IN AND BEFORE THE OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE AND SUPERVISION
STATE OF OKLAHOMA

STATE OF OKLAHOMA *ex rel.* The Oklahoma Board of Medical Licensure and Supervision,	)	
Plaintiff,	)	
vs.	)	Case No. 09-10-3861
STEVEN CONSTANTINE ANAGNOST, M.D., License No. 21194,	)	
Defendant.	)	

FIRST AMENDED COMPLAINT

COMES NOW the Plaintiff, the State of Oklahoma *ex rel.*, the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, Daniel B. Graves of the firm GRAVES MCLAIN PLLC, and for its First Amended Complaint against the Defendant, Steven Constantine Anagnost, M.D. ("Defendant" or "Dr. Anagnost"), alleges and states as follows:

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. §480 *et seq.*

2. Defendant, Dr. Anagnost, holds Oklahoma license No. 21194 and practices as an orthopedic surgeon in Tulsa, Oklahoma.

3. On information and belief, Defendant has engaged in gross or repeated negligence in the practice of medicine and surgery in violation of OAC 435:10-7-4(15).

4. On information and belief, Defendant has engaged in practice or other behavior that demonstrates an incapacity or incompetence to practice medicine and surgery in violation of OAC 435:10-7-4(18).

5. On information and belief, Defendant has made false, fraudulent, or deceptive statements in documents connected with the practice of medicine and surgery in violation of OAC 435:10-7-4(19).

6. On information and belief, Defendant has entered into adverse settlements arising from medical liability claims related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in OAC 435:10-7-4, in violation of subsection (34) thereof.

7. On information and belief, Defendant has failed to furnish the Board with information lawfully requested by the Board, *i.e.,* disclosure of known adverse settlements of medical malpractice cases. OAC 435:10-7-4(37)

The facts upon which Defendant's unprofessional conduct arise are, as follows:

QUALITY OF CARE/COMPETENCE

1. PATIENT DSM
(Competence: Paralysis with Dorsal Column Stimulator)

8. On or about May 16, 2008, Defendant performed surgery on Patient DSM to place a dorsal column stimulator ("DCS") used to induce paresthesia in patients with chronic pain. (Op Note, DSM 0091)

9. Proper installation of the device requires laminotomy or laminectomy at the appropriate anatomic level for insertion of the stimulator flat against the dorsal column of the spinal cord.

10. On information and belief, Defendant negligently anchored the proximal end of the paddle of the DCS device to the interspinous ligament, ***outside of the spinal canal.*** This caused the paddle to bend, resulting in continuous pressure to Patient DSM's spinal cord by the distal end of the paddle. (Detweiler, M.D. Dep. 41-45; Op. Rpt. DSM 00156; X-Ray Image SF South)

11. The pressure on Patient DSM's spinal cord by the DCS paddle caused severe damage to his spinal cord rendering Patient DSM a paraplegic and causing neurogenic bladder and bowel.

12. The paralysis of Patient DSM is part of a pattern of repeated negligence and demonstrates incompetence in the practice of surgery.

13. On information and belief, Defendant entered into an adverse settlement agreement with Patient DSM in Tulsa County District Court CJ-2008-7710.

2. PATIENT BOM
(Competence: Paralysis Posterior Laminectomy)

14. On or about July 27, 2011, Defendant performed surgery on Patient BOM. According to Defendant's operative report he performed L2-3, L3-4, and L4-5 partial hemilaminectomies with partial medial facetectomies and foraminotomies for decompression of dura and neural elements with use of an operating room microscope. (Op. Rpt. BOM 006)

15. When Patient BOM awoke from surgery she expressed severe pain and was "screaming help me." (Post Anesth. Rec. BOM 0018). She was medicated some sixteen (16) times with Versed, Morphine, or Dilaudid from 12:25 through 13:45 hours per Defendant's post-operative order. *Id.*

16. At 14:30 hours on July 27, 2011, she continued to say "help me," but was unable to follow commands or state what she needed. She was given Toradol and Dr. Anagnost was informed of her status. (Prog. Rec. BOM 0019)

17. At 16:20 hours Patient BOM told Defendant she was "feeling bad all over." She was unable to ambulate to the bathroom requiring the assistance of two personnel. (Prog. Rec. BOM 0019)

18. On information and belief, notwithstanding Patient BOM's pain and immobility, Defendant discharged her to home, which was an extended drive to a rural area, assisted by "caregivers x2." (Prog. Rec. BOM 0019)

19. On July 28, 2011, Patient BOM presented to Jane Phillips Hospital in Bartlesville, Oklahoma where it was noted that, "pt unable to stand." (BOM 0066)

20. On July 28, 2011, she was transported back to Hillcrest to Defendant's care whereupon Defendant belatedly reported that she was "able to stand" after her surgery, although no such notation of mobility exists in the previous medical record. (BOM 0128-129) Defendant also reported that Patient BOM fell at home when she got up to go to the bathroom after surgery. (BOM 0129) He further noted that she had some movement to her quadriceps, hamstrings, gastrocs, and EHL bilaterally. (BOM 0129)

21. After admission to a rehabilitation facility, Patient BOM underwent consultation with Clinton Baird, M.D. ("Dr. Baird"), who found "no movement in the lower extremities at the iliopsoas, quadriceps, hamstrings, tibialis anterior, gastroc, or extensor hallucis longus." Further, Dr. Baird noted that the EMG conduction study "was consistent with complete cauda equina disruption." He further found that, "It is clear by temporal relation, radiographic studies, EMG study, further clinical history, and physical examination that [Patient BOM] certainly sustained a severe catastrophic cauda equina injury ***at the time of her operative intervention."*** (BOM 0645)

22. On information and belief, Defendant caused Patient BOM to suffer a catastrophic iatrogenic surgical injury; and reports by Defendant in subsequent records reciting movement, ability to stand, are false, misleading, and intended to avoid responsibility for negligent injury to Defendant's patient.

23. On information and belief, Patient BOM's permanent paralysis of her lower extremities and neurogenic bladder and bowel were caused by a part of a pattern of repeated negligence and demonstrates incompetence in the practice of surgery.

3. PATIENT JTM
(Competence/Fraud: Nerve injury)

24. On September 21, 2009, Defendant performed surgery on Patient JTM. According to Defendant's operative report he performed the following procedures: a) L3-L4 bilateral lumbar hemilaminectomies with medial facetectomies and foraminotomies; b) Posterior lumbar

interbody fusion at L3-L4 with use of C-spine interbody cage device; c) Bilateral posterior spinal instrumentation using SpineFrontiers transpedical instrumentation screws at L3-L4; d) Posteriorlateral fusion at L3-L4 for completion of anterior and posterior column fusion through single posterior incision; e) Inspection of fusion at L2-L3; f) Attempted removal of deep hardware at L2-L3; and g) Intraoperative EMG and SSEP monitoring. (Op Note JTM 00336)

25. During the course of surgery Defendant claims to have attempted removal of Patient JTM's old hardware from a 1992 surgical fusion at L2-L3, but did not because, "the hardware was markedly encased in bone, making it actually dangerous for removal because of the marked impaction and bony growth around the hardware." He also claimed there was "some stripping of the hardware itself that was present along the edges of the locking bolts..." (Op Note JTM 00337)

26. During the course of fusing L3-L4, Defendant substituted definitive pedicle screws with facet screws because he had not removed the L2-L3 hardware, which he claimed was encased in bone.

27. On information and belief, Defendant did not achieve proper alignment of the facet screws because of the L2-L3 hardware, and drove one of the screws through Patient JTM's central spinal canal and into the L4 nerve root. (11-25-2009 CT Rpt. JTM 01360) On information and belief, Patient JTM developed a deep wound infection with a psoas abcess, which went undiagnosed and untreated for an extended time.

28. On December 11, 2009, Clinton Baird, M.D. re-operated on Patient JTM due to increasing lower back pain and inability to recover from Dr. Anagnost's surgery. He found that the right-sided facet screw "...traversed the spinal canal..." and "...appeared to pierce through the L4 nerve root and into the pedicle." (Op. Rpt. JTM 0444)

29. During the reoperation, Dr. Baird found that the L2-L3 hardware was not encased in bone and easily removed the hardware. (Op. Rpt. JTM 0444; Photo JTM 02146)

30. On information and belief, Dr. Anagnost caused Patient JTM to suffer iatrogenic surgical injury to his L4 nerve root and stenosis due to bone and graft material released into the spinal canal.

31. On information and belief, reports by Dr. Anagnost in his September 21, 2009 Operative Report that the L2-L3 hardware was encased in bone, and could not be removed, were false, fraudulent, and deceptive statements intended to excuse a rushed surgical procedure which resulted in injury to Patient JTM.

32. Patient JTM's injuries are caused by a pattern of repeated negligence and demonstrated incompetence in the practice of surgery.

4. PATIENT CWM
(Competence: Anterior Cervical Discectomy and Fusion-Death)

33. On August 1, 2008, Defendant performed surgery on Patient CWM. According to Defendant's operative report he performed the following procedures: a) C3 to C7 anterior cervical diskectomies with excision of the posterior longitudinal ligament and posterior vertebral body osteophytes for decompression of dura and neural elements with the use of the operating microscope; b) Intracervical interbody fusion, C3 to C7, with Danek Bioimplant device; c) Anterior cervical plating using Homedica Stryker anterior cervical plating system, C3 to C7; d) Right iliac crest bone marrow aspiration through a separate fascial incision; and e) Intraoperative EMG and SCPT monitoring while performing radial EMG by Dr. Kevin Klos, Neurologist. (Op Note CWM 0064)

34. After surgery at 20:30 hours, Patient CWM was noted to have "difficulty swallowing" his oral medications and "coughing and choking" and becoming short of breath. (CWM 0048)

35. On August 2, 2008, at 03:45 post-surgical day 2, Patient CWM was seen by Defendant and apparently told to remove the C-Collar and place ice directly upon his neck to help with swelling. (Phys. Note CWM 0018; NN 0049)

36. At 10:00 Patient CWM was noted to be "tolerating small sips of liquid with occasional episodes of spitting up." (CWM 0049) At 13:30 Patient CWM was discharged without further notation of assessment.

37. According to the pulmonologist consultation note dated August 5, 2008, Patient CWM,

> ***...was sent home...feeling really weak, had a problem eating with episode of choking on his food and also episode of cough and a significant degree of weakness.*** The day prior to admission, the patient started feeling more short of breath to a point that the family decided to call EMSA. However, the patient apparently initially refused and a few minutes later the patient's family felt that he was extremely short of breath, gasping for air and EMSA was called again and he was taken to the hospital. At the hospital he was noted to be in agonal breathing and attempts were made to initially intubate him. However he was noted to have a significant degree of ***pharyngeal edema*** and eventually he was intubated using a 7.0 endotracheal tube. (Cons. Note, CWM 0392)

38. Patient CWM went into cardiopulmonary arrest after intubation and suffered anoxic brain injury.

39. On August 8, 2008, Patient CWM was determined brain dead, extubated, and allowed to die.

40. On information and belief, Defendant failed to properly evaluate the Patient CWM, prematurely discharging him from SouthCrest while exhibiting dangerous signs and symptoms of laryngeal and/or pharyngeal edema.

41. On information and belief, Defendant failed to clear anterior osteophytes on the vertebral bodies at or near the C3 level before installing the Howmedica Stryker anterior cervical plating system. On information and belief, this configuration caused the plate to impinge upon Patient CWM's esophagus, causing aspiration and death.

42. On information and belief, the death of Patient CWM is part of a pattern of repeated negligence and demonstrates incompetence in the practice of surgery.

5. PATIENT EJM
(Competence: Anterior Cervical Discectomy and Fusion-Anoxic Brain Injury)

43. On August 18, 2008, ten days after Patient CWM died at SouthCrest, Defendant performed a similar surgery on Patient EJM at Hillcrest with a similar result. According to Defendant's operative report he performed the following procedures: a) Anterior cervical decompressions with discectomies and bilateral foraminotomies and excision of posterior longitudinal ligament at C5-C6 with use of operating room microscope; b) Anterior cervical interbody fusion using Danek bioimplant device at C5-C6; c) Anterior cervical plating using Howmedica Stryker anterior cervical plating system at C5-C6; d) Right iliac crest bone marrow aspiration through a separate incision along right iliac wing; e) Intraoperative EMG and SSEP monitoring with performing and reading by Dr. Kevin Klos, Neurologist. (Op. Rpt. 08-18-2008, EJM 0381-0383)

44. Patient EJM deteriorated over the two hours following his surgery, ultimately requiring a Code Blue.

45. The events leading to the Code Blue are described by neurologist Jerome Wade, M.D., as follows:

> Two hours after the event [surgery], his wife states she noticed that ***he started to have problems with coughing*** though he was talking and requesting something to eat. This ***became progressively worse,*** at which point the diagnoses [*sic*] was notified. He ***continued to have more difficulty and it was felt that the patient became less responsive*** and emergency code was requested at which point, the patient had a blue tongue according to his wife. Subsequently there was ***a large hematoma*** that was attempted [*sic*] to intubate him, which was less unsuccessful [*sic*] and then he underwent an emergency airway through cricothyroid membrane. [Emphasis supplied] (Wade, M.D. Consult Report, EJM 0255)

46. Responding to the Code Blue, anesthesiologist Mark Halterman, M.D., attempted intubation, noting, "Multiple laryngoscopic attempts at intubation unsuccessful...***massive supraglottic edema*** no visualization of glottic structures." (Op. Progress Notes, EJM 0271)

47. Responding to the Code Blue, general surgeon Eugene Dickens, M.D., performed an emergency tracheostomy, and noted ***"large hematoma*** with open ACDF incision." (Op. Prog. Note 08-18-08, EJM 0269) He further reported, as follows:

> Upon entering the patient's hospital room, full cardiopulmonary resuscitation was undergoing. The patient had no airway. He was being masked with saturations running in the 80's. He initially had no pulse and no chest compressions were being performed. The previous cervical disc fusion had been opened. ***Hematoma had been evacuated.*** There was some staining about the inferior and superior skin flaps consistent with some element of hematoma. [Emphasis supplied] (Dickens, M.D. Op. Note, EJM 0384)

48. Defendant's discharge summary, reads, in pertinent part, as follows:

> He had ***sudden onset of difficulty breathing*** and was emergently trach'd on the floor. While ***in the operating room,*** he ***did not have any large hematoma*** with compressive effect but upon intubation, he had ***severe laryngeal spasm*** according to anesthesia who attempted immediate intubation. (Disch. Summ., EJM 020)

49. On information and belief, Patient EJM suffered a ***progressive airway obstruction*** due to a "large hematoma" and "massive supraglottic edema."

50. On information and belief, Defendant's recitation in his discharge summary to the contrary, *i.e.,* "sudden onset," no "large hematoma, and "laryngeal spasm," is misleading.

51. On information and belief, Defendant failed to properly evaluate and monitor his patient post-operatively, and to respond in a timely manner to an emergent scenario.

52. Patient EJM's ACDF surgery occurred within weeks of Patient CWM's ACDF surgery – both by Defendant and both resulting in grievous patient injury and Patient CWM's death.

53. Patient EJM suffered an anoxic brain injury causing permanent and profound disability with poor prognosis.

54. On information and belief, Patient EJM's brain damage was caused by a pattern of repeated negligence and demonstrates incompetence in the practice of surgery.

6. PATIENT MGM
(Competence: Paralysis/Fraud)

55. On February 15, 2008, Defendant performed surgery on Patient MGM at Southcrest Hospital. According to Defendant's operative report he performed "Revision lumbar hemilaminectomies with medial facetectomies and foraminotomies at L3-4 and L4-5 for decompression or [*sic*] dura and neural elements." (Op. Rpt. MGM 436)

56. After surgery, Defendant described that Patient MGM was "noted to have some weakness into her leg and she was monitored closely and failed to improve in the recovery room during the immediate postoperative period." (Op. Rpt. 2, MGM 439) The Patient Notes entered by the recovery room nurse after the surgery describe a more serious scenario of "No movement or response in bilat [bilateral] lower extrem [extremities]...twitching noted in lt [left] foot, state still no feeling in feet." (Nurse Note MGM 613)

57. Defendant returned Patient MGM back to the operating room with a Preoperative Diagnosis of "Postoperative weakness to right lower extremity." According to his operative report he found "no severe amount of hematoma" and "laminectomies were widened bilaterally at L3-4 and L4-5." He also "accidentally created" a "durotomy" around the "dorsum of the dura around L3-4 level," requiring glue and suturing to repair. (Op. Rpt. MGM 439, 440)

58. Patient MGM attempted rehabilitation, but returned to Hillcrest on February 22, 2008 where Dr. Anagnost noted, "she has been unable to participate due to continued bilateral lower extremity weakness and severe pain." In the same report, Dr. Anagnost notes that, "She is ***unable to move either lower extremity at the time of my examination below the left [sic] of L2.***" (H&P MGM 302)

59. On March 7, 2008, she was noted to have developed ***post-surgical urinary incontinence and decreased bowel motility,*** indicative of cauda equina injury during infectious disease consult. (Okwuasaba Cons. Rpt. MGM 276)

60. Patient MGM did have return of some sensation to her legs, but is wheelchair bound .

61. On September 9, 2009, Clinton Baird, M.D., a minimally invasive spine surgeon, ordered a CT on Patient MGM which revealed that no surgical procedure had been performed at the L4-5 level, in contravention to Defendant's operative report. (09-09-09 CT)

62. On information and belief, Defendant's incompetent surgical technique caused Patient MGM to suffer nerve injury to her cauda equina, and caused paralysis of her lower extremities.

63. On information and belief, Dr. Anagnost did not perform an L4-5 hemilaminectomy, or other related surgical procedures at the L4-5 levels, resulting in a false, fraudulent, and deceptive Operative Note.

64. On information and belief, Patient MGM's cauda equina injury was caused by a pattern of repeated negligence and demonstrates incompetence in the practice of surgery.

7. PATIENT AKM
(Competence: Graft Extrusion/Neurological injury)

65. On or about March 29, 2007, Defendant performed revision surgery on Patient AKM, a 35 year-old female. According to his Operative Report, Defendant performed: a) Revision lumbar hemilaminectomies with medial facetectomies and foraminotomies bilaterally with complete facetectomies along the left and medial facetectomies along the right at L4-L5 for complete decompression of dura and neural elements with the use of operating room microscope; b) Revision discectomy at L4-L5 secondary to recurrent herniated nucleus pulposus with use of operating room microscope; c) Transforaminal interbody fusion using Howmedica Stryker interbody cage device at L4-L5; d) Posterior spinal pedicle screw instrumentation at L4-L5; and e) Posterolateral fusion at L4-L5 for completion of anterior and posterior column fusion through single posterior incision. (Op. Note. AKM 0349)

66. After surgery, Patient AKM developed severe radiculopathy in her lower left extremity.

67. On May 4, 2007, Patient AKM underwent MRI study which revealed, "Extremely large central, left paracentral, and lateral disk herniation is present, creating marked mass affect upon the spinal canal, thecal sac, and left neural foramen with only abutment of the left nerve root identified." (MRI Read, AKM 0124)

68. On May 9, 2007, Dr. Anagnost reviewed these films and found, "The MRI does show ***extrusion of graph [sic] material*** and the implant appears to be in place. This will require a decompression due to the ***large nature of the extrusion of the material, which is impinging along the nerve and the dura at the L4-5 space***...This is ***not an emergency,*** but I do think it should be handled urgently in nature." (Office Note, AKM 0126) Dr. Anagnost attributed the extrusion of graft material to his patient vomiting when she had the flu. (Op. Note AKM 0579)

69. On May 11, 2007, a week after the MRI read which showed the large extrusion of graft material in Patient AKM's interspace, Dr. Anagnost performed surgery and removed the extruded graft material. (Op. Note AKM 0578-0580)

70. On September 12, 2007, Dr. Anagnost operated again on Patient AKM because the pain, radiculopathy and extremity weakness did not resolve. (Op. Note AKM 0222-0223) This surgery did not resolve Patient AKM's neurological injuries.

71. On information and belief, Patient AKM suffered permanent injury as a result of the extrusion of graft material.

72. On information and belief, Patient AKM's neurological injury due to graft extrusion was caused by a pattern of repeated negligence and demonstrates incompetence in the practice of surgery.

8. PATIENT TRM
(Competence: Graft Extrusion/Cauda Equina)

73. On September 16, 2008, Patient TRM, a then-48-year-old female, underwent an MRI and was diagnosed with, "L4-5: ***Mild disc bulge*** and severe facet osteoarthritis. Partial effacement of the ventral thecal sac with ***mild central canal stenosis measuring 0.9 cm AP.*** Bilateral subarticular recess stenosis. ***Mild bilateral foraminal stenosis.***" (MRI Rpt., TRM 01077)

74. On November 17, 2008, Defendant performed surgery on Patient TRM. According to his operative report he performed: a) Lumbar hemilaminectimes with medial facetectomies, foraminotomies at L4-L5 for decompression of dura and neural elements with use of operating room microscope; b) Posterior lumbar interbody fusion at L4-L5 with the use of bone mesh interbody device at L4-L5; c) Posterior spinal transpedicle instrumentation using Spine Frontiers transpedicle instrumentation at L4-L5; d) Posterolateral fusion at L4-L5 for completion of anterior and posterior column fusion through single posterior incision; e) Intraoperative EMG and SSEP monitoring with performing and reading EMG by Dr. Hastings, neurologist. (Op. Note, TRM 1098-1099)

75. Defendant reported in his operative note, "There was ***severe stenosis noted across the L4-L5 level*** with ligamentum flavum hypertrophy and facet hypertrophy causing both central canal foraminal stenoses...The dura was carefully retracted minimally to expose the disc space which revealed ***significant disc herniation.***" (Op. Note, TRM 01098)

76. Dr. Anagnost further noted, "There was very little normal disc material found across the L4-L5 level. Excellent decompression was obtained and the restoration of foraminal height was verified. The ***mesh interbody device was carefully inserted and packed with bone*** with excellent distraction across the interspace and this added immediate stability to ***the lumbar spine and was packed with also autologous bone as well as bone bank bone along the interspace to complete the interbody fusion.***" (Op. Note, TRM 1098-1099)

77. On November 18, 2008, Dr. Anagnost discharged Patient TRM. On November 23, 2008, Patient TRM reported "some complaints of ***urinary incontinence...***" but Dr. Anagnost further noted, "She is ***completely neurologically intact by our conversation over the phone...***" (Office Note, TRM 01103)

78. On November 29, 2008, upon Patient TRM's return to Hillcrest Medical Center, Defendant noted ***"urinary incontinence*** requiring a diaper...constipation...***decreased sensation perianally...burning dysesthesias*** to the dorsum of her right foot and ***unsteadiness of gait."*** (History and Physical, TRM 0572)

79. Also on November 29, 2008, an MRI was obtained showing "what appears to be a ***very large disc fragment within the right side of the spinal canal at the L4-L5 level.***" (CT Read TRM 0623) Defendant ordered Decadron administration but did not reoperate.

80. On December 1, 2008, Patient TRM's condition deteriorated further, developing "acute cauda equina syndrome today with urinary and rectal incontinence. MRI scan was consistent with ***extruded graft material resulting in severe cauda equina syndrome.***" (Op. Note, TRM 069)

81. Dr. Anagnost's partner, Greg L. Wilson, D.O., performed surgery to decompress the dural sac at L4-L5 and found ***"a significant amount of graft material including mesh..."*** (Op. Note, TRM 069)

82. Patient TRM's cauda equina syndrome resolved temporarily but returned when the graft material placed by Defendant's partner extruded requiring another revision surgery by Defendant on December 15, 2008.

83. Patient TRM's cauda equina symptoms and related pain and numbness did not resolve and she suffered permanent neurological injury.

84. On information and belief, and as shown herein, Defendant's patients have suffered repeatedly from extrusion of graft material causing permanent and serious neurological harm.

85. On information and belief, Patient TRM's neurological injury due to graft extrusion was caused by a pattern of repeated negligence and demonstrates incompetence in the practice of surgery.

9. PATIENT LHM
(Competence: Graft Extrusion/Cauda Equina)

86. On February 27, 2009, Defendant caused Patient LHM to undergo MRI to diagnose the cause of back and buttock pain. The MRI read, in pertinent part: "L4-5 reveals primarily left lateral diffuse disk bulge. The posterior component does not significantly narrow the spinal canal. The neural formamen are narrowed bilaterally." (MRI, LHM 0567)

87. On March 4, 2009, Defendant performed surgery on Patient LHM. According to his operative report he performed: a) Lumbar L4-L5 hemilaminectomy with medial facetectomy, and foraminotomy with discectomy for decompression of dura and neural elements with use of operating room microscope; b) Posterior lumbar interbody fusion at L4-L5 using SpineFrontier interbody cage device; c) Posterior spinal instrumentation bilaterally through separate fascial incisions with use of SpineFrontier transpedicle instrumentation screws at L4-L5; d) Posterolateral fusion at L4-L5 for completion of anterior and posterior column fusion through a single posterior incision; and e) Intraoperative EMG and SSEP monitoring. (Op. Note, 0485-0488)

88. Defendant described placement of the graft material during the surgery, as follows:

> Posterior lumbar interbody fusion was carried out using the Spine Frontiers interbody cage device. Ring curettes were used to prepare the endplates in a parallel fashion. Distraction was carried

> out across the interspace to help restore foraminal height and lordosis until proper fit was obtained once trial instrumentation was verified by palpation and visualization. Again, complete irrigation solution was used to irrigate wound. ***Demineralized bone matrix as well as local bone and bone-bank-bone were carefully packed along the interspace at L5-S1 followed by properly sized Spine Frontiers interbody cage device.*** The cage device was placed along the posterior third of the vertebral body ***to prevent any extrusion of any graft material*** and overall improvement in formaminal height and lordosis of the lumbar spine immediately supply support to the anterior column and improved overall stability. [Emphasis supplied] (Op. Note, LHM 0487)

89. At **22:05 hours on March 22, 2009,** Patient LHM presented to Hillcrest ER. The triage note states, "Back surgery 2 or 3 weeks ago. States ***he can't feel from the waist down."*** (ER Nurse Assess., LHM 0244)

90. At **22:00 hours on March 22, 2009,** Defendant was called and made aware of Patient LHM's status. (Op. Note, LHM 085, ¶1) An immediate MRI was ordered.

91. At **23:05 hours on March 22, 2009,** an MRI was taken with the read showing, as follows:

> There is a large low signal intensity ***structure extending posteriorly from the disc space resulting in severe spinal stenosis.*** This is broad-based and extends from left paracentral to right paracentral...OPINION: At the level of the L4-L5 disc implant there is a ***posterior protruding structure that may be made of disc material or disc implant material resulting in severe spinal stenosis.*** [Emphasis supplied] (MRI, LHM 0284-0285)

92. On information and belief, rather than emergently operating on Patient LHM to relieve his "cauda equina-type symptoms," Defendant delayed surgery until after he completed ***his scheduled operations on March 23, 2009.***

93. At approximately **14:00 hours on March 23, 2009,** Defendant performed surgery on Patient LHM, writing in his operative report, as follow:

> There was ***graft that was immediately identified that extruded into the canal*** and was carefully removed...The ***extruded interbody device*** was also carefully removed with little-to-no retraction required along the dura and neural elements. [Emphasis supplied](Op. Note, LHM 085)

94. Patient LHM was left with a neurogenic bladder requiring self-catheterization, lower extremity weakness requiring the use of a cane to ambulate, and burning pain in both legs. (Detwiler Note, LHM 0635-0638)

95. On September 9, 2009, Karl Detwiler, MD performed another revision surgery to alleviate Patient LHM's continued symptoms. He found that, once again, Defendant's surgery had failed causing ***"retropulsed bone and retropulsed graft system at L4-L5"*** and ***"no evidence of fusion"*** at the L4-L5 level. (Detwiler Op. Note, LHM 0622-0624)

96. On information and belief, Defendant wrongly and improperly delayed surgery on Patient LHM under emergent conditions, causing additional harm, pain, and suffering.

97. On information and belief, and as shown herein, Dr. Anagnost patients have suffered repeatedly from extrusion of graft material causing permanent and serious neurological harm.

98. On information and belief, Patient LHM's neurological injury due to graft extrusion was caused by a pattern of repeated negligence and demonstrates incompetence in the practice of surgery.

10. PATIENT JCM
(Competence/Adverse Settlement: Danek Satellite)

99. On information and belief, in or around 2005, Defendant became involved with a manufacturer of a disk spacing system commonly referred to as the Medtronic Sofamor Danek Satellite Interdiscal Stabilization Sphere ("Danek Satellite"). This Danek Satellite is essentially a ball bearing which Defendant inserts into the disk interspace. It was pulled from the market in or around 2007.

100. On information and belief, the Danek Satellite was approved only for anterior or lateral insertion, and with fusion. No posterior insertion was approved. No "motion sparing" use without fusion was approved. (FDA Warning ltr. dtd. 10-01-2007)

101. On information and belief, Defendant was involved in Medtronic's pilot study of the device and was involved in the FDA study panel for the device and knew, or should have known, of limitations for its use. (*Cf.* Anag. Dep. 34:11-18) Further, Defendant was a paid consultant for Medtronic and performed between 10 and 20 promotional lectures and instructional labs for Medtronic in places such as the Bahama islands. (Anag. Dep. 36:7 – 37:3)

102. On or about October 31, 2005, Defendant caused an MRI to be performed on Patient JCM which showed, in pertinent part, "There is moderate broad based disc protrusion at the L5/S1 level. There is thought to be some extrusion of disc material along the posterior aspect of the L5 vertebral body. There is mild impingement on the thecal sac." (MRI, JCM 0184)

103. On November 20, 2005, Defendant recommended surgery with the Danek Satellite based upon the MRI results and "pain related weakness in the right lower extremity and tenderness with facet loading bilaterally in the lumbar spine." (H&P, JCM 0343)

104. On November 22, 2005, Defendant performed surgery using a 14mm Danek Satellite with a ***posterior approach.*** (Op. Rpt., JCM 0355) Defendant described the procedure, in pertinent part, as follows:

> Interbody fusion was then carried out by using the satellite interbody fusion device from fusion stabilization device from Danek. Slow, steady, and sequential paddle distraction instrumentation was carried out across the interspace at L5-S1. Paddle distraction instrumentation was also used to facilitate this until appropriate sized implant was obtained. A size 13 trial was inserted, and a curet was used to curettage the end plate. Bone graft was carefully packed along the ***interior aspect of the anterior longitudinal ligament, and a size 14mm satellite interbody stabilization fusion device was inserted and it was well recessed.*** The entire construct fit very well within the recess of the nuclear sulcus and was very stable upon intraoperative testing. [Emphasis supplied] (Op. Rpt., JCM 0356)

No posterior fusion material was used; no interbody cage device was used; and no external fixation was used. On information and belief, Defendant used the device in a "motion sparing" capacity, without proper fusion, in contravention to the FDA approved use of the device.

105. On December 5, 2005, Patient JCM returned to Defendant's office after she felt a "pop" in her lower back while performing physical therapy causing increased leg pain. (H&P, JCM 0216; Office Note, JCM 095) Defendant describes "some moderate collapse" in the L5-S1 area and decided to perform "interbody stabilization with pedicle screw instrumentation at L5-S1." *Id.*

106. On December 9, 2007, Defendant performed this repeat lumbar surgery on Patient JCM because, "She developed facet arthropathy and collapse around the ***motion-sparing device*** and presented for definitive stabilization with interbody fusion and posterolateral fusion with pedicle screw fixation." (Op. Note, JCM 0228)

107. During the December 9, 2007, surgery Defendant attempted to remove the Danek Satellite, but ended up pushing it deeper into the intervertebral space, as follows:

> There was ***collapse around the device,*** but it was extremely stable and in fact ***attempts were made to remove the motion-sparing interbody device,*** which was extremely stable. It was deemed to reposition the device anteriorly rather than use this as the interbody distractor and stabilizer ***rather than cause any harm by removing it around the end plate***...The area was irrigated using 2 L [liters]

> of bacitracin solution and the entire interspace was then carefully packed with bone graft...Pedicle screw fixation was then carried out using the Danek Legacy pedicle screw instrumentation... [Emphasis supplied] (Op. Note, JCM 0229)

108. The December 9, 2007 revision surgery failed to offer Patient JCM any relief from the pain occurring after collapse around the Danek Satellite.

109. On June 30, 2009, R. Tyler Boone, MD performed another revision surgery finding "very minimal fusion of bone" at L5-S1. He revised Defendant's work, replacing the instrumentation. (Op. Note, JCM 0209).

110. On information and belief, Defendant was involved in the original FDA trials with the Danek Satellite device and was compensated by the manufacturer of the Danek device to teach its use.

111. Defendant knew, or should have known, that: a) posterior insertion of the Danek Satellite device caused high risk of nerve injury; b) that this operative method contravened FDA approval; c) use of the device in a motion sparing manner, without posterior grafting was dangerous; and d) that the FDA had not approved the device without grafting for fusion.

112. On information and belief, Patient JCM's neurological injury was caused by Defendant's pattern of negligence and demonstrates incompetence in the practice of surgery by, *inter alia,* using the Danek Satellite in an unsafe and unapproved manner, and otherwise using surgical techniques resulting in neurological injury.

113. On information and belief, Defendant entered into an adverse settlement agreement with Patient JCM in Tulsa County District Court Case No. CJ-2008-8954.

11. PATIENT RMM
(Competence: Danek Satellite/Cauda Equina)

114. On or about November 11, 2005, Patient RMM underwent an MRI study that showed, in pertinent part, "L4-5 broad-based disk bulge with large central disk spur complex and protrusion causing moderate to severe central canal stenosis. Annular disk tear at L4-5." (MRI, RMM 0546)

115. On January 16, 2006, Defendant performed surgery on Patient RMM. According to his Operative Report, he performed the following procedures: a) Lumbar laminectomies with medial facetectomies and foraminotomies bilaterally for decompression of dura and neural elements at L4-5 with use of the operating room microscope; b) Discectomies at L4-5; and c) Posterior lumbar fusion and stabilization with Danek-satellite interbody fusion and stabilization at L4-5.

116. During the January 16, 2006 surgery, Defendant placed the Danek-satellite device, in the manner described in his Operative Note, as follows:

> Slow, steady paddle distraction instrumentation was across the interspace at L4-5 to restore the normal foraminal height and lordosis. Instrumentation was used also to gently distract the interspace in preparation for the ***interbody fusion*** and stabilization. Excellent fit was obtained with final trial instrumentation and a final implant was inserted across L4-5 level which restored the normal foraminal height and lordosis. [Emphasis supplied] (Op. Note, RMM 0130)

On information and belief, Defendant did not use bone graft material to create "fusion."

117. When Patient RMM awakened in recovery, "he slowly began to have progressive symptoms of worsening weakness to his lower extremities and dysesthesias. Despite observation he did not improve with his symptoms and was returned back to the OR for inspection of his wound for suspicion of hematoma or compression postoperatively." (Op. Note 2, 01-16-2006, RMM 0139) No hematoma or compression were found.

118. When Patient RMM awakened in recovery the second time his cauda equina symptoms continued, described as, "decreased sensation to his scrotum and penis as well as to his extensor hallucis longus (EHL) weakness." (Discharge Summ., RMM 0028) He also suffered with "lower extremity weakness and bowel and bladder symptoms..." *Id.*

119. Defendant denied that Patient RMM's cauda equina syndrome was caused by iatrogenic injury. Rather, Defendant theorized that Patient RMM had "postoperative thoracic cord infarct." (Discharge Summ., RMM 0028) This diagnosis persisted even though a post-operative thoracic MRI ordered on January 18, 2006 showed "The thoracic spinal cord shows normal signal and morphology." (MRI Rpt., RMM 0175) Further, an EMG performed on April 17, 2006 showed, as follows:

> Conclusions: Abnormal study. Electrodiagnostically consistent with ***severe bilateral L5S1 radiculopathy.*** Nerve pathology is lower motor neuron, proximal to the dorsal root ganglion. ***L5S1 nerve root (ventral root) axonal loss is severe***...Clinically, ***the patient's presentation is not consistent with upper motor neuron pathology (e.g. spinal cord infarct).*** [Emphasis supplied] (EMG, RMM 01384)

120. On information and belief, Defendant caused injury to Patient RMM and sought to avoid responsibility for an iatrogenic injury by proposing and sponsoring an unsubstantiated diagnosis to the detriment of the patient.

121. On information and belief, Defendant was involved in the original FDA trials with the Danek Satellite device and was compensated by the manufacturer of the Danek device to teach its use.

122. Defendant knew, or should have known, that: a) posterior insertion of the Danek Satellite device caused high risk of nerve injury; b) that this operative method contravened FDA approval; c) use of the device in a motion sparing manner, without grafting for fusion was dangerous; and d) that the FDA had approved the device only in connection with grafting for fusion.

123. On information and belief, Patient RMM's neurological injury was caused by Defendant's pattern of negligence and demonstrates incompetence in the practice of surgery by, *inter alia,* using the Danek Satellite in an unsafe and unapproved manner, and otherwise using surgical techniques resulting in neurological injury.

12. PATIENT PGM
(Competence/Adverse Settlement: Danek Satellite)

124. On October 16, 2006, Defendant caused Patient PGM to undergo MRI imaging which showed, in pertinent part, "***No central canal stenosis*** or ***significant neural foraminal narrowing*** is identified...1. L4/L5 ***mild diffuse disc bulge*** with flattening of the anterior thecal sac and mild facet arthropathy. 2. ***L5/S1 mild diffuse disc bulge*** with a ***small central disc protrusion.*** Increased T2 signal in the posterior portion of the disc/protrusion ***may represent a small annular disc tear."*** (MRI, PGM 092)

125. On October 30, 2006, Defendant reviewed the MRI and found "MRI shows ***severe collapse with herniation and disk dehydration at L5-S1."*** (H&P, PGM 0114)

126. On November 3, 2006, Defendant performed surgery. Once again he utilized the Danek Satellite in a manner wholly inconsistent with its FDA approval, describing a posterior approach surgery with no bone graft material used. The operative note reads, in pertinent part, as follows:

> With again 80% loss of the nuclear material across the disc space was confirmed [*sic*]. Dilation was carried out across the interspace, it was performed with little-to-no retraction required along the exiting and transversing nerve root. Trial instrumentation was inserted sequentially up to a size 14mm trial which gave excellent fit and restored the normal foraminal height and lordosis. The trial was removed and the area was irrigated using 2 liters of bacitracin solution. Care was taken to protect the media facet and 14-mm satellite interbody stabilization device was inserted across the L5-S1 interspace. (Op. Note, PGM 0132-0134)

On information and belief, no bone graft material was used in the procedure; and the same was performed through a posterior approach, in a "motion sparing non-fusion" manner. (*Cf.* FDA Warning ltr. dtd. 10-01-07)

127. On March 16, 2007, due to Patient PGM's intractable post-surgical pain, she required revision surgery to remove the Danek Satellite device and fusion with an interbody cage. (Op. Note, PGM 0261-0263)

128. On information and belief, Defendant was involved in the original FDA trials with the Danek Satellite device and was compensated by the manufacturer of the Danek device to teach its use.

129. Defendant knew, or should have known, that: a) posterior insertion of the Danek Satellite device caused high risk of nerve injury; b) that this operative method contravened FDA approval; c) use of the device in a motion sparing manner, without grafting was dangerous; and d) that the FDA had not approved the device only in connection with grafting to avoid neurological injury to patients.

130. On information and belief, Patient PGM's neurological injury was caused by Defendant's pattern of negligence and demonstrates incompetence in the practice of surgery by, *inter alia,* using the Danek Satellite in an unsafe and unapproved manner, and otherwise using surgical techniques resulting in neurological injury.

131. On information and belief, Defendant entered into an adverse settlement with Patient PGM in Tulsa County District Court Case No. CJ-2008-7694.

13. PATIENT ABM
(Competence/*Unreported* Adverse Settlement: Danek Satellite)

132. On January 17, 2007, Patient ABM underwent an MRI ordered by Defendant due to sciatic nerve pain. The pertinent findings were, as follows: "L5-S1: There is a mild broad based disc bulge greater than expected for age primarily on the left with mild inferior neural foraminal narrowing primarily in the distal neural foramen." (MRI, ABM 096)

133. On January 29, 2007, Defendant referred Patient ABM to Dr. Jean Bernard for lumbar epidural steroid injection as a result of, "low back pain radiating to her lower extremities." (Off. Note, ABM 052) At that appointment, Patient ABM denied "abdominal pain, nausea, vomiting, diarrhea, and constipation. The patient denies bowel and bladder incontinence." *Id.*

134. When Patient ABM's pain did not improve with the steroid injection, Defendant recommended surgery using the Danek Satellite.

135. On February 12, 2007, Defendant performed surgery on Patient ABM. Once again, Defendant did not note use of fusion material and he inserted the Danek Satellite posteriorly, as follows:

> Interbody stabilization was then carried out by preparing the end plates. Paddle distraction instrumentation was carried out across the L5-S1 level. Little to no retraction was required along the

> exiting and traversing nerve roots as well as the central dura with use of the smooth edged paddle instrumentation, which again restored the foraminal height. Trial instrumentation was carefully inserted with a size 13mm trial placed with excellent restoration of the height and lordosis of the lumbar spine across L5-S1...Once this was verified, irrigation solution was used to irrigate the interspace as well as the entire wound and a 13mm Danek satellite motion preserving interbody stabilization device was then inserted across the L5-S1 level. (Op. Note, ABM 0465)

136. On February 12, 2007, when Patient ABM awoke from surgery, she reported, in pertinent part, as follows:

a. 02-12-07 15:00: ***Tingling lower extremities*** "Pt. states it is worse than before surgery;"

b. 02-12-07 20:00: ***bladder accident;***

c. 02-12-07 20:10: pt states ***not able to feel urge to void,*** just goes to bathroom and "hears the urine come out". Occasional incontinence.

> Parasthesia numbness lower extremities mild. Tingling lower extremities. Pt. states it is worse than before surgery, reports "needle like" sensations with touching the bottom of feet, and starts from bottom all the way to feet, was not pre op.

d. 02-13-07: 06:50: very upset. ***can't control her bladder changed linen and had accident 3 times in one hour*** [Emphasis supplied] (D/C Assess., ABM 0494-0501)

137. On February 13, 2007, at 07:15 Defendant notes "c/o labial numbness [decreased] bladder control...rectal + tone but weak & labial [reduced] sensation but not numb" (Prog. Note, ABM 0458) Defendant ordered an MRI for Patient ABM.

138. The February 13, 2007, 09:14 MRI read recites, in pertinent part, as follows:

> Recent postoperative changes seen at the L5-S1 level. There is a rounded circular device seen within the right lateral aspect of the L5-S1 disc space. ***Mixed intensity signal changes are seen within the anterior aspect of the spinal canal at the operative level*** which may represent ***small postoperative hematoma.*** These changes may be within acceptable limits for recent postoperative status. [Emphasis supplied] (MRI, 0477)

139. On February 13, 2007, at 14:12, notwithstanding Patient ABM's cauda equina symptoms and MRI findings, she was discharged to home.

140. On February 19, 2007, Patient ABM returned to Hillcrest due to severe headaches, continued incontinence, reduced sphincter sensation, nausea, and vomiting. Defendant's first History & Physical recites that after Patient ABM's 02/12/2007 surgery, "She was discharged the following morning ***without difficulty. Upon arriving home, she describes that she had a tingling sensation in her buttock and also in her vaginal region.*** She has had ***incontinence of the bladder several times since her surgery.*** She describes yesterday evening she developed headache that has been an 8/10 throughout the evening." (H&P, ABM 0248-0249; *Cf.* D/C Assess., ABM 0494-0501, *supra.*)

141. On February 19, 2007, Defendant dictated a second History & Physical, he included in his differential Patient ABM having suffered a ***thoracic cord infarct*** – the same diagnosis Defendant wrongly made of ***Patient RMM*** the year before when he awoke with the same symptoms. Defendant further speculated that Patient ABM's acute post-surgical symptoms were due to ***multiple sclerosis*** and ordered a full work-up and consult by a neurologist. (H&P, ABM 0250-0252) Patient ABM's neurologist, selected by Defendant, was immediately skeptical of this diagnosis, noting at the first office visit, as follows:

> She has additionally had problems with ***bladder control as well as bowels...***
>
> In addition to this she had some parasthesia or she has some weakness involving her right hand. This also ***occurred following surgery.*** An MRI scan subsequently showed a single hyperintense lesion, raising the possibility of MS is an explanation for these symptoms.
>
> IMPRESSION: This patient presents with symptoms that are ***very suggestive of lower motor neuron issue*** although she did have minimal hyperreflexia at the knees. I think the most important thing is to rule in or out the possibility of ***multiple sclerosis. I suspect she does not have this disease and I have told her such.*** [Emphasis supplied] (Off. Note, B 0673)

142. As with Patient RMM, *supra,* Defendant's "thoracic cord infarct" theory for Patient ABM was ruled out by MRI. (MRI 2-20-07, ABM 0280) Although a single small lesion was found on ABM's brain, an EMG showed that Patient ABM's problems were due to "Severe radicular fashion active denervating process in bilateral L5 S1 distribution. Lumbosacral radiculopathies, Cauda Equina abnormalities can give rise to similar picture." (EMG Rpt., Box 0662) Upon reviewing these results, Patient ABM's neurologist found, as follows:

> IMPRESSION: This patient has ***symptoms that are most consistent with a lower motor neuron problem*** rather than

multiple sclerosis...I would recommend ***no further workup for MS*** at this time...[Emphasis supplied] (Off. Note, B 0675)

143. On February 20, 2007, Patient ABM underwent surgery at Hillcrest Medical Center to inspect her surgical wound and to determine if she had an abcess, a CFS leak, or some other cause of the severe headache, pain, and dysesthesia. Defendant found and drained a seroma. (Op. Note, ABM 0269)

144. On March 4, 2007, Patient ABM once again returned to Hillcrest Medical Center for further wound drainage. In his Operative Note, Defendant recites Patient ABM's post-operative symptoms from her 2-12-2007 surgery and then falsely states, "she was found to have multiple sclerosis." (Op. Note, ABM 0144)

145. On March 4, 2007, Defendant found Patient ABM's dural tear that had apparently been missed, or caused, during the February 20, 2007 surgery. (Op. Note, ABM 0145)

146. By March 15, 2007, Patient ABM's wounds had dehisced and "The multiple sutures that were retaining the wound have come loose." (Photos)

147. On June 15, 2007, Patient ABM had undergone further MRI imaging under the direction of a neurosurgeon who found that, "Her MRI shows that the Fernstrom [Danek Satellite] ball ***has migrated to the spinal canal.*** (Main Prog. Note, ABM 0658)

148. On June 21, 2007, due to the Danek Satellite's migration to her spinal canal, and Patient ABM's continued compromised ability to ambulate, her dysesthesias, and incontinence, she underwent surgery by John Main, D.O. to remove the Danek Satellite from Patient ABM's spinal canal (Op. Note, ABM 0544)

149. On information and belief, Defendant diagnosed Patient ABM with multiple sclerosis without cause in order to avoid responsibility for iatrogenic injury to the patient.

150. On information and belief, Defendant was involved in the original FDA trials with the Danek Satellite device and was compensated by the manufacturer of the Danek device to teach its use.

151. Defendant knew, or should have known, that: a) posterior insertion of the Danek Satellite device caused high risk of nerve injury; b) that this operative method contravened FDA approval; c) use of the device in a motion sparing manner, without fusion was dangerous; and d) that the FDA approved the device only in connection with grafting for fusion to avoid neurological injury to patients.

152. On information and belief, Patient ABM's neurological injury was caused by Defendant's pattern of negligence and demonstrates incompetence in the practice of surgery by, *inter alia,* using the Danek Satellite in an unsafe and unapproved manner.

153. On information and belief, Defendant entered into an adverse settlement with Patient PGM in Tulsa County District Court Case No. CJ-2008-8990.

154. On information and belief, Defendant failed to disclose this settlement upon submitting his *Application for Renewal of Oklahoma License* in years subsequent to this settlement.

14. PATIENT KTM
(Competence/*Undisclosed* Adverse Settlement: Amputation)

155. On or about January 24, 2005, Patient KTM was T-Boned in a motor vehicle accident with an SUV, causing a mid-shaft right femur fracture and a right talus fracture and dislocation. (Consult Note, KTM 0181)

156. On January 25, 2005, Defendant performed open reduction of the right femur and closed reduction and attempted internal fixation of the talus fracture dislocation. (Op. Note, KTM 0253)

157. Over the next year, Patient KTM was treated by Defendant for ulcerations and infections.

158. On June 26, 2006, due to Defendant's failure to adequately treat the infection, Patient KTM required amputation of her right leg below the knee. (Op. Note, KTM 0427)

159. On information and belief, Defendant entered into an adverse settlement with Patient KTM in Tulsa County District Court Case No. CJ-2007-2935.

160. On information and belief, Defendant failed to disclose this settlement upon submitting his *Application for Renewal of Oklahoma License* in years subsequent to this settlement.

FRAUDULENT MEDICAL RECORDS/SURGICAL PROCEDURES

15. PATIENT DHM
(Fraudulent Op. Note/Procedure)

161. On or about March 6, 2009, Defendant performed surgery on Patient DHM. According to his Operative Report, he performed Lumbar Hemilaminectomies at L2-L3 and L3-L4 with decompression of the Dura and neural elements. Patient DHM continued to suffer problems with her back and sought treatment with David Fell, M.D.

162. Dr. Fell subsequently conducted surgery on Patient DHM and upon examining the previous surgery of Defendant, concluded that **Defendant did not operate on the L2-L3 level as represented in his Operative Report** and that the Patient still had herniated disc material at L2-L3. Dr. Fell additionally concluded that, although not reflected in Defendant's Operative Report, Defendant had operated at the L4-L5 level and that the nerve roots were damaged from

Defendant's previous surgery at the L4-L5 level. Dr. Fell concluded that Defendant operated at the wrong levels and damaged the nerve root, but did not disclose his mistake and additional surgery to the patient.

16. PATIENT PLM
(Fraudulent Op. Note/Procedure)

163. On or about September 12, 2007, Defendant performed surgery on Patient PLM. According to his Operative Report, he performed Lumbar Hemilaminectomies at L4-L5 and L5-S1 with medial facetectomies or foraminotomies at both levels on the right as well as the left though minimally undermining along the left side. The preoperative MRI obtained by Defendant identified the left side at L4-L5 as more severe than the right. The patient continued to suffer problems with her back and sought treatment with Frank Tomecek, M.D.

164. Dr. Tomecek subsequently performed surgery on Patient PLM and upon examining the previous surgery of Defendant, concluded that Defendant did not operate on the left at L4-L5 as represented in his Operative Report. Additionally, Dr. Tomecek found very little evidence the Defendant performed any surgery on L5-S1 on either side. Dr. Tomecek concluded that Defendant did not perform the surgeries as represented in his Operative Report and did not disclose this information to the patient.

17. PATIENT GMM
(Fraudulent Op. Note/Procedure)

165. On or about January 5, 2004, Defendant performed surgery on Patient GMM. According to his Operative Report, he performed Bilateral Hemilaminectomies with bilateral medial facetectomies and bilateral foraminotomies with discectomy at L3-L4 for complete decompression of the spinal cord and neural elements secondary to spinal stenosis. Defendant also represented in his Operative Report that he performed Bilateral Hemilaminectomies with bilateral medial facetectomies and bilateral foraminotomies at L4-L5 for complete decompression of the spinal cord and neural elements secondary to spinal stenosis. The patient continued to suffer problems with her back and sought treatment with Frank Tomecek, M.D.

166. Dr. Tomecek subsequently performed surgery on Patient GMM and upon examining the new MRI and the previous surgery of Defendant, concluded that Defendant performed **only** a hemilaminectomy and discectomy at L3-L4 on the left side, and that he did not perform the hemilaminectomy at L3-L4 on the right side, did not perform bilateral medial facetectomies at L3-L4, nor did he perform bilateral hemilaminectomies and bilateral medial facetectomies and foraminotomies at L4-L5. He additionally did not perform a discectomy at L4-L5 as represented in his Operative Report. Dr. Tomecek concluded that Defendant did not perform all of the surgeries noted in the Operative Report, and that the lack of decompression at L4-L5 and the decompression only on the left side at L3-L4 led to the patient's ongoing symptoms and need for a second operation.

18. PATIENT LSM
(Fraudulent Op. Note/Procedure)

167. On or about February 28, 2007, Defendant performed surgery on Patient LSM. According to the Operative Report, he performed Bilateral hemilaminectomies at L3-L4, with medial facetectomies and foraminotomies bilaterally at L3-L4 and L4-L5. The patient continued to suffer problems with his back and sought treatment with Frank Tomecek, M.D.

168. Dr. Tomecek subsequently performed surgery on Patient LSM and upon examining the new MRI, as well as the previous MRI and surgery by Defendant, concluded that Defendant performed only a minimal right L4 laminotomy, and that he did not perform surgery on the left side at L4-L5, nor did he perform any surgery at L3-L4 as represented in his Operative Report. Dr. Tomecek concluded that Defendant did not perform all of the surgeries noted in the Operative Report, and that his failure to do so necessitated a second surgery for Patient LSM.

19. PATIENT LPM
(Fraudulent Op. Note/Procedure)

169. On or about November 14, 2005, Defendant performed surgery on Patient LPM. According to the Operative Report, he performed Bilateral Laminectomies with bilateral medial facetectomies and bilateral foraminotomies at L3-L4 and L4-L5 for complete decompression of dura and neural elements. The patient continued to suffer problems with her back and sought treatment with Christopher Covington, M.D.

170. Dr. Covington subsequently performed surgery on Patient LPM and upon examining her spine during surgery as well as x-rays taken before surgery, concluded that Defendant performed only a minimal decompression on the left side at L4-L5 and on the right side at L4, and that he did not perform surgery on the right side at L4-L5, nor did he perform any surgery at L3-L4 as represented in his Operative Report. Dr. Covington concluded that Defendant did not perform all of the surgeries noted in the Operative Report, and that his failure to do so necessitated a second surgery for Patient LPM.

20. PATIENT POM
(Fraudulent Op. Note/Procedure)

171. On March 4, 2009, Defendant performed surgery on Patient POM. According to his Operative Note he performed the following procedures: "Unilateral lumbar hemilaminectomies with medial facetectomies and foraminotomies at L2-L3, L3-L4, and L4-L5 for decompression of dura and neural elements with use of operating room microscope. (Op. Note, POM 0267)

172. Due to Patient POM's continued symptoms, on January 3, 2011, Christopher Boxell, MD performed an open redo of the lumbar levels, as well as other procedures. As to the lumbar procedures he performed the following: a) L2 through L5 laminectomies and subarticular decompressions; b) bilateral fascetectomies at L2-3 and L5-S1; c) bilateral

diskectomies at L5-S1 and L2-3; d) pedicle wedge osteotomy at L3; and e) transforaminal lumbar interbody fusion at L5-S1 will allograft, cortico-cancellous bone grafts. (Op. Note, POM 059)

173. During the January 3, 2011, surgery Dr. Boxell dictated, "I would note that although the patient had undergone previous reported minimally invasive laminotomies with possible diskectomy, I was not able to identify any area where laminotomy had been previously performed and there was no evidence for prior diskectomy." (Op. Note, POM 059)

174. On information and belief, Defendant did not perform the procedures recorded in his operative note dated March 4, 2009.

21. PATIENT LWM
(Fraud/Negligence: Unnecessary Procedure/Surgery)

175. Patient LWM suffered intermittent low back pain and sought treatment from Defendant.

176. On September 6, 2005, Defendant saw Patient LWM after MRI and CT scans noting that, "I reviewed her MRI's as well as her CT myelogram and her x-rays and they showed no herniation or gross impingement." (Off. Note, LWM 031) Defendant ordered a diskogram.

177. On October 27, 2005, Patient LWM underwent diskogram with the only finding being, "There is globular extension of contrast into the middle third of the annulus fibrosis along the left anterolateral aspect and right posterior lateral aspect at L4-5, suggesting an element of mild degeneration." (CT Diskogram, LWM181-183; LWM 0275)

178. Defendant diagnosed Patient LWM with "L4-5 stenosis, instability, and radiculopathy." (H&P, LWM 0189)

179. On December 16, 2005, he performed a fusion at L4-5 with interbody cage device and posterior pedicle screw instrumentation with iliac crest bone graft. (Op. Note, LWM 0242)

180. On information and belief, the December 16, 2005, surgery was unnecessary, not medically indicated, and the recommendation for the surgery was either negligent or fraudulent.

22. PATIENT SBM
(Fraud/Gross Negligence: Nondisclosure/Misrepresentation of Surgical Error)

181. On January 29, 2009, Defendant ordered an MRI for Patient SBM, which showed, in pertinent part, "Moderate sized right paracentral disk extrusion C5-C6 with associated moderate central canal stenosis." (MRI, SBM 082)

182. On April 6, 2009, Defendant performed surgery on Patient SBM. According to Defendant's Operative Note he performed the following procedures: a) Cervical decompression with discectomies and bilateral foraminotomies and excision of posterior longitudinal ligament

and posterior vertebral body osteophytes at C5-C6 for complete decompression of dura and neural elements with use of operating room microscope; b) Anterior cervical ***interbody fusion using Synthes interbody cage device at C5-C6;*** c) Anterior cervical plating and instrumentation using Synthes instrumentation plating system at C5-C6; and d) right iliac crest bone marrow aspiration through separate incision, right iliac wing. (Op. Note, SBM 0323)

183. On May 10, 2011, Patient SBM returned to Defendant with, "Worsening left shoulder pain, arm pain, and burning from neck into left forearm in the C3-4 disc." (TSOI Note, SBM 0170) Defendant recited that his "PLAN" as follows:

> I have told him the risks of creating a bone sandwich with ***fusion at C3-4*** and ***fusion at C5-6*** [from April 6, 2009 surgery], leaving the intervening level. Despite these risks, I think this is probably the wisest thing to do, as he ***is really not symptomatic from the C4-5 disc at this time,*** but this area may give way or accelerate. It is impossible to really predict the future, but he certainly has a little bit of increased risk for the future. ***I would not want to fuse him, with him having basically a normal appearing disc at this time*** [at C4-5] just because it may give way in the future. He certainly understands my thoughts on this, as well as the various risks of the treatment plan. [Emphasis supplied] (TSIO Note, SBM 0171)

With this recitation Defendant writes, "Again, I have recommended ***C3-4 stabilization.*** We will ***watch C4-5 level."*** *Id.*

184. On May 25, 2011, Defendant operated on Patient SBM and *errantly fused the healthy disc at C4-C5.* (Op. Note, SBM 0226-0228; TSOI Note, SBM 0162)

185. On July 19, 2011, when Patient SBM returned to Defendant with increasing neck pain, Defendant failed to inform him of his error. Instead, he simply renamed C5-6 as C4-5, and then claimed to have done an *adjacent fusion* at C3-4, writing, as follows:

> CHIEF COMPLAINT: 1. Status post C4-5 fusion. 2. ***Status post adjacent level fusion at C3-C4.*** 3. Cervical anomaly with C2-3 autologous fusion and collapse. 4. Recent increasing neck pain. [Emphasis supplied] (TSOI Note, SBM 0162)

186. The "adjacent level" to the previous fusion at C5-6 was the healthy disc at C4-5. There was no plan for an "adjacent level fusion" but rather to skip a level to C3-4 and fuse there. (TSIO Note SBM 0171, *supra.*]

187. Defendant never fused C3-4, but continued to document fusion at this level even after reviewing radiography showing fusion adjacent to what Defendant knew to be his previous C5-6 fusion. (TSIO Note, SBM 0162, 0158)

188. On information and belief, Defendant's concealment of his errror prolonged the pain and potential neurological damage caused by the disc problem at C3-4, which Patient SBM believed had been resolved by surgery.

189. On information and belief, Defendant's failure to reveal the error was either willful fraud to avoid responsibility for the error, or gross negligence.

23. PATIENT WKM
(Fraudulent Op. Note/Procedure)

190. On or about December 19, 2011, Defendant performed surgery on Patient WKM. According to Defendant's Operative Note he performed the following procedures: Left side greater than right side partial hemilaminectomies with partial medial facetectomies and foraminotomies at L4-L5 and L5-S1 for decompression of dura and neural elements with use of operating room microscope. (Op. Note, WKM 038)

191. The December 19, 2011 Operative Note describes the procedure, in pertinent part, as follows:

> Through the operating microscope, ***left-sided partial hemilaminectomies with partial medial facetectomies and foraminotomies*** were carried out across ***L4-L5 and L5-S1.*** The stenosis was quite profound with hypertrophied ligamentum flavum and central canal foraminal stenosis. (Op. Note, WKM 038)

192. On March 27, 2012, Patient WKM presented to Clinton Baird, M.D., for continued lumbar radiculopathy. Upon reviewing the CT films, Dr. Baird determined, as follows:

> RADIOGRAPHIC STUDIES: I reviewed a CT scan of the lumbar spine, which is not adequate to full interpretation of his present complaints. It does, however, reveal a L4 hemilaminotomy and undercutting of the right-sided L4-5 medial facet and foramen. There is no foraminotomy on the left. There is no foraminotomy or laminotomy at the L5-S1 levels bilaterally. (OSBI Note, WKM 092)

193. On information and belief, Defendant did not perform the procedures recorded in his operative note dated December 19, 2011.

OVERBILLING OF MEDICARE

194. Beginning April 1, 2005 and continuing through May 15, 2006, Defendant performed surgeries at Hillcrest Medical Center in Tulsa, Oklahoma. Hillcrest is considered a "teaching hospital" under Medicare rules since it allows residents to complete rotations in its facility. According to Medicare rules, a physician may utilize and bill for the use of a physician

assistant who assists in surgery in non-teaching hospitals. However, in a teaching hospital, the physician may **not** bill for the physician assistant unless no qualified resident is available to assist in the surgery.

195. During this period of time, Defendant utilized physician assistants during his surgeries at Hillcrest and billed Medicare for their services even though residents were present and assisting in the surgeries. Defendant accomplished this by not mentioning the residents in his Operative Reports.

196. When the residents completed their rotations at Hillcrest and were asked to account for all surgeries where they had assisted, the residency program learned that when Defendant had billed Medicare, he had not documented that the residents had assisted him in surgeries. By not recognizing the presence of the residents, Defendant was able to wrongfully obtain reimbursement for the services of his physician assistant.

197. Upon learning that Medicare had been improperly billed for physician assistant services by Defendant, he agreed to reimburse Medicare for all overbillings in the total amount of $30,085.47.

198. Defendant is guilty of unprofessional conduct in that he:

a. Engaged in conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. §509(8) and OAC 435:10-7-4(11).

b. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509(13) and OAC 435:10-7-4(39).

c. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient in violation of 59 O.S. §509(18).

d. Engaged in gross or repeated negligence in the practice of medicine and surgery in violation of OAC 435:10-7-4(15).

e. Engaged in practice or other behavior that demonstrates an incapacity or incompetence to practice medicine and surgery in violation of OAC 435:10-7-4(18).

f. Used a false, fraudulent, or deceptive statement in any document connected with the practice of medicine and surgery in violation of OAC 435:10-7-4(19).

g. Obtained any fee by fraud, deceit, or misrepresentation, including fees from Medicare, Medicaid, or insurance in violation of OAC 435:10-7-4(28).

h. Directly or indirectly gave or received any fee, commission, rebate, or other compensation for professional services not actually and personally rendered in violation of OAC 435:10-7-4(30).

i. Abused the physician's position of trust by coercion, manipulation or fraudulent representation in the doctor-patient relationship in violation of OAC 435:10-7-4(44).

CONCLUSION

WHEREFORE, the Plaintiff respectfully requests that the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to Defendant's medical license, and an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

By: _____

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Attorneys for Plaintiff, State of Oklahoma

VERIFICATION

STATE OF OKLAHOMA)
) ss
COUNTY OF TULSA)

Daniel B. Graves, of lawful age, being first duly sworn upon his oath, deposes and states that that the foregoing pleading is true and correct to the best of his knowledge and belief.

By: _____
Daniel B.Graves

SUBSCRIBED AND SWORN to before me, the undersigned notary public, this 27th day of July, 2012.

_____
Notary Public

My Commission Expires: Sept. 15, 2015
Commission #: 11008481

Carrie M. Hennessee
Notary Public in and for
STATE OF OKLAHOMA
Commission # 11008481
Expires: Sept. 15, 2015

CERTIFICATE OF MAILING

This is to certify that on this 27th day of July, 2012, a true and correct copy of the above and foregoing writing was sent *via* U.S. Mail to the following by depositing the same with the proper U.S. Postal Service, postage prepaid:

Barry L. Smith, Esq.
Christina M. Vaughn, Esq.
McAfee & Taft
1717 S. Boulder Ave., Ste. 900
Tulsa, OK 74119

Daniel B. Graves