BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD

STATE OF GEORGIA

IN THE MATTER OF:	)	
	)	
NEDRA DODDS, M.D.,	)	DOCKET NO.
License No. 39170,	)	
	)	
Respondent,	)	

ORDER OF SUMMARY SUSPENSION

1.

WHEREAS, Respondent is licensed by the Georgia Composite Medical Board ("Board") to practice medicine in the State of Georgia, and has been so licensed since October 6, 1994.

2.

WHEREAS, Respondent is the owner, Medical Director, and principal surgeon at Opulence Aesthetic Medicine in Kennesaw, Georgia. Respondent is Board Certified in Emergency Medicine. Respondent is not Board Certified in Plastic Surgery.

3.

WHEREAS, the Board has received reliable information that Respondent's surgical care and treatment of patient A. J. was unprofessional and fell below the standard of care, causing patient A.J. significant pain during surgery and causing or significantly contributing to patient A.J.'s death:

a. A.J., a 37 year old woman, presented for liposuction and fat injections into her buttocks on February 19, 2013.

b. Respondent completed the procedure in less than one hour and 45 minutes.

c. During the liposuction portion of the procedure, A.J.'s diaphragm and liver capsule were lacerated, and A.J.'s intercostal spaces were penetrated twice, causing

hemorrhaging of 250 cc of blood into the abdominal cavity from the liver, GI mesentery, and right renal fat pad.

d. A.J. was not properly sedated and remained largely conscious during portions of the procedure. Two staff members reported that A.J. was "completely conscious" or "fully aware"; that she protested loudly, complaining that the procedure was "tearing" and "burning"; and that Respondent told A.J. to be quiet because "she had paid for this." One of these staff members reported that Respondent placed a rag in A.J.'s mouth to quiet her during the procedure.

e. Upon completion of the liposuction procedure, A.J., a partially sedated overweight woman, was turned prone for the fat injections into her buttocks without appropriate airway control.

f. Upon completion of the fat injections, at 19:45, A.J. made a loud snore and flexed her legs backwards into the air, then dropped her legs, became incontinent, and coded.

g. A.J. was turned supine and bagging was initiated. From the records available, it appears that A.J. was not intubated, and aspirated. Atropine could not be located at the surgical center. CPR was not initiated, and Respondent did not contact 911 for aid or transport until 20:17.

h. A.J. was transported to the emergency room at Wellstar Kennestone Hospital, and was pronounced dead on arrival.

i. The Cobb County Medical Examiner determined that A.J. died from pulmonary fat emboli in her lungs. Pulmonary fat emboli are a known complication of buttock fat injections, and their avoidance requires extreme care. Introduction of fat emboli into the pulmonary system can be aggravated by poor surgical technique. With proper

protocols and monitoring during surgery, and prompt, appropriate treatment after symptoms of pulmonary fat emboli arise, patient survival is possible.

j. Respondent's surgical techniques, surgical management, anesthetic management, intra-operative monitoring and documentation, and Respondent's ability to recognize, react to, and treat life-threatening complications all fell significantly below the standard of care, and caused or significantly contributed to A.J.'s death.

4.

WHEREAS, the Board has received reliable information that Respondent's surgical care and treatment of patient E.B. on June 20, 2013, was unprofessional and fell below the standard of care, causing patient E.B.'s death:

a. E.B. had received previous surgical treatment from Respondent to remove especially hard silicone from her buttocks, at which time E.B. suffered significant tachycardia and hypotension coinciding with the silicone removal. The most likely cause of the tachycardia and hypotension was hypovolemia from excessive bleeding.

b. E.B. presented on June 20, 2013, for liposuction, including a continuation of the removal of the silicone from her buttocks, and fat transfers to the thighs.

c. Respondent described the silicone removal as vigorous and physically taxing.

d. Early in the surgery, E.B. had a pulse of 125 and a BP of 89/44, suggesting hypovolemia. She improved with a liter of fluid, but from the end of surgery through the time of her cardiac arrest, she had consistently low blood pressure and a rapid pulse.

e. From the end of the surgery at 17:35 until 18:50, E.B. remained cold, never fully awoke from the sedation, and was monitored with a malfunctioning oximeter. At

18:50, there was an acute EKG change, E.B. became pulseless, and Respondent was notified. Respondent did not contact 911 for aid or transport until 19:15.

f. The EMTs arrived at 19:23 to find E.B. in cardiac arrest, unresponsive with fixed, dilated pupils, lying in a pool of blood estimated to be 500 ccs, no MD in charge, and no ongoing CPR. The EMTs identified a fast, organized heart rate on the monitor, but without carotid pulses, the EMTs immediately initiated CPR. Respondent advised that the pool of blood was from the incision sites.

g. E.B. was transported to Wellstar Kennestone Hospital, where after ninety minutes of unsuccessful resuscitative efforts, E.B. was pronounced dead at 21:10.

h. The Cobb County Medical Examiner first observed E.B. at 22:40, and observed the pads beneath her arms to be saturated with blood; and the bedding, gown, her compression stockings, and the floor around the gurney all showed blood and blood tinged fluid. Of the nine trocar sites, only two were closed, each with a single suture. The cause of death was determined to be cardiac dysrhythmia from hemorrhage, without a localized collection of blood.

i. Respondent's pre-operative, intra-operative, post-operative, and resuscitative care all fell significantly below the standard of care, causing E.B's death.

5.

WHEREAS, the Board has received reliable information that Respondent exercised clinical judgment below the standard of care in at least two additional instances by proceeding with elective surgery when the patients were not fit for surgery:

1. On October 30, 2012, Respondent proceeded with liposuction on patient G.B. without medical evaluation or clearance. G.B. was 54 years old, overweight with

uncontrolled diabetes, Hepatitis C, and hypertension at the time of surgery. It was below the standard of care for Respondent to perform liposuction on G.B. under these circumstances.

2. On February 26, 2013, Respondent proceeded with cosmetic surgery on patient K.S. despite a reported history of uncontrolled hypertension, and without obtaining a pre-operative EKG or medical clearance. K.S. was hypertensive before and after surgery. During surgery his oxygen saturation dropped to 90% and there is no record of intra-operative EKG monitoring. After surgery, Respondent contacted K.S. to discuss his hypertension and refer him to a Dr. Kaufman for treatment. K.S. told respondent he would not take his medications, and he did not consult with Dr. Kaufman. Nevertheless, Respondent again proceeded with elective cosmetic surgery on K.S. on March 7, 2013. K.S. was again hypertensive throughout surgery, with oxygen saturation varying between 92% and 95%, putting K.S. at risk of myocardial infarction and stroke. It was below the standard of care for Respondent to perform elective cosmetic surgery on K.S. under these circumstances.

6.

WHEREAS, of the clinical records available for review for the above patients, none had a standard history, physical exam or vital signs pre-operatively. Examinations by Respondent did not occur or were not documented. There were minimal operative notes. Estimated blood loss was often omitted. There was no documentation of EKG during surgery, except for G.B. The other 3 cases appear to have been monitored by BP, pulse, and oxygen saturation alone. The two patients who survived were discharged almost immediately. There were no or scant recovery

room records. Each of the foregoing falls below the standard of care. Respondent's record keeping generally falls below the standard of care.

7.

NOW THERFORE, the Board finds that Respondent's continued practice of medicine poses a threat to the public health, safety, and welfare and imperatively requires emergency action and hereby ORDERS that Respondent's license to practice medicine in the State of Georgia be and is hereby SUMMARILY SUSPENDED pursuant to O.C.G.A. § 50-13-18(c)(1), pending further proceedings on behalf of the Board, which shall be promptly instituted.

If the Respondent wishes to have an expedited hearing, Respondent shall execute and file with the Office of State Administrative Hearings the original and one copy of the attached REQUEST FOR EXPEDITED HEARING no later than fourteen (14) days from the day of service or receipt of this Order. Respondent also shall serve a copy of such REQUEST upon counsel for the Board as identified in the REQUEST.

This Order is signed and attested by the Executive Director on behalf of the Georgia Composite Medical Board.

This 28th day of February, 2014.

GEORGIA COMPOSITE MEDICAL BOARD

RICHARD WEIL, M.D.
Chairperson

(BOARD SEAL)

LASHARN HUGHES
Executive Director

PLEASE DIRECT CORRESPONDENCE TO:

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