Medical Consultant Report and Summary

Case No: MD-xx-xxxxA **Physician: Licensee MD**
Date: **Medical Consultant: OMC, MD**

1. **Complaint:**
   - Inappropriate Prescribing

2. **Details of the Case:**

The complainant (JK) claims that Dr. xxxx failed to treat her husband's (GK's) post acute withdrawal symptoms properly by prescribing buprenorphine-naloxone. JK asserts that GK initiated treatment with Dr. xxxx in November of 2015 after experiencing post acute withdrawal symptoms upon completing a two-week detox from both Buprenorphine-naloxone and benzodiazepines earlier that month. According to JK's complaint, Dr. xxxx believed the proper treatment was to restart Buprenorphine-naloxone. JK disagreed, as she felt GK did not do well on Buprenorphine-naloxone as it made him aggressive, compulsive and hyper focused. Nevertheless, they ultimately agreed to restart Buprenorphine-naloxone at a relatively low dose, which Dr. xxxx subsequently raised, to JK's dismay. JK further asserts that she and GK opted to disengage from treatment with Dr. xxxx and instead went through seven-day detox that was so traumatic that GK went into a "tailspin" requiring hospitalization and residential treatment. Lastly, JK questions why Dr. xxxx did not prescribe Naltrexone to address GK's symptoms

Dr. xxxx responds to this complaint by noting that GK presented on 11-16-15 with the above cited post acute withdrawal symptoms. Dr. xxxx reports that GK had a history of both opioid and benzodiazepine dependence, including several past failed attempts to discontinue benzodiazepine use. Additionally, GK suffered from anxiety and depression. Dr. xxxx notes that he opted to restart buprenorphine maintenance for at least 3 months until GK was more stable off benzodiazepines as previously GK noted buprenorphine provided relief from the anxiety/insomnia that occurred from benzodiazepine withdrawal. GK was also on a combination of Effexor, Doxepin, and Gabapentin that Dr. xxxxfelt was unsafe and made adjustments. xxxxagrees that GK only remained under his care for 2 months and then opted for the above cited traumatic detox. Lastly, Dr. xxxx notes that JK believed GK should have been prescribed Naltrexone to treat his post acute withdrawal symptoms. Dr. xxxx believes this would have been decidedly counterproductive, because if given too early, Naltrexone can further elevate withdrawal symptoms.

A review of the medical records reveals surprisingly detailed notes that are quite consistent with Dr. xxxx's above response. Throughout the notes there is evidence of informed consent as well as ongoing reminders and reviews of risks and rationale for treatment. There is documentation that GK was benefitting from treatment, and there is documentation of GK voicing ongoing marital problems. Urine drug screens are performed.

A review of records from other providers also documents considerable marital turmoil that predates encounters with Dr. xxxx Additionally, the most recent medical records I have available to review are from Dr. xxxx-xxxx These records reveal that despite being placed on Vivitrol (once-monthly Naltrexone) GK continues to complain of considerable anxiety and insomnia. However, an even more current note from GK's therapist notes that GK is in the best emotional state since the therapist began working with him 18 months prior. (Note: This documentation occurred on the exact same date the complaint against Dr. xxxx was filed).

3. **Proposed Standard(s) of Care:**
   - Adequately assess and document substance dependence and the need for ongoing maintenance treatment with buprenorphine-based products

- Encourage behavioral support
- Provide appropriate dosing of controlled substance and minimize polypharmacy with multiple controlled substances.
- Perform appropriate urine drug screen.
- There is no defined Standard of Care with Post Acute Withdrawal Syndrome as there have been few scientific studies supporting its existence. Because of this, the disorder is not recognized by the DSM-V, ICD-10, or major medical associations.

4. Deviation from the Standard of Care:

None.

5. Actual Harm Identified:

None

6. Potential Harm Identified:

None

7. Aggravating Factor(s):

None

8. Mitigating Factor(s):

None

9. Consultant's Summary:

Dr. xxxx met standard of care. His notes are comprehensive and his rationale for utilizing Buprenorphine-naloxone was relatively appropriate. While there are no compelling data to support the use of either Buprenorphine-naloxone or Naltrexone to specifically address post acute benzodiazepine withdrawal symptoms, given GK's poly-drug dependence, and his admitted past benefit from Buprenorphine-naloxone, Dr. xxxx's treatment plan was reasonable. The dose of Buprenorphine-naloxone prescribed is well within FDA Guidelines. Furthermore, Dr. xxxx removed a potentially lethal combination of Effexor and Doxepin.

10. Records Reviewed:

- Medical Records and Dr. xxxx's response
- Complaint from JK, letter from GK
- Additional Records from Dr. xxxx-xxxxx, Dr. x, Dr. xx, and Counselor xxx
- Various Pharmacy and AZPMP Reports
- Consultant Summary from Dr. first OMC (Note: Though I reviewed this Summary and agree with Dr. first OMC's conclusion, I was not in the least bit influenced by his report)

OMC, MD
Print Name

xx/xx/20xx
Date

_____
Signature

Medical Consultant Report and Summary

Case No: MD-xx-xxxxA
Date: xx/xx/xxxx

Physician: Licensee MD Medical
Consultant: OMC, MD

1. **Complaint:**
   - Inappropriate Prescribing and Medication Management

2. **Details of the Case:**
   The complainant, expressed concerns that Dr. xxxx
   - Deliberately shorted patient's Venlafaxine prescriptions causing her to run out early
   - Cut patient off from her Klonopin
   - Harassed and sabotaged patient's mental health

Dr. xxxx responds via her attorney, xxxx Dr. xxxx reports that patient initially presented to her having recently expressed dissatisfaction with her last provider, xxxx, NP. He reduced her Effexor from 300 mg to 150 mg daily, as well as decreased her Geodon from 160 mg to 140 mg daily. However, patient had in fact almost completely discontinued her Geodon, thus establishing a pattern of medication non-adherence. Dr. xxxx reports discussing the non-adherence with patient and encouraging her to maintain 100 mg Geodon and 150 mg Effexor. However, when patient returned approximately 7 weeks later, she had completely tapered off Effexor and had reduced Geodon to only 40 mg daily. patient requested changing Effexor to Wellbutrin, however Dr. xxxx felt that would be inappropriate as Wellbutrin is often associated with anxiety as an adverse effects. Several days later, patient called and stated that she restarted Effexor at 75 mg daily and requested a refill. Dr. xxxx complied with the request, but notes that she was confused as to how the patient had access to 75 mg capsules. On July 3 patient had her next medication management appointment with Dr.xxxx, patient, on her own, had returned to Effexor 300 mg daily. Dr. xxxx was somewhat concerned about activation on this higher dose and wanted to monitor patient's blood pressure, but noted no activation at the time of the appointment, and therefore requested patient follow-up in on month. Instead of writing for 60 capsules of Effexor 150 mg, Dr. xxxxx only wrote for 30 capsules. patient filled her prescription for Effexor on July 6th. She should have run out of Effexor (if taken as directed) on July 21st. However, during a home visit on July 27th patient did not mention being out of Effexor and she was noted to be relaxed and calm. However, on July 31st patient called and stated that she had been out of Effexor and was simply using her sister's medication. Dr. xxxx meant to call in a 10-day supply to last until patient's next appointment, but once again, accidentally wrote for only a 5-day supply. On August 2nd (when patient should have still had ample Effexor), she presented to the clinic as "seeming delusional" and stating thing such as "Dr. xxxx wasn't a real human. Patient subsequently requested a transfer to yet another provider.

Dr. xxxx readily admits she made an entry mistake when prescribing patient's Effexor. She reports the electronic medical record system (EMR) used by the clinic is quite cumbersome and prone to error. Despite this error, there was certainly no intent by Dr. xxxx to cause patient harm. Given patient's past abrupt discontinuation of Effexor without any reported consequences, as well as recent home visits, noting that patient was relaxed and calm, that no damage occurred to patient as a result of this error. Nevertheless, Dr. xxxx reports taking several additional steps to prevent any such dispensing errors in the future to include:

- discontinuing orders that are not active prior to an appointment
- reading back each order to the patient

- providing a printout of instructions to the patient and asking them to compare this with medications received at the pharmacy

Regarding patient's complaint on her Klonopin prescription, Dr xxxx had previously reduced patient's dose from 2 mg daily to 1.5 mg daily out of concerns that she was taking too many sedating (and potentially habit-forming) medications. However, patient simply maintained 2 mg daily and as a result, ran out early. In this case, Dr. xxxx felt it would be inappropriate to call in additional Klonopin for someone who was over/misusing a controlled substance. And though abrupt discontinuation of Klonopin can lead to withdrawal symptoms, patient did not seem to display such symptoms, as she was noted during home visits to be stable and calm. In fact the only episode of behavioral instability documented occurred when patient presented to the clinic to complain about Dr. xxxx.

I reviewed the provided medical records in detail and in brief, Dr. xxxx first saw patient on March 10, 20xx for a routine medication appointment, to manage her Schizoaffective Disorder. Patient had recently requested a transfer in care as she was unsatisfied with her previous provider, xxxx, NP, because he wanted her to maintain an adequate dose of her anti-psychotic, Geodon. Patient had not been doing so and NP Borcherding documented "paranoia" and "delusions"

There is clear documentation of patient's non-adherence to medication instructions. There is also clear documentation that Dr. xxxx had rightful concerns about the number of sedating medications patientwas taking. Dr. xxxx documents a phone call to patient, apologizing for the mix-up with the patient's Effexor, allowing patient to vent, and helping facilitate a second opinion.

There is also documentation that patient was spending significant financial resources working (over the phone) with a "healer" that was discouraging patient from taking her medications properly.

The medication reconciliation documentation in the EMR is quite complicated and confusing. I can understand how errors are easily made. Much of this is a systems issue and beyond Dr. xxxx's ability to control.

Proposed Standard(s) of Care:

- Adequately assess the need for medications and prescribe them in an appropriate dose
- Minimize habit-forming, sedating medications
- Addressing errors when they occur

3. Deviation from the Standard of Care:

None

4. Actual Harm Identified:

None

5. Potential Harm Identified:

Discontinuation symptoms could have occurred with abrupt cessation of Effexor and/or Klonopin, but did not.

6. Aggravating Factor(s):

None

7. Mitigating Factor(s):

None

8. **Consultant's Summary:**

There is good documentation throughout the medical records that patient had a history of non-adherence to medications and dissatisfaction with treatment providers. I completely agree with Dr. xxxx's rationale as it pertained to both patient's Effexor and Klonopin dosing. The incorrect quantity of Effexor was a simple error within a complex EMR. It was remedied with a phone call (though it did require a second correction after the initial error was repeated). Nevertheless, it appears Dr. xxxx has taken additional steps to minimize these EMR errors. Regarding patient's Klonopin, I further agree that one cannot tolerate a patient overusing a controlled substance by simply allowing them to take more. As such, Dr. xxxx has met standard of care

9. **Records Reviewed:**

- Complaint
- Initial Notice
- Licensee Response
- Medical Records

OMC, MD — xx/xx/xxxxx

Print Name — Date

_____

Signature

Case: MD-09-[redacted] Physician: [redacted] MD

Date: August 8, 2009 Medical Consultant: [redacted] MD

1. Detailed Chronological Analysis: The complaint initiated by the Arizona Medical Board against [redacted] MD alleges that there was a failure to evaluate a patient, [redacted] with syncope and a thoracic aneurysm for an abdominal aneurysm.

The patient was a 73 year old female with a history of hypertension, hypothyroidism and depression who presented to the [redacted] Hospital emergency department on 03/16/2006 with the chief complaint of syncope. Two days prior to admission, the patient passed out as she was getting out of the shower. She does not recall the length of time that she was unconscious. She admitted to experiencing at least one similar episode previously. She also admitted to never having a medical workup for this. The patient was in Tucson, visiting from Sacramento, Ca.

According to the documented initial evaluation by the emergency department physician at [redacted] Hospital, the only pertinent physical finding was a right periorbital hematoma. Her vital signs were stable and she was in a normal sinus rhythm. The diagnostic workup showed a normal CBC and electrolyte panel but she did have an elevated d-dimer. The chest x-ray, an AP portable, showed a prominent aortic knob and calcification of same. The CT scan of the brain showed a right lateral maxillary sinus wall fracture with blood in the sinus cavity. The elevated d-dimer prompted the ordering of a CT scan of the pulmonary arteries. This examination showed no evidence of pulmonary emboli but it did demonstrate ectasia and diffuse atherosclerotic changes of the thoracic aorta as well as a discreet aneurysm measuring 4.9-5.0cm at the level of the diaphragm. A second small aneurysm was also noted in the proximal celiac artery. The scan stopped at this level and I can find no images of the rest of the abdominal aorta.

Based upon the finding of the scan, a vascular surgical consultation was obtained. Dr. [redacted] evaluated the patient. He documented a normal physical examination including the neck and abdomen. His recommendations were that the work up for syncope should continue because the patient required no acute intervention for the thoraco-proximal abdominal aortic aneurysm and added that the aneurysm should be followed frequently by a vascular surgeon in her hometown of Sacramento, Ca. The patient actually expressed a desire for this as Dr. [redacted] did offer to have the aneurysm taken care of in Tucson.

Because of the discovery of the thoraco-proximal abdominal aortic aneurysm and in spite of the normal physical examination, the entire aorta should have been imaged radiographically or sonographically.

The patient remained stable throughout the subsequent hospitalization and was found to have witnessed and well-documented episodes of paroxysmal atrial fibrillation with a rapid ventricular response. This indicates a sick sinus syndrome and the most likely etiology of her syncope.

The cardiologist, Dr [redacted] determined that because of the patient's cardiac issues, she should be anticoagulated and worked up for coronary artery disease. In addition she was immediately started on anti-arrythmic medication. She did undergo a nuclear stress test which was negative for ischemia and an echocardiogram corroborated normal left ventricular function.

On his weekend rounds, Dr [redacted] ordered a carotid duplex scan on 3/18/2006 which showed no hemodynamically significant extracranial carotid disease.

The patient was discharged from [redacted] Hospital on 3/19/2006 on warfarin, sotalol, vytorin, and keflex. She was to be followed by [redacted] as an outpatient. She was in a normal sinus rhythm at the time of her discharge.

On 3/21/2006, two days following her discharge from [redacted] Hospital, she presented to the [redacted] Medical Center complaining of a two-day history of right lower quadrant pain. The pain started in her right lower quadrant and groin on the day prior to admission with progressive worsening. The pain was gradual in onset and radiated around to her lower back on the same side. This symptom complex included nausea and vomiting. During her transport to the hospital by private vehicle, she had a brief episode of non-responsiveness associated with bladder and bowel incontinence.

Upon presentation to the emergency department her BP was 124/67 with a regular pulse of 54 beats per minute and she was fully awake and oriented. Her physical examination was remarkable for mild right lower quadrant and peri-umbilical tenderness. There was no rebound tenderness or guarding noted. Distal lower extremity pulses were not documented in the record. The hemoglobin concentration was 11.2gm/dl and hematocrit 31.9% as compared to 15.4 and 45.2% on 3/17/2006.

According to the emergency department physician, an acute aortic dissection was high on the differential diagnosis list. Because of this, a CT scan with contrast of the abdomen was ordered stat. It was obvious on this examination that the patient had a ruptured infrarenal abdominal aortic aneurysm measuring greater than 8 cm in maximal diameter. The patient was taken to the operating theater immediately.

Intraoperatively, the patient was found to have a freely ruptured 8.3 cm bilobed infrarenal abdominal aortic aneurysm with a large amount of blood in the right retroperitoneal space and free blood in the peritoneal cavity.

An attempt to repair same was undertaken but the patient expired on the operating table. She essentially had uncontrollable hemorrhage apparently from a lacerated left renal/gonadal vein complex, most likely iatrogenic occurring during the haste in attempting to control the aorta proximal to the ruptured area.

2. Proposed Standard of Care: The standard of care in a 73 year old patient with a history of hypertension, and a newly discovered asymptomatic 4.9-5.0 cm aortic aneurysm at the level of the diaphragm and celiac artery involvement, is to evaluate the entire abdominal aorta to rule out a significant infrarenal component. Vascular surgeons are fully aware the greater than 90% of Aortic

Aneurysms are located in the infrarenal aorta. The dearth or absence of symptoms referable directly to the aneurysm does not preclude the evaluation of the entire aorta.

I conclude, therefore, that the standard of care was not met in this case.

3. Deviation From The Standard of Care: Failure to image the entire abdominal aorta in the known presence of thoraco-proximal abdominal aortic aneurysm.

4. Actual Harm Identified: The patient's demise from a very large ruptured infrarenal abdominal aortic aneurysm which had not been detected due to lack of an appropriate index of suspicion and subsequent failure to have the abdominal aorta imaged.

5. Potential Harm Identified: The potential harm was the failure to detect this very large infrarenal abdominal aortic aneurysm predisposing it to rupture.

6. Aggravating Factors: There are no aggravating factors which would indicate egregious behavior.

7. Mitigating Factors: The focus of this patient's cause for hospitalization was the syncopal episode which she experienced. I am still unsure nor am I able to glean any information as to why the very large infrarenal abdominal aortic aneurysm was not palpable by several different examiners in a patient with a BMI of 24.9. Also, I do not see documentation of any examiner placing a stethoscope on the patient's abdomen to auscultate for bruits. In his response letter to the Board, Dr [redacted] states that he examined the patient's abdomen but his progress notes do not reflect this. If the failure to detect the infrarenal abdominal aortic aneurysm has any mitigating factors, it is the focus on the patient's workup for the problem at hand and attributing the thoraco-proximal abdominal aortic aneurysm to being an asymptomatic incidental finding on a pulmonary artery scan. However, the index of suspicion for additional involvement of the aorta distally should have been much higher.

8. Consultant's Summary: Based upon my knowledge and experience as a Cardiovascular and Thoracic surgeon for the past 23 years, I conclude that the patient, Ms. [redacted] was not completely worked up in order to exclude an infrarenal abdominal aortic aneurysm.

Over 90% of degenerative or atherosclerotic aneurysms develop in the infrarenal segment of the aorta. Knowing that the patient had significant ectasia of the ascending, tranverse and descending thoracic aorta along with significant eccentric calcification of the aortic wall, in addition to the known 4.9-5.0 cm rather discreet aneurysm of the distal thoracic-proximal abdominal aorta and celiac artery, is an indication for imaging the rest of the intraabdominal aorta regardless of the patient's symptoms. The vast majority of infrarenal aneurysms are asymptomatic.

Another fact that I have difficulty reconciling is the lack of physical findings on the multiple abdominal examinations which the patient underwent by several different physicians. My reason for doubt stems from the fact that the patient's aneurysm measured 8.3cm in maximal diameter and her BMI was 24.9. An aneurysm of this size does not grow to this magnitude in a short period of time. Also, when Dr. [redacted] examined the patient's abdomen as he states in his response letter to the board, he should have stated so in his written progress notes.

Had the abdominal aorta been imaged in its entirety, the very large infrarenal abdominal aortic aneurysm would have been discovered and the patient would have undergone the appropriate procedure under quite different circumstances and with a markedly reduced risk. In other words, she would have not been discharged from [redacted] Hospital because an infrarenal abdominal aortic aneurysm that large is an urgent, bordering on emergent indication for repair. There are not many vascular surgeons which would disagree with this statement.

In conclusion, this is a most unfortunate case and although any retrospective review such as this is imperfect because it is difficult to determine the involved practioner's state of mind, I do believe strongly that the primary focus was on the patient's syncope. This was totally and unequivocally appropriate and wonderfully worked up. However, when the 4.9cm aortic aneurysm was discovered at the level of the diaphragm along with the celiac artery involvement, the rest of the aorta should have been imaged. Had this been done there is a high probability that the outcome would have been much more favorable. I may add, in no uncertain terms, that the radiologist reading and/or performing the pulmonary artery CT scan should have continued imaging the rest of the aorta at that juncture. I do not think he/she needed an order or permission for same.

I have to state that the Board's allegation of "failure to evaluate a patient with syncope and thoracic aneurysm for abdominal aortic aneurysm" has merit and the care which this patient received on this point fell below the standard of care.

9. Records Reviewed:

1. Communication from [redacted] 7/15/2009
2. Initial complaint letter 7/15/2009
3. Licensee response 7/15/2009
4. [redacted] Hospital Records 7/15/2009
5. [redacted] Medical Center Records 7/15/2009
6. Image CD's from [redacted] Hospital 7/22/2009
7. Image CD from [redacted] Center 8/8/2009

Respectfully submitted,

[redacted] MD

Medical Consultant Report and Summary

Case No: MD[redacted] **Physician:** [redacted] M.D
Date: July 25, 2009 **Medical Consultant:** [redacted] MD

1. **Detailed (Chronological) Analysis:** A 59 year old woman, [redacted] was under the care of Dr. [redacted] for 19 years. The physician reported that the patient was healthy and on no medications. On the morning of February 9, 2007, the patient called her physician complaining of two weeks of dyspnea (shortness of breath) on exertion, dry cough and atypical chest pain. The patient was seen at 4 PM by the physician. Her heard rate was increased from previous exams; the physician reports that the patient was in no distress and did an EKG on the same day (February 9) which showed no change since October 2006. Other orders were sent to rule out anemia and thyroid disease. The patient was sent home with an appointment with a cardiologist in five days on February 12, 2007. ON February 11, 2007 at 9:55 AM, EMS found the patient at her home in cardiac arrest and brought her to [redacted] ED. EMS performed CPR, noting a blood pressure of 97/12, heart rate of 0, respiratory rate of 0, temperature of 30° with bilateral fixed and dilated pupils and no breath sounds. Atropine, epinephrine and bicarbonate were given by IV. Patient was brought to the Emergency Room at [redacted] where the ER Nurse [redacted] documented intubation with assisted breathing with bluish and cool skin, clear lung sounds, abdominal distention, bilateral, nonreactive pupils and no distal pulses in the feet. CPR continued without change in patient's status. AT 10:10 AM, despite intervention, patient continued to be unresponsive. AT 10:16 AM, CPR ceased and the patient was pronounced by Drs. [redacted] (resident) and [redacted] (attending). At 14:30, the Medical Examiner was notified of the patient's death; patient was sent to the morgue. [redacted] MD, forensic pathologist, wrote the pathological diagnosis as 1) bilateral pulmonary embolism (PE) 2) bile duct adenoma and 3) fractures in the left ribs 1-6 and right ribs 2-5, probably secondary to the resuscitative efforts. Cause of death was cited as bilateral pulmonary embolism (with right main pulmonary arteries completely occluded (closed) by thrombus (clot) extending fully into right upper middle and lower lobes and the left main pulmonary artery was also occluded (closed) by a thrombus (clot) into the left lower lobe with some in the left upper lobe of the lungs.

2. **Proposed Standard(s) of Care:** The standard of care for a middle-aged woman with acute shortness of breath, cough, and atypical chest pain requires a thorough history, exam including vital signs such as blood pressure, heart rate, respiratory rate, temperature as well as exam of lungs, heart, abdomen, and extremities, and routine blood count and chemistries as well as an ABG (arterial blood gas), D-dimer and an EKG to rule out pulmonary as well as cardiac disease.

3. **Deviation from the Standard of Care:** The deviation from the standard of care occurred in Dr. [redacted] exclusive focus on cardiac work up and failure to consider an important differential diagnosis. Despite the patient's acute cough, shortness of breath and atypical chest pain, he failed to consider pulmonary diseases including pulmonary embolus, pneumonia, COPD and asthma. Specifically, the doctor did not order a CBC (complete blood count) in a timely fashion and failed to order an ABG (arterial blood gas) or D-dimer.

4. **Actual Harm Identified:** By not considering and identifying serious pulmonary diseases, the doctor did not recognize an acute situation requiring immediate attention with the need to transfer to the hospital emergency department. This failure ultimately led to the patient's death.

5. **Potential Harm Identified:** (See "Actual Harm Identified.)

6. **Aggravating Factor(s):** None identified.

7. **Mitigating Factor(s):** None identified

8. **Consultant's Summary:** This evaluator feels that Dr. [redacted] did not meet the standard of care for a short of breath, tachycardic, coughing adult with chest pain because he did not consider reasons other than cardiac for her symptoms. He failed to do other necessary tests promptly including an ABG, CBC, and D-dimer. Because he dismissed her symptoms and signs after reviewing a normal EKG, she was not sent to a hospital immediately. Had she gone immediately, she would have received the necessary assessment tests in addition to Ventilation/Perfusion (V/Q) scan or contrast-CT scan that would have uncovered her disease (PE) and treatment (anticoagulation) which might have saved her life.

9. **Records Reviewed:**

October 4, 2006: Physician Office Notes
February 9, 2007: Physician Office Notes
February 11, 2007: [redacted] Emergency Department Records, nurses notes, physician notes, progress reports
February 11, 2007: Postmortem routine, pathology notes/report
February 11, 2007: Death Certificate
April 30, 2009: Physician letter

10. **Additional Documents and Information Necessary:**
ACP-Medical Knowledge Self-Assessment Program (MKSAP) 14: Pulmonary and Critical Care Medicine; p. 42-43.

11. **Investigational Questions for Physician:** None

[redacted] MD July 25, 2009

Print Name Date

[redacted] MD

Signature

Medical Consultant Report and Summary

Case No: MD-09-[redacted] **Physician:** [redacted] M.D.
Date: July 1, 2009 **Medical Consultant:** [redacted] M.D.

1. Detailed (Chronological) Analysis:

11/06/08
Patient [redacted] is a 37y/o female with a past history of neck pain who presented to the [redacted] Emergency Department at 0236 for evaluation and treatment of posterior neck pain that radiates to the right shoulder for the past three months. She describes being under chiropractic care and possibly medical care for this neck pain. She has taken ibuprofen without resolution.

Emergency department documentation demonstrates that Ms. [redacted] was evaluated by Dr. [redacted] at 0242.

Dr. [redacted] documentation demonstrates no evidence that the patient was experiencing an acute neurological emergency. While Dr. [redacted] emergency department documentation is limited, he clarifies, in a response letter to the Arizona Medical Board, that he routinely performs a comprehensive review of systems and physical exam for a patient complaining of neck pain. It is reasonable to assume that he did so in this case and would have documented and addressed any abnormal review of systems or physical exam findings that were present at the time of Ms. [redacted] initial emergency room visit. This is an assumption, yet this form of documentation is commonly practiced as many physicians document only pertinent positive physical findings. Nevertheless, a complete and detailed neurological review of systems and physical exam is not documented.

No pain management was provided in the emergency room and the patient describes her pain as having improved from a 10/10 to a 7/10.

Emergency department documentation demonstrates that Dr. [redacted] wrote a discharge order for Ms [redacted] at 0302. Her diagnosis at the time of discharge was cervical strain with radiculopathy.

While the emergency physician chart documents that the patient received Percocet at the time of discharge, the patient was provided discharge prescriptions for Flexeril and Penicillin VK. Ms. [redacted] was also provided instructions to take Tylenol or Motrin as needed.

Discharge instructions provided by Dr [redacted] instruct the patient to return promptly if her pain worsens or spreads into her arms or she experiences weakness or numbness. The patient was also instructed to follow up with her doctor in 1-2 days for a checkup and a copy of the medical transcription was requested by Dr. [redacted] to be provided to [redacted] D.O.

11/13/08
Ms. [redacted] presented to the [redacted] Emergency Department with persistent neck pain that radiated down her right arm. She complained of paresthesias in her right hand. No documented focal neurological deficit was discovered by physical examination.

MRI of the c-spine w/o contrast performed at [redacted] demonstrated disc protrusions at C4-C5 and C6-C7.

12/10/08
EMG performed by [redacted] D.O. demonstrated a mild right median neuropathy about the wrist with no electrical evidence of radiculopathy.

12/17/08
Ms. [redacted] was evaluated by Dr. [redacted] M.D. at the [redacted] Institute with recommendations for selective nerve root injections.

1/26/09
Ms [redacted] returned to the [redacted] Emergency Department complaining of neck pain, increased numbness and tingling. Physical examination demonstrated decreased sensory over the volar aspect of the right upper extremity as well as over the dorsal aspect of the right thumb. The patient was admitted and subsequently underwent operative management by Dr. [redacted] on 1/27/09.

2. Proposed Standard(s) of Care:

The standard of care of a 37y/o female with a past medical history of chronic neck pain who presents to the emergency department complaining of posterior neck pain that radiates to the right shoulder, worsening over the past three months includes: a comprehensive history and physical examination with a focused musculoskeletal, vascular and neurological exam to determine if any emergent process is present.

Without any bony tenderness to palpitation of the spine or objective evidence of vascular or neurological compromise, emergent diagnostics, such as a radiograph or MRI, are not required.

Analgesia should be provided to assist in treatment.

Instructions for urgent follow up should be provided as well as precautions to return to the emergency department immediately if symptoms worsen or progress.

3. Deviation from the Standard of Care:

I do not appreciate a deviation from the proposed standard of care.

4. Actual Harm Identified:

I do not identify any actual harm to the patient.

5. Potential Harm Identified:

N/A

6. Aggravating Factor(s):

N/A

7. Mitigating Factor(s):

N/A

8. Consultant's Summary:

In my professional opinion, the care of Ms. [redacted] provided by Dr. [redacted] on 11/06/08 did meet the standard of care. I do not believe Dr [redacted] failed to diagnose and treat Ms. [redacted] based upon my review of the medical records provided by the Arizona Medical Board. There is no documentation to support any focal neurological deficit that Ms. [redacted] was experiencing at the time of her initial emergency department visit on 11/06/08 that would have required further investigation with an MRI. Follow up and medical therapy was provided at the time of discharge.

I am concerned that the emergency department documentation by Dr. [redacted] was quite poor. There are a number of inaccuracies including an allergy to morphine, which the patient does not appear to have, evaluation of the patient's tonsils with a history of a prior T&A, and final assessment of abdominal pain, which the patient clearly didn't have. An inappropriate medical prescription was provided and the appropriate analgesic was not.

I recommend that Dr. [redacted] include in his future documentation a complete representation of the review of systems and physical examination performed during his evaluation and not continue his current practice of only including pertinent positives.

9. Records Reviewed:

Complaint
Initial notice letter
Licensee response
[redacted] Hospital records
[redacted] treating physician records
[redacted] Hospital records

[redacted] M.D. July 1, 2009

Print Name Date

Signature

Medical Consultant Report and Summary

Case No: MD-[redacted] **Physician: [redacted]**
Date: June 13, 2009 **Medical Consultant: [redacted]**

1. **Detailed (Chronological) Analysis:**

On 11/2/2005 at approximately 18:45, a 5 month old infant with no significant past medical history, was reported by his grandparents to have fallen off a bed hitting his head on a tile floor. They took him to the Emergency Room at [redacted] Hospital where an evaluation by the attending physician was performed, including a skull xray read as normal. The patient was discharged, but was brought back to the Emergency Room several hours later with increasing irritability, swelling of the scalp, and vomiting. The same ER physician evaluated the patient and a CT of the head at 12:50 am revealed a large epidural hematoma, acute, with mass effect and shift of the brain. A transfer request was made to [redacted] Hospital and the patient arrived at 2:33 am.

Dr. [redacted] discussed the case with the resident physician on call in the hospital when the patient arrived at [redacted] Hospital, approximately seven and a half hours after the injury. His report indicates that the patient demonstrated evidence of brainstem herniation, including presence of posturing motor responses. The patient was treated with emergency surgical intervention, consisting of a craniotomy to evacuate the hematoma.

At surgery, the patient was found to have a massive acute epidural hematoma consisting of nearly a third of the inctracranial volume. Postoperatively the patient did not fully recover and suffered significant neurological injury.

2. **Proposed Standard(s) of Care:**

The standard of care for an infant presenting with a history of a closed head injury, neurological symptoms, and a large acute epidural hematoma on imaging is surgical evacuation. Generally, this is undertaken in an urgent fashion as sudden neurological deterioration can occur even in patients who are relatively asymptomatic on initial presentation. For large hematomas in patients with evidence of neurological injury, emergent surgery is essential if there is to be any hope of functional recovery.

3. **Deviation from the Standard of Care:**

There was no deviation from the standard of care by Dr. [redacted] All the parameters set forth above were met. He was prompt in his response to the condition of the patient when he became aware of it and his decision making was sound. There was no delay in care which would have in any way impacted on the outcome of the patient.

4. **Actual Harm Identified:**

There was no actual harm to this patient from Dr. [redacted] neurosurgical care.

5. Potential Harm Identified:

Minor criticisms of the evaluation include the timeliness of access intravenously provided to the patient and the discussion with the anesthesiologist regarding the need for transfusion. The patient did complete surgery at the Trauma center acidotic and anemic, which would generally indicate a need for correction through improved oxygenation and administration of blood products. However, in this case, no preoperative levels were available and it is unclear what the condition of this patient was on arrival. Additional evaluation was apparently performed in the [redacted] Hospitals emergency department which included a necessity for reintubation. There is no evidence that Dr. [redacted] was responsible for any delay after arrival to the emergency department.

6. Aggravating Factor(s):

None identified

7. Mitigating Factor(s):

The fact that the patient did not present to Neurosurgical attention until many hours after the injury and in a state reflecting profound neurological injury reflects a very poor prognosis for functional recovery despite appropriate and timely treatment.

8. Consultant's Summary:

This evaluator feels that Dr. [redacted] met the standard of care for an infant with a large epidural hematoma by promptly arriving at the diagnosis and determining the infant's level of profound neurological injury. He met the standard by proceeding to emergent surgical intervention and there was no significant delay in care which could have impacted the outcome. The criticism that he did not perform an adequate preoperative evaluation is not appropriate, since under these circumstances prompt surgical evacuation of the hematoma is necessary for any hope of neurological recovery to be realistic. His actions were appropriate.

9. Records Reviewed:

November 2, 3, 2005 - Emergency Dept, Records
November , 2005 - Hospital Records, progress notes, nurses notes, lab and radiology data, Operative Report
August 6, 2008 - Deposition [redacted] MD
July 2, 2008 - Deposition [redacted] MD

January 25, 2008 - Deposition [redacted] MD
January 8, 2009- Medical Malpractice Payment report

_____[redacted] _____June 15, 2009_____
Print Name Date

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Signature

Medical Consultant Report and Summary

Case No: MD-09-[redacted] **Physician: [redacted] M.D.**
Date: 9/15/09 **Medical Consultant: [redacted], M.D.**

1. **Detailed (Chronological Analysis:** Mr.[redacted] presented to Dr. [redacted] on 8/6/07. He had ongoing pain and a total hip arthroplasty which had been placed November of 2005 by another physician. The patient was complaining of pain in his groin. The patient had been evaluated by a pain management institution and had previous blocks. After the first visit the patient was thoroughly evaluated with labs, bone scan and MRI of the lumbar spine. He had minimally elevated C-reactive proteins and his MRI did show degenerative changes in his lower back. These studies were completed to rule out the various etiologies of pain to be sure that the pain was actually coming from the total hip area. The patient returned in June of 2008 with ongoing complaints of hip discomfort. Hip revision was discussed with Mr. [redacted] at that time. The actual noted from June 11, 2008, mentions that the risks and benefits of the procedure were discussed with Mr. [redacted].

   Mr. [redacted] underwent the revision procedure July 15, 2008. A Zimmer implant was utilized. It has been noted in the records reviewed from Zimmer that Dr. [redacted] has actually completed a special course in using this implant and has been involved in instructing others in how to use it. The patient had follow up visits and healed without sign of infection. The patient complained of some numbness around the incision but otherwise was doing reasonably well. He returned to the office on September 22, 2008, with continual pains and left groin pain. Radiographs showed no acute abnormality of the implant. Dr. [redacted] proceeded to evaluate him more thoroughly to look for etiology of pain. He underwent an MRI of the lumbar spine. He also was started on physical therapy. In October the patient mentioned that he had increased trauma with a twisting injury to the leg. Apparently this happened on a construction site. Radiographs were repeated and noted to be negative and not show any acute sign of change. MRI's were reviewed and were consistent with arthritis in the lower back. The back issues were treated to see if this might not relieve some of his pain and he was sent for injections. In November the patient continued to have pain. The pain was located over the trochanter. An injection was given in this area to try to alleviate symptoms. In other words, Dr. [redacted] was trying to explain Mr. [redacted] pain and treat him adequately, hoping that the pain, possibly coming from the hip joint, would continue to improve and to rule out other etiologies for pain since the radiographs at that point had been normal. On November 19, 2008 the patient continued to have thigh pain and was non tender over the trochanter. He had little relief from injections. At this point the patient was thoroughly, once

Case No: MD-09-[redacted] **Physician: [redacted] M.D.**
Date: 9/15/09 **Medical Consultant: [redacted], M.D.**

again, evaluated for infection. Blood work was obtained with a normal white cell count but the patient did have an elevated SED rate and C-reactive protein. In a dual isotope white blood cell scan was appropriately ordered and there was also the scan which was inconclusive for infection. Further investigation was performed with a CT scan to try to understand why this man was having symptoms. The CT scan was negative for prosthetic loosening and there was some question of a Pubic Ramus fracture which would be unrelated to the hip surgery.

A regular bone scan was actually obtained, looking and trying to understand why this man was having so much pain. The pain was being evaluated for all possible etiologies. At this stage, infection seemed unlikely with the studies being questionable. Lab work was again repeated and there was an elevated SED rate and C-reactive protein. To ensure that the patient had no infection, Dr. [redacted] took him to the operating room to aspirate fluid from the hip to try to be sure there was no infection and the specimens were negative for infection.

Notes were mentioned that phone calls were completed to phone the patient but Mr. [redacted] had gone to another physician, Dr. [redacted].

Mr. [redacted] was seen on January 27, 2009. Dr. [redacted] records mention the possibility of impingement of the iliopsoas muscle on the implant causing pain. Dr. [redacted] initial work up was not positive for infection though this still was considered a possibility. At this stage this man had been significantly evaluated for infection and continued to have pain.

The patient elected to continue his care with Dr. [redacted]. In March 2009, an exploration was completed and a biopsy at the time of surgery revealed white blood cells and later a culture showed Staph epidermitis. The patient had the implant removed and a cement spacer with antibiotics was placed. The patient was discharged and later returned with elevated temperatures and in April, the patient was placed on a PICC line approximately April 21, 2009.

The final procedure was completed on May 21, 2009. The cement spacer was removed and the revision implant placed.

Case No: MD-09-[redacted] **Physician: [redacted] M.D.**
Date: 9/15/09 **Medical Consultant: [redacted] M.D.**

2. **Proposed Standards of Care:** The standard of care for evaluation of a painful total hip prosthesis is to rule out various etiologies of pain. The implant itself can be infected or loose. The pain can come from other soft tissues surrounding the implant such as the trochanteric bursa or lower back pain problems. To try to be more specific, standard of care requires a physician to try to be as specific as possible with the etiology of the pain. This includes appropriate evaluation with blood studies including white cell counts, C-reactive proteins and SED rate, bone scans as well as white cell label scans are sometimes necessary. MRI's or CT scans can be completed as well to evaluate the patient for other causes of pain. If the etiology of the pain is not specific with these studies, then certainly it is the standard for the physician to evaluate the patient over time and not be too aggressive with care. If the patient does not improve over a period of 4-6 months, then further studies would be indicated and consideration of exploration completed. If the studies are positive, including C-reactive protein and SED rate, then the appropriate studies should be completed to evaluate for infection including white cell scan studies and aspiration of the joint itself. If all fails then revision open procedures are indicated.

3. **Deviation from the Standard of Care:** There was no deviation from the Standard of care by Dr. [redacted]. All of the parameters set forth above were met extremely well. Unfortunately the patient had ongoing issues but they were appropriately addressed by Dr. [redacted] and he should be applauded for his significant and involved evaluation.

4. **Actual Harm Identified:** No actual harm was caused by the actions and evaluation of Dr. [redacted]. His evaluation was timely and appropriate for this man's ongoing symptoms. Problems known are complications related to such difficult tertiary surgery.

5. **Potential Harm Identified:** There are no criticisms in regard to Dr. [redacted] evaluation and treatment of this individual.

Case No: MD-09-[redacted] Physician: [redacted]
Date: 9/15/09 Medical Consultant: [redacted], M.D.

6. **Aggravating Factors:** None identified.

7. **Mitigating Factors:** There is no deviation from the Standard of Care.

8. **Consultant's Summary:** Based on my professional opinion, Dr. [redacted] actions did meet the Standard of Care in caring for [redacted] with his significantly complicated issues. Judgment of Dr. [redacted] to use a Zimmer implant did not cause this man's infection to occur. The problems related to a complex revision total hip procedure can occur with any type of implant. Dr. [redacted] appropriately evaluated the ongoing pain issues that Mr. [redacted] presented to him over a period of time. He should actually be highly commended for the thorough job that he performed in evaluating and trying to understand why Mr. [redacted] continued to have symptoms. Ultimately Dr. [redacted] cared for Mr. [redacted] and Dr. [redacted] initial assessment was not the correct one. It was not the problem of positioning but an indolent, very difficult to diagnose infection that was occurring. Despite multiple studies including aspiration, this was not diagnosed until the actual open revision was performed by Dr. [redacted] This was the last resort treatment plan by a tertiary care physician being necessitated by a difficult diagnostic dilemma.

9. **Records Reviewed:**

   a. Complaint filed by [redacted], 6/15/08.
   b. Letters from [redacted] in regard to the implant utilized in his care, dated 6/26/09.
   c. Letter submitted on 6/29/09 from [redacted] Clinic in response to the complaint.
   d. Office and surgical records produced by Dr. [redacted] in regard to the treatment provided to Mr. [redacted] dating from 8/6/07 through March of 2009.
   e. Records from Dr. [redacted] office dating from January 2009 through June 2009.
   f. Hospital records from admissions for Dr. [redacted] care provided in March, April and May of 2009.

10. **Additional documentation and information necessary:** None.

Medical Consultant Report and Summary

Case No: MD [redacted]
Date: December 4, 2008

Physician: [redacted] **M.D.**
Medical Consultant: [redacted] **M.D.**

1. **Detailed (Chronological) Analysis:** On February 14, 2002, the patient, [redacted] age 23, was working for [redacted] assigned to the [redacted] company where he was lifting pallets when, according to a handwritten note dictated by the patient to [redacted], "I felt a little pain in my right groin area…I noticed that my right testicle was larger than usual. Also I had pain from the right front groin to the back of my right hip."

   The patient was apparently seen by a family physician, [redacted] D.O., who ordered an MRI scan of the lumbar spine. The report of this study, performed on May 2, 2002, was, "Normal lumbar spine MRI." The patient had chiropractic manipulations by [redacted], D.C. with the last visit on August 19, 2002. After seeing another physician, Dr. [redacted] (no further information available), the patient next saw [redacted] M.D., an Orthopaedic Surgeon, on January 22, 2003.

   Dr. [redacted] reviewed the patient's lumbar spine plain films and MRI scan and agreed with the radiologist's reading of normal MRI. He had the patient get a new MRI scan of the lumbar spine at a different facility. This study, on February 11, 2003, showed "…subtle/minimal annular disc bulging laterally on the right at L4-5 and L5-S1 which approaches the right lateral L4 and L5 nerve roots respectively. There is no focal disc protrusion, central canal stenosis, or significant neural foramen stenosis at any level."

   Dr. [redacted] performed a lumbar discogram on September 26, 2003. In the Operative Report, he described the study as showing, "trace degeneration" at L4 and "central degeneration with posterior leakage into the epidural space…" at L5. On October 8, 2003, Dr. [redacted] noted that, "The discogram did not find a surgical lesion." The patient still complained of pain radiating to the testicle; a urologist had seen the patient for that problem. Dr. [redacted] referred the patient to a Dr. [redacted] for physical therapy.

   The patient then saw [redacted] M.D., an internist, who referred him to [redacted] M.D., a specialist in Rehabilitation Medicine, who examined him on April 20, 2004. Dr. [redacted] physical examination was most instructive: he noted:

   "Light axial compression on the vertex of the skull produced low back pain."

   "SLR [Straight Leg Raising] at 45 degrees in the supine position produced low back pain but double-leg sitting SLR with the patient's ability to lean forward and touch his knees produced no grimacing or discomfort from the patient. In the supine position with SLR, the patient did indicate pain, both by grimacing, groaning, and indicating it was painful."

   The patient had "give-way" weakness throughout both lower extremities. He also had symmetric, normal reflexes at the knees and ankles with intact sensation throughout both legs.

   Dr. [redacted] performed Electromyograms and Nerve Conduction Tests (EMGs and NCTs) on the patient's back and both legs on May 14, 2004. These studies were normal, with Dr. [redacted] noting that there were "No electrodiagnostic signs of a left or right lower extremity radiculopathy."

   In 2008, the patient was evaluated at The CORE Institute (Center for Orthopedic Research and Education). The evaluation included physical examinations, x-rays, and other studies. I have reviewed the x-ray films of the lumbar and sacral spine.

2. **Proposed Standard(s) of Care:** A patient with complaints of low back pain should have a history, physical examination, x-rays, and, if indicated, diagnostic studies such as CAT scan or MRI scan. Not all patients with low back pain , however, require diagnostic studies.

3. **Deviation:** None.

4. **Actual Harm Identified:** None.

5. **Potential Harm Identified:** None.

6. **Aggravating Factor(s):** None.

7. **Mitigating Factor(s):** This patient alleged complaints of low back and right testicular-to-low-back pain in February 2002. Despite his subjective complaints, he had a physical examination performed by a Board Certified specialist in rehabilitation medicine, Dr. [redacted] two full years later, in April 2004, in which not only did Dr. [redacted] find clear signs of malingering—low back pain on axial compression of the skull; markedly positive straight leg raising with completely negative bilateral sitting root tests; bilateral give-away weakness—but also EMGs and NCTs then were completely normal, ruling out any nerve root irritation and/or lumbar radiculopathy.

   Moreover, the lumbar spine x-rays taken in 2008, which I have personally reviewed show no loss of the height of the L4-5 or L5-S1 disc spaces. This is incontrovertible proof that, despite the truly minimal MRI findings in 2003 and 2004 and the questionable findings on the lumbar discogram in 2003, there has been no objective evidence that either disc has degenerated.

8. **Consultant's Summary:** This patient had proper orthopaedic care by Dr. [redacted]. He needed no treatment other than the physical therapy which Dr. [redacted] suggested.

9. **Records Reviewed:**

   1. Complaint filed by the patient, consisting of 57 pages.
   2. Initial letter to Dr. [redacted] from the Arizona Medical Board
   3. Complete office records of Dr. [redacted]
   4. Complete office records of Dr. [redacted]
   5. Complete office records of Dr. [redacted]
   6. Complete office records of CORE, the Center for Orthopedic Research and Education

[redacted]
Print Name

December 4, 2008
Date

[redacted]
Signature

Medical Consultant Report and Summary

Case No: [redacted] **Physician:** [redacted]
Date: [redacted] **Medical Consultant:** [redacted]

1. **Detailed (Chronological) Analysis:** On 12/17/2008, [redacted] the patient, received medical treatment from [redacted] The provided medical records begin on this date, with a brief history and procedure note describing [redacted] attempted performance of a cervical epidural steroid injection. There is no indication of any medical evaluation being performed prior to this date. Notably absent are a complete history and physical examination, imaging studies, and a diagnosis. The attempted procedure was performed "blindly" (without the use of fluoroscopy), with the patient in the sitting position, and with the use of "hanging drop" technique. The patient received 60mg of Diprivan (propofol), a general anesthetic agent, for sedation during the procedure (a separate hospital nursing report, entitled "Pre Injection Phone Call" reports the dose of propofol to be 160mg).

   Immediately after the procedure, it is noted that [redacted] the patient, was unable to move her right leg, had weakness in her right arm, was flexing her right leg, and was experiencing tingling in her left arm. She also experienced increased pain. [redacted] received emergent care for a presumed spinal cord injury and was transferred to the Yavapai Regional Medical Center.

   No medical records beyond this time are provided, but [redacted] did provide a letter in which he states that [redacted] has not fully recovered from this incident.

2. **Proposed Standard(s) of Care:** The standard of care for the performance of cervical epidural steroid injections mandates that patients are awake and able to communicate during the procedure. If sedation is administered, it must be done so judiciously, in a manner consistent with conscious sedation, as opposed to general anesthesia.

   The standard of care also mandates that prior to the performance of a cervical epidural steroid injection, a complete history and physical examination be performed, and a diagnostic workup, including imaging studies be obtained. A specific treatment plan must also be determined.

   The standard of care regarding the proper technique for the performance of cervical epidural steroid injections calls for the use of intra-procedure fluoroscopic imaging. It is noted that in the past, fluoroscopy was not considered part of the standard of care, and it is difficult to determine with certainty whether this is a universally accepted standard. The use of fluoroscopy is, however, universally recommended by every major Pain Management society, including the American Society of Anesthesiologists and the American Society of Regional Anesthesia.

   The standard of care regarding the technique for the performance of cervical epidural steroid injections as it relates to the use of hanging drop technique, as opposed to loss of resistance technique, relates to the standard regarding the use of fluoroscopy. Specifically, in almost all cases, when fluoroscopy is utilized, the patient is positioned in the prone position, in which case, hanging drop technique is not utilized. The technique employed is loss of resistance technique and once again, while it is difficult to determine if this is technically the standard of care, it is the universally recommended method to perform this procedure.

3. **Deviation from the Standard of Care:** The first deviation from the standard of care relates to the administration of propofol, a general anesthetic agent, for sedation during the performance of a cervical epidural steroid injection.

   The second deviation relates to the lack of obtaining a history, performing a physical examination, obtaining imaging studies, and determining a diagnosis and treatment plan.

   The third deviation arguably relates to the performance of a cervical epidural steroid injection "blindly," or without the use of fluoroscopy, and by employing hanging drop technique, as opposed to loss of resistance technique.

4. **Actual Harm Identified:** The patient in this case experienced sudden-onset loss of motor control of her right lower extremity, weakness and tingling in her right upper extremity, and increased pain. The records provided do not include the ultimate diagnosis and outcome, although a cervical spine MRI following the procedure did not reveal a specific spinal cord injury.

5. **Potential Harm Identified:** Under these circumstances, this patient quite easily could have become a quadrapelegic, or might have died. Less severe but permanent neural injury may also have occurred.

6. **Aggravating Factor(s):** There are several aggravating factors in this case. As [redacted] points out, [redacted] has received another complaint from the Arizona Medical Board for similar reasons. [redacted] had not received that complaint prior to the date of [redacted] procedure, but [redacted] was aware of the outcome of that prior procedure. A review of that complaint reveals that during the performance of that procedure, the needle was passed through the spinal cord. With that knowledge, and an abundance of literature available describing the dangers of performing a procedure in that manner, [redacted] persisted in employing the same, risky technique without making any corrections or modifications.

   The provided records also reveal that this case resulted in a malpractice suit that settled in the amount of one million dollars. The documents report that [redacted] utilized improper technique, administered the wrong medication, that the procedure resulted in major permanent injury, and that fluoroscopy should have been utilized during the procedure.

7. **Mitigating Factor(s):** [redacted] states that since this event, he has spent a considerable amount of time and money to attend interventional pain medicine courses.

8. **Consultant's Summary:** This tragic case represents both medical malpractice and extremely poor medical judgment. Cervical epidural steroid injections should never be performed on an unconscious patient. If sedation is administered, it must be done so cautiously as conscious sedation, utilizing medications that allow for the safe performance of this technique. Propofol is a general anesthetic that rapidly induces unconsciousness, and should never be used in this setting. Additionally, the administration of this agent to a patient in the sitting position is fraught with potential patient harm.

   Performing cervical epidural steroid injections by hanging drop technique, with a patient in the sitting position, without the use of fluoroscopy, is a method that is all but abandoned. There is no valid reason for a skilled interventional pain management specialist to utilize this antiquated and unsafe technique. Additionally, a physician performing a cervical epidural steroid injection on a deeply sedated or unconscious patient must immediately recognize the danger of that situation and abort or delay the procedure until the patient recovers sufficiently to ensure that the patient is capable of consciously remaining still in order to avoid needle misplacement due to patient movement.

   [redacted] indicates that he has since attended interventional pain management workshops, and while he states that he has changed his sedation technique, it is unclear if he has trained in the use of fluoroscopy or the proper use of loss of resistance technique. Pain medicine is an expanding, dynamic, and complex specialty, and as this case clearly demonstrates, experience and skill in the field of anesthesiology does not at all qualify a physician to practice interventional pain medicine.

9. **Records Reviewed:** All provided medical records were reviewed, including documentation from the malpractice suit settlement, [redacted] clinical records, a summary from [redacted] hospital medical records, and the formal complaint from the Arizona Medical Board,

[redacted] [redacted]

Print Name Date

Signature

Medical Consultant Report and Summary

Case No: MD [redacted] **Physician:** [redacted] **MD**

Date: [redacted] **Medical Consultant:** [redacted] **MD**

1. **Detailed (Chronological) Analysis:** On 12/12/2007, [redacted] presented to Dr. [redacted] for a 2 year well check. At the time, the mother had the complaint of "Coughs when he runs, always". There is no mention at any previous visit of a chronic cough. Dr. [redacted] performed the usual components of a 2 year well check and also a brief evaluation of the chronic cough. He placed a PPD, ordered a CBC with differential and a chest x-ray, and asked that the patient follow-up for a re-check in 1 week. The patient went to radiology to have the chest x-ray performed but did not go to the laboratory. He returned two days later to have the PPD read. There is no notation of whether his mother asked about the chest x-ray at the time. The chest x-ray results were received by Dr [redacted] s office and one attempt was made by a nurse to contact the patient. Apparently there was no answer and no option to leave a message. At the time, there was only one telephone number available in the chart for the nurse to try. The report was then mistakenly filed instead of being held to make another attempt to reach the family and the result was not brought to Dr [redacted] s attention. The patient appears never to have made an appointment for the 1 week follow-up as requested by Dr [redacted]

   The patient's mother called Dr. [redacted]'s office on 1/10/2008 (nearly 1 month later) at 5:10pm asking about the results of the chest x-ray. An appointment was made with Dr. [redacted] for the following morning to discuss results, re-check the child, and initiate treatment. The patient did not keep this appointment and also missed an appointment re-scheduled for later in the day. On 1/12/2008 the patient kept an appointment with another doctor at Dr. [redacted] s clinic, at which time antibiotics and albuterol were prescribed. At this visit, it was noted that the cough had worsened, though there were no signs of severe respiratory disease on examination. There is no notation on this clinic note as to whether follow-up was recommended. No further information is available as to the patient's response to treatment as he was not seen at Dr. [redacted] s clinic again.

2. **Proposed Standard(s) of Care:** The standard of care in this case is to make a reasonable attempt to contact a patient after obtaining a radiological study and receiving the results, then to initiate appropriate treatment and/or further workup.

3. **Deviation from the Standard of Care:** There is a minor deviation from the standard of care in this case because only one attempt was made to contact the family and then the report was filed without being brought to the attention of the physician who ordered the test.

4. **Actual Harm Identified:** It is unlikely that there was any real harm in this case. The chest x-ray was not very informative and, in the reviewer's opinion, the significance of the "finding" is suspect. In fact, the radiologist's reading states that the film was most consistent with bronchiolitis, which usually does not require treatment. So, antibiotic treatment was likely not necessary and the delay in reporting results to the family probably had little impact. The biggest impact came from the lack of a follow-up appointment, which was never made by the family.

5. **Potential Harm Identified:** If the finding on the chest x-ray had actually been an early acute pneumonia as was listed as an unlikely but possible interpretation, then the patient could have suffered progressive symptoms of worsening pneumonia, which can be very serious. However, the most logical course of treatment after seeing the x-ray would not have involved antibiotics for this child anyway, and the follow-up exam 1 week later (or prn worsening symptoms) would have been much more important than the chest x-ray in the first place.

6. **Aggravating Factor(s):** The medical records kept by Dr. [redacted]'s office are inadequate. There is very little information in the clinic notes. The format of the notes leaves little room, if any, for family history, past medical history, or even a thorough history of present illness. As a result, it appears that all clinicians who have seen this child include very little detail in their histories and in their assessments and plans. Dr. [redacted]'s handwriting is also very difficult to read. Dr. [redacted] states that he remembers reviewing family and past history at the visit in question; however there is no notation to that effect and there is almost no detail in the history of present illness. Also, Dr. [redacted]'s notes have almost no detail in the area of the physical examination. Instead, there is a line through the "Normal" column for everything. There is no listing of pertinent negatives (this applies to all of the visits, not just the one in question). Though it appears that Dr. [redacted]'s assessment, plan, and course of treatment were appropriate, it leaves many potential questions unanswered when reviewing this case.

7. **Mitigating Factor(s):** This is a very difficult case for Dr. [redacted] as it is clear from the medical records that this is a chronically non-compliant family that misses appointments frequently. For example, there are several notations throughout the chart that the mother was told to stop giving the child the bottle, but he still was using a bottle on the last visit. The child did not present for the 2 month or 4 month visits, receiving the first set of vaccines at 6 months of age. Many other visits were missed or cancelled. Dr. [redacted]'s office sent this family 2 letters regarding the no-shows instead of simply asking them to find a new pediatrician as many other pediatricians might have done after such a large number. In this respect, he should be applauded for his patience with this difficult family.

   The non-compliance of this family was a definite factor in the results of this particular illness as well. The family did not follow-up as requested and did not go to the laboratory for the blood test that Dr. [redacted] had ordered. If they had done either of these things, or simply called a few days after the x-ray when they hadn't heard anything and the child was supposedly worsening, then the results would have come to Dr. [redacted]'s attention and the child would have received treatment in a timely manner.

8. **Consultant's Summary:** The reviewer feels that there was a minor deviation from the standard of care on the part of Dr. [redacted] and his office. However the mitigating factors listed above outweigh the deviation from the standard of care. Dr. [redacted]'s office appears to be well-organized when it comes to dealing with telephone calls and reports in general and what happened in this case appears to have been an anomaly. His office has, in fact, improved its system of dealing with reports since this case.

   It is true that more than one attempt should have been made to reach this family with the results of the chest x-ray, but there does not appear to have been any real harm done by this and that the bigger problem was the fact that the patient did not follow up as requested.

Also, it is the recommendation of the reviewer that Dr. [redacted] and his colleagues improve their documentation in order to be more clear of their thought processes in the future.

9. <u>Records Reviewed:</u>

Complete medical records from Dr. [redacted] s office 9/15/2005 through 1/12/2008
Radiology report dictated 12/13/2007
Viewed x-rays taken on 12/12/2007

_____ _____
Print Name Date

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Medical Consultant Report and Summary

Case No: MD-08[redacted] **Physician:** [redacted] M.D.
Date: February 19, 2009 **Medical Consultant:** [redacted] M.D.

Detailed (Chronological) Analysis:

In December 2008, Dr. [redacted] received notice from the Board that an attorney representing J.A., a patient upon whom Dr. [redacted] had operated several months prior, had filed a complaint against him. The complaint alleges "failure to provide a safe environment during a cosmetic procedure (Liposuction) by allowing the patient to directly come in contact with a heating pad, resulting in a third degree burn to the patient's abdomen."

Dr. [redacted] performed liposuction of the abdomen and waist as well as fat injections to the buttocks on J.A. in his clinic on April 30, 2008; apparently the same day that he saw her for an initial consultation and evaluation. A burn to the skin of the right lower quadrant of the abdomen was discovered at the end of the procedure when the patient was turned from the prone to the supine position in order to apply the dressings; the towels used to cover an ordinary electric heating pad placed beneath the patient to keep her warm during surgery had fallen away, exposing the patient's anesthetized (numbed) abdominal skin to direct contact with the heating pad resulting in the aforementioned burn.

The occurrence and cause of the burn were immediately disclosed to the patient and in addition to routine post-operative care for the liposuction, the patient received satisfactory burn wound care from Dr. [redacted] in the days and weeks that followed. On May 20, 2008 Dr. [redacted] refunded the entire surgical fee to the patient.

During the early post-op period, the patient also sought care from the [redacted] Burn Center where she was seen on May 21 and 23. The burn was described as full thickness (third degree) and excision and grafting of the burn was recommended but not performed; the patient continued care with Dr. [redacted] instead.

Ultimately, the patient discontinued care with Dr. [redacted] and was seen and followed for her burn by Dr. [redacted] a facial plastic surgeon, who she visited on June 6 and June 24, 2008. Dr. [redacted] continued routine local burn care. Photographs provided by the patient's attorney dated September 19, 2008 reveal a healed wound measuring approximately 4 x 10 cm consisting largely of red, hypertrophic scar tissue.

1. Proposed Standard(s) of Care:

A. Heating pads are medical devices regulated by the FDA. Any recommendations made by the FDA concerning their use can be considered the standard of care. On its website (www.fda.gov/cdrh/safety/071207-heatingpads-qa.html), the FDA recommends certain precautions when using a heating pad:

i) Always place heating pad on top of, and not underneath of, the body part in need of heat. (The temperature of a heating pad increases if heat is trapped.)

ii) Never use on a person who is paralyzed or has skin that is not sensitive to temperature changes.

iii) Never use on a sleeping or unconscious person

B. The standard of care for liposuction and fat injections requires the surgeon to perform an appropriate pre-operative evaluation, carry out the surgery in a technically satisfactory manner and provide timely and adequate post-operative care. All properly documented with adequate medical records, of course. According to the state of Arizona "adequate records" means legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment.

2. Deviation from the Standard of Care:

A. Dr, [redacted] use of a heating pad directly underneath a sedated patient with insensitive (numbed) skin, contrary to the recommendations of the FDA, resulted in a significant burn to the abdominal skin of patient, J.A., and falls below the standard of care.

B. Dr. [redacted] medical records for the pre-operative evaluation are inadequate. There is no consultation note, no chief complaint, and no physical examination (of the abdominal are or buttocks) to support a preoperative diagnosis or to justify the subsequent surgery performed on J.A.

3. Actual Harm Identified:

Patient J.A. sustained a significant third degree burn of the abdominal skin as a result of the incorrect use of an electric heating pad. She is left with significant scarring that will likely require reconstructive surgery.

4. Potential Harm Identified:

None

5. Aggravating Factor(s):

Dr. [redacted] defends the use of the heating blanket in his responsorial letter and seems not to recognize the dangers associated with the improper use of a heating pad in surgery.

6. Mitigating Factor(s):

i) The patient is happy with the results of her liposuction and fat injections.

ii) Dr. [redacted] refunded the patient's surgical fee.

iii) Dr. [redacted] provided timely and appropriate burn care post-operatively.

7. Consultant's Summary:

Patient J.A. sustained a third degree burn of her abdominal skin from a heating pad used during cosmetic surgery performed by Dr. [redacted] in his clinic. Using published FDA rules regarding the use of heating pads as the basis for establishing the standard of care Dr. [redacted] clearly fell below the standard of care by using the heating pad in an area of numbed skin directly beneath a sedated patient. Additionally, Dr. [redacted] fell below the standard of care by failing to generate adequate medical records regarding the pre-operative evaluation of patient J.A.

8. <u>Records Reviewed:</u>

i) Medical records and photos provided by the attorney for patient J.A.

ii) Medical records provided by Dr. [redacted]

iii) Patient complaint letter

iv) Dr. [redacted] responsorial letters

v) Medical records from the [redacted] Burn Center

vi) Medical Records from Dr. [redacted]

_____ _____
Print Name Date

_____
Signature

Medical Consultant Report and Summary

Re: [redacted] **M.D. (Case MD-09-**[redacted]
Date: May 24, 2009 **Medical Consultant:** [redacted]

1. **Detailed (Chronological) Analysis:** On Tuesday March 10, 2009, at 8:50 in the morning a ten year old female, JM, was brought by her mother to the [redacted] clinic in Queen Creek. JM was seen by [redacted], PA-C. JM was reported to have sustained an injury to her R leg/hip some three days prior. JM was experiencing more pain in the extremity and spiked a fever of 104F per mother's complaint (103F as noted in the record) the early morning prior to presenting. No other source of fever, outside the painful extremity, is suggested by either the patient or the provider in her report. Mother reported that the area of concern was swollen to the size of a fist and extremely hot to the touch. PA [redacted] took a history which was consistent with the above events. PA [redacted] performed a physical exam, which revealed no source other than the leg/groin for JM's fever. JM's vital signs were noted as follows: Temperature (tympanic) 100.4, blood pressure 103/94, and a pulse of 146. The exam describes: **"*gait: affected by a leg limp, tenderness noted in the R groin, erythema and warmth along the medial superior right thigh.*"** A complete blood count and a sedimentation rate were ordered, with the results expected in about one working day. PA [redacted] working differential included: ***"unspecified infective arthritis, pelvic area and thigh."*** The discharge diagnosis was: ***"leg pain and fever unspecified."*** JM was discharged home with prescriptions of Keflex (antibiotic) and Tylenol with codeine (narcotic pain preparation). There was no documentation as to whether the PA discussed this case with the physician that was in attendance.

   JM's mother called the clinic the next day and again several times in the ensuing week to check on laboratory data, which was unavailable. No return calls were made to JM and her mother. JM again spiked a fever and was having more complaints with her leg on Thursday March 19. As she was traveling, JM was brought to [redacted] Hospital in Oklahoma. There, the diagnosis of cutaneous abscess was made and the lesion was incised and drained. The wound grew Streptococcal Pyogens and a prescription for Bactim was issued. After using a second Bactrim prescription by her primary physician, the infection seems to have resolved. No long term sequela has been reported by this series of events.

   On March 28, **18 days after having her blood drawn at** [redacted] JM's mother received a call telling her that JM's white count was extremely elevated with a white count of 29,000 and 89% polymorphic neutrophils.

   Dr. [redacted] **is the supervising physician for PA** [redacted]**. As well he is the medical director for the** [redacted] **clinic.**

   In his response to the Board, Dr. [redacted] states the following: ***"After reviewing the chart I can state that the patient did not present with an obvious abscess or source of infection."***

   He further states: "***Even in retrospect, based on the initial patient presentation of March 10, 2009 I doubt a different approach taken by the Physicians Assistant would have resulted in a significantly different outcome.***

2. **Proposed Standard(s) of Care:** The standard of care in running a medical practice is to have in place the necessary means for the prompt reporting of critically abnormal lab values. Further, the standard when utilizing a PA is to have in place a system that will direct the more potentially unstable patients to the care of the physician on duty. As well, as a supervising physician, Dr. [redacted] is entrusted with adequate chart review and supervision of the PA in his charge.

3. **Deviation from the Standard of Care:** Dr [redacted] deviated from the standard by not having an adequate system in place to follow up on critical lab values. Further, he is below the standard in his chart review of the PA in his charge. It was clear to JM's mother, PA [redacted] (who examined the patient) and this OMC that the source of JM's infection was her groin/leg area.. How Dr. [redacted] can review this same set of facts and find: ***"After reviewing the chart I can state that the patient did not present with an obvious abscess or source of infection."*** This analysis seems questionable at best. Further, Dr [redacted] is below the standard in not having in place a system which directs the more critical patients to the physician on duty, rather than the PA.

4. **Actual Harm Identified:** The actual harm was in the delay in reviewing the critically high white count in JM. This most likely led to a worsening of her cutanous abscess.

5. **Potential Harm Identified:** The potential harm in this case is very worrisome to this OMC. In this particular case, a missed septic joint or necrotizing fasciitis would have potential life long consequences, including possible amputation and even end-organ damage and death. In a broader sense, Dr. [redacted] lack of insight into the severity of the clinical picture, even in retrospect, is frankly, disquieting at best. The constellation of high fever (103-104F), limp, erythema and tenderness in the groin, severely elevated pulse and white count should serve as an alarm for immediate intervention.

6. **Aggravating Factor(s):** As noted above, Dr. [redacted] lack of insight into the potential seriousness of this presentation, even retrospectively, is very aggravating. As well, the apparent lack of any meaningful follow-up with this patient after numerous phone calls deserves mention here. Not recognizing and reporting a critically high white count **for 18 days** stands as an aggravating factor.

7. **Mitigating Factor(s):** Dr. [redacted] spends a good deal of time in his response elucidating the fact that there was a systems change occurring in his practice with the use of electronic medical records. He feels that this was the source of the delay in obtaining timely lab values. As well, in using his PA, the doctor never met or examined JM on her clinic visit.

8. **Consultant's Summary: Dr. [redacted] was below standard in not assuring that critical lab values were reported in a timely fashion. He has further fallen below the standard by not recognizing the potential critical nature of the presentation of JM and in not adequately supervising the PA after the fact.**

9. **Records Reviewed:**

[redacted] clinic record	3/10/2009
JM Complaint	4/1/2009
Board Notice	4/6/2009
Dr. [redacted] response	4/16/2009
[redacted] Hospital records	3/19/2009 and 3/21/2009
Office visit [redacted] DO	4/10/2009

[redacted] May 24, 2009

Print Name Date

[redacted]

Outside Medical Consultant Report
January 3, 2019

JAN 08 2019

To: Arizona Medical Board
Re: Case: MD-[redacted]
Provider: [redacted], M.D.
Consultant: [redacted], M.D.

This is an ongoing review of this physician to ensure that he is continuing to practice within his restrictions set forth by the Board.

His restrictions include that he is not supposed to prescribe opioid type controlled pain management medications at this time.

I reviewed the records sent by the Board and Dr. [redacted] continues to practice within his practice restrictions.

Dr. [redacted] works at a behavioral health medical center where he does intake evaluations. Dr. [redacted] also works in private practice as a primary care physician (PCP).

The patient records that I was sent for review were all well within his practice restrictions.

I have no issues or concerns.

The five patients that I reviewed were as follows:

SM, a 57 year old woman, was being treated for opioid dependence.

JP, a 36 year old man, was treated for opioid abuse.

JT, a 26 year old man, was being treated for drug abuse.

TM, a 70 year old man, was being treated by Dr. [redacted] as his PCP, in private practice. Of note, is that he does prescribe Clonazepam for insomnia, which is acceptable, but not the first step that one would choose for treatment of insomnia.

PG, a 70 year old woman, was being treated by Dr. [redacted] as her PCP, in private practice.

[redacted]
[redacted] M.D.