

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **MITCHELL R. HALTER, M.D.**

4 Holder of License No. 29626  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Board Case Nos. MD-05-0861A

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand and Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on  
8 December 6, 2006. Mitchell R. Halter, M.D., ("Respondent") appeared before the Board with legal  
9 counsel Daniel P. Jantsch for a formal interview pursuant to the authority vested in the Board by  
10 A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of  
11 Law and Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

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

15 2. Respondent is the holder of License No. 29626 for the practice of allopathic  
16 medicine in the State of Arizona. Respondent completed nine months of pathology residency and  
17 then changed to psychiatry. Respondent's next residency was neurology and he completed a  
18 fellowship in anesthesiology pain management.

19 3. The Board initiated case number MD-05-0861A after a hospital summarily  
20 suspended Respondent's privileges over concerns regarding infection rate, lack of sterile  
21 technique, and competency. The Board reviewed the cases of eight patients and identified four  
22 distinct issues: 1) a cardiac arrest suffered by a patient after Respondent performed a thoracic  
23 epidural sensory blockade in an unmonitored setting; 2) two episodes of cardiac arrest in a  
24 patient following Respondent's implantation of an intrathecal infusion pump; 3) infection related to  
25 implanted devices and subsequent management of infections in the cases of five patients. In

1 each case Respondent failed to remove part of or the entire implanted device requiring  
2 subsequent surgery for persistent/recurrent infections and/or removal of foreign material; and 4)  
3 placement of a peripheral nerve stimulator in an unconventional location.

4 4. A seventy-seven year-old female patient ("EL") presented to Respondent with  
5 metastatic breast cancer and known pleural and bone metastases. Respondent admitted her to  
6 the hospital for pain management and her workup revealed a new compression fracture thought  
7 to be the source of the new and more severe pain. Respondent performed a sensory blockade  
8 via thoracic epidural in EL's hospital room without resuscitative medications immediately  
9 available. Respondent did not document EL's vital signs post-procedure. EL was left unattended  
10 and unmonitored during the post-procedure period and began experiencing distress 17 to 20  
11 minutes after Respondent infused the epidural anesthetic. Respondent returned to EL's bedside,  
12 determined treatment with ephedrine was necessary and ordered it from the pharmacy. EL  
13 suffered a cardiac arrest shortly after the medication arrived on the floor. EL died three days later.

14 5. In his private practice Respondent does not routinely perform thoracic epidurals on  
15 hospital wards and would typically do them in an outpatient ambulatory facility. If Respondent is  
16 called on to do a thoracic epidural in a hospital setting he will do it either in an outpatient  
17 ambulatory setting, ambulatory surgery center or in the room in a monitored unit. According to  
18 Respondent, forty-five minutes after the initial infusion one would expect the main effects of the  
19 medication to be wearing off and for EL's event to occur so late out leads him to believe there  
20 was another cause. Respondent indicated events that would bring EL down so quickly would be a  
21 massive intracranial hemorrhage, a pulmonary embolus, a very large MI or an exsanguinating  
22 wound. Respondent believed because EL had been bed-bound for weeks, had metastatic cancer  
23 and probable hypocoagulable state, a pulmonary embolus caused the event.

24 6. In EL's chart the last blood pressure that is noted was done by a nurse at 1500. In  
25 Respondent's dictation he documented a set of vital signs noting a blood pressure of 108 over 51,

1 a temperature of 98.2 and a pulse of 110. The computer documented vital signs in the nursing  
2 note are identical.

3 7. The standard of care for performing a thoracic epidural regional anesthetic  
4 requires intra and post-procedure monitoring of vital signs and that the procedure be performed in  
5 a setting with immediate availability of skilled nursing and resuscitation equipment. Respondent  
6 deviated from the standard of care by performing a thoracic epidural regional anesthetic in a  
7 hospital room without monitoring, by failing to monitor post-procedure vital signs, by failing to  
8 have immediate access to resuscitative medications and equipment, and by leaving EL  
9 unattended and unmonitored minutes after onset of sensory blockade. EL was at risk for  
10 respiratory failure, aspiration, myocardial infarction, stroke, and seizure. EL suffered cardiac  
11 arrest and died.

12 8. A fifty-seven year-old female diabetic patient ("SM") with peripheral vascular  
13 disease and Chronic Obstructive Pulmonary Disease presented to Respondent after an above-  
14 the-knee amputation. SM was also a smoker. SM complained of uncontrollable twitching of the  
15 stump. Respondent recommended a three to five day trial infusion of intrathecal Baclofen to  
16 control the twitching. Respondent did not try administering oral Baclofen before proceeding with  
17 the infusion. After a successful response to a single trial of intrathecal Baclofen, Respondent  
18 implanted an intrathecal pump and added a low dose of intrathecal Morphine, noting it would be  
19 beneficial in suppressing involuntary movements. Respondent also discontinued SM's Coumadin  
20 for safety purposes while he implanted the device.

21 9. SM became obtunded ninety minutes after the procedure and was admitted to the  
22 hospital. SM was intubated due to hypoxemia and respiratory insufficiency. SM was extubated  
23 the following day. The day after she was discharged from the hospital SM was found  
24 unresponsive at home. Paramedics reported she responded to the administration of Narcan.  
25 Upon arrival to the emergency department she was noted to be arousable, but somnolent. SM

1 was admitted to the intensive care unit for decreased responsiveness, hypotension and airway  
2 protection issues and placed on a Narcan drip. During this admission Respondent noted he  
3 "decreased" the Baclofen infusion rate to 250 mcg/day. However, other records Respondent  
4 provided indicated 250 mcg/day was the original infusion rate. In his record Respondent  
5 described the Morphine intrathecal infusion dose of 0.4 mg/day as "infinitesimal" and unlikely to  
6 cause opioid overdose. Opioid tolerance has no bearing on the respiratory depressant effects of  
7 Baclofen, a non-opioid. The package insert for intrathecal Baclofen states chronic infusion of the  
8 drug via an implantable pump should be reserved for patients with spasticity that is unresponsive  
9 to oral Baclofen therapy or who experience intolerable CNS effects at effective oral dosages.

10 10. SM was discharged home by a hospitalist on January 23 at about 2:00 and was  
11 readmitted through the emergency department about 1:30 the morning of the 24<sup>th</sup> because she  
12 was unresponsive. Respondent's differential diagnosis at the time SM was admitted was  
13 hypercapnic and profound sleep deprivation. When SM returned to the hospital, Respondent tried  
14 playing with different dosages, but turning the pump down to very little dosage did not change her  
15 status. SM's respiratory failure occurred after the initial pump placement on January 21 after  
16 dosing of 250 micrograms of Baclofen on a daily basis and .4127 of morphine. The pump was  
17 changed at 7:36 p.m. down to Baclofen 200, morphine .3305. SM was discharged on January 23  
18 at about 2:30 after Respondent noted the day before that he was aware of SM's co-morbidities.  
19 On January 24, noted on pump interrogation, the pump was changed to Baclofen 500  
20 micrograms and morphine .8253 milligrams despite the problems with SM. SM returned twelve  
21 hours later with respiratory arrest. Respondent increased the pump dosage based on clinical  
22 response and at a lower dose SM had complete wild, flailing movements of the stump, and the  
23 idea was to get her to whatever minimal dose would control these movements. SM was  
24 discharged at double the dose after having had a respiratory arrest on half the dose. Nothing in  
25 the chart documents either the change or the reasoning for the change and during SM's

1 emergency department admission, the physicians had no idea what dose of medication SM was  
2 on. Respondent was asked to explain. Respondent testified the programming is in the chart and  
3 becomes a permanent part of SM's record so anyone who looked at the programming should be  
4 able to interpret exactly what was going on. The programming is on page 30 of 787 of  
5 Respondent's medical record and it is not reasonable to expect an emergency room physician to  
6 find the information.

7 11. The standard of care requires the introduction and continuation of intrathecal  
8 opioid be done for a documented medical reason, particularly when the patient has known severe  
9 pulmonary disease, a recent episode of acute respiratory failure, and concurrent intrathecal  
10 infusion of another medication with CNS depressant effects. Respondent deviated from the  
11 standard of care by introducing and continuing morphine to the intrathecal infusion pump, which  
12 was unnecessary because the Baclofen eliminated SM's stump twitching and, therefore, her pain.

13 12. The standard of care requires a physician to be knowledgeable of and recognize  
14 the hallmarks of overdose of a medication he prescribes, dispenses, and/or infuses. Respondent  
15 deviated from the standard of care because he did not recognize that intrathecal Baclofen  
16 overdose presents as somnolence and respiratory depression and that this can be potentiated by  
17 intrathecal morphine.

18 13. The standard of care requires a physician to administer individualized titration to  
19 determine the lowest intrathecal Baclofen dose with optimal response. Respondent deviated from  
20 the standard of care by initiating intrathecal Baclofen at a relatively high dose without  
21 individualized titration to effect.

22 14. SM was harmed because she received a relative intrathecal Baclofen overdose  
23 resulting in a complicated post-procedure course, including intubation and two hospitalizations for  
24 respiratory failure. SM was subject to complications of respiratory failure, including aspiration,  
25 brain damage and death. SM was also subject to complications associated with the

1 discontinuation of anticoagulant therapy. Because SM was diabetic she was at risk for infection  
2 with the implanted pump.

3 15. Respondent performed an occipital peripheral nerve stimulator implantation one  
4 week after a thirty-five year-old female patient ("SF") was hospitalized for pneumonia. One month  
5 later SF's thoracic wound was infected and Respondent returned her to the operating room for  
6 wound irrigation, debridement and revision. Respondent left the device intact. Respondent did not  
7 obtain a wound culture, although he gave SF cephalosporin intraoperatively and discharged her  
8 on oral cephalosporin. At a later date, Respondent performed thoracic wound irrigation,  
9 debridement, and revision for wound infection. Respondent did not remove the device.  
10 Respondent gave SF cephalosporin intraoperatively and discharged her on oral first-generation  
11 cephalosporin. Respondent performed a wound culture that grew third-generation cephalosporin  
12 resistant staph epidermidis. There is no evidence in the record that Respondent changed SF's  
13 antibiotic based on the sensitivities and there was no evidence of persistent or recurrent infection.

14 16. Respondent did not perform cultures on SF on the 26<sup>th</sup> because he believed there  
15 was no reason to do so for an uncomplicated, open skin wound without any sign of infection.  
16 According to Respondent, a suture had split, there was no foreign body, there was no deep  
17 wound that had compromised any subcutaneous tissues, and it was a plain, uncomplicated  
18 wound that required closing. SF returned to Respondent for another wound dehiscence, as  
19 described by Respondent, and he cleaned it up, took some sutures out and left the device in.

20 17. The standard of care for treatment of infection associated with an implantable  
21 device extending into or adjacent to the neuraxis for chronic pain requires a physician to remove  
22 the entire foreign body, obtain culture and sensitivities, and institute antibiotic treatment specific  
23 to the organism. Respondent deviated from the standard of care by failing to remove the foreign  
24 body on May 26, 2004 and on July 16, 2004 and by failing to obtain culture and sensitivities on  
25 May 26, 2004.

1           18.     In circumstances when removal of the foreign body is physically difficult, potentially  
2 dangerous, and/or impractical the standard of care requires a physician to consider an infectious  
3 disease consultation, delayed wound closure, intravenous antibiotics, frequent local wound care,  
4 and observation for signs of systemic and/or central nervous system involvement. Respondent  
5 deviated from the standard of care by failing to obtain an infectious disease and/or surgical  
6 consultation for the wound infections on May 26, 2004 and July 16, 2004 and by closing the  
7 wound on those two dates despite retention of a foreign body that extended into the cervical  
8 region.

9           19.     SF required a second surgery for recurrent/persistent wound infection. SF was at  
10 risk for complications of localized, systemic, and spinal infection, including, but not limited to,  
11 sepsis, epidural abscess, meningitis, brain damage and death.

12           20.     On March 21, 2003 Respondent performed a trial peripheral nerve stimulation and  
13 on July 15, 2003 performed a permanent peripheral nerve stimulation implantation on a fifty-year-  
14 old female patient ("LF"). On September 3, 2003 Respondent removed LF's peripheral nerve  
15 stimulator due to a wound infection. On January 30, 2004 Respondent re-implanted a permanent  
16 peripheral nerve stimulator resulting in LF developing a buttock wound infection. The infection  
17 required Respondent to surgically remove the peripheral nerve stimulator on March 9, 2004.  
18 Respondent performed surgery for LF's recurrent/persistent buttock wound infection on May 26,  
19 2004 and outpatient treatment of thoracic wound infection and retained foreign material on March  
20 21, 2005. On April 28, 2005 Respondent performed surgery on LF for neck wound infection and  
21 retained foreign material. On May 23, 2005 Respondent reimplanted the peripheral nerve  
22 stimulation system and achieved excellent relief of LF's head pain. The next six months of  
23 records available to the Board show no recurrent infection.

24           21.     The standard of care for treatment of local subcutaneous infection associated with  
25 an implanted foreign body in a diabetic patient is to remove the entire foreign body, obtain culture

1 and sensitivities and institute antibiotic treatment specific to the organism. Respondent deviated  
2 from the standard of care because he failed to remove the entire foreign body on March 9, 2004,  
3 May 26, 2004 and March 21, 2005 and because he failed to obtain culture and sensitivities on  
4 May 26, 2004 and April 28, 2005.

5 22. The standard of care requires extra caution in a patient at high risk of infection  
6 and/or with a history of repeated infection associated with an implanted device and also requires  
7 a physician to recognize circumstances in which consultation with a specialist is appropriate.  
8 Respondent deviated from the standard of care when he failed to obtain infectious disease and/or  
9 surgical consultation in a patient at high risk for infectious complications due to poorly controlled  
10 diabetes.

11 23. LF required three additional surgeries for recurrent infection and retrieval of foreign  
12 bodies after initial surgical irrigation and closure of the infected wound and retention of foreign  
13 material. LF was subjected to potential complications of chronic and recurrent infection and LF's  
14 on-going difficulties with blood glucose control may have been exacerbated by chronic underlying  
15 infection associated with retained foreign material.

16 24. A sixty-four year-old male patient ("JB") presented to Respondent for management  
17 of chronic nonmalignant pain and multiple total joint replacements. On August 6, 2004, after  
18 conducting an appropriate evaluation, Respondent placed a permanent intrathecal opioid infusion  
19 system. On February 7, 2005 Respondent performed surgery to relocate the abdominal pocket  
20 for the pump to a more comfortable location. Despite suspicion of a local fungal skin infection in  
21 March, April, and May 2005, and the presence of yellow drainage in early May 2005, Respondent  
22 did not obtain either cultures or an infectious disease consult. Respondent failed to do so in spite  
23 of the severe risks related to infection in the presence of multiple artificial joints and an intrathecal  
24 infusion device. On May 19, 2005, after attempting surgical removal of the system, Respondent  
25 left behind a portion of the system and did not obtain an infectious disease consultation until the

1 fifth post-operative day. Once consulted the infectious disease specialist recommended catheter  
2 removal to allow the infectious process to resolve and to prevent ongoing colonization. On May  
3 31, 2005 Respondent surgically removed the remaining catheter. JB was discharged on IV  
4 antibiotics under the direction of the infectious disease consultant.

5 25. The standard of care requires early identification and aggressive treatment of any  
6 infection in a patient with total joint replacements. Respondent deviated from the standard of care  
7 because he did not timely identify and aggressively treat an infection in a patient with total joint  
8 replacements.

9 26. When a skin infection is suspected in the area of the pump reservoir the standard  
10 of care requires a physician to culture the fluid from the reservoir. Respondent deviated from the  
11 standard of care because he failed to culture reservoir aspirate and yellow discharge despite  
12 proximity of erythema and drainage to the pump and suspicion of fungal infection in a patient with  
13 multiple joint replacements.

14 27. The standard of care for the treatment of local subcutaneous infection associated  
15 with an implanted foreign body requires resolution of the local process and prevention of  
16 extension of the infectious process systemically and/or to the central nervous system.  
17 Respondent deviated from the standard of care because he did not resolve the local process or  
18 prevent extension of the infectious process systemically and/or to the central nervous system.

19 28. The standard of care requires cultures and sensitivities be obtained of the wound  
20 and catheter tip and institution of antibiotic treatment specific to the organism. Respondent  
21 deviated from the standard of care because he did not obtain cultures and sensitivities of the  
22 wound and catheter tip and did not institute antibiotic treatment specific to the organism.

23 29. In cases where removal of the entire foreign body is physically difficult and/or  
24 potentially dangerous the standard of care requires a physician to consider delayed wound  
25 closure, intravenous antibiotics, frequent wound cleansing and observation for signs of systemic

1 and/or central nervous system involvement. Respondent deviated from the standard of care  
2 because he failed to consider these options.

3 30. The standard of care also requires a physician to recognize when consultation with  
4 a specialist is appropriate. Respondent deviated from the standard of care when he failed to  
5 obtain surgical consultation despite his difficulties in surgically removing the catheter on May 19,  
6 2005 and when he failed to obtain an infectious disease consultation until post-operative day five.

7 31. The standard of care required Respondent to remove the entire foreign body.  
8 Respondent deviated from the standard of care when he failed to remove the entire foreign body.

9 32. JB required a second surgery to retrieve foreign material (the catheter leading to  
10 the intrathecal space) left behind after Respondent initially irrigated and closed the infected  
11 wound. JB was subject to complications of localized, systemic, total joint and spinal infection,  
12 including, but not limited to, total joint removal, loss of mobility, loss of limb(s), sepsis, epidural  
13 abscess, meningitis, brain damage, and death.

14 33. A thirty-five year-old female ("WS") was under Respondent's care for management  
15 of chronic headaches that were poorly controlled with medication. On February 28, 2003  
16 Respondent performed occipital, supraorbital and supratrochlear nerve blocks. On July 15, 2003  
17 Respondent implanted a trial occipital peripheral nerve stimulator for chronic headache. On April  
18 2, 2004 Respondent implanted a permanent supraorbital peripheral nerve stimulator. On April 24,  
19 2004 Respondent planned to revise the stimulator due to lack of benefit. WS was admitted to the  
20 hospital on June 1, 2004 with fever and "cellulitis" of the left anterior chest wall at the site of the  
21 implanted impulse generator. WS was started on IV cephalosporin antibiotic. On June 2, 2004  
22 Respondent took WS to the operating room and removed the impulse generator and electrodes.  
23 Respondent cultured and closed the wound and placed a small Penrose drain. Per Respondent's  
24 instructions the drain was pulled prior to WS's discharge on June 3, 2004. Respondent  
25 discharged WS on Keflex.

1           34.     Despite 24 hours of IV cephalosporin the culture from the electrode tip grew  
2 >100,000 CFU/ml Staph epidermidis, resistant to the only cephalosporin tested (Rocephin). No  
3 medical record documented Respondent changing the Keflex to an antibiotic to which the  
4 cultured organism had been found sensitive. On May 18, 2005 WS reported a painful, hardened  
5 area over her left ear that sometimes drained pus and that the symptoms had been present on  
6 and off for several months. On May 23, 2005 Respondent took WS to the operating room for a  
7 diagnosis of post-operative "wound dehiscence" and performed a wound revision, removed a  
8 retained silastic anchor, and closed the wound. The record does not reflect Respondent obtained  
9 cultures or prescribed antibiotics. Respondent did not obtain infectious disease or surgical  
10 consultations. WS did not have any of the indications listed in the literature Respondent provided  
11 to the Board to support the procedure. Respondent also did not have the tools required for the  
12 procedure or the necessary technical training.

13           35.     The standard of care for treatment of local subcutaneous infection associated with  
14 an implanted peripheral nerve stimulator that lies adjacent to the orbit requires a physician to  
15 remove the entire foreign body, obtain culture and sensitivities, and institute antibiotic treatment  
16 specific to the organism. Respondent deviated from the standard of care because he did not  
17 remove the entire foreign device and because he failed to prescribe antibiotics consistent with the  
18 culture and sensitivities. Respondent deviated from the standard of care when he failed to obtain  
19 culture despite history of wound drainage and dehiscence.

20           36.     WS required a second surgery to remove a silastic anchor that Respondent did not  
21 remove during initial surgery for infection one year earlier. WS was subject to chronic localized  
22 infection, including extension of infection to the orbital region related to the retained foreign body  
23 associated with infection.

24           37.     A fifty-nine year-old female patient ("LS") initially presented to Respondent on  
25 March 12, 2003 in consultation for chronic head pain. On this same date and again on March 27,

1 2003 Respondent performed an occipital nerve block. On July 11, 2003 LS underwent a trial  
2 occipital peripheral nerve stimulator for a problem of "cervical cranial syndrome" with intractable  
3 headaches. On December 19, 2003 Respondent implanted a permanent occipital nerve  
4 stimulator. On February 2, 2004 Respondent took LS to the operating room for lead revision.  
5 Respondent noted LS had excellent response to the stimulator, but the leads had migrated.  
6 Respondent made a thoracic incision and disconnected and removed the leads. Respondent  
7 replaced these leads with two new leads. Respondent gave LS one gram Kefzol by IV and  
8 discharged LS on Keflex 500 mg bid.

9 38. On June 4, 2004 Respondent returned LS to the operating room under general  
10 anesthesia for treatment of thoracic chest wall infection and erythematous skin ulceration  
11 associated with exposed leads of the peripheral nerve stimulator. Respondent gave LS one gram  
12 of IV Kefzol pre-operatively. Respondent cut the leads and removed them, although a portion of  
13 the proximal leads attached to the pulse generator were re-buried. Respondent left the pulse  
14 generator in place and irrigated and closed the wound. Respondent discharged LS with a  
15 prescription for two weeks oral antibiotics. Mixed flora were identified on wound culture.  
16 Respondent's June 30, 2004 office note states LS reported that the mid back incision had been  
17 draining pus and red fluid the previous week. LS had continued on oral antibiotics and, at the time  
18 of the visit, there was no evidence of drainage. A cursory July 28, 2004 note appears to reflect  
19 that LS underwent I&D of a non-draining "blister" at the back incision. The procedure was done in  
20 Respondent's office. Respondent obtained a culture and a July 29, 2004 lab report showed the  
21 specimen grew "mixed skin flora."

22 39. On August 27, 2004 Respondent returned LS to the operating room for re-  
23 implantation of the percutaneous peripheral nerve stimulator leads. Respondent removed the  
24 neural stimulator lead extension he had left intact at the prior surgery and implanted a new one.  
25 Respondent's rationale for leaving this behind at the initial June 4, 2004 surgery for infection, yet

1 removing it on August 27, 2004 cannot be determined. Respondent did not obtain an infectious  
2 disease or surgical consultation.

3 40. The standard of care for treatment of a local subcutaneous infection associated  
4 with an implanted foreign body requires a physician to remove the entire foreign body, obtain  
5 culture and sensitivities and institute antibiotic treatment specific to the organism. Respondent  
6 deviated from the standard of care because he failed to remove the entire foreign body.

7 41. The standard of care also requires a physician recognize circumstances in which  
8 consultation with a specialist is required. Respondent deviated from the standard of care when he  
9 failed to obtain an infectious disease and/or surgical consultation.

10 42. The standard of care required Respondent not close a wound in the presence of a  
11 retained foreign body at the time of surgery for infection. Respondent deviated from the standard  
12 of care when he closed a wound despite a retained foreign body at the time of surgery for  
13 infection.

14 43. LS was subject to complications of localized and systemic infection related to a  
15 retained foreign body associated with infection.

16 44. A forty-nine year-old male patient ("JZ") with chronic head pain had been treated  
17 by Respondent with placement of an occipital nerve stimulator. On June 11, 2004 Respondent  
18 attempted to percutaneously implant a peripheral nerve stimulator in the supraorbital region. In  
19 order to do so Respondent was required to bend the epidural introducer needle to conform to JZ's  
20 head and attempt to advance the needle over the supraorbital ridge. Respondent's procedure  
21 note documents the target area was beneath the surgical drapes and he requested the scrub  
22 technician and anesthesiologist to look beneath the drapes and identify the position of the  
23 epidural introducer needle, the tip of which was noted to have pierced the skin and was exposed  
24 on three separate attempts with two different needles. The second needle was flash sterilized.  
25 Respondent indicated his finger was beneath the surgical drapes to maintain tactile contact.

1 Respondent aborted the procedure due to technical difficulties after three unsuccessful attempts  
2 at advancing the epidural introducer needles across the supraorbital ridge. The anesthesia  
3 records indicate the procedure took over two hours under general anesthesia.

4 45. On February 28, 2005 Respondent successfully implanted a supraorbital  
5 peripheral stimulator. JZ was unsuccessful in decreasing his pain medication with the exception  
6 of two or three weeks in June 2005. As of May 26, 2006 JZ's opioid pain medications were Actiq  
7 (immediate release transmucosal Fentanyl) 1600 mcg 1-4 per day and Fentanyl 75 mcg  
8 transdermal patch q 72 hours. This appears to be unchanged compared to prior to the stimulator  
9 implantation. JZ did not have any of the indications for the procedure that are listed in the  
10 literature Respondent provided to the Board. Respondent did not have the tools required for the  
11 procedure or the technical training to perform the procedure.

12 46. The standard of care for placement of a peripheral nerve stimulator in the  
13 supraorbital ridge area for treatment of headache pain is to establish indications for the  
14 procedure. Respondent deviated from the standard of care because he did not establish  
15 appropriate indications for the placement of a peripheral nerve stimulator.

16 47. The standard of care requires a physician performing a procedure have technical  
17 training, skill, or expertise and the proper tools to perform the procedure. Respondent deviated  
18 from the standard of care because he did not have technical training, skill, expertise or proper  
19 tools to perform the procedure.

20 48. JZ was placed under general anesthesia, but after two hours Respondent aborted  
21 the surgical procedure. JZ was subject to complications associated with an implanted nerve  
22 stimulator, including infection, lead migration, and re-operation.

23 49. Since 2005 Respondent has stopped implanting peripheral nerve stimulators for  
24 head pain/headache both because he does not have access to do them in the hospital setting  
25 and because he did not have privileges at freestanding outpatient centers and also because it is

1 difficult to get scheduling time for these procedures because they are considered low priority in  
2 the hospital operating rooms and are not profitable.

3 50. According to Respondent he is the physician that other physician experts, send  
4 their sickest and most complicated patients to. Respondent testified he is well-trained and has  
5 only had the interest of providing the best, most cutting edge, effective treatment for people who  
6 very often have no other hope.

7 51. A physician is required to maintain adequate medical records. An adequate  
8 medical record means a legible record containing, at a minimum, sufficient information to identify  
9 the patient, support the diagnosis, justify the treatment, accurately document the results, indicate  
10 advice and cautionary warnings provided to the patient and provide sufficient information for  
11 another practitioner to assume continuity of the patient's care at any point in the course of  
12 treatment. A.R.S. § 32-1401(2). Respondent's records do not meet this standard.

13 **CONCLUSIONS OF LAW**

14 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof  
15 and over Respondent.

16 2. The Board has received substantial evidence supporting the Findings of Fact  
17 described above and said findings constitute unprofessional conduct or other grounds for the  
18 Board to take disciplinary action.

19 3. The conduct and circumstances described above constitutes unprofessional  
20 conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records  
21 on a patient"); A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or  
22 dangerous to the health of the patient or the public"); and A.R.S. § 32-1401(27)(II) ("[c]onduct that  
23 the board determines is gross negligence, repeated negligence or negligence resulting in harm to  
24 or the death of a patient.").

25

**ORDER**

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand for inadequate monitoring of eight patients.

2. Respondent is placed on probation for two years with the following terms and conditions:

a. Respondent's practice is restricted in that he shall not implant pain management related devices until he has obtained further training acceptable to the Board in the techniques of implantation and the treatment of complications of the implanted devices, specifically:

b. Respondent shall obtain 15 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in implantation of pain management devices and management of complications. Respondent shall provide Board Staff with satisfactory proof of attendance. The CME hours are in addition to the hours required for biennial renewal of Respondent's medical license.

c. Respondent may not apply for modification of the practice restriction for a minimum of six months.

d. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

3. 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

1 residence or practice outside Arizona or of non-practice within Arizona, will not apply to the  
2 reduction of the probationary period.

3 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

4 Respondent is hereby notified that he has the right to petition for a rehearing or review.  
5 The petition for rehearing or review must be filed with the Board's Executive Director within thirty  
6 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review  
7 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.  
8 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a  
9 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)  
10 days after it is mailed to Respondent.

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

13 DATED this 13<sup>th</sup> day of April 2007.



14 THE ARIZONA MEDICAL BOARD

15 By [Signature]  
16 TIMOTHY C. MILLER, J.D.  
17 Executive Director

18 ORIGINAL of the foregoing filed this  
19 13<sup>th</sup> day of April, 2007 with:

20 Arizona Medical Board  
21 9545 East Doubletree Ranch Road  
22 Scottsdale, Arizona 85258

23 Executed copy of the foregoing  
24 mailed by U.S. Mail this  
25 13<sup>th</sup> day of April, 2007, to:

26 Daniel P. Jantsch  
27 Olson, Jantsch & Bakker, P.A.  
28 7243 North 16<sup>th</sup> Street  
29 Phoenix, Arizona 85020-7250

1 Mitchell R. Halter, M.D.  
2 Address of Record

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*Mitch Halter*