1 **BEFORE THE REVIEW COMMITTEE OF THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **MARCO B. SAUCEDO, M.D.**

4 Holder of License No. 27068
For the Practice of Allopathic Medicine
5 In the State of Arizona.

Case No. MD-20-0167A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND

6 The Review Committee of the Arizona Medical Board ("Board") considered this
7 matter at its public meeting on June 9, 2023. Marco B. Saucedo, M.D. ("Respondent"),
8 appeared with legal counsel, Michele G. Thompson, Esq., before the Review Committee
9 for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-
10 1451(P). The Review Committee voted to issue Findings of Fact, Conclusions of Law and
11 Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

13 1. The Board is the duly constituted authority for the regulation and control of
14 the practice of allopathic medicine in the State of Arizona.

15 2. The Board initiated case number MD-20-0167A after receiving a complaint
16 regarding Respondent's care and treatment of a 66-year-old female patient ("KN") with
17 allegations including failure to adequately perform a breast lift.

18 3. On February 14, 2019, KN presented to Respondent's office for consultation
19 regarding a breast lift, implant exchange, liposuction, and tummy tuck. KN decided that
20 she would undergo a breast lift and implant exchange as well as liposuction of the
21 abdomen and axilla.

22 4. On March 19, 2019, Respondent performed a bilateral breast implant
23 exchange on KN, changing her implants from Mentor 400cc gel breast implants to
24 Allergan 420cc gel breast implants. Respondent's Assessment/Plan on that date stated,
25 "The patient is stable for a breast lift implant exchange, lateral chest lipo and frontal

abdominal lipo." Additionally, Respondent performed a de-epithelialization of an ellipse of skin from the inframammary fold and liposuction of the abdomen and axilla. During the procedure, Respondent administered anesthetic using 3.5mg Bupivacaine and 25mic Fentanyl that was supplemented with local injections of Klein Solution. Moderate Conscious Sedation was also used and consisted of a continuous infusion of Propofol with intermittent boluses of intravenous Fentanyl, Versed and Propofol. The antibiotics Kefzol and Flagyl were given, as well as Zofran intravenously.

5. On March 28, 2019, KN presented for a post-operative appointment and Respondent determined she was healing well. A follow-up appointment was scheduled for two weeks later. KN cancelled numerous follow-up appointments and never returned to the clinic.

6. KN subsequently engaged in a text message conversation with Respondent's office staff regarding billing issues and potential future surgeries. KN inquired regarding healing, breast redness and suture extrusion. KN sent Respondent's office staff photographs, and office staff told KN she was healing well, and everything appeared normal except for adhesive irritation. KN continued to report suture extrusion.

7. On April 22, 2019, KN texted office staff expressing frustration regarding ongoing suture extrusion, infection and poor healing. KN further advised that her primary care physician took a culture that was positive for methicillin resistant staphylococcus aureus ("MRSA").

8. On April 24, 2019, Respondent sent KN a registered letter stressing the importance of follow up care.

9. On July 31, 2019, KN texted office staff regarding concerns of breast implant associated anaplastic large cell lymphoma ("BIA-ALCL"). KN also expressed

disappointment that her breasts were still as wide as they were and appeared barely lifted and only slightly changed.

10. The standard of care requires a physician to adequately perform a breast lift. Respondent deviated from the standard of care by failing to adequately perform a breast lift.

11. The standard of care requires a physician to properly monitor an anesthetized patient. Respondent deviated from the standard of care by failing to properly monitor an anesthetized patient. Respondent lacked proper monitoring equipment and appropriately qualified anesthesia personnel to continuously interpret the monitor readings on the patient.

12. Actual patient harm was identified in that the patient did not receive an adequately performed breast lift.

13. There was the potential for patient harm in that spinal anesthesia can create significant hypotension and bradycardia requiring immediate recognition and treatment. Additionally, moderate conscious sedation can create hypotension, dysrhythmias, and apnea requiring immediate recognition and treatment.

14. Medical consultants who reviewed Respondent's care and treatment of KN also identified documentation deficiencies including that the intraoperative documentation lacked End-Tidal CO2 readings, an EKG, respiratory rate or body temperature.

Procedural History

15. Effective August 25, 2021, Respondent entered into an Interim Consent Agreement for Practice Restriction prohibiting him from performing cosmetic breast procedures and requiring him to utilize a Certified Registered Nurse Anesthetist ("CRNA") to provide pre-operative, intraoperative, and post-operative care for all other procedures performed ("Interim Practice Restriction").

16. Respondent concurrently provided Board staff with a contract with an anesthesiology group to provide qualified personnel to administer anesthesia during his procedures.

17. On February 3, 2022, Respondent attended a Formal Interview with a Board Review Committee ("First Formal Interview"). During the First Formal Interview on this matter, Respondent testified regarding his care and treatment of Patient KN. Respondent recognized that he failed to amend the consent form or recognize KN's expectations. Respondent stated that he had adequate training and that he was competent to perform cosmetic surgical procedures. Respondent additionally acknowledged his deviation from the standard of care regarding anesthesia administration for KN. Respondent referenced letters of support from colleagues that he submitted during the course of the Board's investigation.

18. During deliberations following the First Formal Interview, Review Committee members commented that there was insufficient information to determine whether Respondent was competent to perform cosmetic procedures and voted to return the case for further investigation to have an MC review Respondent's care and treatment of additional patients to whom Respondent recently provided care. Additionally, the Committee directed Board staff to lift the Interim Practice Restriction.

Additional Investigation

19. Effective February 7, 2022, the Interim Practice Restriction was terminated by the Executive Director.

20. Based on the Committee's direction, Board staff requested MC review of Respondent's care and treatment of four patients. The MC opined that Respondent met the standard of care with regard to three of the patients reviewed but identified deviations from the standard of care with regard to Respondent's care and treatment of Patient CB.

21. On March 30, 2019, Respondent performed a superior pedicle mastopexy and liposuction for Patient CB, a 63-year-old female. Respondent documented liposuction of the abdomen (tumescent infiltrated 2.5L and liposuction plus tumescent aspirated 2800cc), flanks (tumescent infiltrated 2300cc and liposuction plus tumescent aspirated 3000cc), and sacrum (fat aspirated 300cc) with fat grafting to her buttocks (right side 420cc and left side 600cc). The surgery was initiated at 1640 and concluded at 2220. At 2100, CB was discharged to a hotel. CB followed up with the office once after the surgery and followed up with her primary care for suture removal and further care.

22. The standard of care prohibits a physician from removing more than five liters of liposuction plus aspirate without adequate postoperative monitoring. Respondent deviated from the standard of care by failing to adequately monitor a post-operative patient subsequent to a high-volume liposuction procedure.

23. There was potential for patient harm in that Patient CB was at risks of significant fluid shifts and lidocaine toxicity.

Second Formal Interview

24. On June 9, 2023, the case returned to the Committee for completion of the Formal Interview ("Second Formal Interview"). During the interview, Respondent testified that he continued to use a qualified anesthesia provider for sedation during procedures. Respondent testified that he has stopped performing breast lift procedures in his office due to COVID and the economy, and his last breast implant procedure was approximately nine months prior to the interview. Respondent stated that due to the decrease in demand, he may also cease performing breast implant procedures as well. Respondent testified he still performs liposuction and abdominoplasty. Respondent testified that he takes a more conservative approach to volumization of the buttocks, in order to avoid problems with fat necrosis or tissue breakdown.

25. When asked by a Committee member about changes to his documentation procedures, Respondent testified that he takes extra care when reviewing and providing informed consent to patients prior to procedures, both in his office and at the hospital.

26. Also, during the Second Formal Interview, Committee members discussed the appropriate outcome for the case. Committee members agreed that the case rose to the level of discipline and warranted issuance of a Letter of Reprimand. However, Committee members noted that the issues regarding Respondents anesthesia practices had been mitigated by his ongoing use of qualified personnel during procedures, and agreed that probation was not necessary.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a

rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 3 ~~4th~~ day of August, 2023.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 3rd day of August, 2023 to:

Marco B. Saucedo, M.D.
Address of Record

Michele G. Thompson, Esq.
Udall Law Firm, LLP
4801 East Broadway Boulevard, Suite 400
Tucson, Arizona 85711-3609
Attorney for Respondent

ORIGINAL of the foregoing filed
this 3rd day of August, 2023 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Robles
Board staff