IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

STATE OF OKLAHOMA, *ex. rel.* OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
v.	)	**Case No. 15-05-5144**
LESLIE ANN MASTERS, M.D., LICENSE NO. 21537,	)	
Defendant.	)	

VERIFIED COMPLAINT FOR PROFESSIONAL MISCONDUCT

The State of Oklahoma, *ex rel.* Oklahoma State Board of Medical Licensure and Supervision ("Board"), alleges and states as follows for its Complaint against the Defendant Leslie Ann Masters, M.D.:

I. JURISDICTION

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 O.S. § 480, *et seq*.

2. This action is authorized by 59 O.S. Supp. 2014, § 503 (authorizing sanctions for unprofessional conduct).

3. Dr. Masters holds Oklahoma medical license no. 21537.

4. The acts and omissions complained of herein occurred while Dr. Masters was acting as a physician pursuant to her medical license conferred upon her by the State of Oklahoma. Such acts and omissions occurred within the physical territory of the State of Oklahoma.

II. BACKGROUND

A. Prior Board Action

5. Previously, Dr. Master's medical license was suspended by this Board in 2004 for substance misuse which was followed by five years of probation. Dr. Masters completed her probation in July 2009.

B. The NPDB Reports

6. This case arises out of a notice of settlement sent from the National Practitioner Data Bank ("NPDB") to the Board in May 2015. The NPDB notified the Board staff of a settlement of a medical malpractice lawsuit against Dr. Masters for $750,000.00. The lawsuit alleged a patient died during a liposuction procedure.

7. NPDB records show over $1.327 Million was paid between March 2011 to April 2015 to settle seven (7) lawsuits against Dr. Masters involving injury allegedly caused by or resulting from cosmetic procedures, and liposuction in particular, performed by Dr. Masters. The dates of surgeries span from 2008 to 2014.

8. Dr. Masters has no formal surgical training. She has been licensed to practice medicine in Oklahoma since 2000. Dr. Masters completed a residency in internal medicine and a fellowship in oncology. She is not board certified in any specialty.

C. Review and Expert Analysis of Patient Records

9. Seven (7) patient records were subpoenaed by Board investigators from Dr. Masters and submitted to a qualified expert for review. The seven patients had filed medical malpractice lawsuits against Dr. Masters. The information in the medical records include, but are not limited to, the following:

a. **Patient BC:** BC underwent four liposuction procedures between January 2007 and April 2008. The tumescent fluid used contained Xylocaine but no epinephrine. BC was sedated with Cephalexin, Halcion and Mepergan prior to each procedure.

b. **Patient MG:** MG underwent four liposuction procedures between July 2007 and May 2009. The tumescent fluid used consisted either of "Lido / NS / Kenalog / HCL3 / Epi" or of Lidocaine, saline, sodium bicarbonate, Solu-Medrol, and epinephrine. In neither case can the exact amounts of lidocaine be found. MG was sedated with Cephalexin, Halcion and Mepergan prior to each procedure.

c. **Patient KC:** KC underwent twelve liposuction and three fat grafting procedures between 22 August 2007 and 5 May 2009. The constituents of the tumescent fluid used are unknown. However, in one instance, the amount of Xylocaine used for a procedure in January 2008 is 68.1 milligrams per kilogram, well above what is commonly accepted as safe for tumescent anesthesia.

d. **Patient LM:** LM underwent three liposuction, one string lift and one fat transfer procedures between September 2010 and January 2011. The patient was given Demerol pre-operatively on several occasions. In the last surgery, LM was discharged with an oxygen saturation level of 90%.

e. **Patient CB:** CB underwent two liposuction and one fat transplant procedures between April and May 2011. Preoperative medications included Halcion, Demerol, Phenergan and Ativan. No post-operative vital signs were taken for

CB's first procedure. For the last procedure, no discharge time or postoperative vital signs are noted.

f. **Patient MD:** MD underwent one facelift and one fat transplant procedure between May and July 2013. For the first procedure, MD was sedated with Halcion, Phenergan and Percocet. Vital signs were taken sporadically and the patient was discharged with an oxygen saturation level of 91%. The vital signs, start and discharge times for the second procedure are illegible.

g. **Patient JB:** JB underwent three liposuction and one fat transplant procedures between September 2013 and April 2014. JB died during the last procedure. The patient intake sheet shows a positive history of high blood pressure and diabetes. Although the patient denied having acute or chronic pain, JB listed Tramadol as a drug JB occasionally took for pain. During the first procedure, JB was sedated with Halcion, Percocet and Phenergan. No tumescent solution infusion amounts are noted. During the second procedure, JB was sedated with Halcion, Percocet, Phenergan, and Versed. The tumescent fluid used for this procedure contained a Xylocaine amount giving a drug-to-weight ratio of 45 milligrams of Xylocaine per kilogram. Yet vital signs were only taken four times during this five hour procedure. During the third procedure, the tumescent fluid consisted of 1 liter of saline, 50 milliliters of Xylocaine, 12.5 milliliters of bicarbonate, 0.25 milligrams of Kenalog, and 1 milligram of epinephrine. 1800 milliliters of tumescent fluid were administered. JB was sedated with Halcion, Cephalexin, Percocet, Phenergan, and Versed. The procedure began at about 1030. A blue code was called at approximately 1205 when JB's oxygen saturation level fell to 82% and JB exhibited reduced arousability. JB died the same day.

10. Based on the subpoenaed patient charts, the qualified expert made the following general findings:

a. Dr. Masters routinely performed multiple tumescent liposuction procedures in short intervals on the same patient. Because tumescent liposuction procedures have a metabolic effect on the body similar to burns and soft tissue trauma, patients should have had blood chemistry taken. Dr. Masters did not have any ongoing or serial laboratory work performed on patients, resulting in risk of patient harm.

b. The patient records reflect several instances in which Dr. Masters failed to take adequate documentation of procedures, patient health histories or conduct physical exams, resulting in increased risk of patient harm. In addition, there is no documentation showing that assisting personnel were licensed health care professionals.

c. Dr. Masters failed to take sufficient steps to safely discharge patients. Dr. Masters did not use a consciousness scale despite having patients being heavily sedated for procedures, and at least two patients were discharge with an oxygen

saturation level around 90%. Such practices result in an increased risk of patient harm.

d. Significantly, Dr. Masters consistently failed to take necessary steps to ensure patient safety during procedures. The patient records reflect each patient received large amounts of sedatives and were undergoing "conscious sedation." The patients were also given large quantities of Xylocaine, and Patient JB received an injection of Versed during the procedure when JB died. Patient LM also received Demerol during procedures. The constellation of these drugs given to patients gives rise to the significant risk of depressed respiration during procedures. Yet the medical records show:

1. No continuous monitoring of patient vital signs, or even timely, routine monitoring of vital signs, were made;

2. No supplemental oxygen was given during any procedure; and

3. No one was dedicated to patient monitoring and airway management.

11. The subpoenaed charts, along with the expert review, illustrate a pattern of repeated negligence, in some instances gross negligence, by Dr. Masters while performing surgical procedures. This pattern of negligence presents systemic problems with Dr. Master's performance that jeopardizes patient safety. The level of care in the charts fails to comport with the minimal Board guidelines for office-based surgeries.

D. The RK Complaint

12. Board investigative staff received a complaint from RK regarding Dr. Masters on 21 March 2016.

13. In 2015, after several elective cosmetic procedures, Dr. Masters gave RK syringes filled with fat tissue taken from RK's body. Dr. Masters instructed RK to take the fat-filled syringes home and for RK to self-inject in RK's face when she desired to do so. Dr. Masters had the fat-filled syringes wrapped in a surgical towel and instructed RK to take them home and place them in RK's freezer. Dr. Masters advised RK that the fat would remain "good" for about one year.

14. RK took home the fat-filled syringes, put them in the freezer, self-injected with them, and subsequently developed a serious bacterial infection in her face. Dr. Masters treated the infection for about three months, but the treatment regimen did not resolve the infection. Dr. Masters then gave RK Juvederm injections (mostly consisting of hyaluronic acid), which made RK's condition even worse.

15. RK asked for a refund of her money for the procedures. Dr. Masters refused and instead offered RK a laser skin therapy on the infected areas of her face at no charge. Later, Dr. Masters offered a refund of all the money RK spent on cosmetic procedures in exchange for RK dropping RK's complaint with the Board and deleting negative social media comments about Dr. Master's practice.

16. On 31 March 2016, Dr. Masters executed an agreement to restrict her practice to not perform surgical procedures.

17. A qualified expert reviewed RK's medical charts and made the following observations and conclusions:

    a. A complete lack of adequate documentation for this patient, including a lack of documentation regarding the procedures on this patient;

    b. A complete lack of any attempts to adhere to appropriate cryopreservation protocols;

    c. Dr. Master's actions fell below the minimum standard of care in this instance and significantly advanced the possibility of patient harm.

III. VIOLATIONS

18. Based on the foregoing, Dr. Masters is guilty of professional misconduct as follows:

    a. Engaging in dishonorable or immoral conduct likely to deceive, defraud or harm the public, in violation 59 O.S. 2011, § 509(8) and Okla. Admin. Code § 435:10-7-4(11);

    b. Failing to keep adequate medical records for at least eight (8) different patients, in violation of 59 O.S. 2011, § 509(18), (20), and Okla. Admin. Code § 435:10-7-4(36), (41);

    c. Engaging in gross or repeated negligence in the practice of medicine and surgery on at least eight (8) different patients, in violation of Okla. Admin. Code § 435:10-7-4(15);

    d. Engaging in behavior demonstrating an incapacity or incompetence to practice medicine and surgery with reasonable skill and safety on at least eight (8) different occasions, in violation of Okla. Admin. Code § 435:10-7-4(17), (18); and

    e. Failing to provide a proper and safe medical facility setting for a recognized medical act, in violation of 59 O.S. 2011, § 509(20) and Okla. Admin. Code § 435:10-7-4(41);

IV. CONCLUSION

Given the foregoing, the undersigned requests the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to Dr. Master's professional license, including an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

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VERIFICATION

I, Robbin Roberts, under penalty of perjury, under the laws of the State of Oklahoma, state as follows:

1. I have read the above Complaint regarding Defendant, Leslie Masters, M.D.; and

2. The factual statements contained therein are true and correct to the best of my knowledge and belief.

Robbin Roberts, Investigator
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION

Date: 8-16-16

Oklahoma County, OK
Place of Execution