

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **DENNIS L. LITTLE, M.D.**

4 Holder of License No. 13890
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-14-0318A

**ORDER FOR DECREE OF
CENSURE AND PROBATION;
AND CONSENT TO THE SAME**

7 Dennis L. Little, M.D. ("Respondent"), elects to permanently waive any right to a
8 hearing and appeal with respect to this Order for a Decree of Censure and Probation;
9 admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of
10 this Order by the Board.

11 **FINDINGS OF FACT**

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

14 2. Respondent is the holder of license number 13890 for the practice of
15 allopathic medicine in the State of Arizona.

16 3. The Board initiated case number MD-14-0318A after receiving a complaint
17 regarding Respondent's care and treatment of a 25 year-old male patient ("SP") alleging
18 inappropriate prescribing of controlled substances and failure to recognize drug seeking
19 behavior.

20 4. SP established care with Respondent in May of 2010. At the time,
21 Respondent documented tingling, weakness, and insomnia in a review of SP's symptoms.
22 Respondent's assessment and plan included Tramadol #180 with five refills, Lorazepam
23 #30 with five refills, Soma #30 with no refills, and Oxycodone/APAP #150 with no refills.
24 Respondent did not document adverse effects of medications, effectiveness of pain
25 control, and Respondent did not document his reasoning for providing SP with a
prescription for Tramadol. Respondent did not document consideration of other treatment

1 modalities, or any patient education regarding the risk of addiction for use of multiple
2 central nervous system depressants.

3 5. On June 8, 2010, SP presented for a clinical appointment for a refill of his
4 medication and follow up. SP reported using his medications frequently, and requested
5 fewer pills that were longer acting. Respondent's assessment and plan included lowering
6 the dose of SP's Oxycodone/APAP from 10/325 to Oxycodone/APAP 5/325 #90, and
7 adding an immediate release Oxycodone (OxylR #120). Respondent also provided SP
8 with a prescription for #30 Soma with five refills, and Respondent's note mentioned the
9 consideration of a physical therapy referral at SP's next visit. Respondent did not
10 document patient education or consideration of medication risks, benefits or alternatives,
11 and Respondent also did not document consideration of drug interactions or addictive
12 toxicities.

13 6. On July 6, 2010, SP presented for follow up and stated that he was
14 increasing his medications on his own. Respondent referred SP to physical therapy.
15 Respondent issued prescriptions for SP including an increase in Soma, OxylR #150, and
16 Oxycodone/APAP #120. Respondent did not document patient education, consideration of
17 preventing adverse effects, did not document any inquiry into whether SP was receiving
18 pain medication from other providers. On July 27, 2010, SP presented for follow up and
19 requested higher doses of medications. Respondent increased the OxylR dose. On
20 August 2, 2010, SP called the office requesting prescriptions for Zolpidem and Miralax.

21 7. On August 10, 2010, the pharmacy called Respondent's office reporting an
22 early refill request for Soma and that SP attempted to pay cash for the medication. That
23 same day, SP's wife called Respondent's office expressing concern that SP was taking too
24 many medications. She reported SP's symptoms of constipation and vomiting blood. On
25 August 11, 2010, SP was seen at Respondent's office for complaints of rectal pain and

1 bleeding. SP requested a change in his medications, based on a self-report of pain and
2 vomiting for two weeks. SP requested a Fentanyl Patch and Methadone. He admitted to
3 receiving narcotics from an urgent care. Respondent documented performing a rectal
4 examination but the patient instructions in SP's chart are illegible.

5 8. On August 25, 2010, SP's wife called the office stating that SP checked
6 himself into a facility for detoxification. SP was discharged the following day and he was
7 scheduled to be seen by Respondent to discuss non-narcotic pain control. Respondent
8 provided SP with Valium IM in the office, and renewed SP's prescriptions for
9 Oxycodone/APAP #35 and OxyIR #35. Respondent did not document any request for
10 records from the detox facility for verification.

11 9. On September 1, 2010, SP called the office requesting a one-week refill of
12 medications. Respondent's response included a request for SP to be seen in the office the
13 same day. SP presented to the office and Respondent documented that SP's pain was
14 controlled while being back on narcotics, and that SP's constipation was controlled on
15 Miralax. Respondent refilled SP's current prescription for Oxycodone/APAP and OxyIR.

16 10. One week later, SP was seen in the office for a pain medication refill, and
17 Respondent prescribed Oxycodone/APAP #56 and OxyIR #70. On September 22, 2010,
18 SP requested a higher dose and reported that he was going to a support group twice a
19 week. Respondent prescribed Oxycodone/APAP #120 and OxyIR #150. The next day, SP
20 called the office claiming that his medications were stolen. Respondent requested that SP
21 schedule an appointment. Respondent noted that SP was court ordered to complete
22 behavioral and drug treatment on October 20, 2010 to November 26, 2010 at an inpatient
23 treatment facility.

24 11. On October 21, 2010, Respondent's office received a faxed request from
25 SP's inpatient treatment facility requesting authorization for SP to take Tramadol. There

1 was no documented response in the patient's chart. Four days later, Respondent's office
2 received a call from the treatment facility requesting Respondent's response to their
3 previous request. Respondent prescribed Tramadol for SP. That same day, SP requested
4 an increase of the Tramadol dose. On November 2, 2010, Respondent's office received a
5 pharmacy request for medication refill. Respondent approved Tramadol #180 and an
6 Ibuprofen refill. On November 19, 2010, SP was seen by Respondent for rehab discharge
7 follow up. Respondent noted that SP was off of all narcotics, and that SP's medications
8 included Ibuprofen and Tramadol only. Respondent documented a discharge plan per
9 SP's self-report only, and did not reference any attempts to confirm the information with
10 the facility itself. Respondent restarted SP's narcotics and prescribed OxyIR #150.

11 12. On December 14, 2010, SP was seen by Respondent for a medication refill.
12 SP reported that he ran out of medications and requested breakthrough pain medications.
13 Respondent refilled SP's OxyIR and added Oxycodone/APAP for SP's breakthrough pain.
14 Respondent did not document discussion or consideration of SP's anxiety status, and did
15 not document any discussion or consideration of alternative anti-anxiety medication or a
16 combination with lifestyle modifications for anxiety. On January 18, 2011, SP was seen in
17 the office for medication management. He was noted to be taking Dilaudid without an
18 explanation of the source. Respondent discontinued SP's OxyIR due to SP's loss of
19 insurance. Respondent also prescribed Soma #44, a six month refill of Tramadol, and
20 refilled SP's Dilaudid.

21 13. On January 25, 2011, SP called the office requesting an increase in his
22 medication. Respondent increased SP's Dilaudid and added Lunesta without an office
23 visit. Respondent also restarted SP's OxyIR, and did not document a plan to see SP in
24 the office for reassessment. On January 28, 2011, SP called the office reporting that he
25 was denied AHCCS insurance. Respondent approved a Dilaudid refill for after January 31,

1 2011. On February 8, 2011, SP called the office reporting that he lost the prescription for
2 Dilaudid. Respondent refilled SP's prescription for Dilaudid.

3 14. On February 11, 2011, SP was seen for an emergency room follow up. SP
4 claimed that he had a seizure secondary to opioid withdrawal and that his Soma and
5 Xanax was thrown out by the Safe House. SP further reported that he ran out of Tramadol,
6 Lunesta, and Dilaudid. Respondent provided prescription refills for Soma, OxyIR, Xanax,
7 and discontinued SP's Dilaudid. Respondent did not document any attempt to confirm the
8 emergency room visit. One week later, SP was seen by Respondent, reporting that he was
9 taking OxyIR six times a day for continued leg pain and back strain. Respondent provided
10 refills for OxyIR, Soma and Ativan. On February 25, 2011, SP was seen by Respondent,
11 who provided refills for OxyIR, Soma and Ativan. SP expired on March 1, 2011. Per the
12 death certificate, SP's death was accidental due to mixed substance toxicity.

13 15. The standard of care required Respondent to query the controlled substance
14 prescription monitoring profile ("CSPMP") to determine whether the patient was receiving
15 narcotic prescriptions from multiple providers. Respondent deviated from the standard of
16 care by failing to query the CSPMP to determine whether the patient was receiving
17 narcotic prescriptions from other providers.

18 16. The standard of care requires a physician to avoid using narcotics as first-
19 line treatment of the patient's neuropathic pain. Respondent deviated from the standard of
20 care by using narcotics as first-line treatment of SP's neuropathic pain.

21 17. Actual patient harm was identified in that SP's chronic narcotic abuse was
22 facilitated by Respondent's care.

23 **CONCLUSIONS OF LAW**

24 a. The Board possesses jurisdiction over the subject matter hereof and over
25 Respondent.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

b. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

c. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order.

DATED AND EFFECTIVE this 8th day of October, 2015.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1
2 1. Respondent has read and understands this Consent Agreement and the
3 stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent
4 acknowledges he has the right to consult with legal counsel regarding this matter.

5 2. Respondent acknowledges and agrees that this Order is entered into freely
6 and voluntarily and that no promise was made or coercion used to induce such entry.

7 3. By consenting to this Order, Respondent voluntarily relinquishes any rights to
8 a hearing or judicial review in state or federal court on the matters alleged, or to challenge
9 this Order in its entirety as issued by the Board, and waives any other cause of action
10 related thereto or arising from said Order.

11 4. The Order is not effective until approved by the Board and signed by its
12 Executive Director.

13 5. All admissions made by Respondent are solely for final disposition of this
14 matter and any subsequent related administrative proceedings or civil litigation involving
15 the Board and Respondent. Therefore, said admissions by Respondent are not intended
16 or made for any other use, such as in the context of another state or federal government
17 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
18 any other state or federal court.

19 6. Upon signing this agreement, and returning this document (or a copy thereof)
20 to the Board's Executive Director, Respondent may not revoke the consent to the entry of
21 the Order. Respondent may not make any modifications to the document. Any
22 modifications to this original document are ineffective and void unless mutually approved
23 by the parties.

24
25

1 7. This Order is a public record that will be publicly disseminated as a formal
2 disciplinary action of the Board and will be reported to the National Practitioner's Data
3 Bank and on the Board's web site as a disciplinary action.

4 8. If any part of the Order is later declared void or otherwise unenforceable, the
5 remainder of the Order in its entirety shall remain in force and effect.

6 9. If the Board does not adopt this Order, Respondent will not assert as a
7 defense that the Board's consideration of the Order constitutes bias, prejudice,
8 prejudgment or other similar defense.

9 10. Any violation of this Order constitutes unprofessional conduct and may result
10 in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation,
11 consent agreement or stipulation issued or entered into by the board or its executive
12 director under this chapter.") and 32-1451.

13 11. Respondent acknowledges that, pursuant to A.R.S. § 32-2501(16), he
14 cannot act as a supervising physician for a physician assistant while his license is on
15 probation.

16 12. *Respondent has read and understands the conditions of probation.*

17
18 
19 _____
DENNIS LITTLE, M.D.

DATED: 8/4/15

21 EXECUTIVE COPY of the foregoing mailed
22 this 8th day of October, 2015 to:

23 Renee Coury
24 Campbell, Yost, Clare & Norell, Pc
25 101 North First Ave., Suite 2500
Phoenix, AZ 85003-1904
Attorney for Respondent

1 ORIGINAL of the foregoing filed
2 this 8th day of October, 2015 with:

3 Arizona Medical Board
4 9545 E. Doubletree Ranch Road
5 Scottsdale, AZ 85258

6 
7 _____
8 Board Staff

9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25