard to Paragraph 70, Respondent states this paragraph requires no response.

///

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I hereby declare, under penalty of perjury, that the foregoing Answer and Notice of Defense, and all facts therein stated, are true and correct to best of my knowledge.

Dated this 17th day of October, 2022.

On behalf of Respondent:

NUTILE LAW

Maria Nutile, Esq.
Nevada Bar No.: 7847
Bridget Kelly, Esq.
Nevada Bar No.: 14388
NUTILE LAW
7395 S. Pecos Rd., Suite 103
Las Vegas, Nevada 89120
Telephone: (702) 307-4880
Facsimile: (702) 307-4881
Email: maria@nutilelaw.com
bridget@nutilelaw.com

CERTIFICATE OF SERVICE

I hereby certify that I am an employee of NUTILE LAW, and that on this 17th day of October, 2022, I caused to be filed via email an electronic copy of the foregoing Answer and Notice of Defense to the following at the Nevada State Board of Medical Examiners:

Brandee Mooneyhan, J.D., Deputy General Counsel mooneyhanb@medboard.nv.gov.

/s/ Bridget Kelly
An employee of NUTILE LAW

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

FILED
OCT 26 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBER, M.D., Respondent.**	**Case No. 22-27891-1** **Early Case Conference: October 31, 2022, at 1:30 p.m.**

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

ORDER SETTING EARLY CASE CONFERENCE

TO: Brandee Mooneyhan, J.D.
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

~and~

George P. Chamber, M.D.
c/o Maria Nutile, Esq.
7395 S. Pecos Road, Ste. 103
Las Vegas, NV 89120

NOTICE IS HEREBY GIVEN in compliance with NRS 630.339(3)[1], an Early Case Conference will be conducted on October 31, 2022, beginning at the hour of 1:30 p.m. The Early Case Conference will be held via conference call. The conference call number is (605) 313-5564

[1] Within 20 days after the filing of an answer or 20 days after the date on which an answer is due, whichever is earlier, the parties shall hold an early case conference at which the parties and a hearing officer appointed by the Board or a member of the Board must preside. At the early case conference, the parties shall in good faith:
(a) Set the earliest possible hearing date agreeable to the parties and the hearing officer, panel of the Board or the Board, including the estimated duration of the hearing;
(b) Set dates:
(1) By which all documents must be exchanged;
(2) By which all prehearing motions and responses thereto must be filed;
(3) On which to hold the prehearing conference; and
(4) For any other foreseeable actions that may be required for the matter;
(c) Discuss or attempt to resolve all or any portion of the evidentiary or legal issues in the matter;
(d) Discuss the potential for settlement of the matter on terms agreeable to the parties; and
(e) Discuss and deliberate any other issues that may facilitate the timely and fair conduct of the matter.

and the access code is 4033717#.

The scheduled Early Case Conference shall be attended by the parties in person or by any party's legal counsel of record and will be conducted by the undersigned Hearing Officer to discuss designate the dates for the Pre-Hearing Conference and Hearing and other procedural matters established in NRS 630.339.

At the Pre-Hearing Conference, in accordance with NAC 630.465[2], each party shall provide the other party with a copy of the list of witnesses they intend to call to testify, including therewith, the qualifications of each witness so identified, and a summary of the testimony of each witness. If a witness id not on the list of witnesses, that witness may subsequently not be allowed to testify at the Hearin unless good cause is shown for omitting the witness from said list[3]. Likewise, all evidence, except rebuttal evidence, that is not provided to each party at the Pre-Hearing Conference may also not be introduced or admitted at the Hearing unless good cause is shown.

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

---

[2] 1. At least 30 days before a hearing but not earlier than 30 days after the date of service upon the physician or physician assistant of a formal complaint that has been filed with the Board pursuant to NRS 630.311, unless a different time is agreed to by the parties, the presiding member of the Board or panel of members of the Board or the hearing officer shall conduct a prehearing conference with the parties and their attorneys. All documents presented at the prehearing conference are not evidence, are not part of the record and may not be filed with the Board.

2. Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.

3. All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown.

4. Each party shall submit to the presiding member of the Board or panel or to the hearing officer conducting the conference each issue which has been resolved by negotiation or stipulation and an estimate, to the nearest hour, of the time required for presentation of its oral argument.

(Added to NAC by Bd. of Medical Exam'rs, eff. 1-13-94; A by R149-97, 3-30-98; R167-99, 1-19-2000; R108-01, 11-29-2001)

[3]In identifying a patient as a witness, parties are cautioned to omit from any pleadings filed with undersigned Hearing Officer any addresses, telephone numbers, social security numbers or other personal information regarding that individual and to confine their submissions in this regard to the name of witness, the relevancy of any testimony sought to be elicited from that witness and a summary of their anticipated testimony.

IT IS FURTHER ORDERED that legal counsel for the Nevada State Board of Medical Examiners and the Respondent shall keep undersigned Hearing Officer advised of each issue which has been resolved by negotiation or stipulation, if any. At the Early Case Conference, the parties must also provide an estimate, to the nearest hour, of time required for presentation of their respective cases.

IT IS SO ORDERED.

DATED this 24th day of October, 2022.

NANCY L. MOSS GHUSN, ESQ.
Administrative Hearing Officer
Tel: 775-772-5644
Email: nmg416@gmail.com

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I certify that on this day, I served by personally delivering or mailing, postage pre-paid, a true and correct file-stamped copy of the foregoing **ORDER SETTING EARLY CASE CONFERENCE** to the following parties:

Brandee Mooneyhan, J.D.
Deputy General Counsel
Nevada State Board of Medical Examiners
mooneyhanb@medboard.nv.gov
9600 Gateway Drive
Reno, NV 89521

George P. Chamber, M.D.
c/o Maria Nutile, Esq.
maria@nutilelaw.com
7395 S. Pecos Road, Ste. 103
Las Vegas, NV 89120

DATED this 26th day of October, 2022.

Signature

Mercedes Fuentes
Printed Name

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: GEORGE PETER CHAMBERS, M.D., Respondent.	**Case No. 22-27891-1**

FILED
NOV 15 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

SCHEDULING ORDER

TO: Brandee Mooneyhan, J.D.
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

~and~

George P. Chambers, M.D.
c/o Maria Nutile, Esq.
7395 S. Pecos Road Ste. 103
Las Vegas, NV 89120

On October 31, 2022, an Early Case Conference was held via *Zoom* conference call. Together with Hearing Officer Nancy Moss Ghusn, Brandee Mooneyhan, J.D., Deputy General Counsel, appeared on behalf of the Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) and Maria Nutile, Esq., appeared on behalf of Respondent George P. Chambers, M.D.

In compliance with Nevada Administrative Code 630.465, a prehearing conference will be conducted on **November 21, 2022, via *Zoom* (either with or without video is acceptable) beginning at the hour of 1:30 p.m. Pacific Daylight Time.** The *Zoom* teleconference has been coordinated by the Hearing Officer and links have been sent.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

All parties shall exchange witness and documents intended for use at the hearing on or before the pre-hearing conference. This list shall include the qualifications and anticipated testimony of the witness and the Bates stamp numbers on each of the exhibits. If a witness is not included on the list, that witness may not be allowed to testify at the hearing unless good cause is shown for their testimony. Likewise, if a document has not been listed in a prehearing conference statement, it may not be admitted into evidence unless good cause is shown for its admittance.

All prehearing motions shall be served on all parties and this hearing officer on a date to be determined at the Pre-Hearing Conference, as well as releated Responses, Oppositions, and Replies. Service of prehearing motions, responses and replies may be effectuated by U.S. Mail or by electronic mail (e-mail) to all parties known email addresses and this hearing officer.

The formal hearing in this matter will be scheduled at the Pre-Hearing Conference, when it will be determined whether the instant hearing will be an in-person hearing in Las Vegas, Nevada, rather than a remote hearing. A court reporter will take sworn testimony during the formal hearing and will produce a transcript to the hearing officer and all parties at their request and at their expense.

Once the formal hearing is concluded the hearing officer will submit to the Board a synopsis of the testimony recorded by the court reporter and will make a recommendation on the veracity of witnesses, if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the Board will render its decision. *See* NAC 630.470.

If a witness wishes to appear remotely[1] a request must be made to the hearing officer and the hearing officer must approve via order for appearance by the witness remotely. A request must be made in writing for a remote appearance on a date to be determined at the Pre-Hearing Conference.

Stipulation to stay the above dates shall be made to the hearing officer either by email or by formal, filed stipulation as soon as the parties are aware of the necessity for a stay. Any stay request will require a status conference to be set unless a formal settlement agreement is being presented to the Board at the next regularly held Board meeting. If a formal settlement agreement is being placed on the Board meeting agenda, notification of acceptance or denial of the settlement agreement by the

[1] Remotely means witness appearances not occurring in the Las Vegas office or Reno office of the Nevada State Board of Medical Examiners.

Board shall be delivered to this hearing officer no later than five (5) days after the Board meeting by the Board attorney.

All parties to this case are required to keep the hearing office informed of events, progress and resolution of this case.

IT IS SO ORDERED.

DATED this 14th day of November, 2022.

NANCY MOSS GHUSN, ESQ.
Email: nmg416@gmail.com
Tel: (775) 772-5644
Hearing Officer

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, M.D.** **Respondent.**	**Case No. 22-27891-1**

FILED

NOV 15 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Scheduling Order, filed on November 15, 2022.

I. LIST OF WITNESSES

The IC of the Board lists the following witnesses whom it may call at the hearing on the charges in the Complaint against Respondent filed herein:

a. Johnna LaRue, Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ms. LaRue is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Patient A
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Patient A is expected to testify regarding her encounter with Respondent on November 17, 2020.

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c. Casey Carden
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ms. Carden is expected to testify regarding her interactions with Patient A and Respondent on November 17, 2020.

d. Patient B
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Patient B is expected to testify regarding her encounter with Respondent on or about October 29, 2018.

e. Patient C
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Patient C is expected to testify regarding her encounter with Respondent on or about October 15, 2019.

f. Richard W. Rafael, M.D.
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Dr. Rafael is expected to testify regarding his review of this case and Respondent's care of Patient A, Patient B, and Patient C.

g. George Peter Chambers, M.D.
c/o Maria Nutile, Esq.
Nutile Law
7395 S. Pecos Road, Ste. 103
Las Vegas, NV 89120

Dr. Chambers is expected to testify as to his conduct and to respond to the allegations in the Complaint.

h. All witnesses identified by Respondent in his prehearing conference statement and/or in any subsequent amended, revised, or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons he may call to testify at the hearing herein.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

II. LIST OF EXHIBITS

The IC of the Board lists the following exhibits that it may introduce at the hearing on the charges in the Complaint against Respondent filed herein. Additionally, the IC of the Board reserves the right to rely on all exhibits listed in Respondent's prehearing conference statement and any supplement and/or amendment thereof.

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
1	Board's Allegation Letter to Dr. Chambers Regarding Patient A and accompanying Order to Produce Health Care Records, dated September 2, 2021	0001-0005
2	Dr. Chambers's Response to Board's Allegation Letter Regarding Patient A, dated January 20, 2022	0006-0014
3	Patient A's Medical Records provided by Dr. Chambers in response to Order to Produce Health Care Records	0015-0028
4	Photographs of Patient A taken by Dr. Chambers with Patient A's cellular telephone	0029-0040
5	Board's Allegation Letter to Dr. Chambers Regarding Patient B and accompanying Order to Produce Health Care Records, dated February 3, 2022	0041-0044
6	Dr. Chambers's Response to Board's Allegation Letter Regarding Patient B, dated March 17, 2022	0045-0046
7	Patient B's Medical Records provided by Dr. Chambers in response to Order to Produce Health Care Records	0047-0136
8	Board's Allegation Letter to Dr. Chambers Regarding Patient C and accompanying Order to Produce Health Care Records, dated February 17, 2022	0137-0140
9	Dr. Chambers's Response to Board's Allegation Letter Regarding Patient C, dated March 17, 2022	0141-0142
10	Patient C's Medical Records provided by Dr. Chambers in response to Order to Produce Health Care Records	0143-0155

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

11	Ethics Committee Opinion No. 796, The American College of Obstetricians and Gynecologists: "Sexual Misconduct" (January 2020)	0156-0163
12	Practice Bulletin No. 214, The American College of Obstetricians and Gynecologists: "Pelvic Organ Prolapse" (Interim Update, November 2019)	0164-0180
13	Report & Recommendations of the Federation of State Medical Boards Workgroup on Physician Sexual Misconduct: "Physician Sexual Misconduct" (May 2020)	0181-0211
14	Journal of Missouri State Medical Association, Vol. 109(3): "Sexual Misconduct by Professionals: A New Paradigm of Understanding" by George E. Skipper, M.D., and Stephen Schenthal, M.D. (May-June 2012).	0212-0214
15	Code of Professional Ethics of the American College of Obstetricians and Gynecologists (2018)	0215-0218
16	Curriculum Vitae for Dr. Richard W. Rafael	0219-0235

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

DATED this 15th day of November, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

BRANDEE MOONEYHAN, J.D.
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: mooneyhanb@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 15th day of November, 2022, I served a file-stamped copy of the foregoing **PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS**, with accompanying Exhibits 1-16 via Fed Ex 2-Day with Adult Signature Required to:

GEORGE PETER CHAMBERS, M.D.
c/o Maria Nutile, Esq.
Bridget Kelly, Esq.
Nutile Law
7395 S. Pecos Road, Ste. 103
Las Vegas, NV 89120
**Tracking No.: 7705 0159 8410*
Attorneys for Respondent

And by USPS Regular Mail to:

NANCY L. MOSS GHUSN, ESQ.
675 W. Moana Ln., Ste. 107
Reno, NV 89509
Hearing Officer

DATED this 15th day of November, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, M.D., Respondent.**	**Case No. 22-27891-1**

FILED
NOV 16 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

PROOF OF SERVICE

I, Mercedes Fuentes, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on November 15, 2022, I sent a filed stamped copy of the **PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS**, with accompanying Exhibitis 1-16 to:

GEORGE PETER CHAMBERS, M.D.
c/o Maria Nutile, Esq.
Bridget Kelly, Esq.
Nutile Law
7395 S. Pecos Road
Las Vegas, NV 89120

via Fed Ex 2-Day mailing with adult signature required, tracking number 770501598410, and was delivered on November 16, 2022. *See* **Exhibit 1**.

DATED this 16th day of November, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT 1

EXHIBIT 1

FedEx

November 16, 2022

Dear Customer,

The following is the proof-of-delivery for tracking number: 770501598410

Delivery Information:			
Status:	Delivered	**Delivered To:**	Receptionist/Front Desk
Signed for by:	M.BRIDGET	**Delivery Location:**	
Service type:	FedEx 2Day AM		
Special Handling:	Deliver Weekday; Adult Signature Required		LAS VEGAS, NV,
		Delivery date:	Nov 16, 2022 09:35

Shipping Information:			
Tracking number:	770501598410	**Ship Date:**	Nov 15, 2022
		Weight:	3.0 LB/1.36 KG

Recipient:	**Shipper:**
LAS VEGAS, NV, US,	Reno, NV, US,

Signature image is available. In order to view image and detailed information, the shipper or payor account number of the shipment must be provided.

Thank you for choosing FedEx

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FedEx® Tracking

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Wednesday

11/16/2022 at 9:35 am

Signed for by: M.BRIDGET

Obtain Proof of delivery

DELIVERY STATUS

Delivered

TRACKING ID

770501598410

FROM
Reno, NV US

Label Created
11/15/2022 2:44 PM

PACKAGE RECEIVED BY FEDEX
RENO, NV
11/15/2022 4:00 PM

IN TRANSIT
LAS VEGAS, NV
11/16/2022 7:08 AM

OUT FOR DELIVERY
LAS VEGAS, NV
11/16/2022 8:25 AM

DELIVERED
LAS VEGAS, NV US

DELIVERED
11/16/2022 at 9:35 AM

↓ View travel history

Want updates on this shipment? Enter your email and we will do the rest!

YOUR EMAIL

SUBMIT

Manage Delivery

Maria Nutile, Esq.
Nevada Bar No.: 7847
Bridget Kelly, Esq.
Nevada Bar No.: 14388
NUTILE LAW
7395 S. Pecos Rd., Suite 103
Las Vegas, Nevada 89120
Telephone: (702) 307-4880
Facsimile: (702) 307-4881
Email: maria@nutilelaw.com
bridget@nutilelaw.com

Attorneys for George Peter Chambers, Jr., M.D.

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.,** **Respondent.**	**CASE NO.: 22-27891-1**

PREHEARING CONFERENCE STATEMENT OF RESPONDENT GEORGE P. CHAMBERS, JR., M.D.

Respondent George P. Chambers, Jr., M.D., by and through his attorneys Maria Nutile, Esq. and Bridget Kelly, Esq. of Nutile Law, submits the following Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Scheduling Order, filed November 15, 2022.

I. LIST OF WITNESSES

Respondent lists the following witnesses whom he may call at the hearing on the charges in the Complaint against him filed herein:

a. Michael P. Goodman, M.D.

c/o Nutile Law
7395 S. Pecos Rd., Ste. 103
Las Vegas, NV 89120

Dr. Goodman is expected to testify as an expert in female genital plastic and cosmetic surgery; and as to the training, qualifications, and character of Respondent.

b. Maria McPhee, APRN

c/o Nutile Law
7395 S. Pecos Rd., Ste. 103
Las Vegas, NV 89120

APRN McPhee is a current patient, former nursing student who rotated through Dr. Chambers's practice, former subtenant of Dr. Chambers, and occasional chaperone to Dr. Chambers while subletting office space. She is expected to testify as to Dr. Chambers's character, demeanor, office practices and standards, and medical training provided by Dr. Chambers to APRN McPhee

c. Brittany Turner

c/o Nutile Law
7395 S. Pecos Rd., Ste. 103
Las Vegas, NV 89120

Ms. Turner is a patient of Dr. Chambers and is expected to testify as to Dr. Chambers's character, demeanor, and office practices and standards.

d. Kendra Millard

c/o Nutile Law
7395 S. Pecos Rd., Ste. 103
Las Vegas, NV 89120

Ms. Millard is a patient of Dr. Chambers and former model for some of his print advertisements, and is expected to testify as to Dr. Chambers's character, demeanor, and office practices and standards.

e. All witnesses identified by the Investigative Committee (IC) of the Nevada State Board of Medical Examiners (NSBME) in its prehearing conference statement and/or any subsequent amended, revised, or supplemental prehearing conference statement, or list of witnesses disclosed by the IC and/or the NSBME of persons it may call to testify at the hearing herein.

Respondent reserves the right to amend and supplement this list as required to defend himself in this case.

II. LIST OF EXHIBITS

Respondent lists the following exhibits which it may introduce at the hearing on the charges in the Complaint filed against him by the IC herein. Additionally, Respondent reserves the right to rely on all exhibits listed in the prehearing conference statement of the IC of the NSBME and any supplement or amendment hereof.

EXHIBIT NO.	DESCRIPTION	BATES RANGE (CHAMBERS)
A	Curriculum Vitae, George P. Chambers, Jr., M.D.	001-004
B	Female Genital Plastic/Cosmetic Surgery Masters Course certificate (2013)	005
C	American Academy of Anti-Aging Medicine, Sexual Health Certification certificate (2014) and program description	006-010
D	National Society of Cosmetic Surgeons, 7th Annual Congress on Aesthetic Vaginal Surgery, October 20-21, 2012 (Red M. Alinsod, M.D.), certificate of completion and course workbook	011-018
E	Forensic Psychiatric Report by Gregory P. Brown M.D., April 16, 2021	019-023
F	Physician Communication Percentile Ranks, January 2020 – May 2022, Spring Valley Hospital and Medical Center	024
G	Chambers & Assoc. print advertisement	025
H	Patient A color medical record photographs	026-027
I	Women's Health, "What Exactly Is A Designer Vagina? What To Know About Labiaplasty," February 2020	028-033
J	*Aesthetic Surgery Journal*, "Guidelines for the Standardization of Genital Photography," 2018	034-041
K	Textbook, *Female Genital Plastic and Cosmetic Surgery*, Michael P. Goodman, M.D., Editor	042-073
L	PRS Global Open, "The Safe Practice of Female Genital Plastic Surgery," 2021	074-084
M	*Ultrasound in Obstetrics and Gynecology*, "Vaginal laxity: which measure of levator ani distensibility is most predictive?" 2020	085-089
N	*Annals of Translational Medicine*, "The strategy for vaginal rejuvenation: CO_2 laser or vaginoplasty?" 2021	090-096
O	*Canadian Journal of Emergency Nursing*, "Fisting—What is it and why should I have a high index of suspicion?" 2016	097-099
P	NORCAL Group/ProAssurance, "Shared Decision Making During the Informed Consent Process," 2018	100-104
Q	ACOG Committee Opinion No. 795, "Elective Female Genital Cosmetic Surgery," 2020	105-111

R	Curriculum Vitae, Michael P. Goodman, M.D.	112-126
S	Genital cosmetic surgery photography examples, South Coast Urogynecology (Red M. Alinsod, M.D.), www.urogyn.org	127-157
T	Patient Information Booklet, Aesthetic Vulvovaginal Surgery at South Coast Urogynecology (Red M. Alinsod, M.D.), 2018 www.urogyn.org	158-239

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I hereby declare, under penalty of perjury, that the foregoing Answer and Notice of Defense, and all facts therein stated, are true and correct to best of my knowledge.

Dated this 21st day of November 2022.

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On behalf of Respondent:

NUTILE LAW

/s/ Maria Nutile

Maria Nutile, Esq.
Nevada Bar No.: 7847
Bridget Kelly, Esq.
Nevada Bar No.: 14388
NUTILE LAW
7395 S. Pecos Rd., Suite 103
Las Vegas, Nevada 89120
Telephone: (702) 307-4880
Facsimile: (702) 307-4881
Email: maria@nutilelaw.com
bridget@nutilelaw.com

CERTIFICATE OF SERVICE

I hereby certify that I am an employee of NUTILE LAW, and that on this 21st day of November 2022, I caused to be served a copy of the foregoing **PREHEARING CONFERENCE STATEMENT OF RESPONDENT GEORGE P. CHAMBERS JR., M.D.,** with accompanying Exhibits A through T, to the following:

Nevada State Board of Medical Examiners

Via FedEx to:

9600 Gateway Dr.
Reno, NV 90521
Attn: Brandee Mooneyhan, J.D., Deputy General Counsel

Digital copy via Citrix Sharefile to:

mooneyhanb@medboard.nv.gov.

Hearing Officer

Via USPS Certified Mail to:

Nancy L. Moss Ghusn, Esq.
675 W. Moana Ln, Ste. 107
Reno, NV 89509

Digital copy via Citrix Sharefile to:

nmg416@gmail.com

/s/ Bridget Kelly
An employee of NUTILE LAW

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, M.D., Respondent.**	**Case No. 22-27891-1**

FILED
DEC - 6 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

ORDER SETTING HEARING

TO: Brandee Mooneyhan, J.D.
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

~and~

George P. Chambers, M.D.
c/o Maria Nutile, Esq.
7395 S. Pecos Road Ste. 103
Las Vegas, NV 89120

On November 21, 2022, a prehearing conference was held via *Zoom* conference call. Together with Hearing Officer Nancy Moss Ghusn, Brandee Mooneyhan, J.D., Deputy General Counsel, appeared on behalf of the Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) and Maria Nutile, Esq., appeared on behalf of Respondent George P. Chamber, M.D.

At the outcome of the prehearing conference, it was determined that all prehearing motions shall be served on all parties and this hearing officer by **January 5, 2023**. Responses and Oppositions to pre-hearing motions shall be served on or before **January 13, 2023**. Replies, if any, shall be served on or before **January 20, 2023.** Counsel shall inform the hearing officer if they do not intend to submit Replies as soon as possible after **January 13, 2023.** Service of prehearing

motions, responses and replies may be effectuated by U.S. Mail or by electronic mail (e-mail) to all parties known email addresses and this hearing officer.

The formal hearing in this matter will be scheduled for **9:00 a.m. on February 15-16, 2023**, and will be held at the Las Vegas office of the Nevada State Board of Medical Examiners at 325 E. Warm Springs Rd., Suite 225, Las Vegas, Nevada, and will be in-person rather than a remote hearing. However, counsel agree that some witnesses may appear remotely. A court reporter will take sworn testimony during the formal hearing and will produce a transcript to the hearing officer and all parties at their request and at their expense.

Once the formal hearing is concluded the hearing officer will submit to the Board a synopsis of the testimony recorded by the court reporter and will make a recommendation on the veracity of witnesses, if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the Board will render its decision. *See* NAC 630.470.

If a witness wishes to appear remotely[1] a request must be made to the hearing officer and the hearing officer must approve via order for appearance by the witness remotely. A request must be made in writing for a remote appearance on a date to be determined at the Pre-Hearing Conference.

Stipulation to stay the above dates shall be made to the hearing officer either by email or by formal, filed stipulation as soon as the parties are aware of the necessity for a stay. Any stay request will require a status conference to be set unless a formal settlement agreement is being presented to the Board at the next regularly held Board meeting. If a formal settlement agreement is being placed on the Board meeting agenda, notification of acceptance or denial of the settlement agreement by the Board shall be delivered to this hearing officer no later than five (5) days after the Board meeting by the Board attorney.

All parties to this case are required to keep the hearing office informed of events, progress and resolution of this case.

IT IS SO ORDERED.

DATED this 4th day of December, 2022.

[1] Remotely means witness appearances not occurring in the Las Vegas office or Reno office of the Nevada State Board of Medical Examiners.

NANCY MOSS GHUSN, ESQ.
Email: nmg416@gmail.com
Tel: (775) 772-5644
Hearing Officer

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, M.D.** **Respondent.**	**Case No. 22-27891-1**

FILED
JAN - 5 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

MOTION TO PROTECT PATIENT LIKENESSES

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through its undersigned counsel, hereby moves the Hearing Officer to direct all persons present at the hearing in this matter to refrain from photographing or otherwise recording the likenesses of Patient A, Patient B, and Patient C.[1]

MEMORANDUM OF POINTS AND AUTHORITIES

On September 21, 2022, the IC filed a formal Complaint asserting that Respondent committed several violations of the Medical Practice Act with respect to Patient A, Patient B, and Patient C. As part of its prehearing disclosures, *see* NRS 630.339(3)(b)(1), the IC provided the documents on which it intends to rely in the prosecution of this matter, including letters sent to and from Respondent during the investigations of the underlying complaints, the patients' medical records, and photographs of Patient A's body taken by Respondent. *See* Exhibits 1-10 to *Prehearing Conference Statement of the Investigative Committee* filed November 15, 2022 [hereinafter, "the subject documents"].

The hearing will be open to the public and the subject documents will be relied upon and discussed therein, however, the law requires that "appropriate procedures" be "utilized to protect the

[1]This motion is made in accordance with the Order Setting Hearing filed December 6, 2022, which set forth that all prehearing motions shall be served by January 5, 2023. To the extent it is necessary, the IC requests leave to make the instant motion, as the relief requested herein is necessary and appropriate. *See* NRS 622A.360(2)(f).

identity of the patient[s] from public disclosure." NRS 629.061(7)(b)[2]; *see also* NRS 622.310(1)(a) (protecting from disclosure the "personal medical information or records of a patient that are confidential or otherwise protected from disclosure by any other provision of federal or state law"); NRS 622.310(1)(b) (protecting from disclosure the "personal identifying information of a person alleged to have been injured by any act of another person for which a license, certificate or permit is required to be issued by a licensing board"). Accordingly, in all documents not filed under seal in this proceeding, the Patients have been referred to by the fictitious names of Patient A, Patient B, and Patient C.[3] The IC contemplates that, consistent with NRS 639.061(7)(b), the practice of using the fictitious names will continue throughout the remainder of the proceedings, including the hearing.

The IC makes the instant motion to address potential media coverage of the hearing. While the hearing will be public, and news reporters may of course attend, observe, and report on the hearing, because the likenesses of Patients A, B, or C could be used to identify them, any broadcast of their likenesses in a media platform, such as a newspaper, television, or internet, will violate the requirement in NRS 629.061(7)(b) that their identities be protected from public disclosure. While it appears that the policies of many media companies already prevent the broadcasting of such information, in an abundance of caution and in accordance with the legal requirements noted

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[2]The identities of Patient A, Patient B, and Patient C were shared with Respondent's attorney, who will also maintain the confidentiality thereof. *See* NRS 629.061(8).

[3]Respondent and the Hearing Officer have been served with a Patient Designation, filed under seal, which sets forth the Patients' actual names.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

above, the IC requests that the Hearing Officer direct all persons present at the hearing, including any news reporters, to refrain from recording the likenesses of Patient A, Patient B, and Patient C through photographs, video, drawings, or other medium.[4]

DATED this 5th day of January, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

DONALD K. WHITE
Senior Deputy General Counsel
BRANDEE MOONEYHAN
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: mooneyhanb@medboard.nv.gov
Attorneys for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

[4]The IC notes that the Nevada Rules on Electronic Coverage of Court Proceedings, set forth in Supreme Court Rules 229 through 246, while arguably not mandatory here, provide a reasonable framework for handling media coverage of legal proceedings in Nevada, including the hearing in this matter. *See Solid v. Eighth Judicial Dist. Ct.*, 133 Nev. 118, 123, 393 P.3d 666, 672 (2017) ("The Supreme Court Rules governing media in the courtroom are applicable to all civil and criminal trials in Nevada, recognize the importance of preserving the decorum and dignity of the court, and require limitations imposed when any media representative is interfering in any way with the proper administration of justice." (internal quotations and citations omitted)).

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 5th day of January, 2023, I served a file-stamped copy of the foregoing **MOTION TO PROTECT PATIENT LIKENESS**, via USPS Regular Mail to:

GEORGE PETER CHAMBERS, M.D.
c/o Maria Nutile, Esq.
Bridget Kelly, Esq.
Nutile Law
7395 S. Pecos Road, Ste. 103
Las Vegas, NV 89120
**Tracking No.: 7705 0159 8410*
Attorneys for Respondent

NANCY L. MOSS GHUSN, ESQ.
675 W. Moana Ln., Ste. 107
Reno, NV 89509
Hearing Officer

Courtesy copy by email to the following:

Maria Nutile, Esq.: maria@nutilelaw.com
Bridget Kelly, Esq.: bridget@nutilelaw.com
Nancy L. Moss Ghusn, Esq.: nmg416@gmail.com

DATED this 5th day of January, 2023.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

Maria Nutile, Esq.
Nevada Bar No.: 7847
Bridget Kelly, Esq.
Nevada Bar No.: 14388
NUTILE LAW
7395 S. Pecos Rd., Suite 103
Las Vegas, Nevada 89120
Telephone: (702) 307-4880
Facsimile: (702) 307-4881
Email: maria@nutilelaw.com
bridget@nutilelaw.com

Attorneys for George Peter Chambers, Jr., M.D.

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.,** **Respondent.**	**CASE NO.: 22-27891-1** **RESPONDENT'S MOTION TO EXCLUDE TESTIMONY OF PEER REVIEWER WITNESS**

Respondent George Peter Chambers, Jr., M.D., by and through his attorneys of Nutile Law, move to exclude the testimony of Richard W. Rafael, M.D., identified as a potential witness for Petitioner the Investigative Committee ("IC") of the Nevada State Board of Medical Examiners (the "Board"). Dr. Rafael is not qualified to testify as to the standard of care in Respondent's specialized fields of cosmetic gynecological surgery and sexual health medicine, which is pertinent to this case. This Motion is brought pursuant to NRS 622A.360(2)(f) and the Order Setting Hearing filed December 6, 2022 ("Order"), the attached Memorandum of Points and Authorities, and any argument that the Hearing Officer will allow upon a hearing in this matter.

Dated this 5th day of January 2023.

On behalf of Respondent:

NUTILE LAW

/s/ Maria Nutile

Maria Nutile, Esq.
Nevada Bar No.: 7847
Bridget Kelly, Esq.
Nevada Bar No.: 14388
NUTILE LAW
7395 S. Pecos Rd., Suite 103
Las Vegas, Nevada 89120
Telephone: (702) 307-4880
Facsimile: (702) 307-4881
Email: maria@nutilelaw.com
bridget@nutilelaw.com

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Respondent is a board-certified obstetrician/gynecologist, specializing in cosmetic gynecological surgery and sexual health medicine, licensed by the Board to practice medicine in Nevada. This case concerns allegations related to Respondent's care of three (3) female patients, known as Patients A, B, and C. *Inter alia,* the allegations in the Complaint filed by the IC paint a lurid picture of Respondent as a sex fiend of some sort, preying on his patients for some twisted purpose of his own. Although the Complaint does not actually charge Respondent with any "sexual misconduct,"[1] the Complaint incriminates Respondent as having been "seductive," "sexually aggressive," and "sexually demeaning" towards his patients, participating in "sexual innuendo, sexually suggestive humor, and sexually provocative remarks" with them. (Complaint, ¶¶ 3, 4.) In reality, the IC prejudged and misconstrued Respondent's cosmetic gynecology practice as a depraved means to (allegedly) sexually victimize women, rather than accept it as a legitimate surgical practice serving women's historically "taboo" needs.

According to the *curriculum vitae* of Dr. Rafael supplied by the IC (NSBME0219-0235), Dr. Rafael's training and professional practice are in obstetrics and gynecology. Dr. Rafael does not appear to have any training, experience, or expertise in cosmetic gynecological surgery or sexual health medicine. He therefore is not qualified to opine as to the standard of care provided by Respondent to Patients A, B, or C, and his testimony should therefore be excluded.

This Motion is submitted pursuant to NRS 622A.360(2)(f) and the Order.

II. PROCEDURAL HISTORY

A. The IC filed the Complaint on September 21, 2022. The Complaint alleges eight (8) Counts total.

1. With regard to Patient A: Counts I and II, Disruptive Behavior (NRS

[1] "Sexual misconduct" is not defined or delineated as a violation of the Nevada Medical Practice Act.

630.301(6)); Count III, Engaging in Conduct Intended to Deceive (NRS 630.306(1)(b)(1)); and Count IV, Failure to Maintain Accurate Medical Records (NRS 630.3062(1)(a)).

2. With regard to Patient B: Count V, Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

3. With regard to Patient C: Count VI, Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

4. With regard to Patients A, B, and C: Count VII, Continual Failure to Practice Medicine Properly (NRS 630.306(1)(g)); and Count VIII, Disreputable Conduct (NRS 630.301(9)).

B. Respondent timely filed his Answer and Notice of Defense on October 18, 2022.

C. This Motion is timely filed in accordance with the Order.

III. LEGAL STANDARDS

A. Pre-Hearing Motion

NRS 622A.360(2)(f) provides that a party in a contested case before a regulatory body may, with leave of the regulatory body or hearing panel or officer, file any motion not otherwise set forth in NRS 622A.360(2)(a) through (e), requesting appropriate action or relief before the date of the hearing. Pursuant to NRS 622A.360(4), the regulatory body or hearing panel or officer shall rule on any prehearing motion before or on the date of the hearing.

B. Testimonial Evidence

Evidence presented in an administrative hearing must be excluded if is irrelevant, immaterial, or unduly repetitious. NRS 622A.370(2), 233B.123(1). If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by special knowledge, skill, experience,

training or education may testify to matters within the scope of such knowledge. NRS 50.275. "Although administrative proceedings typically need not strictly follow the rules of evidence..., the fact-finder is charged with making a decision based only on evidence of a type and amount that will ensure a fair and impartial hearing." *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 249, 327 P.3d 487, 490 (2014).

Testimony by a peer reviewer in an administrative case is akin to expert witness testimony in a jury trial. "[A]n expert's testimony will assist the jury only when it is relevant and the product of reliable methodology." *Hallmark v. Eldridge*, 124 Nev. 492, 500 (2008). This requires consideration of whether the opinion is:

> (1) within a recognized field of expertise; (2) testable and has been tested; (3) published and subjected to peer review; (4) generally accepted in the scientific community (not always determinative); and (5) based more on particularized facts rather than assumption, conjecture, or generalization.
>
> *Id.* at 510.

IV. MOTION TO EXCLUDE PEER REVIEWER TESTIMONY

Respondent has completed specialized training in both female genital plastic/cosmetic surgery and sexual health medicine. (Chambers 005-006). His training in female genital plastic/cosmetic surgery included, in pertinent part, proper patient and procedure selection, proper record keeping and documentation, how to interact with prospective patients, use and misuse of photo documentation, and marketing tips.[2] Respondent's outpatient practice, through which each of Patients A, B, and C were seen, is focused on cosmetic gynecological surgery and sexual health medicine.

Unlike Respondent, Dr. Rafael does not have any "special knowledge, skill, experience, training or education" in cosmetic gynecological surgery or sexual health medicine. More specifically, and without limitation, Dr. Rafael is not qualified to testify as to whether or not

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[2] See, Michael Goodman, M.D., "Master's Preceptorship and Proctoring Program in Female Genital Plastic/Cosmetic Surgery," https://www.drmichaelgoodman.com/labiaplasty-training-courses/

Respondent's alleged photography during a pre-surgical consult for cosmetic surgical repair of a damaged perineum was clinically appropriate; whether or not measurement of a 7cm-wide intraoital opening using four (4) fingers falls within the standard of care for a pre-operative cosmetic gynecology consult; whether or not the distinction between measuring with two (2) or four (4) fingers is clinically significant for documentation purposes; whether "fisting" could be an acceptable reference with regard to a 7cm-wide intraoital opening which could accommodate the width of four (4) of examiner's fingers without resistance; or what styles of advertisement are considered acceptable and/or effective for a targeted population of individuals likely to consider or seek out cosmetic gynecology services. Further, Dr. Rafael is not qualified to opine as to whether Respondent's conversations with his patients regarding intimate cosmetic gynecology procedures and desired outcomes (including potential sexual benefits) should be considered "sexually aggressive" or "sexually demeaning" within his professional realm.

Stated simply, Dr. Rafael is not Respondent's "peer". He is not qualified to testify as to the standards of care in cosmetic gynecological surgery or sexual health medicine, which are material to the determination of whether or not Respondent committed any violations of the Medical Practice Act as alleged by the IC.

V. CONCLUSION

As Dr. Rafael does not possess the scope of knowledge necessary to opine as to the care provided by Respondent to Patients A, B, and/or C, his testimony must be excluded as immaterial and/or irrelevant.

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CERTIFICATE OF SERVICE

I hereby certify that I am an employee of NUTILE LAW, and that on this 5th day of January 2023, I caused to be filed via email an electronic copy of the foregoing **RESPONDENT'S MOTION TO EXCLUDE TESTIMONY OF PEER REVIEWER WITNESS** to the following:

Brandee Mooneyhan, J.D., Deputy General Counsel mooneyhanb@medboard.nv.gov;
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/s/ Bridget Kelly
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BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.,** **Respondent.**	**CASE NO.: 22-27891-1** **RESPONDENT'S MOTION TO DISMISS FOR FAILURE TO STATE FACTS WHICH WOULD FORM A SUFFICIENT BASIS FOR DISCIPLINE**

Respondent George Peter Chambers, Jr., M.D., by and through his attorneys of Nutile Law, move to dismiss the complaint ("Complaint") filed by Petitioner the Investigative Committee ("IC") of the Nevada State Board of Medical Examiners (the "Board") on September 21, 2022 and each of the charges therein, for failure to state facts which would form a sufficient basis for discipline . This Motion is brought pursuant to NRS 622A.360(2)(e) and the Order Setting Hearing filed December 6, 2022 ("Order"), the attached Memorandum of Points and Authorities, and any argument that the Hearing Officer will allow upon a hearing in this matter.

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Dated this 5th day of January 2023.

On behalf of Respondent:

NUTILE LAW

/s/ Maria Nutile

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Respondent is a board-certified obstetrician/gynecologist, specializing in cosmetic gynecological surgery and sexual health medicine, licensed by the Board to practice medicine in Nevada. This case concerns allegations related to Respondent's care of three (3) female patients, known as Patients A, B, and C. *Inter alia,* the allegations in the Complaint filed by the IC paint a lurid picture of Respondent as a sex fiend of some sort, preying on his patients for some twisted purpose of his own.

In reality, the IC prejudged and misconstrued Respondent's cosmetic gynecology practice as a depraved means to (allegedly) sexually victimize women, rather than accept it as a legitimate surgical practice serving women's historically "taboo" needs. When the allegations and charges in the Complaint are scrutinized objectively, with an understanding of the context of cosmetic gynecology, it is clear the Complaint fails to allege facts which, if true, would form a sufficient basis for discipline pursuant to any of the Counts charged.

In accordance with NRS 622A.360(2)(e), we respectfully request that the Complaint be dismissed, with prejudice. Alternatively, we respectfully request that Counts I, II, III, IV, V, VI, VII, and/or VIII each be dismissed as the alleged facts, even if true, would not form a sufficient basis for discipline.

II. PROCEDURAL HISTORY

A. The IC filed the Complaint on September 21, 2022. The Complaint alleges eight (8) Counts total.

1. With regard to Patient A: Counts I and II, Disruptive Behavior (NRS 630.301(6)); Count III, Engaging in Conduct Intended to Deceive (NRS 630.306(1)(b)(1)); and Count IV, Failure to Maintain Accurate Medical Records (NRS 630.3062(1)(a)).

2. With regard to Patient B: Count V, Engaging in Conduct that Violates the

Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

3. With regard to Patient C: Count VI, Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

4. With regard to Patients A, B, and C: Count VII, Continual Failure to Practice Medicine Properly (NRS 630.306(1)(g)); and Count VIII, Disreputable Conduct (NRS 630.301(9)).

B. Respondent timely filed his Answer and Notice of Defense on October 18, 2022.

C. This Motion is timely filed in accordance with the Order.

III. LEGAL STANDARD

NRS 622A.360(2)(e) provides that a party in a contested case before a regulatory body may file a written, pre-hearing motion requesting dismissal of the charging document for failure to state facts which, if true, would form a sufficient basis for discipline. Pursuant to NRS 622A.360(4), the regulatory body or hearing panel or officer shall rule on any prehearing motion before or on the date of the hearing.

IV. MOTION TO DISMISS

A. Count I: NRS 630.301(6) – Disruptive Behavior

The Complaint alleges that Respondent's taking approximately ten (10) photographs of Patient A's vaginal and rectal areas, allegedly not for purposes of medical examination or treatment, constituted disruptive behavior.

NRS 630.301(6) provides that disciplinary action may be initiated for disruptive behavior, "if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient."[1]

[1] We note that the Board, on the recommendation of the hearing officer, previously dismissed a disruptive behavior charge against a trauma surgeon despite allegations that he called a patient's family member a "bitch" or "fucking asshole" and engaged in a heated altercation with family members in

The Complaint alleges Patient A was seen by Respondent for an initial consultation only (Complaint, ¶ 6). The Complaint does not allege that Patient A received any treatment or underwent any procedures by Respondent, either during the visit in question or at any other time.

The Complaint further alleges that approximately twelve (12) photographs were taken by Respondent with Patient A's cellphone during the course of the consultation (Complaint, ¶ 8), of which two (2) became part of the medical record and were used to show and explain to Patient A the proposed procedures (Complaint, ¶ 17). Respondent allegedly "did not direct" Patient A to send the remaining ten (10) pictures to him (Complaint, ¶ 19), thus they remained exclusively in Patient A's possession and control, and she was free to keep or delete them as she wished.

The Complaint fails to establish that Patient A's consultation with Respondent was incomplete, inadequate, or adversely impacted by Respondent's allegedly taking photographs clinically relevant to Patient A's desired surgical repair of a damaged perineum. Further, the Complaint fails to establish that Respondent's ultimate decision to keep only two (2) of the photographs as part of the medical record (leaving the remaining ten (10) photographs in Patient A's exclusive possession and control) interfered with or adversely impacted Respondent's consultation with Patient A.

As the facts alleged in violation of Count I, even if true, do not form a sufficient basis for discipline, we request that Count I be dismissed with prejudice.

B. Count II: NRS 630.301(6) – Disruptive Behavior

The Complaint alleges Respondent told Patient A that he had attempted to "fist" her, allegedly constituting disruptive behavior "adversely affect[ing] the quality of care rendered to her." (Complaint, ¶ 28). Significantly, it has not been alleged that Respondent actually did attempt to "fist" Patient A.

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a hospital setting. Tate v. State, Bd. of Med. Examiners, 129 Nev. 1156 (2013).

NRS 630.301(6) provides that disciplinary action may be initiated for disruptive behavior, "if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient."

As noted above, the Complaint alleges Patient A was seen by Respondent for an initial consultation only (Complaint, ¶ 6). The Complaint does not allege that Patient A received any treatment or underwent any procedures by Respondent, either during the visit in question or at any other time. The Complaint fails to establish that Patient A's consultation with Respondent was incomplete, inadequate, or adversely impacted by Respondent's alleged reference to "fisting". Further, the Complaint fails to establish that reference to the act of "fisting" was clinically inappropriate as a matter of reference in the context of sizing an intraoital opening with a width of 7cm horizontally and vertically (Complaint, ¶ 13) (approximately 2.75 inches).

As the facts alleged in violation of Count II, even if true, do not form a sufficient basis for discipline, we request that Count II be dismissed with prejudice.

C. Count III: NRS 630.306(1)(b)(1) – Engaging in Conduct Intended to Deceive

The Complaint alleges Respondent knowingly made statements to the Board "designed to conceal that he had inserted four (4) fingers into Patient A's vagina during his examination." (Complaint, ¶ 34).

NRS 630.306(1)(b)(1) provides that engaging in conduct intended to deceive constitutes grounds for initiating disciplinary action.

As noted in the Complaint, Respondent duly documented that he measured Patient A's intraoital opening with his fingers. (Complaint, ¶ 13). As additionally noted in the Complaint, "The photograph of Respondent inserting four (4) fingers into Patient A's vagina was not one of the photographs he asked her to text to him," and thus was not one of the two (2) photographs included in the medical record. (Complaint, ¶¶ 11, 17, emphasis added). Without that particular photograph in the record, any description of the method of measurement (two-fingers and/or four-fingers) would be drawn from memory of events occurring nearly one (1) year prior to the investigation.

The Complaint alleges that "Respondent did not document in the medical record, nor inform the IC during its investigation," and "fail[ed] to otherwise document" that he had inserted four (4) fingers into Patient A's vagina. (Complaint, ¶¶ 15, 32, emphases added). The Complaint does not allege that Respondent attempted to "fist" Patient A, that inserting four (4) fingers constitutes "fisting" or attempted "fisting," or that utilizing four (4) fingers to measure an intraoital opening with a width of 7cm horizontally and vertically (Complaint, ¶ 13) (approximately 2.75 inches) would be inappropriate or clinically significant for documentation purposes. In short, the Complaint fails to allege that Respondent intended to deceive the Board by describing introital measurement using two (2) fingers instead of four (4), or that he would have been reasonably motivated to do so.

As the facts alleged in violation of Count III, even if true, do not form a sufficient basis for discipline, we request that Count III be dismissed with prejudice.

D. Count IV: NRS 630.3062(1)(a) – Failure to Maintain Accurate Medical Records

The Complaint alleges that Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment, and care of Patient A because he did not document in the medical record that he had inserted four (4) fingers into her vagina as part of his consultation. NRS 630.3062(1)(a) provides that "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitutes grounds for initiating disciplinary action.

As noted in the Complaint, Respondent documented that he used his fingers to measure Patient A's intraoital opening, which he recorded as "open[ing] to a width of 7cm horizontally and vertically." (Complaint, ¶ 13). This sizing measurement is related to the diagnosis and recommended treatment and care through "surgical repair of [Patient A's] damaged perineum," for which Patient A sought consultation from Respondent, and was documented in the medical record. However, the method used to obtain this measurement was not relevant to diagnosis, recommended treatment, or future care of Patient A. The Complaint fails to assert how utilization

of four (4) fingers rather than two (2) fingers to obtain this measurement would materially relate to Respondent's diagnosis and recommended treatment and care of Patient A, how using one method or the other for obtaining such measurement was clinically significant to merit documentation, or how failure to document the method of measurement should constitute grounds for initiating disciplinary action.[2]

As the facts alleged in violation of Count IV, even if true, do not form a sufficient basis for discipline, we request that Count IV be dismissed with prejudice.

E. Count V: NRS 630.301(7) – Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship With the Patient for Financial or Other Personal Gain

The Complaint alleges that Respondent expressed to Patient B in the midst of a medical encounter that he would pay her or other patients one thousand dollars ($1,000) to pose for nude photographs to use in an advertisement for his services.

NRS 630.301(7) provides that "engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain" constitutes grounds for initiating disciplinary action. (Emphasis added.)

The Complaint fails to assert how Respondent's allegedly expressing a general offer for a compensated modeling job violated Patient B's trust and exploited their relationship. The Complaint does not allege that Respondent made any representation that the photographs would be used for the purposes of medical examination or treatment, or that Patient B's treatment would be contingent upon her acceptance of the offer. The Complaint alleges Respondent informed

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[2] By way of comparison, the Board previously entered into a settlement agreement with a physician who allegedly failed to document any medical history or medical workup for six (6) patients prescribed narcotics for back pain in violation of NRS 630.3062(1), pursuant to which the physician received only a public letter of reprimand, was required to take 10 hours of CME, and to pay investigation costs. In the Matter of Charges and Complaint Against Kofi Ebenezer Sarfo, M.D., Case No. 12-29257-1. https://nsbme.us.thentiacloud.net/rest/public/data/downloadannotation/index.php?id=62d9c92604f436784aee9f0c&entity=$2y$10$AYZgz5iZHSS6X2Yw4mfYx.0j4TD7.z7bL2qE4.tCymLQ.nvFimnCm; https://nsbme.us.thentiacloud.net/rest/public/data/downloadannotation/index.php?id=62d9c95d81edb57d915d9436&entity=$2y$10$3111xuuNMEiXPjG7dkztduOE.eujRpDU7mQ7UFzqfEdFrnbIPPwba

Patient B at the outset that the photography would be nude (Complaint, ¶ 42), thereby avoiding any misunderstanding or misrepresentation as to the nature of the modeling offer. The Complaint alleges Respondent offered financial compensation in exchange for the modeling (Complaint, ¶ 42), contradicting the exploitation charge. As alleged in the Complaint, the photographs would be used in advertisement of Respondent's services (Complaint, ¶42), which would necessarily generate additional costs for Respondent without any guarantee of return on his investment, thus negating any "financial or other personal gain". The facts alleged in the Complaint do not support charges that Respondent either violated the patient's trust or exploited the therapeutic relationship, let alone both as required under the statute.

As the facts alleged in violation of Count V, even if true, do not form a sufficient basis for discipline, we request that Count V be dismissed with prejudice.

F. Count VI: NRS 630.301(7) – Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship With the Patient for Financial or Other Personal Gain

The Complaint alleges Respondent offered Patient C one thousand dollars ($1,000) to pose nude for photographs to be used in advertisement and/or a "portfolio" of Respondent's work.

NRS 630.301(7) provides that "engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain" constitutes grounds for initiating disciplinary action. (Emphasis added.)

The Complaint alleges that during an office visit, "Patient C mentioned to Respondent that she was struggling financially." (Complaint, ¶ 51). The Complaint further alleges that sometime "[a]fter" that visit, therefore knowing that Patient C was "struggling financially", Respondent offered Patient C a nude modeling job, for which she would be compensated. The Complaint does not allege how Respondent's alleged offer of a job opportunity to a person "struggling financially" constitutes either a violation of Patient C's trust or exploitation of their relationship, let alone both as required under the statute.

As noted above, the Complaint does not allege that Respondent made any representation that the photographs would be used for the purposes of medical examination or treatment, or that Patient C's treatment would be contingent upon her acceptance of the offer. The Complaint alleges Respondent informed Patient C at the outset that the photography would be nude (Complaint, ¶ 52), thereby avoiding any misunderstanding or misrepresentation as to the nature of the modeling offer. The Complaint alleges Respondent offered financial compensation in exchange for the modeling (Complaint, ¶ 52), contradicting the exploitation charge. As alleged in the Complaint, the photographs would be used in promotion of Respondent's services (Complaint, ¶42), which would necessarily generate additional costs for Respondent without any guarantee of return on his investment, thus negating any "financial or other personal gain". The facts alleged in the Complaint do not support charges that Respondent either violated the patient's trust or exploited the therapeutic relationship, let alone both as required under the statute.

As the facts alleged in violation of Count VI, even if true, do not form a sufficient basis for discipline, we request that Count VI be dismissed with prejudice.

G. Count VII: NRS 630.306(1)(g) – Continual Failure to Practice Medicine Properly

The Complaint alleges that by "repeatedly engaging in sexual misconduct with Patients A, B, and C,...Respondent has continually failed to exercise the skill and diligence and use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in his field of obstetrics and gynecology." (Complaint, ¶ 65).

NRS 630.306(1)(g) provides that "[c]ontinual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field." (Emphasis added).

The statute calls for comparison with the skill, diligence, and methods under the same circumstances by physicians "practicing in the same specialty or field." However, the Complaint charges Respondent in comparison with the field of obstetrics and gynecology. As each of the charges in the Complaint relate to Respondent's practice as a cosmetic gynecological surgeon, the

comparison with general obstetrics/gynecology standards is inconsistent with the statute. Only by comparison with the skill, diligence, and methods of other cosmetic gynecological surgeons under the same circumstances could Respondent's practice be judged. General obstetrics/gynecology standards do not address, for example, the accepted methods of sizing a particularly lax intraoital opening; or utilization of photography for patient education, "before-and-after" documentation, and advertisement for cosmetic gynecological procedures.[3]

The Complaint's support for this charge, that Respondent allegedly "repeatedly engag[ed] in sexual misconduct," is wholly unjustified. Although neither NRS not NAC Chapters 630 define "sexual misconduct," an article published in the Board's Newsletter in December 2016 characterized physician "sexual misconduct" as malpractice and/or criminal conduct.[4] At no point does the Complaint accuse Respondent of engaging in "sexual misconduct" with any of the patients. To review, the Complaint charges Respondent with disruptive behavior, engaging in conduct intended to deceive, failure to maintain accurate medical records, and engaging in conduct that violates the trust of a patient and exploits the relationship with the patient for financial or other personal gain. Without even a single allegation of "sexual misconduct" related to any of the patients, a "continual failure" based upon alleged "repeated" sexual misconduct is simply not possible.

As the facts alleged in violation of Count VII, even if true, do not form a sufficient basis for discipline, we request that Count VII be dismissed with prejudice.

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[3] See, e.g., Michael Goodman, M.D., "Master's Preceptorship and Proctoring Program in Female Genital Plastic/Cosmetic Surgery," https://www.drmichaelgoodman.com/labiaplasty-training-courses/ (Course goals include, in pertinent part, proper patient and procedure selection, proper record keeping and documentation, how to interact with prospective patients, use and misuse of photo documentation, and marketing tips in the context of female genital plastic/cosmetic surgery.)

[4] Rachel V. Rose, JD, MBA, "The Duty to Report: An Overview of Sexual Misconduct and Physicians," Nevada State Board of Medical Examiners Newsletter, Vol. 61 (December 2016), 1-5. http://epubs.nsla.nv.gov/statepubs/epubs/213935-2016-12.pdf

H. Count VIII: NRS 630.301(9) – Disreputable Conduct

The Complaint alleges that Respondent brought the medical profession into disrepute by repeatedly engaging in sexual misconduct and violating his patients' trust and exploiting his relationships with them.

NRS 630.301(9) provides that engaging in conduct that brings the medical profession into disrepute is grounds for initiating disciplinary action.

As discussed under Count VII above, "sexual misconduct" has not been alleged, and would grossly mischaracterize the allegations in the Complaint. As discussed under Counts V and VI above, the Complaint fails to allege how a general offer for a compensated modeling job, tailored to advertise Respondent's cosmetic gynecology practice, constitutes violation of trust or exploitation. By necessity, this charge must be dismissed if the foregoing underlying charges are not supported by the Complaint.

As the facts alleged in violation of Count VIII, even if true, do not form a sufficient basis for discipline, we request that Count VIII be dismissed with prejudice.

V. CONCLUSION

As discussed under each count above, the Complaint as a whole fails to state facts which, if true, would form a sufficient basis for discipline. In accordance with NRS 622A.360(2)(e), we therefore request the Complaint be dismissed in its entirety with prejudice. Alternatively, we request that each of Counts I, II, III. IV, V, VI, VII, and/or VIII be dismissed for failure to state facts which, if true, would form a sufficient basis for discipline.

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CERTIFICATE OF SERVICE

I hereby certify that I am an employee of NUTILE LAW, and that on this 5th day of January 2023, I caused to be filed via email an electronic copy of the foregoing **RESPONDENT'S MOTION TO DISMISS FOR FAILURE TO STATE FACTS WHICH WOULD FORM A SUFFICIENT BASIS FOR DISCIPLINE** to the following:

Brandee Mooneyhan, J.D., Deputy General Counsel mooneyhanb@medboard.nv.gov;

Donald K. White, J.D., Deputy General Counsel dwhite@medboard.nv.gov;

Nancy Moss Ghusn, Esq., Hearing Officer nmg416@gmail.com

/s/ Bridget Kelly
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BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.,** **Respondent.**	**CASE NO.: 22-27891-1** **RESPONDENT'S MOTION TO DISMISS FOR DUE PROCESS CLAUSE VIOLATIONS**

Respondent George Peter Chambers, Jr., M.D., by and through his attorneys of Nutile Law, move to dismiss the complaint ("Complaint") filed by Petitioner the Investigative Committee ("IC") of the Nevada State Board of Medical Examiners (the "Board") on September 21, 2022 for violation of Respondent's due process rights under the Fifth and Fourteenth Amendments of the United States Constitution, and Article I, Section 8 of the Constitution of the State of Nevada by the Board and/or its agents and representatives. This Motion is brought pursuant to NRS 622A.360(2)(f) and the Order Setting Hearing filed December 6, 2022 ("Order"), the attached Memorandum of Points and Authorities, and any argument that the Hearing Officer will allow upon a hearing in this matter.

Dated this 5th day of January 2023.

On behalf of Respondent:

NUTILE LAW

/s/ Maria Nutile

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Respondent is a board-certified obstetrician/gynecologist, specializing in cosmetic gynecological surgery and sexual health medicine, licensed by the Board to practice medicine in Nevada. This case concerns allegations related to Respondent's care of three (3) female patients, known as Patients A, B, and C. *Inter alia,* the allegations in the Complaint filed by the IC paint a lurid picture of Respondent as a sex fiend of some sort, preying on his patients for some twisted purpose of his own. Although the Complaint does not actually charge Respondent with any "sexual misconduct,"[1] the Complaint incriminates Respondent as having been "seductive," "sexually aggressive," and "sexually demeaning" towards his patients, participating in "sexual innuendo, sexually suggestive humor, and sexually provocative remarks" with them. (Complaint, ¶¶ 3, 4.) In reality, the IC prejudged and misconstrued Respondent's cosmetic gynecology practice as a depraved means to (allegedly) sexually victimize women, rather than accept it as a legitimate surgical practice serving women's historically "taboo" needs.

The Board has exhibited deliberate indifference and/or reckless disregard for Respondent's due process rights in its pursuit of the instant matter. Although Respondent has yet to enjoy a fair hearing on his medical license itself, he has nonetheless been deprived of his right to earn a living as a physician due to Board policies and actions, including (1) prejudicial publication of the Complaint in this matter on the Board's website, which (2) was drafted to include salacious factual allegations extraneous to the Board's charges against Respondent. By unnecessarily injecting the Complaint into the public domain, without equivalent access to Respondent's Answer denying the allegations or even any *caveats* as to "innocence until proven

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[1] NRS Chapter 630 prohibits sexual activity by a licensee with a current patient, exploitation of a patient relationship through sexual contact with a surrogate, and influencing a patient to engage in sexual activity (none of which Respondent has been accused of); and authorizes the initiation of disciplinary action following a licensee's conviction of criminal sexual offenses (with which Respondent has not been charged). "Sexual misconduct" is not defined or delineated as a violation of the Medical Practice Act.

guilty," the Board bypassed the due process owed to Respondent in the form of a fair hearing. The Board has already successfully convicted Respondent in the eyes of the public and effectively destroyed his practice, without any accountability. The Board has abused its authority and wrongfully deprived Respondent of his ability to practice without the benefit of due process, to the same extent as if his license had been formally revoked.

This Motion is submitted pursuant to NRS 622A.360(2)(f) and the Order. Given the constitutional infringement and actual (and possibly irrevocable) harm already inflicted upon Respondent, we request that the Complaint be dismissed with prejudice.

II. PROCEDURAL HISTORY

A. The IC filed the Complaint on September 21, 2022. The Complaint alleges eight (8) Counts total.

1. With regard to Patient A: Counts I and II, Disruptive Behavior (NRS 630.301(6)); Count III, Engaging in Conduct Intended to Deceive (NRS 630.306(1)(b)(1)); and Count IV, Failure to Maintain Accurate Medical Records (NRS 630.3062(1)(a)).

2. With regard to Patient B: Count V, Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

3. With regard to Patient C: Count VI, Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

4. With regard to Patients A, B, and C: Count VII, Continual Failure to Practice Medicine Properly (NRS 630.306(1)(g)); and Count VIII, Disreputable Conduct (NRS 630.301(9)).

B. Respondent timely filed his Answer and Notice of Defense on October 18, 2022.

C. This Motion is timely filed in accordance with the Order.

III. LEGAL STANDARDS

A. Pre-Hearing Motion

NRS 622A.360(2)(f) provides that a party in a contested case before a regulatory body may, with leave of the regulatory body or hearing panel or officer, file any motion not otherwise set forth in NRS 622A.360(2)(a) through (e), requesting appropriate action or relief before the date of the hearing. Pursuant to NRS 622A.360(4), the regulatory body or hearing panel or officer shall rule on any prehearing motion before or on the date of the hearing.

B. Due Process

The Due Process Clause of the Fifth Amendment of the United States Constitution states that "[n]o person shall be...deprived of life, liberty, or process without due process of law." U.S. Const. amend. V. The Due Process Clause provides heightened protection against government interference when certain fundamental rights and liberty interests are at stake. *Washington v. Glucksburg*, 521 U.S. 702, 720 (1997). This protection is incorporated at the state level through the Fourteenth Amendment (U.S. Const. amend. XIV) and the Constitution of the State of Nevada (Nev. Const. art. I, § 8).

It has been well-established through case law that a physician's license to practice medicine is a property right, and his right to earn a living is a liberty interest, neither of which may be impaired without due process of law. *Tate v. State, Bd. of Med. Exam'rs*, 131 Nev. 675, 681, 356 P.3d 506, 511 (2015); *Minton v. Bd. of Med. Examiners*, 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (1994), disapproved of on other grounds by *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014); *Stretten v. Wadsworth Veterans Hosp.*, 537 F.2d 361, 366 (9th Cir. 1976). "The 'liberty interest' is the interest an individual has in being free to move about, live, and practice his profession without the burden of an unjustified label of infamy." *Stretten,* 537 F.2d at 366 (emphasis added). Due process protections apply to a liberty interest as much as to a property interest: "Where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are

essential." *Wisconsin v. Constantineau*, 400 U.S. 433, 437, 91 S. Ct. 507, 510, 27 L. Ed. 2d 515 (1971).

IV. MOTION TO DISMISS

A. Presumption of Innocence

As the Federation of State Medical Boards ("FSMB") states,

> Whatever the complaint, physicians are afforded the right of due process as a state medical board investigates an allegation of unprofessional conduct. Due process asserts that an individual is innocent until proven guilty. This principle applies to formal hearings and judicial procedures that the medical board conducts. Boards must adhere to established rules and principles to ensure that a physician is not treated unfairly, arbitrarily or unreasonably. [2]

Moreover, "A licensee has a clear expectation of continued enjoyment of a license absent proof of conduct warranting its suspension, revocation, or withdrawal."[3]

As a state regulatory agency, anything published on the Board's official website carries the *gravitas* of truth. Allegations contained in a Complaint posted on the Board's website are likely to be interpreted by the public as established facts rather than mere accusations. Tragically, the Board does not protect its licensees' presumption of innocence or due process rights in that it regularly publishes unproven, even erroneous, allegations, bearing the *gravitas* of fact, in the form of complaints in pending matters posted unnecessarily and recklessly for public consumption on its official website.

B. Publication of Complaints in Pending Matters Is Unduly Prejudicial and Fundamentally Unfair

Currently, the Board website publishes licensee complaints in pending matters in at least two locations: under "Public Filings"[4] and under the individual licensee's license verification

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[2] Federation of State Medical Boards, "About Physician Discipline: How State Medical Boards Regulate Physicians after Licensing," https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-discipline/. (Emphases added.)

[3] Murphy, Allaina M., "Preponderance, Plus: The Procedure Due to Professional Licensees in State Revocation Hearings," Connecticut Law Review, Vol. 52:2 (July 2020) at 954. Available at: https://opencommons.uconn.edu/cgi/viewcontent.cgi?article=1426&context=law_review

[4] https://medboard.nv.gov/Resources/Public/Public Filings by Year/

profile ("Profile")[5]. Both Public Filings and Profiles include any formal complaints (open and resolved, though case status is not indicated with complaint listing), settlement agreements, and findings of fact related to a licensee. It is not clear to a public user/consumer that complaints in pending matters are not final or proven, making it extremely easy for a licensee to be deemed guilty in the eye of the public.

To our knowledge, the Board is not required to publish formal complaints filed in pending matters against licensees on its website. It is only required to post disciplinary actions once taken,[6] which it does on its "Disciplinary Actions" webpage[7] and under the Profiles. Upon review of comparable websites for the Nevada State Boards of Osteopathic Medicine, Pharmacy, and Nursing, it does not appear that complaints in matters pending before any of those boards are posted online.[8]

To make matters worse, the Board fails to publish its licensees' formal answers, filed in response to filed complaints, along with the complaints themselves.[9] Even though both complaints and answers are considered public documents[10], only the complaint containing the Board's allegations and version of events is injected into the public domain. Anyone wishing to view a

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[5] e.g., https://nsbme.us.thentiacloud.net/webs/nsbme/register/#/profile/chambers/0/20/5fd29a2eb952d61efc798bed

[6] See, NRS 239.008(4) (forms and procedures to obtain public documents must be posted on agency website); and NRS 630.144(3)(c),(f) ("The Board shall place on its Internet website:

...

(c) An alphabetical list, by last name, of each licensee and a brief description of each disciplinary action, if any, taken against the licensee, in this State and elsewhere, which relates to his or her practice and which is noted in the records of the Board. The Board shall include, as part of the list on the Internet website, the name of each licensee whose license has been revoked by the Board. The Board shall make the list on the Internet website easily accessible and user friendly for the public.

...

(f) Any other information that the Board is required to place on its Internet website pursuant to any other provision of law.")
(Emphases added).

[7] https://medboard.nv.gov/Patients/Disciplinary/DisciplinaryActions/

[8] The Nevada State Board of Osteopathic Medicine posts complaints filed in resolved matters, along with the status/disposition of the complaint, including dismissal.

[9] Although additional case documents may be posted as part of meeting agenda exhibits, a matter may not be included on the Board's agenda for months after the complaint has been filed and posted.

[10] NRS 630.336(5)

licensee's answer (assuming they are aware an answer might have been filed) must file a separate request with the Board. [11] It is extremely unlikely that members of the public will expend the time, effort, and $0.02/page expense to request a copy of the licensee's answer in any matter through a public records request.[12] This system is unduly prejudicial against the physician, who is supposed to be considered innocent until proven otherwise.

Notably, orders of dismissal are not posted. Instead, it appears a dismissed complaint is removed from Public Filings and Profiles, without any explanation. This means that a consumer or credentialer (i.e., for a medical staff, insurance plan, or other licensing board) could verify a license through a Profile and see that a formal complaint is pending against the licensee, but the resolution of that complaint as a dismissal (whether due to factual errors by the Board[13] or adjudication by the Board that the standard of proof was not met[14]) is never posted and the licensee's name never "cleared". Even if it were, once the complaint has been posted, the damage has been done and "you can't put the toothpaste back in the tube."

At minimum, the filed answer should be available alongside the complaint, so that an interested party can obtain a more complete picture of the issues at hand mad make an informed judgment of their own. This is particularly significant where the Board's allegations are salacious in nature or otherwise attract the attention of the press or public, as has occurred in this case.

C. Risk of Erroneous Deprivation

As a result of the Board's online publication of complaints in pending matters, the as-yet unsubstantiated charges against a licensee are made readily available to consumers by the Board, but the licensee's denials and defenses of any pending charges are not. This creates a significant risk of erroneous deprivation of a licensee's livelihood without due process and represents a deplorable failure of the seminal *Mathews* due process balancing test:

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[11] https://medboard.nv.gov/uploadedFiles/medboardnvgov/content/Forms/PublicRecordsRequest.pdf
[12] https://medboard.nv.gov/uploadedFiles/medboardnvgov/content/Forms/PublicRecordsRequest.pdf
[13] See, BME case no. 22-38864-1.
[14] See, BME case no. 21-38084-1.

> [I]dentification of the specific dictates of due process generally requires consideration of three distinct factors: [1] the private interest that will be affected by the official action; [2] the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and [3] the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.[15]

The private interests at issue under (1) above are the licensee's property interest in his or her license authorizing practice; and the liberty interest in the licensee's right to earn a living[16] by virtue of facilities, insurers, medical practices, and individual consumers being willing to utilize his or her services. Procedural safeguards under (2) above are in place to protect against the erroneous deprivation of a licensee's legal authority to practice (in the form of the fair hearing process prior to any restriction or revocation). However, it is absurdly easy for the Board to constructively deprive a licensee of his ability to practice by enabling the public to convict him in their eyes through publication of mere allegations under the guise of fact.

Physicians have had their hospital privileges restricted or suspended, participation on insurance panels terminated, practice transactions postponed or cancelled, and/or professional reputations irreparably destroyed due to pending charges and unproven allegations recklessly published by the Board. In Respondent's case, he has lost employment and payor contracts, had to defend his medical staff memberships and clinical privileges, and give up his office practice and office space due to severely diminished patient referrals These (we believe, erroneous) deprivations of livelihood without due process could have been limited, if not prevented, if the Board either (a) declined to post unproven allegations in pending matters against its licensees, or (b) at minimum, posted the licensees' answers online alongside the complaints. Neither of these options would create significant administrative burdens under (3) above, and in fact declining to post pending complaints at all would even eliminate an administrative burden.

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[15] Mathews v. Eldridge, 96 S. Ct. 893, 903 (1976).
[16] See, e.g., Painter v. Abels, 998 P.2d 931, 941 (Wyo. 2000).

The inclusion of extraneous "factual" statements within the Board's complaints further illustrates the Board's deliberate indifference and/or reckless disregard for a licensee's due process rights and magnifies the resulting harm. Such statements are not necessary for the Board to prove its charges against the licensee, and serve only to further malign the licensee. In Respondent's Answer in the present case[17], objections were noted (and are here reiterated) to three (3) paragraphs of the Complaint as "irrelevant to support any of the charges against Respondent; and/or as presenting a danger of unfair prejudice against respondent, confusion of the issues, and/or misleading the adjudicators in this matter." (Answer, ¶¶ j(2), o(2), and p(2)).

D. Actual Harm Suffered by Respondent

Since the Complaint was filed on the Board's website, and the notoriety gained due to its salacious content, Respondent has been terminated from an employment contract, had to defend his hospital medical staff membership and clinical privileges, has lost patient referrals and payor contracts, and had to give up his office space and close his outpatient practice. All due to as-yet unproven allegations published by the Board, without any disclaimer or balance from Respondent's position. He has already been "burden[ed] of an unjustified label of infamy" (*Stretten,* 537 F.2d at 366) as the sexual deviant portrayed in the Complaint, based solely on the Board's accusations. He is treated within the community as if his license had been revoked, and he has not yet had his fair hearing.

This harm could have been easily mitigated, if not avoided entirely, if the Board had refrained from posting the Complaint on its website while the matter is pending, or at least posted a conspicuous disclaimer and Respondent's Answer along with the Complaint. The Board failed to do this in Respondent's case, or in any other licensee's case to our knowledge. Respondent's practice has been decimated, all due to irresponsible publication of allegations in a pending matter. It is a travesty that the Board treats its licensees' reputations and livelihood with such blatant disregard.

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[17] Answer and Notice of Defense, Case No. 22-27891-1, filed October 18, 2022 ("Answer").

V. CONCLUSION

As set forth above, the Board has deprived Respondent of his liberty interest in the practice of his profession in violation of his Due Process rights, by recklessly and unfairly publishing unproven allegations with the force of truth on its website, resulting in actual harm akin to final disciplinary action against Respondent. We therefore request the Complaint be dismissed in its entirety with prejudice.

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CERTIFICATE OF SERVICE

I hereby certify that I am an employee of NUTILE LAW, and that on this 5th day of January 2023, I caused to be filed via email an electronic copy of the foregoing **RESPONDENT'S MOTION TO DISMISS FOR DUE PROCESS CLAUSE VIOLATIONS** to the following:

Brandee Mooneyhan, J.D., Deputy General Counsel mooneyhanb@medboard.nv.gov;

Donald K. White; J.D. Deputy General Counsel dwhite@medboard.nv.gov

Nancy Moss Ghusn, Esq., Hearing Officer nmg416@gmail.com

/s/ *Bridget Kelly*
An employee of NUTILE LAW

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D., Respondent.**	**Case No. 22-27891-1**

FILED
JAN 12 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OPPOSITION TO RESPONDENT'S "MOTION TO EXCLUDE TESTIMONY OF PEER REVIEWER WITNESS"

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through its undersigned counsel, hereby opposes Respondent's "Motion to Exclude Testimony of Peer Reviewer Witness," submitted January 5, 2023, and filed January 6, 2023 ("Motion"). Such a motion is misplaced in an administrative proceeding, and Respondent will be able to examine Dr. Rafael's testimony at the hearing, and the Motion should therefore be denied.

MEMORANDUM OF POINTS AND AUTHORITIES

I. BACKGROUND

The Nevada State Legislature has found that it is among the responsibilities of the State Government to ensure the competency of its practitioners of medicine, perfusion, and respiratory care. *See* NRS 630.003(1)(a). To further that aim, the Legislature delegated to the Board the responsibility of determining initial and continuing competency to practice medicine and respiratory care in the State of Nevada. *See* NRS 630.003(1)(b).

It is the therefore the statutory responsibility of the Board to monitor the continuing competency of allopathic physicians (M.D.s), physician assistants, respiratory care practitioners and perfusionists licensed in the State of Nevada. *See generally* NRS 630.003. The Board accomplishes this through its investigation process and prosecution of disciplinary actions against

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those individuals who hold a license to practice medicine or respiratory care in the State of Nevada. *See* NRS 630.311. In determining the continued competency of those individuals issued licenses by the Board, the Board operates under a state statutory scheme that sets out the grounds for initiating disciplinary action against a licensee. *See* NRS 630.301 et seq. The Board is required to enforce the provisions of NRS Chapter 630 and NAC 630 (collectively, the Medical Practice Act or MPA). *See* NRS 630.003. If the IC[1] of the Board determines that there is a reasonable basis to file a formal complaint, or that any violation of the MPA has occurred, a formal complaint (Complaint) may be brought against a licensee.

II. ARGUMENT

A. Relevant Law

NRS Chapters 233B and 630 both contain administrative procedures applicable to these proceedings. Additionally, in 2017, the Nevada Legislature amended NRS 622A.120(1) to remove the Board from the list of regulatory agencies specifically exempted from NRS Chapter 622A, which sets forth certain supplemental administrative procedures. *See* 2017 Nev. Stat. 2844. Thus, certain procedures and remedies provided in NRS Chapter 622A must now be utilized in Board cases, when applicable. NRS 622A.360(2) specifically states that "a party may file only the following prehearing motions," and a motion to exclude the IC's expert from testifying is certainly not one of them.[2]

Respondent's Motion hardly references NRS 622A.370(2) and NRS 233B.123, which are the statutes that establish the standard for the admission of evidence at this hearing. Respondent proceeds to refer to statutes pertaining to the admissibility of evidence in jury trials and

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[1] IC members are a limited number of Board members (3), including two (2) physician members and one (1) public member that review investigations files and determine if there is a basis for filing a formal complaint or if other action is needed.

[2] NRS 622A.360(2) specifically states that "a party may file only the following prehearing motions: (a) A motion requesting a continuance or an extension of time. (b) A motion requesting, for good cause, the recusal of the hearing officer, a member of the hearing panel or a member of the regulatory body from participation in the case. (c) A motion requesting the separation of consolidated cases. (d) A motion requesting a more definite statement regarding the allegations in the charging document on the ground that there is not enough information in the charging document to formulate a defense. (e) A motion requesting dismissal of the charging document for failure to state facts which, if true, would form a sufficient basis for discipline. (f) With leave of the regulatory body or hearing panel or officer, any other motion requesting appropriate action or relief before the date of the hearing.

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corresponding case law that expressly do not govern this administrative proceeding and are largely irrelevant. Respondent's argument is immediately misplaced in its entirety.

First, pursuant to NRS 622A.370(2), in this administrative proceeding, the parties are "not bound by strict rules of procedure or rules of evidence when conducting the hearing, except that evidence must be taken and considered in the hearing pursuant to NRS 233B.123." NRS 233B.123 provides simply that "[e]vidence may be admitted, except where precluded by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs." This statute was thoroughly interpreted in *Department of Motor Vehicles v. Kiffe*, 101 Nev. 729, 709 P.2d 1017 (1985), and again in *Department of Motor Vehicles & Pub. Safety v. Evans*, 114 Nev. 41, 952 P.2d 958 (1998). The Nevada Supreme Court has stated consistently that in an administrative hearing, evidence, including hearsay evidence, is expressly admissible as provided under NRS 233B.123, that is, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs.

That is the standard that applies. For the evidence at issue to be excluded, the hearing officer must conclude, and the Board must agree, that the evidence is not "of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs," that is, that the evidence is so unreliable that reasonable and prudent persons could not make proper sense of it, place it in proper context, or give it appropriate probative value.

Second, it is well established that the rules of evidence are "relaxed" in an "inquiry of a board of [this] character," and that the Board's inquiry "should not be too narrowly constrained by technical rules as to the admissibility of proof. Its function is largely one of investigation, and it should not be hampered in making inquiry . . . by those narrow rules which prevail in trials at common law, where a strict correspondence is required between allegation and proof." *Interstate Commerce Commission v. Baird*, 194 U.S. 25, 44 (1904). The Board "is an administrative body and, even where it acts in a quasi-judicial capacity, is not limited by the strict rules, as to the admissibility of evidence, which prevail in suits between private parties." *Interstate Commerce Commission v. Louisville & Nashville R.R. Co.*, 227 U.S. 88, 93 (1913).

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This is not a jury trial before a jury of laypeople, who may be easily confused or prejudiced by scandalous or impertinent material, etc. – and the rules of evidence applicable to this proceeding reflect that. Motions to exclude witnesses are a tool reserved for jury trials, not for the administrative process. Assertion(s) that expert testimony should be precluded are almost unheard of in administrative hearings, and for good reason: the law clearly trusts and defers to the judgment of the hearing officer and the individual Board members utilizing their skill, training and position in making up their own minds during an adjudication as to what evidence they ought to consider, and what weight they ought to give it, if any. By the very nature of this proceeding, involving questions of professional responsibility before a professional licensing board, such motions are largely out of place.

In light of that context, let us address Respondent's argument.

B. Dr. Rafael is Qualified to Testify as an Expert in an Administrative Hearing.

As stated above, throughout his Motion, Respondent refers to irrelevant statutes and case law when administrative proceedings have specific applicable statutes and administrative rules governing them.

NRS 630.346(1), which governs the Board, provides in part: "The Board, a panel of the members of the Board and a hearing officer are not bound by formal rules of evidence, except that evidence must be taken and considered in the hearing pursuant to NRS 233B.123...." NRS 630.346(1). Since the formal rules of evidence are not binding in administrative proceedings such as this one, Dr. Rafael's testimony is relevant and helpful to the fact-finding body, who will be tasked with giving his testimony the weight it deserves.

While Dr. Rafael's qualifications will be the subject of examination at the hearing, the IC notes that he is a board certified obstetrician-gynecologist who practiced in Nevada for 32 years in private practice, was a diplomate of the American Board of Obstetrics and Gynecology for over 22 years, and has also served as an assistant professor of obstetrics, and thus is amply qualified to testify to the standard of care for an obstetrician-gynecologist in Nevada. Respondent complains that Dr. Rafael "does not appear to have any training, experience, or expertise in cosmetic gynecological surgery or sexual health medicine." *Motion* at 3:18-20. Notably, the complaint

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does not assert that Respondent completed a cosmetic gynecological procedure or one related to sexual health medicine; while Patient A was meeting with him to explore the possibility of surgical repair of a damaged perineum, which could be considered cosmetic, she did not meet with him again after this initial encounter, and he was providing routine gynecological care to Patient B and Patient C during the encounters described in the complaint. Additionally, the nature of Respondent's training in cosmetic gynecological surgery and sexual health medicine, which do not appear to be recognized by the American Board of Medical Specialties, and whether they affect the standard of care in this matter, are subjects ripe for exploration at the hearing. It is the merits of such issues that the fact-finding body will be tasked with evaluating, including issues of witness credibility, through following the proper procedure, including direct examination and Respondent's right to cross-examination.

To reiterate, the Nevada State Legislature has found that it is among the responsibilities of the State Government to ensure the competency of its practitioners of medicine, perfusion, and of respiratory care. NRS 630.003(1)(a). To further that aim, the legislature delegated to the Board the responsibility of determining initial and continuing competency of its licensees. *See* NRS 630.003(1)(b). Respondent will have ample opportunity to cross-examine Dr. Rafael as to whether his testimony is based on speculation and the fact-finding body will have the task of ruling on the credibility of every witness including Dr. Rafael.

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III. CONCLUSION

The Board not only has a duty to enforce the provisions of NRS 630 but is required to ensure the competence of its licensees by statute. *See* NRS 630.003(1)(b). Furthermore, pursuant to NRS 622A.360(2)(f), Respondent did not request leave to the regulatory body or hearing panel or officer to file the motion as required for this administrative proceeding. For the foregoing reasons, the Respondent's "Motion to Exclude Testimony of Peer Reviewer Witness" must be denied as a matter of law.

DATED this 12th day of January, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 13th day of January, 2023, I served a file-stamped copy of the foregoing **OPPOSITION TO RESPONDENT'S "MOTION TO EXCLUDE TESTIMONY OF PEER REVIEWER WITNESS"** via USPS Regular Mail to:

GEORGE PETER CHAMBERS, M.D.
c/o Maria Nutile, Esq.
Bridget Kelly, Esq.
Nutile Law
7395 S. Pecos Road, Ste. 103
Las Vegas, NV 89120
Attorneys for Respondent

NANCY L. MOSS GHUSN, ESQ.
675 W. Moana Ln., Ste. 107
Reno, NV 89509
Hearing Officer

Courtesy copy by email to the following:

Maria Nutile, Esq.: maria@nutilelaw.com
Bridget Kelly, Esq.: bridget@nutilelaw.com
Nancy L. Moss Ghusn, Esq.: nmg416@gmail.com

DATED this 13th day of January, 2023.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against:	**Case No. 22-27891-1**
GEORGE PETER CHAMBERS, M.D.	
Respondent.	

OPPOSITION TO RESPONDENT'S "MOTION TO DISMISS FOR DUE PROCESS CLAUSE VIOLATIONS"

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through its undersigned counsel, hereby opposes Respondent's "Motion to Dismiss for Due Process Clause Violations" submitted January 5, 2023, and filed January 6, 2023. Respondent has received and will continue to receive all due process to which he is entitled, and his motion therefore should be denied.

MEMORANDUM OF POINTS AND AUTHORITIES

I. BACKGROUND

On September 21, 2022, the IC filed a formal Complaint asserting that Respondent committed several violations of the Medical Practice Act with respect to Patient A, Patient B, and Patient C. The Complaint clearly states that it includes the IC's "charges and allegations," and requests, in part, that Respondent be allowed to answer the Complaint and that a time and place for a formal hearing be scheduled. Respondent filed a timely answer to the Complaint, a hearing officer was duly appointed, and the hearing in this matter is set to be held on February 15 and 16, 2023.

The Complaint notes that Respondent specializes in obstetrics and gynecology and notes that Patient A was referred to him for a consultation regarding surgical repair of a damaged perineum. *Complaint* at 1:19, 2:9-11. This reference to repair of a damaged perineum is the only reference—and a tangential one at that—to Respondent's practice of cosmetic gynecology in the Complaint,

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contrary to Respondent's assertion that the Complaint represents the IC's having "prejudged and misconstrued" his practice as a "depraved means to (allegedly) sexually victimize women, rather than accept it as a legitimate surgical practice serving women's historically 'taboo' needs." *Motion* at 3:13-16. However, Respondent's attempts to characterize the Complaint as something beyond a recitation of the allegations the IC believes support the charges in the Complaint cannot render the Complaint, or its subsequent publication on the Board's website, as violative of his due process rights.

II. ARGUMENT

A. Relevant Law

The IC agrees that Respondent is entitled to due process in this proceeding. *Dutchess Bus. Servs., Inc. v. Nevada State Bd. of Pharmacy*, 124 Nev. 701, 711, 191 P.3d 1159, 1166 (2008) ("Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply."). The Nevada Supreme Court has explained that in an administrative proceeding, "it is the opportunity to prepare a defense that defines due process." *Id.* at 712, 191 P.3d at 1167 (citing *Nevada State Apprenticeship Council v. Joint Apprenticeship & Training Comm.*, 94 Nev. 763, 765, 587 P.2d 1315, 1317 (1978)). Thus, a process that ensures that a respondent is apprised of the charges against him and the factual bases underlying them, and where the administrative body follows its established procedural guidelines, provides the required due process. *See id.* at 711-12, 191 P.3d at 1166-67.

With respect to Respondent's argument that he has been deprived of due process because he has been "constructively" deprived of his right to earn a living as a physician by the Complaint and its posting on the Board's website, there appears to be a dearth of case law addressing the effect of negative attention a licensee may receive prior to the hearing in an administrative proceeding. Indeed, the case on which Respondent relies for the proposition that a person's liberty interest includes "practic[ing] his profession without the burden of an justified label of infamy," *Stretten v. Wadsworth Veterans Hospital*, 537 F.2d 361, 366 (1976), was an appeal from a federal lawsuit arising from a resident physician being dismissed from his job, rather than a licensing matter, and ultimately concluded that due process did not require a full adversary hearing there. While the

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writing of a complaint and posting it on a licensing agency's website do not equate with affirmative attempts to generate publicity, examination of authorities considering pre-proceeding publicity provide guidance here. For example, with respect to prehearing publicity in other contexts, one Nevada Supreme Court Justice has noted that prehearing publicity "can only be of constitutional dimension if it deprives the petitioner of his due process right to an unbiased decision-maker." *Whitehead v. Nevada Comm'n on Jud. Discipline*, 110 Nev. 874, 925-26, 878 P.2d 913, 945 (1994) (Shearing, J., dissenting). Other Nevada case law supports this observation, as examinations of potentially prejudicial pre-proceeding publicity focus on the perceived effect on the factfinder and whether it affects a party's right to a fair proceeding, *see, e.g.*, *Sicor, Inc. v. Hutchison*, 127 Nev. 904, 266 P.3d 608 (2011); *Sonner v. State*, 112 Nev. 1328, 930 P.2d 707 (1996), *on reh'g in part*, 114 Nev. 321, 955 P.2d 673 (1998). Accordingly, the pertinent inquiry is whether the Complaint's contents or its posting on the website affects the factfinder in this proceeding—which Respondent has not asserted.

B. Respondent Has Received, and Will Continue to Receive, All Due Process to Which He is Entitled

Respondent has not been deprived of his license to practice medicine; as of this date, his license is active, and, consistent with the governing procedures, *see* NRS 630.339 *et seq.*, a hearing has been scheduled in this matter to consider the charges against him prior to any restriction on his license being imposed. As Respondent has been apprised of the charges against him and the factual bases underlying them, all applicable procedural guidelines have been adhered to, and Respondent has been afforded the opportunity to prepare a defense, he has received all required due process in this proceeding. *See Dutchess Bus. Servs., Inc.*, 124 Nev. at 711-12, 191 P.3d at 1167. Due process does not require that the Complaint in this matter be drafted to, or the Board's website designed in accordance with, Respondent's approval.

With respect to the contents of the Complaint in this matter, it contains only allegations connected to the charges against Respondent. Respondent asserts that three (3) paragraphs of the Complaint, namely Paragraphs 12, 18, and 21, are "salacious" and "extraneous" to the charges against him. In brief, those paragraphs make assertions relative to the taking and transmission of

photographs of Patient A's vaginal and rectal during her encounter with Respondent, and Patient A's experience that was consistent with comments Respondent made to her during the encounter, which the IC believes are pertinent to fully explaining and providing context to the encounter giving rise to Counts I through IV of the Complaint. Respondent will have the opportunity during the forthcoming hearing to examine and argue regarding the relevance of these allegations. Their inclusion in the Complaint does not deprive him of due process.[1]

Respondent also complains that the Complaint was posted on the Board's website, consistent with the posting of formal complaints against other licensees. *See* NRS 630.336(5) (noting that the Board's formal complaints are public records). In his arguments regarding the alleged affect that publication of the Complaint on the Board's website has had on his medical practice, Respondent attempts to stretch the requirements of due process to include protection from all possible negative effects arising from the filing or publication of a formal complaint. However, due process does not require such a result. *See Dutchess Bus. Servs., Inc.*, 124 Nev. at 711-12, 191 P.3d at 1167 .

III. CONCLUSION

For the foregoing reasons, Respondent's "Motion to Dismiss for Due Process Clause Violations" should be denied.

DATED this 12th day of January, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

DONALD K. WHITE
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[1]Here, Respondent essentially argues that the IC includes too many details in its Complaint, while maintaining in a contemporaneously filed motion that the Complaint does not include sufficient facts to proceed. Respondent's conflicting arguments demonstrate the relative sufficiency of the charges. Accordingly, evidence offered in support of them are properly the subject of an adversarial hearing, rather than summary disposition.

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 13th day of January, 2023, I served a file-stamped copy of the foregoing **OPPOSITION TO RESPONDENT'S "MOTION TO DISMISS FOR DUE PROCESS CLAUSE VIOLATIONS"** via USPS Regular Mail to:

GEORGE PETER CHAMBERS, M.D.
c/o Maria Nutile, Esq.
Bridget Kelly, Esq.
Nutile Law
7395 S. Pecos Road, Ste. 103
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Hearing Officer

Courtesy copy by email to the following:

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Bridget Kelly, Esq.: bridget@nutilelaw.com
Nancy L. Moss Ghusn, Esq.: nmg416@gmail.com

DATED this 13th day of January, 2023.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, M.D.** **Respondent.**	**Case No. 22-27891-1**

FILED
JAN 12 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

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OPPOSITION TO RESPONDENT'S "MOTION TO DISMISS FOR FAILURE TO STATE FACTS WHICH WOULD FORM A SUFFICIENT BASIS FOR DISCIPLINE"

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through its undersigned counsel, hereby opposes Respondent's "Motion to Dismiss for Failure to State Facts Which Would Form a Sufficient Basis for Discipline" submitted January 5, 2023, and filed January 6, 2023. Respondent's motion lacks merit and should be denied.

MEMORANDUM OF POINTS AND AUTHORITIES

I. BACKGROUND

On September 21, 2022, the IC filed a formal complaint asserting that Respondent committed several violations of the Medical Practice Act with respect to Patient A, Patient B, and Patient C. Respondent has now moved to dismiss the Complaint, arguing that it fails to state facts forming a sufficient basis for discipline.

II. ARGUMENT

A. Relevant Law

NRS 622A.360(2)(e) provides that a party in in administrative hearing may file a motion "requesting dismissal of the charging document for failure to state facts which, if true, would form a sufficient basis for discipline." While there is no case law examining this statute, discussion of analogous provisions allowing for dismissal for failure to state a claim, for example, NRCP 12(b)(5), indicates that when deciding such a motion, the judicial officer must accept all

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factual allegations as true and draw all inferences in the plaintiff/prosecuting party's favor. *See Buzz Stew, LLC v. City of N. Las Vegas*, 124 Nev. 224, 227-28, 181 P.3d 670, 672 (2008); *see also Breliant v. Preferred Equities Corp.*, 109 Nev. 842, 846, 858 P.2d 1258, 1260 (1993) (explaining that, to avoid dismissal for failure to state a claim, a plaintiff must allege facts sufficient to provide respondents "fair notice of the nature and basis of a legally sufficient claim").

Additionally, "Nevada is a notice-pleading state." *Western States Constr., Inc. v. Michoff*, 108 Nev. 931, 936, 840 P.2d 1220, 1223 (1992). Therefore, "a complaint need only set forth sufficient facts to demonstrate the necessary elements of a claim for relief so that the defending party has adequate notice of the nature of the claim and relief sought." *Id.*; *see also Harris v. State*, 138 Nev. Adv. Op. 40, 510 P.3d 802, 807 (2022).

B. The Complaint Sufficiently Alleges Facts Demonstrating the Existence of the Elements of Each Count

In his motion, Respondent attempts to create his own standard for what should be included in the complaint and then find the complaint lacking in that regard, to complicate straightforward language, and, while arguing that the complaint alleges insufficient facts to support the complaint, to simultaneously argue that some facts have not been "established." Arguing the merits of the counts underscores that the charges have been set forth in sufficient detail for Respondent to understand and defend against them. *See Western States Constr.*, 108 Nev. at 936. The Complaint sets forth sufficient facts to support each of the counts therein, and Respondent's arguments do not change that.

The Complaint in this matter alleges that Respondent violated numerous provisions of the Nevada Medical Practice Act in his treatment of Patient A, Patient B, and Patient C. Notably, Respondent did not perform cosmetic gynecologic surgery on any of these patients, and the Complaint only refers to such procedure when it notes that Patient A presented at Respondent's practice for a consultation for such a procedure. Despite cosmetic gynecologic surgery being only tangentially relevant to the charges here, Respondent attempts to frame the Complaint as misconstruing and rejecting the legitimacy of his cosmetic gynecology practice and asserts that if

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the Complaint is read with an understanding of such a practice, the counts charged fail to set forth a sufficient basis for discipline. While Respondent may certainly attempt to argue at the hearing that the nature of his practice renders his alleged behavior acceptable, this does not render the Complaint insufficient to proceed.

Respondent also repeatedly attempts to argue the merits, i.e., whether he knowingly or intentionally attempted to deceive the Board or that the IC has failed to "establish" certain facts—but exploration of such facts relating to the charges is the purpose of the hearing. The allegations in the Complaint are sufficient to support the charges made, and the facts asserted therein—as well as the facts asserted by Respondent—will be subject to testing through the adversarial process. The Complaint is not intended or required to "establish" all facts, and conclusory refutations of asserted facts are not adequate to support dismissal.

The IC submits that the Complaint speaks for itself, and each count therein is alleged with sufficient specificity. Nonetheless, the counts are addressed briefly below in response to Respondent's arguments:

i. Count I and Count II

Respondent apparently believes that if Patient A's visit to him on November 17, 2020, was called a "consultation," he can somehow conclude that a pelvic examination is not "medical treatment" or a "medical procedure," and he therefore is not subject to the provisions of NRS 630.301(6), which provides that "disruptive behavior with . . . patients . . . if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient" constitutes grounds for discipline. It appears Respondent is arguing that a physician's behavior is not subject to the requirements of the Medical Practice Act if he simply refers to an encounter as a "consultation." However, common sense belies such an argument.

The Complaint clearly asserts that taking ten (10) unnecessary photos of Patient A's vaginal and rectal areas, including one photo of him inserting four (4) fingers into her vagina, and telling her that he attempted to "fist" her during the examination humiliated and sexually demeaned her, thereby adversely affecting the quality of care rendered to Patient A during her encounter with Respondent—an encounter that occurred because Respondent is a physician to whom she was

referred to address a medical issue, and this is true regardless of what that encounter was called.

ii. Count III and Count IV

Counts III and IV of the Complaint arise from the discrepancies between Respondent's records made contemporaneously with his encounter with Patient A on November 17, 2020, his response to the Board's inquiry into the matter, and a photograph he took during the encounter. In his motion, Respondent appears to attempt to argue that he cannot be held responsible for the inaccuracy of his response to the Board's inquiry in this matter because his description of his measurement of Patient A's introital opening "would be drawn from memory of events occurring nearly one (1) year prior to the investigation." *Motion* at 6, ll. 28. This argument fails to account for the alleged discrepancy between Respondent's statement in the medical record, allegedly made contemporaneously with the examination, that he measured Patient A's introital opening with "two examining fingers" and the photograph taken during the examination, *see Complaint*, ¶ 32, or that the response "drawn from memory of events occurring nearly one (1) year prior" were quite detailed; these details and the credibility of any testimony regarding them are the proper subject to the forthcoming hearing.

Respondent also summarily concludes that "the method used to obtain this measurement was not relevant to diagnosis, recommended treatment, or future care of Patient A." *Motion* at 7:27-28. Arguments about the relevance of evidence are appropriate for the hearing on the Complaint, and demonstrate that the Complaint has placed Respondent on notice as to what is being alleged against him, and that he has the opportunity to respond to those allegations, and thus the sufficiency of the Complaint.

iii. Counts V and VI

The relationship between a physician and patient involves the placement of the patient's trust in the physician and the maintenance of appropriate professional boundaries. *See Hoopes v. Hammargren*, 102 Nev. 425, 431, 725 P.2d 238, 242 (1986) ("The physician-patient relationship is based on trust and confidence."). The Complaint alleges that by offering Patients B and C money to pose nude for photographs, Respondent violated that trust, and exploited his relationship with the patients for his own financial or other personal gain. This is sufficient to state a violation of

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NRS 630.301(7). The details of these offers and their nature, i.e., whether they were suggestive or demeaning, or whether or what Respondent stood to gain from them, may be explored at the hearing, as can Respondent's assertions that these offers were appropriate.

iv. Counts VII and VIII

With respect to charges that he continually failed to practice medicine properly and brought the medical profession into disrepute, Respondent complains it is improper for him to be compared with other obstetrician-gynecologists in determining whether he adhered to the appropriate standard of care because of his certifications in other areas. The nature of Respondent's certifications, that is, the requirements underlying each and the body issuing such certifications is, again, ripe for exploration at the hearing. Notably, the Complaint does not assert that Respondent completed a cosmetic procedure with respect to any of the patients in this matter—while Patient A was meeting with him to explore the possibility of such a procedure, she did not meet with Respondent again after this initial encounter; and he was providing routine gynecologic care to Patient B and Patient C. Nonetheless, Respondent is free to argue at the hearing why he believes he is subject to a standard different than his colleagues who do not practice cosmetic gynecology; however, the Complaint is sufficient to support proceeding to such a hearing on these charges.

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III. CONCLUSION

Because the Complaint sets forth "sufficient facts to demonstrate the necessary elements of [the] claim[s] for relief so that the defending party has adequate notice of the nature of the claim and relief sought," *Western States Constr.*, 108 Nev. at 936, Respondent's "Motion to Dismiss for Failure to State Facts Which Would Form a Sufficient Basis for Discipline" should be denied.

DATED this 12th day of January, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 13th day of January, 2023, I served a file-stamped copy of the foregoing **OPPOSITION TO RESPONDENT'S "MOTION TO DISMISS FOR FAILURE TO STATE FACTS WHICH WOULD FORM A SUFFICIENT BASIS FOR DISCIPLINE"** via USPS Regular Mail to:

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DATED this 13th day of January, 2023.

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BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.,** **Respondent.**	**CASE NO.: 22-27891-1** **RESPONDENT'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE'S MOTION TO PROTECT PATIENT LIKENESSES**

Respondent George Peter Chambers, Jr., M.D., by and through his attorneys of Nutile Law, hereby files his Opposition to the Motion to Protect Patient Likenesses ("Motion") filed by the Investigative Committee ("IC") of the Nevada State Board of Medical Examiners (the "Board"). This Opposition is brought in accordance with the Order Setting Hearing filed December 6, 2022 ("Order"), the attached Memorandum of Points and Authorities, and any argument that the Hearing Officer will allow upon a hearing in this matter.

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Dated this 13th day of January 2023.

On behalf of Respondent:

NUTILE LAW

/s/ Maria Nutile

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

The charges in this case arose from allegations related to three (3) of Respondent's patients, referred to in public documents as Patient A, Patient B, and Patient C (together, the "Patients"). Respondent is an obstetrician/gynecologist specializing in female genital cosmetic and plastic surgery and sexual health medicine. Not surprisingly, the allegations against him are characterized in the Complaint as forms of "sexual misconduct", and generally as sensitive and salacious in nature.

The IC's Motion indicates an expectation that the identities of the Patients will be protected through the fair hearing process, and requests an order to further protect their likenesses from being recorded.

Responded opposes any confidentiality protections or guarantees for any of the Patients. As a matter of fundamental fairness, the Patients are not entitled to a cloak of anonymity after inviting media attention and publicly accusing Respondent of being a sexual abuser, which is a death knell for the professional reputation of any OB/GYN. Additionally, the confidentiality protections pursuant to Nevada law cited in the Motion do not apply to patients who consent to the use of their medical records and/or who bring complaints themselves against physicians, particularly once a formal complaint has been filed and all documents become part of the public record.

As discussed below, Respondent requests that the IC's Motion be denied, with further clarification that patient identities are not subject to any guarantees of anonymity in this case.

II. STATEMENT OF FACTS

The IC filed the Complaint in this matter on September 21, 2022. The Complaint alleges eight (8) Counts total.

1. With regard to Patient A: Counts I and II, Disruptive Behavior (NRS 630.301(6)); Count III, Engaging in Conduct Intended to Deceive (NRS

630.306(1)(b)(1)); and Count IV, Failure to Maintain Accurate Medical Records (NRS 630.3062(1)(a)).

2. With regard to Patient B: Count V, Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

3. With regard to Patient C: Count VI, Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

4. With regard to Patients A, B, and C: Count VII, Continual Failure to Practice Medicine Properly (NRS 630.306(1)(g)); and Count VIII, Disreputable Conduct (NRS 630.301(9)).

The Complaint includes salacious allegations that Respondent sexually demeaned each of Patients A, B, and C by way of words and actions including vaginal photography. In its Motion, the IC has requested that the Hearing Officer direct all persons present at the hearing to refrain from recording the likenesses of any of the Patients, and presumes that their identities will be equally protected through continued use of pseudonyms throughout the proceedings.

While Respondent has no intention of advertising the Patients' identities or encouraging broadcast of their likenesses, we disagree that the Patients are entitled to any confidentiality protections when they, and the Board itself, have taken deliberate actions to publicly brand Respondent as a sexual abuser, defame his reputation, and destroy his professional practice.

A. Media Attention Invited by Patients

On September 30, 2022—a mere nine (9) days after the Complaint was filed—an article fiercely critical of Respondent was published online by the *Daily Beast* ("Article"),[1] a copy of which is attached as Exhibit A. Patient A and Patient B are directly quoted in the Article and

[1] Kate Briquelet, "'Vagina Whisperer' OBGYN Accused of Sexual Misconduct by Medical Board," *The Daily Beast*, September 30, 2022, available at https://www.thedailybeast.com/vagina-whisperer-obgyn-dr-george-chambers-accused-of-sexualmisconductby-medical-board

referred to as having "told The Daily Beast" various scandalous allegations, far more colorful than those included in the Complaint. They intentionally launched an attack in the public opinion assault of Respondent by inviting, or at least participating in, media coverage of his alleged misdeeds. The Article was then picked up by other news outlets, including FOX5Vegas (KVVU)[2] and the United Kingdom's Daily Mail[3]. As a result, Respondent's medical practice and professional reputation have been decimated, based on what remain mere allegations.

According to the Article, "Patient B told The Daily Beast that she's sharing these private details because she wants people to have a clear picture of how she believes he manipulated her," adding that she " 'felt violated, embarrassed and angry' " when he asked " 'with a creepy smile on his face' " if she had ever posed nude. (Emphasis added.) Patient B also reportedly told The Daily Beast that Respondent would "ask invasive questions about her sex life and libido and, unsolicited, discussed his sexual activities with her." Patient B went so far as to (reportedly) share text messages between her and the Respondent with The Daily Beast.

Patient A went to even greater lengths to publicly accuse Respondent of sexually-related misdeeds. The Article states,

> Before the medical board filed the complaint, Patient A also tried other avenues to hold [Respondent] accountable for what she believes was sexual assault. She says she reached out to attorneys, other physicians in the community, media outlets, Yelp, and the FBI. "Every single one of these efforts, up until now, has failed to protect women or command justice and has resulted in compounding trauma for myself," Patient A said.

(Emphasis added.)

Both Patient A and Patient B deliberately publicized their "sexual misconduct"

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[2] Elaine Emerson, "Las Vegas OBGYN subject of sexual misconduct complaint," FOX5 KVVU-TV, September 30, 2022, available at https://www.fox5vegas.com/2022/09/30/las-vegas-obgyn-subject-sexual-misconduct-complaint/

[3] James Gordon, "Las Vegas gynecologists - who called himself the 'Vagina Whisperer' - is accused of sexual misconduct by Nevada Medical Board: Patients say 'doctor touched them inappropriately then offered $1,000 to pay for nudes,' *The Daily Mail*, September 30, 2022, available at https://www.dailymail.co.uk/news/article-11268873/Las-Vegas-OB-GYN-Vagina-Whisperer-accused-sexual-misconduct-Nevada-Medical-Board.html

accusations against Respondent, allegedly hoping to "protect women" and make sure "people [ ] have a clear picture" of Respondent. Although neither Patient A nor Patient B was identified by name in the Article, it is reasonable to assume that the reporter (at minimum) knew their identities in order to communicate with them.

B. Public Derision Invited by the Board

As detailed in Respondent's MOTION TO DISMISS FOR DUE PROCESS CLAUSE VIOLATIONS ("MTD"), the Board itself exhibited deliberate indifference and reckless disregard for Respondent's due process rights by needlessly posting the Complaint in this matter in two (2) different places on its official website, without any disclaimers as to Respondent's presumption of innocence, and without equal dissemination of Respondent's Answer denying the allegations and objecting to aspects of the Complaint. We refer to the MTD for additional information.

III. LEGAL ARGUMENT

A. Anonymity Exception

A medical licensing board's functions of "holding hearings, taking evidence, and adjudicating are functions that are inherently judicial in nature." Mishler v. Clift, 191 F.3d 998, 1008 (9th Cir. 1999). The Ninth Circuit has held that "[A] party may preserve his or her anonymity in judicial proceedings in special circumstances when the party's need for anonymity outweighs prejudice to the opposing party and the public's interest in knowing the party's identity." Does I thru XXIII v. Advanced Textile Corp., 214 F.3d 1058, 1068 (9th Cir. 2000). Special circumstances include the need "to preserve privacy in a matter of sensitive and highly personal nature." *Id.*, citing *James v. Jacobson,* 6 F.3d 233, 238 (4th Cir.1993).

In *Doe v. City of Las Vegas* (No. 219CV00382GMNBNW, 2019 WL 2601554, at *3 (D. Nev. (June 25, 2019)), a plaintiff's request to proceed anonymously to avoid harassment, ridicule and extreme personal embarrassment, and public condemnation was denied because she had "purposefully availed herself of news media, broadcasting the case, and putting it in the public

eye." Further, "While her name was not used, she facilitated others' ability to learn of the existence of the case....[T]he controlling fact is that her actions do not indicate the desire to maintain privacy. *Id* (emphasis added).

Although claims of sexual assault tend to concern "matters of a sensitive and highly personal nature," in a recent case of alleged rape under Title IX, the court denied anonymity to a plaintiff who had publicly named the defendant. Doe v. Liberty Univ., Inc., No. 6:21-CV-00059, 2022 WL 4781727, at *5 (W.D. Va. Sept. 30, 2022). Plaintiff had "sought to avail herself of the protections of anonymity..., all the while single-handedly precluding the Named Defendant from the ability to avail himself of similar protections." *Id.* Regardless of the forum, "Equity does not support parties' strategic use of litigant anonymity as both sword and shield." *Id.* (emphasis added).

We have no doubt that the Patients wish to proceed anonymously to avoid harassment, ridicule, extreme personal embarrassment, and/or public condemnation, and that the IC/Board wishes to do the same on their behalf. However, just as in *Doe v. City of Las Vegas,* Patient A, Patient B, and the Board have deliberately put Respondent's case in the public eye, "facilitat[ing] others' ability to learn of the existence of the case," in an effort to discredit Respondent without the need for a hearing. Just as in *Doe v. City of Las Vegas*, Patient A and Patient B have "purposefully availed [themselves] of news media, broadcasting the case." The sexual nature of the allegations (including Patient A's overt allegation of sexual assault in the Article) liken Respondent's position to that of a rape suspect, in which case the alleged "victims" should only be afforded anonymity protection if the suspect had been equally protected. Regardless of whether or not the patients' names have been published, they had to be known to the Article's writer. In any event, their "actions do not indicate the desire to maintain privacy" and thus they have waived the luxury of anonymity of which they have wholly deprived Respondent.

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B. Confidentiality Pursuant to Nevada Law Not Applicable

1. *NRS 629.061(7)*

Pursuant to NRS 629.061(7):

> Records made available to a representative or investigator must not be used at any public hearing unless:
> (a) The patient named in the records has consented in writing to their use; or
> (b) Appropriate procedures are utilized to protect the identity of the patient from public disclosure.

(Emphases added.) The IC must therefore have either the patient's consent to use their records, or, only in the absence of such consent, appropriate procedures must be used to protect the patient's identity. NRS 629.061(7) does not provide that the patient's identity be protected if the patient has consented to the use of their records by the IC. Given that each of the Patients is the presumed complainant and each is listed as a witness for the IC in this case, it is presumed that patient consent has been provided. On its face, NRS 629.061(7) does not provide for anonymity protections for a willing participant.

Upon review of the legislative history of NRS 629.061(7), there was concern that, as the statute was originally drafted, a lack of patient consent could impinge on an investigation or prosecution necessary to protect the public, and/or that a patient's records would be publicized and used without their knowledge. Senate Bill 185 (1977) was amended to include, in part, the language above to "capture the very idea the [Nevada State Senate Judiciary] Committee had in its mind"[4] and avoid either eventuality. To wit:

- "[I]n the case where a patient is filing a complaint, that the act of filing against the physician would constitute a waiver."[5]

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[4] Minutes of the Nevada State Senate Judiciary Committee, March 8, 1977 at 4 Deputy Attorney General William Isaeff). Available at https://www.leg.state.nv.us/Division/Research/Library/LegHistory/LHs/1977/SB185,1977.pdf

[5] Minutes of the Nevada State Senate Judiciary Committee, March 2, 1977 at 4 (Senator Bryan). Available at https://www.leg.state.nv.us/Division/Research/Library/LegHistory/LHs/1977/SB185,1977.pdf

- "When the party makes a complaint about the doctor, … he is waiving his right to the confidentiality of those records."[6]
- When a patient has made an allegation triggering an investigation, he or she "should [not] reasonably be able to say 'wait a minute I have changed my mind now' " and refuse consent to utilize his or her records. "The committee felt very strongly that once you put the wheels in motion, you can't in the interest of the public, stop it."[7]
- "[I]n the case of repeated negligence, there might be the need to look at more people's records who have never filed allegations,"[8] in which case "a notice to the patient that his records were subject to inquiry [should be] given."[9]

It is clear the Nevada Legislature added the language of NRS 629.061(7) to provide the opportunity for state agencies to pursue prosecution in the public interest in the event a patient did not or would not provide consent to release of his or her medical records. That is not the case for the Patients, who brought their complaints to the Board voluntarily and appear to be willing to testify at the public fair hearing.

2. *NRS 622.310(1)*

NRS 622.310(1) provides that:

> If any provision of this title requires a regulatory body to disclose information to the public in any proceeding or as part of any record, such a provision does not apply:
>
> (a) To any personal medical information or records of a patient that are confidential or otherwise protected from disclosure by any other provision of federal or state law.
>
> (b) To any personal identifying information of a person alleged to have been injured by any act of another person for which a license, certificate or permit is required to be issued by a licensing board. Such information must be kept confidential by the licensing board in whose possession the information is held.

According to the legislative history of Senate Bill 220 (2013) which added the foregoing

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[6] Id. at 2 (Senator Sheerin).
[7] Id. at 3 (Senator Hilbrecht).
[8] Id.
[9] Id. at 4 (Senator Bryan).

language, bill sponsor Senator Hardy stated the bill was intended to protect the confidentiality of patients receiving unlicensed medical care, which is not at issue here:[10]

> **Senator Hardy**: The bill protects the patient confidentiality. If patients are getting unlicensed care but think they are getting licensed care, they still have to be protected for their confidentiality. We need to treat them as if they were getting licensed care.[11]
> ...
> If I may go back to the issue of personal identification, with the victim of unlicensed care, the victim must be kept confidential. I will defer to Mr. Lee.
>
> **Keith Lee** [representing the Nevada State Board of Medical Examiners]: Assemblyman Daly, I can speak only for the Board of Medical Examiners, but all information we obtain during an investigation remains confidential until such time as we file a disciplinary complaint. At that point in time, it becomes a matter of public record. I believe the other boards of which I am familiar treat that information the same way.[12]

Specifically, pursuant to NRS 630.336(5), "The formal complaint or other document filed by the Board to initiate disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records." (Emphasis added.) As the medical records in this case are part of the public record, so must be the Patients' identities.

C. Credibility and Confrontation Concerns

Respondent has the constitutional right to confront any witnesses adverse to him:

> [W]here governmental action seriously injures an individual, and the reasonableness of the action depends on fact findings, the evidence used to prove the Government's case must be disclosed to the individual so that he has an opportunity to show that it is untrue. While this is important in the case of documentary evidence, it is even more important where the evidence consists of the testimony of individuals whose memory might be faulty or who, in fact, might be perjurers or persons motivated by malice, vindictiveness, intolerance, prejudice, or jealousy. We have formalized these protections in the requirements of confrontation and cross-examination. They have ancient roots. They find expression in the Sixth

[10] Minutes of the Meeting of the Assembly Committee on Commerce and Labor, May 8, 2013 at 55. Available at https://www.leg.state.nv.us/Session/77th2013/Minutes/Assembly/CL/Final/1074.pdf

[11] Id.

[12] Id. at 59 (emphasis added).

> Amendment. This Court has been zealous to protect these rights from erosion. It has spoken out not only in criminal cases, but also in all types of cases where administrative actions were under scrutiny.

Goldberg v. Kelly, 397 U.S. 254, 270, 90 S. Ct. 1011, 1021, 25 L. Ed. 2d 287 (1970) (internal quotation omitted). This right of confrontation is especially true in this case given the damning "he said/she said" allegations. The credibility of the Patients as witnesses, or possible lack thereof, will be crucial to Respondent's defense.

In order to establish credibility or lack thereof, it will be necessary to validate the identity of each witness to ensure his or her testimony is relevant to the case and thus admissible. Further, the identity of a Patient witness testifying as to a medical record in evidence must be confirmed as matching the identity of the patient in the medical record. Neither of these steps can be accomplished on the record without public disclosure of the patient's identity.

Moreover, Respondent may find it necessary as part of his defense to confront a Patient-witness in a manner or in relation to facts which may directly or indirectly reveal a Patient's identity to the public. Respondent's confrontation of a Patient-witness should not be limited, and his rights thereby infringed, out of concern for violating the confidentiality and/or anonymity of his accuser.

IV. CONCLUSION

By filing their complaints with the Board, and later inviting public scrutiny of Respondent without protecting his identity, the Patients waived and/or are not entitled to the protection of anonymity. Similarly, the IC/Board's deliberate indifference and reckless disregard for Respondent's due process rights precludes its ability to now protect the identities and/or likenesses of the Patients in a public forum. State law confidentiality protections were not intended to apply to the circumstances of this case, and enforcing them would likely result in further infringement of Respondent's constitutional rights.

For reasons set forth above, Respondent opposes the IC's Motion with regard to both the requested confidentiality of the Patients' likenesses, as well as the presumed confidentiality of

the Patients' identities.

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CERTIFICATE OF SERVICE

I hereby certify that I am an employee of NUTILE LAW, and that on this 13th day of January 2023, I caused to be filed via email an electronic copy of the foregoing **RESPONDENT'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE'S MOTION TO PROTECT PATIENT LIKENESSES** to the following:

Brandee Mooneyhan, J.D., Deputy General Counsel mooneyhanb@medboard.nv.gov;

Donald K. White; J.D. Deputy General Counsel dwhite@medboard.nv.gov

Nancy Moss Ghusn, Esq., Hearing Officer nmg416@gmail.com

/s/ *Bridget Kelly*
An employee of NUTILE LAW

EXHIBIT A

EXHIBIT A

https://www.thedailybeast.com/vagina-whisperer-obgyn-dr-george-chambers-accused-of-sexual-misconduct-by-medical-board

'Vagina Whisperer' OBGYN Accused of Sexual Misconduct by Medical Board

CREEPS IN SCRUBS

Patients claim the doctor pressured them to pose for "boudoir" photos and made sexually explicit comments, including while delivering a baby.

Kate Briquelet

Senior Reporter

Updated Sep. 30, 2022 12:46PM ET / Published Sep. 30, 2022 11:04AM ET

https://www.thedailybeast.com/vagina-whisperer-obgyn-dr-george-chambers-accused-of-sexual-misconduct-by-medical-board

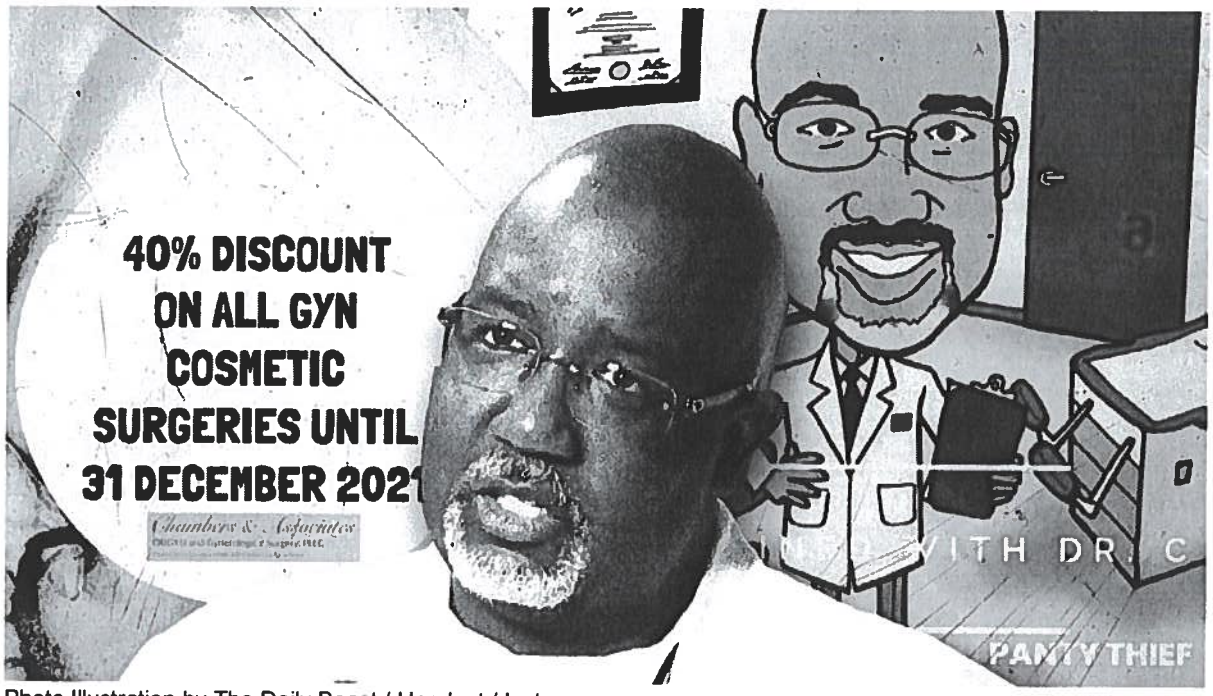

Photo Illustration by The Daily Beast / Handout / Instagram

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A Las Vegas gynecologist—who billed himself as a certified sexual health clinician under an Instagram account that used the words "vagina whisperer"—is facing a complaint from Nevada's medical board, which has accused him of repeated "sexual misconduct," including asking female patients to pose for sexually explicit photographs for his business.

The new filing charges Dr. George Chambers with disruptive behavior, disreputable conduct, engaging in conduct intended to deceive, failure to maintain accurate medical records, continual failure to practice medicine properly, and engaging in conduct that violates the trust of a patient and exploits the relationship with the patient for financial or other personal gain.

https://www.thedailybeast.com/vagina-whisperer-obgyn-dr-george-chambers-accused-of-sexual-misconduct-by-medical-board

Details in the state Board of Medical Examiners' complaint paint an unsettling picture of the 51-year-old OBGYN, who allegedly "violated patients' trust by engaging in sexual improprieties" such as inviting them to "boudoir" photography sessions. Before these accusations, at least one woman filed a police report against Chambers that ultimately didn't lead to criminal charges.

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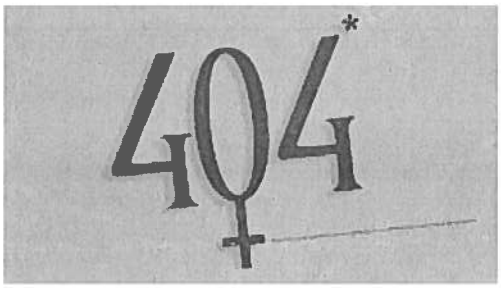
Scientific American Yanks 'Hit Piece' on Twitter's Fave Gyno

STRONG MEDICINE

Emily Shugerman



Two patients identified in the complaint told The Daily Beast that they're coming forward to prevent other women from experiencing similar conduct with Chambers or any other doctor. "I knew the situation was not normal, it felt wrong, and many things that were done and said by

Dr. Chambers completely shocked and upset me," said one woman, who is referred to as "Patient A" in the complaint. "But my frame of reference kept me from recognizing, in those moments, the true nature of what was happening to me."

According to the document, when "Patient A" visited Chambers for a surgery consultation in November 2020, he injured and humiliated her by sticking his hand in her vagina. He then allegedly used sexual slang to describe his actions, telling the 36-year-old that he'd attempted to "fist" her. The complaint says Chambers also used the woman's cellphone to take photos of her vagina and asked her to text him two of the images for her medical file.

In another episode, Chambers allegedly offered 35-year-old "Patient B" $1,000 for nude photos. The filing says the images were "ostensibly to use in an advertisement for his services," and "not for purposes of medical examination or treatment."

The doctor is accused of making a similar pitch to "Patient C" during an October 2019 appointment after the 27-year-old mentioned she was struggling financially. Chambers told the patient he was "seeking models to participate in a photography session in which photos would be taken of the model's vaginal area and nude body," the complaint alleges, adding that the images would be used for his "portfolio" or for advertising.

The gynecologist allegedly tried to sweeten the proposal by claiming he'd give her a thumb drive of the "boudoir" photos from their session. "Patient C thought it was odd that [Chambers] was soliciting

photographs of her vaginal area as a representative of his work because he had never performed any cosmetic procedure on her genitals," the filing adds.

The medical board alleges Chambers "repeatedly exploited his relationships with patients and violated patients' trust by engaging in sexual improprieties that constitute sexual misconduct," and that his "repeated acts of sexual misconduct" and Medical Practice Act violations "undermine the public's trust and respect for the medical profession."

Chambers did not return messages seeking comment.

The doctor, who was licensed in Nevada in 2003, was active on Instagram under the handle @vaginawhispererlasvegas before deactivating the account on Thursday. He marketed himself as a board-certified OBGYN also specializing in cosmetic gynecology, and touted his glowing Yelp reviews and a "top doctor" distinction from *Health Care Quarterly*.

On his practice's website, which was also shut down recently, Chambers boasted that he is "the only board certified obstetrician and gynecologist in Nevada who is also certified in sexual health medicine." The site added, "As a gynecological surgeon who was raised and positively influenced by women, Dr. Chambers recognizes that all women want to look and feel beautiful."

"I am living my dream every day because I was blessed to have discovered my true purpose in life," Chambers wrote in a bio on his now-defunct site.

"I use four guiding principles when I approach patient care: 1. I provide the same level of care as I would want for the women in my family. 2. I obey the basic rules of surgery to ensure a safe outcome for my patients. 3. I respect the human body; thus, I create surgical incisions that will be aesthetically pleasing to my patients and to me. 4. I take pride in my work."

His TikTok and Instagram accounts shared videos of surgeries and closeups of vaginas. One showed Chambers dancing into his disposable surgery gown, past what appears to be the body of a patient on a table. "Dr. C living his best life," reads text superimposed on the video. It's unclear whether patients knew he was recording himself during these procedures.

On Instagram, he promoted his services with images that appeared to be amateur photographs of women's bodies that were edited or filtered. A regular feature on his account was "Sexplained with Dr. C," which delved into fetishes and sexual terminology that some audiences might find more fitting for pornography than a medical office. "Why do some men steal women's panties?" one post in that series asked. Another explored the term "cuckold."

Chambers' account also posted a meme that declared: "If it doesn't bring you income, motivation or orgasms it doesn't belong in your life."

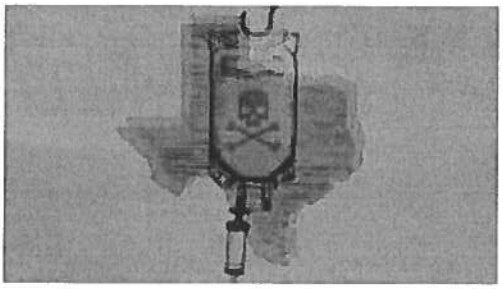
The woman referred to as "Patient B" told The Daily Beast that Chambers, over her seven years as his patient, appeared "very focused on sex."

She says Chambers had a "charming personality and great bedside manner" but some aspects of his practice seemed off—such as when he'd ask invasive questions about her sex life and libido and, unsolicited, discussed his sexual activities with her. Sometimes during her visits, they'd spend over an hour chit-chatting in the exam room.

- Doc Probed in Death of Colleague Via IV Drip Has Scary Past

'HISTORY OF VIOLENCE'

Kate Briquelet



"He was different from other OBGYNs," she said. "He wouldn't wait for me to ask a question about my sexual health, he would just fire questions away ... I'm sitting in the room feeling like I have no choice but to answer these questions."

"He also would ask me about past trauma, things like that," the patient said. "I was raped when I was 16 years old. He knew things like this. He was very kind. I felt heard. I trusted him with a lot of personal information." The patient said she'd referred other women to Chambers over the years and told people, "You either really like him or really hate him."

But one particular encounter raised red flags. She says that after Chambers delivered her baby and was stitching her up, she overheard him make "inappropriate comments" about women and their vaginas. She says these comments arrived when she was particularly vulnerable, legs spread on a hospital bed, and in front of a male nurse. "He said it's good that I tore because that means I wasn't loosey goosey," she said, adding that she was so disturbed by his comments that she wrote them down to document them.

Still, Patient B and Chambers had a friendly relationship. "He would make comments over the years such as, 'You're beautiful.' But I never took it to mean anything other than he's trying to build my self-confidence, make me feel better," she said. Chambers also texted the patient and asked her to vote for him in "top doctor" awards contests.

Her October 2018 visit, however, would be her last. That day, Patient B had a breast exam in front of two female student doctors and a nurse. "He walks in and right off the bat, he starts telling the student doctors, 'Oh, this is my patient. She was gang-raped.' So right there I'm thinking this is personal information that I trusted you with. You're telling people I've never met as a way to brag that you have a good relationship with your patients."

Patient B told The Daily Beast that she's sharing these private details because she wants people to have a clear picture of how she believes he manipulated her.

According to the patient, the nurse left the room and Chambers then asked his underlings to follow her. "He said, 'Have you ever posed nude?' with a creepy smile on his face," the patient said. "I said, 'No, why do you ask?' And then he went on to tell me that he needs models to pose nude for his ads for his labiaplasty website."

"It was very awkward. I didn't know what to do or what to say. I kept trying to steer the conversation away from that topic."

She said Chambers told her she was "so beautiful" and "perfect" for his ads and suggested that while he could pay less for stock photos of women, he wanted to photograph her instead. "I want the real women, the women who have been through so much," Chambers allegedly told her, adding that he'd pay her $1,000.

Patient B says Chambers brought out his cellphone and showed her a photo of a woman squatting and looking at the camera. The image appeared to be edited with photo filters. "He told me that he does this with his patients," she said. "He told me his patients get very provocative and seductive in front of him, especially when he tells them to 'fuck the camera.'"

Patient B said she ticked off excuses to reject his proposal, including informing him that she'd had laser hair removal. During the entire conversation, the patient was naked with a paper gown covering her bottom half. Chambers then asked her to stand so he could look at her,

she says. After she stood, Chambers allegedly commented, "Perfect, even more perfect."

While she says Chambers claimed to need photos for his labiaplasty practice, she'd never had the surgery or planned to; there would be no before or after photos from her.

Chambers was persistent, she says, and offered her copies of the photos to give to her husband. "What husband wouldn't want nude professional photos of their wife?" Chambers asked, according to the patient. The doctor then allegedly warned, "But just make sure your husband doesn't know that I was the photographer. You can't tell him I was the photographer and you can't tell him where it was taken."

She said that before she left his office, Chambers asked her to text him with her decision but to keep the details vague, only referring to his offer as a "project."

"I felt violated, embarrassed and angry," the patient said in an interview, "and I knew I was never going to come back there."

The Daily Beast reviewed a copy of a text message Patient B sent to Chambers after the visit. "I feel that doing this project would be crossing several boundaries and would be highly unethical," she wrote. "I am not interested. I will also be picking up copies of my medical records and will be seeing a different gynecologist."

Chambers replied, in part, "I respect ur decision. Sorry the request offended u, but it the only way I recruit models for my ads. It does not

violate the code of medical ethics. I will miss u as a patient. I hope and wish for u continued good health and best wishes."

He added, "U know, I am in the process of developing a YouTube channel and Instagram page for sexual health medicine. I was concerned about losing patients. Again, my sincerest apology to u."

"He kept trying to convince me that because I've been through so much in my life, that if I were to do this for him that it would be incredibly empowering for me as a woman," Patient B said. "And he really tried to stress that point. You're telling me that this will be empowering for me. The empowering thing is to walk out of your office."

Meanwhile, Patient A told The Daily Beast that she'd contacted the Las Vegas Metropolitan Police Department weeks after her November 2020 encounter with Chambers.

She says officers downloaded the entire contents of her cellphone and, over a seven-month period, claimed to be investigating Chambers. But in July 2021, a detective allegedly called her and said they had "good news": They determined Chambers had not sexually assaulted her.

"I responded asking how 'fisting' someone was not sexual assault, to which the detective said that they 'don't know what Chambers put in your vagina,'" the patient said. "I responded saying, 'I know what he put in my vagina. I felt it, and Dr. Chambers told me and showed me exactly what it was.'" She said she then reminded the officer of the "excruciating pain and damage" that Chambers allegedly caused her, which resulted in a visit to her OBGYN six days later.

"Detectives maintained that they didn't know what was put in my vagina and I was not sexually assaulted," Patient A said.

She says that when she spoke to a detective on another occasion, he told her that she consented to Chambers' exam, so it wasn't sexual assault. "I consented only to an exam to assess damage to the perineum, not to 'fisting,'" she told The Daily Beast.

"I called the lieutenant overseeing the investigation and was assured that no matter how many women report Dr. Chambers to the police, my case would never be reopened," she said.

"Through my experience," she said. "I have come to understand that women are at risk everywhere of not only being sexually abused, but also of having the systems meant to protect them from such abuse, instead, compound their trauma."

The Daily Beast has reached out to Las Vegas police for comment.

The medical board's complaint says that Patient A's regular gynecologist referred her to Dr. Chambers for a damaged perineum. During her office visit, the filing states, Chambers asked her to undress and to keep her cellphone nearby, so that he could use it to take photographs of her body during his examination.

Chambers then used her phone to take a dozen photos of her vaginal and anal areas, the complaint states, and asked her to text him two of the images. "Patient A was uncomfortable texting the pictures to [Chambers'] cellular phone, in part because she had no assurances that

the data was being exchanged securely, how the pictures might be used, or who might have access to them once they were sent," the filing says.

The board's complaint says that one of the photographs—which the doctor did not request from her—showed him inserting four fingers into her vagina.

- Celebrity Cheer Coach Hit With Bombshell Sex Abuse Suit

  SPEAKING OUT

  Pilar Melendez

The filing says Chambers told the medical board investigators that he had only inserted two fingers to evaluate her pelvic floor muscles. But, according to the complaint, he failed to document what the patient's cellphone pic actually revealed in medical records.

After the physical exam, the complaint adds, Chambers told the patient that "he had attempted to 'fist' her, that is, insert his entire hand into her vagina ... but had been unable to insert his entire hand, and he showed her how much of his hand he had been able to insert." The woman "suffered pain and tenderness in her genital area" after Chambers' maneuver, the filing says.

The document alleges that Chambers' "action in taking numerous pictures" of Patient A "were not for purposes of medical examination or treatment" and that his use of the "the nonmedical term 'fisting'" had "humiliated and sexually demeaned Patient A."

The medical board adds that Chambers' decision to take multiple photographs of Patient A and direct her to send them via text "was disrespectful of Patient A's privacy."

In a statement to The Daily Beast, Patient A said she never expected to receive anything "other than appropriate and competent medical care."

"I was confident that I would be safe and trusted that my body and personal health information would be handled with respect and proper attention," Patient A said. "It is because of that confidence, those expectations, and also the understanding that gynecological visits are, by their nature, uncomfortable that I was initially unable to recognize what a dangerous situation I was in."

Before the medical board filed the complaint, Patient A also tried other avenues to hold Dr. Chambers accountable for what she believes was sexual assault. She says she reached out to attorneys, other physicians in the community, media outlets, Yelp, and the FBI.

"Every single one of these efforts, up until now, has failed to protect women or command justice and has resulted in compounding trauma for myself," Patient A said. "Being rejected repeatedly after having been put in the most exposed and vulnerable position that I had ever been in made me feel worthless and made me believe that the failed systems were somehow my fault."

In 2021, Patient A left a brief review about her experience with Chambers on Yelp, using a pseudonym. "What I experienced is very concerning," she wrote. "To say Dr. Chambers was inappropriate with me would be a gross understatement in my opinion. I hope that any woman who has had a similar experience will come forward."

Chambers posted an answer stating, "No one with your name appears in my patient database. So, you are clearly using an alias to besmirch my name and reputation with this review because you believe you will remain anonymous."

"If you were actually evaluated by me and you believe I was inappropriate, please report me to the Nevada State Board of Medical Examiners," Chambers wrote. "If you believe I committed a crime, please go to the police. By doing so, there would be an appropriate investigation of you and me. But, don't hide behind social media to trash my name in such a vile manner."

She told The Daily Beast she has a message for women in similar situations.

"There are people out there who care about them, believe them, value them, and want to support them through what they are enduring,"

Patient A said. "And I want them to know that their value is not determined by the failures of the systems which are meant to protect them."

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.** **Respondent.**	**Case No. 22-27891-1**

FILED
FEB - 7 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

MOTION FOR STATUS CONFERENCE

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through its undersigned counsel, hereby moves the Hearing Officer to direct that the hearing set to begin in this matter on February 15, 2023, be converted to a telephonic status conference during which the parties will be prepared to schedule a new hearing date.

MEMORANDUM OF POINTS AND AUTHORITIES

On September 21, 2022, the IC filed a formal Complaint asserting that Respondent committed several violations of the Medical Practice Act. On December 6, 2022, the Hearing Officer filed an "Order Setting Hearing," which directed that the hearing in this matter would occur at 9:00 a.m. on February 15 and February 16, 2023, at the Las Vegas Board Office. On January 17, 2023, counsel for Respondent informed the Hearing Officer and counsel for the IC that they were withdrawing from representing Respondent in this matter; the attorneys sent a formal letter to this effect on January 18, 2023. As part of their withdrawal, Respondent's former attorneys requested a continuance to allow Respondent to seek new counsel or prepare to represent himself at the hearing.

Thereafter, the Hearing Officer and the parties engaged in an email discussion about how the case might proceed, with the Hearing Officer noting that this matter should not languish indefinitely. Ultimately, the Hearing Officer granted Respondent's request for a continuance in order to allow him an opportunity to obtain new counsel, while maintaining the original hearing dates on calendar

in the event Respondent's new counsel wished to proceed on those dates. The Hearing Officer stated that two (2) weeks was a reasonable amount of time to allow Respondent to obtain new counsel and directed Respondent to inform her no later than 4:00 p.m. on Wednesday, February 1, 2023, of his new counsel. Late on the afternoon of February 1, 2023, Respondent informed the Hearing Officer that he had scheduled "an initial consultation with an attorney tomorrow [February 2, 2023] at 0900 hours." The Hearing Officer granted Respondent one more day to obtain counsel, which the IC did not oppose. On February 2, 2023, Respondent informed the Hearing Officer that on that morning, he had consulted with an attorney who previously represented him in other matters, and that attorney would be referring him to a litigator later in the day. The Hearing Officer responded that she looked forward to hearing from the new attorney later that day; she also reiterated that she was continuing the hearing but keeping it on calendar because counsel for the IC was prepared to proceed and Respondent's new attorney might want to proceed on that date.

Respondent failed to provide an update on February 2, 2023, as contemplated by the Hearing Officer's previous emails. The next day, February 3, 2023, the Hearing Officer asked via email if Respondent had any update; Respondent failed to respond. On Monday, February 6, 2023, the Hearing Officer asked both parties to provide an update on the status of this matter. As of the submission of this motion, Respondent has failed to respond.

As Respondent has failed to abide by the Hearing Officer's direction to inform her of his new counsel by February 2, 2023, and has otherwise ignored her subsequent requests for an update, the IC submits that proceedings in this matter should resume by February 15, 2023, regardless of whether new counsel has appeared for Respondent by that time. While the IC understands Respondent's desire to be represented by counsel in this matter, and has stated that it does not oppose a reasonable continuance for him to obtain new counsel, it respectfully submits that an open-ended continuance is not reasonable, especially when Respondent has failed to diligently keep the Hearing Officer apprised of his efforts to secure new counsel.

While due process requires that Respondent be afforded an opportunity to prepare a defense, *see Dutchess Bus. Servs. v. Nevada State Bd. of Pharmacy*, 124 Nev. 701, 712 (2008), including the

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right to retain counsel to represent him in the matter, being afforded the opportunity to retain counsel does not mean that Respondent has unlimited time to retain counsel or may disregard the Hearing Officer's directions to keep her informed of his efforts. While a criminal defendant's Sixth Amendment right to counsel does not apply here, the governing principles in that context are instructive in that "whatever the precise contours of the right to counsel in the administrative context, the outer limits of the right to *particular* counsel in an administrative proceeding, insofar as a request for a continuance is concerned, are certainly no greater than the right provided to a criminal defendant." *Virginia Bd. of Med. v. Hagmann*, 797 S.E.2d 422, 429 (2017) (citing *Turner v. Rogers*, 564 U.S. 431, 441 (2011)).

In Nevada, even in the criminal context, the right to retain counsel of one's own choosing is not absolute. *Rimer v. State*, 131 Nev. 307, 326-27 (2015) (citing *United States v. Gonzales-Lopez,* 548 U.S. 140, 144 (2006)). Therefore, while "the denial of a continuance may infringe upon the defendant's right to counsel of choice, . . . only an unreasoning and arbitrary insistence upon expeditiousness in the face of a justifiable request for delay violates the right to the assistance of counsel." *Id.* (citation omitted).

Here, after an investigation, the IC determined that Respondent violated the Medical Practice Act and proceeded to file a formal complaint with the Board. NRS 630.311(2). Such activity was undertaken for the protection and benefit of the public, *see* NRS 630.003, and thus the IC agreed with Respondent's previously stated position that this matter should proceed to hearing as soon as possible. While the IC acknowledges that the Hearing Officer must balance the IC's concerns of public protection while also affording Respondent due process, the requirements of due process are met when a respondent is given a reasonable amount of time to procure new counsel after prior counsel withdraws, especially when the respondent has not demonstrated that he has acted diligently in attempting to do so. *See Matter of Wong*, 827 P.2d 90, 94 (Mont. 1992) ("In making its decision on a requested continuance due to lack of counsel, a court or agency must assess whether the party petitioning for continuance has acted diligently in seeking counsel. 17 Am.Jur.2d § 23. If the party has not acted diligently in procuring representation, a tribunal does not abuse its discretion in denying the continuance.").

Here, Dr. Chambers has known since January 17, 2023, that former counsel withdrew, yet has shown little diligence since then in obtaining new counsel. He finally met with an attorney the day after the deadline previously given to him, however has failed to update the Hearing Officer since that date and has ignored all requests for more information, and thus has not shown a timely, continuing effort to obtain counsel.

In light of the foregoing, as well as the logistical challenges inherent in many hearing participants being required to travel to Las Vegas, Nevada, for the hearing, and the high likelihood that any new counsel or Respondent himself will be unable to prepare for the hearing in the next ten (10) days, the IC respectfully suggests that the current hearing date of February 15, 2023, be converted to a telephonic status conference at which the parties—including Respondent on his own behalf if counsel has not appeared for him by that time—be prepared to schedule a new hearing date.

DATED this 7th day of February, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

DONALD K. WHITE
Senior Deputy General Counsel
BRANDEE MOONEYHAN
Deputy General Counsel
9600 Gateway Drive
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Email: mooneyhanb@medboard.nv.gov
Attorneys for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 8th day of February, 2023, I served a file-stamped copy of the foregoing **MOTION FOR STATUS CONFERENCE**, via USPS Regular Mail to:

GEORGE PETER CHAMBERS, JR., M.D.
5875 S. Rainbow Blvd., Suite 201
Las Vegas, NV 89118
Respondent

NANCY L. MOSS GHUSN, ESQ.
675 W. Moana Ln., Ste. 107
Reno, NV 89509
Hearing Officer

Courtesy copy by email to the following:

George Chambers, Jr., M.D..: drgchambersjr@gmail.com
Nancy L. Moss Ghusn, Esq.: nmg416@gmail.com

DATED this 8th day of February, 2023.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.** **Respondent.**	**Case No. 22-27891-1**

ORDER GRANTING INVESTIGATIVE COMMITTEE'S MOTION FOR STATUS CONFERENCE

TO: Brandee Mooneyhan
Donald K. White
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 8952

George Peter Chambers, Jr., M.D.
[redacted]

A Complaint in the above-referenced matter was filed September 21, 2022. An Affidavit of Service was filed September 27, 2022, showing service of the Complaint upon Respondent. An Answer and Notice of Defense was filed October 18, 2022. An Early Case Conference was held on October 31, 2022, at which the date for the Prehearing Conference were scheduled. On December 6, 2022, an Order Setting Hearing was filed setting the Hearing for February 15 and 16, 2023, and motion practice deadlines. The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), submitted and filed a Motion to Protect Patient Likenesses on January 5, 2023. Counsel for Respondent submitted three (3) motions: Motion to Exclude Testimony of Peer Reviewer Witness, Motion to Dismiss for Failure to Set Facts Which Would Form a Sufficient Basis for Discipline, and Motion to Dismiss for Due Process Clause Violations on January 5, 2023. Both parties submitted timely oppositions to the filed motions.

On January 17, 2023, counsel for Respondent withdrew from representing Respondent and requested a continuance of the scheduled hearing on his behalf in order for him to obtain new counsel. On January 20, 2023, the undersigned Hearing Officer granted such a request by electronic mail and gave a deadline of February 1, 2023, no later than 4:00 p.m., for Respondent to either obtain counsel or prepare to proceed and kept the Hearing date in place until that time. On February 1, 2023, Respondent indicated that he had not obtained counsel by the deadline, however had an attorney consultation scheduled the following morning and would provide an update thereafter. Respondent did not obtain new counsel, and again requested a continuance for the Hearing. The undersigned Hearing Officer gave Respondent until the end of the same day to provide an update and kept the scheduled Hearing date in place. On February 6, 2023, this Hearing Officer requested an update from both parties, with no response from Respondent. The IC submitted on February 7, 2023, a Motion for Status Conference. Having considered the same, the undersigned Hearing Officer finds as follows.

Although it is of utmost importance that Respondent be afforded due process protections by allowing him the time to obtain counsel or decide for himself how he wishes to proceed, the undersigned Hearing Officer finds that due process has been accomplished and that the IC's request for a status conference to be held February 15, 2023, to set new Hearing dates is hereby GRANTED.

Accordingly, the hearing set for February 15, 2023, at the Las Vegas Board office is hereby vacated and instead a telephonic status conference shall be set for that date at 11:00 a.m.

IT IS SO ORDERED.

DATED this 8th day of February, 2023.

By: _____

NANCY MOSS GHUSN, ESQ.
Email: nmg416@gmail.cmom
Tel: (775) 772-5644
Hearing Officer

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 10th day of February, 2023, I served a file-stamped copy of the foregoing **ORDER GRANTING INVESTIGATIVE COMMITTEE'S MOTION FOR STATUS CONFERENCE**, via USPS Regular Mail to:

GEORGE PETER CHAMBERS, JR., M.D.
5875 S. Rainbow Blvd., Suite 201
Las Vegas, NV 89118
Respondent

NANCY L. MOSS GHUSN, ESQ.
675 W. Moana Ln., Ste. 107
Reno, NV 89509
Hearing Officer

Courtesy copy by email to the following:

George Chambers, Jr., M.D..: drgchambersjr@gmail.com
drcobg@gmail.com

Nancy L. Moss Ghusn, Esq.: nmg416@gmail.com

DATED this 10th day of February, 2023.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.** **Respondent.**	**Case No. 22-27891-1**

FILED
FEB 2 2 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

STIPULATION AND ORDER

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through its undersigned counsel, and Respondent George Peter Chambers, Jr., M.D., Nevada License No. 10476, hereby stipulate to the following:

1. This stipulation is made pursuant to the parties' discussion at the Status Conference held in this matter on February 15, 2023, in consideration of public protection, and does not resolve the underlying Complaint, which remains pending.

2. Respondent agrees that until the underlying Complaint has been resolved, he will refrain from taking photos or videos of any and all patients.

3. Respondent agrees that in non-hospital settings, he will be accompanied by a medical chaperone during the entirety of all patient interactions.

4. Respondent shall submit the name of a proposed medical chaperone to counsel for the IC at least three (3) days prior to utilizing that person as a medical chaperone. The IC may raise any objections to proposed medical chaperones to the Hearing Officer in this matter, Ms. Ghusn; the parties agree that Ms. Ghusn will resolve any disputes regarding the use of any proposed medical chaperone.

5. Prior to acting as a medical chaperone, a proposed medical chaperone will complete training as a medical chaperone as set forth at: https://pbieducation.com/courses/ctp-2/,

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with certificate of such training provided to counsel for the IC prior to them acting as a medical chaperone.

6. The first and last name of the medical chaperone present will be recorded in the record of every patient encounter.

7. Respondent shall notify the IC within twenty-four (24) hours if there is a change to the identity or availability of the medical chaperone.

8. Respondent will allow Board personnel and/or a private monitoring company (for example, Strategic Management Services or a similar company identified by counsel for the IC) to review any patient records and/or interact with medical chaperones without prior notice to Respondent.

9. Respondent shall bear the cost of the medical chaperones.

10. Respondent agrees that in hospital settings, he will ensure the presence of a nurse during all patient examinations (including but not limited to pelvic examinations) and deliveries and be responsible for ensuring that the nurse's presence is recorded in the notes of all such encounters.

11. Respondent agrees and acknowledges that upon approval and acceptance of this Stipulation and Order said terms and conditions shall be considered to be an Order of the IC and that knowingly or willfully failing to comply with said Order is grounds for disciplinary action against him pursuant to NRS 630.3065(2)(a).

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
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12. Should Respondent fail to comply with any term or condition of this Order it shall cause the immediate suspension of his license to practice medicine in Nevada pending an Order to Show Cause Hearing, which will be duly noticed.

DATED this 22nd day of February, 2023.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

DONALD K. WHITE
Senior Deputy General Counsel
BRANDEE MOONEYHAN
Deputy General Counsel
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Tel: (775) 688-2559
Email: dwhite@medboard.nv.gov
mooneyhanb@medboard.nv.gov
Attorneys for the Investigative Committee

DATED this 22nd day of February, 2023.

By:

GEORGE PETER CHAMBERS, JR., M.D.
Nevada License No. 10476
Respondent

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

ORDER

IT IS HEREBY ORDERED that the Investigative Committee of the Nevada State Board of Medical Examiners has adopted the foregoing **STIPULATION AND ORDER** and the terms set forth therein shall be considered an Order of this Investigative Committee.

DATED this 22 day of February, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

VICTOR M. MURO, M.D.,
Chairman of the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 22nd day of February, 2023, I served a file-stamped copy of the foregoing **STIPULATION AND ORDER**, via USPS Regular Mail to:

GEORGE PETER CHAMBERS, JR., M.D.
5875 S. Rainbow Blvd., Suite 201
Las Vegas, NV 89118
Respondent

NANCY L. MOSS GHUSN, ESQ.
675 W. Moana Ln., Ste. 107
Reno, NV 89509
Hearing Officer

Courtesy copy by email to the following:

George Chambers, Jr., M.D..: drgchambersjr@gmail.com
drcobg@gmail.com

Nancy L. Moss Ghusn, Esq.: nmg416@gmail.com

DATED this 22nd day of February, 2023.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.** **Respondent.**	**Case No. 22-27891-1**

ORDER RESCHEDULING HEARING

TO: Donald K. White
Brandee Mooneyhan
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 8952

George Peter Chambers, Jr., M.D.
5875 S. Rainbow Blvd., Ste. 201
Las Vegas, Nevada 89118

The formal hearing in this matter was previously scheduled to be held on February 15 and February 16, 2023.[1] However, those hearing dates were subsequently vacated and the parties participated in a telephonic status conference on February 15, 2023.[2] During that status conference, the undersigned hearing officer granted Respondent's request for a continuance to allow him to attempt to retain new counsel, and directed that further discussion regarding rescheduling the hearing date would ensue between the parties and the undersigned.

Pursuant to that ensuing discussion, the formal hearing in this matter is continued to May 2, 2023, May 3, 2023, and June 1, 2023. The hearing shall proceed as follows: The hearing shall commence at 1:00 p.m. on May 2, 2023, and will continue until at least 5:00 p.m. or until a reasonable hour to which the parties and the undersigned agree. The hearing will continue

[1] *See* Order Setting Hearing filed in this matter on December 6, 2022.
[2] *See* Order Granting Investigative Committee's Motion for Status Conference filed in this matter on February 10, 2023.

beginning at 9:00 a.m. on May 3, 2023, and will continue until the anticipated proceedings are complete. It is contemplated that all witnesses previously identified by the parties, except for two witnesses identified by the IC, will testify on May 2 and/or May 3, 2023. On June 1, 2023, the hearing will continue via *Zoom* or similar platform, beginning at 9:00 a.m. and will continue until 5:00 p.m., during which the two remaining witnesses identified by the IC will testify, and the parties will present closing arguments or agree to present closing arguments in writing.

The hearing proceedings on May 2 and 3 will be held at the Las Vegas Office of the Nevada State Board of Medical Examiners at 325 E. Warm Springs Road, Suite 225, in Las Vegas, Nevada, and the Reno Office of the Nevada State Board of Medical Examiners at 9600 Gateway Drive, in Reno, Nevada, with the proceedings being video conferenced between the two locations. Participants will attend in person at one of these locations unless the parties and the undersigned previously agree that they may appear remotely. As noted above, the hearing proceedings on June 1, 2023, will be held on *Zoom* or a similar platform. A court reporter will take sworn testimony during all hearing proceedings and will produce a transcript to the hearing officer and all parties at their request and expense.

Following the hearing, the undersigned hearing officer will submit a synopsis of the testimony taken at the hearing to the Nevada State Board of Medical Examiners and make a recommendation as to the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor; and, thereafter, the Nevada State Board of Medical Examiners will render its decision. *See* NAC 630.470.

IT IS SO ORDERED.

DATED this 8th day of March, 2023.

NANCY L. MOSS GHUSN, ESQ.
Email: nmg416@gmail.com
Tel: 775-772-5644
Hearing Officer

CERTIFICATE OF SERVICE

I certify that on this day, I served by personally delivering or mailing, postage pre-paid, a true and correct file-stamped copy of the foregoing **ORDER RESCHEDULING HEARING** to the following parties:

Donald K. White
Brandee Mooneyhan
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 8952

George Peter Chambers, Jr., M.D.
5875 S. Rainbow Blvd., Ste. 201
Las Vegas, Nevada 89118

DATED this 8th day of March, 2023.

Signature

Mercedes Fuentes
Printed Name

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, Jr., M.D.** **Respondent.**	**Case No. 22-27891-1**

FILED
APR 10 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

MOTION TO PROTECT PATIENT LIKENESSES

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through its undersigned counsel, hereby moves the Hearing Officer to direct all persons present at the hearing in this matter to refrain from photographing or otherwise recording the likenesses of Patient A, Patient B, and Patient C.[1]

MEMORANDUM OF POINTS AND AUTHORITIES

On September 21, 2022, the IC filed a formal Complaint asserting that Respondent committed several violations of the Medical Practice Act with respect to Patient A, Patient B, and Patient C. As part of its prehearing disclosures, *see* NRS 630.339(3)(b)(1), the IC provided the documents on which it intends to rely in the prosecution of this matter, including letters sent to and from Respondent during the investigations of the underlying complaints, the patients' medical records, and photographs of Patient A's body taken by Respondent. *See* Exhibits 1-10 to *Prehearing Conference Statement of the Investigative Committee* filed November 15, 2022 [hereinafter, "the subject documents"].

The hearing will be open to the public and the subject documents will be relied upon and discussed therein, however, the law requires that "appropriate procedures" be "utilized to protect the

[1]The IC filed a similar motion on January 5, 2023. Since then, the hearing in this matter has been rescheduled and, via an email discussion with the parties, the Hearing Officer set new dates for motion practice in this matter, including that motions are due April 10, 2023. The IC files the instant motion in accordance with that direction. To the extent it is necessary, the IC requests leave to make the instant motion, as the relief requested herein is necessary and appropriate. *See* NRS 622A.360(2)(f).

identity of the patient[s] from public disclosure." NRS 629.061(7)(b)[2]; *see also* NRS 622.310(1)(a) (protecting from disclosure the "personal medical information or records of a patient that are confidential or otherwise protected from disclosure by any other provision of federal or state law"); NRS 622.310(1)(b) (protecting from disclosure the "personal identifying information of a person alleged to have been injured by any act of another person for which a license, certificate or permit is required to be issued by a licensing board"). Accordingly, in all documents not filed under seal in this proceeding, the Patients have been referred to by the fictitious names of Patient A, Patient B, and Patient C.[3] The IC contemplates that, consistent with NRS 639.061(7)(b), the practice of using the fictitious names will continue throughout the remainder of the proceedings, including the hearing.

The IC makes the instant motion to address potential media coverage of the hearing. While the hearing will be public, and news reporters may of course attend, observe, and report on the hearing, because the likenesses of Patients A, B, or C could be used to identify them, any broadcast of their likenesses in a media platform, such as a newspaper, television, or internet, will violate the requirement in NRS 629.061(7)(b) that their identities be protected from public disclosure. While it appears that the policies of many media companies already prevent the broadcasting of such information, in an abundance of caution and in accordance with the legal requirements noted

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[2]The identities of Patient A, Patient B, and Patient C were shared with Respondent through his former attorney; both Respondent and his counsel are also required to maintain the confidentiality of the patients' identities. *See* NRS 629.061(8).

[3]Respondent and the Hearing Officer have been served with a Patient Designation, filed under seal, which sets forth the Patients' actual names.

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above, the IC requests that the Hearing Officer direct all persons present at all hearing proceedings, including those to be held in person and video conferenced on May 2 and May 3, 2023, and those to be held via *Zoom* or similar platform on June 1, 2023, to refrain from recording the likenesses of Patient A, Patient B, and Patient C through photographs, video, drawings, or other medium.[4]

DATED this 10th day of April, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

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[4]The IC notes that the Nevada Rules on Electronic Coverage of Court Proceedings, set forth in Supreme Court Rules 229 through 246, while arguably not mandatory here, provide a reasonable framework for handling media coverage of legal proceedings in Nevada, including the hearing in this matter. *See Solid v. Eighth Judicial Dist. Ct.*, 133 Nev. 118, 123, 393 P.3d 666, 672 (2017) ("The Supreme Court Rules governing media in the courtroom are applicable to all civil and criminal trials in Nevada, recognize the importance of preserving the decorum and dignity of the court, and require limitations imposed when any media representative is interfering in any way with the proper administration of justice." (internal quotations and citations omitted)).

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PO Box 401177
Las Vegas, Nevada 89140-1177
Telephone: (702) 463-0800
Facsimile: (702) 463-0801
Email: drcobg@gmail.com

Pro se

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaints Against: **GEORGE P. CHAMBERS, JR., M.D., FACOG** **Respondent**	**Case No.: 22-27891-1** **RESPONDENT'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE'S "OPPOSITION TO RESPONDENT'S 'MOTION TO EXCLUDE TESTIMONYOF PEER REVIEWER WITNESS' "**

Respondent George P. Chambers, Jr., MD, FACOG, *pro se*, hereby file my Opposition to the Investigative Committee's "Opposition to Respondent's 'Motion to Exclude Testimony of Peer Reviewer Witness.' " This Opposition is brought pursuant to NRS 622A.360(2)(f).

Dated this 10th day of April 2023.

George P. Chambers, Jr., M.D., FACOG
Respondent

I. INTRODUCTION

I am a board-certified obstetrician and gynecologist (Ob/Gyn). I have practiced as an Ob/Gyn in Las Vegas, Nevada for two decades. I have also subspecialized in cosmetic gynecological surgery and sexual health medicine for almost a decade. I have been licensed by the Nevada State Board of Medical Examiners since April 30, 2003. To reiterate, the allegations in the Complaint filed by the Investigative Committee (IC) suggest that I am a sexual deviant who preyed on my patients for self-serving reasons. The Complaint does not charge me with any "sexual misconduct," but it incriminates me as having been "seductive," "sexually aggressive," and "sexually demeaning" towards my patients, participating in "sexual innuendo, sexually suggestive humor, and sexually provocative remarks" with them. The IC did not acknowledge the fact that I also practice cosmetic gynecological surgery, but instead branded me a perverted Ob/Gyn.

Through cosmetic gynecological surgery I repair damage caused by childbirth or other trauma, correct congenital malformation, and restore or even enhance female sexual function. Given my certification in sexual health medicine, I am uniquely qualified to:

(1) Address the hormonal regulation of female sex drive and orgasm.

(2) Address the causes of female painful sex disorders.

(3) Perform diagnostic evaluations on women with sexual dysfunction,

(4) Provide medical and surgical treatments for female sexual dysfunction.

(5) Educate women about ways to enhance their sexual pleasure.

I consider reproductive wellness and sexual health to be intertwined, requiring equal consideration as part of any comprehensive female evaluation.

II. ARGUMENT

According to the American College of Obstetricians and Gynecologists (ACOG), "although female sexual dysfunction is relatively prevalent, women are unlikely to discuss it with their health care providers unless asked, and many health care providers are uncomfortable asking for a variety of reasons, including lack of adequate knowledge and training in diagnosis and management, inadequate clinical time to address the issue, and an underestimation of the prevalence."[1] *Inter alia* patients are referred to me by my local physician colleagues to address their sexual health issues. This is the reason why Patient A was referred to me by her general Ob/Gyn. Patients also hire me on their own and eventually bring up their sexual health issues as was done by Patient B who painted a different picture during an interview with the Las Vegas Review-Journal, which was also added to the journal's TikTok page, in which she used her first name.

NRS 50.275 stipulates that an expert witness with "special knowledge, skill, experience, training or education may testify to matters within the scope of such knowledge." Dr. Rafael is a general Ob/Gyn. Therefore, he is not qualified to testify as to the standard of care provided by me in my work as a trained cosmetic gynecological surgeon or sexual health clinician. Patient A sought consultation for both cosmetic gynecological and sexual health issues. Patients B and C sought consultation for gynecologic problems which were addressed and had nothing to do with their allegations made against me.

According to ACOG, "The American College of Obstetricians and Gynecologists recognizes that it is the duty of obstetricians and gynecologists who testify as expert witnesses on behalf

[1] *Female Sexual Dysfunction*, ACOG Practice Bulletin Number 213, July 2019.

of defendants, the government, or plaintiffs to do so solely in accordance with their judgment on the merits of the case. Furthermore, ACOG cannot condone the participation of physicians in legal actions where their testimony will impugn performance that falls within the accepted standards of practice or, conversely, will support obviously deficient practice. Because experts articulate the standards in a given case, care must be exercised to ensure that such standards do not narrowly reflect the experts' views to the exclusion of other choices deemed acceptable by the profession."[2]

The Society of Obstetricians and Gynecologists of Canada recommended that "physicians who choose to undertake cosmetic procedures to the vagina and vulva should be appropriately trained in the gynaecologic and/or plastic surgery aspects of cosmetic surgery of the lower genital tract."[3] I have said training whilst Dr. Rafael does not.

As delineated in my initial motion objecting to Dr. Rafael's testimony, testimony by a peer reviewer in an administrative case is akin to an expert witness in a jury trial. "[A]n expert's testimony will assist the jury only when it is relevant and the product of reliable methodology." *Hallmark v. Eldridge*, 124 Nev. 492, 500 (2008). This requires consideration of whether the opinion is:

> (1) within a recognized field of expertise; (2) testable and has been tested; (3) published and subjected to peer review; (4) generally accepted in the scientific community (not always determinative), and (5) based more on the particularized facts rather than assumption, conjecture, or generalization.
>
> *Id.* at 510.

[2] *Expert Testimony*, ACOG Committee Opinion Number 374, August 2007.
[3] *Female Genital Plastic and Cosmetic Surgery*, First Edition. Edited by Michael P. Goodman, MD, 2016.

III. MOTION TO EXCLUDE PEER REVIEWER TESTIMONY

Dr. Rafael is not my peer no more than I am the peer to a gynecologic oncology surgeon or any of the other subspecialties in obstetrics and gynecology. He is not qualified to give expert testimony on vaginal sizing, pre-operative and post-operative photography in cosmetic gynecological surgery, or in the marketing of such surgeries.

IV. CONCLUSION

Given Dr. Rafael's training and experience, he does not meet the admissible standard to give expert testimony in this case under NRS 50.275.

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CERTIFICATE OF SERVICE

I hereby certify that I am George P. Chambers, Jr , MD, FACOG (respondent) and that on this 10th day of April 2023, I caused to be filed via email an electronic copy of the foregoing **RESPONDENT'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE'S "OPPOSITION TO RESPONDENT'S 'MOTION TO EXCLUDE TESTIMONYOF PEER REVIEWER WITNESS' "** to the following:

Brandee Mooneyhan, J.D.
Deputy General Counsel
mooneyhanb@medboard.nv.gov

Donald K. White, J.D.
Deputy General Counsel
dwhite@medboard.nv.gov

Nancy Moss Ghusn, Esq.
Hearing Officer
Nmg416@gmail.com

Dated this 10 th day of April 2023

George P. Chambers, Jr., MD, FACOG
Respondent, *Pro se*

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, M.D.** **Respondent.**	**Case No. 22-27891-1**

FILED

APR 14 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

REPLY TO OPPOSITION TO MOTION TO PROTECT PATIENT LIKENESSES

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through its undersigned counsel, hereby replies in support of its Motion to Protect Patient Likenesses and reiterates its request that the Hearing Officer direct all persons present at the hearing to refrain from photographing or otherwise recording the likenesses of Patient A, Patient B, and Patient C.[1]

MEMORANDUM OF POINTS AND AUTHORITIES

Consistent with Nevada law requiring that the identity of the patients in this matter be protected from public disclosure, *see* NRS 629.061(7)(b); NRS 622.310(1), and in anticipation of potential media coverage of the hearing in this matter, the IC moved to protect the likenesses of Patient A, Patient B, and Patient C from being recorded by any persons attending the hearing. Respondent has dedicated the majority of his opposition to that motion to arguing that the patients are not entitled to protection of their identities *at all*. However, Respondent cannot

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/ / /

[1]The IC filed its motion on April 10, 2023, noting that it had filed a similar motion on January 5, 2023, and was filing a new version of the motion in accordance with new deadlines for motion practice set by the Hearing Officer. In an email response to receipt of the motion, Respondent stated he would "like the opposition motion previously submitted" by his former counsel "to stand" and "would like to use it to oppose this current motion." *See* Exhibit 1. Accordingly, herein, the IC replies to the arguments set forth in "Respondent's Opposition to the Investigative Committee's Motion to Protect Patient Likenesses" filed on January 13, 2023. *See* Exhibit 2.

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overcome the plain language of the applicable law. *See R.J. Reynolds Tobacco Co. v. Eighth Jud. Dist. Ct.*, 138 Nev. Adv. Op. 55, 514 P.3d 425, 429 (2022) (noting that when "a statute's language is plain and unambiguous," it should be enforced as written, "without resorting to the rules of construction").

Respondent asserts that by discussing this matter with the media, Patient A and Patient B "invit[ed] media attention" in this matter and therefore are not entitled to the normal protections.[2] However, the governing provisions do not contain an exception for patients who speak with the media about matters involving them, *see* NRS 629.061; NRS 622.310. The Court of Special Appeals of Maryland addressed a similar argument in a case where a civil plaintiff sought to protect the confidentiality of his identity by way of "an order restraining [the opposing parties] from disclosing his identity or any facts likely to lead to such disclosure." *Doe v. Shady Grove Adventist Hosp.*, 598 A.2d 507, 509, 514 (Md. Ct. Spec. App. 1991). The defendants in *Shady Grove* argued that the plaintiff "had waived any rights he may have had to protection of his identity by giving interviews to the press." *Id.* The court noted that, similar to the article submitted by Respondent in support of his opposition, neither of the newspaper articles submitted in support of defendants' argument identified him by name. *Id.* at 510. Even though the plaintiff in that case "made extensive contacts with the press," including issuing press releases and granting interviews with news organizations, he had taken precautions to keep his identity confidential, and thus the court concluded that "he did not relinquish his right to keep his name out of the public record." *Id.* at 515. Similarly, here, Patient A and Patient B have not relinquished the right to keep their identities confidential.

Respondent also relies on inapposite federal case law and out-of-context legislative history to argue that by making a complaint with the Board, the patients consented to their identities being revealed in this matter. First, Respondent's citation to decisions arising from federal lawsuits where a *party* requested to proceed anonymously is misplaced in this state administrative proceeding which was brought by the IC, not the patients themselves. Additionally, Respondent's admitted *assumption* that the patients have consented in writing to the use of their records and the

[2] Patient C has not been quoted in the media reports noted by Respondent; accordingly, Respondent's arguments do not apply to Patient C.

unwarranted conclusion that they have therefore waived the confidentiality of their identity is simply incorrect. Accordingly, NRS 629.061(7)(b), requiring that "appropriate procedures [be] utilized to protect the identity of the patient from public disclosure," applies.

As the language of NRS 629.061(7)(b) is plain, there is no reason to resort to legislative history to discern the Legislature's intent in enacting the statue. *See R.J. Reynolds Tobacco Co.*, 138 Nev. Adv. Op. 55, 514 P.3d at 429. However, even if consulting the legislative history was warranted, the history cited by Respondent is misplaced because it is concerned with the use of patient records for investigation by entities like the Board, not with whether patients' identities are subject to protection. *See, e.g.*, Hearing on S.B. 185 Before the Senate Judiciary Committee, 59th Leg. (Nev., March 2, 1977) ("When the party makes a complaint about the doctor, it seems to me, he is waiving his right to the confidentiality of those records. Once he makes that complaint there is no question that *the board* should be able to get at those records. (statement of Senator Sheerin) (emphasis added)). *See also* Summary of Legislation, S.B. 185 (1997), *available at* https://www.leg.state.nv.us/Division/Research/Library/LegHistory/LHs/1977/SB185,1977.pdf, at page 2 (summary of S.B. 185 (1977), in which the Nevada Legislature adopted the language now codified as NRS 629.061(7), prepared by the Legislative Counsel Bureau, indicating that if health care records "are used for investigatory purposes, *the identity of a patient may not be divulged in any public hearing unless the patient agrees.*" (emphasis added)). Similarly, arguing that the patients' records are public records does not render all information therein being subject to disclosure—portions may remain confidential. *See* NRS 239.010(1) (including NRS 622.310 and information "otherwise declared by law to be confidential" as exceptions to public records that are open to inspection).

Finally, Respondent claims that he "has the constitutional right to confront any witnesses adverse to him," *Opposition* at 10:18, and that this somehow morphs into the right to expose the identity of the patients. Respondent will be able to cross-examine all witnesses at the hearing, including the patients—nothing in the IC's motion contemplated otherwise. However, the ability to do so does not translate to the ability to name or otherwise identify the patients. All participants to this proceeding—Respondent, the IC, the Hearing Officer, and ultimately, the adjudicating

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members of the Board—are privy to the identity of the patients. Respondent cannot credibly argue that he is in any way prejudiced by other persons not learning the patients' identities. The ultimate issue to be decided in this matter is whether Respondent violated the Medical Practice Act as alleged in the Complaint, and people other than the participants knowing the Patients' identities does not bear on this determination.

The IC reiterates the arguments in its Motion to Protect Patient Likenesses, and Respondent's opposition to that motion has failed to demonstrate that the straightforward requirements of NRS 639.061(7)(b) should be ignored. The patients should continue to be referred to by the fictitious names of Patient A, Patient B, and Patient C, and all persons present at the hearing should be directed to refrain from recording the likenesses of Patient A, Patient B, and Patient C through photographs, video, drawings, or other medium.[3]

DATED this 14th day of April, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

DONALD K. WHITE
Senior Deputy General Counsel
BRANDEE MOONEYHAN
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[3]As to Respondent's mention of the arguments in his "Motion to Dismiss for Due Process Clause Violations," and reference thereto "for additional information," *Opposition* 6:5-13, the IC likewise refers to its counterarguments presented in its "Opposition to Respondent's 'Motion to Dismiss for Due Process Clause Violations," filed January 12, 2023.

EXHIBIT 1

EXHIBIT 1

From:	George Chambers
To:	Mercedes Fuentes
Cc:	Brandee Mooneyhan; Donald K. White; NM G
Subject:	Re: George P. Chambers, Jr., M.D., Case No. 22-27891-1 - Motion to Protect Patient Likenesses
Date:	Monday, April 10, 2023 5:05:08 PM
Attachments:	image001.png

Good afternoon,

Ms. Ghusn, as this motion to protect patient likenesses appears to be the same one filed on 01/05/2023, I would like the opposition motion previously submitted by Maria Nutile, Esq and Bridget Kelly, Esq to stand. I'm not sure of the precise legal terminology, but I would like to use it to oppose this current motion.

Thank you.

- George P. Chambers, Jr., MD, FACOG

On Mon, Apr 10, 2023 at 14:32 Mercedes Fuentes <fuentesm@medboard.nv.gov> wrote:

> Good Afternoon All,
>
> Please see the attached **Motion to Protect Patient Likenesses** filed **April 10, 2023**. Please let me know if you would like paper copies mailed to you.
>
> Respectfully,
>
> *Mercedes Fuentes*
>
> Legal Assistant to:
>
> Sarah A. Bradley, J.D., MBA, Deputy Executive Director
>
> Brandee Mooneyhan, Deputy General Counsel
>
> William P. Shogren, Deputy General Counsel
>
> NEVADA STATE BOARD OF MEDICAL EXAMINERS
>
> 9600 Gateway Drive, Reno, NV 89521

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fuentesm@medboard.nv.gov

--
Cheers,

George P. Chambers, Jr., M.D., FACOG
Office Phone: (702) 463-0800
Office Fax: (702) 463-0801
Office Website: www.chambersobgynlv.com

EXHIBIT 2

EXHIBIT 2

Maria Nutile, Esq.
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Bridget Kelly, Esq.
Nevada Bar No.: 14388
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Email: maria@nutilelaw.com
bridget@nutilelaw.com

Attorneys for George Peter Chambers, Jr., M.D.

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.,** **Respondent.**	**CASE NO.: 22-27891-1** **RESPONDENT'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE'S MOTION TO PROTECT PATIENT LIKENESSES**

Respondent George Peter Chambers, Jr., M.D., by and through his attorneys of Nutile Law, hereby files his Opposition to the Motion to Protect Patient Likenesses ("Motion") filed by the Investigative Committee ("IC") of the Nevada State Board of Medical Examiners (the "Board"). This Opposition is brought in accordance with the Order Setting Hearing filed December 6, 2022 ("Order"), the attached Memorandum of Points and Authorities, and any argument that the Hearing Officer will allow upon a hearing in this matter.

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Dated this 13th day of January 2023.

On behalf of Respondent:

NUTILE LAW

/s/ Maria Nutile

Maria Nutile, Esq.
Nevada Bar No.: 7847
Bridget Kelly, Esq.
Nevada Bar No.: 14388
NUTILE LAW
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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

The charges in this case arose from allegations related to three (3) of Respondent's patients, referred to in public documents as Patient A, Patient B, and Patient C (together, the "Patients"). Respondent is an obstetrician/gynecologist specializing in female genital cosmetic and plastic surgery and sexual health medicine. Not surprisingly, the allegations against him are characterized in the Complaint as forms of "sexual misconduct", and generally as sensitive and salacious in nature.

The IC's Motion indicates an expectation that the identities of the Patients will be protected through the fair hearing process, and requests an order to further protect their likenesses from being recorded.

Responded opposes any confidentiality protections or guarantees for any of the Patients. As a matter of fundamental fairness, the Patients are not entitled to a cloak of anonymity after inviting media attention and publicly accusing Respondent of being a sexual abuser, which is a death knell for the professional reputation of any OB/GYN. Additionally, the confidentiality protections pursuant to Nevada law cited in the Motion do not apply to patients who consent to the use of their medical records and/or who bring complaints themselves against physicians, particularly once a formal complaint has been filed and all documents become part of the public record.

As discussed below, Respondent requests that the IC's Motion be denied, with further clarification that patient identities are not subject to any guarantees of anonymity in this case.

II. STATEMENT OF FACTS

The IC filed the Complaint in this matter on September 21, 2022. The Complaint alleges eight (8) Counts total.

1. With regard to Patient A: Counts I and II, Disruptive Behavior (NRS 630.301(6)); Count III, Engaging in Conduct Intended to Deceive (NRS

630.306(1)(b)(1)); and Count IV, Failure to Maintain Accurate Medical Records (NRS 630.3062(1)(a)).

2. With regard to Patient B: Count V, Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

3. With regard to Patient C: Count VI, Engaging in Conduct that Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain (NRS 630.301(7)).

4. With regard to Patients A, B, and C: Count VII, Continual Failure to Practice Medicine Properly (NRS 630.306(1)(g)); and Count VIII, Disreputable Conduct (NRS 630.301(9)).

The Complaint includes salacious allegations that Respondent sexually demeaned each of Patients A, B, and C by way of words and actions including vaginal photography. In its Motion, the IC has requested that the Hearing Officer direct all persons present at the hearing to refrain from recording the likenesses of any of the Patients, and presumes that their identities will be equally protected through continued use of pseudonyms throughout the proceedings.

While Respondent has no intention of advertising the Patients' identities or encouraging broadcast of their likenesses, we disagree that the Patients are entitled to any confidentiality protections when they, and the Board itself, have taken deliberate actions to publicly brand Respondent as a sexual abuser, defame his reputation, and destroy his professional practice.

A. Media Attention Invited by Patients

On September 30, 2022—a mere nine (9) days after the Complaint was filed—an article fiercely critical of Respondent was published online by the *Daily Beast* ("Article"),[1] a copy of which is attached as Exhibit A. Patient A and Patient B are directly quoted in the Article and

[1] Kate Briquelet, "'Vagina Whisperer' OBGYN Accused of Sexual Misconduct by Medical Board," *The Daily Beast*, September 30, 2022, available at https://www.thedailybeast.com/vagina-whisperer-obgyn-dr-george-chambers-accused-of-sexualmisconductby-medical-board

referred to as having "told The Daily Beast" various scandalous allegations, far more colorful than those included in the Complaint. They intentionally launched an attack in the public opinion assault of Respondent by inviting, or at least participating in, media coverage of his alleged misdeeds. The Article was then picked up by other news outlets, including FOX5Vegas (KVVU)[2] and the United Kingdom's Daily Mail[3]. As a result, Respondent's medical practice and professional reputation have been decimated, based on what remain mere allegations.

According to the Article, "Patient B told The Daily Beast that she's sharing these private details because she wants people to have a clear picture of how she believes he manipulated her," adding that she " 'felt violated, embarrassed and angry' " when he asked " 'with a creepy smile on his face' " if she had ever posed nude. (Emphasis added.) Patient B also reportedly told The Daily Beast that Respondent would "ask invasive questions about her sex life and libido and, unsolicited, discussed his sexual activities with her." Patient B went so far as to (reportedly) share text messages between her and the Respondent with The Daily Beast.

Patient A went to even greater lengths to publicly accuse Respondent of sexually-related misdeeds. The Article states,

> Before the medical board filed the complaint, Patient A also tried other avenues to hold [Respondent] accountable for what she believes was sexual assault. She says she reached out to attorneys, other physicians in the community, media outlets, Yelp, and the FBI. "Every single one of these efforts, up until now, has failed to protect women or command justice and has resulted in compounding trauma for myself," Patient A said.

(Emphasis added.)

Both Patient A and Patient B deliberately publicized their "sexual misconduct"

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[2] Elaine Emerson, "Las Vegas OBGYN subject of sexual misconduct complaint," FOX5 KVVU-TV, September 30, 2022, available at https://www.fox5vegas.com/2022/09/30/las-vegas-obgyn-subject-sexual-misconduct-complaint/

[3] James Gordon, "Las Vegas gynecologists - who called himself the 'Vagina Whisperer' - is accused of sexual misconduct by Nevada Medical Board: Patients say 'doctor touched them inappropriately then offered $1,000 to pay for nudes,' *The Daily Mail*, September 30, 2022, available at https://www.dailymail.co.uk/news/article-11268873/Las-Vegas-OB-GYN-Vagina-Whisperer-accused-sexual-misconduct-Nevada-Medical-Board.html

accusations against Respondent, allegedly hoping to "protect women" and make sure "people [ ] have a clear picture" of Respondent. Although neither Patient A nor Patient B was identified by name in the Article, it is reasonable to assume that the reporter (at minimum) knew their identities in order to communicate with them.

B. Public Derision Invited by the Board

As detailed in Respondent's MOTION TO DISMISS FOR DUE PROCESS CLAUSE VIOLATIONS ("MTD"), the Board itself exhibited deliberate indifference and reckless disregard for Respondent's due process rights by needlessly posting the Complaint in this matter in two (2) different places on its official website, without any disclaimers as to Respondent's presumption of innocence, and without equal dissemination of Respondent's Answer denying the allegations and objecting to aspects of the Complaint. We refer to the MTD for additional information.

III. LEGAL ARGUMENT

A. Anonymity Exception

A medical licensing board's functions of "holding hearings, taking evidence, and adjudicating are functions that are inherently judicial in nature." Mishler v. Clift, 191 F.3d 998, 1008 (9th Cir. 1999). The Ninth Circuit has held that "[A] party may preserve his or her anonymity in judicial proceedings in special circumstances when the party's need for anonymity outweighs prejudice to the opposing party and the public's interest in knowing the party's identity." Does I thru XXIII v. Advanced Textile Corp., 214 F.3d 1058, 1068 (9th Cir. 2000). Special circumstances include the need "to preserve privacy in a matter of sensitive and highly personal nature." *Id.*, citing *James v. Jacobson,* 6 F.3d 233, 238 (4th Cir.1993).

In *Doe v. City of Las Vegas* (No. 219CV00382GMNBNW, 2019 WL 2601554, at *3 (D. Nev. (June 25, 2019)), a plaintiff's request to proceed anonymously to avoid harassment, ridicule and extreme personal embarrassment, and public condemnation was denied because she had "purposefully availed herself of news media, broadcasting the case, and putting it in the public

eye." Further, "While her name was not used, she facilitated others' ability to learn of the existence of the case....[T]he controlling fact is that her actions do not indicate the desire to maintain privacy. *Id* (emphasis added).

Although claims of sexual assault tend to concern "matters of a sensitive and highly personal nature," in a recent case of alleged rape under Title IX, the court denied anonymity to a plaintiff who had publicly named the defendant. Doe v. Liberty Univ., Inc., No. 6:21-CV-00059, 2022 WL 4781727, at *5 (W.D. Va. Sept. 30, 2022). Plaintiff had "sought to avail herself of the protections of anonymity..., all the while single-handedly precluding the Named Defendant from the ability to avail himself of similar protections." *Id.* Regardless of the forum, "Equity does not support parties' strategic use of litigant anonymity as both sword and shield." *Id.* (emphasis added).

We have no doubt that the Patients wish to proceed anonymously to avoid harassment, ridicule, extreme personal embarrassment, and/or public condemnation, and that the IC/Board wishes to do the same on their behalf. However, just as in *Doe v. City of Las Vegas,* Patient A, Patient B, and the Board have deliberately put Respondent's case in the public eye, "facilitat[ing] others' ability to learn of the existence of the case," in an effort to discredit Respondent without the need for a hearing. Just as in *Doe v. City of Las Vegas*, Patient A and Patient B have "purposefully availed [themselves] of news media, broadcasting the case." The sexual nature of the allegations (including Patient A's overt allegation of sexual assault in the Article) liken Respondent's position to that of a rape suspect, in which case the alleged "victims" should only be afforded anonymity protection if the suspect had been equally protected. Regardless of whether or not the patients' names have been published, they had to be known to the Article's writer. In any event, their "actions do not indicate the desire to maintain privacy" and thus they have waived the luxury of anonymity of which they have wholly deprived Respondent.

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B. Confidentiality Pursuant to Nevada Law Not Applicable

1. *NRS 629.061(7)*

Pursuant to NRS 629.061(7):

> Records made available to a representative or investigator must not be used at any public hearing unless:
> (a) The patient named in the records has consented in writing to their use; or
> (b) Appropriate procedures are utilized to protect the identity of the patient from public disclosure.

(Emphases added.) The IC must therefore have either the patient's consent to use their records, or, only in the absence of such consent, appropriate procedures must be used to protect the patient's identity. NRS 629.061(7) does not provide that the patient's identity be protected if the patient has consented to the use of their records by the IC. Given that each of the Patients is the presumed complainant and each is listed as a witness for the IC in this case, it is presumed that patient consent has been provided. On its face, NRS 629.061(7) does not provide for anonymity protections for a willing participant.

Upon review of the legislative history of NRS 629.061(7), there was concern that, as the statute was originally drafted, a lack of patient consent could impinge on an investigation or prosecution necessary to protect the public, and/or that a patient's records would be publicized and used without their knowledge. Senate Bill 185 (1977) was amended to include, in part, the language above to "capture the very idea the [Nevada State Senate Judiciary] Committee had in its mind"[4] and avoid either eventuality. To wit:

- "[I]n the case where a patient is filing a complaint, that the act of filing against the physician would constitute a waiver."[5]

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[4] Minutes of the Nevada State Senate Judiciary Committee, March 8, 1977 at 4 Deputy Attorney General William Isaeff). Available at https://www.leg.state.nv.us/Division/Research/Library/LegHistory/LHs/1977/SB185,1977.pdf

[5] Minutes of the Nevada State Senate Judiciary Committee, March 2, 1977 at 4 (Senator Bryan). Available at https://www.leg.state.nv.us/Division/Research/Library/LegHistory/LHs/1977/SB185,1977.pdf

- "When the party makes a complaint about the doctor, … he is waiving his right to the confidentiality of those records."[6]
- When a patient has made an allegation triggering an investigation, he or she "should [not] reasonably be able to say 'wait a minute I have changed my mind now' " and refuse consent to utilize his or her records. "The committee felt very strongly that once you put the wheels in motion, you can't in the interest of the public, stop it."[7]
- "[I]n the case of repeated negligence, there might be the need to look at more people's records who have never filed allegations,"[8] in which case "a notice to the patient that his records were subject to inquiry [should be] given."[9]

It is clear the Nevada Legislature added the language of NRS 629.061(7) to provide the opportunity for state agencies to pursue prosecution in the public interest in the event a patient did not or would not provide consent to release of his or her medical records. That is not the case for the Patients, who brought their complaints to the Board voluntarily and appear to be willing to testify at the public fair hearing.

2. *NRS 622.310(1)*

NRS 622.310(1) provides that:

> If any provision of this title requires a regulatory body to disclose information to the public in any proceeding or as part of any record, such a provision does not apply:
>
> (a) To any personal medical information or records of a patient that are confidential or otherwise protected from disclosure by any other provision of federal or state law.
>
> (b) To any personal identifying information of a person alleged to have been injured by any act of another person for which a license, certificate or permit is required to be issued by a licensing board. Such information must be kept confidential by the licensing board in whose possession the information is held.

According to the legislative history of Senate Bill 220 (2013) which added the foregoing

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[6] Id. at 2 (Senator Sheerin).
[7] Id. at 3 (Senator Hilbrecht).
[8] Id.
[9] Id. at 4 (Senator Bryan).

language, bill sponsor Senator Hardy stated the bill was intended to protect the confidentiality of patients receiving unlicensed medical care, which is not at issue here:[10]

> **Senator Hardy**: The bill protects the patient confidentiality. If patients are getting unlicensed care but think they are getting licensed care, they still have to be protected for their confidentiality. We need to treat them as if they were getting licensed care.[11]
> ...
> If I may go back to the issue of personal identification, with the victim of unlicensed care, the victim must be kept confidential. I will defer to Mr. Lee.
>
> **Keith Lee** [representing the Nevada State Board of Medical Examiners]: Assemblyman Daly, I can speak only for the Board of Medical Examiners, but all information we obtain during an investigation remains confidential until such time as we file a disciplinary complaint. At that point in time, it becomes a matter of public record. I believe the other boards of which I am familiar treat that information the same way.[12]

Specifically, pursuant to NRS 630.336(5), "The formal complaint or other document filed by the Board to initiate disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records." (Emphasis added.) As the medical records in this case are part of the public record, so must be the Patients' identities.

C. Credibility and Confrontation Concerns

Respondent has the constitutional right to confront any witnesses adverse to him:

> [W]here governmental action seriously injures an individual, and the reasonableness of the action depends on fact findings, the evidence used to prove the Government's case must be disclosed to the individual so that he has an opportunity to show that it is untrue. While this is important in the case of documentary evidence, it is even more important where the evidence consists of the testimony of individuals whose memory might be faulty or who, in fact, might be perjurers or persons motivated by malice, vindictiveness, intolerance, prejudice, or jealousy. We have formalized these protections in the requirements of confrontation and cross-examination. They have ancient roots. They find expression in the Sixth

[10] Minutes of the Meeting of the Assembly Committee on Commerce and Labor, May 8, 2013 at 55. Available at https://www.leg.state.nv.us/Session/77th2013/Minutes/Assembly/CL/Final/1074.pdf

[11] Id.

[12] Id. at 59 (emphasis added).

> Amendment. This Court has been zealous to protect these rights from erosion. It has spoken out not only in criminal cases, but also in all types of cases where administrative actions were under scrutiny.

Goldberg v. Kelly, 397 U.S. 254, 270, 90 S. Ct. 1011, 1021, 25 L. Ed. 2d 287 (1970) (internal quotation omitted). This right of confrontation is especially true in this case given the damning "he said/she said" allegations. The credibility of the Patients as witnesses, or possible lack thereof, will be crucial to Respondent's defense.

In order to establish credibility or lack thereof, it will be necessary to validate the identity of each witness to ensure his or her testimony is relevant to the case and thus admissible. Further, the identity of a Patient witness testifying as to a medical record in evidence must be confirmed as matching the identity of the patient in the medical record. Neither of these steps can be accomplished on the record without public disclosure of the patient's identity.

Moreover, Respondent may find it necessary as part of his defense to confront a Patient-witness in a manner or in relation to facts which may directly or indirectly reveal a Patient's identity to the public. Respondent's confrontation of a Patient-witness should not be limited, and his rights thereby infringed, out of concern for violating the confidentiality and/or anonymity of his accuser.

IV. CONCLUSION

By filing their complaints with the Board, and later inviting public scrutiny of Respondent without protecting his identity, the Patients waived and/or are not entitled to the protection of anonymity. Similarly, the IC/Board's deliberate indifference and reckless disregard for Respondent's due process rights precludes its ability to now protect the identities and/or likenesses of the Patients in a public forum. State law confidentiality protections were not intended to apply to the circumstances of this case, and enforcing them would likely result in further infringement of Respondent's constitutional rights.

For reasons set forth above, Respondent opposes the IC's Motion with regard to both the requested confidentiality of the Patients' likenesses, as well as the presumed confidentiality of

the Patients' identities.

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CERTIFICATE OF SERVICE

I hereby certify that I am an employee of NUTILE LAW, and that on this 13th day of January 2023, I caused to be filed via email an electronic copy of the foregoing **RESPONDENT'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE'S MOTION TO PROTECT PATIENT LIKENESSES** to the following:

Brandee Mooneyhan, J.D., Deputy General Counsel mooneyhanb@medboard.nv.gov;

Donald K. White; J.D. Deputy General Counsel dwhite@medboard.nv.gov

Nancy Moss Ghusn, Esq., Hearing Officer nmg416@gmail.com

/s/ *Bridget Kelly*
An employee of NUTILE LAW

EXHIBIT A

EXHIBIT A

https://www.thedailybeast.com/vagina-whisperer-obgyn-dr-george-chambers-accused-of-sexual-misconduct-by-medical-board

'Vagina Whisperer' OBGYN Accused of Sexual Misconduct by Medical Board

CREEPS IN SCRUBS

Patients claim the doctor pressured them to pose for "boudoir" photos and made sexually explicit comments, including while delivering a baby.

Kate Briquelet

Senior Reporter

Updated Sep. 30, 2022 12:46PM ET / Published Sep. 30, 2022 11:04AM ET

https://www.thedailybeast.com/vagina-whisperer-obgyn-dr-george-chambers-accused-of-sexual-misconduct-by-medical-board

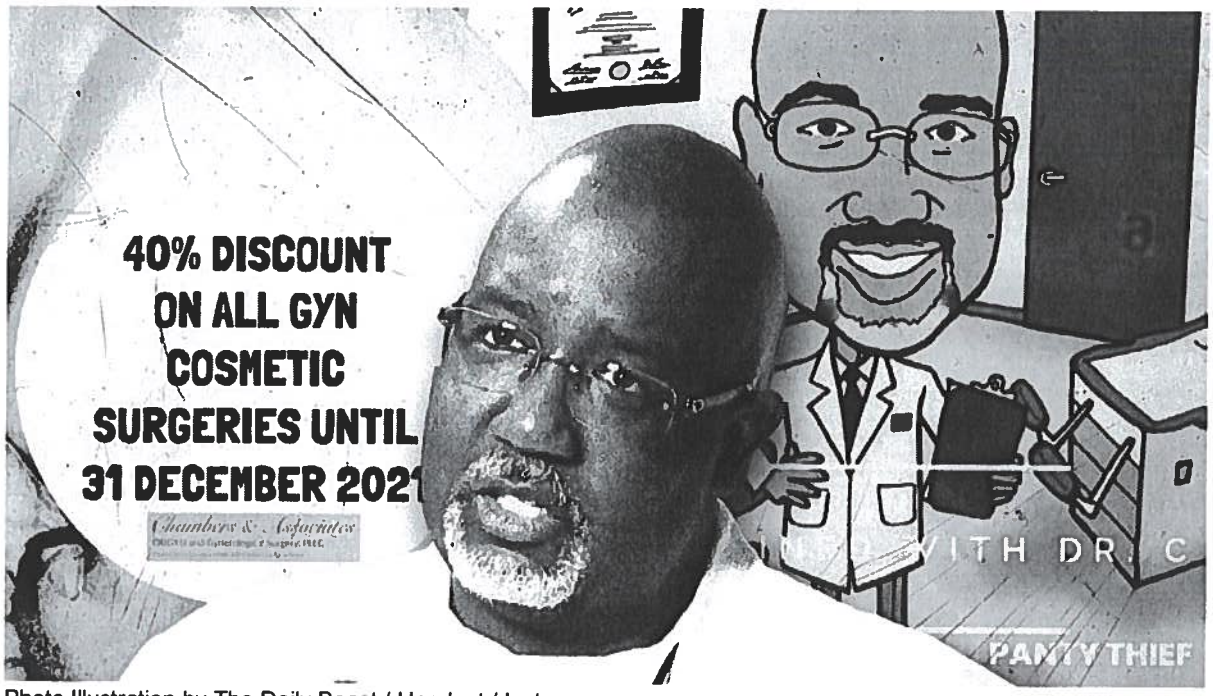

Photo Illustration by The Daily Beast / Handout / Instagram

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A Las Vegas gynecologist—who billed himself as a certified sexual health clinician under an Instagram account that used the words "vagina whisperer"—is facing a complaint from Nevada's medical board, which has accused him of repeated "sexual misconduct," including asking female patients to pose for sexually explicit photographs for his business.

The new filing charges Dr. George Chambers with disruptive behavior, disreputable conduct, engaging in conduct intended to deceive, failure to maintain accurate medical records, continual failure to practice medicine properly, and engaging in conduct that violates the trust of a patient and exploits the relationship with the patient for financial or other personal gain.

https://www.thedailybeast.com/vagina-whisperer-obgyn-dr-george-chambers-accused-of-sexual-misconduct-by-medical-board

Details in the state Board of Medical Examiners' complaint paint an unsettling picture of the 51-year-old OBGYN, who allegedly "violated patients' trust by engaging in sexual improprieties" such as inviting them to "boudoir" photography sessions. Before these accusations, at least one woman filed a police report against Chambers that ultimately didn't lead to criminal charges.

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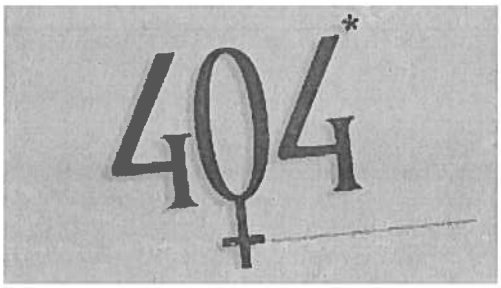
Scientific American Yanks 'Hit Piece' on Twitter's Fave Gyno

STRONG MEDICINE

Emily Shugerman



Two patients identified in the complaint told The Daily Beast that they're coming forward to prevent other women from experiencing similar conduct with Chambers or any other doctor. "I knew the situation was not normal, it felt wrong, and many things that were done and said by

Dr. Chambers completely shocked and upset me," said one woman, who is referred to as "Patient A" in the complaint. "But my frame of reference kept me from recognizing, in those moments, the true nature of what was happening to me."

According to the document, when "Patient A" visited Chambers for a surgery consultation in November 2020, he injured and humiliated her by sticking his hand in her vagina. He then allegedly used sexual slang to describe his actions, telling the 36-year-old that he'd attempted to "fist" her. The complaint says Chambers also used the woman's cellphone to take photos of her vagina and asked her to text him two of the images for her medical file.

In another episode, Chambers allegedly offered 35-year-old "Patient B" $1,000 for nude photos. The filing says the images were "ostensibly to use in an advertisement for his services," and "not for purposes of medical examination or treatment."

The doctor is accused of making a similar pitch to "Patient C" during an October 2019 appointment after the 27-year-old mentioned she was struggling financially. Chambers told the patient he was "seeking models to participate in a photography session in which photos would be taken of the model's vaginal area and nude body," the complaint alleges, adding that the images would be used for his "portfolio" or for advertising.

The gynecologist allegedly tried to sweeten the proposal by claiming he'd give her a thumb drive of the "boudoir" photos from their session. "Patient C thought it was odd that [Chambers] was soliciting

photographs of her vaginal area as a representative of his work because he had never performed any cosmetic procedure on her genitals," the filing adds.

The medical board alleges Chambers "repeatedly exploited his relationships with patients and violated patients' trust by engaging in sexual improprieties that constitute sexual misconduct," and that his "repeated acts of sexual misconduct" and Medical Practice Act violations "undermine the public's trust and respect for the medical profession."

Chambers did not return messages seeking comment.

The doctor, who was licensed in Nevada in 2003, was active on Instagram under the handle @vaginawhispererlasvegas before deactivating the account on Thursday. He marketed himself as a board-certified OBGYN also specializing in cosmetic gynecology, and touted his glowing Yelp reviews and a "top doctor" distinction from *Health Care Quarterly*.

On his practice's website, which was also shut down recently, Chambers boasted that he is "the only board certified obstetrician and gynecologist in Nevada who is also certified in sexual health medicine." The site added, "As a gynecological surgeon who was raised and positively influenced by women, Dr. Chambers recognizes that all women want to look and feel beautiful."

"I am living my dream every day because I was blessed to have discovered my true purpose in life," Chambers wrote in a bio on his now-defunct site.

"I use four guiding principles when I approach patient care: 1. I provide the same level of care as I would want for the women in my family. 2. I obey the basic rules of surgery to ensure a safe outcome for my patients. 3. I respect the human body; thus, I create surgical incisions that will be aesthetically pleasing to my patients and to me. 4. I take pride in my work."

His TikTok and Instagram accounts shared videos of surgeries and closeups of vaginas. One showed Chambers dancing into his disposable surgery gown, past what appears to be the body of a patient on a table. "Dr. C living his best life," reads text superimposed on the video. It's unclear whether patients knew he was recording himself during these procedures.

On Instagram, he promoted his services with images that appeared to be amateur photographs of women's bodies that were edited or filtered. A regular feature on his account was "Sexplained with Dr. C," which delved into fetishes and sexual terminology that some audiences might find more fitting for pornography than a medical office. "Why do some men steal women's panties?" one post in that series asked. Another explored the term "cuckold."

Chambers' account also posted a meme that declared: "If it doesn't bring you income, motivation or orgasms it doesn't belong in your life."

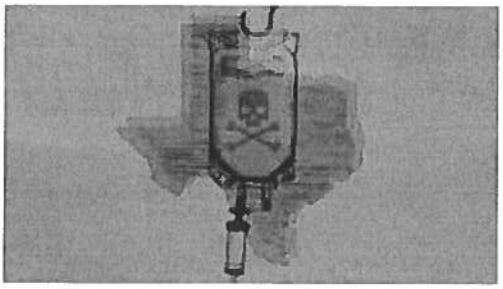
The woman referred to as "Patient B" told The Daily Beast that Chambers, over her seven years as his patient, appeared "very focused on sex."

She says Chambers had a "charming personality and great bedside manner" but some aspects of his practice seemed off—such as when he'd ask invasive questions about her sex life and libido and, unsolicited, discussed his sexual activities with her. Sometimes during her visits, they'd spend over an hour chit-chatting in the exam room.

- Doc Probed in Death of Colleague Via IV Drip Has Scary Past

'HISTORY OF VIOLENCE'

Kate Briquelet



"He was different from other OBGYNs," she said. "He wouldn't wait for me to ask a question about my sexual health, he would just fire questions away ... I'm sitting in the room feeling like I have no choice but to answer these questions."

"He also would ask me about past trauma, things like that," the patient said. "I was raped when I was 16 years old. He knew things like this. He was very kind. I felt heard. I trusted him with a lot of personal information." The patient said she'd referred other women to Chambers over the years and told people, "You either really like him or really hate him."

But one particular encounter raised red flags. She says that after Chambers delivered her baby and was stitching her up, she overheard him make "inappropriate comments" about women and their vaginas. She says these comments arrived when she was particularly vulnerable, legs spread on a hospital bed, and in front of a male nurse. "He said it's good that I tore because that means I wasn't loosey goosey," she said, adding that she was so disturbed by his comments that she wrote them down to document them.

Still, Patient B and Chambers had a friendly relationship. "He would make comments over the years such as, 'You're beautiful.' But I never took it to mean anything other than he's trying to build my self-confidence, make me feel better," she said. Chambers also texted the patient and asked her to vote for him in "top doctor" awards contests.

Her October 2018 visit, however, would be her last. That day, Patient B had a breast exam in front of two female student doctors and a nurse. "He walks in and right off the bat, he starts telling the student doctors, 'Oh, this is my patient. She was gang-raped.' So right there I'm thinking this is personal information that I trusted you with. You're telling people I've never met as a way to brag that you have a good relationship with your patients."

Patient B told The Daily Beast that she's sharing these private details because she wants people to have a clear picture of how she believes he manipulated her.

According to the patient, the nurse left the room and Chambers then asked his underlings to follow her. "He said, 'Have you ever posed nude?' with a creepy smile on his face," the patient said. "I said, 'No, why do you ask?' And then he went on to tell me that he needs models to pose nude for his ads for his labiaplasty website."

"It was very awkward. I didn't know what to do or what to say. I kept trying to steer the conversation away from that topic."

She said Chambers told her she was "so beautiful" and "perfect" for his ads and suggested that while he could pay less for stock photos of women, he wanted to photograph her instead. "I want the real women, the women who have been through so much," Chambers allegedly told her, adding that he'd pay her $1,000.

Patient B says Chambers brought out his cellphone and showed her a photo of a woman squatting and looking at the camera. The image appeared to be edited with photo filters. "He told me that he does this with his patients," she said. "He told me his patients get very provocative and seductive in front of him, especially when he tells them to 'fuck the camera.'"

Patient B said she ticked off excuses to reject his proposal, including informing him that she'd had laser hair removal. During the entire conversation, the patient was naked with a paper gown covering her bottom half. Chambers then asked her to stand so he could look at her,

she says. After she stood, Chambers allegedly commented, "Perfect, even more perfect."

While she says Chambers claimed to need photos for his labiaplasty practice, she'd never had the surgery or planned to; there would be no before or after photos from her.

Chambers was persistent, she says, and offered her copies of the photos to give to her husband. "What husband wouldn't want nude professional photos of their wife?" Chambers asked, according to the patient. The doctor then allegedly warned, "But just make sure your husband doesn't know that I was the photographer. You can't tell him I was the photographer and you can't tell him where it was taken."

She said that before she left his office, Chambers asked her to text him with her decision but to keep the details vague, only referring to his offer as a "project."

"I felt violated, embarrassed and angry," the patient said in an interview, "and I knew I was never going to come back there."

The Daily Beast reviewed a copy of a text message Patient B sent to Chambers after the visit. "I feel that doing this project would be crossing several boundaries and would be highly unethical," she wrote. "I am not interested. I will also be picking up copies of my medical records and will be seeing a different gynecologist."

Chambers replied, in part, "I respect ur decision. Sorry the request offended u, but it the only way I recruit models for my ads. It does not

violate the code of medical ethics. I will miss u as a patient. I hope and wish for u continued good health and best wishes."

He added, "U know, I am in the process of developing a YouTube channel and Instagram page for sexual health medicine. I was concerned about losing patients. Again, my sincerest apology to u."

"He kept trying to convince me that because I've been through so much in my life, that if I were to do this for him that it would be incredibly empowering for me as a woman," Patient B said. "And he really tried to stress that point. You're telling me that this will be empowering for me. The empowering thing is to walk out of your office."

Meanwhile, Patient A told The Daily Beast that she'd contacted the Las Vegas Metropolitan Police Department weeks after her November 2020 encounter with Chambers.

She says officers downloaded the entire contents of her cellphone and, over a seven-month period, claimed to be investigating Chambers. But in July 2021, a detective allegedly called her and said they had "good news": They determined Chambers had not sexually assaulted her.

"I responded asking how 'fisting' someone was not sexual assault, to which the detective said that they 'don't know what Chambers put in your vagina,'" the patient said. "I responded saying, 'I know what he put in my vagina. I felt it, and Dr. Chambers told me and showed me exactly what it was.'" She said she then reminded the officer of the "excruciating pain and damage" that Chambers allegedly caused her, which resulted in a visit to her OBGYN six days later.

"Detectives maintained that they didn't know what was put in my vagina and I was not sexually assaulted," Patient A said.

She says that when she spoke to a detective on another occasion, he told her that she consented to Chambers' exam, so it wasn't sexual assault. "I consented only to an exam to assess damage to the perineum, not to 'fisting,'" she told The Daily Beast.

"I called the lieutenant overseeing the investigation and was assured that no matter how many women report Dr. Chambers to the police, my case would never be reopened," she said.

"Through my experience," she said. "I have come to understand that women are at risk everywhere of not only being sexually abused, but also of having the systems meant to protect them from such abuse, instead, compound their trauma."

The Daily Beast has reached out to Las Vegas police for comment.

The medical board's complaint says that Patient A's regular gynecologist referred her to Dr. Chambers for a damaged perineum. During her office visit, the filing states, Chambers asked her to undress and to keep her cellphone nearby, so that he could use it to take photographs of her body during his examination.

Chambers then used her phone to take a dozen photos of her vaginal and anal areas, the complaint states, and asked her to text him two of the images. "Patient A was uncomfortable texting the pictures to [Chambers'] cellular phone, in part because she had no assurances that

the data was being exchanged securely, how the pictures might be used, or who might have access to them once they were sent," the filing says.

The board's complaint says that one of the photographs—which the doctor did not request from her—showed him inserting four fingers into her vagina.

- Celebrity Cheer Coach Hit With Bombshell Sex Abuse Suit

  SPEAKING OUT

  Pilar Melendez

The filing says Chambers told the medical board investigators that he had only inserted two fingers to evaluate her pelvic floor muscles. But, according to the complaint, he failed to document what the patient's cellphone pic actually revealed in medical records.

After the physical exam, the complaint adds, Chambers told the patient that "he had attempted to 'fist' her, that is, insert his entire hand into her vagina ... but had been unable to insert his entire hand, and he showed her how much of his hand he had been able to insert." The woman "suffered pain and tenderness in her genital area" after Chambers' maneuver, the filing says.

The document alleges that Chambers' "action in taking numerous pictures" of Patient A "were not for purposes of medical examination or treatment" and that his use of the "the nonmedical term 'fisting'" had "humiliated and sexually demeaned Patient A."

The medical board adds that Chambers' decision to take multiple photographs of Patient A and direct her to send them via text "was disrespectful of Patient A's privacy."

In a statement to The Daily Beast, Patient A said she never expected to receive anything "other than appropriate and competent medical care."

"I was confident that I would be safe and trusted that my body and personal health information would be handled with respect and proper attention," Patient A said. "It is because of that confidence, those expectations, and also the understanding that gynecological visits are, by their nature, uncomfortable that I was initially unable to recognize what a dangerous situation I was in."

Before the medical board filed the complaint, Patient A also tried other avenues to hold Dr. Chambers accountable for what she believes was sexual assault. She says she reached out to attorneys, other physicians in the community, media outlets, Yelp, and the FBI.

"Every single one of these efforts, up until now, has failed to protect women or command justice and has resulted in compounding trauma for myself," Patient A said. "Being rejected repeatedly after having been put in the most exposed and vulnerable position that I had ever been in made me feel worthless and made me believe that the failed systems were somehow my fault."

In 2021, Patient A left a brief review about her experience with Chambers on Yelp, using a pseudonym. "What I experienced is very concerning," she wrote. "To say Dr. Chambers was inappropriate with me would be a gross understatement in my opinion. I hope that any woman who has had a similar experience will come forward."

Chambers posted an answer stating, "No one with your name appears in my patient database. So, you are clearly using an alias to besmirch my name and reputation with this review because you believe you will remain anonymous."

"If you were actually evaluated by me and you believe I was inappropriate, please report me to the Nevada State Board of Medical Examiners," Chambers wrote. "If you believe I committed a crime, please go to the police. By doing so, there would be an appropriate investigation of you and me. But, don't hide behind social media to trash my name in such a vile manner."

She told The Daily Beast she has a message for women in similar situations.

"There are people out there who care about them, believe them, value them, and want to support them through what they are enduring,"

Patient A said. "And I want them to know that their value is not determined by the failures of the systems which are meant to protect them."

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Pro se

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaints Against:	**Case No.: 22-27891-1**
GEORGE P. CHAMBERS, JR., M.D., FACOG **Respondent**	**REPLY TO THE IC'S OPPOSITION TO RESPONDENT'S MOTION TO THE INVESTIGATIVE COMMITTEE'S MOTION TO PROTECT PATIENT LIKENESSES**

Respondent George P. Chambers, Jr., MD, FACOG, *pro se*, hereby file my **REPLY TO THE IC'S OPPOSITION TO RESPONDENT'S MOTION TO THE INVESTIGATIVE COMMITTEE'S MOTION TO PROTECT PATIENT LIKENESSES**. Patients A, B and C have forfeited their protection to be anonymous under NRS 629.061(7)(b), NRS 622,310 (1)(a) as well as NRS 622.310 (1)(b). Given their extensive contact with the news and social media, including Patient B using her first name and a possible pseudonymous last initial (that is, if she did not adopt her husband's surname), they have waived their right to confidentiality.

Date this 14th day of April 2023.

George P. Chambers, Jr., M.D., FACOG
Respondent

I. INTRODUCTION

The charges in the Complaint filed against me by the Nevada State Board of Medical Examiners (NSBME) on September 21, 2023, included salacious allegations from Patients A, B and C. This is a result of me being a board-certified obstetrician and gynecologist who is also certified in sexual health medicine with additional training and almost a decade experience in cosmetic gynecology surgery.

As delineated in the initial motion filed on my behalf, on January 13, 2023, by my former attorneys (Maria Nutile, Esq and Bridget Kelly, Esq), I oppose any confidentiality protection for Patients A, B, or C. These patients invited the media attention to this case. They have given a plethora of print and video interviews in which they besmirched my character and professional reputation as well as branded me a sexual abuser which destroyed my medical practice.

II. STATEMENT OF FACTS

The Complaint was filed on September 21, 2022. I was served on September 26, 2022. The NSBME did not post the Complaint on its website until a day or so later. Yet, an article entitled " 'Vagina Whisperer' OBGYN Accused of Sexual Misconduct by Medical Board" was published in *The Daily Beast* on September 30, 2023[1]. This was a coordinated effort to smear me as both Patients A and B were directly quoted in the article. Patient A stated in the cited articles that she filed a police report against me. Anyone requesting a copy of my police report history will find her report. In said report, Patient A's name and address will be found.

[1] Kate Briquelet, " 'Vagina Whisperer' OBGYN Accused of Sexual Misconduct by Medical Board," *The Daily Beast* on September 30, 2022.

Patients A and B went out of their way to paint me as a sexual deviant whilst failing to mention that I inquired about their sex lives only after they brought up their sexual dysfunctions to me. Patient A did so in the two-page list of concerns entitled "Vaginal Repair Consultation" that she handed me during her consultation. This is found in her medical record. Patient B did so during a sexual health consultation on April 27, 2015. The IC has her medical record in which I noted on April 27, 2015:

> She "reports that while she achieves orgasms with her vibrator, she's unable to do so during sex or oral sex with her husband. Fearful to tell her husband what she wants in bed because she worries about what he'll think. However, she believes her problem would be solved with uninhibited sex with a stranger she'll never see again."

Based on the aforementioned statements I asked questions, then counseled and treated her. Yet, during an interview with Mary Hynes (reporter) in a TikTok video posted on the *Las Vegas Review-Journal*'s page **using her name**, Patient B said something to the effect that whereas other doctors would ask about her libido, that wasn't enough for Dr. Chambers. To reiterate, she failed to mention that she sought consultation because I am certified in sexual health medicine; therefore, I had to inquire about her emotional, psychological as well as physical response to her husband.

Patient B also gave an interview with the *Las Vegas Review-Journal* on January 25, 2023, that was published on February 10, 2023, during which she used her first name which was accompanied by a darkened photograph of her profile[2]. Patient B also wrote a review on Yelp.com (see Exhibit A) in which she continued to besmirch my name. She used her name and last initial in the review. The review was removed by Yelp.com. Both Patients A and B were

[2] Mary Hynes, " 'All-around traumatic' More patients of Las Vegas ob-gyn allege misconduct," *Las Vegas Review-Journal*, February 10, 2023.

also quoted in another article published in the *Las Vegas Review-Journal*[3].

III. LEGAL ARGUMENT

My legal argument remains the same as was so well delineated by my former attorneys in our initial motion filed on January 13, 2023. However, I would like to highlight the following two case laws brought forth by my former attorneys. In *Doe v. City of Las Vegas* (No. 219CV00382GMNBNW, 2019 WL 2601554, at *3(D. Nev. (June 25, 2019)), a plaintiff's request to proceed anonymously to avoid harassment, ridicule and extreme personal embarrassment, and public condemnation was denied because she had "purposefully availed herself of news media, broadcasting the case, and putting it in the public eye." ... [T]he controlling fact is that her actions do not indicate the desire to maintain privacy. *Id* (emphasis added).

Although claims of sexual assault tend to concern "matters of a sensitive and highly personal nature," in a recent case of alleged rape under Title IX, the court denied anonymity to a plaintiff who had publicly named the defendant. Doe v. Liberty Univ., Inc., No. 6:21-CV-00059, 2022 WL 4781727, at *5 (W.D. Va. Sept. 30, 2022). Plaintiff had "sought to avail herself of the protections of anonymity ..., all the while single-handedly precluding the Named Defendant from the ability to avail himself of similar protections." *Id.* Regardless of the forum, "Equity does not support parties' strategic use of litigant anonymity as both sword and shield." *Id.* (emphasis added).

[3] Mary Hynes, "Las Vegas OB-GYN accused of sexual misconduct will have chaperone," *Las Vegas Review-Journal*, February 27, 2023

IV. CONCLUSION

Patients A, B and C have forfeited their protection to confidentiality under NRS 629.061(7)(b), NRS 622,310 (1)(a) as well as NRS 622.310 (1)(b). Given their extensive contact with the media[1, 2, 3], including Patient B using her first name and a possible pseudonymous last initial (that is, if she did not adopt her husband's surname), they have waived their right to confidentiality. *DOE V. CITY OF LAS VEGAS* (NO. 219CV00382GMNBNW, 2019 WL 2601554, AT *3(D. NEV. (JUNE 25, 2019)) supports this position.

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CERTIFICATE OF SERVICE

I hereby certify that I am George P. Chambers, Jr., MD, FACOG (respondent) and that on this 14th day of April 2023, I caused to be filed via email an electronic copy of the foregoing **REPLY TO THE IC'S OPPOSITION TO RESPONDENT'S MOTION TO THE INVESTIGATIVE COMMITTEE'S MOTION TO PROTECT PATIENT LIKENESSES** to the following:

Brandee Mooneyhan, J.D.
Deputy General Counsel
mooneyhanb@medboard.nv.gov

Donald K. White, J.D.
Deputy General Counsel
dwhite@medboard.nv.gov

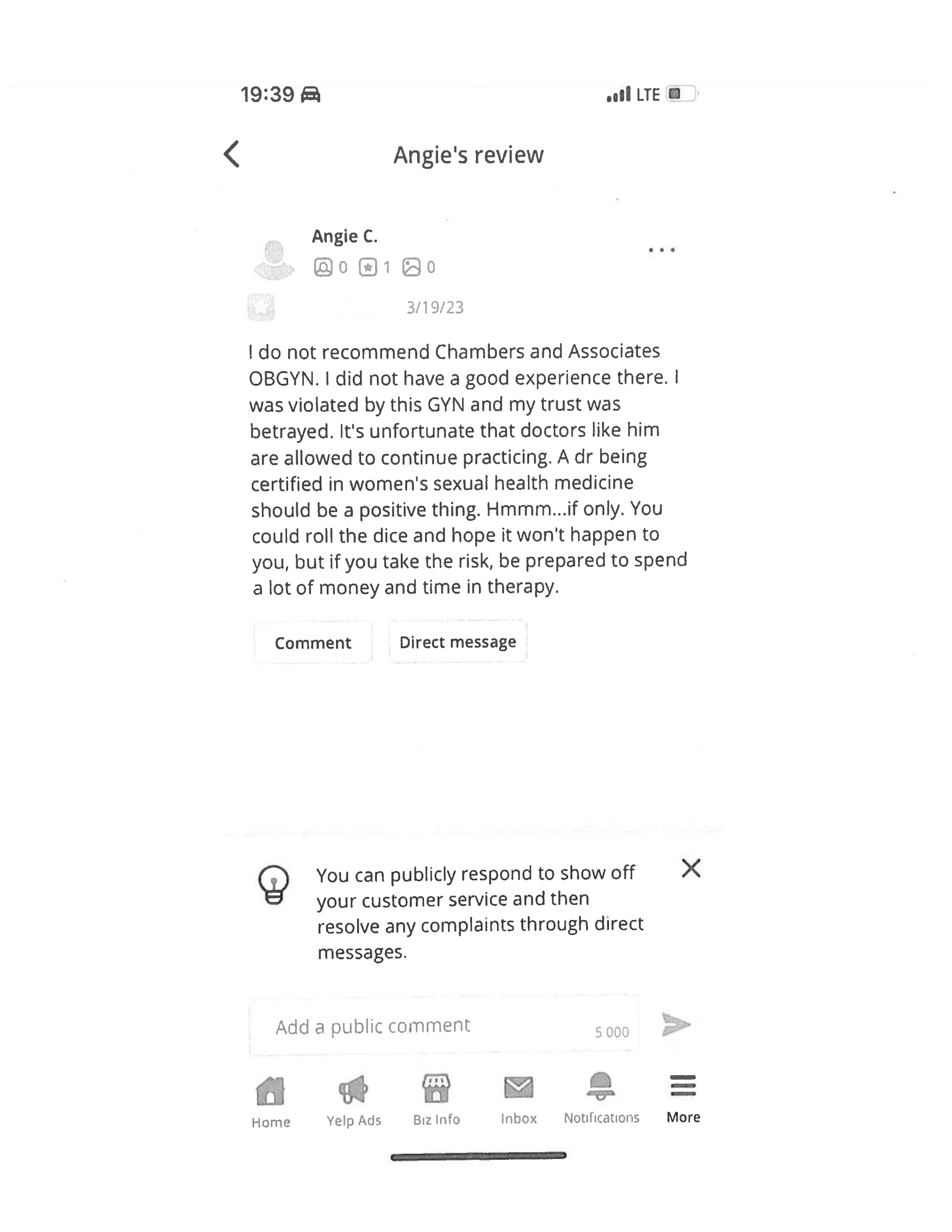
Nancy Moss Ghusn, Esq.
Hearing Officer
Nmg416@gmail.com

Dated this 14th day of April 2023.

George P. Chambers, Jr., MD, FACOG
Respondent, *Pro se*

EXHIBIT A

EXHIBIT A


19:39
LTE
Angie's review
Angie C.
0 1 0
3/19/23
I do not recommend Chambers and Associates OBGYN. I did not have a good experience there. I was violated by this GYN and my trust was betrayed. It's unfortunate that doctors like him are allowed to continue practicing. A dr being certified in women's sexual health medicine should be a positive thing. Hmmm...if only. You could roll the dice and hope it won't happen to you, but if you take the risk, be prepared to spend a lot of money and time in therapy.
Comment
Direct message
You can publicly respond to show off your customer service and then resolve any complaints through direct messages.
Add a public comment
5,000
Home
Yelp Ads
Biz Info
Inbox
Notifications
More

14:08

We've Removed the Review You Recently Reported [13183317] Inbox

Yelp HQ 10:00

to me

Hello,

We're writing to let you know that we've evaluated Angie C.'s review of Chambers & Associates OBGYN and Gynecological Surgery that you recently reported. After assessing the review carefully against our Content Guidelines, we agree that this review should be removed.

We rely on community engagement to help keep Yelp useful. Thanks so much for taking the time to bring this matter to our attention!

For further information on using Yelp, please find answers to frequently asked questions in our Support Center (http://www.yelp-support.com).

- The Yelp Support Team

Reply Forward

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D., Respondent.**	**Case No.: . 22-27891-1**

FILED
APR 24 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

ORDER GRANTING INVESTIGATIVE COMMITTEE'S MOTION TO PROTECT PATIENT LIKENESSES

On April 10, 2023, the Investigative Committee ("IC") renewed its Motion to Protect Patient Likenesses, originally filed on January 5, 2023. Respondent, Dr. Chambers, in *pro per* after his attorney withdrew from this matter, requested that the original Opposition filed by his former attorney on January 13, 2023, be submitted on his behalf and filed an additional Opposition *in pro per* on April 17, 2023. In response to both Oppositions, the IC filed its Reply, April 14, 2023, in response to both Oppositions submitted by Dr. Chambers. This Hearing Officer notes that these documents were originally entitled otherwise, but for purposes of clarity will be referred to as the IC's "Motion," Respondent's "Opposition," and the IC's "Reply."

In the interest of brevity as this hearing is quickly approaching, this Hearing Officer will briefly address the Parties' arguments and dispose of these matters.

Within the IC's Motion, the IC argues that the law is clear that patient identities are required to be protected, and, in a case such as this where there is media interest, an order needs to be put in place to ensure such protection, citing, *inter alia,* NRS 629.061(7)(b), and NRS 622.310(1). In his Opposition, the heart of Dr. Chambers argument is that Patients A, B, and C waived any right of confidentiality by because "[t]hese patients invited the media attention to

this case." Respondent's *pro per Opposition*, p. 2. He delineates Patients A and B's interaction with social conventional media and concludes that, as a result, these patients "have forfeited their protection to confidentiality" under Nevada law. *Id.* at 5.

In its Reply, the IC's central argument is that the language of NRS 629.061(7)(b) and NRS 622.310(1) are plain and unambiguous and should be enforced as written. As such, the IC argues, it is unnecessary to consult the legislative history of the controlling statutes, but the legislative history would also support the right of a patient to maintain confidentiality in a board proceeding. Finally, the IC argues that Respondent's concern that his right to confront any witness is misplaced as he will indeed have the right and ability to cross-examine all witnesses.

This Hearing Officer finds the IC's arguments persuasive and agrees with it on each of these issues. First, the controlling statutes are clear and unambiguous: NRS 629.061(7)(b) ("appropriate procedures" must be "utilized to protect the identity of the patient[s]; NRS 622.310(1)(a) ("personal medical information or records of a patient that are confidential or otherwise protected from disclosure by any other provision of federal or state law" must be protected); and NRS 622.310(1) (the "personal identifying information of a person alleged to have been injured by any act of another person for which a license, certificate or permit is required to be issued by a licensing board" must be protected from disclosure).

As the language of the controlling statutes is clear and unambiguous, it is not necessary to inquire into the legislative history of these laws to reach the conclusion that patient likenesses be protected. However, legislative history also supports this conclusion as well.

Finally, Respondent will have every due process protection to which he is entitled, including, of course, the right to confront and cross-examine any witnesses who testify at the hearing. This Hearing Officer agrees with the IC that his constitutional right to confront any

witnesses does not "morph into the right to expose the identity of the patients." *Reply*, p. 3. Indeed, if that were the case, there would be no question that would cast a chilling effect on members of the public coming forward to report allegations of questionable medical care.

CONCLUSION

In light of the above, this Hearing Officer directs that all persons present at the hearing and any related proceedings, including those to be held in-person and remotely on May 2, May 3, and June 1, 2023, refrain from recording the likenesses of Patient A, Patient B, and Patient C through photographs, video, drawings, or any other medium. This conclusion does not restrain any party may make their own choices whether or not to speak to the media or to discuss their circumstances on social media.

Dated this 24th day of April, 2023.

NANCY MOSS GHUSN, ESQ.
Email: nmg416@gmail.com
Tel: (775) 772-5644
Hearing Officer

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In The Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D., Respondent.**	**Case No.: . 22-27891-1**

FILED
APR 24 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

ORDER DENYING RESPONDENT'S MOTION TO EXCLUDE TESTIMONY OF PEER REVIEWER WITNESS

On January 6, 2023, Respondent, by and through his attorney at the time, filed his "Motion to Exclude Testimony of Peer Reviewer Witness." On January 12, 2023, the Investigative Committee ("IC") filed its Opposition thereto. On April 11, 2023, Respondent Dr. Chambers, in *pro per* after his attorney withdrew from this matter, filed his Reply. In response to both Oppositions, the IC filed its Reply in response to both Oppositions submitted by Dr. Chambers. For purposes of clarity, these documents will be referred to as the Respondent's "Motion," the IC's "Opposition," and the Respondent's "Reply."

In the interest of brevity as this hearing is quickly approaching, this Hearing Officer will briefly address the Parties' arguments and dispose of these matters.

The Respondent requests this Hearing Officer to exclude the IC's "Peer Reviewer" or "Expert Witness," Dr. Richard W. Rafael, M.D., arguing that Dr. Rafael is not qualified to testify as to the standard of care in the specialized fields of cosmetic gynecological surgery and sexual health medicine, but is only qualified as a general OB/GYN.

In its Opposition, the IC argues, first, that Respondent's Motion should be denied at the outset as he did not request leave to file such motion as required by NRS 622A.360(2). In addition,

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the IC argues, even if the Respondent had followed the procedures required by NRS 622A.360(2), Dr. Rafael is qualified to testify as an expert in an administrative hearing.

This Hearing Officer agrees with the IC's arguments and thereby denies the Respondent's Motion.

Under Nevada's statutory scheme with respect to the Nevada State Board of Medical Examiners, only certain prehearing motions may be filed. *See*, NRS 622A.360(2). If a certain motion is not one of the five enumerated motions, such as the instant motion, a party must request "leave of the regulatory body or hearing panel or officer, any other motion requesting appropriate action or relief before the date of the hearing." NRS 622A.360(2)(f).

The language of this statute is clear, unambiguous, and mandatory, and such leave was never requested in this matter. Accordingly, this Hearing Officer is not able to consider this motion, and it must be denied as a matter of law.

Even if the Respondent's Motion were to be considered, it is without merit in an administrative hearing setting. In an administrative hearing, the factfinder, such as this Hearing Officer, is not required to adhere to the formal rules of evidence but may admit evidence that is relevant and helpful. The Respondent will have the opportunity to cross-examine Dr. Rafael as to his qualifications and experience and to object to the same. Additionally, the Hearing Officer, as factfinder, is able to ask questions and is also able to give appropriate weight and determine the probative value to Dr. Rafael's testimony.

Accordingly, it would be inappropriate to exclude Dr. Rafael's testimony in an administrative proceeding such as this, and, pursuant to Nevada law governing prehearing motions, it would be particularly inappropriate in this matter.

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CONCLUSION

In light of the above, this Hearing Officer denies the Respondent's Motion to Exclude Testimony of Peer Reviewer Witness, but without prejudice to renew his objections as to Dr. Rafael's qualifications during the course of the hearing.

Dated this 24th day of April, 2023.

NANCY MOSS GHUSN, ESQ.
Email: nmg416@gmail.com
Tel: (775) 772-5644
Hearing Officer

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **GEORGE PETER CHAMBERS, JR., M.D.** **Respondent.**	**Case No. 22-27891-1**

FILED
MAY - 8 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

ORDER GRANTING INVESTIGATIVE COMMITTEE'S MOTION FOR STATUS CONFERENCE

TO: Brandee Mooneyhan
Donald K. White
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 8952

George Peter Chambers, Jr., M.D.
5875 Rainbow Blvd., Ste. 201
Las Vegas, NV 89118

On May 2 and May 3, 2023, Dr. Chambers' Hearing was conducted at both the North and South Offices of the Nevada State Board of Medical Examiners ("NSBME").

At that time, the Hearing Officer and all parties and counsel for the Investigative Committee ("IC") of the NSBME reaffirmed the agreement of a continued hearing date of June 1, 2023, in which the witness known as Patient C and Casey Carden would be scheduled to testify. In addition, at the conclusion of testimony on May 3, 2023, the Hearing Officer, Dr. Chambers, and counsel for the IC also agreed to schedule Dr. Chambers' expert witness, Dr. Goodman, to complete Dr. Chambers' testimony and cross-examination, and to schedule the testimony of the remaining witnesses, all via *Zoom*, as follows:

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9:00 a.m.: cross-examination and completion of Dr. Chambers' testimony;

11:00 a.m.: Dr. Goodman;

1:30 p.m. : Patient C and Ms. Casey Carden

Again, the formal hearing in this matter is hereby continued and has been confirmed by all parties for June 1, 2023, starting at the hour of 9:00 a.m., via *Zoom*. A court reporter will take sworn testimony during the formal hearing and will produce a transcript to deliver to the Hearing Officer and all parties at their request and at their expense.

Once the formal hearing is concluded the Hearing Officer will submit to the NSBME a synopsis of the testimony recorded by the court reporter and will make a recommendation on the veracity of witnesses, if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the NSBME will render its decision. *See* NAC 630.470.

All requests for remote appearances have been made in this matter.

Stipulation to stay the above dates shall be made to the hearing officer either by email or by formal, filed stipulation as soon as the parties are aware of the necessity for a stay. Any stay request will require a status conference.

All parties to this case are required to keep the Hearing Officer informed of events, progress and resolution of this case.

IT IS SO ORDERED.

DATED this 8th day of May, 2023.

By: _____

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Hearing Officer