BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **DAVID K. TOM, M.D.** Holder of License No. 43118 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-17-0873A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION**

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 7, 2020. David K. Tom, M.D. ("Respondent"), appeared with legal counsel, Fredrick M. Cummings, Esq., before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand and Probation after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

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

2. Respondent is the holder of license number 43118 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-17-0873A after receiving a complaint regarding Respondent's care and treatment of a 35 year-old female patient ("TH") alleging failure to properly perform cervical spine epidural injection.

4. TH established care with a Pain Management Practice in March, 2017. TH received cervical medial branch nerve blocks (MBB) and radiofrequency ablation (RFA) from practitioners at the Pain Management Practice without relief. A cervical MRI from March 6, 2017, showed early degenerative changes of cervical spine without significant canal or foraminal stenosis.

5. On July 18, 2017, TH presented to a Pain Management Practice and saw a nurse practitioner (NP) for complaints of severe neck pain and headaches. The NP diagnosed TH with cervical myelopathy, chronic headache, cervicalgia, and muscle pain. The NP's plan was for TH to receive a cervical epidural steroid injection (CESI) for cervical radiculopathy.

6. On July 22, 2017, Respondent performed a CESI at the C6-C7. Per the anesthesia record TH received Versed 4mg, Fentanyl 100mcg, and Propofol 230mg. TH complained post-procedure of right upper extremity pain, headache, and decreased sensation of her left upper extremity. Emergency services were called to transport TH to Hospital. An MRI of the cervical spine performed at the Hospital showed T2 hypointense signal extending along the left aspect of the cervical spinal cord starting at approximately level the C2-C3 disc space superiorly and extending inferiorly to at least the level of the C7-T1 disc space. The findings were noted to be highly worrisome for intramedullary blood tracking superiorly and inferiorly within the left aspect of the cervical spinal cord. Neurosurgery evaluated the patient and decided not to evacuate the hematoma.

7. On July 30, 2017, TH was discharged from the Hospital with the diagnoses of intramedullary C2-C7 hematoma from epidural injection and left-sided hemiparesis.

8. The standard of care requires a physician to have adequate medical indication prior to proceeding with a high-risk intervention. Respondent deviated from this standard of care by performing a CESI procedure without adequate medical indication.

9. The standard of care requires a physician to utilize appropriate anesthesia based on the procedure being performed. Respondent deviated from the standard of care by utilizing inappropriate anesthesia with high dose Propofol for a CESI procedure.

10. Actual patient harm was identified in that the patient had cervical spinal cord injury with intramedullary hematoma.

11. There was the potential for patient harm in that the patient was at risk for nerve damage, increase in pain, sensory and motor function loss

12. During a Formal Interview on this matter, Respondent testified regarding the technique used during the procedure performed on TH. Respondent stated that during the procedure, he did not feel that he went past the dura into the patient's spinal cord. Respondent also testified regarding the loss of the images taken during the procedure. Respondent stated that he has changed his practice and no longer relies on x-ray technicians to save images taken during procedures, and now directs technicians to save specific images. With regard to his operative note, Respondent stated that his general practice is to utilize a template, and to then complete the note after the procedure is over and the patient is discharged. In this case, Respondent stated that he failed to complete the note due to the confusion surrounding TH's injury.

13. Respondent testified that with regard to the choice to use Propofol, Respondent stated that he wanted to utilize a combination of fentanyl and Versed; however, TH requested Propofol due to medication tolerance issues. Respondent stated that although he felt that his clinical judgment was appropriate, he would not make the same choice with a similar presentation for a future patient.

14. During that same Formal Interview, Board members discussed Respondent's care and treatment of TH. Board members expressed concern with regard to the vagueness inherent in Respondent's treatment and medical recordkeeping. Additionally, when discussing whether the matter rose to the level of discipline, Board members expressed concern regarding Respondent's apparent lack of ownership for the complication that occurred during TH's procedure. Board members agreed that continuing education in both medical recordkeeping and cervical spine pain procedures would assist the Respondent in remediating his practice.

CONCLUSIONS OF LAW

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

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

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

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.
2. Respondent is placed on Probation for a period of six months with the following terms and conditions:

a. Continuing Medical Education

Respondent shall within 6 months of the effective date of this Order obtain no less than 10 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person course regarding medical recordkeeping and no less than 5 hours of Category I CME in cervical spine pain procedures. Respondent shall within **thirty days** of the effective date of this Order submit his request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. The Probation shall terminate upon Respondent's proof of successful completion of the CME.

RIGHT TO PETITION FOR REHEARING OR REVIEW

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

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

DATED AND EFFECTIVE this 8th day of April ,2020

ARIZONA MEDICAL BOARD

By _____ for
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed this 8th day of April, 2020 to:

David K. Tom, M.D.
Address of Record

Fredrick M. Cummings, Esq.
Dickenson Wright, PLLC
1850 North Central Avenue, Suite 1400
Phoenix, Arizona 85004
Attorney for Respondent

ORIGINAL of the foregoing filed
this 8th day of April, 2020 with:

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

Michelle Rubus
Board staff