



1 months apart), three right multilevel cervical radiofrequency ablation ("RFA") procedures  
2 (at six month intervals) and three left multilevel cervical radiofrequency ablation  
3 procedures (at six months intervals). Six of the RFA procedures were accompanied by  
4 phenol injections (two lumbar, four cervical). During this time, Respondent performed  
5 physical examinations on two occasions, and Respondent noted tenderness to palpation.  
6 At no time was there any cervical or lumbar neurologic evaluation (motor, sensory,  
7 reflexes, straight leg raises), cervical range of motion testing, or documented objective  
8 findings on physical exam. During this 13 month interval and despite the frequent  
9 interventional procedures, the narcotic dosage was increased from 60 mg morphine  
10 equivalent daily ("MED") to 135 mg MED.

11         5.       DR was then treated by other practitioners in Respondent's practice group,  
12 who performed other lumbar and cervical spine procedures and increased DR's narcotic  
13 dose to 240 mg MED.

14         6.       Respondent resumed care of DR in October of 2009. Respondent increased  
15 DR's narcotic dosage from 240 to 330 mg MED. This dose was continued for  
16 approximately 18 months, until DR's final visit on March 24, 2011. During this eighteen  
17 month interval, Respondent performed 20 spine related procedures. This included 5  
18 lumbar epidural steroid injections, 2 cervical epidural steroid injections, 2 right multilevel  
19 cervical RFAs, 2 left multilevel cervical RFAs, 2 right multilevel lumbar RFAs, 2 left  
20 multilevel lumbar RFAs, 2 occasions of bilateral multilevel thoracic facet joint injections,  
21 and 2 occasions of bilateral multilevel lumbar facet injections. On five occasions, a 6%  
22 phenol injection was performed at the same time as RFAs (two cervical, three lumbar).

23         7.       Respondent asserts that at DR's appointment on March 24, 2011, he  
24 complained of significant worsening of pain. Respondent performed a repeat multilevel  
25 cervical radiofrequency ablation with the injection of phenol. DR's patient record on that

1 date documents unchanged pain complaints and a pain level compared to the previous  
2 visits. Additionally, Respondent did not record a physical examination or work-up for  
3 worsening complaints.

4 8. On May 26, 2011, DR presented to the Emergency Department ("ED") with  
5 increased neck pain, weakness and difficulty walking and standing. A cervical MRI was  
6 interpreted by the radiologist to show the interval appearance of diffusely abnormal central  
7 spinal cord signal with edema since the MRI on June 18, 2007. The radiologist opined that  
8 the findings likely represented an acute inflammatory process. DR was subsequently  
9 transferred to another hospital for a higher level of neurologic care.

10 9. The standard of care requires a physician to consider using phenol when  
11 patients have malignant pain. Respondent deviated from the standard of care with patient  
12 DR by repeatedly performing phenol injections in the neuraxis in a patient with non-  
13 malignant pain.

14 10. The standard of care requires a physician to utilize one method of nerve  
15 destruction at a time. Respondent deviated from the standard of care by simultaneously  
16 applying two different methods of nerve destruction on patient DR.

17 11. The standard of care requires a physician to perform an appropriate  
18 evaluation, examination, and work-up prior to performing injections. Respondent deviated  
19 from the standard of care by performing a multitude of cervical spine interventional  
20 procedures on patient DR without documenting a physical examination of the cervical  
21 spine.

22 12. The standard of care requires a physician to document and investigate  
23 complaints of new or worsening symptoms prior to performing interventional pain  
24 procedures. Respondent deviated from the standard of care by failing to document any  
25

1 reports of significantly increased pain for patient DR and by failing to consider further work-  
2 up.

3 13. The standard of care requires a physician to sign medical records in a timely  
4 fashion. Respondent deviated from the standard of care by failing to timely sign off on  
5 DR's medical records.

6 14. Actual harm occurred in that DR experienced phenol-induced myelopathy  
7 with paraplegia.

8 15. There was the potential for patient harm in that DR was exposed to an  
9 unnecessary and unacceptable risk for a patient with non-cancer pain and a normal life  
10 expectancy.

11 **MD-15-0308A**

12 16. The Board initiated case number MD-15-0308A after receiving a complaint  
13 regarding Respondent's care and treatment of a 42 year-old male patient ("MM") alleging  
14 that Respondent failed to properly perform an occipital nerve block, which caused  
15 nystagmus, head spinning, and a ringing noise in his ears. MM also alleged that  
16 Respondent discharged him in that state and failed to follow-up with him after the  
17 procedure.

18 17. On March 3, 2015, MM presented to Respondent for a diagnostic cervico-  
19 thoracic medial branch block as well as a left occipital nerve block. During the nerve  
20 block, MM complained of symptoms consistent with central nervous system local  
21 anesthetic toxicity. While experiencing these symptoms, MM had to be restrained while  
22 Respondent injected contrast to evaluate the needle position. MM was subsequently  
23 taken to the recovery room. The nurse's notes do not remark on MM's status, the need for  
24 Zofran and Toradol, or the length of time in recovery, which was one hour. MM reported  
25 being nauseated, having tinnitus, and being unable to stand at discharge and his sister

1 confirmed his reports, noting that he had to be taken outside of the office in a wheelchair  
2 and had incoherent speech.

3 18. On March 5, 2015, Respondent saw MM again and noted that his nystagmus  
4 had improved but the tinnitus and vertigo persisted. Respondent ordered an MRI with and  
5 without contrast, which was found to be normal.

6 19. On March 6, 2015, MM was seen by a VA provider who commented that MM  
7 had similar symptoms prior to the injection, including tinnitus, but noted that the symptoms  
8 had worsened. MM reported that he would be going to Barrow's for a neurologic  
9 evaluation.

10 20. The standard of care requires a physician to document all procedures  
11 performed on patients. Respondent deviated from the standard of care by failing to  
12 document a procedure note.

13 21. The standard of care requires a physician to fully document procedure  
14 complications. Respondent deviated from the standard of care by failing to adequately  
15 document procedure complications.

16 22. The standard of care requires a physician to document a neurologic exam  
17 and clinical decision making when a patient complains of significant neurologic side  
18 effects. Respondent deviated from the standard of care by failing to perform a neurologic  
19 examination.

20 23. Actual patient harm occurred in that patient MM experienced CNS toxicity.

21 24. There was potential for patient harm in that MM was at risk for persistent  
22 anxiety, increased tinnitus and vertigo.

23 25. During a Formal Interview on the matter, Respondent testified that he no  
24 longer uses intercostal radiofrequency ablation and the procedure should not be used for  
25 regular pain or a first-time patient.



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

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

5 DATED AND EFFECTIVE this 5<sup>th</sup> day of October, 2016.

6 ARIZONA MEDICAL BOARD

7  
8 By Patricia E. McSorley  
9 Patricia E. McSorley  
10 Executive Director

11 EXECUTED COPY of the foregoing mailed  
12 this 5<sup>th</sup> day of October, 2016 to:

13 Richard A. Kent, Esq.  
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15 111 W Monroe St, Suite 1000  
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17 Attorney for Respondent

18 ORIGINAL of the foregoing filed  
19 this 5<sup>th</sup> day of October, 2016 with:

20 Arizona Medical Board  
21 9545 E. Doubletree Ranch Road  
22 Scottsdale, AZ 85258

23 Mary Butler  
24 Board staff  
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